Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership Board

Date: Thursday, 27 June 2024

Time: 15:00

Format: Hybrid Meeting, Civic Space, 16 Church Street, Dumbarton G82 1QL

Contact: Lauren Simeon, Committee Officer
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Dear Member

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

Members will have the option to attend the meeting in person at the Civic Space, 16 Church Street, Dumbarton G82 1QL or remotely via Zoom Video Conference.

The business is shown on the attached agenda.

Yours faithfully

BETH CULSHAW

Chief Officer
Health and Social Care Partnership Board

Distribution:-

Voting Members

Michelle McGinty (Chair)
Rona Sweeney (Vice Chair)
Martin Rooney
Lesley Rousselet
Clare Steel
Michelle Wailes

Non-Voting Members

Barbara Barnes
Beth Culshaw
Shirley Furie
Lesley James
John Kerr
Helen Little
Diana McCrone
Anne MacDougall
Kim McNab
Saied Pourghazi
Selina Ross
Julie Slavin
David Smith
Val Tierney

Senior Management Team – Health and Social Care Partnership
Chief Executive – West Dunbartonshire Council

Date of Issue: 20 June 2024

Audio Streaming

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WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

AGENDA

THURSDAY, 27 JUNE 2024

1 STATEMENT BY CHAIR – AUDIO RECORDING

2 APOLOGIES

3 DECLARATIONS OF INTEREST

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

4 RECORDING OF VOTES

The Board is asked to agree that all votes taken during the meeting be carried out by roll call vote to ensure an accurate record.

5 (a) MINUTES OF PREVIOUS MEETING 7 - 16

Submit for approval, as a correct record, the Minutes of Meeting of the Health and Social Care Partnership Board held on 28 March 2024.

(b) ROLLING ACTION LIST 17 - 18

Submit for information the Rolling Action list for the Partnership Board.

6 VERBAL UPDATE FROM CHIEF OFFICER

Beth Culshaw, Chief Officer, will provide a verbal update on the recent business of the Health and Social Care Partnership.

7/

7 PRIMARY CARE STRATEGY 19 - 88

Submit report by Fiona Taylor, Head of Health and Community Care updating the HSCP Board on the development and implementation of the NHSGGC Primary Care Strategy, and sharing the Strategy and Implementation Plan for noting.

8 FINANCIAL PERFORMANCE UPDATE REPORT 89 - 146

Submit report by Julie Slavin, Chief Financial Officer, providing Members with the draft outturn position for the period 1 April 2023 to 31 March 2024.

9 A COMPREHENSIVE REVIEW OF LEARNING DISABILITY SERVICES 147 - 170

Submit report by Sylvia Chatfield, Head of Mental Health, Learning Disability and Addictions providing an update on the review of Learning Disability Services across West Dunbartonshire Health & Social Care Partnership and the engagement and consultation required with stakeholders to re-shape services in line with Scottish Government guidance.

10 NHS GGC DIRECTOR OF PUBLIC HEALTH REPORT WORKING TOGETHER TO STEM THE TIDE IN WEST DUNBARTONSHIRE 171 - 402

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, regarding the above.

11 NHS GREATER GLASGOW AND CLYDE HEALTH AND WELLBEING SURVEY 403 - 596

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, updating the HSCP Board following a review of NHS Greater Glasgow and Clyde's Health and Wellbeing West Dunbartonshire Report, to identify any emerging areas of concern that West Dunbartonshire HSCP Board requires to consider from a strategic planning perspective.

12 ANNUAL PERFORMANCE REPORT To Follow

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, regarding the above.

13/

13 HSCP DIGITAL STRATEGY 2024 – 2027 **597 - 644**

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, presenting the HSCP Digital Strategy 2024 – 2027, and the associated Delivery Plan and Equalities Impact Assessment to the West Dunbartonshire Health and Social Care Partnership Board.

14 CLINICAL AND CARE GOVERNANCE - ANNUAL REPORT 2023 **645 - 676**

Submit report by Val Tierney, Chief Nurse, describing the clinical and care governance oversight arrangements in West Dunbartonshire HSCP and the progress made in assuring and improving the quality of health and social care.

15 STRATEGIC RISK REGISTER **677 - 690**

Submit report by Margaret-Jane Cardno, Head of Strategy and Transformation, presenting the Strategic Risk Register to Members for approval.

16 MINUTES OF MEETING FOR NOTING **691 - 706**

Submit for noting the Approved Minutes of Joint Staff Forum (JSF) Meetings held on:-

(a) 7 March 2024; and

(b) 11 April 2024.

17 DATE OF NEXT MEETING

Members are asked to note the next meeting of West Dunbartonshire Health and Social Care Partnership Board will be held on Tuesday, 20 August 2024 at 2.00 p.m. as a Hybrid Meeting in the Civic Space, 16 Church Street, Dumbarton G82 1QL.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

At a Hybrid Meeting of the West Dunbartonshire Health and Social Care Partnership Board held in the Civic Space, 16 Church Street, Dumbarton on Thursday, 28 March 2024 at 2.03 p.m.

Present: Rona Sweeney, Lesley Rousselet and Michelle Wailes, NHS Greater Glasgow and Clyde; and Councillors Michelle McGinty, Martin Rooney and Clare Steel, West Dunbartonshire Council.

Non-Voting Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Barbara Barnes, Chair of the Locality Engagement Network – Alexandria and Dumbarton; Selina Ross, Chief Officer – West Dunbartonshire CVS; Helen Little, MSK Physiotherapy Manager; Kim McNab, Service Manager – Carers of West Dunbartonshire; Dr Saied Pourghazi, Associate Clinical Director and General Practitioner; and Val Tierney, Chief Nurse.

Attending: Alan Douglas, Chief Officer – Regulatory and Regeneration; Margaret-Jane Cardno, Head of Strategy and Transformation; Sylvia Chatfield, Head of Mental Health, Learning Disabilities and Addiction; Fiona Taylor, Head of Health and Community Care; Gillian Gall, Head of Human Resources; Lesley James, Head of Children's Health, Care and Criminal Justice and Chief Social Work Officer; Shirley Furie, Trade Union Representative; David Smith, Unpaid Carers Representative; Carol-Ann Burns, Senior Democratic Services Manager and Lynn Straker, Committee Officer.

Apologies: Apologies for absence were intimated on behalf of Anne MacDougall, Chair of the Locality Engagement Network – Clydebank and Diana McCrone, Staff Representative (NHS Greater Glasgow and Clyde)

Councillor Michelle McGinty in the Chair

STATEMENT BY CHAIR

Michelle McGinty, Chair, advised that the meeting was being audio streamed and broadcast live to the internet and would be available for playback.

DECLARATIONS OF INTEREST

Councillor Clare Steel noted her declaration of interest as she sits on the Board of the Carers Centre, she will not contribute to discussion and any decision making for Item 8 – 2024-2025 Annual Budget Setting Update and Item 9 – Local Carer Strategy 2024-2026 Improving Lives with Carers as detailed in the Agenda.

Councillor Martin Rooney noted a transparency statement in that his wife works within West Dunbartonshire Care at Home Service. The Care at Home Redesign project, although it is a major change to ways of working, applies on a much broader spectrum than the role of his wife and through legal advice, can advise that his current circumstances would not influence his decision making on this item, but wanted to clarify to Members and the public.

Councillor Michelle McGinty, Chair, noted a transparency statement in that her sister and her daughter both work within Crosslet House Care Home and although within the proposed Budget setting items there was a reduction in beds at Crosslet House Care Home, this would not affect the number of staff at the premises and as such, with appropriate legal advice, can note would not influence her decision making on this item, but wanted to clarify to Members and the public.

RECORDING OF VOTES

The Board agreed that all votes taken during the meeting would be carried out by roll call vote to ensure an accurate record.

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the Health and Social Care Partnership Board held on 20 February 2024 were submitted and approved as a correct record.

ROLLING ACTION LIST

The Rolling Action list for the Health and Social Care Partnership Board was submitted for information and relevant updates were noted and agreed.

VERBAL UPDATE FROM CHIEF OFFICER

Beth Culshaw, Chief Officer, provided a verbal update on the recent business of the Health and Social Care Partnership. She noted in recent weeks, the Partnership had been challenged with the scale of delayed discharges. There is a high number of patients being referred in from Mental Health and Acute Services and also due to a high level of staff sickness currently, which is affecting performance. The Senior Management team have been working together to face this challenge and work around to bring the figure down.

Over the last week, the partnership has currently had a net reduction of 12 delayed discharges so hopefully this will continue however it is worth noting the Easter Bank Holiday weekend brings another set of challenges.

Ms Culshaw noted the Budget setting report within the Agenda proposed a number of bed losses at the Crosslet House Care Home in Dumbarton however she was pleased to announce that due to a successful recruitment campaign, the outstanding 11 beds at Queens Quay Care Home in Clydebank would now be opened on 8 April 2024, bringing additional capacity to our number of beds in our local authority area.

Ms Culshaw advised since the last meeting of the HSCP Board, she had provided a separate brief to Members regarding the delivery of Home Care services, and indeed it was included as a substantive Agenda item at today's meeting for further discussion. She also advised they had received notification from GMB Trade Union of proposed planned industrial action and there was work ongoing to address this.

Ms Culshaw stated there were some key Agenda items which would be discussed at today's meeting which were pivotal to moving forward the work of the HSCP Board as a whole and the financial challenges which the partnership currently faces is front and centre of the Agenda today. Many of the savings proposed provide non-recurring savings for this year only, so it is also important to focus on our several redesign projects, some of which will be discussed at the meeting today, to maximise our financial longer-term stability.

Lastly, Ms Culshaw asked Members to note that budget setting was predicated on a number of packages for different client groups and we need to ensure that when our population has a requirement for any of our services, be it health or social care, that they have a clear pathway to access this. We must assess and deliver that need to the best suitability for the individual. Cost containment would be a key element to the partnerships approach to the budget this year, ensuring that budget management is the focus across all of our levels of service.

2023/24 FINANCIAL PERFORMANCE REPORT AS AT PERIOD 10 (31 JANUARY 2024)

A report was submitted by Julie Slavin, Chief Financial Officer, providing an update on the financial performance as at period 10 to 31 January 2024 and a projected outturn position to the 31 March 2024.

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

(1) to note the updated position in relation to budget movements on the 2023/24 allocation by West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board and approve the direction for 2023/24 back to our partners to deliver services to meet the HSCP Board's strategic priorities;

(2) to note the reported revenue position for the period 1 April 2023 to 31 January 2024 is reporting an adverse (overspend) position of £1.349m (0.82%);

(3) to note the projected outturn position of £1.607m overspend (0.80%) for 2023/24 including all planned transfers to/from earmarked reserves and the implementation of the recovery plan as approved at the November HSCP Board;

(4) to note the update on the monitoring of savings agreed for 2023/24;

(5) to note the current reserves balances;

(6) to note the update on the capital position and projected completion timelines; and

(7) to note that the progress to date on the budget planning process for 2024/25 to 2026/27 is detailed in a separate report within the agenda for this HSCP Board meeting.

Note: Councillor Clare Steel left the meeting after discussion of this report.

2024/25 BUDGET SETTING UPDATE (REVENUE ESTIMATES)

A report was submitted by Julie Slavin, Chief Financial Officer, setting out the financial allocations from West Dunbartonshire Council (WDC) and NHS Greater Glasgow and Clyde Health Board (NHSGGC), the main cost pressures and key financial risks for the HSCP Board in 2024/25 and to seek members' approval to set an indicative 2024/25 revenue budget.

Members first heard from Ms Kim McNab, Service Manager – Carers of West Dunbartonshire, in her deputation to the HSCP Board regarding the potential impact the proposed savings detailed within the report would have on Carers with West Dunbartonshire. Members then heard from Ms Gillian Kirkwood, Chief Executive – Y-Sort It provide her deputation and concern of the significant impact the proposed savings would have on their current work with the community. Lastly, Members heard from Ms Alison McCurley, Board Representative from Ben View, who noted again the significant impact the proposed cuts would have on the important work they do in the community.

ADJOURNMENT

Councillor Michelle McGinty, Chair, adjourned the meeting for a short recess. The meeting reconvened at 4.18 p.m. with the following voting members in attendance: Councillors Michelle McGinty, Martin Rooney and Clare Steel and Lesley Rousselet, Rona Sweeney and Michelle Wailes.

Councillor McGinty moved the following Motion which was unanimously agreed by Members:-

'The Board thanks the Chief Officer and all of her staff for all the work they have done over many months in bringing forward these proposals for a balanced budget for 2024/25.

The Board agrees the recommendations at 2.1 of the report as follows:

a) Accept the flat cash offer from West Dunbartonshire Council;
b) Accept the total 2024/25 allocation from WDC;
c) Approve the required increase to the Scottish Living Wage;
d) Note the analysis of the reserves position;
e) Accept the indicative 2024/25 budget allocation from NHS Greater Glasgow and Clyde Health Board;
f) Approve an overall indicative funding allocation to the Partnership;
g) Note the range of management adjustments;
j) Note that 2024/25 budget allocations for Housing Aids and Adaptations;
k) Note the update to the WDC's 10 Year Capital Plan;
l) Note that the updated Medium-Term Financial Plan; and
h) Approve:

- The 3 year smoothing of the pension value review of £3.700m, and
- The drawdown of a range of reserves to the value of £1.802m. All contained within Table 7.

In relation to the range of Health savings the Board agrees all the health savings totalling £96,000.

In terms of the Social Care savings, the Board, after hearing the concerns from the impacted groups, agrees the following:-

ST01: A 5% saving of **£20,000** rather than the proposed £40,000. In doing so it is noted that the Carers Centre has been proactive and have already decided to relocate to smaller premises saving of £13,000 in their running costs.

The net impact on the Carers of West Dunbartonshire would be a reduction of £7,000 out of a circa £500,000 budget.

ST02: A 5% saving of **£10,000** to be applied rather than the proposed £20,000.

This takes account of the fact that the HSCP has agreed a funding allocation for Y-Sort it over the coming years which means that its service will remain sustainable and with minimal impact on the organisation and the outcomes for young people.

We would encourage both organisations to put in applications to the new Cost Of Living Transitional Fund to ensure that there is no impact on the services they provide whilst discussion with the HSCP take place.

CH02 Agree the savings related to Crosslet House, noting that the overall number of care beds in West Dunbartonshire will be available as the bed capacity in Queens Quay would see a corresponding increase.

This makes best use of available resources, it addresses current and future demand, and there are no job losses as the staff posts to support the 14 beds at crosslet are already vacant positions.

BC01 In terms of the Reduction in Block Funded Contracts, these are agreed with the exception of the £62,000 of savings proposals for Ben View.

The service provides two HSCP Social Care Services, namely the Lunch Club and the Bathing service for eligible social care clients.

The HSCP will fully fund the current and future social care clients a framework model of care, rather than the current Block Funding model.

However, it is recognised that the removal of £62,000 from Ben View budget could put the charity into immediate hardship and they may not be able to maintain the vital social care elements that they do on behalf of the HSCP.

Therefore, the intention is to reduce that savings proposal from £62,000 down to **£31,000**, in order to give them time to redesign their services and to seek funding from other providers.

It is noted that West Dunbartonshire Council has agreed to provide additional support to Ben View and has encouraged them to work with Council officers so that they can submit funding applications to the Dumbarton Common Good Fund, the Cost of Living Fund, and to the newly established funds set up on 6 March 2024 by the Council Administration.

The effect of this is that even with the proposed £31,000 reduction, they will still be able to provide the same level of services over the next two years or so while they explore external funding opportunities.

The effect of the above measures means that the Social Care Savings reduce from £629,000 to £568,000, which would need to be covered from the range of reserves.

The Chief Financial Officer is requested to utilise £61,000 from a combination of the residual balance within the Carers earmarked reserve of **£30,000** and the remaining **£31,000** from the Unachieved Savings earmarked reserves to balance the 2024/25 budget.

If the organisations secure additional funding through the other available routes the application of reserves will be reconsidered accordingly.

Agree that if all options set out in (h) above are approved, this delivers a balanced budget of £199.602m for 2024/25 consisting of:

- Partners financial allocation of £197.512m
- Total application of reserves of £2.151m.’

Members also agreed to:-

(1) to accept the flat cash offer from West Dunbartonshire Council of the roll forward of the 2023/24 recurring base allocation of £84.995m and the full pass through of the allocated share of the £241.5m related to Scottish Living Wage and Free Personal and Nursing Care of £4.025m;

(2) to accept the total 2024/25 allocation from WDC based on (a) above and other minor adjustments of £88.947m;

(3) to approve the required increase to the Scottish Living Wage for adult commissioned services as per the letter in Appendix 1;

(4) to note the analysis of the reserves position and the projected balances as at 31 March 2024;

(5) to accept the indicative 2024/25 budget allocation from NHS Greater Glasgow and Clyde Health Board of £108.565m, subject to confirmation of the final month 12 recurring base (£108.381m), MDT funding (£0.184m) and indicative set aside budget of £40.596m;

(6) to approve an overall indicative funding allocation to the Partnership of £197.512m, excluding set aside for delegated health and social care services for 2024/25;

(7) to note the range of management adjustments to the value of £3.447m contained within Table 7;

(8) to approve:

- the range of savings options to the value of £0.725m;
- the 3 year smoothing of the pension value review of £3.700m; and
- the drawdown of a range of reserves to the value of £1.802m. All contained within Table 7.

(9) that if all options set out in (h) above are approved, this delivers a balanced budget of £199.602m for 2024/25 consisting of:

- Partners financial allocation of £197.512m; and
- Total application of reserves of £2.090m

(10) to note that 2024/25 budget allocations for Housing Aids and Adaptations of £0.100m and the Care of Gardens budget of £0.229m;

(11) to note the update to the WDC's 10 Year Capital Plan from 2024/25 to 2033/34; and

(12) to note that the updated Medium-Term Financial Plan covering 2024/25 to 2033/34 will be presented to the August HSCP Board.

LOCAL CARER STRATEGY: 2024-2026 IMPROVING LIVES WITH CARERS

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation, seeking approval for the Local Carers Strategy 2024-2026 "Improving Lives with Carers" and to update the Board on how the plan will be implemented.

After discussion and having heard the Head of Strategy and Transformation and the Head of Children's Health, Care and Justice and Chief Social Work Officer in further explanation and in answer to Members' questions, the Board agreed:-

(1) to approve "Improving Lives with Carers" the HSCP Local Carer Strategy;

(2) to approve the Delivery Plan which is the means of implementing the Local Carer Strategy; and

(3) to approve the use of financial resources as outlined in Table 2, Section 4 of the report.

Note: Councillor Clare Steel returned to the meeting after discussion of this report.

CHILDRENS HEALTH AND CARE SERVICES STRATEGY IMPROVING LIVES WITH CHILDREN AND YOUNG PEOPLE IN WEST DUNBARTONSHIRE

A report was submitted by Lesley James, Head of Children's Health, Care and Justice and Chief Social Work Officer, presenting the Children's Health and Care Services Strategy, "Improving Lives with Children and Young People in West Dunbartonshire, What Would It Take? 2024 – 2029" to the HSCP Board for its approval.

After discussion and having heard the Head of Children's Health, Care and Justice and Chief Social Work Officer in further explanation, the Board agreed:-

(1) to note the content of this report;

(2) to approve the Children's Health and Care Services Strategy "Improving Lives with Children and Young People in West Dunbartonshire, What Would It Take? 2024 - 2029";

(3) to approve the Medium-Term Financial Plan (MTFP) aligned to the strategy; and

(4) the MTFP will be subject to annual scrutiny and review by the HSCP Board.

CARE AT HOME REDESIGN UPDATE

A report was submitted by Fiona Taylor, Head of Health and Community Care, providing an update on the progress of the Care at Home redesign including the outcome of recent consultations which have informed the final proposal for implementation.

After discussion and having heard the Head of Community Health and Care in further explanation and in answer to Members' questions, the Board agreed:-

(1) to note the content of this report; and

(2) the following proposed changes which were being recommended as part of the consultation feedback, in order to deliver the review of Care at Home services.

RISK APPETITE STATEMENT

A report was submitted by Margaret-Jane Cardno, Head of Strategy and Transformation, seeking the agreement of the HSCP Board in respect of the amount of risk that the Partnership is prepared to accept, tolerate, or be exposed to at any point in time.

After discussion and having heard the Head of Strategy and Transformation in further explanation and in answer to Members' questions, the Board agreed:-

(1) the risk appetite statement as shown in Appendix 1; and

(2) that the risk appetite statement be reviewed annually, when the HSCP Boards strategic plan is reviewed, or more frequently if required.

REVIEW OF HSCP BOARD FINANCIAL REGULATIONS

A report was submitted by Julie Slavin, Chief Financial Officer, present for review and approval, amendments to the current Financial Regulations of the West Dunbartonshire Health and Social Care Partnership Board.

After discussion and having heard the Chief Financial Officer in further explanation and in answer to Members' questions, the Board agreed to approve the revised IJB Financial Regulations.

DATE OF NEXT MEETING

Members noted that the next meeting of West Dunbartonshire Health and Social Care Partnership Board would be held on Tuesday, 25 June 2024 at 3.00 p.m. as a Hybrid Meeting in the Civic Space, 16 Church Street, Dumbarton G82 1QL.

The meeting closed at 4.50 p.m.

WEST DUNBARTONSHIRE HSCP BOARD
ROLLING ACTION LIST

Agenda Item	Decision / Minuted Action	Responsible Officer	Timescale	Progress/ Update/ Outcome	Status
A REFRESH OF THE STRATEGY FOR MENTAL HEALTH SERVICES IN GREATER GLASGOW AND CLYDE 2023 – 2028	Cllr McGinty questioned the accessibility of the new specialised unit. Head of service to be contacted to find out from users how accessible they consider the unit to be.	Sylvia Chatfield	Information to be provided to members as soon as possible	Update: Sylvia Chatfield sought assurances with the Head of Service that pathways were in place to ensure accessibility to a wide range of patients to the new unit, and building on existing pathways and strengthening to ensure access is readily available in a timely and needs-appropriate way.	**Closed**
SCOTTISH GOVERNMENT FUNDING FOR CHILDREN AND YOUNG PEOPLE'S COMMUNITY MENTAL HEALTH SUPPORTS AND SERVICES	Briefing Note to be provided to all members detailing to work of the Planet Youth in west Dunbartonshire.	Lesley James	Information to be provided to members as soon as possible	Update: Brief provided to Members w/c 22/03/24 detailing the work of Planet Youth in West Dunbartonshire.	**Closed**

REVIEW OF INTEGRATION SCHEME	Rona Sweeney queried the reference to delegated services within the document. The Chief Officer to provide revised definitions of delegated services.	Beth Culshaw	Information to be provided to members as soon as possible		**Open**

WEST DUNBARTONSHIRE COUNCIL – HEALTH AND SOCIAL CARE BOARD

Report by Fiona Taylor, Head of Health & Community Care

27 June 2024

Subject: Primary Care Strategy

1. Purpose

1.1 The purpose of the report is to update the HSCP Board on the development and implementation of the NHSGGC Primary Care Strategy, and share the Strategy and Implementation plan for noting.

2. Recommendations

2.1 The Board is asked to:

a) Note the contents of this report and its appendices:

- Appendix 1: NHSGGC Primary Care Strategy 2024-29
- Appendix 2: NHSGGC Primary Care Strategy 2024-29 – Summary Implementation Plan
- Appendix 3: NHSGGC Primary Care Strategy 2024-29 – EQIA

b) Receive an annual update on delivery of the programme.

3. Background

3.1 This is NHSGGC's first Primary Care Strategy, which was approved by NHSGGC Board on 30 April 2024. It spans five years to 2029 and aligns to NHSGGC's Delivery Plan and long term transformation programme (*Moving Forward Together*), as well as West Dunbartonshire HSCP's Strategic Plan 2023-2026.

3.2 As the strategy applies to Greater Glasgow and Clyde there has been significant engagement with West Dunbartonshire and other HSCPs. The engagement with people accessing our services and with people providing them has driven Strategy development. Over two development phases, there were almost 2,000 contacts with patients/public partners and professionals, with engagement across both sectors broadly balanced.

3.3 Within West Dunbartonshire, input from local citizens and groups informed strategy development via a June 2023 Church Street event and local health centre pop up sessions. The Head of Primary Care engaged with both locality groups and the Primary Care Strategy Survey was shared through West Dunbartonshire's engagement network. Professional leads and HSCP representatives were directly involved in Primary Care Strategy events relating to their specific areas of expertise.

3.4 Priorities and wider areas for development were identified and agreed with the Primary Care Programme Board Strategic Group, whose membership includes independent contractor and provider member bodies (e.g. Local Medical Committee (LMC) and GP Sub Committee) and representatives from NHSGGC Area Partnership Forum (APF).

4. Main Issues

Key strategic risks to the success of the Strategy are set out below:

4.1 Achieving the strategy's ambitions will require meaningful collaboration across NHSGGC/HSCP and independent contractor workforces.

4.2 A continued increase and/or large swings in prescribing costs and accompanying impacts of same on primary care budgets could lead to additional funding pressure on HSCP budgets.

4.3 Insufficient funding, system resource/capacity and delayed confirmation of budgets significantly restrict the ability to effectively plan and deliver, including limited availability of good quality primary care data and analytical capacity.

4.4 Increases in demand and levels of poor health create significant pressures with the potential to impact on primary care's ability to deliver effectively.

4.5 Recruitment and retention difficulties across most staff groups.

4.6 Sufficient pace of digital transformation across primary care e.g. e-prescribing.

4.7 Managing public expectations and securing their support to change primary care responses to need.

4.8 Lack of appropriate accommodation to facilitate the expansion of multi-disciplinary working and/or locally available care.

NHSGGC Primary Care Strategy scope and focus

4.9 The attached Primary Care Strategy (PCS/'the Strategy') 2024-2029 sets out NHSGGC's strategic ambitions for primary care over the next five years, alongside a high level work plan, which (once approved) will support West Dunbartonshire HSCP's Strategic Delivery Plan 2023-26.

4.10 The Strategy defines primary care as all those services and staff working within the four independent contractor settings (dentistry, general practice, optometry, and pharmacy) as well as a range of NHSGGC / HSCP provided services. Together, these include:

- Advanced Practitioner Physiotherapists
- Dental and Oral Health, including Dental Out of Hours
- Chronic Disease Management
- Community Optometry

- Community Pharmacy; Pharmacotherapy Service (Practice based and Hub models)
- Community Treatment and Care
- General practice and GP Out of Hours including Urgent care (Advanced Practitioners)
- Community Link Workers (social prescribing)
- Mental Health in Primary Care
- Pharmacy Service
- Vaccination

4.11 The Strategy sets out a vision for a sustainable primary care at the heart of the health system. People who need care will be more informed and empowered, will access the right professional at the right time, and will remain at or near home whenever possible. Multi-disciplinary teams will deliver care in communities and be involved in the strategic planning of our services.

4.12 Long term primary care outcomes are aligned to NHSGGC's transformation programme Moving Forward Together, and the associated transfer of the balance of care, based on a tiered model of provision.

4.13 The long term outcomes for primary care are as follows:
- We are more informed and empowered when using primary care
- Our primary care services better contribute to improving population health
- Our experience as patients in primary care is enhanced
- Our primary care workforce is expanded, more integrated and co-ordinated with community and secondary care
- Our primary care infrastructure – physical and digital – is improved
- Primary care better addresses health inequalities.

4.14 The Strategy sets out the operating context of primary care in NHSGGC and its HSCPs, including key challenges and risks to success. The ambition is that Strategy delivery will enable, in the short term:
- A sustainable workforce that is sufficiently staffed and skilled, and shares a common purpose;
- A step-change in data and digital technology innovations to improve patient health and care outcomes;
- Integrated care and well-connected services, supported by effective teams, improved system-wide working, leadership and planning; and
- Patients to have an improved understanding of available services and a better ability to navigate between primary care services.

4.15 In the medium to long term, the Strategy aims to enable:
- People to access the right service at right time, more flexibly and in ways that suit them
- Strengthened prevention, early intervention and wellness
- Better access to trusted information on health and care
- Strengthened contribution to reducing health inequalities.

4.16 The Strategy has been developed following wide consultation with strategic and operational health and care staff in NHSGGC, as well as with members of

the public, and this has enabled its ambitions and priorities to be collaboratively defined, validated and refined.

5. Options Appraisal

5.1 Not applicable.

6. People Implications

6.1 There are staffing implications in terms of future workforce planning, composition and enhancement that will be further defined as the Primary Care Workforce Strategy is developed in 2024-25. Such changes will be identified and managed in partnership with NHS Staff Side Partnership representatives and professional bodies, and in accordance with Health and Care (Staffing) (Scotland) Act 2019 and organisational change policies.

7. Financial and Procurement Implications

7.1 The Strategy sets out the funding arrangements for primary care services in NHSGGC. Supporting delivery, as set out in the summary implementation plan, will be delivered within the agreed financial allocations which for contractor group are set nationally.

8. Risk Analysis

8.1 The NHS GGC Primary Strategy sets out the future role of primary care as the centre of our health and care, building on current provision with care at or close to home wherever possible and clinically appropriate, and supporting wider transformational change in NHSGGC. An initial risk register has been developed and will be updated following Board approval of the Strategy plus summary implementation plan and onward programme progress.

9. Equalities Impact Assessment (EIA)

9.1 The Strategy sets out dedicated action to improve equity and reduce inequalities in the design and delivery of primary care services, as well as targeted action in each of the Strategy priorities and wider areas for development (pages 42-43).

An equality impact assessment (EQIA) has been completed on the Strategy. This can be found at appendix C and will be finalised on approval of the Strategy by NHSGGC Board. It commits to continued patient engagement, incorporation and review of equalities learning in implementation, aligned to our Public Sector Equality Duties, 2010 (Scottish Government, 2016).

10. Environmental Sustainability

10.1 Health and social care services are required to be responsive to individuals' presenting needs and consider the long-term socio and environmental impacts.

10.2 Strategy implementation will prioritise action in key areas with greatest impact on primary care sustainability, working to improve and innovate to increase capacity and efficiency. Wider areas for development will progress at a scale in line with available resource.

11. Consultation

11.1 Within West Dunbartonshire there has been engagement with the Chief Officer, Strategic Planning Groups, NHS Staff Side Partnership representatives, senior clinicians, managers and practitioners in health and social care, as well as with members of the public. Staff groups and contractor representatives have been routinely consulted and briefed on the strategy, including its key priorities.

12. Strategic Assessment

12.1 Transforming primary care services is a vital element of the IJB's strategy, given that a significant volume of patient contacts take place within primary and community care each year. Estimates suggest that up to 90% of health care episodes start and finish in primary and community care.

The Primary Care Strategy is relevant to all partnership priorities set out in West Dunbartonshire HSCP's Strategic plan 2023-2026, particularly:

Strategic Outcome	Priority
Caring Communities	• whole pathway reviews ensuring coordination and equity of access
Sustainable Communities	• work with people to maintain their independence at home and in their local community • focus on reablement • best use of technology enabled care
Equal Communities	• support people to overcome the impact of the wider determinants of health • ensure equality is mainstreamed across our services
Healthy Communities	• address the preventable risk factors for poor physical and mental health including: obesity; smoking; the use of alcohol and drugs

12.2 The Primary Care Strategy will also contribute to four of West Dunbartonshire HSCP's five Strategic Enablers, i.e. workforce; technology; partnerships and infrastructure.

13. Directions

13.1 No Directions are required.

Name: Fiona Taylor

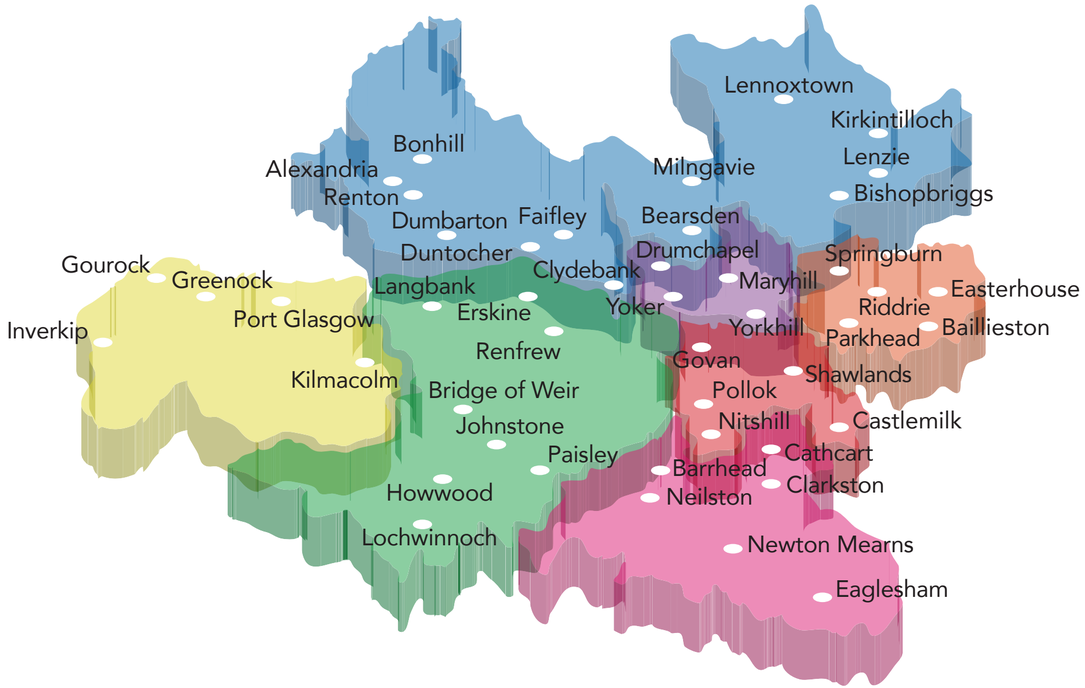
Designation: Head of Health & Community Care

Date:	30 May 2024

Person to Contact:	Ann Forsyth/Sarah McCullough
Appendices:	1. Appendix 1: NHSGGC Primary Care Strategy 2024-29 2. Appendix 2: NHSGGC Primary Care Strategy 2024-29 – Summary Implementation Plan 3. Appendix 3: NHSGGC Primary Care Strategy 2024-29 - EQIA
Background Papers:	None

Primary Care Strategy 2024 - 2029

NHS Greater Glasgow and Clyde



Foreword

We are pleased to set out primary care's shared contribution to the health and wellbeing of people in NHS Greater Glasgow and Clyde (NHSGGC) over the next five years.

For the first time, primary care services in NHSGGC have come together to define shared ambitions and make a joint strategic commitment to achieve them.

We have developed this strategy collaboratively, bringing together representatives from the full range of primary care services to grow our shared vision and purpose. We have also engaged with the wider network of health and social care, community and specialist services to incorporate their perspectives around the best improvements to make. Perhaps most importantly, we have spoken with a substantial number and range of patients to understand what is most important in a 'good' primary care.

The Strategy launches at a time of significant challenge, which is a fundamental driver for combined action to sustain and improve our impact. Focussing on our shared opportunities to improve will allow us to make best use of available resource and real advances across our services.

Our vision is of a sustainable primary care, at the heart of the health system. People who need care will be more informed and empowered, able to access the right professional at the right time, and remain at or near home where possible. Multi-disciplinary teams will deliver care in communities and be involved in the strategic planning of our services.

We commit to improving patient care, our workforce, and our system of care. We will work together to ensure that we improve services, with patients at the centre. Realising our ambitions in the current context requires a sharp focus on where we can best bring benefit. We will do this through a whole system approach across primary care, plus collaboration with the wider system, data and evidence-informed approaches, and national advocacy. This approach will ensure that our strategic ambitions align with broader NHSGGC transformational change.

We would like to thank everyone for their support and contributions through the process.

Jane Grant
Chief Executive, NHSGGC

Contents

Executive Summary

Primary care is the first point of contact in the healthcare system – a front door to the wider NHS. It is critical to our health and wellbeing and to sustaining wider health and care resilience by intervening early to protect health and prevent ill-health, as far as possible.

Our five year strategy for primary care sets out our long term vision and approach to primary care transformation in NHS Greater Glasgow and Clyde (NHSGGC).

Our priorities and areas for action are set within a strategic framework that builds on the significant work already underway to improve our communities' health and wellbeing.

We know that the pandemic changed the conditions that we operate within. It rapidly accelerated how services are planned and delivered and opened up new ways for people to access them. As our population needs grow, primary care must evolve to be able to continue to respond. We need to do this in a way that makes best use of current resource and aligns well with wider system change.

This Strategy provides a high-level overview of our contribution, the context that we operate within, and the changes we want to make. It also defines our contribution to plans for wider system transformation across all-NHSGGC.

This Strategy is an opportunity for all of primary care to take a whole system approach to transformation, through new ways of working and by scaling up good practice.

Our ambition is that, by 2029, we will enable:

In the short term:

1. A sustainable workforce that is sufficiently staffed and skilled, and shares a common purpose;
2. A step-change in data and digital technology innovations to improve patient health and care outcomes;
3. Integrated care and well-connected services, supported by effective teams, improved system-wide working, leadership and planning; and
4. Patients to have an improved understanding of available services and a better ability to navigate between primary care services.

In the medium to long term:

5. People to access the right service at right time, more flexibly and in ways that suit them;
6. Strengthened prevention, early intervention and wellness;
7. Better access to trusted information on health and care; and
8. Strengthened contribution to reducing health inequalities.

Scope of the Strategy

We use the term 'primary care' to describe those services that people often use as the first NHS point of contact for their health needs. These are usually provided by general practice, pharmacy, dentistry, optometry (the four main independent contractor and practitioner groups) in our local communities.

Primary care also includes a range of professionals working in wider multi-disciplinary teams e.g., community link workers, pharmacy professionals, allied health professionals e.g. physiotherapists, occupational therapists, dieticians, podiatrists, advance nurse practitioners (ANPs), health support workers, practice managers, care co-ordinators, and social prescribers.

We describe a whole system approach being taken by all our primary care services and workforce working together, as set out above. We also want to work with the wider health and care system – that is, specialist and hospital services, as well as social care and third sector partners.

How we will deliver

Implementation of the Strategy will be directed and overseen by NHSGGC Primary Care Programme Board whose members include all primary care sectors and leads, as well as professional representatives for all independent contractor and provider bodies.

Progress with implementation will be reported primarily to the NHSGGC Corporate Management Team and HSCP Chief Officers, which will ensure that delivery of the Strategy aligns with wider NHSGGC strategic change and HSCP Strategic Plans.

We will set out our work to deliver the Strategy in a five-year implementation plan, which will include key areas of delivery: what will be done, when, and how we will know we have been successful.

It will also set out arrangements to progress wider primary care commitments from existing NHSGGC strategies. We will refresh this annually to ensure it remains up to date.

We will undertake regular monitoring and evaluation of our work to deliver the Strategy to ensure that we can understand and improve the impact of our work. That will focus on the positive results for our patients, as well as to our workforce and healthcare system. Learning will shape future service planning and delivery, including our next strategy for primary care.

Introduction

This Strategy sets out how we will maximise our contribution to the health and wellbeing of the people of NHSGGC, through collaborative action. It is for everyone in NHSGGC: people who need primary care services and those who are working in primary care. Our Strategy launches at a time of significant strategic and operational challenge. Ensuring we continue our crucial work is the first and fundamental focus of this Strategy.

Primary Care is understood to support the majority of all healthcare contacts across NHSGGC, undertaking a wide diversity of treatment and support through dentistry, general practice, optometry, pharmacy, and services provided by Health and Social Care Partnerships.

As a very broad guide during 2022/23, approximately 83% of all NHSGGC activity took place in general practice, dentistry, optometry, and community pharmacy services alone (see Appendix 2). Our services are delivered by Health and Social Care Partnership (HSCP) and Health Board employees, as well as by independent contractors and providers and their employees within dentistry, general practice, optometry and pharmacy, plus commissioned services. Primary care is generally accessible close to home, in local communities and HSCP areas.

Figure 1: NHSGGC Primary care services

The following sections set out our vision for future primary care and the outcomes we want to achieve - for patients, our workforce, and our health and care services. We describe key aspects of the context that we operate within, and our current contribution, and then set out our areas for action.

Our vision and outcomes

As we launch our first primary care strategy for NHSGGC, we want to maintain our ambition while appreciating the constraints that we work within. In doing so we aim to maximise our contribution to protecting and improving health, and to the success of all our health and care.

Our future primary care

Our vision is of a sustainable primary care, at the heart of the health system. People who need care will be more informed and empowered, will access the right professional at the right time, and will remain at or near home whenever possible. Multi-disciplinary teams (MDTs) will deliver care in communities and be involved in the strategic planning of our services.

Primary and community care services are core to the success of this vision, and we recognise that we will need to grow our resource to support the increased demand and volume of care.

We want to see a sustainable primary care at the centre of our healthcare system. This means a tiered model of care available to everyone, with different levels of advice, treatment and support tailored to what we need. It means a model responsive to changing levels of demand and resource, designed and resourced to deliver on our goals, and with people at the centre of all that we do. This will increase locally available care, with the best professional to provide it. More direct access to MDTs will reduce the need for routing through general practice, and free up GP and other professionals' time for patients needing their specific expertise.

In the long term, we aim to continue and expand local care, with less dependency on hospital treatment.

The tiers can be visualised as follows:

Figure 2: Tiered model of healthcare (NHSGGC, 2019: 75)

These tiers of care range from:

- good advice that helps us look after our health daily to the best of our ability - ('supported self-management'); to
- the first point of contact for health needs (primary, community services); to
- wider supports and specialist outreach teams - all close to home (specialist community and acute outreach); to
- more specialised care delivered in dedicated centres, where the complexity or seriousness of our health concerns demand it (hospital care).

The outcomes we want to achieve

Figure 2 sets out our primary care outcomes in NHSGGC. These include improvements to our patients' health and wellbeing, to our workforce, and across our primary care system. We want to better contribute to population health, and to action on health inequalities. We want to support patients to be more confident and knowledgeable when using primary care, and to have a better experience in the process. People will be able to access the right professional when they need it, at home or as near to home as possible. MDTs will become increasingly important in the delivery of local care in our communities, and be involved, alongside patients and partners, in the strategic planning of our services.

Primary Care Outcomes

We are more informed and empowered when using primary care	Our primary care services better contribute to improving population health	Our experience as patients in primary care is enhanced
Our primary care workforce is expanded, more integrated and co-ordinated with community and secondary care	Our primary care infrastructure – physical and digital – is improved	Primary care better addresses health inequalities

Figure 3: NHSGGC primary care outcomes

These outcomes will support NHSGGC's strategic aims of better health and better care. Shared action will support local HSCP strategic plans, which align to NHSGGC's ambitions and cover all health and social care activities.

We have set out our aims in the context of significant wider transformational change, as set out in NHSGGC's Moving Forward Together (MFT) programme, which aspires to modernise all NHS care and spans the next 20-30 years.

Our three horizons

The following model sets out the changes that we aim to achieve in the short, medium and long term. These reflect our early attention to putting in place long term plans to improve key enablers, such as our workforce and estate. The changes that we expect to see in the medium term, and their longer term impacts are also described.

We will undertake a range of activities to achieve our ambitions and these are summarised below. Perhaps the most crucial of these is whole system action across primary care.

The complexities of primary care arrangements mean that we need to collaborate with and across independent contractor and provider groups, through local and national negotiation. We recognise that we must deliver together to achieve our aims.

We will develop this model further throughout Strategy delivery. It will inform our onward approach to monitoring and evaluating the impact of our actions.

The actions in this Strategy align with and compliment the global ambitions of MFT, which include:

Our action across primary care will also support our national ambitions, as set out in our national health and wellbeing outcomes (Scottish Government, online).

Our model for change

INPUTS	ACTIVITIES	OUTPUTS	SHORT (1 Year)	MEDIUM (2-4 Years)		LONG (5 Years and beyond)		IMPACT
Primary Care Programme Board (PCPB)	Strategy design and delivery	5 year Workforce and Estates Strategies	Strategies are in place to optimise our enablers	Improved access to pt records, health information & care	Improved self management	Primary care delivers a model that builds on people's expertise and draws on the resources available to support them in their local communities	We are more informed and empowered when using primary care	Positive health impacts of primary care are sustained and maximised
Collaboration, leadership, system working and planning	Develop a shared care record	Shared care record accessible to all primary care			Improved access to the right advice, from the right professional, at the right time		Our experience as patients in primary care is enhanced	
Funding	Patient pathway review and development	Guidance on new patient pathways		More adaptable estate	Enhanced journeys into and through PC	Improved knowledge, skills and awareness (patients and workforce)	Our primary care services better contribute to improving population health	
Workstream delivery groups	System and process improvements	Process and system improvements	Increased understanding of local health needs through data	Patients are more informed and empowered	Increased workforce access to resource necessary to holistic, person-centred care (IT/ Digital/clinical/ wider)	Prevention is strengthened across primary care	Primary care better addresses health inequalities	
Infrastructure – digital and estate	Communications and engagement plan design and delivery	Enhanced accommodation				Increased general practice capacity		
Strategy, data and evidence	Consultation and engagement with professionals and patients	Communications and engagement plan		Improved pt & professional awareness of services/supports	Resources are more targeted at those who need them most	Improved leadership, culture and practice	Our primary care infrastructure, physical and digital, is improved	
Patient and Public Involvement	Quality improvement	Communications campaign		Multidisciplinary teams, partners & patients better involved in planning and delivery of services	Patients receive care at or near home wherever possible	Strengthened PC contribution to reducing health inequalities	Our primary care workforce is expanded, more integrated, and coordinated with community and secondary care	
Workforce (independent and GGC/HSCP)	Partnership working	Patient information				Reduced unnecessary use of urgent and secondary care		
	Monitoring and evaluation	Professional toolkits						
		Governance reporting						

Better and more sustainable primary care, through improvements for patients, workforce and system

External factors (political, economic, social, technological) may impact on success:
e.g. New government; collaboration; cost of living; social determinants; national delivery in key areas such as e-prescribing or estates

Current State

My health & wellbeing

I usually go to my GP first for help with my health and wellbeing

Sign-posting & communication

I don't know what supports are available to me or how to access them

Easier access

I often have to travel to appointments near or further from home

I sometimes struggle to get an appointment and wait what feels like a long time

Digitally enabled care

My health professionals don't always have the information they need to provide my care

Better care quality, experience and outcomes

I sometimes see a lot of specialists before speaking to the right service

Future State

My health & wellbeing

I know how to access a range of local primary care services directly

Sign-posting & communication

I can access the information I need to look after my health with confidence and as well as possible

Easier access

I can receive care closer to home wherever possible, virtually or in-person if I choose

I can make appointments more easily

Digitally enabled care

My care is better informed and coordinated and I don't have to repeat my health concerns

Better care quality, experience and outcomes

I receive the right care, at the right place, at the right time

Figure 4 - Current and Future Pathways

Future patient experience

Figure 3 illustrates the future patient pathways and experience that we will work to achieve in the Strategy life course. These will involve being better able to manage our own health and care on a day to day basis, and to access care and support when needed. Many of the service developments will be guided by nationally-defined contract terms and resources. Figure 3 sets out our aspirations for the future patient experience, with the exact model being defined in line with the emerging national advice about our scope for change, e.g. through contract negotiations with independent contractors and providers.

These improvements will support longer term healthcare transformation over the next 20 to 30 years, our third horizon.

The MFT Primary and Community Care Target Operating Model (TOM) and supporting framework for implementation set out that vision.

Our context and contribution

Population health

NHS Greater Glasgow and Clyde serves some 1.3 million registered patients, around 25% of Scotland's population. It is the largest health board in the United Kingdom.

Thirty-four percent of our residents live in the 20% most deprived Scottish neighbourhoods and have significantly worse health outcomes, living shorter lives and suffering ill health for longer. A minority of people therefore need the most care, support and treatment to stay as well and independent as possible, for as long as possible.

Current and projected demographic change will increase the level and diversity of demand on services, property and premises.

Looking ahead, national forecasts predict more than 20% increases to the burden of disease in the next twenty years, despite a reducing population. Improvements to our healthy life expectancy have slowed and recently started to reverse. Joint with NHS Lanarkshire, improvements to life expectancy in NHSGGC are projected to be lowest in Scotland, an increase of just 0.2 years to 79.6 for women and 74.8 for men (National Records of Scotland, 2023). Infectious diseases, such as Covid-19 and influenza, will continue to be challenges for our health and care, including our ability to treat them effectively. We face real pressures to recover quickly from the pandemic, because of the high numbers of people waiting for care and presenting to us later, or with more complex concerns. Efforts to improve health are undermined by the current economic conditions, and these disproportionately disadvantage those of us with least power, money and resource (Walsh et al, 2022). We have also seen greater population diversity through our welcoming of asylum seekers, refugees, and displaced persons from war torn countries. These factors translate to greater and new asks of primary care.

We know that these changes can also create barriers to accessing care, and we have heard patients' frustrations around how quickly appointments can be arranged in primary care and more specialist services. Expectations have been heightened at a time when demand is greater than our available capacity. Primary care continues to support people prior to specialist appointments, while these services also work to recover their usual delivery. This means more frequent, ongoing and more complex patient support in primary care before people reach secondary care. More patients need help to **wait well** and for longer than before the pandemic (NHS Inform, online).

The following sections set out our contribution to health and wellbeing, our operating context and our ambitions for improvement.

Our contribution to health and wellbeing

NHS Greater Glasgow and Clyde's primary care has a significant role in protecting and improving our health. It prevents ill-health by supporting behaviour change, reducing health-harming activities, and encouraging healthy behaviours. It identifies disease as early as possible, supports us to manage our health as well as possible, and enables support with social stressors and specialist treatment. Continuing to grow our capacity in these areas will support people to stay well for longer, and our strategic focus on reducing reliance on hospital care.

Experimental data suggest that in an average month, we undertake around 540,000 patient encounters in general practice, more than 70,000 dental examinations, over 37,000 eye examinations and 116,690 Pharmacy First patient contacts (see Appendix 2).

Local access to health and care has already increased significantly. Newly rolled out community hubs for Pharmacotherapy, Vaccination and Community Treatment and Care (CTAC) now cover 80-100% of our GP practices. Our mental health and wellbeing services now cover 86% of GP practices. We continue to work to increase patient access to help with social stressors via Community Link Workers, with 73% of all GP practices having access to the service in 2022/23, although with reducing coverage for some. These improvements have been achieved through Primary Care Improvement Plan (PCIP) investment in general practice, and through rapid workforce development, including the growth of new roles e.g. Pharmacy support staff, Health Care Support Workers (HCSWs) and Advance Practitioners in primary care.

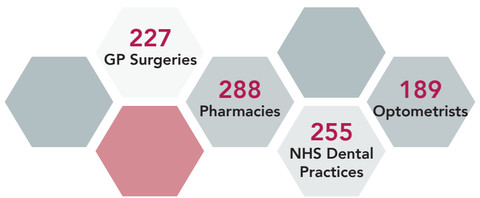
We continue to develop the 'first port of call' initiative across primary care, where patients can attend directly without needing to see a GP. Direct access is increasing for local pharmacies, opticians and dentists for advice, support and treatment. The new community glaucoma service, introduced in 2023, enables people with low risk glaucoma to be seen locally by accredited optometrists. This makes patient care more timely and efficient, and reduces the need for appointments in secondary care. Community pharmacy continues to extend access to clinical advice on common health conditions through Pharmacy First, without the need for an appointment. This creates capacity in general practice for more specialist patient care.

Primary care delivers a substantial and growing contribution to chronic disease management. We support people with long term conditions to have the best possible health and wellbeing for as long as possible. This includes living at home or in a homely setting, and often aided by prescriptions. Realistic Medicine means patient-centred care is based on shared decision making, and people can make treatment choices that take account of their individual needs and circumstances and better manage risk.

Urgent and unscheduled care enables patients with time sensitive issues to be triaged by pharmacy and general practice, and often have their needs addressed on the day. Triage and signposting systems enable patients to be directly supported or reviewed by an appropriate health professional in practice MDTs without first needing to see a GP. This enables patients to see the right health professional more quickly, and also creates capacity for GPs to focus on more complex medical presentations. Through continued strengthening of links between primary and secondary care, patients are signposted or referred directly to the right service and specialism when needed. This ensures the best possible outcomes and experiences and effective patient flow, including reduced time in hospital.

In NHSGGC, we offer in the region of 1,000 'front doors' to the NHS, where people can present for healthcare treatment and support

This translates as:



Case study - Improving the primary-secondary care interface to help people get home sooner

Delays at the point of hospital discharge are often caused by the need for patients to wait for their medications to be dispensed. A recent quality improvement project in NHSGGC looked at whether the discharge process could be improved for patients and services by using community pharmacy staff and medicines, rather than those in the hospital. Evaluation showed that the new community pharmacy model resulted in a median time saving of 142 minutes per patient. Researchers concluded that this model has the potential to deliver transformational change in patient flow, and to free up hospital pharmacy staff capacity for other clinical interventions, if delivered more widely.

General Practice Out of Hours (OOH) provides people with urgent advice and treatment during evenings and weekends, when they are referred to the service by NHS24. Staff undertake telephone/video consultations and home visits with patients, and support access to hospital care where necessary. The service is delivered by both employed and sessional staff. Dental Out of Hours' patients are referred in after triage by NHS24 and the service is staffed on a sessional basis. Both Out of Hours services support patients to receive the right care at or close to home, as far as possible. This means that fewer people need to go to secondary care, which increases hospitals' capacity to focus on patients with greater clinical need.

Together, these areas contribute significantly to NHSGGC's Corporate Objectives of improving our health and our care, and using our resource to the best possible value. We work to support people to get the care they need locally, and hospitals' capacity to be optimised.

Our resources

Our people

Our workforce is diverse, and a significant proportion is made up of independent contractors and providers which employ their own staff. Together they deliver services in general practice, community optometry, dental and pharmacy. Given the independence of this part of our workforce, health boards hold limited information about its totality, meaning that we are currently unable to definitively measure and profile the sector. National activity continues to improve workforce data.

We are proud to have achieved real improvements to primary care provision in the last 5 years.

We have increased coordination of PCIP delivery across HSCPs, and developed a new general practice MDT workforce with more diverse mix of professionals and skills. This workforce has increased the provision of direct treatment and care, removing the need for patients to first see a GP, and has grown to include an additional 750 whole time equivalent (WTE) staff. Roles include nursing, pharmacy staff, physiotherapy and community link worker (CLW) staff. In the GP Out of Hours' service, we have promoted the role of employed (rather than sessional) GPs. Looking ahead, we will further extend our MDTs to include advance practitioners as well as a continually expanding skillset. These changes will support all our professionals to work to the top of their license, and increase GPs' capacity to focus on complex medical care adding system capacity to provide suitable care, on a 24/7 basis.

Consistent with the national trend, it is a challenge to attract, retain and grow an appropriately skilled workforce. This is made more difficult by the large proportion of our workforce not directly employed, whose terms are decided within their own practices. Our independent provider workforce is also reducing, which creates additional pressure on our ability to provide enough care. We have recently seen a decrease in the number of general practice surgeries due to mergers, and an increase in dental providers delivering private care.

Within services directly delivered by NHSGGC/HSCPs, our recruitment and retention requirements remain significant, with pressure on a range of sectors and professions where demand is high.

Our systems, digital and data resources

Given the independent nature of current primary care provision, our services use a range of IT systems. Many are individual to particular services and hold service specific patient health information. All general practice and relevant community pharmacy, optometrists and dentist have access to the NHSGGC digital health record. General practice have a comprehensive clinical record, and other contractors have read-only access to a summary of this, via the digital health record.

This means that primary care professionals' ability to read and update full health records is variable, and the lack of communication between systems often requires a duplication of work. Patients' own access to their health records is also limited.

Local and national investments have allowed us to make significant progress in this area.

Improvements include the Electronic Patient Record (EPR) Portal systems, which link with primary, community and secondary care.

Further developments are underway to improve shared data access and system efficiency. These will support better and timelier patient care, particularly within general practice.

Developments also aim to increase data consistency and capacity to better inform our planning, and we recognise that it will be important to grow primary care's familiarity and use of the portal. NHSGGC have also invested significantly in infrastructure with investment in PCs, servers and Wi-Fi upgrades for general practice.

The potential of more significant system improvements is recognised, however as the majority of primary care budget is allocated to specific activities, this type of long term investment is challenging.

Our accommodation and property

Our primary care estate is substantial, and accessible locally to most people living in the NHSGGC area. It includes around 230 GP practices, almost 290 community pharmacies, 189 optometry places, 255 dental practices, at least three Out of Hours sites during evenings and weekends, plus a range of HSCP multi-use buildings. While large, the majority of our estate is not NHS owned or managed. It is made up

of a mix of health board, privately owned and leased accommodation.

While a huge resource, there are significant challenges around achieving an estate that supports our ambitions. These impact on our ability to expand to meet local health need through, for example, growing local hubs. We want to be able to better support greater need in certain geographic areas. For example, where new communities develop quickly as a result of housing developments. We want also to expand our growing primary care offer.

While there is an established need and desire to develop our estate, funding to upgrade and maintain our properties remains a challenge.

We continue to work with the Scottish Government to obtain a clearly defined position on general practice lease assignation and property standards. Clarity in these areas, including what support – if any – will be available to fund this additional pressure on NHS Boards, will help us to sustain general practice for the future, and better support **2018 General Medical Services (GMS) contract** implementation. Progress in this area is crucial; its absence undermines our ability to make long term improvements to the NHSGGC estate in the ways that we know are needed. Our ability to provide sufficient and suitable space is limited and short term, interim solutions can be costly.

Our funding

The importance of primary care in contributing to NHS recovery is **set out nationally** and supported by a Scottish Government commitment to increase primary care spending by at least 25%, by the end of the current parliament (Scottish Government, 2021: 9).

Within NHSGGC, the 2022/23 financial envelope for primary care (workforce and wider costs) was approximately 20% of the health board's annual budget.

Primary care funding is complex and made up of two broad budgets. Family Health Services (FHS) finances independent contractors and providers and is managed by NHSGGC HSCPs, under nationally agreed terms around the care that is provided. The Primary Care Improvement Fund (PCIF) covers a range of services under the 2018 GMS Contract. One is Community Treatment and Care (CTAC), which includes the Phlebotomy and Vaccination programmes and is allocated to HSCPs on a non-recurring basis.

The 2023/24 year has seen real time reductions in national funding to NHSGGC for HSCPs at a time of increased expenditure, through pay uplifts and utilities for example, and the amount to spend on care delivery is expected to reduce further in 2024/25. In addition, these allocations are currently subject to annual adjustments that reflect changes to the national funding formula ('NRAC'), which in turn impacts on delivery of agreed programmes, for example through a reduction in whole time equivalent staff, to reflect the revised budget. National communications on our short term funding have outlined a reduction in the Board budget of £71.1M in 2023/24, then £79.8m and £54.5m for subsequent years, assuming savings targets are met (**NHSGGC, 2023**). Current funding levels are insufficient to fully deliver the Memorandum of Understanding (MOU), and scoping has found funding uplifts of 30-50% to be necessary to deliver and benefit all practices equitably (NHSGGC, 2022). As a result, our plans need to be restricted to what is deliverable with the available finance. The most recent financial constraints create uncertainty around national commitments to increase primary care spend.

Wider finance allocations generally remain the same year on year, making it difficult to respond to growing demand. This also creates additional pressure when other costs increase, such as inflation, salaries, capital investment, Covid-19 and energy costs, with funding confirmation often received part-way or late in the financial year. Pressures also include a lack of investment in some GMS budgets (such as pension contributions, out of hours, IT and estates), which have not had any inflationary uplifts over the last several years. To spend funds during the award period risks reactive delivery within a reduced timeframe.

The majority of our funding is committed to specific activities, and acknowledged to be insufficient to meet current patient need. Both of these factors acutely limit our ability to make local decisions about where we should best focus our efforts.

The challenges that we share with wider health and care around increased demand and stretched resources make shared improvement harder - and all the more important. Aligned resources, particularly our estate and workforce, will be key enablers to successful transformation of all our health and care.

Prescribing cost pressures

The greatest risk to delivery is the cost of prescribing,

which arises from local demand and is the responsibility of HSCPs to meet. In 2022/23, community pharmacy contractors dispensed 25.5 million prescriptions, mainly from general practice. This is an average of 2.13 million items per month, and a 3.5% increase from the previous year. Just over 70% of the NHSGGC population had at least one prescription item dispensed to them. The total cost for these was £263m compared with £246m the previous year (for 24.6m items).

The volatile and very variable nature of drug costs also creates significant challenges. For example, Omeprazole (20mg) is a drug that reduces stomach acid and was prescribed 900,000 times last year. Its price increased almost four times from £0.89 to £3.20 and then to £2.90, per pack of 28. The volume prescribed translates

to increased costs of £1.8m for this drug alone. To continue to meet these rising costs in practice, HSCPs must use service budgets or make savings from elsewhere in health and social care services, for example by reducing whole time equivalent staff headcount.

Pressure on prescribing costs is expected to continue in 2023/24 as a result of drug price inflation across all therapeutic areas and a growth in the volume of items prescribed. It is estimated that NHSGGC will dispense over 26 million prescription items in 2023/24. In addition, Scottish Government national funding allocations for 2024/25 do not include any inflationary uplift for prescribing budgets, which is adding to the already significantly high pressure within this area. Figure 4 illustrates the continued increase in prescribed items' number and cost since 2018/19.

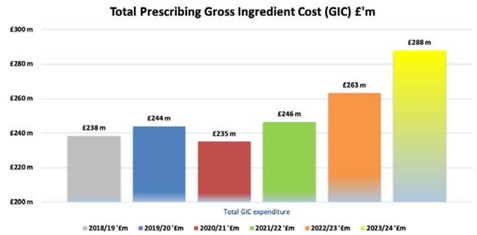


Figure 5: NHSGGC primary care prescribed drugs 2018/19-2023/24: total items and per item cost per annum

Our approach to developing the Strategy

Our Strategy has been developed in collaboration with patients, primary care, health and social care and the wider network of community services to identify our priorities for the next 5 years. From the outset, our aim has been to reach consensus on our ambition and purpose across primary care as well as wider health and care. We aim to continue that to successfully implement change.

We developed our Strategy through:

- Phased, extensive engagement with our strategic partners, including independent contractors and providers and PCIP services, the public; secondary care, HSCP strategic planning groups and our staff
- Working to identify and agree areas of shared focus
- Making best use of our existing engagement and communication structures, networks and groups.

Our key stakeholders

Our key stakeholder groups are as follows:

Those accessing our services	Those delivering our services
• Patients, carers and family members • Local communities • People in protected characteristic groups and/or marginalised groups (dedicated engagement to support effective action to reduce health inequalities)	• Primary care service staff • Independent contractors and providers and representative bodies e.g. Local Medical Committee (LMC) • Partners across all sectors of health and social care support

Table 1: Key NHSGGC primary care stakeholder groups

In the first phase, we sought to raise awareness of the primary care strategy and understand priority issues common to all parts of primary care, alongside the opportunities and strengths that we could draw upon to respond to them. To do so we engaged with both the public and professionals and, for the latter, focussed on engaging with primary care service staff. We achieved over a thousand contacts, mostly through focussed workshops.

Stakeholder feedback was organised into strategic change areas, with proposed actions under each. These were shortlisted then prioritised by senior primary care leaders on the basis of their feasibility to deliver and their impact on our strategic ambitions. They were further refined in the following stage.

In the second phase, we repeated and grew our engagement to test and refine proposals and identify any gaps. Sessions were held with HSCP leadership, strategic planning groups, and frontline staff as well as stakeholders from phase one. Over 912 staff and service representatives, strategic partners and members of the public attended sessions (some staff attended more than one session). Our engagement with professionals and patients over both phases was fairly equally balanced between both groups.

The table below sets out our engagement with professionals and members of the public in Phases one and two.

	Phase one	Phase two
Professionals	388	623
Public	624	324
Total	1012	947

Table 2: Engagement with professionals and the public to support primary care strategy development

This process of engagement has helped us to understand, shape and refine our priorities over the next five years.

Our primary care ambitions

We will focus on eight areas of improvement across primary care.

We will deliver this Strategy within our existing budget, working together to greatest effect. Given our constraints and challenges, we will prioritise action in a small number of key areas that will have most impact in promoting primary care sustainability, working to improve and innovate to increase our capacity and efficiency. We will progress wider developments in line with the available resource.

Our ambition is that, by 2029, our primary care strategy will enable:

In the short term:

1. A sustainable workforce that is sufficiently staffed and skilled, and shares a common purpose;
2. A step-change in data and digital technology innovations to improve patient health and care outcomes;
3. Integrated care and well-connected services, supported by effective teams, improved system-wide working, leadership and planning; and
4. Patients to have an improved understanding of available services and a better ability to navigate between primary care services.

Focussing on the above ambitions first will support achievement of our medium to long term goals:

5. Access to the right service at right time, more flexibly and in ways that suit patients;
6. Strengthened prevention, early intervention and wellness;
7. Better access to trusted information on health and care; and
8. A strengthened contribution to reducing health inequalities, including through increased equity.

We will continually look at how we make best use of our resources, for example, our professionals, our time, and our premises. This will enable us to review whether there are things that we should do less of, or stop, so that we can continue to improve our effectiveness and efficiency and to reduce waste.

This Strategy is the parent document setting out the shared strategic ambition across all NHSGGC primary care. Our goals align to a range of existing expectations of NHSGGC primary care in local strategies and plans, and we will ensure that our implementation plans and structures support coordinated delivery.

The existing key NHSGGC and HSCP plans relevant to primary care include:

Key local strategies and plans	
NHSGGC	**HSCPs**
• Moving Forward Together • Delivery Plan • Public Health – Turning the Tide through Prevention Strategy • Adult Mental Health Strategy • eHealth Digital Strategy • Unscheduled Care Commissioning Plan • Moving Pharmacy Forward	• Strategic Plans • Medium Term Financial Plans • Primary Care Improvement Plans • Local Transformation Plans • Primary Care Premises Strategies

Table 3: Key NHSGGC and HSCP strategies and plans relevant to primary care

The following sections set out our priorities and the actions we will take to achieve them, before setting out wider areas of development.

Our priorities are:

1. Optimising our workforce – through development and delivery of a five-year workforce strategy;
2. Digitally enabled care – through development of a shared care record for all primary care, in- and out of hours;
3. Improving our patient pathways – by making them clearer, more consistent and effective; and
4. Improving primary care access to the right advice at the right time – by mainstreaming professional to professional decision making.

Our priorities

The following pages set out our four priorities in more detail, explaining what we want to achieve and why, and the actions we will take.

Optimising our workforce

Our professionals - current and future - are our greatest strength as they provide the services for our patients. It is our top priority to optimise our workforce to support long term sustainability of primary care.

Benefits of our action

By optimising the primary care workforce, we can better achieve our current commitments as well as our ambitions in this Strategy and longer term. We can support staff to be more effective in all that they do, through improved trust, communication and information sharing across professionals, as well as better job satisfaction and staff morale. Increased staff retention, alongside a fuller staff complement, will reduce the need to rely on sessional, locum and bank staff and retain organisational memory, improving efficiency and resilience. Strong primary care leadership will support a whole system transformation within primary care.

Supporting all our professionals to work confidently to the top of their license will increase our capacity and effectiveness across primary care and beyond.

We will develop a five-year NHSGGC primary care workforce strategy in year one, focussed on primary care sustainability and security, and setting out how we will:

1. Embed strong primary care leadership and influence in primary care and NHSGGC;
2. Focus on improving workforce attraction, retention, and progression;
3. Develop workforce knowledge and skills;
4. Improve staff health and wellbeing; and
5. Promote NHSGGC area as a vibrant and progressive place to work.

This will align with the four pillars of the NHSGGC Workforce Strategy 2021-2025: health and wellbeing, attraction & retention, learning and support and leadership and set out how we will 'grow our own' staff locally, and offer training and development in key areas. We will take action to improve working conditions through collaborative working, and improve our understanding of NHSGGC and independent contractor capacity to flex to changing service demands. We will continue to engage nationally, e.g. with the new National Centre for Workforce Supply.

We will work to protect, develop and retain our current workforce, and improve our ability to attract new, high quality professionals. Through successful action across both areas we will increase our capacity to respond to emerging need and models of care. We will collaborate locally and nationally to progress this. Not doing so risks our ability to maintain service continuity, deliver improvements, and meet our ambition of increasing our primary care offer.

We will draw on national developments to deliver our growing ambitions around MDTs, independent prescribers and supporting staff to work within the full scope and range of their competency, to ensure effective delivery of the NHS Recovery Plan 2021-26. For example, all pharmacists should be able to prescribe from the point of qualification from 2026.

We will align with emerging national workforce developments, including implementation of the Health and Care (Staffing) (Scotland) Act 2019, to ensure safe, high-quality services that meet patient needs. This will enable us to meet our statutory duties around appropriate staffing in health, and to manage any related risks.

NHSGGC recognises the significance of partnership working with independent contractors and providers. We will work to strengthen our collaboration to achieve our shared ambitions together.

Achieving a digitally enabled primary care

We aim to develop systems so that patients no longer need to repeat their health concerns and can directly share their information.

We will develop a shared care record across primary care, accessible to all primary care professionals, both in- and out of hours.

We will deliver this by procuring and implementing new systems which meet the needs of services, are integrated and contribute to the electronic patient record (EPR) to broaden professional access to systems through data sharing agreements.

We will increase patients' digital access to information, treatment and care through opportunities to submit health information for remote monitoring, digital triage and signposting solutions and putting in place the foundations for future Digital Front Door initiatives. Following the growth in popularity of telephone appointments as an option for patients, we will also look to increase video appointments where appropriate and where patients choose.

We will continue to dedicate support to the national progression of a step change in digital improvements in primary care. Through the NHS Recovery Plan 2021-2026 we will work with Scottish Government to protect investment in digital solutions, e.g. to GP IT re-provisioning, digital solutions for ePrescribing and eDispensing, which will enable us to better manage demand and effectively use our workforce.

The Digital Prescribing and Dispensing Pathways (DPDP) programme aims to radically improve prescribing and dispensing by digitising the full process, making ordering and receiving of prescriptions easier, faster and more efficient. Due to begin during the life course of the Strategy, the programme will increasingly interface with other NHS eHealth clinical systems over time.

We want to improve patients' experience of primary care, supported by digital improvements for both patients and professionals.

Benefits of our action

With the necessary investment, digital primary care improvements carry enormous promise for improving patient access and experience, automating routine tasks and reducing duplication of effort, better organising care, and freeing up time for patient facing care.

Shared records can bring improvements to both patients and staff, in reducing the need for repeat conversations, and time spent sending and retrieving information between partners (such as hospital discharge records, changes to care plans).

Optimising e-prescribing and e-dispensing will increase efficiency, safety and speed. Multi-professional and multi-location digital prescribing will enable new service models to be developed and delivered. It will also contribute to wider climate sustainability by reducing the use, transport, scanning and destruction of paper.

Case study: Using digital tools to better support patients to look after their own health and create new primary care capacity

Since December 2022 around 4,400 Connect Me blood pressure monitors have become available to NHSGGC patients, via their general practice. NHSGGC's primary care support and digital (ehealth) teams have continued to promote the monitors to GP practices.

Connect Me is a remote monitoring tool that patients use independently at home. It collects clinical readings and the data is automatically sent to their general practice for GP or nurse review. It is offered to patients with high blood pressure and aims to improve early detection and intervention around their condition, as well as to support them to look after their own conditions well, with personalised support where needed. This means that patients whose condition is well managed do not need to attend regular appointments, and GPs' capacity is increased to support those whose condition is more complex. People's risks of developing cardiovascular disease (CVD) are reduced through improved detection and control of elevated blood pressure, in turn reducing their risk of heart attack and stroke.

Patients receive prompts (e.g. by text or phone) to take blood pressure recordings at daily, weekly or monthly intervals. The data is automatically sent to their general practice for review by the GP or nurse.

At February 2024, fourteen months after the launch, 106 GP practices across NHSGGC had taken up Connect Me, 4,046 patients have registered to use it so far. Looking ahead, NHSGGC will continue to support its adoption. While blood pressure is the first clinical area where remote monitoring has been offered to general practice, it is hoped that more may be supported in future, for example long term conditions.

Improving our patient pathways

We aim to put in place more consistent, timely and effective patient pathways in primary care and to onward health and care.

We need to strengthen our connections with other services in primary and community care, and our ability to refer patients to the right professional directly. We want to connect better with secondary care, for the necessary specialist advice to support people locally. We also want to grow our integration with wider social care, and the third sector. This will require a joined up and person-centred approach across professional and geographical boundaries.

We will improve the clarity, consistency and effectiveness of patient pathways into and out of primary care

We will do this in collaboration with secondary and specialist care, structured quality improvement activity, evidence based review and update of our patient pathways, increasing awareness and adoption of updates, and monitoring and evaluating the impact of our actions for patients, workforce and the system.

Case study: how local, specialist MDTs improve the ease, efficiency and quality of care for patients, primary and secondary care services

General Practice Advanced Practice Physiotherapists (GP APPs) act as the first point of contact in primary care for patients with suspected musculoskeletal (MSK) problems. The team provide expert care and diagnosis without patients needing to first see a GP, and are currently based in 89 of NHSGGC's general practices and accessible to 44% of NHSGGC's population. Our GP APPs saw just under 60,000 patients with suspected musculoskeletal (MSK) complaints in 2022/23 with anticipated increase of 10% patients to be supported in 2023/24.

Advanced Practice Physiotherapists are part of our MDTs and provide care closer to home, help people to look after their own health as well as possible while living independently in the community, and support any onward referrals to be more direct and timely. The vast majority of patients seen are supported within primary care, reducing referrals into secondary care. The advanced triage skills of the team are enabling

people to see the right service, first time – resulting in earlier, quicker, and higher quality care for patients, alongside reduced inefficiency and better value for our healthcare system.

In 2022/23, our advanced practice physiotherapists:

- Provided support to enable ~80% of patients to self-manage (e.g. with advice and guidance, exercise prescription, corticosteroid injection, signposting to third sector support);
- Enabled patients to access care closer to home, with only ~20% of patients needing onward referral to secondary care;
- Demonstrated the value of our Multi-Disciplinary Teams with, on average, 15.7% lower referral rates to orthopaedics than practices without a GP APP; and
- Undertook skilled triage and effective diagnosis, with Rheumatology confirming that 95% of referrals to them were correctly made and treated, compared to wider general referral rates being as low as 33% confirmed as appropriate.

Improving primary care access to the right advice at the right time

We will work with wider health and care to mainstream and standardise professional-to-professional decision making, broadening its access across primary care professionals, including MDTs.

Our aim is to ensure we can give patients the very best care informed by the right advice, support better patient retention in primary care, and reduce the need for specialist service intervention.

Benefits of our action

Improved care pathways will mean patients can see the right professional more directly. They will get the right treatment quicker, and achieve more favourable outcomes, including satisfaction. Clearer, and more consistently effective pathways will reduce referrals requiring redirection and create capacity for our workforce and wider system.

Better advice, interfacing and pathways will strengthen our contribution to health and wellbeing through improvements to culture, relationship and trust – in primary care and with wider health and care, based on the principle of civility saves lives.

Together, both of these priorities will support better primary care integration and interfacing within primary care and across the wider health system. The next section sets out the combined benefits that we anticipate seeing, as a result of our work.

Wider areas for development

This section sets out a number of wider areas where will seek to make meaningful improvements over the next five years. As with our priorities, these are themed around the changes we want to make, and set out high level plans for how we will achieve them.

Improving our communications and engagement

Effective communication and information will support people to use primary care confidently when they need to, in ways that suit them, and with fewer unnecessary contacts.

We will take a strategic and structured approach to growing public and professional awareness of what primary care delivers, and how access is changing. We will work to ensure that, when people don't need to see a professional, they can obtain reliable information and advice that enables them to manage their health as well as possible.

We want to ensure that our primary care improvements include patient perspectives, and recognise that one size does not fit all. We will grow patient involvement in our strategic and operational work to strengthen our person centred design and delivery.

In year one, we will develop a five-year primary care communications and engagement plan, setting out how we will:

1. Develop and grow a single, agreed NHSGGC 'primary care offer';
2. Strengthen shared action to support primary care sustainability;
3. Promote primary care as the first point of contact in most care journeys;
4. Improve health literacy, particularly around system navigation and supported self-management; and
5. Embed patient voice in our strategic planning and delivery.

We will consult with patients and professionals to develop our plan. We will improve information access and grow a culture of listening and learning with patients, the public and our workforce. We will continue to advocate for national communications that raise awareness of current healthcare challenges, what people can expect and how we can all support primary care recovery.

Benefits of our action

A joint approach to primary care communications and engagement can contribute to measurable improvements in the proportion of patients accessing the right care. Improvements should reduce the number of interactions required per completed episode of care. This will increase efficiency, reduce reliance on services for signposting, create capacity to help those who need it most, and improve patient care.

People will be able to access the care and information they need in a way that suits them, when they need it. They will be better informed and empowered to act to improve their health and wellbeing and to better understand their health needs.

By ensuring we understand how to tailor information and support equitably, we will better contribute to action on health inequalities.

Improving access to care

We aim to support patients to access care when and how it suits them.

Alongside making it easier for people to see the right professional on first contact, we want to increase choice around how people make and have appointments when they need them, to better suit their needs and preferences, whether they need care during the week or out of hours.

We will make a range of process and system improvements to enhance journeys into and through primary care:

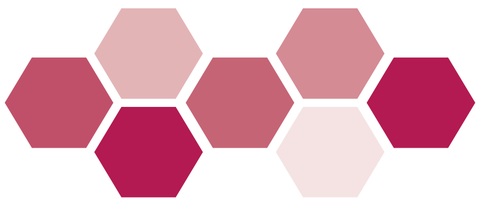
This will include work to increase direct access into and across primary care services, in-person and digitally. We will also work to improve access to high quality information and advice, and support patients to make decisions about their health and care that are right for them, based on what matters to them, aligned to the principles of Realistic Medicine.

Benefits of our action

We will make it simpler for everyone to access the right care with as few appointments as possible. That will improve the quality of patient care, by increasing its person-centredness and timeliness. Improved efficiency and effectiveness will increase our patient facing capacity, and our ability to focus on complex care, including better continuity of care for those needing it most.

By using evidence to inform what we do, and working with patients to support them to make the best decisions about their care, we will maximise the value added by our work and focus on where we can make the biggest impact.

We will work to prioritise improved access for those who need it most to avoid any negative impact on inequalities.



Strengthening prevention, early intervention and wellness

As part of a wider system, primary care plays a significant role preventing ill-health and mitigating health inequalities, through primary, secondary and tertiary approaches.

As the first point of NHS contact for most patients, primary care takes direct action to:

- promote physical and mental wellbeing, including through community leadership, connection and empowerment;
- prevent illness and protect health;
- support early diagnosis of key conditions to better manage chronic conditions and reduce long-term complications; and
- with partners, advocate for better health in marginalised groups, and support improvements in life circumstances that impact on health.

Given the huge projected worsening of our burden of disease, preventing illness, promoting wellbeing, early diagnosis and reducing health inequalities will be more crucial than ever. Investing our time and resource in these areas hold promise of a substantial health return on investment, leading to longer, healthier lives for the people of NHSGGC. However, prevention is all the more

challenging when increased demand creates additional pressures on non-statutory provisions.

We will continue to grow our capacity to provide continuity of care for patients with the most complex needs, keeping them as well and as independent as possible, for as long as possible. We will also grow our collaboration with wider parts of health and care to ensure our work is as impactful as possible.

We will work to strengthen prevention to better avoid ill-health, protect wellbeing, and improve supported self-management

Areas for development include increases to strengths-based approaches and a move away from more traditional models of care, growing our offer around accessible health information for supported self-management, and promoting uptake of routine vaccination and screening programmes across primary care.

Benefits of our action

Continuing to support prevention allows us to invest in keeping the people of NHSGGC healthier for longer. These approaches contribute to much lower-cost improvements in life-expectancy, including healthy life expectancy. For example to:

- Encourage and support people to live healthier lives will improve mental wellbeing, and mean that fewer people suffer with chronic conditions;
- Through early diagnosis and treatment of cancers, we can effect lasting cures.

Tackling the underlying causes of ill health can lead to healthcare cost-savings. For example, resolving causes of stress, anxiety, and depression could lead to a reduction in physical ailments, chronic disease severity, medication use and harmful behaviours.

Case study – Community Link Worker model

The Community Link Worker (CLW) programme enables general practices to directly support people experiencing issues impacting their health and wellbeing. People can be linked with appropriate supports to stressors such as isolation or financial difficulty, and empowered to engage in their community.

Emma was almost 16 and due to leave school to start college. She rarely socialised and her mother was concerned that this affected her mood. Emma previously attended attended Child and Adolescent Mental Health Services (CAMHS) for depression and panic attacks. Emma's GP referred her to the practice CLW. Emma received 1:1 support; a referral for a gym pass and a shadowing opportunity at local nursery.

Outcome: A local nursery offered Emma volunteering and Emma advised that she was finding it enjoyable and rewarding. Emma enjoyed using her gym pass and found that exercise helped her mental health and was keen to continue using the gym. Emma's mum stated that her daughter's confidence had improved substantially and is very grateful to the CLW for the support she provided. Emma recently had a CAMHS appointment and they were happy with her progress. She was looking forward to starting college and felt a lot more confident and well-prepared than three months ago.

Wider patient experience of CLW programme:

'I didn't know that there was any help out there, now after talking to you I can't believe how much there is'

A range of existing actions, outlined in wider NHSGGC strategies[1], will also support this commitment. These actions include:

- Continuing to work to embed a sustainable community link worker model;
- Supporting people to improve their health and reduce health harms, through social prescribing and health improvement programmes;
- Targeted action to identify and intervene early in key health conditions;
- Aligning primary care with mental health and wellbeing resources and promoting good mental health;
- Supporting children to have the best start in life, with a focus on the early years; and
- Providing effective support to people with multi-morbidities and / or complex health needs.

1 See for example, our NHSGGC Delivery Plan, Moving Forward Together Implementation Strategy, Public Health and Mental Health strategies.

Enhancing our primary care accommodation and property

Where possible and clinically appropriate, we want people to be able to access care in our local communities. We also want our existing property to support our longer term ambitions of moving more care into community settings.

We aim to enhance the primary care estate so that it is fit for the future, by making sure it can both deliver existing care, be a better workplace and be adaptable to future models of care.

Work is underway in NHSGGC to develop a Primary Care Asset Strategy (PCAS) focussed on optimising our estate. This will be supported by through an improved understanding of current strengths and weaknesses, and anticipated future demands, for example through new housing developments or population changes. We will deliver the PCAS within five years. We recognise that deprivation is likely to translate into more space being needed per head of population in certain areas, reflecting the fact that greater health need requires greater space for relevant services to support it.

The PCAS will provide the vehicle for HSCPs to take a shared and strategic approach to estate transformation, in line with future population need and local authority plans. HSCP property strategies and supporting work will form the foundation for effective PCAS links with the Board's wider **Moving Forward Together (MFT) Implementation Strategy**. All will recognise the crucial need for a whole system approach to clinically-led NHS estate transformation.

We will develop and deliver a Primary Care Asset Strategy that aims to:

1. Maximise the patient facing estate and support HSCPs' new accommodation plans;
2. Prioritise the HSCP estate and general practice leased accommodation;
3. Ensure the transformation of our primary care estate aligned to long term plans for all NHSGGC as set out in Moving Forward Together;
4. Create accommodation that supports greater levels of integrated care in our own and other multi-use buildings over the life of the strategy, including via hub and spoke models; and to
5. Take an equitable approach, supported by increased use of good quality population data in planning.

Benefits of our action

People will get the right care in the right place at the right time, in local communities close to or at home whenever possible, and supported by multi-disciplinary teams and digital improvements. In parallel, we will grow whole system capacity to shift the balance of care from secondary to primary and community settings, reducing reliance on hospital services.

Case study – Increasing local health and care availability

NHSGGC is the first health board in Scotland to move glaucoma services out of specialist services and into primary care. Launched in April 2023, the new service model offers patients with glaucoma the opportunity to now see accredited optometrists on the high street, rather than as a hospital outpatient.

Early patient feedback has been positive, with a reduction in long waits and the removal of parking challenges often experienced in acute sites. The new model allows follow up appointments more flexibly, in line with patient needs/preferences, and is intended to reduce waiting times for outpatient appointments and bring care closer to where people live.

Clinicians have reported that the widening Optometry role and response in primary care is enabling care reviews to happen more quickly, in patients' local area and reducing clinic time.

In the remainder of 2023/24 we aim to transfer care of 1,000 glaucoma patients to primary care. Over the next 3-5 years, we will continually increase our primary care capacity to be able to support 3,000 people, and who are currently seen as outpatients.

Improving equity and reducing inequality

Health inequalities in NHSGGC are the deepest and worst in Scotland, and our Strategy launches at a time of considerable economic uncertainty, including a cost of living crisis. While primary care is just one of a number of services taking action to mitigate against inequalities, the current climate means that this is all the more crucial.

We will strengthen system-wide action to increase equity and reduce health inequalities in re-designing and delivering primary care services by:

1. Giving particular attention to improving the health and wellbeing of those worst off in this Strategy's delivery;
2. Focussing on inequalities most affecting health and wellbeing, including gender, socioeconomic status and ethnicity; and
3. Targeting activities to protect and improve the health and wellbeing of those who need them most, including identifying and resourcing measurable improvements to key service areas (such as screening and immunisation), and reducing inequalities in those areas.

Benefits of our action

Because of difficulties in accessing appropriate care, people who most need care are often those who are least able to access it. By being deliberate in ensuring that care is accessible in accordance with the level of need, we can better contribute to reducing health inequalities.

We will deliver targeted and tailored action across our priorities and wider areas of development:

Optimising our workforce - training and development that includes:

1. Improving population health knowledge to support a system-wide shift to prevention and early intervention; and
2. Effective action to reduce inequalities in access and supported self-management.

Achieving a digitally enabled primary care:

3. Paying particular attention to the needs of equality and inequality groups in digital developments, to avoid widening inequalities in health.

Improving patient pathways and primary care access to specialist advice:

4. Focussing quality improvement approaches firstly on those conditions and pathways that will bring greatest population health benefit.

Improving communications and engagement:

5. Embedding patient voice in our strategic planning and delivery; and
6. Ensuring equality impact assessments meaningfully inform our public engagement, so that we understand and tailor responses to their needs.

Improving access:

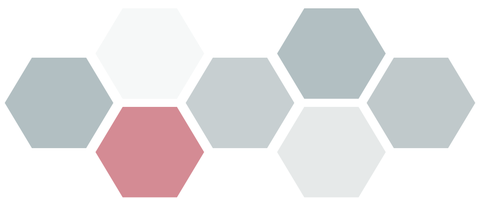
7. Meaningfully identifying and acting upon the barriers to equal and equitable access to care; and
8. Focussing improvements on improving access to information on health advice and services that will be most beneficial to people.

Strengthening prevention, early intervention and wellness:

9. Ensuring health information and support is accessible, known and used by patients, supported by needs-led approaches to content development and dissemination; and
10. Actively improving pathways to early diagnosis of serious health conditions like cancer, diabetes and heart disease.

Enhancing our primary care accommodation and property:

11. Growing the use of good quality data on population need in our property planning.



How we will implement this Strategy

Implementation of the Strategy will be directed and overseen by NHSGGC's Primary Care Programme Board (PCPB), whose members include all primary care sectors and leads, as well as professional representatives for Dental, General Practitioner, Pharmacy, and Optometry contractor/provider bodies and staff side representatives.

The Programme Board will report into NHSGGC Corporate Management Team, linking with HSCP Chief Officers, then into Finance Performance and Planning (FP&P) and Integrated Joint Boards (IJBs). This ensures that delivery of the Primary Care Strategy will align with wider NHSGGC Board Strategies (including remobilisation and MFT's transformational change) and with individual HSCPs' Strategic Plans.

We will actively work with and to the six IJBs within NHSGGC on their local strategies and commissioning of individual contractor services. We will do this through the continued work of PCPB and respective HSCP primary care support teams.

We will set out the detail of how we will implement the strategy in a five-year action plan, which will set out all board wide primary care commitments, the benefits we expect each to bring and their contribution to our strategic outcomes.

It will set out our key areas of delivery, what will be done, by whom, when, and how we will know we have been successful, alongside any dependencies.

We will undertake regular monitoring and evaluation of our Strategy and its implementation to ensure that we can understand, measure and continually seek to improve the impact of our work. We will focus on those actions that will maximise the positive outcomes for our patients, as well as our workforce and healthcare system. Learning will shape future service planning and public health interventions.

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Appendix 2 – Primary care data

The following tables set out experimental primary care data that are drawn from a range of published sources.

While substantial amounts of activity across primary and secondary care are included below, they are not complete. Activities listed are not meant to be exhaustive, there are services where data are not collected nationally (or are not readily available at NHS Board level). The most recently available datasets have been used.

The Primary care In-hours general practice activity figures are based on experimental statistics, so it is important that users understand that limitations may apply to the data.

Sector	Activity	Measure	Value	Time period	Source	Link
Primary Care	In-hours general practice (GP)	Number of encounters	4,647,498	2022/23	ESCRO data extraction tool, PHS	Link
	In-hours general practice (other clinicians)	Number of encounters	1,883,471	2022/23		
	Dental services	Number of claims	884,504	2022/23	MIDAS, PHS	Link
	Ophthalmic services	Number of eye examinations	447,921	2022/23	Ophthalmic Data Warehouse, PHS	Link
	Out of hours primary care services	Number of consultations	190,320	2021/22	GP OOHs datamart	Link

Sector	Activity	Measure	Value	Time period	Source	Link
Secondary Care	Accident and Emergency	Number of attendances	400,666	2022/23	A&E datamart, PHS	Link
	Inpatient and daycase	Continuous inpatient stays	314,773	2022/23	SMR01, PHS	Link
	Mental health inpatient	Continuous inpatient stays	3,700	2021/22	SMR04, PHS	Link
	Outpatient	Number of attendances	965,965	2022/23	SMR00, PHS	Link

Notes

General	• The activities listed here are not meant to be exhaustive, there are services that exist where data is not collected nationally or is not readily available at NHS Board level (e.g. Community Services, Pharmacy Services etc.).
In-hours general practice	• These are experimental statistics published to involve users and stakeholders in their development and as a means to build in quality at an early stage. It is important that users understand that limitations may apply to the interpretation of this data. • Mappings between raw data and groupings remain provisional, figures quoted exclude a significant number of encounters classified as 'Unmapped'. • Includes direct encounters only: Surgery consultation, Telephone consultation, Home Visit, Clinic, Video consultation & eConsultation. **Refer to 'Methdology and Metadata' for more information - https://www.publichealthscotland.scot/media/21991/methodology-and-metadata-v11.pdf**
Dental	• Each claim may cover a single appointment or multiple appointments depending on the treatment provided.
Ophthalmic	• Includes primary and supplementary eye examinations.
OOH primary care	• Includes consultations that took place attending a Primary Care Emergency Centre/Primary Care Centre (PCEC/PCC), a Home Visit or an OOH GP/Nurse Advice Telephone Call.
A&E activity	• All attendances at Emergency Departments and Minor Injury Units. Includes new and unplanned return attendances only.
Inpatient and daycase	• Figures are based on NHS Board of Treatment so include all activity at NHSGGC hospitals.
Mental health inpatient	• SMR01 returns are approximately 98% complete in NHSScotland for financial year 2022/23. • Excludes Genito-Urinary Medicine (GUM) and Geriatric Long Stay specialties.
Outpatient	• Figures are based on NHS Board of Treatment so include all activity at NHSGGC hospitals. • Consultant led new and return attendances. • SMR00 new attendances are approximately 98% complete in NHSScotland for financial year 2022/23.

Appendix 3 – Glossary of acronyms and terms

Below, we list the key acronyms used in the Strategy set out in full. We include a brief explanation for a small number of these, where they are likely less familiar to all readers.

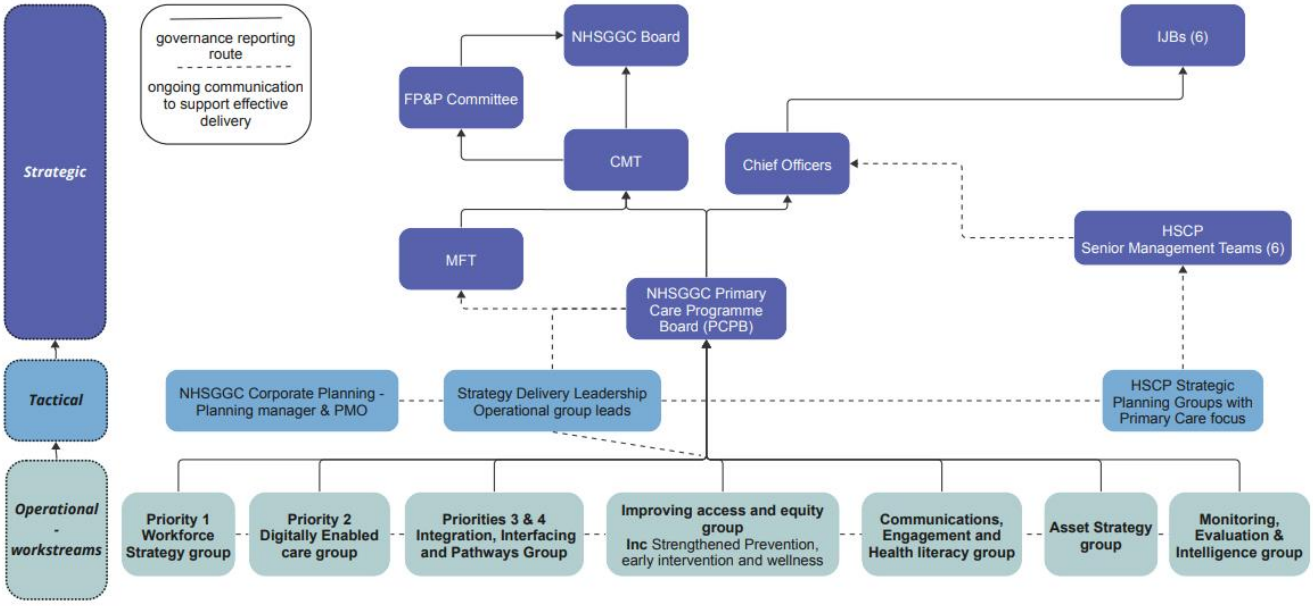
AHPs	Allied Health Professionals – a range of regulated and specialised professions in areas of health and care, such as physiotherapy, occupational therapy, and dietetics and podiatry
APP	Advanced Physiotherapy Practitioner
CAMHS	Child and Adolescent Mental Health Services
Community Link Worker (CLW)	There are many recognised Community Link Worker (CLW) models, most frequently including the principles of working as a core member of a GP Practice Team while helping patients find the right support with any social issues affecting health and wellbeing. CLWs provide non-medical support, and they work to address health inequalities created by socio-economic issues while enabling and empowering patients to identify and achieve their priorities and goals. They provide a bespoke service which connects patients to resources and/or services to meet their individual practical, social and emotional needs.
CTAC	Community Treatment and Care
GP	General Practice / General Practitioner
HWSW	Healthcare Support Worker
HSCP	Health and Social Care Partnership
IJB	Integrated Joint Board
LTCs	Long term conditions – these include both physical conditions such as diabetes or cardiovascular disease (CVD), as well as severe and enduring mental illnesses such as psychosis, schizophrenia, bipolar disorder, or personality disorders.
MFT	Moving Forward Together is NHSGGC's long term programme for the transformation of healthcare delivery
MDTs	Multi-disciplinary Teams
NHSGGC	NHS Greater Glasgow and Clyde
PCAS	Primary Care Asset Strategy
PCIP	Primary Care Improvement Programme
PCIF	Primary Care Improvement Fund
Pharmacy professionals	A range of pharmacy professionals including pharmacists, pharmacy technicians and pharmacy support workers
RM	Realistic Medicine puts the person at the centre of decisions about their care and encourages health and care professionals to find out what matters most to the patient and treat the patient as an equal partner. This, along with discussing the benefits and risks of treatment allows shared decisions and reduced chances of care not adding value to the patient. There are 6 principles: 1. Shared Decision Making 2. Personalised Approach to Care 3. Reduce Harm and Waste 4. Reduce Unwarranted Variation 5. Managing Risk Better 6. Becoming Innovators and Improvers The vision for Realistic Medicine is that by 2025 everyone providing healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine.
VBH&C	Value Based Health and Care is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person (University of Oxford, 2019). This is also the name of the initiative through which we will implement Realistic Medicine. By 2030 all health and care colleagues will be supported to deliver VBH&C. We will continue to practice Realistic Medicine and achieve the outcomes that matter to people.

Primary Care Strategy 2024-29
Summary Implementation Plan

Overview

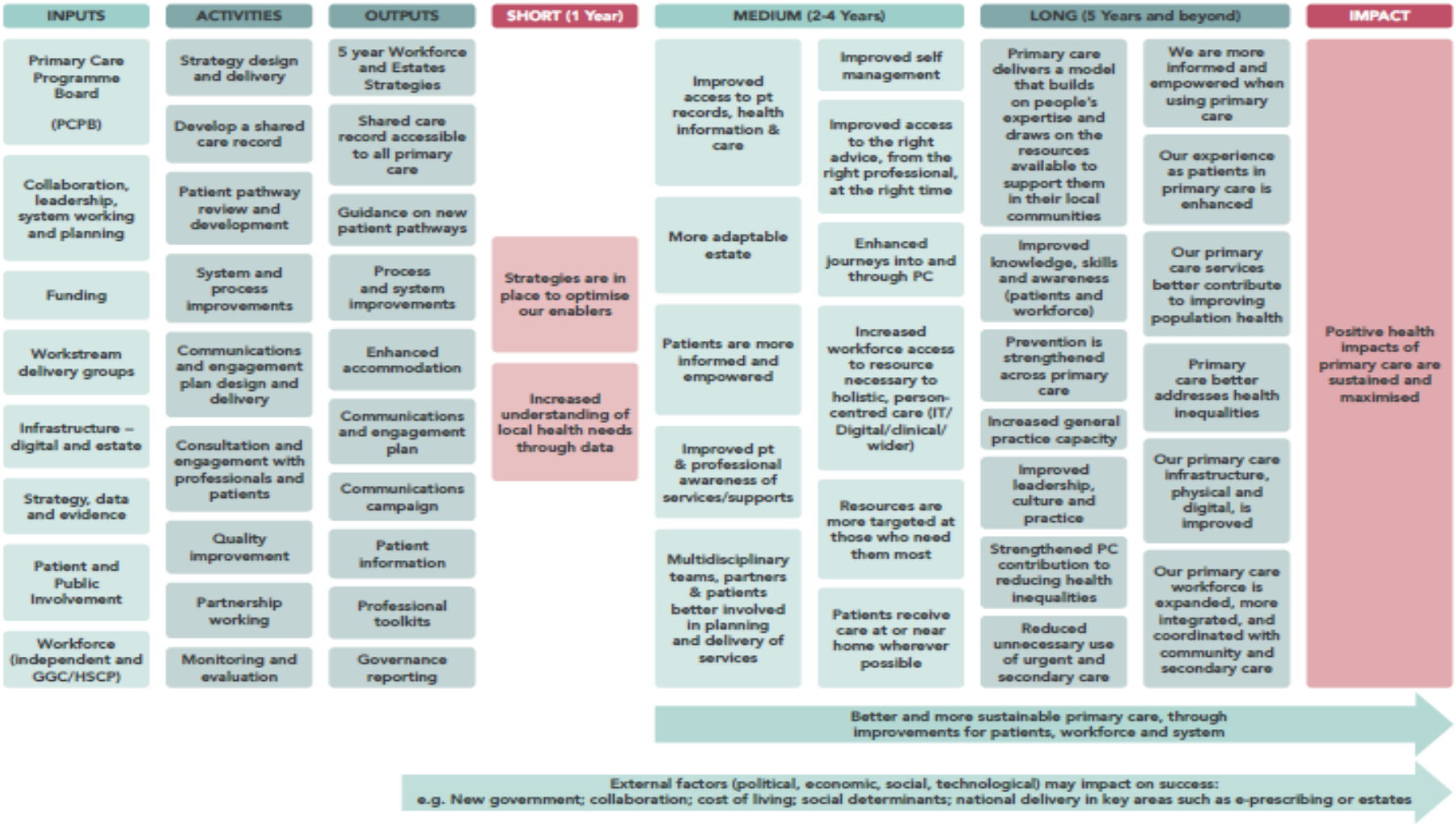
- The high level implementation Plan sets out arrangements to deliver NHSGGC's Primary Care Strategy 2024-2029.
- The term 'primary care' describes services that people often use as the first NHS point of contact and that are usually provided by general practice, pharmacy, dentistry, optometry (the four main independent contractor and practitioner groups) in our local communities.
- The Plan will be reviewed annually and refreshed as required (including as directed by our strategic oversight group, the Primary Care Programme Board).
- The Plan builds on the collaborative approach taken with partners to develop the Strategy, and we will update the remit and membership of existing work groups to ensure alignment of our deliverables and to effectively adopt whole system approaches at operational, tactical and strategic levels.
- Below is the Primary Care Strategy governance structure, followed by our logic model. The model illustrates the changes we want to achieve through our priorities in the short, medium and longer term.

Primary Care Strategy Governance Structure



Primary Care Strategy Logic Model

The model below sets out the changes we want to achieve short, medium and longer term, alongside the resource and activities required to achieve them. Our focus is on achieving our aspirations within the five year period of the Strategy and we will continue to work to align with NHSGGC transformation ambitions in the much longer term.



Primary Care Strategy deliverables and milestones 2024 – 2029: Our priorities

We aim to deliver this Strategy within our existing budget, working together to greatest effect. Given our constraints and challenges, we will prioritise action in a small number of key areas of greatest impact on our sustainability, capacity and efficiency – and therefore patient care. We will progress activity set out under our wider areas for development in line with available resource. As set out under Deliverable 9, we will develop a monitoring and evaluation framework by summer 2024, including agreed measures.

Deliverable	Actions	Dependencies	Impact	Delivery milestone
Primary Care Strategy priorities				
1. **Develop and deliver an NHSGGC primary care workforce strategy**	1. Establish Workforce Strategy development group 2. Ongoing national advocacy/influence to optimise trainees 3. Inform NHSGGC Workforce strategy 2025-30 with primary care requirements	✓ Support by HR SMT ✓ Primary care representation at workforce supply group ✓ Engagement and collaboration with independent contractors and providers; higher education	✓ A sustainable, sufficiently staffed and skilled workforce ✓ Aligned workforce strategy across NHSGGC ✓ NHSGGC primary care as a vibrant and progressive place to work	1. 2025: Strategy draft completed 2. 2025-26: Workplan development and initiation
2. A shared care record accessible to all primary care	1. Roll out read access to Electronic Patient Record (EPR) 2. Deliver information sharing (IS) agreement(s) 3. GPIT re-provisioning 4. Procurement of and access to Clinical Systems	✓ Independent contractor and provider support, adoption and compliance with developments	✓ Health professionals have improved ability to work together to improve patient outcomes: ✓ Improved real time information sharing to support patient flow ✓ Increased flexibility in patient and general practice time ✓ Further ability for patient dialogue, self-referrals and signposting	1. 2026/27: shared care record accessible to all primary care 2. 2026: complete IS agreements 3. 2026: 100% general practices adopt GP IT reprovisioning 4. 2025/26: Documentation management system adopted by general practices

Deliverable	Actions	Dependencies	Impact	Delivery milestone
3a. Improving care pathways into and from wider health and social care – *developing our system*	1. Review and update patient pathways 2. Develop key principles for streamlined, effective and efficient pathways; link with wider system to agree, embed and improve delivery 3. Develop and deliver NHSGGC-specific content on the national Right Decision resource – providing support to referrers and patients	✓ Whole system agreement of overarching principles to ensure strong risk management ✓ Support for Prof-to-Prof ✓ Whole system support e.g. acute, planning, change management and eHealth ✓ National and local developments (e.g. Centre for Sustainable Delivery) ✓ PEPI/Public engagement ✓ Monitoring, evaluation and intelligence group	✓ Patients get the right treatment from the right professional quicker and have a better experience and outcomes ✓ Increased workforce and system capacity ✓ Strengthened primary care contribution to health and wellbeing ✓ Improved health literacy across patients and professionals ✓ Improved culture, relationship and trust across patients and professionals	1. 2024/25: workstream/ workplan development and initiation 2. 2024/25: principles developed and agreed 3. TBC via workplan
3b. Improving care pathways into and from wider health and social care – *developing workforce capacity*	1. Mainstream and standardise primary care clinician access to professional-to-professional decision making *('Prof-to-Prof')* with acute services 2. Prioritise improvements to pathways identified in deliverable 3a. Extend primary care Prof-to-Prof access to include wider multi-disciplinary teams	✓ Collaboration with partners	✓ Improved access to specialist advice will improve our ability to provide local care reduce specialist service intervention ✓ Patients at risk of/with serious health conditions are better supported by primary care ✓ Improvements to culture, relationship and trust in primary care and wider health and care	1. By 2029: Professional to professional decision making is normalised across agreed primary care professions

Deliverable	Actions	Dependencies	Impact	Delivery milestone
Wider Areas for Development				
4. **Improve access to primary care**	1. Collaborative action to scope and agree our vision for change, identifying how we will maximise our efficiency and effectiveness through an evidence and value-based approach 2. Engage with patients on digital improvements to health information access (Digital Front Door) 3. Support patients to make decisions about care that is right for them	✓ Independent contractors support ✓ Improvements in line with general practice access principles ✓ Practitioner and patient support to change ✓ National developments/ directions ✓ Digital Strategy delivery	✓ Better understanding and improve our impact with patients and professionals ✓ Strengthen equity/better contribute to health inequalities ✓ Ensure compliance with public sector equality duties	1. 2024/25: Agree workplan and priorty areas for change 2. TBC via workplan; aligned to Digital Strategy delivery c2026-9
5. **Strengthen prevention and early intervention**	1. Promote uptake of routine vaccination and screening 2. With key NHSGGC strategies, map existing activity underway, identify gaps and agree priority areas 3. Increase use of strength-based approaches to empower people to look after their own health as well as possible	✓ Collaboration with stakeholders ✓ System capacity to develop and deliver ✓ Resource for new treatments ✓ National programmes (including vaccination records)	✓ Vaccination is one of the most successful and cost-effective interventions to save lives and improve health (WHO) ✓ Reduced variation in uptake strengthens our contribution to health inequalities ✓ Compliance with legal duties outlined in Carers (Scotland) Act 2016	1. 2024/25: Undertake collaborate planning sessions with key leads 2. 2024/25: Update implementation plan 3. By 2024/25: recommendations on for approval

Deliverable	Actions	Dependencies	Impact	Delivery milestone
6. Improve equity and reduce inequality	1. Cross-cutting action across PCS workstream delivery to strengthen prevention and better target action in areas of greatest need, to include: a. Engagement with providers b. Ongoing: support to strategy delivery in line with wider workplan c. Ongoing: translation of learning throughout implementation	✓ Sustainable and sufficient resource in place ✓ Establishment of strategy workstreams ✓ Collaboration with contractors and providers	✓ Better avoid ill-health, protect wellbeing, and improve supported self-management ✓ Targeted activities to protect and improve the health and wellbeing of those needing these most ✓ More person centred, effective and equitable information supports (self-management and primary care access)	1. Autumn 2024/25: principles and proposal for areas for action agreed
7. Support self management and improved primary care navigation/use	1. Develop and deliver a primary care communications and engagement plan 2. Grow our offer of accessible health information for supported self-management 3. Embed patient voice in our strategic planning and delivery	✓ Communications and engagement plan approval ✓ Required resources in place ✓ Right decision resource ✓ Collaboration with independent contractors and providers	✓ Increase patient & professional awareness of primary care offer and how to access ✓ People are more able to look after their health to the best of their ability ✓ Person-centred, effective and equitable information supports (for patients & professionals) ✓ Improved patient flow and increases to primary care capacity	1. 2024: Membership of PCPB expanded to include Communicaitons 2. 2024-6: Communications and engagement plan developed and initiated

Deliverable	Actions	Dependencies	Impact	Delivery milestone
8. Optimising primary care accommodation and property	1. Asset Strategy development and delivery 2. Grow the use of good quality data on population need in our property planning	✓ Independent contractor and provider collaboration ✓ Reconciliation of medium-long term delivery ambitions with contract terms (e.g. GP Contract changes) ✓ HSCP support ✓ Updated GMS Premises Directions ✓ Support nationally and locally for capital investment and on-going revenue investment to primary care buildings ✓ Business Intelligence capacity	✓ People get the right care in the right place at the right time, close to/at home when possible, and supported by MDTs and digital improvements. ✓ Increased capacity to shift care from secondary to primary and community ✓ NHSGGC-wide approach to primary care estate optimisation, with HSCPs ✓ Greater levels of integrated care in multi-use buildings including hub and spoke ✓ Primary care contributes to achieving our wider sustainability and climate change targets	1. 2024/25: Target to commence Asset Strategy (Commence on conclusion of MFT Implementation Strategy, aligned to Sustainability strategy and Strategic Delivery Plan) 2. Align to NHSGGC transforamitonal programme
9. Monitor and evaluate our Strategy	1. Develop and implement a monitoring and evaluation framework with work stream leads 2. Define relevant primary care intelligence population health indicators to inform ongoing strategic planning and delivery, and local quality improvement	✓ Agreement of oversight and delivery responsibilities ✓ Public Health capacity ✓ Availability of relevant / appropriate primary care data ✓ Business Intelligence capacity	✓ We know and improve upon the impact of our work on for our patients, workforce and system ✓ Our future strategy development and implementation is informed by improved data and evidence	1. By summer 2024: approval of Strategy monitoring and evaluation framework 2. 2024/25: Development of Primary Care Monitoring, Intelligence, and Evaluation Group annual work plan 3. 2024-2029: regular monitoring reports

NHS Greater Glasgow and Clyde Equality Impact Assessment Tool

ITEM 7 APPENDIX 3

Equality Impact Assessment is a legal requirement as set out in the Equality Act (2010) and the Equality Act 2010 (Specific Duties) (Scotland) regulations 2012 and may be used as evidence for cases referred for further investigation for compliance issues. Evidence returned should also align to Specific Outcomes as stated in your local Equality Outcomes Report. Please note that prior to starting an EQIA all Lead Reviewers are required to attend a Lead Reviewer training session or arrange to meet with a member of the Equality and Human Rights Team to discuss the process. Please contact Equality@ggc.scot.nhs.uk for further details or call 0141 2014560.

Name of Policy/Service Review/Service Development/Service Redesign/New Service:

NHSGGC Primary Care Strategy

Is this a: Current Service ☐ Service Development ☒ Service Redesign ☐ New Service ☐ New Policy ☐ Policy Review ☐

Description of the service & rationale for selection for EQIA: (Please state if this is part of a Board-wide service or is locally driven).

What does the service or policy do/aim to achieve? Please give as much information as you can, remembering that this document will be published in the public domain and should promote transparency.

NHSGGC's Primary Care Strategy: 2024/25 -2029/30 sets out our long term vision and approach to primary care transformation across NHSGGC.

The Strategy provides a set of principles and commitments which will support the long term future of primary care services to maintain and improve patient care. It will inform the Primary care delivery/ implementation plan which will detail the actions to maintain and develop the role of primary care as part of the patient's journey of care within the wider health & social care system. It will also provide a spotlight on primary care as a foundation on which to deliver more integrated care to patients throughout NHSGGC. Primary care services provide the first point of contact in the healthcare system, estimates suggest that around 90% of health care episodes start and finish in primary community care.

In addition to our principles and commitments, this strategy includes a set of initiatives that cover the NHSGCC wider responsibilities in relation to primary care, including responsibilities for managing the primary care prescribing budget, the interdependencies between NHSGGC, HSCPs in working with primary contractors i.e. GPs, optometrists, dentists and community pharmacists and support for promoting improvement and the sustainability of primary care in NHSGGC.

The Core principles are:

1. Within our overall Scottish Government funding implement the requirements of primary care contracted services in line with emerging guidance
2. Promoting the sustainability of primary care services
3. Making sure we have a high quality of engagement with primary care contractors, third sector networks, our locality engagement forums and equality groups
4. Progress our support for quality improvement (QI) in primary care
5. Ensuring that our primary care strategy is connected to the NHSGGC MFT programme, the 6 HSCP's strategic plans for other transformation programmes and to the policy developments by the health board and Scottish Government
6. Improving our performance management framework for those primary care functions where we have a responsibility

Why was this service or policy selected for EQIA? Where does it link to organisational priorities? (If no link, please provide evidence of proportionality, relevance, potential legal risk etc.). Consider any locally identified Specific Outcomes noted in your Equality Outcomes Report.

The Primary Care Strategy is a key strategic document for NHSGGC and the 6 HSCPs which sets out how primary care service ambitions will be met in order to deliver the best possible care to our communities in the most efficient way.

The Strategy is a guide to how we will approach the development of primary care which has many work streams and covers a large number of primary care services and contractors. For context, NHSGGC hosts 189 optometrist practices; 228 general practices (GPs); 255 general dental practices (GDS) and 288 community pharmacies (CP) delivering primary care services to around 1.3 million GP registered patients.

The 2023-2028 strategy will set out how those care ambitions will be underpinned with due regard to meeting the legal requirements of the Public Sector Equality Duty (or general duty) of the Equality Act 2010 and the 2018 Fairer Scotland Duty (the duty). In the past a number of primary care programmes & services have conducted EQIAs to support the 3 parts of the General Duty. For example, the Mental Health Strategy & PCIP, HSCP PCIPs and travel health vaccination provision. Additional EQIAs will therefore be undertaken by individual services in the future as part of primary care implementation plan. These will be captured and tracked centrally to ensure coordination of assessments and identify any recurring or related risks to protected characteristic groups.

Our ambitions contained within the strategy are:

In the short term:

1. Shared purpose across a sustainable, sufficiently staffed and skilled workforce

2. Step-change innovations in data and digital technology to improve patient health and care outcomes
3. Integrated care and well-connected services, supported by effective teams, system working, leadership and planning
4. Improved understanding and navigation across our primary care

In the medium to long term:

5. People can access the right service at right time, more flexibly and in ways that suit them
6. Strengthened prevention, early intervention and wellness
7. Better access to trusted information on health and care
8. Strengthened contribution to reducing health inequalities.

The priorities to help realise the ambitions are:

Our priorities are:

1. Development and delivery of a five-year primary care workforce strategy
2. Development of a shared care record accessible to all primary care, both in- and out of hours
3. Improvements to the clarity, consistency and effectiveness of patient pathways
4. Improvements to primary care's access to the right advice at the right time

We will also work to deliver:

1. A five-year communications and engagement plan
2. A range of process and system improvements to enhance journeys into and through primary care
3. Public engagement around digital options to better access information and services
4. Strengthened prevention to better avoid ill-health, protect wellbeing, and improve supported self-management
5. Enhancements to our accommodation and property
6. A strengthen contribution to reducing health inequalities, including through targeted and tailored action.

We will proportionately increase activity around these areas in the event additional resource becomes available.

Who is the lead reviewer and when did they attend Lead reviewer Training? (Please note the lead reviewer must be someone in a position to authorise any actions identified as a result of the EQIA)

Name: Ann Forsyth, Head of Primary Care Support	**Date of Lead Reviewer Training:** Updated 2019

Please list the staff involved in carrying out this EQIA
(Where non-NHS staff are involved e.g. third sector reps or patients, please record their organisation or reason for inclusion):

PC Strategy Communications & engagement group:
Daniel Connelly, Deputy Director Public Engagement, Public Experience and Public Involvement (PEPI)
Lisa Martin, Manager, PEPI Team
Calum Lynch, Project Manager PEPI Team
Josh Kane, Senior Communications Officer, Communications Department
Alastair Low, Planning Manager, Equality and Human Rights
Helen Cadden, Public Partner Primary Care
Ronnie Nicol, Public Partners Primary Care
Gaynor Darling, Family Health Service Advisor, Primary Care Support
Debra Allen, Senior Planning & Policy Development Officer, Renfrewshire HSCP

Consultation with members of the: Primary Care Programme Board – Strategic group

Christine Laverty, Chief Officer Renfrewshire Health & Social Care Partnership
Gary Dover, Assistant Chief Officer, Primary Care and Early Intervention (Glasgow City HSCP)
Allen Stevenson, Director Primary Care
Ann Forsyth, Head of Primary Care Support
Dr Kerri Neylon, Deputy Medical Director Primary Care
Claire McArthur, Director of Planning

		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
1.	**What equalities information is routinely collected from people currently using the service or affected by the policy? If this is a new service proposal what data do you have on proposed service user groups. Please note any barriers to collecting this data in your submitted evidence and an explanation for any protected characteristic data omitted.**	***A sexual health service collects service user data covering all 9 protected characteristics to enable them to monitor patterns of use.***	Equalities data is collected to varying degrees by the primary care services. Where information is not routinely available, equalities data can be collected where necessary to inform the design of a service and the overall demographic trends in NHSGGC will also be taken into account. These are outlined in the NHSGGC Glasgow City Health and Social Care Partnership Demographic and Needs Profile June 2022. Primary care contractors do not routinely collect data on the nine protected characteristics. However, each pathway/service (either direct, public sector or contracted) has a duty to comply with any legislation relating to the nine protected characteristics and to ensure provision of goods and services complies with the Equality Act and Public Sector Equality Duty. As many primary care services are independent contractors in different services, data completeness and sharing practice and systems varies, and data is not owned by NHSGGC. The complexity of service pathways within the Primary Care (and their respective patient information systems) means it is not possible to create a single data repository that captures equality monitoring data across all nine protected characteristics.	We recognise the limitations of the data currently being collected by the varying services and contractors but continue to work on improving this in line with the recommendations made by the Scottish Government's Equalities Data Improvement Programme. Opportunities will be identified to encourage both primary care contractors and HSCP to gather data related to the nine protected characteristics. This will include incorporating the requirement for equalities data to be collected when commissioning services from other organisations.

		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
2.	**Please provide details of how data captured has been/will be used to inform policy content or service design.** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	***A physical activity programme for people with long term conditions reviewed service user data and found very low uptake by BME (Black and Minority Ethnic) people. Engagement activity found promotional material for the interventions was not representative. As a result an adapted range of materials were introduced with ongoing monitoring of uptake. (Due regard promoting equality of opportunity)*** √	Services are required to ensure consideration of equalities in all areas of service planning, development and implementation, with evidence that some services have adapted their model of service design and delivery to ensure effective access for protected characteristic groups who may experience related barriers. A recent example of where service uptake data has been used to inform practice is the **Vaccination Transformation Programme (VTP).** Innovative ways of engaging with disadvantaged communities and to increase uptake amongst underrepresented groups (Black, Asian and minority ethnic) providing various targeted provisions now includes; • Mass drop-in clinics across local community venues including the Central Mosque • Vaccination mobile bus • Older people & adult residential care homes • Patient home visiting service. Translated materials, NHS Inform, use of interpreting services and sign language are provided to support inclusive practice.	As described above, there is no single shared mainstream data collection system across all primary care service providers. While this hampers the ability to aggregate all service use data and understand access patterning by protected characteristic, each system can be interrogated independently where data fields allow. We recognise that that collection of quantitative data is not uniform across all services but within primary care there are a number of opportunities to share good practice, case studies and reporting mechanisms in place through operational & strategic groups.

		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
3.	**How have you applied learning from research evidence about the experience of equality groups to the service or Policy?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☒ **2) Promote equality of opportunity** ☒ **3) Foster good relations between protected characteristics** ☒ **4) Not applicable** ☐	***Looked after and accommodated care services reviewed a range of research evidence to help promote a more inclusive care environment. Research suggested that young LGBT+ people had a disproportionately difficult time through exposure to bullying and harassment. As a result staff were trained in LGBT+ issues and were more confident in asking related questions to young people.*** ***(Due regard to removing discrimination, harassment and victimisation and fostering good relations).***	Related recent research has been reviewed to learn and understand what matters to people from equality groups as detailed in section 4 below. Research recommendations for Primary Care are currently being considered. Some of our PCIP programmes and services have been developed as the result of applied research learning. The original need for the community link worker programme came from GPs working in Glasgow's most deprived neighbourhoods (Deep End GPs). The research evidence clearly recognised the additional health needs and barriers to engagement with services among those living in areas of high deprivation. The CLW was therefore developed as a deprivation based targeted service to remove discrimination and promote equality of opportunity. The Glasgow Disability Alliance published a Disabled People's Mental Health Matters report in October 2022. The findings from this paper align with some of the feedback from public engagement sessions held across Glasgow during development of this strategy.	Nationally, public research has been carried out on public views and experiences of primary care services to learn and monitor trends. For example, the Health and Care Experience survey (2022) is conducted every 2 years. The Public understanding and expectations of primary care in Scotland: Survey Analysis Report was published in November 2022. We recognise that these surveys do not provide local data on protected characteristics. To inform future direction of local Primary Care service the Patient Engagement & Public Involvement team (PEPI) have conducted local engagement (detailed below) and is also currently leading board wide engagement as part of the strategy development. We are actively monitoring and reviewing emerging

			This strategy (and in its alignment to the NHSGGC Mental Health and Public Health strategies) will begin to address some specific barriers experienced by those facing discrimination, exclusion and hardship.	equalities learning to ensure this can be incorporated into the Primary Care Strategy development. Protected characteristic data is not collected as part of the National Health & Social Care survey therefore unable to extract NHSGGC data.
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
4.	**Can you give details of how you have engaged with equality groups with regard to the service review or policy development? What did this engagement tell you about user experience and how was this information used? The Patient Experience and Public Involvement team (PEPI) support NHSGGC to listen and understand what matters to people and can offer support.** **Your evidence should show which of the 3 parts of the General Duty have been**	***A money advice service spoke to lone parents (predominantly women) to better understand barriers to accessing the service. Feedback included concerns about waiting times at the drop in service, made more difficult due to child care issues. As a result the service introduced a home visit and telephone service which significantly increased uptake.*** ***(Due regard to promoting equality of opportunity)***	In 2022/23, the strategy project team, supported by the Patient Engagement and Public Involvement (PEPI) Team undertook a wide variety of in-person and virtual events to understand the experiences of primary care contractors, HSCP staff and service users on primary care services. There was no exclusion criteria and the team engaged with a broad spectrum of community groups, across Greater Glasgow, many of which represented people with protected characteristics with a total of 324 members of the public engaging in the sessions. Specific protected characteristics were represented by some of the groups listed below: BME people; new Scots; asylum seekers; refugees; older people; carers; disabled people; men and women.	We recognise that due to the scale and scope of primary care services and for the reasons outlined, we were unable to capture all staff & service users' experiences. The findings will be proactively taken into consideration to shape the direction for primary care services. We will take into account all aspects of the General Duty i.e.: remove discrimination, harassment and victimisation, promote equality of opportunity and foster good relations between protected characteristics.

	considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ☒ **2) Promote equality of opportunity** ☒ **3) Foster good relations between protected characteristics** ☒ **4) Not applicable** ☐	**** The Child Poverty (Scotland) Act 2017 requires organisations to take actions to reduce poverty for children in households at risk of low incomes.***	**Primary Care Strategy Public Engagement Sessions**: 27/04/23 Inverclyde Your Voice Community Forum 22/05/23 Renfrewshire In-Ren Network 25/05/23 East Dunbartonshire Senior Carers Forum 30/05/23 Public virtual/online open session 01/06/23 Public virtual/online session 07/06/23 Glasgow The Life I Want Group 08/06/23 HSCP Locality Engagement Forum 09/06/23 East Renfrewshire Big Lunch Event 13/06/23 West Dunbartonshire Clydebank Pop-up Session 19/06/23 West Dunbartonshire Locality Group, Community Representatives 19/06/23 Glasgow, Chance2change Expert Reference Group 22/06/23 Inverclyde Your Voice Community Forum 29/06/23 West Dunbartonshire Pop-up Session 16/08/23 Public virtual/online session 18/08/23 Public Online/virtual session To ensure the engagement sessions and meetings were easily accessible, several methods were used to engage including presentations and discussions via Microsoft Teams, open discussions during some HSCP meetings, a social media survey and face to face discussions with local community groups. In summary, engagement findings with the stakeholders and staff suggest the NHSGGC should address the sustainability of primary care, quality improvement, communication and engagement, collaborative working and property. The patient and service user findings suggest improvements in	

			access to primary care services, in particular GPs and dentists, and effective communication from and between primary care services. Patients also identified a clear need for improved mental health services.	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
5.	**Is your service physically accessible to everyone? If this is a policy that impacts on movement of service users through areas are there potential barriers that need to be addressed? Your evidence should show which of the 3 parts of the General Duty have been considered.** **1) Remove discrimination, harassment and victimisation** ☒ **2) Promote equality of opportunity** ☒ **3) Foster good relations between protected characteristics.** ☒ **4) Not applicable** ☐	***An access audit of an outpatient physiotherapy department found that users were required to negotiate 2 sets of heavy manual pull doors to access the service. A request was placed to have the doors retained by magnets that could deactivate in the event of a fire.*** ***(Due regard to remove discrimination, harassment and victimisation).***	Primary care services are universal services delivered from community-based premises and are compliant with the Public Sector Duty in terms of physical accessibility, understanding the need to make any reasonable adjustments where barriers may exist. Where services are delivered from premises belonging to primary care contractors, all premises must be DDA Compliant. The location and accessibility of community based premises is a key component of the design of services. For example, with the new integrated social and primary care, mental health and community hub at Parkhead, inequalities have been considered as part of the design. The building will meet the accessibility requirements, be DDA compliant and have a dementia friendly design. Engagement will continue with a wide range of people to ensure that people with protected characteristics can participate in the consultation activities. Work will take place with equalities groups to seek their input in the proposed development and	

			the community facilities within the hub will be designed and managed to support access by all groups, inclusive of those with protected characteristics. In addition to ensuring physical accessibility, the continued investment in patient-facing digital access solutions needs to ensure it does not inadvertently contribute to widening the health gap. Primary care services will ensure that where a digital solution is identified, developed and integrated into access pathways, it will not be to the detriment of those who experience digital exclusion and are unable to benefit from the investment. Access will be underpinned with the principle that no one will be left behind and that digital access to appointments as the first option will not be the default position.	
		Example	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
6.	**How will the service change or policy development ensure it does not discriminate in the way it communicates with service users and staff?** **Your evidence should show which of the 3 parts of the General Duty have been**	***Following a service review, an information video to explain new procedures was hosted on the organisation's YouTube site. This was accompanied by a BSL signer to explain service changes to Deaf service users.***	Primary care services that are delivered to NHSGGC patients/service users are supported by mainstream interpreting and translation resources. This means that where a communication support is identified for an individual, provision can be made, either in spoken language, BSL or alternative format. All NHSGGC Service in the development of communications should utilise the NHSGGC Clear to All guide. The guide has been developed to support	We will continue to engage with patients around access to services and how we can improve this equally and equitably

	considered (tick relevant boxes). **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ☐	***Written materials were offered in other languages and formats.*** ***(Due regard to remove discrimination, harassment and victimisation and promote equality of opportunity).***	creation of simple, clear and concise information that allows us to meet our legislative requirements and the needs of our patients. In this context, patient information refers to written information such as leaflets, flyers and posters, as well as video and audio recordings. Many patient information systems will highlight communication support to allow for pro-active planning. Where patients who require communication support access a service where additional needs are unknown, telephone interpreting can be accessed immediately.	
7	**Protected Characteristic**		**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(a)	**Age** **Could the service design or policy content have a disproportionate impact on people due to differences in age? (Consider any age cut-offs that exist in the service design or policy content. You will need to objectively justify in the evidence section any segregation on the grounds of age promoted by the policy or included in the service design).** **Your evidence should show which of the 3 parts of the General Duty have been considered.**		The Primary Care Strategy Team and PEPI team engaged with groups of primary care contractors, HSCP staff and members of the public. Primary care services are universal, so open to all members of the population regardless of age. Feedback from engagement with the East Dunbartonshire Seniors and Carers Forum (31 attendees) showed that people were concerned about the equity of services and a need for improvement to the consistency and variations across the Greater Glasgow & Clyde area.	NHSGGC acknowledge that funding challenges have led to some inconsistencies in service availability across the 6 HSCP areas. This strategy seeks to take a proportionate approach to delivering services where it is needed most, tackling

	1) Remove discrimination, harassment and victimisation ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	The impact of such inconsistencies mean that people's experience of care can differ depending on where they live. A large number of primary care users are over 65 or under 5 years of age. The number of people aged over 65 in the population is due to increase by nearly 32% over the next 20 years. A key focus when designing services will be availability and accessibility of services for this age group. Services will also be adapted for children under 5, where appropriate.	inequalities and promoting fairness across the system.
(b)	**Disability** **Could the service design or policy content have a disproportionate impact on people due to the protected characteristic of disability?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	'The Life I Want Group' is a social partnership covering Greater Glasgow to create opportunities for people with learning difficulties. An engagement session with this group highlighted mixed views and experiences of primary care. Digital developments were generally viewed as potentially helpful for people with disabilities but assumptions regarding access should be avoided and alternatives offered. Other feedback related to gaps in staff awareness of equalities and patient rights in general, a higher susceptibility (for people with disabilities) towards misleading health information and signposting to services should be accessible to all. A questionnaire was also specifically sent to members of the Involving People Network (IPN). Primary care services are open to all members of the population and the engagement undertaken didn't highlight any specific areas to be addressed in	Through implementation of the strategy any redesign of service and /or policy redesign that impact on protected characteristics will be subject to EQIA process to identify potential and consequential impacts

		relation to disability that weren't expressed by those who engaged as a whole. All of the above will be taken into account when designing the Primary Care Strategy and implementation / delivery Plan with focused attention during service related specific review.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(c)	**Gender Reassignment** **Could the service change or policy have a disproportionate impact on people with the protected characteristic of Gender Reassignment?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ■ **4) Not applicable** ☐	The Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people (NHSGGC, NHS Lothian and Public Health Scotland, 2022) found that most participants were happy with their Primary Care experiences. Of those people using their GP in the previous year, 88% reported a positive experience. It is possible that where a service user is signposted to a health professional other than their own GP, that healthcare professional may not know the patient's trans history. Where any services are configured on a separate or single sex basis in a primary care setting, the EHRC document – Separate and Single Sex Service Providers – A Guide on the Equality Act Sex and Gender Reassignment Provisions will be referred to.	Staff training on gender re-assignment issues can support mitigation against any patient being discriminated against. Close links can be developed with the Sandyford Clinic to ensure that all aspects of the service take cognisance of gender re-assignment issues.
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(d)	**Marriage and Civil Partnership**	Not applicable to this strategy.	

	Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Marriage and Civil Partnership? **Your evidence should show which of the 3 parts of the General Duty have been considered** **1) Remove discrimination, harassment and victimisation** ☐ **2) Promote equality of opportunity** ☐ **3) Foster good relations between protected characteristics** ☐ **4) Not applicable** ■		
(e)	**Pregnancy and Maternity** **Could the service change or policy have a disproportionate impact on the people with the protected characteristics of Pregnancy and Maternity?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■	The Strategy project team and the Patient Engagement and Public Involvement (PEPI) Team engaged with groups of primary care contractors, HSCP staff and members of the public which were representative of the overall population. Primary care services are open to all members of the population and the engagement undertaken didn't highlight any specific areas in relation to pregnancy or maternity which needed addressed. However, Primary care service design will continue to consider pregnant women and maternity services. For example, the Vaccination Transformation Programme facilitated ease of access for pregnant	

	2) Promote equality of opportunity ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** ☐	women, by delivering vaccination within the maternity services which women were already attending.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(f)	**Race** **Could the service change or policy have a disproportionate impact on people with the protected characteristics of Race?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics** ■ **4) Not applicable** ☐	Feedback from the In-Ren (Renfrewshire) network highlighted that New Scots communities can experience limited information on how the healthcare system in Scotland works compared to other countries. This group also noted a need to consider communication methods for non-English speaking individuals and communities. Currently alternative language formats for health information is available to all on request from members of staff.	Overall, NHSGGC has a higher proportion of people from a BAME backgrounds compared to the overall national average. Service design in all areas will need to take the needs of this group into account. For example, when providing interpreting services at healthcare appointments and providing information in different languages. The primary contractors currently use the interpreting service when required to book an interpreter over the phone or in person.
(g)	**Religion and Belief**	The health records of individual patients may contain information on religion or belief which could affect the care they wish to receive.	

	Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Religion and Belief? **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☒ **2) Promote equality of opportunity** ☒ **3) Foster good relations between protected characteristics.** ☒ **4) Not applicable** ☐	However, in terms of the population as a whole, the strategy project team and the PEPI team engaged with groups of primary care contractors, HSCP staff and members of the public which were representative of the overall population. Primary care services are universal to all members of the population and the engagement undertaken didn't highlight any specific areas in relation to religion or belief which needed addressed.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(h)	**Sex** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sex?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).**	Primary care services are open to all members of the population. Health records of individual patients may contain information on sex which could affect the care they wish to receive. This may because certain sex specific services are due to biology, rather than any exclusion of service user e.g. cervical screening. In terms of the population as a whole, the strategy project team and the PEPI team engaged with a broad range of primary care contractors, HSCP staff and members of the public which were	

	1) Remove discrimination, harassment and victimisation ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	representative of the overall population. The engagement undertaken didn't highlight any specific areas in relation to sex which needed addressed.	
(i)	**Sexual Orientation** **Could the service change or policy have a disproportionate impact on the people with the protected characteristic of Sexual Orientation?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ■ **2) Promote equality of opportunity** ■ **3) Foster good relations between protected characteristics.** ■ **4) Not applicable** □	In terms of the population as a whole, the strategy project team and the PEPI team engaged with a broad range of primary care contractors, HSCP staff and members of the public. Primary care services are open to all members of the population. Due to initial challenges identifying an appropriate LGBTQ group available to participate and subsequently securing suitable dates, we were unable to deliver this specific session within the agreed phase two engagement period. However, we have agreed to continue to engage with the identified group re further opportunities for participation as the strategy moves forward and in particular around any local or service-specific actions and improvements that arise from the implementation phase. Additionally, we will continue to develop our knowledge of and relationships with local LGBTQ groups and networks, to ensure that the programme of ongoing engagement provides accessible and	As part of implementation change require to consider engagement with LGB service users during implementation given limited engagement during strategy development

		appropriate opportunities that reflect peoples' lived experience. Recent recommendations from NHSGGC, NHS Lothian and Public Health Scotland's LGBTQ+ report will also be considered.	
	Protected Characteristic	**Service Evidence Provided**	**Possible negative impact and Additional Mitigating Action Required**
(j)	**Socio – Economic Status & Social Class** **Could the proposed service change or policy have a disproportionate impact on people because of their social class or experience of poverty and what mitigating action have you taken/planned?** **The Fairer Scotland Duty (2018) places a duty on public bodies in Scotland to actively consider how they can reduce inequalities of outcome caused by socioeconomic disadvantage when making <u>strategic</u> decisions. If relevant, you should evidence here what steps have been taken to assess and mitigate risk of exacerbating inequality on the ground of socio-economic status. Additional information available here:** Fairer Scotland Duty: guidance for public bodies - gov.scot (www.gov.scot). 7 Qs? 1. What evidence has been considered in preparing for the decision, and are there any gaps in the evidence?	The strategy project team and the PEPI team engaged with many diverse groups of primary care contractors, HSCP staff and members of the public. The negative impact of health inequalities and poverty on health and wellbeing is immense. There is evidence that austerity measures and increases in the cost of living compound health inequality by affecting mental health, so as the cost of living increases, it is more important than ever to design services with this in mind. Furthermore, it is crucial to recognise this when designing services for Primary Care, as it has been recognised that strong primary care systems are positively associated with better health. Recent learning has highlighted digital exclusion as an issue to consider, particularly for people with less resource and/or older adults. With this in mind it is vital that an approach which prioritises investment in	We will further explore prevalence and patterning of digital exclusion in NHSGGC and ensure that we retain patient choice around ways to access information, care and treatment and support that include non-digital routes. Impact of commitments will be monitored through the evaluation framework which will be developed to support monitoring of the strategy

	2. What are the voices of people and communities telling us, and how has this been determined (particularly those with lived experience of socio-economic disadvantage) 3. What does the evidence suggest about the actual or likely impacts of different options or measures on inequalities of outcome that are associated with socio-economic disadvantage 4. Are some communities of interest or communities of place more affected by disadvantage in this case than others? 5. What does our Duty assessment tell us about socio-economic disadvantage experienced disproportionately according to sex, race, disability and other protected characteristics that we may need to factor into our decisions 6. How has the evidence been weighed up in reaching our final decision? 7. What plans are in place to monitor or evaluate the impact of the proposals on inequalities of outcome that are associated with socio-economic disadvantage?	developing a digital 'front door' to primary care services does not inadvertently compound barriers to access for people living in poverty. Poverty is often a common denominator for protected characteristic groups most marginalised in society. To this end, digital exclusion will have the greatest impact on the frail/elderly, those with disabilities, transgender people and those from Black, Asian and/or ethnic minority communities. Due to Primary Care Improvement Plan funding, the Community Link Worker (CLW) service was established in some GP practices located some HSCPs in the most deprived areas of NHSGGC. One of the services offered by CLW's is financial advice and they also link clients to the Welfare Advice Health Partnership project located within some GP surgeries or Third sector financial inclusion organisations.	
(k)	**Other marginalised groups** **How have you considered the specific impact on other groups including homeless people, prisoners and ex-offenders, ex-service personnel, people with addictions, people involved in prostitution, asylum seekers & refugees and travellers?**	The strategy project team and the Patient Engagement and Public Involvement (PEPI) Team engaged with many groups of primary care contractors, HSCP staff and members of the public. In addition to the feedback (as per section F) from public engagement which outlined the main concerns in relation to New scots and non-English speaking communities, the communication and engagement commitments and associated delivery plans will set	The strategy aligns with the NHSGGC mental health and public health strategies and all marginalised and/or underrepresented groups will be considered and included as part of development of this strategy and its associated implementation/delivery plans.

		out how we will work with marginalised groups in the future.	All workstreams and change proposals will be subject to EQIA.
8.	**Does the service change or policy development include an element of cost savings? How have you managed this in a way that will not disproportionately impact on protected characteristic groups?** **Your evidence should show which of the 3 parts of the General Duty have been considered (tick relevant boxes).** **1) Remove discrimination, harassment and victimisation** ☒ **2) Promote equality of opportunity** ☒ **3) Foster good relations between protected characteristics.** ☒ **4) Not applicable** ☐	A draft budget for primary care services has been set which reflects the anticipated funding. We are following the Scottish Government guidance and anticipate delivery within current forecasted funds.	We recognise that if any service was removed due to financial constraints, consideration would need to be given to the impact and this would have on patients in terms of access and travel, for example. Planning would be put in place to minimise or mitigate any foreseen adverse consequences.
		Service Evidence Provided	**Possible negative impact and Additional Mitigating Action Required**
9.	**What investment in learning has been made to prevent discrimination, promote equality of opportunity and foster good relations between protected characteristic**	Equalities Training and staff development for primary care staff deliver are being further developed. Work is ongoing to progress this action, including a	

	groups? As a minimum include recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering equality, diversity and human rights.	newsletter and updates provided to all staff on primary care initiatives with requirement for equalities training, including undertaking of EQIAs. Mechanisms are in place to record statutory & mandatory equalities training for HSCP staff and contractor groups as employer responsible for providing and maintaining training of their staff.	

10. In addition to understanding and responding to legal responsibilities set out in Equality Act (2010), services must pay due regard to ensure a person's human rights are protected in all aspects of health and social care provision. This may be more obvious in some areas than others. For instance, mental health inpatient care or older people's residential care may be considered higher risk in terms of potential human rights breach due to potential removal of liberty, seclusion or application of restraint. However risk may also involve fundamental gaps like not providing access to communication support, not involving patients/service users in decisions relating to their care, making decisions that infringe the rights of carers to participate in society or not respecting someone's right to dignity or privacy.

The Human Rights Act sets out rights in a series of articles – right to Life, right to freedom from torture and inhumane and degrading treatment, freedom from slavery and forced labour, right to liberty and security, right to a fair trial, no punishment without law, right to respect for private and family life, right to freedom of thought, belief and religion, right to freedom of expression, right to freedom of assembly and association, right to marry, right to protection from discrimination.

Please explain in the field below if any risks in relation to the service design or policy were identified which could impact on the human rights of patients, service users or staff.

Through the delivery of a coordinated EQIA programme for aligned service developments, the Primary Care Strategy and Implementation plan will ensure the right to protection from discrimination is upheld.

Please explain in the field below any human rights based approaches undertaken to better understand rights and responsibilities resulting from the service or policy development and what measures have been taken as a result e.g. applying the PANEL Principles to maximise Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality or FAIR* .

PANEL principles were used as part of this EQIA of the Primary Care Strategy 2023 – 2028 to ensure that services and programmes take a human rights-based approach with a focus on responding to and tackling inequality.

Participation- Primary care seeks active participation and engagement of patients and service users through direct engagement and evaluation. A comprehensive engagement exercise was undertaken from March - June 2023 with primary care contractors, HSCP staff and service users as detailed in Section 4.

Accountability- a dedicated equalities assessment of Primary Care Strategy 2023 – 2028 is now being undertaken and will be reviewed on a six monthly basis. Component programmes and services within the Primary Care have or will also produce EQIAs.

Non-discrimination - primary care services are universal services which are open to all.

Equality/Empowerment- The Primary Care Strategy seeks to promote equality and equity within NHSGGC and has continued to commission and utilise research reports to raise awareness, plan, resource and act on the significant health inequality challenges for the board. We have introduced and will embed patient and public involvement via the Communications and Engagement Sub-group.

Legality-The service is compliant with UK and Scottish Law.

- **F**acts: What is the experience of the individuals involved and what are the important facts to understand?
- **A**nalyse rights: Develop an analysis of the human rights at stake
- **I**dentify responsibilities: Identify what needs to be done and who is responsible for doing it
- **R**eview actions: Make recommendations for action and later recall and evaluate what has happened as a result.

Having completed the EQIA template, please tick which option you (Lead Reviewer) perceive best reflects the findings of the assessment. This can be cross-checked via the Quality Assurance process:

☐ Option 1: No major change (where no impact or potential for improvement is found, no action is required)

■ Option 2: Adjust (where a potential or actual negative impact or potential for a more positive impact is found, make changes to mitigate risks or make improvements

☐ Option 3: Continue (where a potential or actual negative impact or potential for a more positive impact is found but a decision not to make a change can be objectively justified, continue without making changes)

☐ Option 4: Stop and remove (where a serious risk of negative impact is found, the plans, policies etc. being assessed should be halted until these issues can be addressed)

11. If you believe your service is doing something that 'stands out' as an example of good practice - for instance you are routinely collecting patient data on sexual orientation, faith etc. - please use the box below to describe the activity and the benefits this has brought to the service. This information will help others consider opportunities for developments in their own services.

As part of GP contract and HSCPs associated PCIP 2019-21, the Community Links Worker programme was developed. The programme is a service that is in most HSCPs deprivation focused and operates within the GP practices. The enhanced support to patients within universal GP practices provides non-stigmatising targeted action against health inequalities. NHSGGC recognises the particular need to reduce inequalities of outcome caused by socioeconomic disadvantage, so the programme continues to request additional financial investment and further expansion at national level.

Actions – from the additional mitigating action requirements boxes completed above, please summarise the actions this service will be taking forward.	**Date for completion/ Who is responsible? (initials)**
Progress developing access to LearnPro community for the non HSCP workforce to provide opportunity for staff to complete the Equality and Human Rights modules to ensure competence with regard to the protected characteristics.	TBC with Implementation
Provide or support access to awareness sessions in the NHSGGC and wider primary care workforce on issues affecting marginalised groups to ensure staff are able to understand and recognise the needs of marginalised groups.	TBC with Implementation
Provide or support access to more specialist training in NHSGGC and wider primary care workforce on issues affecting specific marginalised groups to ensure staff are knowable and skilled at responding to the needs of specific marginalised groups.	TBC with Implementation

With an increasing BAME, asylum seeking and refugees population, 80 different languages are spoken within NHSGGC. We will: • Support the pathway for primary care contractors / practice requests for information in other languages and formats. • Provide information to practice staff with regard to the use of interpreters in primary care settings.	TBC with Implementation
Opportunities will be identified to encourage both primary care contractors and HSCP staff to gather standardised data related to the nine protected characteristics. This will also include incorporating the requirement for equalities data to be collected when commissioning services from other organisations.	TBC with Implementation
We will continue to look to other data sources in NHSGGC and nationally to benchmark and assess the equalities data as required.	TBC with Implementation
It is important that we understand the experience of equalities groups who access our service. We will build on our previous engagement events to gather the views of primary care contractors, HSCP staff and service users on primary care services. We will continue to progress our engagement work to seek to capture patient and service users experiences and perspectives across equalities groups. We will seek public health advice and support to ensure that Strategy actions do not negatively impact on equalities (and where possible, will positively impact on them).	TBC with Implementation
Throughout the duration of this Strategy and implementation phase, we have committed to build on and share learning from the PC services.	TBC with Implementation
We will continue to review and report on equalities performance to NHSGGC Primary Care programme Board – Strategic Group, on an as required basis.	TBC with Implementation

Ongoing 6 Monthly Review- please write your 6 monthly EQIA review date:

Oct 2024

Lead Reviewer:	**Name:**	Ann Forsyth
EQIA Sign Off:	**Job Title:**	Head of Primary Care Support
	Signature:	
	Date:	**17/11/2023**
Quality Assurance Sign Off:	**Name**	**Alastair Low**
	Job Title	**Planning Manager**
	Signature	**Alastair Low**
	Date	**15/11/2023**

NHS GREATER GLASGOW AND CLYDE EQUALITY IMPACT ASSESSMENT TOOL
MEETING THE NEEDS OF DIVERSE COMMUNITIES
6 MONTHLY REVIEW SHEET

Name of Policy/Current Service/Service Development/Service Redesign:

Please detail activity undertaken with regard to actions highlighted in the original EQIA for this Service/Policy

		Completed	
		Date	Initials
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			
Action:			
Status:			

Please detail any outstanding activity with regard to required actions highlighted in the original EQIA process for this Service/Policy and reason for non-completion

		To be Completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any new actions required since completing the original EQIA and reasons:

		To be completed by	
		Date	Initials
Action:			
Reason:			
Action:			
Reason:			

Please detail any discontinued actions that were originally planned and reasons:

Action:	
Reason:	
Action:	
Reason:	

Please write your next 6-month review date

Name of completing officer:

Date submitted:

If you would like to have your 6 month report reviewed by a Quality Assuror please e-mail to: alastair.low@ggc.scot.nhs.uk

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

Report by Julie Slavin, Chief Financial Officer

27 June 2024

Subject: 2023/24 Financial Performance Draft Outturn Report

1. Purpose

1.1 To provide the Health and Social Care Partnership Board with the draft outturn position for the period 1 April 2023 to 31 March 2024.

2. Recommendations

2.1 The HSCP Board is recommended to:

a) **Note** the updated position in relation to budget movements on the 2023/24 allocation by West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board and **approve** the direction for 2023/24 back to our partners to deliver services to meet the HSCP Board's strategic priorities;
b) **Note** the draft outturn position (subject to audit) for the period 1 April 2023 to 31 March 2024 is reporting an adverse (overspend) position of £1.731m (0.86%) including all planned transfers to/from earmarked reserves;
c) **Note** the update on the monitoring of savings agreed for 2023/24;
d) **Note** the draft reserves balances (subject to audit);
e) **Approve** the requirement to increase to £12/hr Social Care Workers commissioned to provide services to Children and Young People, within the level of affordability, as per the letters attached as Appendices 8 to 10;
f) **Note** the update on the capital position and projected completion timelines; and
g) **Note** the HSCP Board's Audit and Performance Committee considered the 2023/24 draft unaudited accounts at the 27 June 2024 meeting.

3. Background

3.1 At the meeting of the HSCP Board on 15 March 2023 members agreed the 2023/24 revenue estimates. A total indicative net revenue budget of £191.016m (excluding Set Aside) was approved as the health allocation was subject to NHSGGC Board formal approval. The set aside, notional budget agreed for 2023/24 is £40.596 million.

3.2 Since the March HSCP Board report there have been several budget adjustments. A total net budget of £200.643m is now being monitored as detailed within Appendix 1.

3.3 Draft set aside figures have been received indicating an outturn position of £43.914m.

4. Main Issues

Summary Position

4.1 The March HSCP Board received a comprehensive update on the projections to 31 January 2024, this report refreshes any significant movements since then. The outturn position as of 31 March 2024 is an overspend of £1.731m (0.86%). The consolidated summary position is presented in within Appendix 3, and individual Health Care and Social Care reports in Appendix 4.

4.2 The overall HSCP summary and the individual head of service positions are reported within Tables 1 and 2 below. Table 3 details the underlying position by head of service, excluding the impact of the local government pay award, and shows a minimal overspend position.

Table 1 – Summary Financial Information as of 31 March 2024

Summary Financial Information	Annual Budget	Actual Spend	Review Adjustments	Actual Spend	Actual Variance	Reserves Adjustment	Recovery Plan	Actual Variance	Variance %
	£000	£000	£000	£000	£000	£000	£000	£000	
Health Care	121,243	120,587	0	120,587	656	656	0	0	0.00%
Social Care	118,269	212,525	(86,826)	125,699	(7,430)	(2,802)	(1,946)	(2,682)	-2.27%
Expenditure	**239,512**	**333,112**	**(86,826)**	**246,286**	**(6,774)**	**(2,146)**	**(1,946)**	**(2,682)**	-1.12%
Health Care	(5,596)	(5,596)	0	(5,596)	0	0	0	0	0.00%
Social Care	(33,273)	(118,171)	85,653	(32,518)	(755)	(1,720)	14	951	-2.86%
Income	**(38,869)**	**(123,767)**	**85,653**	**(38,114)**	**(755)**	**(1,720)**	**14**	**951**	-2.45%
Health Care	115,647	114,991	0	114,991	656	656	0	0	0.00%
Social Care	84,996	94,354	(1,173)	93,181	(8,185)	(4,522)	(1,932)	(1,731)	-2.04%
Net Expenditure	**200,643**	**209,345**	**(1,173)**	**208,172**	**(7,529)**	**(3,866)**	**(1,932)**	**(1,731)**	**-0.86%**

Table 2 – Financial Information as at 31 March 2024 by Head of Service

Summary Financial Information	Annual Budget	Actual Spend	Review Adjustments	Actual Spend	Actual Variance	Reserves Adjustment	Recovery Plan	Actual Variance	Variance %
	£000	£000	£000	£000	£000	£000	£000	£000	
Children's Health, Care & Justice	29,865	31,743	(127)	31,616	(1,751)	(321)	0	(1,430)	-4.79%
Health and Community Care	51,604	55,610	(1,477)	54,133	(2,530)	(156)	(1,470)	(904)	-1.75%
Mental Health, Learning Disability & Addictions	30,365	30,069	(206)	29,863	502	(409)	0	911	3.00%
Strategy & Transformation	2,165	1,723	(9)	1,714	451	143	0	308	14.23%
Family Health Services	33,004	33,075	0	33,075	(71)	0	0	(71)	-0.22%
GP Prescribing	21,323	22,667	0	22,667	(1,344)	0	0	(1,344)	-6.30%
Hosted Services	8,329	9,141	0	9,141	(812)	(812)	0	0	0.00%
Other	23,988	25,317	646	25,963	(1,974)	(2,311)	(462)	799	3.33%
Net Expenditure	**200,643**	**209,345**	**(1,173)**	**208,172**	**(7,529)**	**(3,866)**	**(1,932)**	**(1,731)**	**-0.86%**

Table 3 – Underlying Variance Excluding Impact of Local Authority Pay Award

Summary Financial Information	Revised Forecast Variance	Cost of Local Government Pay Uplift	Variance Exc Cost of Local Government Pay Uplift
	£000	£000	£000
Children's Health, Care & Justice	(1,430)	328	(1,102)
Health and Community Care	(904)	1,049	145
Mental Health, Learning Disability & Addictions	911	124	1,035
Strategy & Transformation	308	30	338
Family Health Services	(71)	0	(71)
GP Prescribing	(1,344)	0	(1,344)
Hosted Services	0	0	0
Other	799	26	825
Total	**(1,731)**	**1,557**	**(174)**

4.3 The draft outturn position is an improvement of £0.569m from that reported at period 10 as highlighted in Table 4 with the main movements detailed in Appendix 6. These movements are mainly due to recruitment challenges, updated prescribing costs, volatility in demand and significant levels of staff sickness in frontline services leading to increased use of agency and overtime cover.

Table 4 – Movement in Reported Position since Period 10 Position

Reconciliation of Movements in Reported Position between Final Outturn and March HSCP Board Report	Forecast Full Year	Drawdown / (Transfer to) Earmarked Reserves	Drawdown / (Transfer to) Unearmarked Reserves
	£000's	£000's	£000's
Final Adverse Variance Reported - Impact on Reserves	(7,529)	(5,798)	(1,731)
Period 10 Adverse Variance Reported - Impact on Reserves	(8,098)	(6,491)	(1,607)
Movement	**569**	**693**	**(124)**

4.4 Members should note that the draft outturn considers the progress on agreed savings programmes, £3.866m of expenditure to be covered from drawdowns in earmarked reserves and the implementation of the recovery plan as approved at the November HSCP Board, which includes a further application of reserves of £1.932m. Further detail on progress of savings is detailed in Appendix 2 with a summary position shown in Table 5 below.

4.5 The progress of savings is tracked by the Senior Management Team, and a RAG (Red, Amber, and Green) status applied to inform further actions. In the period to 31 March 2024 approximately 71% of savings have been achieved, with the remainder requiring further action and carried forward to 2024/25. Summary detail on the anticipated level of reserves, including those approved by the HSCP Board in March 2023 to underwrite the savings challenge, is provided within Appendix 7.

Table 5 – Monitoring of Savings and Efficiencies

Efficiency Detail	Saving to be Monitored	Savings Completed or Anticipated to be Achieved as Planned	Saving Achieved Through Management Action	Savings at Medium Risk of not being achieved as planned and subject to Recovery Planning	Savings at High Risk of not being achieved as planned and subject to Recovery Planning
	£000	£000	£000	£000	£000
Total	7,862	5,307	283	55	2,217
Health Care	1,243	1,243	0	0	0
Social Care	6,619	4,064	283	55	2,217

4.6 Analysis on the projected annual variances more than £0.050m are contained within Appendix 5. The variance analysis highlights the range of pressures being managed across the HSCP delegated budgets. After accounting for anticipated movements in staffing and demand pressure and the application of recovery planning actions, the residual projected overspend of £1.731m is mainly due to the additional unfunded local government staff pay award costs.

Bad Debt Write-Off and Bad Debt Provision

4.7 As agreed by WDC and the HSCP Board in March 2022, the Board are responsible for accounting for bad debt arising from charges levied for HSCP delegated services and as such include a provision for potential bad debt within the HSCP Board's balance sheet.

4.8 While WDC retain the legal power to both set and levy charges, with the collection of those charges being governed by the Council's Corporate Debt Policy any requests to write off HSCP debt now come to the HSCP Chief Financial Officer and HSCP Board for approval depending on the value of the write off request. The policy recognises that where a debt is irrecoverable, prompt and regular write-off of such debts is appropriate in terms of good accounting practice. While the Council and HSCP will seek to minimise the cost of write-offs, by taking all necessary action to recover what is due, where it has not been possible to collect a debt, authorisation to write these debts off will be requested to:

- The HSCP Chief Financial Officer if the debt is under £5,000; or
- The HSCP Board if the debt is valued at more than £5,000

4.9 At the time of writing the analysis of outstanding debt for the Quarter 4 (period 1 January to 31 March 2024) was not yet available, however it will be provided within the first update report of the new financial year. The 2023/24 draft unaudited accounts have considered the current level of bad debt provision, with a financial impact in 2023/24 of £0.150m.

Update on Reserves

4.10 Analysis of reserves is detailed in Appendix 7 and identifies that a total of £5.536m has been drawn down from earmarked reserves to fund actual expenditure in 2023/24 and implement the approved recovery plan, at £3.866m and £1.670m respectively, which includes £1.812m applied in March 2023 to balance the 2023/24 budget.

4.11 As agreed as part of the November Recovery Plan, an element of unearmarked reserves of £0.262m has also being utilised, which equated to the value of "free reserve" over the 2% balance held (as of November), as set out within the HSCP Board's Reserves Policy. However, as no pay award funding has been passed through by WDC, the draft outturn overspend of £1.731m requires to be covered from unearmarked reserves. After accounting for this drawdown this would leave a balance of £2.315m or 1.09% of the overall HSCP's net expenditure. This would breach the HSCP Board's Reserve's Policy of aiming to hold a minimum of 2% in a general, unearmarked reserve to provide some protection from unplanned budget variations and support financial sustainability in the short to medium term.

4.12 A full review of all earmarked reserves has been undertaken to identify any reserve no longer required for its original earmarked purpose, and which can be reallocated to partially replenish unearmarked reserves. Appendix 7 provides detail on £1.239m of earmarked reserves that have been identified for reallocation. These proposals have also been replicated within the Unaudited Annual Report and Accounts as reported to the Audit and Performance Committee on 27 June 2024.

Children's Social Care Pay Uplift

4.13 The Programme for Government 2023 to 2024 included a commitment to pay eligible children's social care workers in private, voluntary, and independent sectors a minimum rate of £12 per hour. Appendices 8 to 10 provide guidance, and detail, on both the implementation of the pay uplift for workers who provide direct care to children and young people (including those workers in scope) and the funding allocated.

4.14 Appendices 8 and 9 relate to the implementation of the pay uplift for registered services and personal assistants respectively. Appendix 8 states that "*where services are delegated to Integration Authorities, funding allocated to Integration Authorities should be* ***additional and not substitutional*** *to each Local Authority's 2024/25 recurring budgets for Children's Social Care services*".

4.15 Appendix 10 provides detail of the funding which will be allocated between West Dunbartonshire Council and the HSCP totalling £0.415m. The distribution method has been signed off by COSLA, and the Settlement Distribution Group and the funding will be paid as a redetermination backdated to the start of the financial year 2024/25.

4.16 Based on a high-level review of the 2023/24 outturn of all services in scope, early indications are that the funding awarded will be insufficient to cover the pay uplift required for registered commissioned services and personal assistants. A definitive calculation of any shortfall cannot be fully determined until Scotland Excel publish agreed 2024/25 uplifts. An update will be provided to the August HSCP Board.

Housing Aids and Adaptations and Care of Gardens

4.17 The Housing Aids and Adaptations and Care of Gardens for delivery of social care services is in scope as part of the minimum level of adult services delegated to the HSCP Board and should be considered as an addition to the HSCP's 2023/24 budget allocation of £84.996m from the council.

4.18 These budgets are managed by the Council's – Roads and Neighbourhood and Housing and Employability Services on behalf of the HSCP Board.

4.19 The draft outturn position for the period to 31 March 2024 is included in Table 6 below and will be reported as part of WDC's financial update position.

Table 6 – Draft Outturn Financial Performance as of 31 March 2024

Budgets Managed on Behalf of WD HSCP by West Dunbartonshire Council	Annual Budget	Actual Spend	Actual Variance	Actual Variance	Variance %
	£000	£000	£000	£000	
Care of Gardens	229	229	0	0	0.00%
Aids & Adaptations	250	73	177	177	70.98%
Net Expenditure	**479**	**302**	**177**	**177**	**37.04%**

2023/24 Capital Expenditure

4.20 The capital updates for Health Care and Social Care are contained within Appendix 11 and details the unaudited outturn position on several capital projects being:

- Minor Health Capital Works;
- Special Needs - Aids & Adaptations for HSCP clients;
- Community Alarm upgrade; and
- HSCP ICT Modernisation

5. Options Appraisal

5.1 None required for this report.

6. People Implications

6.1 Other than the position noted above within the explanation of variances there are no other people implications known at this time.

7. Financial and Procurement Implications

7.1 Other than the financial position noted above, there are no other financial implications known at this time. As the audit of the 2023/24 annual accounts progresses the HSCP Board will be updated on any material changes to the draft outturn position.

8. Risk Analysis

8.1 The main financial risks to the HSCP into 2024/25 relate to:

- ongoing increases in demand for some key social care services,
- complex care packages,
- prescribing costs,
- the potentially insufficient funding allocation in relation to children's social care pay uplift,
- the depletion of both earmarked and unearmarked reserves to maintain current levels of service activity and cover unfunded pay award costs for Local Authority staff.

8.2 The impact of inflationary pressures and costs of imports has added to the volatility of GP Prescribing costs. The complicated contractual arrangements and gathering of monthly data from community pharmacies causes a two-month lag in confirming actual costs. Any differences between actual costs and those accrued will impact on 2024/25.

8.3 As of 9 May 2024 the Bank of England reports that the current rate of inflation is 2.3% compared to the target level of 2%. It is unclear at this time what impact this will have on the future of the UK Economy going into 2024/25 which may have a detrimental impact on public sector funding.

8.4 The Minister for Social Care, Mental Wellbeing and Sport, announced in July 2023 that the proposed model for a National Care Service would be based a shared accountability with Scottish Ministers, Local Government and NHS Boards. The National Care Services Bill is currently at Stage 2 having passed the first stage at Holyrood, with MSP's voting 65 to 50 in favour of backing the general principles of the Bill. While a series of communications have been issued on the interpretation of the current version of the Bill and a revised Financial Memorandum, the possibility of direct allocations to Integration Authorities remains unclear at this stage. The Bill as amended will be published following stage 2 proceedings.

9. Equalities Impact Assessment (EIA)

9.1 None required for this report however any recovery plan may require equality impact assessments to be undertaken.

10. Environmental Sustainability

10.1 None required.

11. Consultation

11.1 This report and the projections and assumptions contained within it has been discussed with both council and health board finance colleagues.

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 priorities of the Strategic Plan – Improving Lives Together.

12.2 Strategic enablers being workforce, finance, technology, partnerships, and infrastructure will support delivery of our strategic outcomes as below:

- Caring Communities;
- Safe and Thriving Communities;
- Equal Communities and
- Healthy Communities

13. Directions

13.1 The recurring and non-recurring budget adjustments up to 31 January 2024 (as detailed within Appendix 2) will require the issuing of a direction, see Appendix 12.

Julie Slavin – Chief Financial Officer
Date: 18 June 2024

Person to Contact: Julie Slavin – Chief Financial Officer, Church Street, WDC Offices, Dumbarton G82 1QL
Telephone: 07773 934 377
E-mail: julie.slavin@ggc.scot.nhs.uk

Appendices:

Appendix 1 – Budget Reconciliation
Appendix 2 – Monitoring of Savings
Appendix 3 – Revenue Budgetary Control 2022/23 (Overall Summary)
Appendix 4 – Revenue Budgetary Control 2022/23 (Health Care and Social Care Summary)
Appendix 5 – Variance Analysis over £50k
Appendix 6 – Movements since Period 10
Appendix 7 – Reserves
Appendix 8 – Letter from Director for Children and Families regarding Children's Social Care Pay Uplift - 30 May 2024.

Appendix 9 – Letter from Director for Children and Families regarding Children's Social Care Pay Uplift: Guidance for the Personal Assistant Workforce – 30 May 2024
Appendix 10 – Letter from Director for Children and Families regarding Children's Social Care Pay Uplift in Commissioned Services – 4 June 2024
Appendix 11 – Capital Update
Appendix 12 – Directions

Background Papers: 2023/24 Annual Budget Setting Report – 15 March HSCP Board

2023/24 Financial Performance Report as at Period 10 (28 March 2024)

Localities Affected: All

West Dunbartonshire Health & Social Care Partnership **Appendix 1**

Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

2023/24 Budget Reconciliation	Health Care £000	Social Care £000	Total £000
Budget Approved at Board Meeting on 15 March 2023	**104,536**	**86,480**	**191,016**
Health Rollover Budget Adjustments			
Realignment of Specialist Children Services	1,564		1,564
Realignment of Specialist Children Services	(1,374)		(1,374)
FHS GMS - Recurring Adjustment to Rollover Budget	807		807
Recurring Transfer of Funding to NHSGGC Corporate Facilities re Clydebank Health Centre	(161)		(161)
Budget Adjustments			
COPD Pulmonary Rehabilitation MSK Recurring Funding	23		23
Specialist Child Services Baseline Pay Award Uplift 2022/23 Recurring Trans	(30)		(30)
Apremilast Acute February 2023 Actual WD Non Recurring Funding	13		13
Apremilast Acute March 2023 Actual WD Non Recurring Funding	11		11
WDHSCP Health Visiting Central Training Non Recurring Funding	40		40
Prescribing Tariff Swap Adustment for 2022/23	(276)		(276)
Budget Adjustment related to Health Pay Award One Off Payment	444		444
PCIP Tranche One Funding	3,011		3,011
Winter Planning 1000 HCSW Funding	622		622
ADP Recurring PFG Funding	301		301
Apremilast Acute 22-23 Accr Diff	(4)		(4)
Apremilast Acute Apr23 Actual	10		10
Apremilast Acute May-mar24 Fyb	145		145
Apremilast Acute Feb23 Reverse	(13)		(13)
Apremilast Acute Mar23 Reverse	(11)		(11)
ADP Tranche One Funding and AFC Uplift	497		497
District Nursing Tranche One Funding	150		150
OU Students	10		10
Winter Planning MDT Funding	563		563

West Dunbartonshire Health & Social Care Partnership **Appendix 1**

Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

2023/24 Budget Reconciliation	Health Care £000	Social Care £000	Total £000
School Nursing Funding	210		210
Prescribing Share Of £20m NRAC	378		378
Smoking Prevention Funding	70		70
WD Lead Nurse	54		54
2023/24 Pay Uplift	1,073		1,073
GMS Budget Adjustments	1,083		1,083
Effective Prev Oc Fw	27		27
Dental Outcomes	8		8
Dementia Post Diagnostic Funding	62		62
Care Home Monies	35		35
Covid Vacc Hb/ch	67		67
Mental Health Sas Contract Reforms	8		8
Retinal Screening Oct Triton	(78)		(78)
Prescribing Contr To Cps Global Sum 23/24	(90)		(90)
Apremil Acute Addit 23/24 M10	12		12
Camchp118 Comm Food Network	24		24
Camchp133 Adp Nm Tr2 Nr	171		171
Camchp135 Action 15	619		619
Camchp136 Dn Tr 2 Wdhscp	64		64
Camchp138 Vale Live Active	(25)		(25)
Camchp145 Hwb Comm Engagement	20		20
Gos Ncl 23-24 Fyb 2023-10	219		219
Gos Ncl 23-24 Fyb 2023-10	264		264
Hscp Gds Ncl Budget 23-24	(151)		(151)
Recommended Scottish Allowance		319	319
SDS and Roundings		9	9
Camchp108 Wd Med Pays Uplift	52		52

West Dunbartonshire Health & Social Care Partnership **Appendix 1**

Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

2023/24 Budget Reconciliation	Health Care £000	Social Care £000	Total £000
Wdhscp App Levy Scs Tfer	(10)		(10)
Wdhscp O365 Scs Tfer	(14)		(14)
Wdhscp Pension Scs Tfer	(1)		(1)
Ncl Fy Budget To Expend 23-24	413		413
Gms Fhs Bud Adj Hscps 2023-12	(34)		(34)
Ldl Team From Ld To Hscps	12		12
Go1202 - Ld Health Checks 23/24	24		24
Camchp129 Pcip Tr2 Nr	137		137
Camchp134 Mdt Tr2 Nr	188		188
Apremil Acute Addit 23/24 M12	6		6
Camchp146 Dyn Scot Copd Pt Wd	2		2
Apremil Central Bud To Hscps	1		1
Camchp139 Ou Students Wdhscp	10		10
Camchp159 Rev To Cap Tf Wdhscp	(6)		(6)
Camchp175	16		16
Camchp176	2		2
Camchp177	8		8
Gms Fhs Bud To Hscp's 2023-12	10		10
Adjustment For Sesp Funding	(62)		(62)
Revised Budget 2023/24	**115,753**	**86,808**	**202,561**
Drawdown from Reserves	**(106)**	**(1,812)**	**(1,918)**
Budget Funded from Partner Organisations	**115,647**	**84,996**	**200,643**

West Dunbartonshire Health & Social Care Partnership **Appendix 2**
Monitoring of Efficiencies and Management Adjustments 2023/24

Ref	Head of Service	Partner	Efficiency Detail	Comment	Total
					£000
Unachieved Savings					
CP01	L James	Social Care	Review of foster carer strategy	The full service redesign has still to commence. External fostering placements are under pressure due to the number of clients and Scotland Excel contract uplifts with the result that this saving is at high risk and is unlikely to be achieved.	215
C&F02	L James	Social Care	Review of Kinship placements as part of redesign*	The full service redesign has still to commence. Kinship placements are under pressure at this time with client numbers 31 in excess of those budgeted with the result that this saving is at high risk of not being achieved due to the current financial projection.	54
C&F05	L James	Social Care	Review of external fostering placements as part of redesign*	The full service redesign has still to commence. External fostering placements are under pressure due to the number of clients and Scotland Excel contract uplifts with the result that this saving is at high risk and is unlikely to be achieved.	91
CAH01	F Taylor	Social Care	Reduction in Care at Home overtime and agency spend	The service is experiencing challenges in staffing levels due to absences and vacancies impacting on overtime and agency spend. Monitoring of spend is taking place with authorisation processes now in place, however until the service redesign is implemented this remains a high risk area.	600
CAH01	F Taylor	Social Care	Part Year Reduction in Care at Home budget reflecting work of Service Improvement Leads	The service is experiencing challenges in staffing levels due to absences and vacancies impacting on overtime and agency spend. Monitoring of spend is taking place with authorisation processes now in place, however until the service redesign is implemented this remains a high risk area.	181

West Dunbartonshire Health & Social Care Partnership **Appendix 2**
Monitoring of Efficiencies and Management Adjustments 2023/24

Ref	Head of Service	Partner	Efficiency Detail	Comment	Total
					£000
CAH02	F Taylor	Social Care	Care at Home service improvement project	The service is experiencing challenges in staffing levels due to absences and vacancies impacting on overtime and agency spend. Monitoring of spend is taking place with authorisation processes now in place, however until the service redesign is implemented this remains a high risk area.	425
CAH03	F Taylor	Social Care	Removal of care at home overnight support as provided by District Nurses	While there has been a delay this saving has been achieved in the new financial year with staff to be rellocated.	140
CAH04	F Taylor	Social Care	One year staff turnover increased from 1% to 4%	The service is experiencing challenges in staffing levels due to absences and vacancies impacting on overtime and agency spend. Monitoring of spend is taking place with authorisation processes now in place, however until the service redesign is implemented this remains a high risk area.	337
RSCH01	L James	Social Care	Restrict Continuing Care Spend	While there are 3 more young people being supported than budgeted with ongoing discussions on establishing a local provision to reduce rental costs incurred under the current contract this saving has been partially achieved.	174

West Dunbartonshire Health & Social Care Partnership **Appendix 2**
Monitoring of Efficiencies and Management Adjustments 2023/24

Ref	Head of Service	Partner	Efficiency Detail	Comment	Total
					£000
S&T04	MJ Cardno	Social Care	New Transport Policy will reduce requirement for taxis and some internal transport across social care services	The process required to achieve this saving is ongoing. Meetings with all relevant Heads of Service have taken place and a meeting has taken place with transport to further understand the charges and the formulae which are applied to determine charges. Interrogation of the actual transport charge versus the actual usage has resulted in stark contrasts and work ongoing to understand, if there is a further reduction in use, how this will affect the uplift the transport service apply. At this time there is a medium risk that this saving may not be achieved as planned.	55
			Total **Health Care** **Social Care**		**2,272** **0** **2,272**

West Dunbartonshire Health & Social Care Partnership **Appendix 3**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

Consolidated Expenditure by Service Area	Annual Budget	Actual Spend	Actual Variance	Reserves Adjustment	Recovery Plan	Actual Variance	Variance %	RAG Status
	£000	£000	£000	£000	£000	£000		
Older People Residential, Health and Community Care	34,360	33,472	888	(156)	(392)	1,436	4.18%	↑
Care at Home	13,935	17,421	(3,486)	0	(1,078)	(2,408)	-17.28%	↓
Physical Disability	2,580	2,497	83	0	0	83	3.22%	↑
Childrens Residential Care and Community Services	29,865	31,342	(1,477)	(321)	0	(1,156)	-3.87%	↓
Strategy, Planning and Health Improvement	2,165	1,713	452	143	0	309	14.27%	↑
Mental Health Services - Adult and Elderly, Community and Inpatients	12,072	11,810	262	(124)	0	386	3.20%	↑
Addictions	3,946	3,836	110	(166)	0	276	6.99%	↑
Learning Disabilities - Residential and Community Services	14,346	14,217	129	(120)	0	249	1.74%	↑
Family Health Services (FHS)	33,004	33,075	(71)	0	0	(71)	-0.22%	↓
GP Prescribing	21,323	22,667	(1,344)	0	0	(1,344)	-6.30%	↓
Hosted Services	8,329	9,141	(812)	(812)	0	0	0.00%	→
Criminal Justice (Including Transitions)	0	274	(274)	0	0	(274)	0.00%	↓
Resource Transfer	17,630	17,630	0	0	0	0	0.00%	→
HSCP Corporate and Other Services	7,088	9,077	(1,989)	(2,310)	(462)	783	11.05%	↑
Net Expenditure	**200,643**	**208,172**	**(7,529)**	**(3,866)**	**(1,932)**	**(1,731)**	**-0.86%**	↓

Consolidated Expenditure by Subjective Analysis	Annual Budget	Actual Spend	Actual Variance	Reserves Adjustment	Recovery Plan	Actual Variance	Variance %	RAG Status
	£000	£000	£000	£000	£000	£000		
Employee	90,083	93,355	(3,272)	(1,937)	(1,730)	395	0.44%	↓
Property	1,286	1,568	(282)	(52)	0	(230)	-17.88%	↓
Transport and Plant	1,355	1,321	34	0	(7)	41	3.03%	→
Supplies, Services and Admin	6,574	5,044	1,530	1,383	(58)	205	3.12%	↑
Payments to Other Bodies	82,288	85,359	(3,071)	(1,329)	(124)	(1,618)	-1.97%	↓
Family Health Services	33,971	34,050	(79)	0	0	(79)	-0.23%	→
GP Prescribing	21,323	22,667	(1,344)	0	0	(1,344)	-6.30%	→
Other	2,633	2,920	(287)	(211)	(27)	(49)	-1.86%	↓
Gross Expenditure	**239,513**	**246,284**	**(6,771)**	**(2,146)**	**(1,946)**	**(2,679)**	**-1.12%**	↓
Income	(38,870)	(38,112)	(758)	(1,720)	14	948	-2.44%	↓
Net Expenditure	**200,643**	**208,172**	**(7,529)**	**(3,866)**	**(1,932)**	**(1,731)**	**-0.86%**	↓

West Dunbartonshire Health & Social Care Partnership **Appendix 4**

Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

Health Care Net Expenditure	Annual Budget	Actual Spend	Actual Variance	Reserves Adjustment	Recovery Plan	Actual Variance	Variance %	RAG Status
	£000	£000	£000	£000	£000	£000		
Planning & Health Improvements	901	633	268	113	0	155	17.20%	↑
Childrens Services - Community	4,197	3,947	250	250	0	0	0.00%	→
Childrens Services - Specialist	0	0	0	0	0	0	0.00%	→
Adult Community Services	11,589	10,674	915	379	0	536	4.63%	↑
Community Learning Disabilities	848	833	15	13	0	2	0.24%	↑
Addictions	2,992	2,447	545	254	0	291	9.73%	↑
Mental Health - Adult Inpatients	0	0	0	0	0	0	0.00%	→
Mental Health - Adult Community	4,818	4,575	243	(182)	0	425	8.82%	↑
Mental Health - Elderly Inpatients	3,705	3,705	0	0	0	0	0.00%	→
Family Health Services (FHS)	33,004	33,075	(71)	0	0	(71)	-0.22%	↓
GP Prescribing	21,323	22,667	(1,344)	0	0	(1,344)	-6.30%	↓
Other Services	6,311	5,664	647	641	0	6	0.10%	↑
Resource Transfer	17,630	17,630	0	0	0	0	0.00%	→
Hosted Services	8,329	9,141	(812)	(812)	0	0	0.00%	→
Net Expenditure	**115,647**	**114,991**	**656**	**656**	**0**	**0**	**0.00%**	→

West Dunbartonshire Health & Social Care Partnership **Appendix 4**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

Social Care Net Expenditure	Annual Budget	Actual Spend	Actual Variance	Reserves Adjustment	Recovery Plan	Actual Variance	Variance %	RAG Status
	£000	£000	£000	£000	£000	£000		
Strategy Planning and Health Improvement	1,264	1,081	183	30	0	153	12.10%	↑
Residential Accommodation for Young People	3,062	2,954	108	0	0	108	3.53%	↑
Children's Community Placements	6,947	7,577	(630)	0	0	(630)	-9.07%	↓
Children's Residential Schools	6,178	7,601	(1,423)	92	0	(1,515)	-24.52%	↓
Childcare Operations	5,262	5,000	262	(279)	0	541	10.28%	↑
Other Services - Young People	4,219	4,263	(44)	(384)	0	340	8.06%	↑
Residential Accommodation for Older People	7,407	7,735	(328)	0	(315)	(13)	-0.18%	↓
External Residential Accommodation for Elderly	9,104	8,950	154	(68)	(77)	299	3.28%	↑
Sheltered Housing	1,508	1,612	(104)	0	0	(104)	-6.90%	↓
Day Centres Older People	1,317	993	324	0	0	324	24.60%	↑
Meals on Wheels	31	25	6	0	0	6	19.35%	↑
Community Alarms	(11)	83	(94)	0	0	(94)	854.55%	↓
Community Health Operations	3,335	3,385	(50)	(467)	0	417	12.50%	↑
Residential - Learning Disability	11,237	11,473	(236)	(133)	0	(103)	-0.92%	↓
Physical Disability	2,315	2,197	118	0	0	118	5.10%	↑
Day Centres - Learning Disabilty	2,261	1,911	350	0	0	350	15.48%	↑
Criminal Justice (Including Transitions)	0	274	(274)	0	0	(274)	0.00%	↓
Mental Health	3,549	3,530	19	58	0	(39)	-1.10%	↓
Care at Home	13,935	17,421	(3,486)	0	(1,078)	(2,408)	-17.28%	↓
Addictions Services	955	1,389	(434)	(419)	0	(15)	-1.57%	↓
Equipu	265	301	(36)	0	0	(36)	-13.58%	↓
Frailty	80	17	63	0	0	63	78.75%	↑
Carers	1,564	1,972	(408)	(444)	0	36	2.30%	↑
HSCP - Corporate	(788)	1,437	(2,225)	(2,508)	(462)	745	-94.54%	↑
Net Expenditure	**84,996**	**93,181**	**(8,185)**	**(4,522)**	**(1,932)**	**(1,731)**	**-2.04%**	↓

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Health Care Variances					
Planning & Health Improvements	901	746	155	17%	↑
Service Description	This service covers planning and health improvement workstreams				
Main Issues / Reason for Variance	The favourable variance is due to delays in implementation of new staffing structures and vacancies in the Health Improvement Team.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend				
Adult Community Services	11,589	11,052	536	5%	↑
Service Description	This service provides community services for adults				
Main Issues / Reason for Variance	The favourable variance is mainly due to staff vacancies and turnover.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend				
Addictions	2,992	2,701	291	10%	↑
Service Description	This care group provides addictions services				
Main Issues / Reason for Variance	The favourable variance is mainly due to staff turnover within the core addictions budget.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Mental Health - Adult Community	4,818	4,393	425	9%	↑
Service Description	This care group provides mental health services for adults				
Main Issues / Reason for Variance	The favourable variance is due to recruitment delays and high levels of staff turnover.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend				
Family Health Services (FHS)	33,004	33,075	(71)	0%	↓
Service Description	Board wide family health services				
Main Issues / Reason for Variance	The adverse variance is due to transfer of SESP funding to Health Board Acute Services.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an overspend				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
GP Prescribing	21,323	22,667	(1,344)	-6%	↓
Service Description	GP prescribing costs				
Main Issues / Reason for Variance	GP prescribing costs reports an adverse variance due to increased volumes and an increase in the average cost per item. While the earmarked prescribing reserve of £0.972m was available and could have been used to partially mitigate the overspend, the favourable variance across the remainder of the health porfolio is significant and is able to mitigate the prescibing pressure in the current financial year. This action has retained the entire prescribing reserve to contribute to balancing the 2024/25 and 2025/26 budgets.				
Mitigating Action	None available at this time				
Anticipated Outcome	The final position is a significant overspend				
Social Care Variances					
Strategy Planning and Health Improvement	1,264	1,111	153	12%	↑
Service Description	This service covers planning and health improvement workstreams				
Main Issues / Reason for Variance	The favourable variance is mainly due to staff vacancies and overachievement of income related to student placements.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Residential Accommodation for Young People	3,062	2,954	108	4%	↑
Service Description	This service provides residential care for young persons				
Main Issues / Reason for Variance	The favourable variance is mainly due to staff vacancies and an overachievement of income related to the National Transfer Scheme partially offset by the additional cost of the unfunded payaward.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				
Children's Community Placements	6,947	7,577	(630)	-9%	↓
Service Description	This service covers fostering, adoption and kinship placements				
Main Issues / Reason for Variance	The adverse variance is mainly due to approved savings of £0.306m relating to a review of foster carers and external foster strategy not being achieved and accommodating an additional 45 children in kinship and external foster care more than budgeted for at a cost of circa £0.452m. These overspends are partially offset by an anticipated underspend in internal foster care, interagency, legal and adoption fees.				
Mitigating Action	None available at this time				
Anticipated Outcome	The final position is a significant overspend which will require to be addressed within the implementation of the "What Would It Take" five year strategy.				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Children's Residential Schools and External Accomodation	6,178	7,693	(1,515)	-25%	↓
Service Description	This service area provides residential education for children and includes the costs of secure placements				
Main Issues / Reason for Variance	The adverse variance is mainly due to the combined impact of overspends within client placements which are 100% funded by the HSCP and housing support of £0.547m and £0.182m respectively and incurring costs for unbudgeted secure placements of £0.740m. The number of clients in residential and exernal accommodation is 8 more than budgeted and since the start of the year there have been 9 new clients.				
Mitigating Action	None available at this time				
Anticipated Outcome	The final position is a significant overspend which will require to be addressed within the implementation of the "What Would It Take" five year strategy.				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Childcare Operations	5,262	4,721	541	10%	↑
Service Description	This service area is mainly comprised of staffing costs and includes the cost of social workers				
Main Issues / Reason for Variance	The favourable variance is mainly due to a significant number of vacant posts with recruitment challenges ongoing, partially offset by the additional cost of the unfunded local authority pay award at £0.114m and an overspend on the cost of taxi transfer to transport children to school of £0.088m.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				
Other Services - Young People	4,219	3,879	340	8%	↑
Service Description	This service area is mainly comprised of staffing costs and includes the cost of social workers				
Main Issues / Reason for Variance	The favourable variance is mainly due to a number of vacant posts with recruitment challenges ongoing, partially offset by the additional cost of the unfunded local authority pay award at £0.073m and an overspend in Direct Payments of £0.136m.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
External Residential Accommodation for Elderly	9,104	8,805	299	3%	↑
Service Description	External residential and nursing beds for over 65s				
Main Issues / Reason for Variance	The unadjusted adverse variance of £0.154m is mainly due to the number of external residential placements being used with a change in the profile of clients from residential to nursing and an increase in the number of free personal and nursing care clients partially offset by a reduction in the cost of direct payments. Earmarked reserves have been drawn down as part of the recovery plan.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				
Sheltered Housing	1,508	1,612	(104)	-7%	↓
Service Description	Warden Service for Housing run sheltered housing service				
Main Issues / Reason for Variance	The adverse variance is mainly due to high levels of staff sickness covered by unbudgeted agency staff and premium rate overtime along with an increased demand for the service.				
Mitigating Action	None available at this time				
Anticipated Outcome	The final position is an overspend.				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Day Centres Older People	1,317	993	324	25%	↑
Service Description	Queens Quay, Crosslet House Daycare, Lunch clubs and daycare SDS/Direct payments.				
Main Issues / Reason for Variance	The favourable variance is due to vacant posts arising from delays in reemploying staff since Covid-19 restrictions have ceased. While the service have had to use agency staff to keep numbers at a safe level for clients due to sickness and holiday absence the overall impact resulted in a favourable variance.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				
Community Alarms	(11)	83	(94)	840%	↓
Service Description	Installation and response service for Community Alarms				
Main Issues / Reason for Variance	The adverse variance is mainly due to the impact of the unfunded local authority pay award and an underachievement of income due to credits being applied and late notification of clients no longer requiring an alarm.				
Mitigating Action	None available at this time				
Anticipated Outcome	The final position is an overspend.				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Community Health Operations	3,335	2,918	417	12%	↑
Service Description	Adult services				
Main Issues / Reason for Variance	The favourable variance is due to funding hospital discharge agency costs from the Winter Planning MDT reserve.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				
Residential - Learning Disability	11,238	11,341	(103)	-1%	↓
Service Description	This service provides residential care for persons with learning disabilities				
Main Issues / Reason for Variance	The adverse variance is mainly due to unbudgeted void rent costs for St Andrews and increase in client packages and costs related to Dunn Street.				
Mitigating Action	None available at this time				
Anticipated Outcome	The final position is an overspend.				
Physical Disability	2,315	2,197	118	5%	↑
Service Description	This service provides physical disability services				
Main Issues / Reason for Variance	The favourable variance is mainly due to an underspend in residential packages arising from reduction in client numbers.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Day Centres - Learning Disability	2,261	1,911	350	15%	↑
Service Description	This service provides day services for learning disability clients				
Main Issues / Reason for Variance	The favourable variance is mainly due staffing vacancies at the Dumbarton Centre				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				
Justice Services	0	274	(274)	0%	↓
Service Description	This service provides support and rehabilitation for offenders				
Main Issues / Reason for Variance	The adverse variance is mainly due to the cumulative impact of unfunded pay awards since 2021/22 totalling £0.250m and the unfunded element of an intensive support package .				
Mitigating Action	None available at this time				
Anticipated Outcome	The final position is an overspend.				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Care at Home	13,935	16,342	(2,408)	-17%	↓
Service Description	This service provides care at home which includes personal care and minor domestic tasks				
Main Issues / Reason for Variance	The unadjusted overspend of £3.486m is mainly due to an ongoing increase in premium rate overtime and agency usage in relation to sickness, staff training and holiday cover. At present staff contracts do not reflect the demands of the service creating inefficiencies and lead to additional costs. The ongoing care at home service review should address this issue with revised contracts put in place to better reflect service demand along with improved scheduling of clients on the CM2000 system. As agreed at the November HSCP Board a recovery plan to utilise earmarked care at home reserves have been used to partially offset the projection, however a net overspend of £2.408m remains which mainly reflects the cost of overtime and agency use at £1.214m, the regrading exercise at £0.309m and the additional costs of the local authority pay award at £0.588m along with an underachievement of income of circa £0.297m.				
Mitigating Action	None available at this time				
Anticipated Outcome	The final position is a significant overspend which will require to be addressed within the implementation of the Care at Home Redesign.				

West Dunbartonshire Health & Social Care Partnership **Appendix 5**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024
Analysis for Variances Over £0.050m

Budget Details	Variance Analysis				
	Annual Budget £000	Actual Full Year £000	Actual Variance £000	% Variance	RAG Status
Frailty	80	17	63	78%	↑
Service Description	This service is the new Focussed Intervention Team				
Main Issues / Reason for Variance	The favourable variance is due to staffing vacancies				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				
HSCP - Corporate	(789)	(1,533)	745	-94%	↑
Service Description	This budget contains Corporate spend and income pending allocation to services				
Main Issues / Reason for Variance	The favourable variance is mainly due to a delay in staff recruitment and utilisation of earmarked reserves as approved at the November HSCP Board as part of the recovery plan.				
Mitigating Action	None required at this time				
Anticipated Outcome	The final position is an underspend.				

West Dunbartonshire Health & Social Care Partnership **Appendix 6**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

Reconciliation of Movements in Reported Position between Final Outturn and March HSCP Board Report		**Forecast Full Year £000's**	**Drawdown / (Transfer to) Earmarked Reserves £000's**	**Drawdown / (Transfer to) Unearmarked Reserves £000's**
Final Adverse Variance Reported - Impact on Reserves		(7,529)	(5,798)	(1,731)
Period 10 Adverse Variance Reported - Impact on Reserves		(8,098)	(6,491)	(1,607)
Movement		**569**	**693**	**(124)**
Represented By:				
Childrens Services Community	Recruitment challenges and increased staff turnover have resulted in a more favourable position than anticipated at period 10 as reported to the March HSCP Board enabling £0.209m to be added to earmarked reserves to create a new reserve to partially fund the "What Would It Take?" Children and Families five year medium term financial plan	160	209	(49)
Adult Community Services	Recruitment challenges within the Focussed Intervention Team has resulted in a more favourable position than anticipated at period 10 as reported to the March HSCP Board which has been utilised to partially offset the increase in the adverse GP Prescribing position.	339	10	329
Addictions	Recruitment challenges and increased staff turnover have resulted in a more favourable position than anticipated at period 10 as reported to the March HSCP Board enabling £0.254m to be added to earmarked reserves.	388	254	134
Mental Health Adult Community	Recruitment challenges, increased staff turnover and increased income have resulted in a more favourable position than anticipated at period 10 as reported to the March HSCP which has been utilised to partially offset the increase in the adverse GP Prescribing position.	228	(26)	254
GP Prescribing	The increase in spend from period 10 is mainly due to a catch up in prescribing costs related to catheters and other miscellaneous items due to 2023/24 NSS system updates and inclusion of unfunded Buvidal costs.	(484)	0	(484)
Children's Community Placements	The increase in the adverse position is mainly due to an increase of 16 new clients and a number of backdated payments, arising due to changes to tax credit entitlement, which have resulted in actual Kinship costs being higher than anticipated at period 10 as reported to the March HSCP Board by £0.054m, while External Fostering numbers have increased by 6 at a cost of £0.055m.	(130)	0	(130)
Children's Residential Schools	The increase in the adverse position is mainly due to the delay in clients transitioning to adult services at a cost of £0.85m.	(104)	0	(104)
Childcare Operations	The reduction in the favourable position is mainly due to the increased cost of taxi provision at £0.054m, section 12 and family contact payments of £0.020m, costs related to supporting asylum seekers of £0.018m and £0.024m incurred in relation to OT overtime which has been drawn down and funded from earmarked reserves.	(133)	(25)	(108)

West Dunbartonshire Health & Social Care Partnership **Appendix 6**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

Reconciliation of Movements in Reported Position between Final Outturn and March HSCP Board Report		**Forecast Full Year £000's**	**Drawdown / (Transfer to) Earmarked Reserves £000's**	**Drawdown / (Transfer to) Unearmarked Reserves £000's**
Residential Accommodation for Older People	The reduction in the adverse position from that reported at period 10 is mainly due to funding lost income related to respite beds from an alternative funding source and agency costs being less than anticipated.	397	(102)	499
External Residential Accommodation for Elderly	The final 2023/24 position has moved from an adverse position at P10 to a favourable position and is mainly due to property accruals being higher than anticipated and a reduction in overall nursing packages.	310	97	213
Community Health Operations	While the reduction in the adverse position is mainly due to a reduction in the cost of anticipated overall agency cover the increase in the drawdown of earmarked reserves relates to the funding of the hospital discharge agency cover from the Winter Planning MDT reserve as detailed in the monitoring return submitted to the Scottish Government.	88	(467)	555
Residential - Learning Disability	The reduction in anticipated spend to be funded from eamarked reserves relates to the reallocation of spend and associated funding which rendered the drawdown of previously anticipated earmarked reserves no longer required.	32	138	(106)
Day Centres - Learning Disabilty	The increase in the favourable position is mainly due to a reduction in transport costs of £0.108m and an increase in staff turnover.	173	0	173
Care at Home	The increase in the adverse position from that reported at P10 is mainly due to unprecendented sickness levels in the last few months of the financial year which have resulted in increased usage of agency staff and overtime.	(911)	0	(911)
HSCP - Corporate	The movement from period 10 is mainly related to the release of uncomitted funding within financial planning arising from non recurring savings which have enabled an increase to earmarked reserves to underwrite the challenging savings programme agreed for 2024/25.	219	432	(213)
Other		(3)	173	(176)
Total		**569**	**693**	**(124)**

Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024 **Appendix 7**

Analysis of Reserves 2023/24

Analysis of Reserves	Actual Opening Balance as at 1 April 2023	Actual Movement in Reserves	Recovery Plan Adjustment	Agreed Reallocations	Proposed Reallocations	Actual Closing Balance as at 31 March 2024
	£000	£000	£000	£000	£000	£000
Unearmarked Reserves						
Unearmarked Reserves	4,308	(1,731)	(262)		1,239	3,554
Total Unearmarked Reserves	**4,308**	**(1,731)**	**(262)**	**0**	**1,239**	**3,554**
Earmarked Reserves						
Scottish Govt. Policy Initiatives	**9,529**	**(1,802)**	**(1,278)**	**(700)**	**(909)**	**4,841**
Community Justice	192	0				192
Carers Funding	1,363	(444)		(700)		219
Child and Adult Disability Payments	132	(132)				0
Informed trauma	100	30				130
Additional Social worker capacity	364	0				364
GIFREC NHS	57	0				57
Mental Health Action 15	26	(26)				0
Mental Health Recovery and Renewal Fund	885	(453)				432
New Dementia Funding	63	0				63
Scottish Government Alcohol and Drug Partnership (including various National Drugs Priorities)	984	(143)				841
Primary Care Boardwide MDT	27	(27)				0
Community Living Change Fund	357	(21)				336
Children's Mental Health and Wellbeing	240	(175)				65
PCIF	65	(65)				0
GP Premises (incl. PCIF)	244	0			(244)	0
SG District Nursing Funding	74	0				74
TEC and Analogue to Digital Project	85	0			(55)	30

Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024 **Appendix 7**

Analysis of Reserves 2023/24

Analysis of Reserves	Actual Opening Balance as at 1 April 2023	Actual Movement in Reserves	Recovery Plan Adjustment	Agreed Reallocations	Proposed Reallocations	Actual Closing Balance as at 31 March 2024
	£000	£000	£000	£000	£000	£000
PEF Funding – Speech & Language Therapy Projects	26	0				26
Winter Planning Funding - MDT	548	(305)			(243)	0
Winter Planning Funding - 1000 Healthcare Workers	367	0			(367)	0
Workforce Wellbeing	70	(3)				67
Winter Planning Funding - Interim Care	985	(175)	(200)			610
Winter Planning Funding - Enhance Care at Home	2,240	0	(1,078)			1,162
Care Home & Housebound Vaccination funding from Health Board and Call Before You Convey	0	94				94
LD Health Checks	36	24				60
Pharmacy NES Funding	0	20				20
HSCP Initiatives	**4,593**	**(1,315)**	**0**	**(30)**	**(374)**	**2,874**
Service Redesign and Transformation	**1,341**	**(759)**	**0**	**0**	**(86)**	**496**
Fixed term development post to progress work on Older People's Mental Health, Adult Mental Health and Learning Disabilities Strategies.	176	(90)			(86)	0
Children at risk of harm inspection action	714	(233)				481
Fixed term posts with the integrated HSCP Finance team	90	(75)				15
Additional six social workers in children and families on a non recurring basis. Approved by the Board at 25 March 2021 meeting.	361	(361)				0
Unscheduled Care Services	692	(295)				397

Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024 **Appendix 7**

Analysis of Reserves 2023/24

Analysis of Reserves	Actual Opening Balance as at 1 April 2023	Actual Movement in Reserves	Recovery Plan Adjustment	Agreed Reallocations	Proposed Reallocations	Actual Closing Balance as at 31 March 2024
	£000	£000	£000	£000	£000	£000
COVID-19 Recovery (HSCP Funded)	**438**	**(88)**	**0**	**6**	**(138)**	**218**
Support to women and children in recovery from Domestic abuse and support redevelopment of the service as a trauma responsive service and Violence against Women coordination to support the development of the Violence against Women Partnership.	234	(22)		6		218
Children's Mental Health and Wellbeing and recruitment of a fixed term 2 year Clinical psychologist.	138	0			(138)	0
Fixed term Physio, Admin Support and Social Work Assistant to support clinical staff in addressing backlog of care resulting from pandemic restrictions within Mental Health Services.	66	(66)				0
Unachievement of Savings	724	361				1,085
Recruitment Campaign for Internal Foster Carers	30	0		(30)		0
Promise Keeper Fixed Term Recruitment	71	(65)		(6)		0
Public Protection Officers	244	0				244
Participatory Budgeting	300	(150)			(150)	0
Digital Transformation	282	(55)				227
Training and Development	327	(120)				207
Change and Transformation	144	(144)				0
Covid-19- Scottish Government Funded	**2**	**0**	**0**	**0**	**0**	**2**

Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024 **Appendix 7**

Analysis of Reserves 2023/24

Analysis of Reserves	Actual Opening Balance as at 1 April 2023	Actual Movement in Reserves	Recovery Plan Adjustment	Agreed Reallocations	Proposed Reallocations	Actual Closing Balance as at 31 March 2024
	£000	£000	£000	£000	£000	£000
COVID-19 Pressures	2	0				2
Health Care	**4,768**	**(324)**	**0**	**922**	**44**	**5,410**
DWP Conditions Management	153	(108)				46
Physio Waiting Times Initiative	829	(726)				103
Retinal Screening Waiting List Grading Initiative	234	(87)				147
Prescribing Reserve	972	0				972
NHS Board Adult Social Care	88	0				88
CAMHS	120	0				120
Planning and Health Improvement	145	103				248
West Dunbartonshire Mental Health Services Transitional Fund	1,454	0				1,454
Children's Community Health Services	302	186		(208)	(280)	0
C&F 5 year MTFP "What Would it Take"	0			1,130		1,130
Property Strategy	453	266			244	963
Health Visiting	0	40			80	120
Workforce Wellbeing	18	0				18
Social Care	**2,982**	**(425)**	**(392)**	**(192)**	**0**	**1,973**
Complex Care Packages/Supporting delay discharges	2,882	(517)	(392)			1,973
Asylum Seeker increasing placements	100	92		(192)		0
Total Earmarked Reserves	**21,874**	**(3,866)**	**(1,670)**	**0**	**(1,239)**	**15,100**
Total Reserves	**26,182**	**(5,597)**	**(1,932)**	**0**	**0**	**18,654**

Director for Children and Families
Andrew Watson

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Scottish Government
Riaghaltas na h-Alba

To: Integration Authority Chief Officers
Integration Authority Chief Finance Officers
Local Authority Chief Executives
Local Authority Directors of Finance
COSLA
Scotland Excel
Chief Social Work Officers
CCPS
EtCS
Unite
UNISON
GMB
STUC
Care Providers

From: Andrew Watson, Director for Children and Families, Scottish Government

Date: 30 May 2024

Children's Social Care Pay Uplift

Dear colleague,

Following agreement at COSLA Leaders on 26 April 2024, I am writing to confirm the details of the funding provided to enable the pay uplift for eligible children's social care workers in private, voluntary and independent sectors, which was announced in the Programme for Government 2023 to 2024.

The commitment is *'to provide the necessary funding in the next Budget to increase the pay of social care workers in the private, voluntary and independent sectors in a direct care role – and those working in the PVI sector to deliver funded early learning and childcare – to at least £12 per hour'*.

Guidance for implementing the pay uplift for workers who provide direct care to adults, and for workers who deliver funded early learning and childcare in commissioned services has already been issued, and is therefore outwith the scope of this letter.

This will be the first time a Real Living Wage pay uplift is implemented in Scotland for all those who provide direct care to children and young people.

Funding to support the delivery of a pay uplift to a minimum of £12 per hour for all eligible Children's Social Care staff in commissioned services will be transferred to Local Authorities via, but additional to, the General Revenue Grant, and will be backdated to the start of the financial year 2024/25.

Where services are delegated to Integration Authorities, funding allocated to Integration Authorities should be additional and not substitutional to each Local Authority's 2024/25 recurring budgets for Children's Social Care services.

Scope

This funding will enable pay for all eligible workers to be uplifted to at least £12 an hour.

The pay uplift will apply to all eligible workers who provide direct care within commissioned Children's Social Care services in the private, voluntary and independent (PVI) sectors, namely:

(a) registered workers in direct care roles in the following services:
- Secure Accommodation Services,
- Care Home Services for Children and Young People,
- School Care Accommodation: Residential Special School services,
- Housing Support Services,
- Care at Home services, and
- Services classed as Other than Care at Home

(b) Personal Assistants employed through Self Directed Support (SDS) Option 1, who provide Care at Home to under 18-year-olds.

Full details of eligible services and roles, as well as a list of exclusions can be found in **Annex A.**

Timing and Process

All payments will be backdated and provided for all hours worked from April 2024.

In line with existing processes in Adult Social Care, Local Government and Integration Authorities will be working through the required governance, legal and contractual arrangements to deliver the funding to enable the pay uplift to providers.

Local indications suggest that most payments will be made across July and August, with funding back dated and provided from April 2024. Best endeavours will be made to have all payments with providers by autumn 2024. However, this relies on a timely return of contract variation letters by providers.

Please note that providers are not expected to implement the pay uplift until funding has been received but, in line with this guidance, can do so if they wish.

To support timely implementation, Scottish Government and COSLA will meet with representatives of the Coalition of Care and Support Providers Scotland (CCPS), Educating through Care Scotland (EtCS), Scottish Care and Trade Unions to discuss any concerns or questions around implementation and to work to resolve these quickly.

A troubleshooting group will meet on a regular basis until the payment is fully implemented.

Policy Implementation

There has been political agreement that the funding to support the delivery of a £12 per hour pay uplift will be delivered in a manner similar to the Adult Social Care pay uplift, by applying a 10.09% uplift to a set percentage (national weighting) of contract values.

The national weightings are the estimated average proportion of workforce costs for eligible staff (wages and on-costs) out of the overall contract value. There are different national weightings for Children's Social Care, for different service types, and for Personal Assistants employed through SDS Option 1.

Service type	***Percentage of contract value that the uplift is applied to***	***This equates to contract uplifts of***
Secure accommodation service	42%	4.21%
Care home service: children and young people	59%	5.94%
School care accommodation service: Residential special school	42%	4.28%
Support Service - Care at Home and Housing Support Service	76%	7.65%
Support Service - Other than Care at home	68%	6.90%
SDS Option 1 (Personal Assistants)	90%	9.08%

Refer to **Annex B** for an explanation of how the national weightings for Children's Social Care were estimated.

This approach assumes that all eligible staff are currently in receipt of £10.90 and require a pay uplift of 10.09% to reach an hourly rate of £12.00 per hour. This is likely to result in providers having funds remaining once the policy intent - **to uplift pay for the workforce delivering direct care to at least £12.00 per hour** - has been fully delivered. Where eligible staff are already paid £12.00 per hour, this funding should be used to increase eligible staff's pay above these levels.

It has been agreed that any surplus funds providers may have from this policy must be spent on uplifting pay for the directly employed workforce working within services for the 2024/25 financial year. It is the provider's discretion of how any remaining funds are to be spent within these stipulations, but this can be used to support pay differentials between eligible staff in receipt of the pay uplift and other categories of staff within eligible services.

Non-workforce costs

This policy, to uplift the minimum rate of pay of workers who provide direct care in Children's Social Care services, provides funding towards wages and on-costs of eligible staff within providers' contracts.

Contract holders (Local Authorities, Integration Authorities, or Scotland Excel) still have the ability to offer increases to providers on the non-workforce costs within their contracts.

Any changes, over and above the funding for the pay uplift, on the rest of local contracts or Scotland Excel National Framework contracts to address other increasing and inflationary non-workforce costs would be outwith the remit of this policy and would form part of the normal local contractual negotiating process with providers and their local commissioners and finance departments. For national arrangements, Scotland Excel will work in collaboration with providers and commissioners in line with the relevant Framework's Price Review process.

Assurance process

For this uplift, providers will be required to sign and return contract variation letters. This will confirm that the funding must only be used for uplifting pay as described above. Contract holders (Local Authorities, Integration Authorities, or Scotland Excel) will be responsible for assuring this funding is used for these purposes through their normal contract monitoring processes.

Funding will then be released to providers as soon as possible after they return their signed contract variation letters, and following completion of the usual local fee variation processes.

Personal Assistants

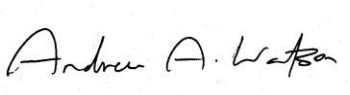
Separate guidance will be issued for PA employers.

Next Steps

The Scottish Government recognises the exceptional work of the children's social care workforce, and we thank them for the important role that they play in the lives of our most vulnerable children.

We appreciate you sharing this with your networks and working with us to get this uplift delivered to the workforce at speed.

Yours Sincerely



ANDREW WATSON
Director, Children and Families

Annex A

Services in scope

The policy intent is to provide a pay uplift to workers who provide direct care in commissioned Children's Social Care services.

Children's Social Care services are services primarily provided to a child in need (defined by reference to section 93(4)(a) of the Children (Scotland) Act 1995) by a registered care service referred to in section 47(1)(a), (b), (c), (f) or (m) of the Public Services Reform (Scotland) Act 2010 (and accompanying definitions in schedule 12).

For the purposes of this pay uplift, a child is anyone under the age of 18.

The registered care services that provide direct care and support to vulnerable children are:

(a) **Secure Accommodation Services.** Also known as Secure Care, Secure Accommodation Services are a form of residential care that deprives the liberty of children and young people under the age of 18. It is for the small number of children who may be a significant risk to themselves, or others in the community.
(b) **Care Home Service: Children and Young People**. Also known as Residential Children's Homes, these residential care homes offer young people, usually of secondary school age, a safe place to live together with other children away from home. They provide accommodation, support and, in some cases, education to looked after children.
(c) **School Care Accommodation Service: Residential Special Schools**. Residential special schools provide residential accommodation to pupils with complex special educational needs or disabilities, in connection with the pupil's attendance at a special school.
(d) **Support Service: Care at Home**. Care at Home is registered by the Care Inspectorate as a support service. A support service is defined as a personal care or personal support service provided by arrangement made by a local authority or health body to a vulnerable person, including children with disabilities or complex needs. This excludes care home services or services providing overnight accommodation.
(e) **Support Service: Other than Care at Home.** Services are registered as Support Service - Other than Care at home (also known as Without care at home) if they do not offer any sort of care at home provision. Examples of these are activity and resource centres and short break facilities for children with complex needs.
(f) **Housing Support Services.** Also known as Supported Living, Housing Support Services provide support, assistance, advice or counselling to a person who has particular needs, with a view to enabling that person to occupy residential accommodation as a sole or main residence. Most Housing Support Services are provided to vulnerable adults. Some providers also offer Housing Support services to care-experienced young people aged 16 to 18, who have left care and are transitioning to independent living.

Eligible roles within registered care services

The roles that provide direct care within registered care services, and are therefore in scope for this pay uplift, are classed by the Scottish Social Services Council as C2 and C3 roles, and defined as:

(a) C2 – Registered care staff* who provide direct care and support (for example, support workers in day care of children services), and
(b) C3 – Registered care staff* who may supervise work of C2 staff and contribute to assessment of care needs and development and implementation of care plans (for example, senior residential care workers).

*Registered in accordance with the Regulation of Care (Scotland) Act 2001.

Personal assistants

Personal assistants, an unregistered and unregulated workforce, are also in scope for the pay uplift, in line with the eligibility criteria for the Adult Social Care pay uplift.

Children's personal assistants are defined as those employed by a supported person in receipt of direct payments (Option 1) from the local authority in terms of section 8 of the Social Care (Self-directed Support) (Scotland) Act 2013, for the purposes of delivering services to children (and/or their families) under section 22 of the Children (Scotland) Act 1995.

Annex B

National Weightings for Children's Social Care

To estimate overall staffing costs, Adult Social Care national weightings were applied to children's social care service contracts (**71.8%** to residential care services, **86.9%** for non-residential care, and **90%** of budgets for SDS Option 1 for Personal Assistants).

To estimate staffing costs for staff in direct care roles, further weightings were applied to overall staffing costs. These weightings are based on national workforce statistics published by the Scottish Social Services Council, and represent the Whole Time Equivalent (WTE) proportion of staff in C2 and C3 roles, out of overall WTE in each service type, as of December 2022.

Service type	***Adult Social Care average full workforce costs as % of contract value***	***Children's Social Care direct care roles (C2, C3) as % of all workforce (WTE)***	***Children's Social Care estimated national weightings for eligible staff***
Secure accommodation service	72%	58%	42%
School care accommodation service: Residential special school	72%	59%	42%
Care home service: children and young people	72%	82%	59%
Support Service - Other than Care at home	87%	79%	68%
Support Service - Care at Home and Housing Support Service	87%	87%	76%
Personal Assistants employed through SDS Option 1	90%	n/a	90%

Director for Children and Families
Andrew Watson

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Scottish Government
Riaghaltas na h-Alba

To: Integration Authority Chief Officers
Integration Authority Chief Finance Officers
Local Authority Chief Executives
Local Authority Directors of Finance
COSLA
Scotland Excel
ILF Scotland
SDS Leads
Chief Social Work Officers
PA Programme Board
PA Network Scotland
SDS Scotland
Social Work Scotland
Inspiring Scotland
SIRDs
CILs
Payroll providers

From: Andrew Watson, Director for Children and Families, Scottish Government

Date: 30 May 2024

Children's Social Care Pay Uplift: Guidance for the Personal Assistant Workforce

Dear colleague,

Following agreement at COSLA Leaders on 26 April 2024, I am writing to confirm the details of the pay uplift for children's social care workers that was announced in the Programme for Government 2023 to 2024.

This guidance is closely aligned to the pay uplift guidance for Personal Assistants (PA) providing social care to adults with assessed needs, which has been designed in conjunction with PA Programme Board members.

I hope it is useful in clarifying how the uplift applies to children's PA workforce.

What does this guidance relate to?

An increase in Self-Directed Support (SDS) Option 1 Budgets will take place which will allow for a pay uplift for the children's Personal Assistant workforce.

Why is the Scottish Government providing this funding?

On 5th September 2023, the First Minister announced a commitment to provide funding and to increase the pay of social care workers in the private, voluntary and independent sectors in a direct care role.

This funding will ensure the minimum hourly rate for workers providing direct care to children and young people under the age of 18, including Personal Assistants, will rise to at least £12 per hour.

Who does it apply to?

This uplift is for directly paid PAs providing assistance for children with assessed needs.

A separate letter regarding the pay uplift for PAs who provide care to adults was issued in February 2024, therefore adults' PAs are outwith the scope of this guidance.

A PA is eligible for this uplift if they are directly paid by a supported person under the age of 18, as defined by the Self-directed support (Scotland) Act 2013, or the representative who is acting on their behalf, who receive funds to pay PAs from a Local Authority or Health and Social Care Partnership through Option 1 of the Social Care (Self Directed Support) Act 2013.

How should it be spent?

This funding is to be spent to uplift the pay of PAs and associated workforce costs including National Insurance and pension contribution on-costs.

This funding will enable pay for these workers to be uplifted to at least £12 per hour. Where PAs are already paid more than £12 per hour, this funding should be used to increase pay above these levels. All funding should be spent on uplifting pay.

Local Authorities or Health and Social Care Partnerships will write to PA employers to advise them of these changes and to inform them of the purpose of this uplift.

How will the uplift be applied to SDS Option 1 budgets?

The funding to support the delivery of a £12 per hour minimum wage for children's PAs will be delivered in a manner similar to the Adult Social Care pay uplift, by applying a 10.09% uplift to 90% of SDS option 1 budgets.

This equates to an uplift of **9.08%** to the overall value of each PA employer's contract, and provides funding for PA wages and on-costs.

This does not prevent local areas from offering any increases to PA employers on the non-workforce costs within their contracts.

Any change to existing contracts - to address other increasing and inflationary non-workforce costs - would be out with the remit of this policy. They would form part of the normal negotiating process agreed between the recipient of the option 1 SDS payment and their local social work team.

When will the uplift be applied from?

This funding takes effect from April 2024. All payments will be backdated and provided for all hours worked from April 2024.

Local Government and Health and Social Care Partnerships will be working at pace to deliver this. Local commissioning teams have confirmed that they expect most payments to be made across July and August.

What assurance processes will be in place around the uplift?

For this uplift, Local Authorities and Health and Social Care Partnerships will follow their own assurance processes related to PA employers funding. These will be in line with previous practices.

What should a PA employer do if they haven't received this uplift?

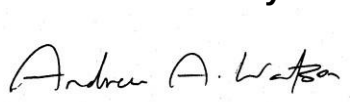
PA employers should contact their Local Authority.

Next steps

I hope this provides clarity on how the policy applies to the PA workforce.

We appreciate you sharing this with your networks and working with us to get this uplift delivered to the children's PA workforce at speed.

Yours Sincerely



ANDREW WATSON
Director, Children and Families

Director for Children and Families
Andrew Watson

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Scottish Government
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gov.scot

To: Local Authority Directors of Finance

Copy to COSLA
Integration Authority Chief Finance Officers

From: Andrew Watson, Director for Children and Families, Scottish Government

Date: 04 June 2024

Dear colleague,

Children's Social Care Pay Uplift in Commissioned Services

Following agreement at COSLA Leaders on 26 April 2024, I am writing to confirm the distribution of the **£19.861** million funding provided to enable the pay uplift for eligible children's social care workers in private, voluntary and independent sectors, which was announced in the Programme for Government 2023 to 2024.

This funding will deliver a minimum rate of £12 per hour for eligible staff, as outlined in the separate guidance letter issued on 30 May 2024.

Please find attached each Local Authority's share of the funding (**Annex A**). The funding is allocated based on the Grant Aided Expenditure (GAE) formula for 'Casework and Related Administration: Children' 2024/25' and will be paid as a redetermination of the General Revenue Grant during the last 2 weeks in March 2025.

Where eligible services are delegated to Integration Authorities, funding is to be passed on to Integration Authorities. This funding should be additional and not substitutional to each Local Authority's 2024/25 recurring budgets for Children's Social Care services.

Yours Sincerely

ANDREW WATSON
Director, Children and Families

ANNEX A

Distribution of funding for the Children's Social Care pay uplift

Local Authority	£ million
Aberdeen City	0.673
Aberdeenshire	0.683
Angus	0.378
Argyll & Bute	0.243
City of Edinburgh	1.541
Clackmannanshire	0.208
Dumfries and Galloway	0.479
Dundee City	0.658
East Ayrshire	0.495
East Dunbartonshire	0.302
East Lothian	0.358
East Renfrewshire	0.290
Falkirk	0.587
Fife	1.407
Glasgow	3.097
Highland	0.734
Inverclyde	0.313
Midlothian	0.377
Moray	0.296
Na h-Eilean Siar	0.068
North Ayrshire	0.569
North Lanarkshire	1.499
Orkney	0.059
Perth & Kinross	0.443
Renfrewshire	0.692
Scottish Borders	0.344
Shetland	0.057
South Ayrshire	0.369
South Lanarkshire	1.212
Stirling	0.266
West Dunbartonshire	0.415
West Lothian	0.750
Scotland	**19.861**

West Dunbartonshire Health & Social Care Partnership **Appendix 11**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

Month End Date	**31 March 2024**
Period	**12**

Budget Details	**Project Life Financials**					
	Budget	**Spend to Date**		**Actual Spend**	**Variance**	
	£000	**£000**	**%**	**£000**	**£000**	**%**
Health Care Capital						
Minor Capital Works						
Project Life Financials	41	70	171%	70	29	71%
Current Year Financials	41	70	171%	70	29	71%
Project Description	Minor Capital Works					
Project Manager	Julie Slavin					
Chief Officer	Beth Culshaw					
Project Lifecycle	Planned End Date		31-Mar-24	Forecast End Date		31-Mar-24

Main Issues / Reason for Variance

Works to Goldenhill of circa £0.070m have been charged to capital with the excess over the budget funded from Health Board slippage.

Mitigating Action

None Required at this time

Anticipated Outcome

Capital works to Goldenhill

West Dunbartonshire Health & Social Care Partnership **Appendix 11**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

Month End Date	**31 March 2024**
Period	**12**

Budget Details	**Project Life Financials**					
	Budget	**Spend to Date**		**Actual Spend**	**Variance**	
	£000	**£000**	**%**	**£000**	**£000**	**%**
Social Care Capital						
Special Needs - Aids & Adaptations for HSCP clients						
Project Life Financials	845	960	114%	960	115	14%
Current Year Financials	845	960	114%	960	115	14%
Project Description	Reactive budget to provide adaptations and equipment for HSCP clients.					
Project Manager	Julie Slavin					
Chief Officer	Beth Culshaw					
Project Lifecycle	Planned End Date		31-Mar-24	Forecast End Date		31-Mar-24
Main Issues / Reason for Variance						
Budget is slightly overspent due to an increase in orders over that required to breakeven.						
Mitigating Action						
None required at this time						
Anticipated Outcome						
Aids and Adaptations for HSCP Clients						

West Dunbartonshire Health & Social Care Partnership **Appendix 11**

Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

Month End Date	**31 March 2024**
Period	**12**

Budget Details	Project Life Financials					
	Budget	Spend to Date		Actual Spend	Variance	
	£000	£000	%	£000	£000	%
Community Alarm upgrade						
Project Life Financials	924	27	3%	924	0	0%
Current Year Financials	308	27	9%	27	(281)	-91%
Project Description	To upgrade Community Alarm					
Project Manager	Margaret Jane Cardno					
Chief Officer	Beth Culshaw					
Project Lifecycle	Planned End Date		31-Mar-24	Forecast End Date		31-Mar-24

Main Issues / Reason for Variance

The project manager post was filled October 2023, and the award for national digital shared platform was awarded in October 2023 with the transition to the new platform due to begin in July 2024. West Dunbartonshire Council are still awaiting a contract (with costs) for the call handling service from EDC. The purchasing of digital alarms and peripherals has faced several delays, however the procurement framework from Scotland Excel "digital alarms & peripherals" is now due to go live at the end of June 2024. Sheltered Housing upgrades have also faced technical delays with the new system planned for Manse Gardens and the digital bridges for the other sheltered housing complexes' being delayed until the end of the summer 2024.

Mitigating Action

None available at this time

Anticipated Outcome

Community Alarm Upgrade

West Dunbartonshire Health & Social Care Partnership **Appendix 11**
Financial Year 2023/24 Period 12 covering 1 April 2023 to 31 March 2024

Month End Date	**31 March 2024**
Period	**12**

Budget Details	**Project Life Financials**					
	Budget	**Spend to Date**		**Actual Spend**	**Variance**	
	£000	**£000**	**%**	**£000**	**£000**	**%**
ICT Modernisation						
Project Life Financials	564	40	7%	40	(524)	-93%
Current Year Financials	564	40	7%	40	(524)	-93%
Project Description	ICT Modernisation Upgrades					
Project Manager	Margaret Jane Cardno					
Chief Officer	Beth Culshaw					
Project Lifecycle	Planned End Date		31-Mar-24	Forecast End Date		31-Mar-24

Main Issues / Reason for Variance
Work is ongoing to consider spend plans which will be developed as part of the digital strategy, however delays in recruitment of the Digital manager has impacted on this to date.

Mitigating Action
None available at this time

Anticipated Outcome
ICT Modernisation

Direction from Health and Social Care Partnership Board. **Appendix 12**

The Chief Officer will issue the following direction email directly after Integration Joint Board approval.

From: Chief Office HSCP
To: Chief Executives WDC and NHSGCC
CC: HSCP Chief Finance Officer, HSCP Board Chair and Vice-Chair
Subject: For Action: Directions from HSCP Board 27 June 2024

Attachment: **2023/24 Financial Performance Report**

Following the recent Integration Joint Board meeting, the direction below have been issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014. Attached is a copy of the original HSCPB report for reference.

DIRECTION FROM WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD			
1	Reference number	HSCPB000063JS27062024	
2	Date direction issued by Integration Joint Board	27 June 2024	
3	Report Author	Julie Slavin, Chief Financial Officer	
4	Direction to	West Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly	
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	Yes HSCPB000060JS28032024	
6	Functions covered by direction	All delegated Health and Care Services as set-out within the Integration Scheme	
7	Full text and detail of direction	West Dunbartonshire Council is directed to spend the delegated net budget of £84.996m in line with the Strategic Plan and the budget outlined within this report. NHS Greater Glasgow and Clyde is directed to spend the delegated net budget of £115.647m in line with the Strategic Plan and the budget outlined within this report No Bad Debt Write Offs are included in this report	
8	Specification of those impacted by the change	2023/24 Revenue Budget for the HSCP Board will deliver on the strategic outcomes for all delegated health and social care services and our citizens.	
9	Budget allocated by Integration Joint Board to carry out direction	The total 2023/24 budget aligned to the HSCP Board is £244.557m. Allocated as follows: West Dunbartonshire Council - £84.996m NHS Greater Glasgow and Clyde - £115.647m Set Aside - £43.914m	
10	Desired outcomes detail of what the direction is intended to achieve	Delivery of Strategic Priorities	
11	Strategic Milestones	Maintaining financial balance in 2023/24	30 June 2024
12	Overall Delivery timescales	30 June 2024	
13	Performance monitoring arrangements	Each meeting of the HSCP Board will consider a Financial Performance Update Report and (where appropriate) the position regarding Debt Write Off's.	
14	Date direction will be reviewed	The next scheduled HSCP Board - 20 August 2024	

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP (HSCP) BOARD

Report by Sylvia Chatfield, Head of Mental Health, Learning Disability and Addictions

27 June 2024

Subject: A Comprehensive Review of Learning Disability Services

1. Purpose

1.1 This report provides an update to the Health and Social Care Partnership Integration Joint Board (IJB) known locally as the HSCP Board on the review of Learning Disability (LD) services across West Dunbartonshire Health & Social Care Partnership (WDHSCP) and the engagement and consultation required with stakeholders to re-shape services in line with Scottish Government guidance.

1.2 The report also refers to the NHS Greater Glasgow and Clyde Board wide Specialist Learning Disability Services (SLDS) report provided to Scottish Government in August 2023 and copies of letters sent by Scottish Government requesting updates in relation to the Community Living Change Fund (CLCF) and these are included as appendices for information.

2. Recommendations

It is recommended that the HSCP Board:

2.1 Agree the Year One proposals of the plan; and

2.2 Note the proposals and planned next steps for phase two of the review of Learning Disability services in 2025/2026.

3. Background

3.1 Having a learning disability can affect how a person learns new things throughout their lifetime. A learning disability affects the way a person understands information and how they communicate. This means they can have difficulty understanding new or complex information, learning new skills, or coping independently.

3.2 People with learning disabilities have individual strengths and abilities that should be recognised, alongside the need to meet any identified and assessed support needs. They may need a range of extra support throughout life, depending on the complexity of their learning disability. The WDHSCP Strategic Plan 2023-2026 “Improving Lives Together” outlines the need to shift the balance of care for children and adults by

strengthening prevention and community based support options, keeping individuals in their community where possible.

3.3 Care and support services for people with a learning disability should be person-centered, empowering people with a learning disability to make their own choices about what is important to them in their life.

3.4 People with learning disabilities experience greater health inequalities. For example, the average age at death for people with a learning disability is 23 years younger for men and 27 years younger for women than the wider population (Source: Learning disability mortality review, 2020). Also, 57% of people in a mental health hospital with a learning disability, autism, or both, have been there for over two years (Source: Health and care of people with learning disabilities, NHS Digital, 2021).

3.5 Considering the diverse needs and persistent health inequalities experienced by people with a learning disability and/or autism, West Dunbartonshire HSCP is committed to improving the health, wellbeing and treatment of people with learning disabilities and autism as an area of priority. In line with several objectives set out in the HSCP's Strategic Plan 2023 – 2026 "Improving Lives Together", the review of LD Services will articulate the service and service user needs, and gaps in meeting need, explore the applicability, potential and opportunities for new workforce interventions and roles to ensure good quality care for people with a learning disability and/or autism.

3.6 The aim to support people with a learning disability to live within the community is also a national priority with the development of the Community Living Change Fund (CLCF), advocating for the reduction in inappropriate hospital admissions and lengths of stay for people with learning disabilities.

3.7 Good practice suggests that commissioners develop sufficient local community-based services to support people with a learning disability and/or autism and mental health and/or behaviours perceived as challenging. This helps reduce the reliance on out-of-area placements. The efficacy of this review will be contingent upon commissioning services supporting the development of high quality, community services for people with learning disabilities, specialist where appropriate, to reduce any overreliance on inpatient care or out of authority placements.

3.8 Learning Disability services within West Dunbartonshire have been provided in the same way for many years against a backdrop of key economic, resource and policy changes, which have altered the landscape for individuals and communities. As such a comprehensive review of current provision is required to ascertain what the structure should be going forward. In addition, new strategy and legislation have subsequently been introduced, which require to be fully implemented within these services. The Self-directed Support (Scotland) Act 2013 makes legislative provisions relating to how care and support services

(Adult services and Children's services) are arranged to provide a range of choices for people in relation to how their support is provided. Within LD services in West Dunbartonshire there are some limited services thus reducing choices for individuals. By reviewing these services, it is expected that alternative types of services can be introduced, giving more choice for individuals to live their lives as independently as possible. This will involve extensive consultation and engagement with all stakeholders over the next 12-18 months to ensure the recommendations and findings from this work are implemented in line with Scottish Government funding and timelines.

3.9 The £20M Community Living Change Fund (CLCF) was allocated to Integration Authorities via NHS Boards in February 2021. The fund was designed to bring home people with complex needs, including intellectual disabilities and autism, and those who have enduring mental health problems that are placed outside of Scotland, to discharge those that have endured long stays in a hospital setting and design community based solutions that negate, or limit, future hospital use and out of area or country placements.

3.10 The funding was to be held in reserve within individual Integration Authorities to be used as plans are developed to deliver this work.

3.11 In the Community Living Change Fund Guidance, circulated in March 2021, the work is required to:

- Reduce the delayed discharges of people with complex needs;
- Repatriate those people inappropriately placed outside of Scotland; and
- Redesign the way services are provided for people with complex needs.

3.12 Delivery is supported by the Coming Home Implementation Report, published by the Scottish Government in February 2022. The Implementation Report aims to improve care for people with learning disabilities and complex needs. Measures include reducing delayed discharge, providing care closer to home and, in 2023, the setting up of a new national register, the Dynamic Support Register (DSR), to improve monitoring of those at risk of hospital admission, or inappropriately placed out of area, or at risk of placement breakdown. Public Health Scotland (PHS) co-ordinate the DSR data on behalf of Scottish Government.

3.13 The Scottish Government paper 'Towards Transformation' 2021 looks at the particular needs of Scotland's autistic community and people with a learning/intellectual disability. A consultation period on the new Learning Disabilities, Autism and Neurodivergence Bill closed on 21st April 2024 exploring how Scotland can build a country that ensures equality of opportunity for all by embedding equality, inclusion and human rights in all it does. Thinking differently should not cause someone to be marginalised, stigmatised, disadvantaged or excluded. A systematic focus on creating the conditions for change, operationally

on the frontline, to ensure people can be successfully supported in more appropriate community settings is needed. This will require whole system engagement to develop a more flexible, specialist workforce to support models of care that focus on prevention and early intervention to promote community connectedness and to avoid placement breakdown.

3.14 In February 2021, the Independent Review of Adult Social Care in Scotland recommended that "investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives".

3.15 Kevin Stewart, Minister for Mental Wellbeing and Social Care sent a letter on 14th July 2022 requesting a return of WDHSCP's proposal highlighting how it is intended to meet the three strategic requirements. In addition the Minister requested an identified lead due to the ongoing priority nature of this work. This was requested again by Maree Todd, MSP, in June 2023 – see 4.3.

3.16 The strategic vision for WDHSCP LD services is aligned to the WDHSCP Strategic Plan and Strategic Delivery Plan 2023-2026, Improving Lives Together, which identifies four strategic outcome areas: caring communities, safe and thriving communities, equal communities and healthy communities. The goal is to provide high quality, local, community based services where, regardless of complexity of need or behavioural challenge, people's right to live a full and purposeful life, free of unnecessary restrictions can be realised.

4. Main Issues

4.1 The LD Review has not yet taken place due to a number of factors. These factors include the global pandemic of March 2020 and beyond; staffing challenges and vacancies; prioritisation of other statutory work to manage risk and protect service user safety; and management capacity to drive forward the change required.

4.2 The CLCF has enabled the HSCP to progress two new additional fixed term posts for two years, which will ensure the review is now undertaken. An extensive amount of work has already been done since late 2021 to secure stability within the community learning disability team (CLDT). The capacity created by CLCF to complete mandated work within set timeframes will complement the overall work required within the scope of the LD Review.

4.3 In a letter to IJB Chief Finance Officers in June 2023 regarding CLCF expectations, Maree Todd, Minister for Social Care, Mental Wellbeing and Sport requested the following:

- WDHSCP to report back on how it has used, or plans to use, this fund;
- A CLCF operational lead is appointed to this priority area; and
- WDHSCP to outline its work on complex care (learning disabilities and autism) delayed discharge to ensure partnership working respects local context and challenges going forward.

4.4 The Coming Home Implementation Report, February 2022 supports the vision of LD services review to support those with the most complex needs, including behaviours perceived as challenging, to live in the community and access appropriate building based supports, if assessed as requiring this, to be able to live as full a life as possible where independence, choice and control is maximised.

4.5 The CLDT and LD registered and non-registered service teams need to make sure that this is embedded within a human rights based approach. In line with WDHSCP's Strategic Delivery Plan 2023-2026, health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. The "Just Enough Support" training programme empowers staff to empower citizens to take greater responsibility for their own outcomes and trauma-informed training across the workforce will further underpin WDHSCP's approach.

4.6 The LD review will engage and consult with staff, in line with strategic outcomes and measures within the Strategic Delivery Plan 2023-2026, to ensure the workforce is skilled and trained to meet the needs of those with the most complex needs, including behaviours perceived as challenging, and that a person-centred, asset based, approach will ensure that those able to access community based supports do so.

4.7 The HSCP Board has a duty to achieve Best Value including the effective use of resources. Work has already started to engage with in house and commissioned services, this includes Dumbarton Centre day service, Community Connections, Housing Support Service, Respite and Short Breaks and Work Connect internally and specialist third sector providers who work closely with WDHSCP LD services.

4.8 A key aim of this review is to embed the practice of effective use of eligibility criteria, assessment and review, ensuring the best outcomes for users of adult social work and social care services.

4.9 As set out in the section on duties, Section one and two of the Social Care (Self-directed Support) (Scotland) Act 2013 provide a legislative framework for the HSCP's approach to assessment of needs for adults, children and carers and the HSCPs social work function will have regard to these principles in conducting assessments.

4.10 Once a service user has a package of care and support in place, it must be checked or reviewed regularly to confirm that it is still

appropriate for the needs of the individual. A service user's package is based on their original needs assessment, which formally records all their needs and intended outcomes. Reviews are an ongoing process used to consider the current package, to discuss what is working, what is not working and what might need to change in future.

4.11 Staffing within the LD social work team has been an ongoing issue and work is underway to stabilise the team so that review work can be effectively progressed. This is vitally important to ensure service users have access to the right level of service to meet their needs and improve their outcomes.

4.12 Consideration for savings and efficiencies is a component part of this review to support the financial sustainability of LD and wider HSCP services in this challenging financial climate. Some options may result in the release of savings and thus ensure the HSCP is meeting its best value duties. For example, there are service users who do not meet the HSCP's eligibility criteria. These service users could have their needs more effectively met through the support of other community based services; this in turn will lead to better outcomes for the individual. It is also clear that the client charge is not consistently implemented, another inequity which will be addressed.

4.13 Once fully reviewed, through the organisational change consultation and engagement process, it may be determined that day and community services need to be modernised to reflect a shared focus, which supports WDHSCP priority areas. The LD Day service within Dumbarton Centre should be prioritised for those with a critical level of need who cannot easily access community supports. Service access is now linked to criteria based on WDHSCP Accessing Adult Social Care Eligibility Criteria, which was approved by the HSCP Board on the 23 September 2020.

4.14 Community Connections provides support to 35 service users in the community to promote outcomes around healthy living, choice and control, independence and active citizenship. It is currently supporting some service users who do not meet the eligibility criteria and therefore these individuals require to be reviewed and signposted on to other local community supports. Community Connections currently employs 18 staff; 13.6 whole time equivalents (WTE).

4.15 Dumbarton Day Centre offers both building based and community supports to service users. Service users accessing this require a higher level of support due to the complexities around diagnosis, e.g. Autistic Spectrum Disorder, restricted mobility, and compromised health conditions. It is also supporting some service users who do not meet the eligibility criteria and these service users could achieve more positive outcomes and have their needs more effectively met by accessing community based supports. It currently employs 29 staff; 23.6 WTE. There is one Registered Service Manager, covering both service registrations. It is expected that a review of the day service and

Community Connections will lead to a modernised service which will provide a more flexible, agile, assertive outreach service to ensure sustainability of community placements for those on the DSR and identified through the CLCF criteria. The current combined LD Day Service budget is £2,315,849 (which includes Community Connections at £620,191).

4.16 The Housing Support Service is a 24/7 registered service operating at the present time across three locations. There are 9 services users in receipt of this support provision. It currently employs 24 staff; 21.5 WTE and also has four staff on casual contracts. The budget is £1,167,683.

4.17 Work Connect is a non-registered supported employability service. This service works with around 100 service users with mental health, acquired brain injury, learning disability and autism. Approximately 50% of service users are deemed to meet the eligibility criteria of substantial or critical need. It employs 12 staff;10.9 WTE. The budget is £427,781.

4.18 Respite and Short Breaks is currently managed by the Service Manager for Development and Involvement and there is a respite coordinator and a respite administrator; 3 staff; 2.8 WTE.

4.19 The review also needs to consider how those transitioning from children services to adult services are fully supported in line with the Social Care (Self-directed Support) (Scotland) Act 2013.

5. Options Appraisal

5.1 The recommendations within this report do not require an options appraisal to be undertaken.

6. People Implications

6.1 The review of LD services will have direct and indirect implications for the workforce. This will be managed in line with the relevant organisational change policies and the process will be followed including an appropriate period of consultation with all stakeholders – trade union colleagues, teams and individual staff members.

6.2 Whilst the review will have an impact on the workforce, development of more flexible, assertive outreach staffing models that support delivery of the CLCF will create positive opportunities for both staff and service users.

6.3 The LD Review will include a review of any additional training required by the workforce to be fully equipped to fulfil their roles within a modernised, integrated and flexible service.

7. Financial and Procurement Implications

7.1 The LD Review is supported by the WDHSCP Medium Term Financial Plan 2022/23 – 2026/27.

7.2 Although it is premature to align definitive savings target to the LD Review in its entirety, the work aligns with the key themes of the Medium Term Financial Plan, specifically:

- Better ways of working – integrating and streamlining teams including the benefits of information technology to deliver services more efficiently will release financial savings and protect front line services;
- Community Empowerment - support the vision for resilient communities with active, empowered and informed citizens who feel safe and engaged to be a main contributor to service change across health and social care;
- Prioritising services – local engagement and partnership working are key strengths of the HSCP. WDHSCP must think and do things differently and find new solutions to providing support to those who need it;
- Equity and Consistency of approach – robust application of Eligibility Criteria for new packages of care and review of current packages using the My Life Assessment tool; and
- Service redesign and transformation – build on the work already underway redesigning support to people to remain or return to their own homes or a homely setting for as long as possible. This will be across all care groups including older people, learning, physical and mental disabilities and children and families, in partnership with Housing services, third sector and local providers.

7.3 The overall 2024/25 budget for Learning Disability Social Care Services is £14.155m. This is net of the approved management adjustments and savings options approved by the HSCP Board in both February and March 2024, as shown below.

Summary of Management Adjustments and Savings

Management Adjustments	**2024/25 £m**	**2025/26 £m**	**2026/27 £m**
Approved 28 March 2024			
Review of LD Social Care Packages	0.500	0.500	0.500
Temporary Non-Filling of LD Vacant Posts	0.350	0.350	0.350
Temporary Non-Filling of IOM Vacant Post	0.079	0.000	0.000
Savings Options			
Approved 20 February 2024			
Closure of Pavilion Café – Fixed Term Posts	0.075	0.090	0.090
Total of Approved Measures	**1.004**	**0.940**	**0.940**

7.4 Although there are key financial considerations associated with this work, this review is primarily around ensuring that local LD services are working to maximise independence, providing choice and services to those with the most complex need including those with behaviours perceived as challenging.

7.5 As outlined in section 3.3 of this report a critical factor to the success of this work will be the HSCP's ability to develop and commission sufficient local community-based services to support people with a learning disability and/or autism and mental health or challenging behaviour needs – in order to reduce the reliance on out-of-area placements. The efficacy of this review will be contingent upon the development of high quality, specialist community services for people with learning disabilities, to reduce any overreliance on inpatient care or out of authority placements. Support will be sought from Contracts, Commissioning and Quality Assurance, alongside colleagues in regulatory services, in order to ensure all stakeholders are appropriately engaged as we seek to meet this ambition.

8. Risk Analysis

There is an element of risk associated with this report:

8.1 Recruitment and retention to posts in what could be perceived as challenging service areas might be more difficult and this may lead to skill gaps being identified.

8.2 Failure to review and scrutinise performance management information; creates a risk of LD services being unable to manage demand analysis, service planning and budget management. In order to mitigate against this clear standard operating procedures will be revised or developed to ensure both health and social care information is captured appropriately through IT systems, such as CareFirst and EMIS to support the reporting requirements to Scottish Government regarding CLCF and the DSR.

8.3 Changes to services bring with it reputational risk. Service users and their families may find any changes, as a result of this review, upsetting and unsettling which may in turn increase the level of complaints received.

9. Equalities Impact Assessment (EIA)

9.1 Completed, see appendix II

10. Environmental Sustainability

10.1 The recommendations within this report do not require the completion of a Strategic Environmental Assessment (SEA).

11. Consultation

11.1 The HSCP Senior Management Team, the HSCP Chief Finance Officer and the HSCP Board Monitoring Solicitor have been consulted in the production of this report and their comments incorporated accordingly.

11.2 Key elements linked to this review feature in the 2024/25 Budget Setting Report. Over the past few months consultation on this report has taken place with the HSCP Senior Management Team (SMT) and Joint Trade Union colleagues, prior to it being presented today to the HSCP Board and Joint Trades Unions.

11.3 Moving forward LD Services will work with key partners, stakeholders and communities throughout the period of the review. Partnership, collaboration and co-production remain pivotal to the success of this work.

11.4 Consultation and engagement with the workforce will be progressed as part of the organisational change process. The majority of the LD workforce is employed by WDC and the Change Management Framework and associated policies will inform this process.

11.5 Wider engagement with service users, their carers and families and community groups will help to outline how a new 'hub' model may be developed to inform ongoing review and re-design beyond years one and two.

12. Strategic Assessment

12.1 On 15 March 2023 the HSCP Board approved its Strategic Plan 2023 – 2026 "Improving Lives Together". The Plan outlines sustained challenge and change within health and social care; these changes bring with them a host of governance implications: cultural, operational, structural, ethical and clinical.

12.2 Improving Lives Together seeks to shift the balance of care for children and adults by strengthening prevention and community-based support options, keeping individuals in their community where possible. This is aligned to the Coming Home Implementation Report recommendations and in accordance with the ambitions of this review, strategic priorities will help guide the Board as to the priority to be given to this report.

13. Directions

13.1 The recommendations within the report require a direction to be issued to the Chief Executives of both NHS GG&C and West Dunbartonshire Council. This can be found in appendix I of the report.

Name	Sylvia Chatfield
Designation	Head of Mental Health, Learning Disability and Addictions
Date	27 June 2024

Person to Contact: Lesley Kinloch, Service Manager LD
Lesley.kinloch@ggc.scot.nhs.uk

Appendices:

Appendix 1 - Directions

Appendix 2 - EIA

Background Papers:

- 14/6/2022 Letter from Kevin Stewart, Minister for Mental Health Wellbeing and
- Social Care. Community Living Change Fund Reporting.

- 3/2/23 – Letter from Kevin Stewart and Shona Robison, Community Living Change Fund – Complex Care Delayed Discharge and Out of Area placements.

- 21/6/23 Letter from Maree Todd Minister for Social Care Mental Wellbeing and Sport – Community Living Change Fund Reporting.

- 28/11/23 Letter from Maree Todd – Update on Coming Home Implementation Programme.

Appendix A: Direction from Health and Social Care Partnership Board

ITEM 9
APPENDIX 1

The Chief Officer will issue the following direction email directly after Integration Joint Board approval:

From: Chief Officer, HSCP
To: Chief Executive(s) WDC and NHSGGC
CC: HSCP Chief Finance Officer, HSCP Board Chair and Vice-Chair
Subject: Direction(s) from HSCP Board 27th June 2024 FOR ACTION
Attachment: A Comprehensive Review of Learning Disability Services

Following the recent HSCP Board meeting, the direction below has been issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014. Attached is a copy of the original HSCP Board report for reference.

DIRECTION FROM WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD		
1	Reference number	HSCPB000058SC27062024
2	Date direction issued by Integration Joint Board	27th June 2024
3	Report Author	Sylvia Chatfield, Head of Mental Health, Learning Disability and Addictions
4	Direction to:	West Dunbartonshire Council and NHS Greater Glasgow and Clyde jointly
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	Learning Disability Services including Learning Disability Review Team, Housing Support Service, Community Connections, Dumbarton Day Centre, Work Connect and Respite service.
7	Full text and detail of direction	1.Agree the Year One plan; 2. and, Note the proposals and planned next steps for phase two of the review of LD services in 2025/2026.
8	Specification of those impacted by the change	Service users, carers, staff and local community providers
9	Budget allocated by Integration Joint Board to carry out direction	NIL
10	Desired outcomes detail of what the direction is intended to achieve	West Dunbartonshire HSCP is committed to improving the health, wellbeing and treatment of people with learning disabilities and autism as an area of priority. In line with several objectives set out in the HSCP's Strategic Plan 2023 – 2026 "Improving Lives Together", the review of LD Services will articulate the (service and service user) needs, and gaps in meeting need, explore the applicability, potential and opportunities

		for new workforce interventions and roles in order to ensure good quality care for people with a learning disability and/or autism.	
11	Strategic Milestones	Full review of Learning Disability Services and implementation of outcomes	*June 2026*
12	Overall Delivery timescales	Two year plan - May 2026	
13	Performance monitoring arrangements	The review will be monitored via the Senior Management Team, Learning disability Operational Steering Group and reported to HSCP Board.	
14	Date direction will be reviewed	24th June 2025	

ITEM 9
APPENDIX 2

Equality Impact Assessment record layout for information

Owner:	Sylvia Chatfield

Resource:	HSCP	**Service/Establishment:**	Learning Disability

	First Name	Surname	Job Title
Head Officer:	Sylvia	Chatfield	Head of Mental Health, Learning Disability and Addictions.

	Include job titles/organisation
Members:	Sylvia Chatfield, Head of Mental Health, Learning Disability and Addictions Gillian Gall, Head of HR Julie Slavin, Chief Financial Officer Lesley Kinloch, Service Manager – Learning Disability

Please note: the word policy is used as shorthand for strategy policy function or financial decision	
Policy Title:	Comprehensive Review of Learning Disability Services

The aim, objective, purpose and intended outcome of policy

The purpose of the learning disability (LD) service review is to develop provision within West Dunbartonshire HSCP which will meet the needs of this group of vulnerable service users. The intended outcome of this work is to ensure that authentic person-centred care is commissioned appropriately and delivered, ensuring people are in control and able to exercise choice about how, and where, care is delivered that best meets their needs and outcomes.

The Community Living Change Fund was allocated to Integration Authorities via NHS Boards in February 2021. The fund was designed to bring home people with complex needs, including intellectual disabilities and autism, and those who have enduring mental health problems that are placed outside of Scotland, to discharge those that have endured long stays in a hospital setting and design community-based solutions that negate, or limit future hospital use and out of country placements. The funding was to be held in reserve within individual Integration Authorities to be used as plans are developed to support improvements.

The LD review, which had already been identified as a priority within West Dunbartonshire HSCP, has not taken place to date due to a number of factors, including; the global pandemic, staffing challenges and vacancies, prioritising other key areas of work to ensure service user safety and lack of management capacity to drive forward the change required. The monies from the Community Living Change Fund has allowed the HSCP to progress two new additional posts for two years; these post holders will be able to drive forward the review.

In addition to the requirement to develop sustainable person centred services, there is the financial context which requires the HSCP Board to identify savings and achieve best value. There are services which are loss making, and others which have a high staff /service user ratio, which require to be reviewed. Also, there are a number of service users receiving support who do not meet the HSCP Accessing Adult Social Care Eligibility criteria. It is important that these service users are signposted to alternative community services, which are more appropriate and will more effectively meet their needs and outcomes.

Service/Partners/Stakeholders/service users involved in the development and/or implementation of policy

HSCP staff, Council staff, Trade Unions, service users and carers will be involved in engagement sessions during the review process in line with Change Management Frameworks.

Does the proposals involve the procurement of any goods or services?	N
If yes please confirm that you have contacted our procurement services to discuss your requirements	

SCREENING	
You must indicate if there is any relevance to the four areas	
Duty to eliminate discrimination (E), advance equal opportunities (A) or foster good relations (F)	Y
Relevance to Human Rights (HR)	Y
Relevance to Health Impacts (H)	Y
Relevance to Social Economic Impacts (SE)	Y

Who will be affected by this policy?

HSCP staff

Service users and carers

Partner organisations

Who will be/has been involved in the consultation process?
1.Joint staff forum and individual Unions in relation to consultation as part of Organisational Change policies. 2. IJB and West Dunbartonshire Council 3. NHSGGC LD Board and Programme Board and Scottish Government for Coming Home Implementation/Community Living Change Fund work in line with deadlines already set. 3. External partner agencies and third sector providers. 4. Consultation and co-production with individual service users and their families.

Please outline any particular need/barriers which equality groups may have in relation to this policy list evidence you are using to support this and whether there is any negative impact on particular groups			
	Needs	**Evidence**	**Impact**

Age	Neutral		Neutral

	Needs	Evidence	Impact
Disability	Service users and carers may be concerned that they will not be able to access services which previously they attended.	At the moment there remain a number of people accessing services who do not meet WDHSCP Eligibility criteria. They continue to receive support from LD services, due to legacy provision, which requires review. The Scottish Government's strategy The Keys to Life; Improving quality of life for people with learning disabilities, conveys the ambition to improve outcomes by increasing choice and control for these individuals; "rather than being a passive recipient of services, citizens can become actively involved in selecting and shaping the support they receive." There is evidence from service users, both pre and post pandemic, that, through active participation in the review of their services, positive outcomes will be achieved. An example of this was when a long term attendee at the day centre came to the decision to stop attending altogether. They stated they felt this was a "fair decision I have made as I still have enough support between PA and community club to meet my needs." By taking greater control over their support they report that they have grown in self-confidence and are now able to enjoy life on their own terms better than before.	There is likely to be a reduction in service users attending LD services, however, access will be more targeted to those with the most complex needs, with behaviours perceived as challenging who may not easily be able to access community supports. This will help to ensure that those attending meet eligibility criteria or are signposted to community supports.
	Needs	**Evidence**	**Impact**

Gender Reassign	Neutral		Neutral
Marriage & Civil Partnership	Neutral		Neutral
Pregnancy & Maternity	Neutral		Neutral
	Needs	**Evidence**	**Impact**
Race	Neutral		Neutral
Religion & Belief	Neutral		Neutral

	Needs	**Evidence**	**Impact**
	Neutral		Neutral

Sex			
Sexual Orientation	Neutral		Neutral

	Needs	**Evidence**	**Impact**
Human Rights (ECHR statutory) **UNCRC (note: currently non statutory)**	Neutral		Neutral
Health	Neutral		Neutral

	Needs	Evidence	Impact
Social & Economic Impact	Concerns in relation to job security may be heightened, especially within certain staff groups.	HR21 records Full review of current staffing shows that all staff within registered and non-registered services are Council employed staff. The Community Learning Disability Team is an integrated team comprising both NHSGGC and Council employed staff.	Negative – if alternative posts are not identified
Cross Cutting	Neutral		Neutral

Policy has a negative impact on an equality group, but is still to be implemented, please provide justification for this
There is potential for staff to be displaced as part of the LD review work and reconfiguring services. This process will be managed in line with the appropriate policies. Service users and their carers will be reviewed and signposted to appropriate services, as required. Support will be provided to ensure a smooth transition to these services where appropriate.
Will the impact of the policy be monitored and reported on an ongoing bases?
All work within the review will be reported back to Senior Management Meeting and PMO and HSCP Board, when appropriate, for update and agreement with progression.
What is your recommendation for this policy?

It is recommended that this work is progressed.

Please provide a meaningful summary of how you have reached the recommendation

There is a requirement to implement the Scottish Government Strategy for complex care Learning Disability service users. It has also been a key HSCP strategic priority to review LD services. Taking into consideration the increasing complexity of need it is imperative that services are robust and resilient for the future.

This review will re-focus the available resources to ensure that those citizens with the greatest and most critical needs are supported to achieve positive and meaningful outcomes. The implementation of this work, will facilitate the development of services that can deliver on the ambitions and priorities of the Scottish Government Strategy for Learning Disability service users with the most complex needs, including behaviours perceived as challenging, as well as WDHSCP's Strategic Plan, with an emphasis on developing the key drivers of Workforce, Finance, Partnerships and Technology to empower staff to empower citizens to take greater responsibility for their own outcomes.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

27 June 2024

Subject: NHS GGC Director of Public Health Report: Working Together to Stem the Tide in West Dunbartonshire

1. Purpose

1.1 Outline the post pandemic population health status (via the new NHS Greater Glasgow and Clyde (NHSGGC) Director of Public Health Report and the findings of the 2023 Adult Health and Well-being Survey for West Dunbartonshire) to inform considerations of the public health priorities for the Health and Social Care Partnership (HSCP) Board and services.

2. Recommendations

2.1 The HSCP Board Meeting is asked to:

a) Acknowledge the health and well-being position of our population informed by the Adult Health and Well-being Survey (2023).

b) Use the analysis and calls to action within the Director of Public Health report within planning structures to capitalise on available opportunities to improve health.

3. Background

3.1 Against the backdrop of the Covid-19 pandemic and cost of living crisis, the Director of Public Health Report *"Working Together to Stem the Tide"* (framed by interviews with over 10,000 residents via NHSGGC's Health and Wellbeing Survey and updated epidemiology evidence) has been published to develop a collective understanding of the health and wellbeing our communities in order to review and refresh NHSGGC's public health strategy: Turning The Tide through Prevention.

4. Main Issues

4.1 With an increased need for health and social care services, the Report recognises the need to reconsider where and how we deliver services as a result of:

- Continuing changes to our population structure
- Worsening life expectancy and healthy life expectancy
- Lower general physical and mental health indictors
- Increase in residents living with a long-term limiting condition or illness

To support strategic population needs assessment and planning processes with local partners, the Board-level Health and Wellbeing Survey Report has been disaggregated into a series of Local Survey Reports. 1058 residents within West Dunbartonshire were interviewed in their homes using a stratified sampling framework.

Key findings included:

- Life expectancy West Dunbartonshire residents is following the same declining pattern as GGC
- One-third (34%) of adults in West Dunbartonshire have a limiting condition or illness, a figure similar to GGC (31%) overall. This figure rises to 73% for individuals aged 75 or older, a higher proportion than GGC (61%).
- Respondents in West Dunbartonshire were less likely than those in the NHSGGC area to rate their mouth/teeth as in good health (66% West Dunbartonshire; 70% NHSGGC)
- Just over half (53%) of adults in West Dunbartonshire indicated that in the last two years they had required services for a dental problem (54% NHSGGC)
- Proportion of people in West Dunbartonshire with a positive view of physical health is similar to GGC overall
- Proportion of people in West Dunbartonshire with a positive view of mental health and wellbeing is higher than GGC overall
- Proportion of people in West Dunbartonshire with WEMWBS score indicative of depression is similar to GGC overall
- Proportion of people in West Dunbartonshire who smoke (17%) is similar to GGC (18%) overall
- Proportion who receive all household income from state benefits is higher than GGC overall
- Proportion with difficulty meeting cost of food and or energy is lower than in GGC overall but still close to 1 in 3 people affected
- Compared to those in the NHSGGC overall, those in West Dunbartonshire are less likely to feel safe using public transport and walking alone
- 1 in 10 do not use the internet (48% of people aged 75+ did not use the internet)

Setting out the contemporary public health challenge, the Director of Public Health Report (January 2024) recognises the role of wider determinants of health and focuses on mobilising the skills and expertise within the NHS and all of our partners to seize all available opportunities to improve health. The priority areas for action are:

- Ensuring the best start for life
- Enabling health weight
- Boosting mental health and wellbeing
- Concerted action to reduce drug harms

- Building financial security for better health
- Creating a trauma-informed response
- Broadening access to digital health
- Affordable, accessible and sustainable transport
- Strengthening communities and places.

5. Options Appraisal

5.1 Not Applicable

6. People Implications

6.1 Not applicable

7. Financial and Procurement Implications

7.1 Not applicable

8. Risk Analysis

8.1 As noted within the report, areas requiring attention will be taken forward by the relevant operational stakeholders. The relevant governance structures are in place to support the implementation of the recommendations.

9. Equalities Impact Assessment (EIA)

9.1 There is no EIA required for this report.

10. Environmental Sustainability

10.1 Not applicable

11. Consultation

11.1 There is no consultation required for this report.

12. Strategic Assessment

12.1 Setting out the contemporary public health challenge, the Director of Public Health Report recognises the role of wider determinants of health and focuses on mobilising the skills and expertise within the NHS and all of our partners to seize all available opportunities to improve health. The priority areas for action are mapped to IJB Strategic Plan priorities below:

DPH Report Sections	DPH Report Calls to Action	Improving Lives Together Priorities (HSCP Strategic Plan)
Opportunities to improve health	Ensuring the best start for life	Recognise the impact of adverse childhood experiences and seek to reduce the incidence and impacts of all types of childhood adversity and trauma.
	Enabling Healthy Weight through healthy eating and active living	Address the preventable risk factors for poor physical and mental health, including obesity, smoking and the use of alcohol and drugs.
	Boosting mental health and mental wellbeing	Address the preventable risk factors for poor physical and mental health, including obesity, smoking and the use of alcohol and drugs. Improve the mental health and wellbeing of children and adults. Work with partners and communities to reduce the number of suicides and drug-related deaths.
	Concerted action to reduce drug harms	Address the preventable risk factors for poor physical and mental health, including obesity, smoking and the use of alcohol and drugs. Work with partners and communities to reduce the number of suicides and drug-related deaths.

Shaping a better future, today	Building financial security for better health	Work to reduce, prevent or undo the impact of the wider determinants of health.
	Creating a Trauma-Informed Response	Recognise the impact of adverse childhood experiences and seek to reduce the incidence and impacts of all types of childhood adversity and trauma.
	Broadening Access to Digital Health	Make the best use of technology-enabled care to transform the way people engage with and control their own health care, empowering them to manage it in a way that is right for them.
	Connecting people and health: affordable, accessible and sustainable transport	Working with partners, enhance opportunities and support measures to tackle barriers to active travel and promote the more effective use of green space.
	Strengthening Communities and Places	Address the preventable risk factors for poor physical and mental health, including obesity, smoking and the use of alcohol and drugs. Working with partners, enhance opportunities and support measures to tackle barriers to active travel and promote the more effective use of green space.

13. Directions

13.1 There is no direction required for the content of this report.

Name: Dr Emilia Crighton

Designation: Director of Public Health

Date: 4 June 2024

Person to Contact	Neil Irwin, Service Lead, NHSGGC, neil.irwin@ggc.scot.nhs.uk
Appendices:	
Appendix 1:	NHS Greater Glasgow and Clyde 2022/23 Adult Health and Wellbeing Survey - West Dunbartonshire Report
Appendix 2:	Director of Public Health Report

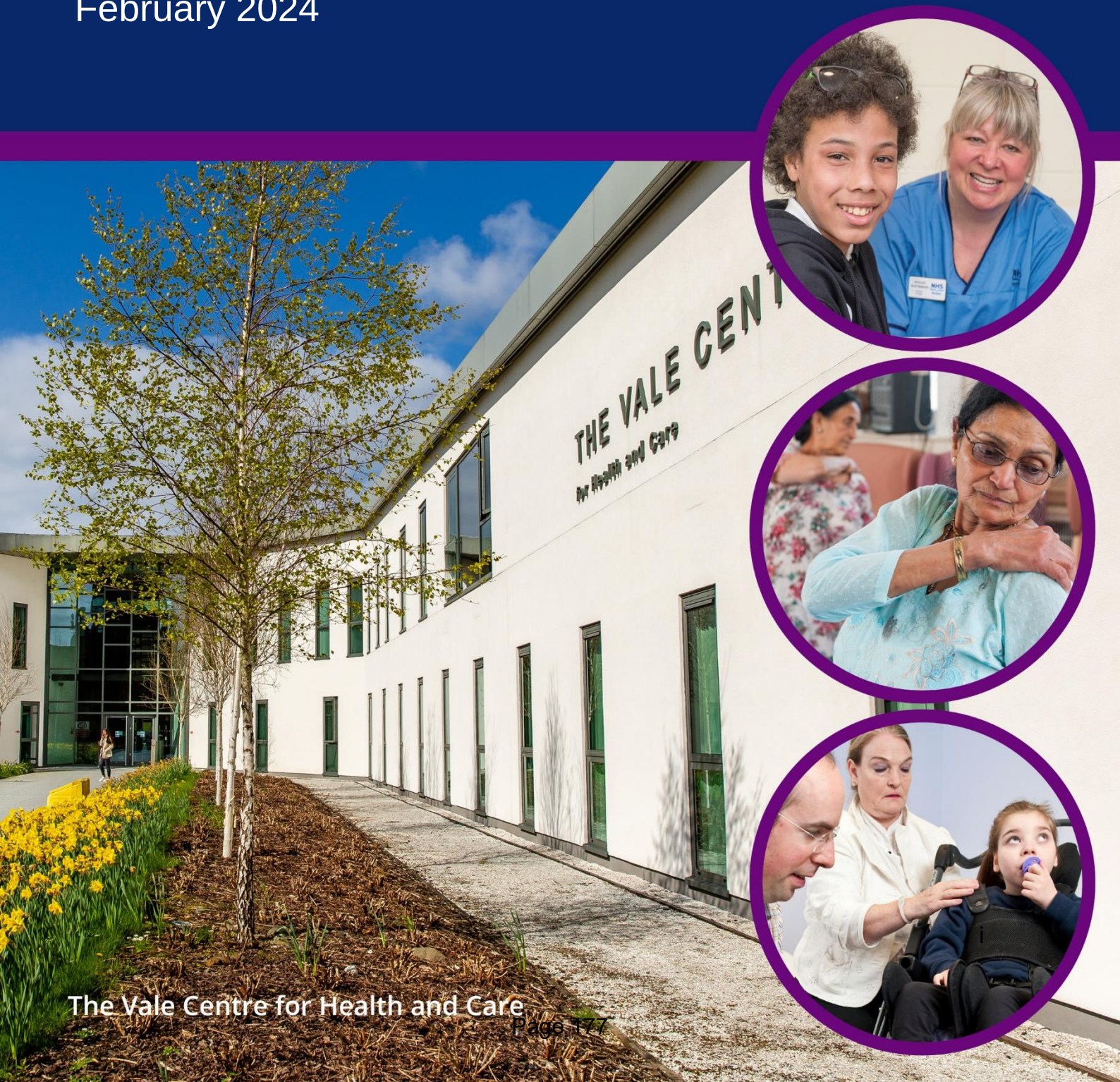
West Dunbartonshire
Health & Social Care Partnership

NHS
Greater Glasgow
and Clyde

NHS Greater Glasgow and Clyde 2022/23 Adult Health and Wellbeing Survey

West Dunbartonshire Report

February 2024



The Vale Centre for Health and Care

Foreword

We would like to welcome you to NHS Greater Glasgow and Clyde's 2022/23 Adult Health and Wellbeing (HWB) Survey Report for West Dunbartonshire. The survey provides information on health trends and analysis by different population groups to inform planning within West Dunbartonshire and NHS Greater Glasgow and Clyde and highlights areas where we need to work with partners and local communities to improve health.

As the interviews were conducted in 2022/23, it is the first HWB survey conducted post-Covid and provides intelligence on the impact of the pandemic for our community. We know that, alongside the pandemic, austerity has also had a more disproportionate negative impact on some of our residents.

Post pandemic, unsurprisingly, the indicators of self-perceived health and wellbeing showed a decline since the last NHSGGC report in 2017/18. Despite these challenging findings, the report provides an opportunity to galvanise and mobilise partners around a shared understanding of the public health priorities for our communities.

As recognised in the West Dunbartonshire HSCP's Strategic Plan 2023-26: Improving Lives Together, the challenges will not be overcome by continuing to do things the same way they have always been done. Our teams within West Dunbartonshire Health and Social Care Partnership and NHSGGC's Public Health Directorate will work differently together, along with other key partners, to improve services, improve health outcomes and focus on reducing inequalities. This will contribute to our vision that everyone in West Dunbartonshire lives in a place they can call home, in communities that care, doing things that matter to them, leading healthy, happy and fulfilling lives, and, when they need it, receiving care and support that prioritises independence, control, choice and recovery.

We hope you find the report useful in providing an overview of the many factors which contribute to people's health and wellbeing. We are keen that the report is used widely to plan for public health change and are happy to make the anonymised data available to partner agencies (both local and national).

We would like to thank staff and contractors for their input in collating, analysing and interpreting the data. Our thanks go to the 1058 residents who gave their time to be interviewed and shared their experiences and situation as part of the West Dunbartonshire Health and Wellbeing Survey.

Beth Culshaw
Chief Officer, West Dunbartonshire HSCP

Dr Emilia Crighton
Director of Public Health

Summary

Introduction
This summary provides an overview of the key findings for West Dunbartonshire from the Health and Wellbeing survey conducted through face-to-face interviews with adult residents across the NHS Greater Glasgow and Clyde area between September 2022 and May 2023. There were 1,058 interviews conducted in West Dunbartonshire. The survey has been conducted every three years since 1999 in the Greater Glasgow area, and in the expanded Greater Glasgow and Clyde area since 2008. The COVID pandemic caused a postponement to the survey in 2020/21, meaning there has been a five-year gap since the previous NHS Greater Glasgow and Clyde survey in 2017/18.

Data were weighted to ensure they are representative of age, gender and deprivation groups.

General Health
Across a range of health and wellbeing indicators, those in the most deprived areas had poorer findings – this included views of general health, physical and mental/emotional wellbeing and quality of life, and having WEMWBS scores indicating depression.

West Dunbartonshire fared poorer than the NHSGGC area as a whole for health and wellbeing indicators including views of general health and dental health and having limiting conditions. One in three adults in West Dunbartonshire had a long-term limiting condition or illness, rising to nearly three in four (73%) of those aged 75 or over. Just under half (46%) of all adults were receiving treatment for at least one condition, rising to 88% of those aged 75 or over. However, adults in West Dunbartonshire were more likely than those in the NHSGGC area as a whole to rate their mental/emotional wellbeing positively.

Health Behaviours
Overall, 17% of adults in West Dunbartonshire were smokers and 23% were exposed to second hand smoke. Rates for both indicators were much higher in the most deprived areas. Exposure to second hand smoke was highest among adults aged under 35 (36%). Use of e-cigarettes was also most common among young adults and those in the most deprived areas.

Men were twice as likely as women to have an AUDIT score which indicated alcohol-related risk (20% of men and 10% of women).

One in four (25%) met the target of consuming five or more portions of fruit in vegetables per day, and just under two in three (64%) met the target of 150 minutes of physical activity per week. Both measures were lower than in the NHSGGC area as a whole.

Social Health
One in six felt isolated from family and friends – lower than the finding for the NHSGGC area as a whole.

The proportion who felt they belonged to their local area or who felt valued as a member of their community was lower in West Dunbartonshire than in the NHSGGC area as a whole. For both these measures, older people showed the most positive findings and those in the most deprived areas fared worse.

Men were more likely than women to feel safe using local public transport or walking alone in their area. Overall, those in West Dunbartonshire were less likely than those in the NHSGGC area as a whole to feel safe doing either of these things.

One in four adults in West Dunbartonshire had caring responsibilities – higher than the proportion in the NHSGGC area as a whole.

Social Capital
Measures of social capital consistently showed less favourable findings for West Dunbartonshire compared to the NHSGGC area as a whole including perceptions of reciprocity and trust, valuing local friendships and engagement in social activism.

Those aged 65 or over were the most likely to have positive indicators of social capital. Those in the most deprived areas consistently had poorer indicators for measures of social capital – e.g. they were less likely to have positive views of reciprocity, trust or social support, less likely to value local friendships, and less likely to volunteer or belong to clubs/associations.

Financial Wellbeing
One in five (19%) received all household income from benefits – higher than in the NHSGGC area as whole (13%). One in four (27%) of those in the most deprived areas and one in three (32%) of those with a limiting condition received all household income from benefits.

Overall, 15% experienced indicators of food insecurity. Groups more likely to experience food insecurity were those aged 35-54, women, those in the deprived areas and those with a limiting condition.

Compared to the NHSGGC area as a whole, adults in West Dunbartonshire were less likely to have difficulty paying for food and /or energy, less likely to have a problem finding sums for unexpected expenses and less likely to have indicators of difficulty affording energy.

Population Characteristics

Overall, one in five adults lived alone, but this rose to nearly half (48%) among those aged 75 or over.

One in five said they had no qualifications, which was higher than the proportion in the NHSGGC area as a whole.

In the most deprived areas, three in ten lived in owner-occupied homes compared to seven in ten of those in other areas.

Just over half (53%) of adults were economically active.

Contents

1 Introduction

1.1 Introduction[1]

This report contains the findings of a research survey on the health and wellbeing (HWB) of NHS Greater Glasgow and Clyde (NHSGGC) residents carried out in 2022/23. The fieldwork and data entry were performed by BMG on behalf of NHSGGC, and the analysis and reporting were performed by Traci Leven Research.

The survey has been conducted every three years since 1999 and is the eighth in the series of studies; initially covering the NHS Greater Glasgow area it was expanded in 2008 to cover the new NHS Greater Glasgow and Clyde area. The health and wellbeing survey was due to be conducted between autumn 2020 and early 2021 but was postponed due to the COVID pandemic.

This report presents the findings for the West Dunbartonshire Health and Social Care Partnership area.

Background

The aims of the survey:

- to provide intelligence to inform Board wide planning e.g. Public Health priorities, Health and Social Health Partnerships and local Community Planning Partnerships;
- to explore the different experience of health and wellbeing in our most deprived communities compared to other areas;
- to provide intelligence on the impact of the COVID pandemic on health behaviours; health and illness; social health; social capital; financial wellbeing; and
- to provide information that would be useful for monitoring health improvement interventions.

There have been many policy changes since the first HWB survey was conducted in 1999. Social Inclusion Partnership areas (SIPs) were in place until around 2005 as a focus of tackling area-based deprivation. The Scottish Index of Multiple Deprivation (SIMD) was established as the main tool for measuring area-based deprivation and focusing of resources. Various structures (some dictated by policy) have been in place during the last 24 years; Community Health & Care Partnerships, Community Health Partnerships and more recently Health and Social Care Partnerships (HSCPs) as a vehicle for integrated planning and delivery of health and social care services at a local authority level. The introduction of Local Outcome Improvement Plans have led to a recognition of the breadth of influencing

[1] This section has been prepared by NHSGGC

factors on health. Locality planning has become a key requirement of local government. There have been many policies and strategies over this time relating to factors which impact on health and wellbeing. These include areas such as: child poverty; mental health; employability; loneliness and isolation; drugs and alcohol; community empowerment and many more. The factors which impact on health and wellbeing are complex and the political and strategic landscape is ever-changing in relation to this.

The HWB survey is formed around a set of core questions which have remained the same since 1999. Prior to the 2022/23 survey an extensive consultation exercise took place to modernise the questionnaire. New questions were included on the impact of the COVID pandemic on health and illness; health behaviours; social health; social capital and financial wellbeing, fuel poverty, dental health and internet use. An online component to the HWB survey was introduced in 2022/23 that covered more sensitive topics on sexual health and relationships, drugs, aspects of health and illness and social health. The 2022/23 survey provides an opportunity to explore trends over time while also exploring some contemporary public health issues.

The survey continues to offer flexible solutions for monitoring the health of the population in a range of geographies within NHSGGC. Again in 2022/23 we conducted neighbourhood level boosts. Intensive interviewing took place in Govanhill; Ruchill/Possilpark; Gorbals; Parkhead/Dalmarnock and Garthamlock/Ruchazie (to provide intelligence for monitoring the Thriving Places Programme). Boosts which enable the exploration of our most deprived areas compared to least deprived areas have taken place in Inverclyde, East Dunbartonshire, Renfrewshire, West Dunbartonshire and East Renfrewshire.

Thanks are due to the working group that led the survey:

Margaret McGranachan	Public Health Researcher
Heather Jarvie	Programme Manager
Katy Levin	Senior Researcher
Rebecca Campbell	Consultant in Public Health

For further information, please contact:
margaret.mcgranachan@ggc.scot.nhs.uk

We would also like to thank our partners for their feedback and comments during the questionnaire consultation.

1.2 Summary of Methodology

The 2022/23 survey comprises 10,030 interviews conducted face-to-face at homes with adults aged 16 or over throughout the NHSGGC area. Of these, 1,084 interviews were conducted in West Dunbartonshire.

The fieldwork was conducted between September 2022 and May 2023. A full account of the sampling procedures, fieldwork and survey response can be found in Appendix A. A comparison with previous survey methods and key changes for the 2022/23 survey are presented in Appendix B. The overall sample profile is in Appendix C. The survey questionnaires are in Appendices F and G.

The sample profile of the 1,084 interviews conducted in West Dunbartonshire is shown in Table 1.1.

Table 1.1: Main questionnaire sample before and after weighting, and Small Area Population Estimates (SAPE) comparison for West Dunbartonshire

	Sample Before Weighting N	Sample Before Weighting %	Sample After Weighting %	SAPE 2020 %
Male	490	45.2%	47.2%	47.0%
Female	594	54.8%	52.8%	53.0%
Other/no answer	0	0.0%	0.0%	N/A
16-24	57	5.3%	11.7%	11.7%
25-34	155	14.3%	15.7%	15.7%
35-44	153	14.1%	14.2%	14.2%
45-54	161	14.9%	16.8%	16.7%
55-64	235	21.7%	18.4%	18.5%
65-74	207	19.1%	13.3%	13.4%
75+	116	10.7%	9.8%	9.8%
Bottom 15%	553	51.0%	30.0%	30.0%
Other Areas	531	49.0%	70.0%	70.0%

Note that the methodology and survey response described in Appendix A details the initial dataset of 10,346 interviews obtained across the whole GGC area. However, this was subsequently reduced to 10,030 when cases with missing compulsory data of age group and/or household size (required for data weighting) were removed.

Social and Economic Context

It is important to consider the very significant social and economic changes that occurred since the previous survey in 2017/18 and continued to change during the survey period. Those surveyed in 2022/23 were living in a very different context to those in 2017/18, not least those associated with:

- **the UK's withdrawal from the European Union** (formally initiated in January 2020)

- **the COVID pandemic** since March 2020 and its impacts on physical health, mental health, isolation, financial wellbeing and other factors. Beyond the period of restrictions (Spring 2022), some lasting changes in lifestyle (e.g. working patterns/home working), long-lasting physical effects (e.g. long Covid), longer term impacts on mental health and knock-on effects (e.g. on hospital waiting lists) etc. should be considered as contextual factors of the 2022/23 survey

- the very significant rise in the **cost of living**, including steep rises in energy costs from October 2021, exacerbated by the war in Ukraine from February 2022. Inflation has been consistently over 5% since January 2022, and was over 10% during most of the survey period.

In addition, the continuing effects of pre-pandemic austerity have been explored by work led by Glasgow Centre of Population Health and University of Glasgow which have linked **austerity** to life expectancy plateauing (or decreasing in the most deprived areas) in Scotland and across the UK since 2012[2], and healthy life expectancy showing a two-year decrease in Scotland between 2011 and 2019[3].

1.3 This Report

Chapters 2-7 report on all the survey findings, with each subject chapter containing its own infographic summary at the start, and a 'key messages' summary at the end. For each indicator, figures and/or tables are presented showing the proportion of the sample which met the criteria, broken down by demographic (independent) variables. Comparisons are also made with the findings for the NHSGGC area as a whole. **Only comparisons with NHSGGC as a whole and findings by independent variables which were found to be significantly different ($p \leq 0.05$) are reported.** The independent variables which were tested were:

- Age group

- Gender

[2] McCartney G, Walsh D, Fenton L, Devine R. Resetting the course for population health: evidence and recommendations to address stalled mortality improvements in Scotland and the rest of the UK. Glasgow; Glasgow Centre for Population Health/University of Glasgow:2022. https://www.gcph.co.uk/assets/0000/8723/Stalled_Mortality_report_FINAL_WEB.pdf

[3] Walsh D, Wyper GMA, McCartney G: Trends in healthy life expectancy in the age of austerity *J Epidemiol Community Health 2022*;76:743-745.https://jech.bmj.com/content/76/8/743

- Age and gender[4]
- Most deprived 20% datazones versus other areas
- Presence versus absence of a long-term limiting condition or illness

An explanation of how the independent variables were derived is in Appendix D.

Data Weighting

Findings are all based on **weighted data**, ensuring that the sample was representative of the geography, population profile and deprivation groups of the NHSGGC area as a whole. An explanation of the weighting process is in Appendix C.

Missing and 'Don't Know' Responses

Unless otherwise stated, all findings exclude 'don't know' and 'prefer not to say' responses.

Online Survey

A much smaller subset of respondents across GGC (N=1,194) responded to an additional online survey. The findings for this are reported in the main report, but not explored for individual HSCPs due to the small sample size.

A Note on Rounding and Interpreting Percentages

Most percentages are presented to the nearest whole number. However, there are some instances where a small proportion gave a particular response and it is helpful to examine statistics to one decimal place. Where whole numbers are used, the convention of '<1%' is used to represent a value greater than 0% but less than 0.5%.

Due to rounding, not all questions recoded into positive or negative type responses will necessarily appear to add up to the quoted overall figure. For example, in Chapter 4 the overall proportion who disagreed that local people could influence local decisions was 8% comprising 5% who disagreed and 2% who strongly disagreed. These appear to sum 7%, but the more precise figures were 5.4% and 2.3% which total 7.7%, thus rounded to 8%.

[4] Findings by the variable 'age and gender' are only reported if they provide additional insight beyond the findings for the separate variables 'age group' and 'gender' – e.g. if gender differences are only observed in some age groups, or more marked in some age groups compared to others.

Columns and bars presented in charts are built with statistics to one decimal place, but the figures on the charts are usually rounded to the nearest whole number.

Some questions, for example experience of crime (reported in Table 4.1), allow the respondent to select more than one category, so total responses can add up to more than proportion who say 'any of the above'.

Unreported Findings

One question from the main survey questionnaire is not reported due to errors/difficulties in data collection. This was question B18 in the main questionnaire (sedentary behaviour) where respondents appeared to misunderstand the question and data parameters were not applied - respondents frequently gave responses outside of expected limits (hours appear to have been given per week rather than per day in many cases).

Other Surveys Cited in This Report

For context and comparison, findings from other surveys are cited in this report. These are:

- The 2022 Scottish Household Survey
  https://www.gov.scot/collections/scottish-household-survey-publications/

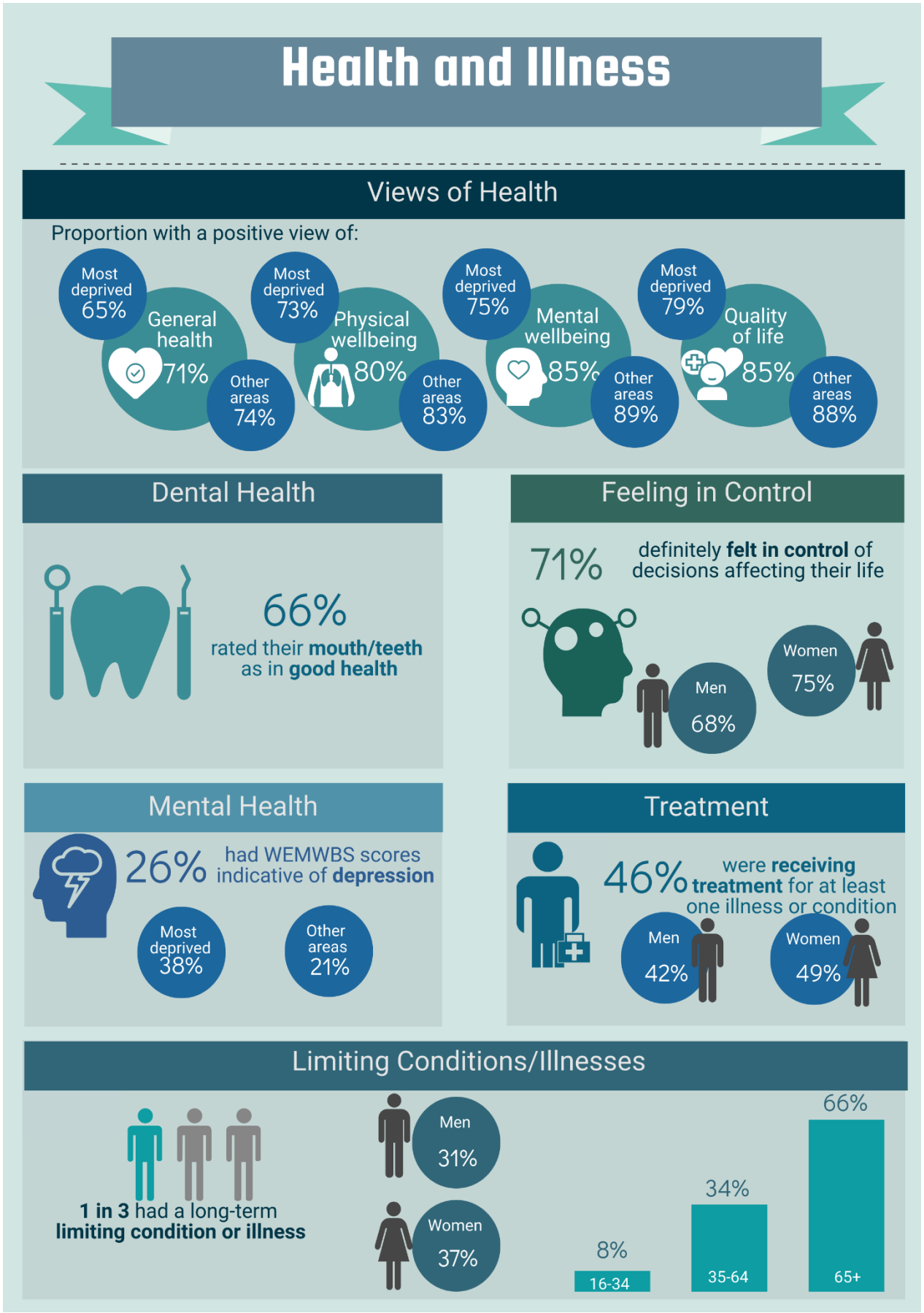
- The 2021 and 2022 Scottish Health Surveys[5]
  https://www.gov.scot/publications/scottish-health-survey-2021-volume-1-main-report/
  https://www.gov.scot/publications/scottish-health-survey-2022-volume-1-main-report/

- Previous NHS Greater Glasgow & Clyde Health and Wellbeing Surveys
  https://www.stor.scot.nhs.uk/ggc/

Policy Context

Policy context is provided for some of the topics within the findings chapters. These are shown in shaded boxes, and have been prepared by policy colleagues in NHSGGC.

[5] 2022 Scottish Health Survey findings are used for comparisons where available, but relevant 2021 findings are used for indicators not included in the 2022 survey.


Health and Illness
Views of Health
Proportion with a positive view of:
General health
Most deprived 65%
71%
Other areas 74%
Physical wellbeing
Most deprived 73%
80%
Other areas 83%
Mental wellbeing
Most deprived 75%
85%
Other areas 89%
Quality of life
Most deprived 79%
85%
Other areas 88%
Dental Health
66%
rated their mouth/teeth as in good health
Feeling in Control
71%
definitely felt in control of decisions affecting their life
Men 68%
Women 75%
Mental Health
26%
had WEMWBS scores indicative of depression
Most deprived 38%
Other areas 21%
Treatment
46%
were receiving treatment for at least one illness or condition
Men 42%
Women 49%
Limiting Conditions/Illnesses
1 in 3 had a long-term limiting condition or illness
Men 31%
Women 37%
8%
16-34
34%
35-64
66%
65+

2.1 Self-Perceived Health and Wellbeing

General Health

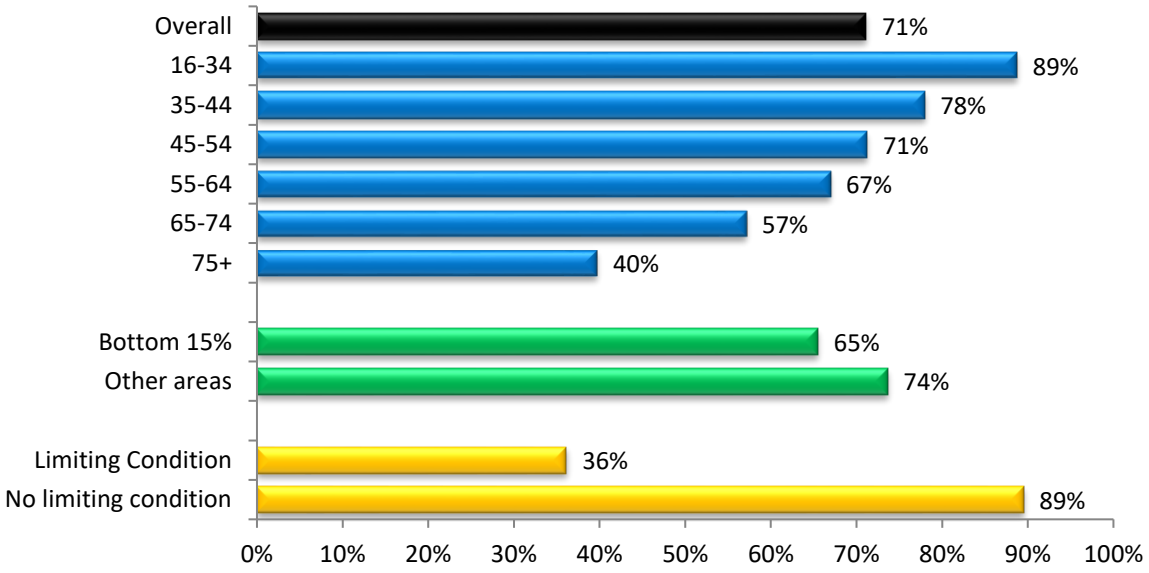
Respondents were asked to describe their general health over the last year on a five point scale (very good, good, fair, bad or very bad). Overall, seven in ten (71%) gave a positive view of their health, with 21% saying their health was very good and 50% saying their health was good. However, 29% gave a negative view of their health, with 19% saying their health was fair, 8% saying it was bad and 2% saying it was very bad.

As Figure 2.1 shows, the likelihood of having a positive view of general health decreased with age, ranging from 89% of those aged under 35 to 40% of those aged 75 or over.

Those in the most deprived areas were less likely than those in other areas to have a positive view of their general health.

As would be expected, those who had a long-term limiting condition or illness were much less likely than others to rate their general health positively.

Figure 2.1: Positive View of General Health by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

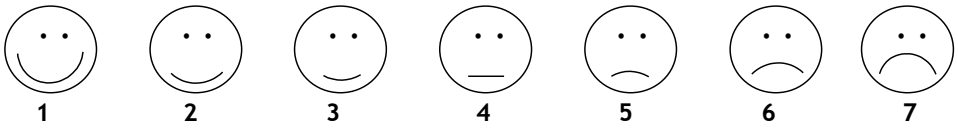
The proportion in West Dunbartonshire who had a positive view of their general health (71%) was lower than in the NHSGGC area as a whole (74%).

Evidence from Other Sources

- The finding of 71% for West Dunbartonshire is similar to the national findings of the **Scottish Health Survey (2022**) which found that overall 70% of adults in Scotland had a positive view of their general health, declining with age from 85% of 16-24 year olds to 52% of those aged 75+.
-

Physical Wellbeing and Mental/Emotional Wellbeing

Respondents were presented with a 7-point 'faces' scale, with the expressions on the faces ranging from very happy to very unhappy:



Using this scale, they were asked to rate their general physical wellbeing and general mental or emotional wellbeing. Those selecting any of the three 'smiling' faces (1-3) were categorised as having a positive perception.

In total, 80% gave a positive view of their physical wellbeing, and 85% gave a positive view of their mental/emotional wellbeing.

- Those in the youngest age groups were the most likely to have a positive perception of their physical wellbeing and those in the oldest age groups were the least likely.
- Men were more likely than women to have a positive perception of their physical wellbeing.
- Those in the most deprived areas were less likely than others to have positive ratings of either physical or mental/emotional wellbeing.
- As would be expected, positive ratings of both measures were higher for those without limiting conditions or illnesses.

Figure 2.2: Positive Perception of Physical Wellbeing by Age, Gender, Deprivation and Limiting Conditions

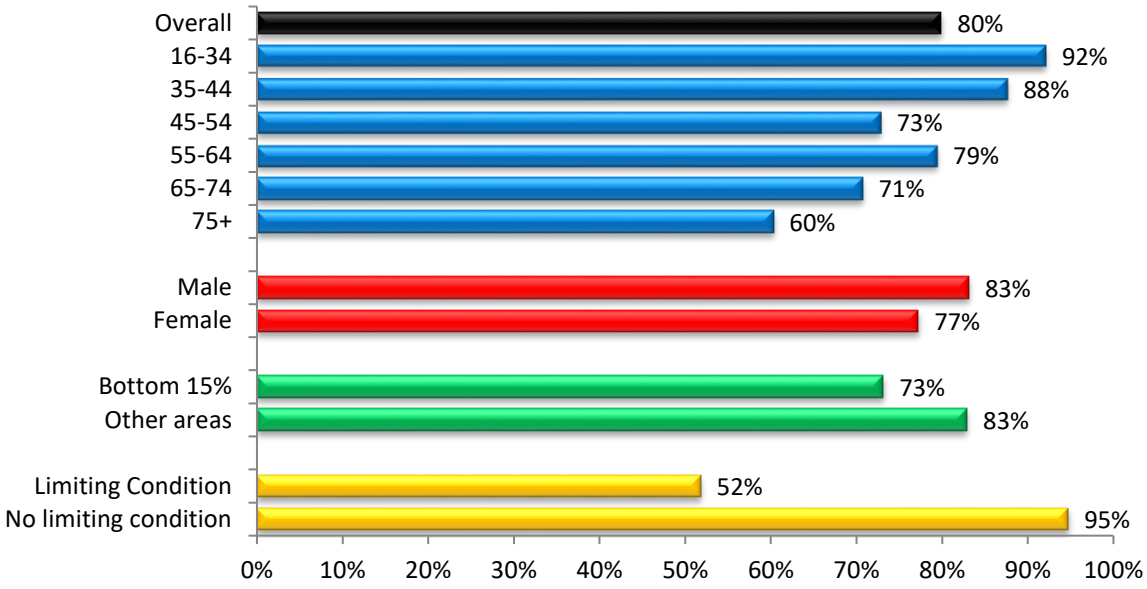
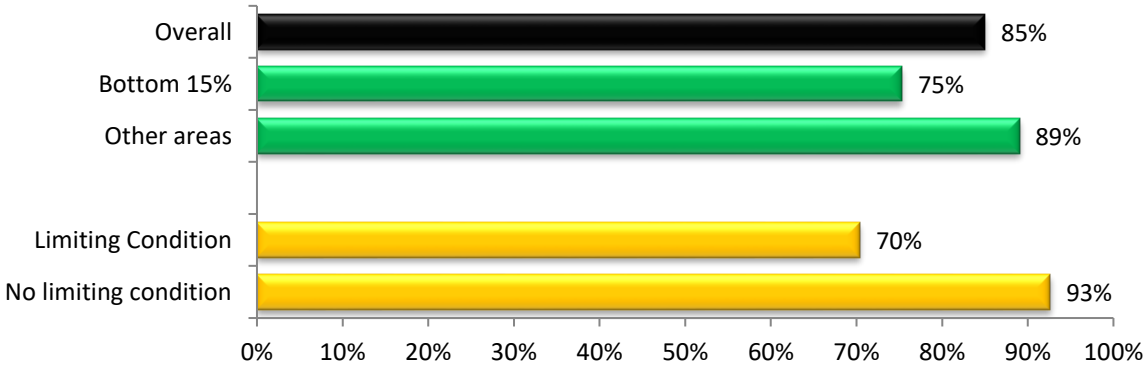


Figure 2.3: Positive Perception of Mental/Emotional Wellbeing by Deprivation and Limiting Conditions



Comparison with NHSGGC

The proportion in West Dunbartonshire who had a positive view of their mental/emotional wellbeing (85%) was higher than in the NHSGGC area as a whole (81%).

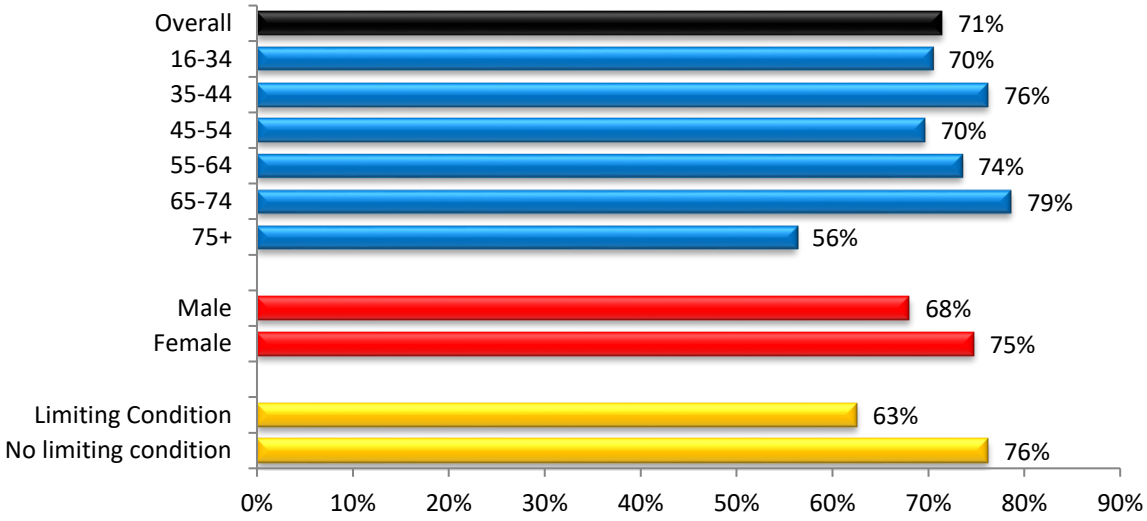
Feeling in Control of Decisions Affecting Life

Respondents were asked whether they feel in control of decisions that affect their life, such as planning their budget, moving house or changing job. Seven in ten (71%) said that they 'definitely' felt in control of these decisions,

while 23% said that they felt in control 'to some extent' and 6% did not feel in control of these decisions.

- Those aged 75 or over were the least likely to say they definitely felt in control of the decisions affecting their life.
- Women were more likely than men to say they definitely felt in control of the decisions affecting their life.
- Those with a limiting condition or illness were less likely than others to feel in control of the decisions affecting their life.

Figure 2.4: 'Definitely' Feel in Control of Decisions Affecting Life by Age, Gender and Limiting Conditions

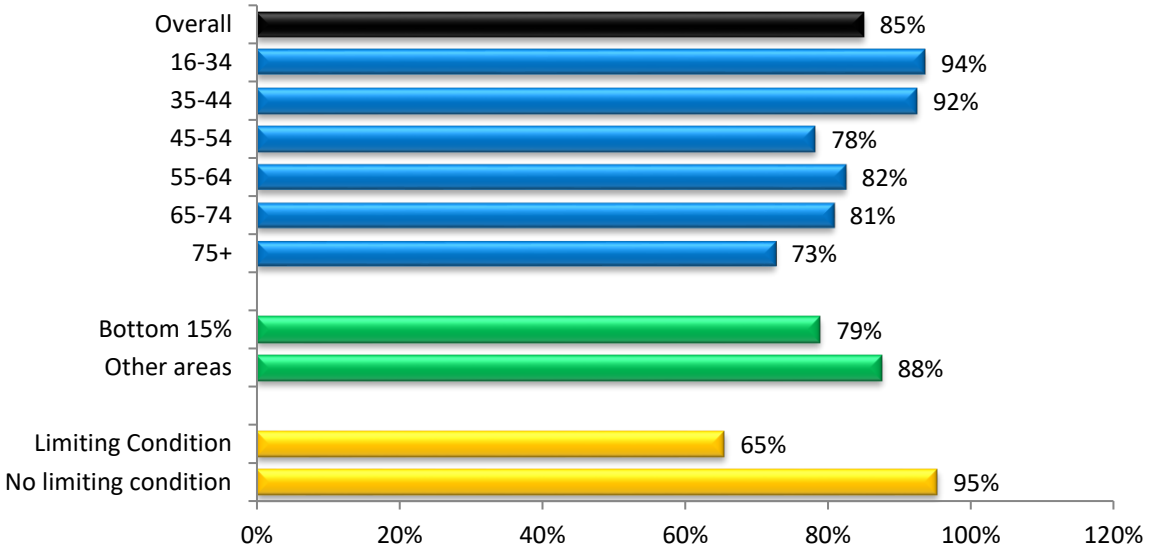


2.2 Self-Perceived Quality of Life

Using the 'faces' scale, respondents were asked to rate their overall quality of life. Overall, 85% gave a positive rating of their quality of life.

- Those aged 75 or over were the least likely to give a positive rating of their overall quality of life, and those aged under 45 were the most likely.
- Those in the most deprived areas were less likely to have a positive perception of their overall quality of life.
- Those with a long-term limiting condition or illness were less likely than others to have a positive view of their quality of life.

Figure 2.5: Positive Perception of Quality of Life by Age, Deprivation and Limiting Conditions



2.3 Long Term Conditions or Illness

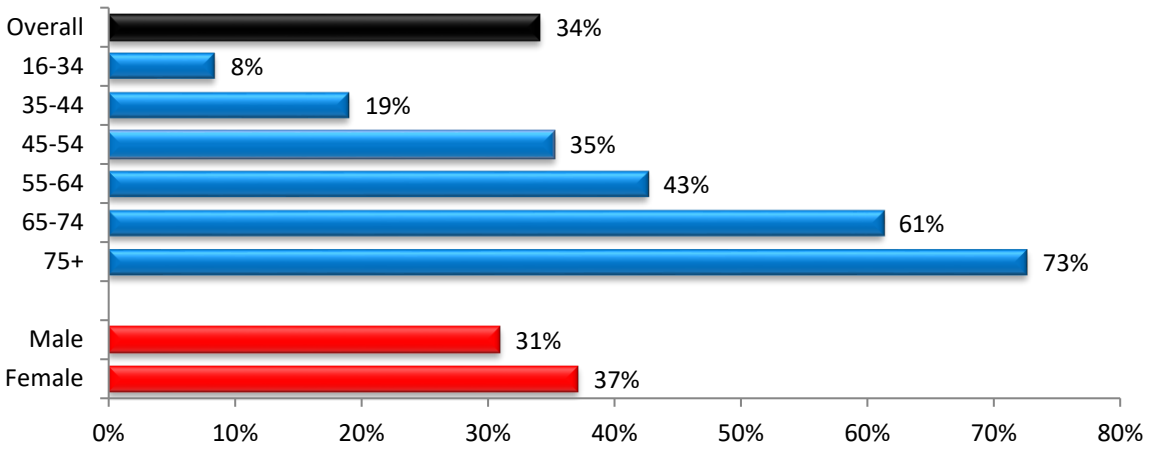
One in three (34%) said they had a long-term condition or illness that substantially interfered with their day to day activities. Of those who had a long-term limiting condition or illness:

- 46% had a physical disability
- 16% had a mental or emotional health problem
- 65% had a long-term illness.

The likelihood of having a long-term limiting condition or illness increased with age from 8% of those aged under 35 to 73% of those aged 75 or over.

Women were more likely than men to have a long-term limiting condition or illness.

Figure 2.6: Limiting Long-Term Condition or Illness by Age and Gender



Although overall women were more likely than men to have a long-term limiting condition or illness, this was mostly attributable to those aged 65 or over, as Table 2.1 shows.

Table 2.1: Limiting Long-Term Condition or Illness by Age and Gender

	Limiting Long-Term Condition or Illness
Men 16-44	11%
Women 16-44	13%
Men 45-64	38%
Women 45-64	40%
Men 65+	57%
Women 65+	73%

Comparison with NHSGGC

The proportion in West Dunbartonshire who had a limiting long-term condition or illness (34%) was higher than in the NHSGGC area as a whole (31%).

Evidence from Other Sources

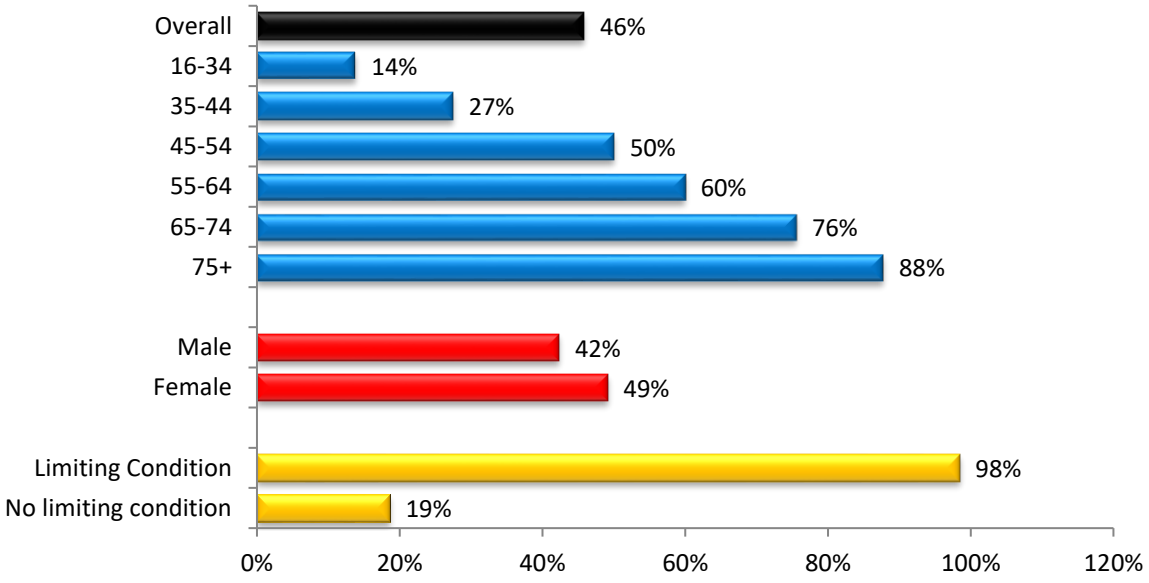
- The proportion who reported having a limiting long-term condition/illness (34%) was slightly lower than the national figure from the **Scottish Health Survey (2022)** which found that overall 37% had a limiting condition/illness, showing an overall increase from 26% in 2008 and from 34% in 2021.

Illnesses/Conditions for Which Treatment is Being Received

Just under half (46%) of respondents said they had one or more illness or condition for which they were currently being treated (not necessarily 'limiting' illnesses/conditions) – 20% were being treated for one condition, and 26% were being treated for two or more.

- The proportion being treated for any conditions/illnesses increased with age from 14% of those aged under 35 to 88% of those aged 75 or over.
- Women were more likely than men to be receiving treatment.
- Most (98%) of those who had a long-term limiting condition or illness said they were receiving treatment.

Figure 2.7: Proportion Receiving Treatment for at Least One Condition by Age, Gender and Limiting Conditions



The overall gender difference was largely attributable to the gender difference observed for those aged 65 and over.

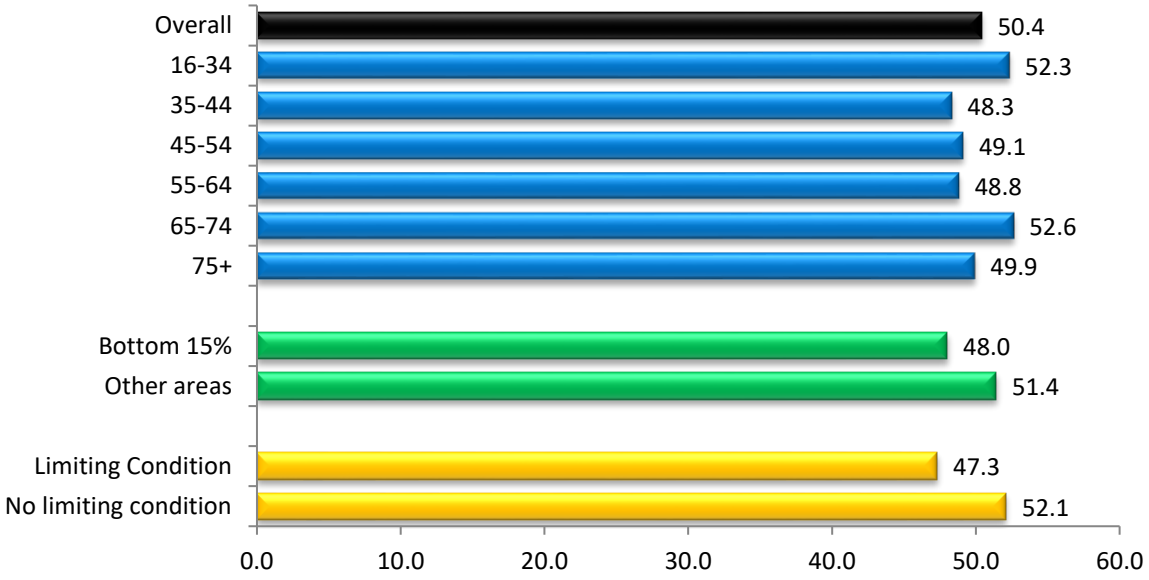
Table 2.2: Proportion Receiving Treatment for at Least One Condition by Age and Gender

	Receiving treatment
Men 16-44	18%
Women 16-44	20%
Men 45-64	54%
Women 45-64	57%
Men 65+	73%
Women 65+	86%

2.4 Mental Health

The self-completion section of the main survey questionnaire included the fourteen questions of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS). This measures mental wellbeing. The mean WEMWBS score was 50.4. Mean WEMWBS scores varied significantly by age, deprivation and limiting conditions, as Figure 2.8 shows.

Figure 2.8: Mean WEMWBS Scores by Age, Deprivation and Limiting Conditions (Higher Scores = better mental wellbeing)



Validated categorisations of WEMWBS scores are:

- Score under 41: Probable clinical depression
- Score 41-44: Possible/mild depression
- Score 45+: No depression

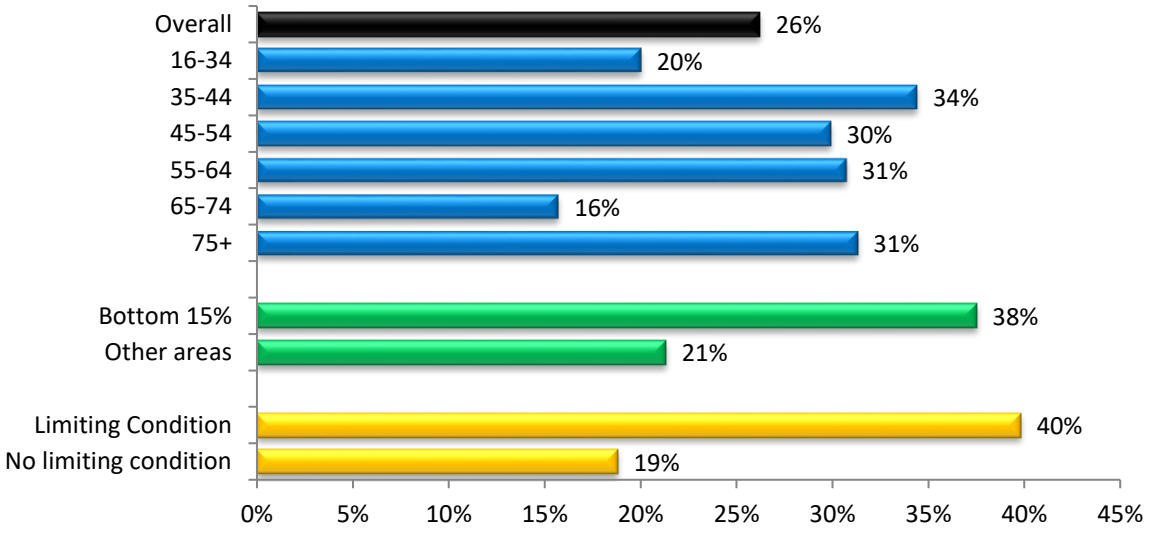
Using these categories, 26% had a WEMWBS score indicating depression – either probable clinical depression (14%) or possible mild/depression (12%).

- Those aged 35-64 were the most likely to have a score indicating depression.

- Just under two in five (38%) of those in the most deprived areas had a score indicating depression, compared to one in five (21%) of those in other areas.

- Those with a limiting condition or illness were much more likely than others to have a score indicating depression.

Figure 2.9: Proportion with WEMWBS Scores Indicating Depression by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire had a lower mean WEMWBS score (50.4 West Dunbartonshire; 51.2 NHSGGC).

Evidence from Other Sources

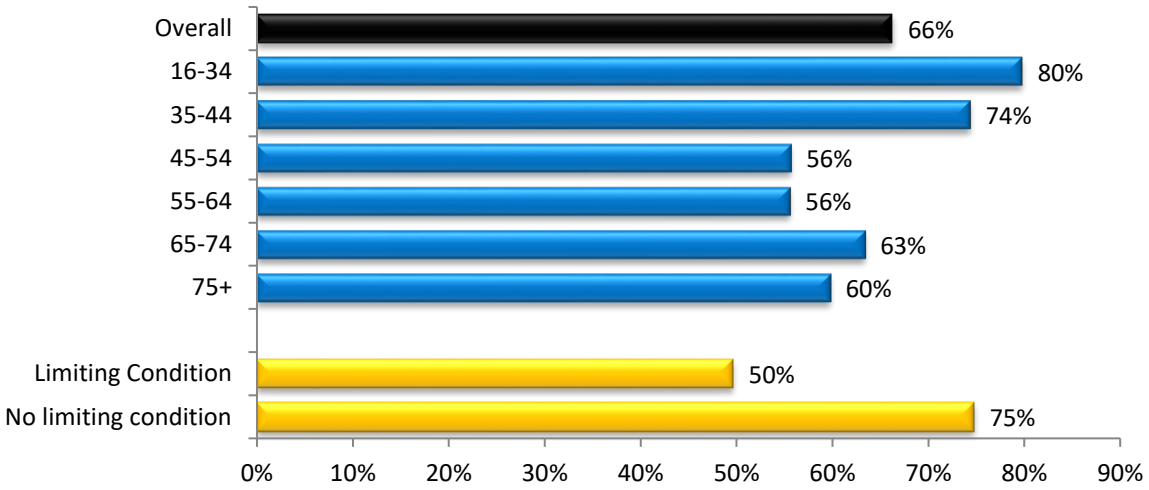
- The **Scottish Health Survey (2022)** found, after a decade of fairly constant mean WEMWBS scores, there was a decrease between 2019 and 2021 from 49.8 to 48.6, and a further decrease to 47.0 in 2022 - lower than the mean of 50.4 in West Dunbartonshire measured by the NHSGGC survey. The mean SHS WEMWBS score in 2022 for the most deprived quintile was 44.7.

2.5 Dental Health

Respondents were asked how they would describe the current state of the health of their mouth and teeth. Two in three (66%) said they felt their mouth and teeth were in good health, while 25% said they felt that their mouth and teeth had some problems that need to be fixed and 9% said they felt their mouth and teeth were in a poor state.

- Those aged under 35 were the most likely to rate their mouth/teeth as being in good health.
- Those with a long-term limiting condition or illness were less likely than others to say they felt their mouth/teeth were in good health.

Figure 2.10: Proportion Rating Mouth/Teeth as in Good Health by Age and Limiting Conditions



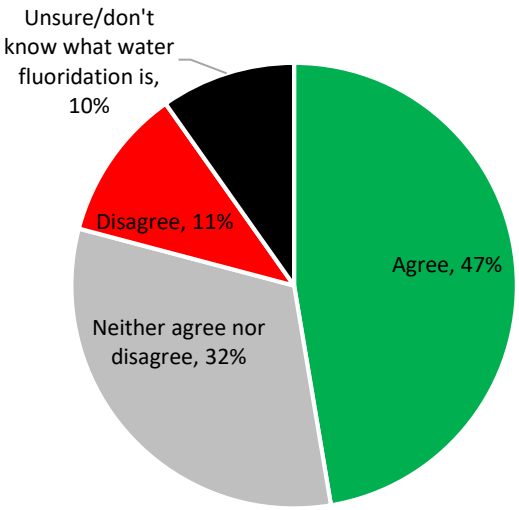
Comparison with NHSGGC

Those in West Dunbartonshire were less likely than those in the NHSGGC area as a whole to rate their mouth/teeth as in good health (66% West Dunbartonshire; 70% NHSGGC).

Just over half (53%) of adults indicated that in the last two years they had required services for a dental problem. Of these, most (90%) had used a high street dental practice. Other services used were: pharmacist (10%), medical GP (6%), out of hours/emergency dental service (4%), and Accident and Emergency Department (2%).

Respondents were asked the extent to which they agreed or disagreed with the statement: 'I am open to the possibility of water fluoridation in my local area'. Overall, 47% agreed with this, while 11% disagreed and 42% either said they did not agree nor disagree or that they were unsure/did not know what fluoridation is.

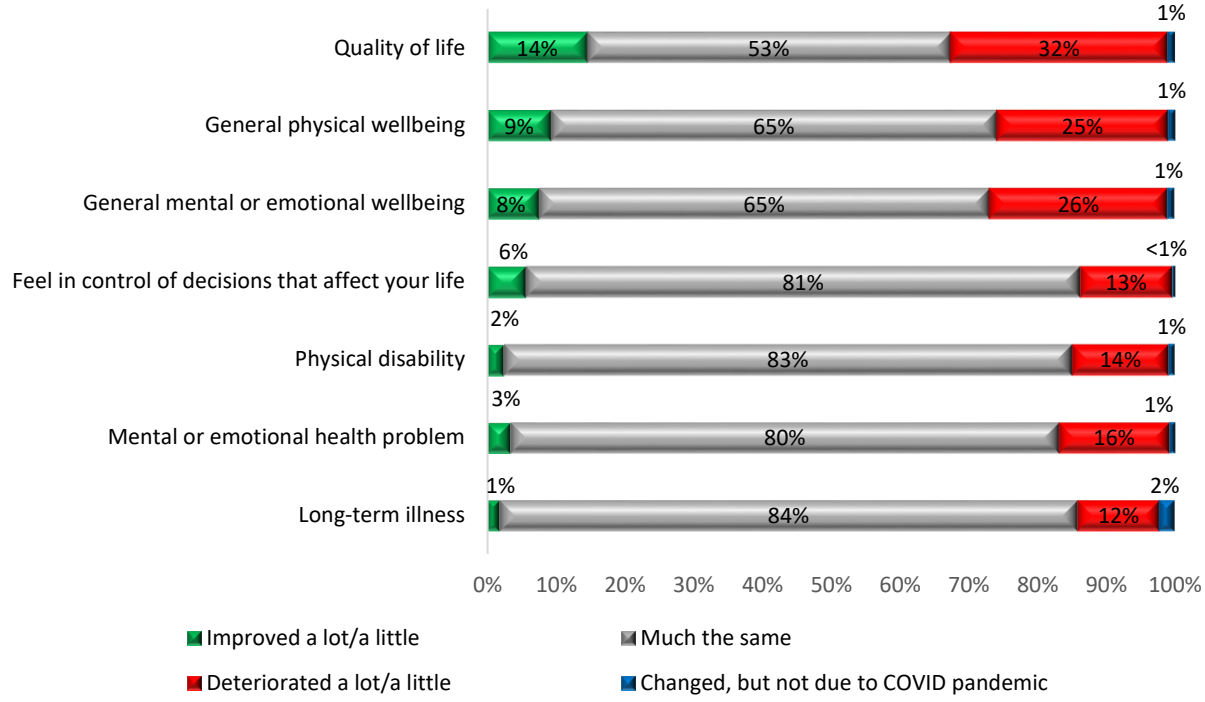
Figure 2.11: Responses to the statement 'I am open to the possibility of water fluoridation in my local area'



2.6 Effects of COVID on Health and Wellbeing

Respondents were asked how a number of health and wellbeing indicators had changed for them due to the COVID pandemic. Responses are shown in Figure 2.12. For each indicator, most said they were 'much the same'. However, 32% said their quality of life had deteriorated due to the pandemic; 26% said their general mental or emotional wellbeing had deteriorated and 25% said their general physical wellbeing had deteriorated due to the pandemic.

Figure 2.12: Perceived Effects of the COVID Pandemic on Wellbeing

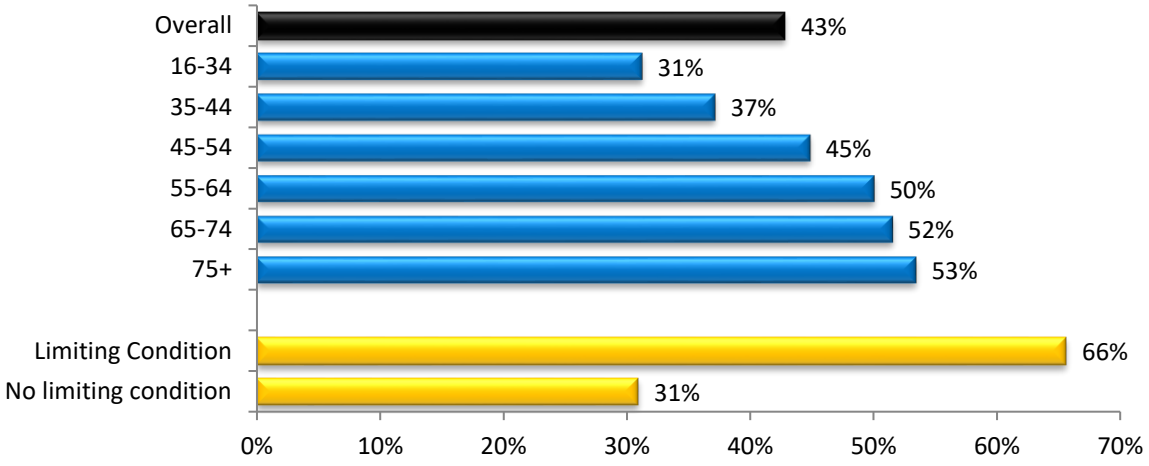


Overall, 43% said that at least one of the health and wellbeing indicators had deteriorated due to the COVID pandemic.

- The likelihood of having perceived negative effects of COVID on health and wellbeing indicators was lowest for the youngest age groups and higher for the oldest groups.

- Those with a limiting condition or illness were much more likely than others to report negative effects of the pandemic on wellbeing.

Figure 2.13: Proportion Reporting Deterioration of at Least One Wellbeing Indicator due to the COVID Pandemic by Age and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to report negative effects of COVID on wellbeing (43% West Dunbartonshire; 47% NHSGGC).

2.7 Summary of Key Messages from This Chapter

Indicators where West Dunbartonshire Compared Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- more likely to have a positive perception of their mental/emotional wellbeing
- less likely to have perceived negative effects of COVID on wellbeing indicators.

Indicators where West Dunbartonshire Compared less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire:

- were less likely to have a positive view of their general health
- were more likely to have a limiting long term condition or illness
- had lower mean WEMWBS scores
- were less likely to rate their mouth/teeth as in good health.

Differences by Age and Gender

- Those aged 75 or over were the least likely to have positive views of their general health, physical wellbeing and quality of life, and the least likely to definitely feel in control of the decisions affecting their life.

- Men were more likely than women to have positive views of their physical wellbeing.

- Women were more likely than men to definitely feel in control of the decisions affecting their life.

- Those aged 75 or over were the most likely to have a limiting long-term condition or to be receiving treatment.

- Women were more likely than men to have a limiting long-term condition or to be receiving treatment.

- Those aged 35-44 were the age group most likely to have a WEMWBS score indicating depression.

- Those aged under 35 were the most likely to rate their mouth/teeth as in good health.

Differences by Deprivation

Those living in the most deprived areas were:

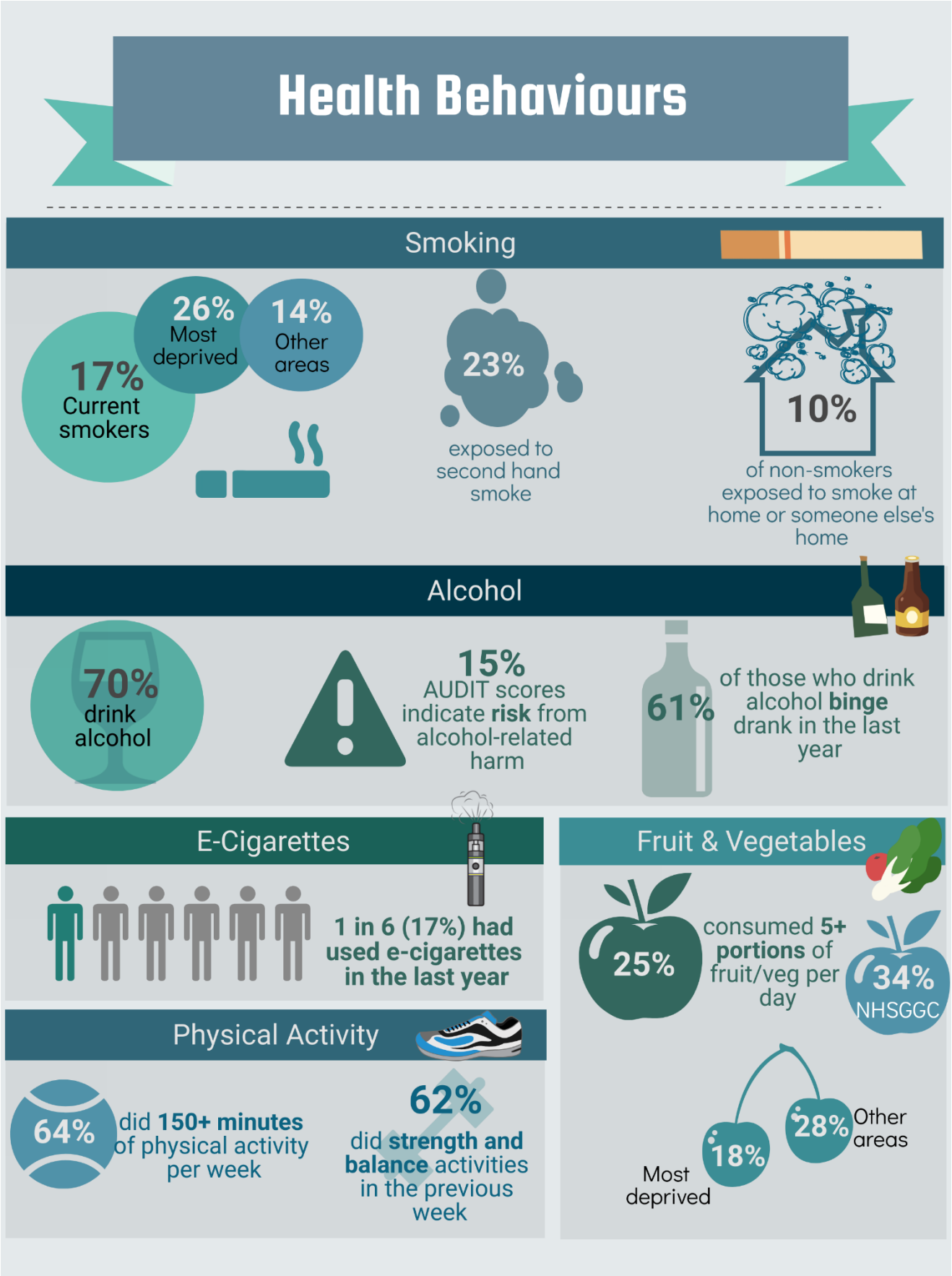
- less likely to have a positive view of their general health, physical wellbeing, mental/emotional wellbeing or quality of life
- more likely to have a WEMWBS score indicating depression.

Differences by Limiting Conditions

Those with a long-term limiting condition or illness were:

- less likely to have positive views of their general health, physical wellbeing, mental/emotional wellbeing and quality of life
- less likely to definitely feel in control of the decisions affecting their life
- more likely to be receiving treatment for at least one condition
- more likely to have a WEMWBS score indicating depression
- less likely to feel their mouth/teeth were in good health
- more likely to report deterioration of wellbeing indicators due to the COVID pandemic.

3 Health Behaviours

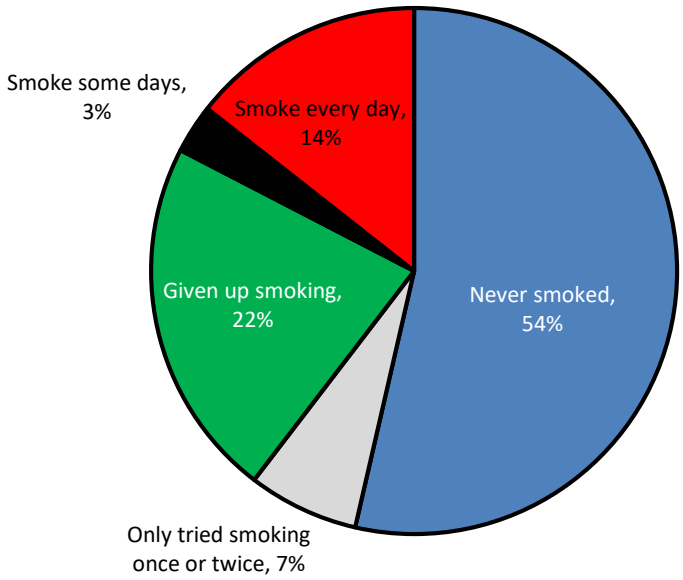


3.1 Smoking

Smoking

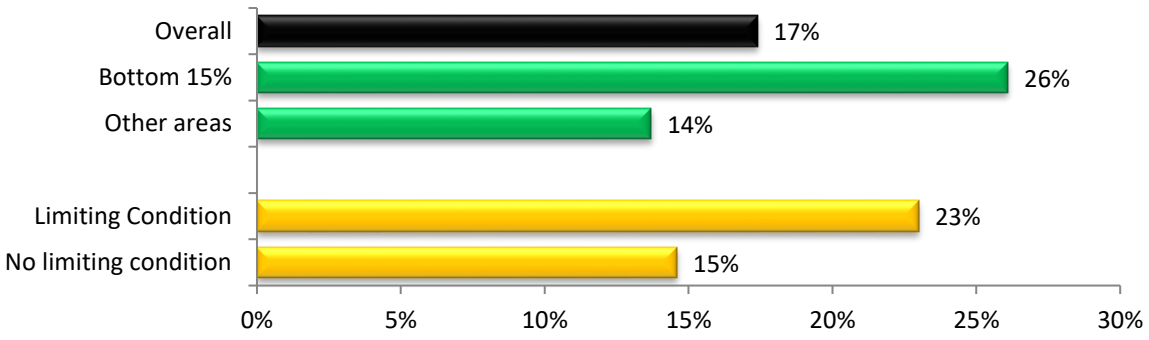
One in six (17%) were smokers, smoking either every day (14%) or some days (3%).

Figure 3.1: Current Smoking Status



- Those in the most deprived areas were much more likely than those in other areas to be smokers.
- Those with a limiting condition or illness were more likely than others to be smokers.

Figure 3.2: Proportion of Current Smokers by Deprivation and Limiting Conditions



Among current smokers, 29% indicated they wanted to stop smoking soon, 40% did not want to stop smoking and a further 31% wanted to stop or felt they should but did not plan to do so soon.

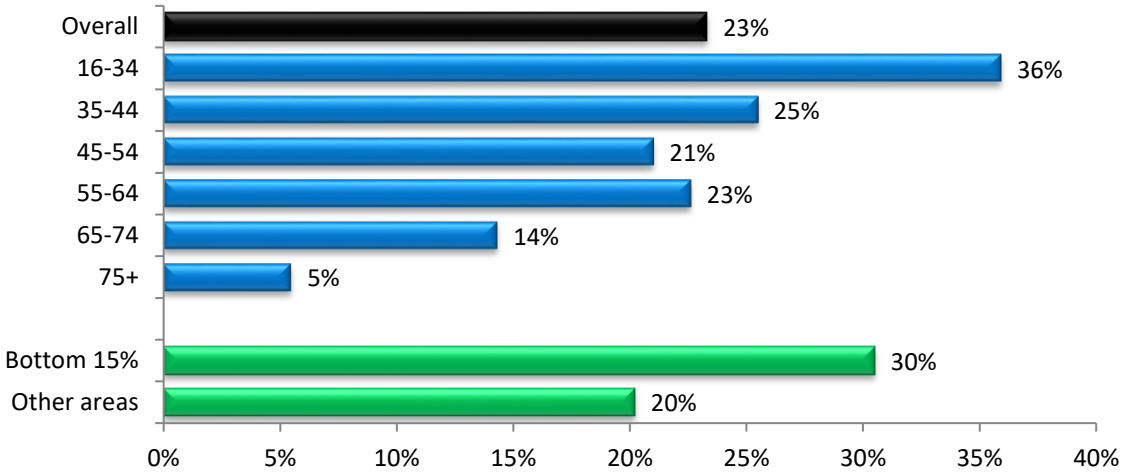
Exposure to Second Hand Smoke

Respondents were asked how often they were in places where there is smoke from other people smoking tobacco. Overall, 23% said that this happened most of the time (8%) or some of the time (15%). A further 23% said that they were seldom exposed to second hand smoke and 53% said they were never exposed.

- Those aged under 35 were the most likely to be exposed to second hand smoke and those aged 75 or over were the least likely.

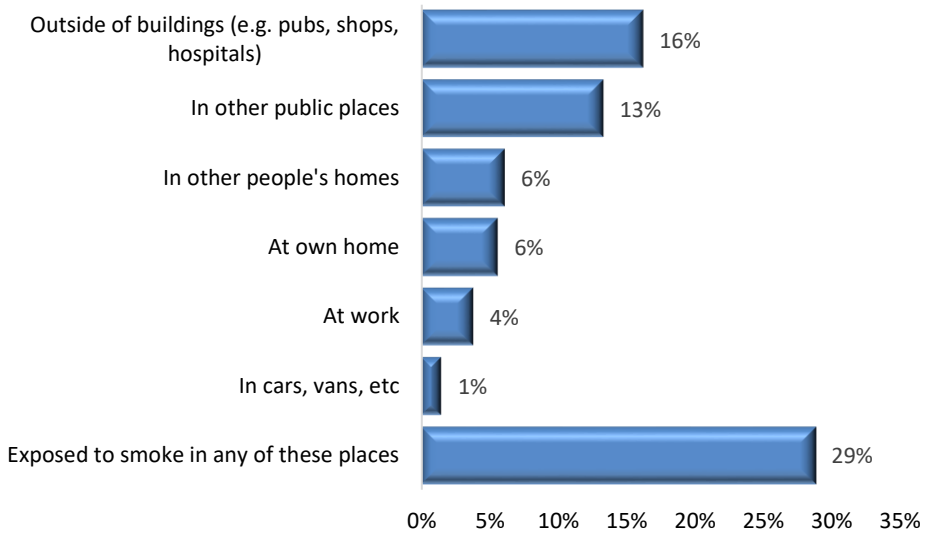
- Those in the most deprived areas were more likely to be exposed to second hand smoke.

Figure 3.3: Exposure to Second Hand Smoke (most/some of the time) by Age and Deprivation



Respondents were also asked whether they were exposed to other people's smoke in any of a number of places. Responses are shown in Figure 3.4 for non-smokers. Overall, 29% of non-smokers were exposed to smoke in at least one of these places, the most common being outside of buildings (16%).

Figure 3.4: Proportion of Non-Smokers Exposed to Second Hand Smoke in Specific Places



Base: Non-smokers (unweighted N=839)

In total, 10% of non-smokers were exposed to cigarette smoke in their own or someone else's home.

Policy Context – Smoking

Legislation and policy in Scotland had sought to decrease smoking and exposure to second hand smoke over the last 15 years as follows.

- In 2006, the Smoking Health and Social Care (Scotland) Act was introduced which banned smoking in enclosed public spaces. https://www.legislation.gov.uk/asp/2005/13/contents
- In 2007, the minimum age for the sale or purchase of tobacco was raised from 16 to 18.
- The Tobacco and Primary Medical Services Act 2010 made provision about the retailing of tobacco products, including provision prohibiting the display of tobacco products and establishing a register of tobacco retailers https://www.legislation.gov.uk/asp/2010/3/contents
- In 2013, the Scottish Government published its strategy on tobacco *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland.* This set a target to reduce smoking rates to 5% or less among the adult population by 2034. https://www.gov.scot/publications/tobacco-control-strategy-creating-tobacco-free-generation/
- The above strategy contained a specific action that 'all NHS Boards will implement and enforce smoke-free grounds by March 2015'. The Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006 allowed for certain exemptions within mental health units, so a phased approach was taken. https://www.legislation.gov.uk/ssi/2006/90/contents/made
- CEL 01(2012) sets out the expectation of all NHS grounds being smoke-free, including mental health units. In 2016 all mental health units in NHS GGC became smokefree.
- The Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill was passed in 2016 which made provisions for the sale and purchase of Nicotine Vapour Products and introduced smoke-free perimeters around NHS hospitals.

http://www.parliament.scot/parliamentarybusiness/Bills/89934.aspx

- At the end of 2016, a ban on smoking in cars carrying anyone aged under 18 was introduced Smoking Prohibition (Children in Motor Vehicles) (Scotland) Act 2016 https://www.legislation.gov.uk/asp/2016/3/contents
- A 5-year action plan was produced in June 2018, *Raising Scotland's Tobacco Free Generation,* the new plan for 2023 onwards is in development. https://www.gov.scot/publications/raising-scotlands-tobacco-free-generation-tobacco-control-action-plan-2018/
- In 2022 Scottish Government launched a consultation on *Tightening rules on advertising and promoting vaping products* to seek views on proposed regulations which aim to strike a balance between protecting non-smokers and making information available to smokers. https://www.gov.scot/publications/tightening-rules-advertising-promoting-vaping-products-consultation-paper-2022/documents/
- The *Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022* made it an offence to smoke within 15 metres of a hospital building. This applies to everyone, including staff, visitors, and patients and applies to all NHS hospital buildings in Scotland. https://www.legislation.gov.uk/sdsi/2022/9780111053843?view=plain
- In 2023 Scottish Government published the Tobacco and vaping framework: roadmap to 2034, which also includes the first implementation plan, which will run until November 2025. https://www.gov.scot/publications/tobacco-vaping-framework-roadmap-2034/documents/

Evidence from Other Sources

- **The 2022 Scottish Health Survey** showed that 15% of adults in Scotland were current smokers, slightly lower than the rate of 17% in West Dunbartonshire as measured by the NHSGGC survey in 2022/23. As in West Dunbartonshire, nationally smoking was more prevalent in the most deprived areas - 25% in the most deprived quintile were smokers.

E-Cigarettes/Vaping

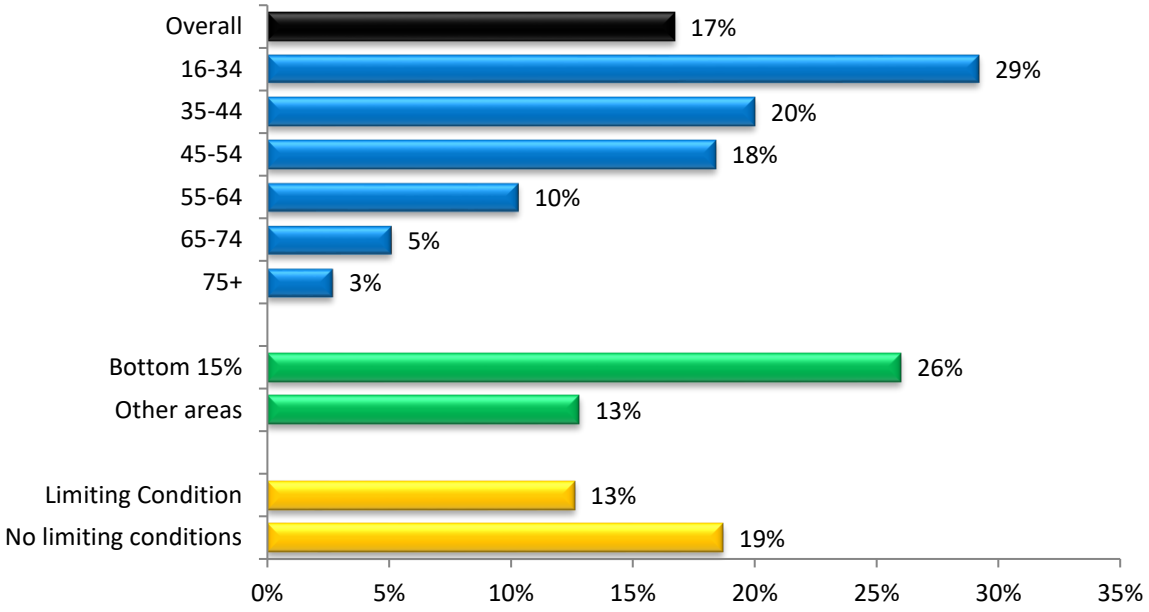
In total, 17% had used e-cigarettes at least some days in the last year. These comprised 6% who had used e-cigarettes every day in the last year, 6% who had done so on some days and 4% who had done so just once or twice in the last year.

- The likelihood of using e-cigarettes decreased with age from 29% of those aged under 35 to 3% of those aged 75 or over.

- Those in the most deprived areas were twice as likely as others to have used e-cigarettes on at least some days in the last year.

- Those with a limiting condition or illness were less likely than others to have used e-cigarettes in the last year.

Figure 3.5: Proportion who had used E-Cigarettes in the Last Year by Age, Deprivation and Limiting Conditions



3.2 Alcohol

AUDIT Scores

The survey used a series of 10 questions which comprise the Alcohol Use Disorders Identification Test (AUDIT). The AUDIT scoring is shown in Appendix E. Together, responses to these questions allow scores to be calculated for each respondent and categorised according to a level of risk. The proportion which fell into each category is shown in Table 3.1.

Table 3.1: Proportion in each Alcohol Use Disorders Identification Test (AUDIT) Category

	%
Low Risk (AUDIT score 0-7)	85.3%
Increasing Risk (AUDIT score 8-15)	14.0%
Higher Risk (AUDIT score 16-19)	0.3%
Possible Dependence (AUDIT score 20+)	0.4%

Those with a score greater than 7 indicates increased risk (15%).

Men were twice as likely as women to have a score indicating risk (20% male; 10% female).

Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to have an AUDIT score indicating risk (15% West Dunbartonshire; 17% NHSGGC).

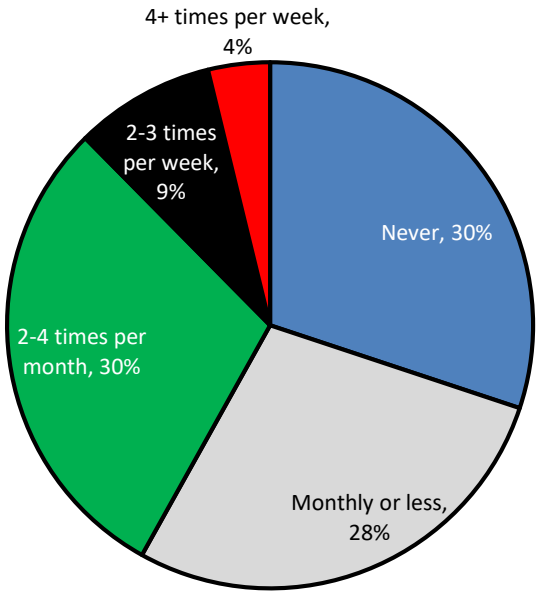
Evidence from Other Sources

- **The 2021 Scottish Health Survey** found that nationally, 14% of adults had AUDIT scores indicating risk (18% for men and 9% for women), similar to the levels measured in West Dunbartonshire in 2022/23.

Frequency of Drinking

Respondents were asked how often they drank alcohol. Three in ten (30%) said they never drank alcohol, but 12% drank alcohol at least twice per week.

Figure 3.6: How Often Drank Alcohol



Those with a limiting condition or illness were less likely than others to drink alcohol (64% compared to 73%)

Evidence from Other Sources

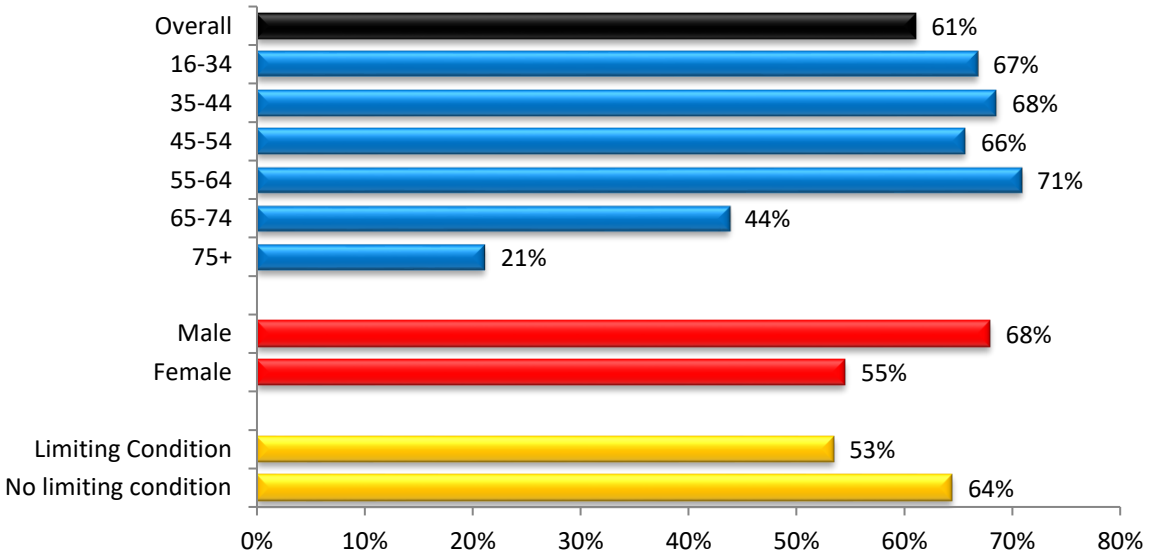
- **The 2022 Scottish Health Survey** found that nationally, 81% of adults drank alcohol (83% of men and 79% of women) - much higher than the 70% in West Dunbartonshire measured by the NHSGGC survey.

Binge Drinking

Those who drank alcohol were asked how often they had 6 or more units if female, or 8 or more if male on a single occasion in the last year. In total, 61% of drinkers had drunk alcohol at this level in the last year – 2% had done so daily/almost daily, 16% weekly, 13% monthly, and 30% less than monthly.

- Drinkers aged under 65 were more likely than older drinkers to binge.
- Male drinkers were more likely than female drinkers to binge.
- Among drinkers, those with a limiting condition or illness were less likely than others to binge.

Figure 3.7: Proportion of Alcohol Drinkers who had Consumed 6+ Units (if female) or 8+ units (if male) on a Single Occasion in the Last Year by Age, Gender and Limiting Conditions



Base: Those who drank alcohol (unweighted N=708).

Policy Context – Alcohol

- The Scottish Government published *Changing Scotland's Relationship with Alcohol: a Framework for Action* in 2009 which set out measures to reduce alcohol consumption, support families and communities, promote positive attitudes and positive choices and improve treatment and support. An updated framework was published in 2018. https://www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/

- Initiatives introduced since the framework was implemented include the delivery of alcohol brief interventions and the establishment of Alcohol and Drug Partnerships. Since ADP's have been formed they have developed strategies, most recently covering 2020 - 2023, with the aims of reducing the harms and health inequalities caused by alcohol and drugs.

- Legislation implemented has included the quantity discount ban and the introduction of a lower drink-drive limit.

- Alcohol Minimum pricing legislation was introduced in 2018 (after the NHSGGC health and wellbeing survey fieldwork concluded) http://www.legislation.gov.uk/asp/2012/4/contents/enacted

- In November 2018, The Scottish Government published *Rights, Respect and Recovery – Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths* https://www.gov.scot/publications/rights-respect-recovery/

Attitudes to Places Selling Alcohol

Three in four (76%) adults felt that there was the right amount of off-licences, local grocers and supermarkets selling alcohol in their local area, while 18% felt there were too many and 5% felt there were too few.

When considering the amount of pubs, bars and restaurants selling alcohol in their local area, 74% felt there was the right amount, 17% felt there was too many and 9% felt there was too few. The proportion saying there were too many was higher for those with a limiting condition or illness (24% limiting condition; 14% others).

3.3 Diet

Fruit and Vegetables

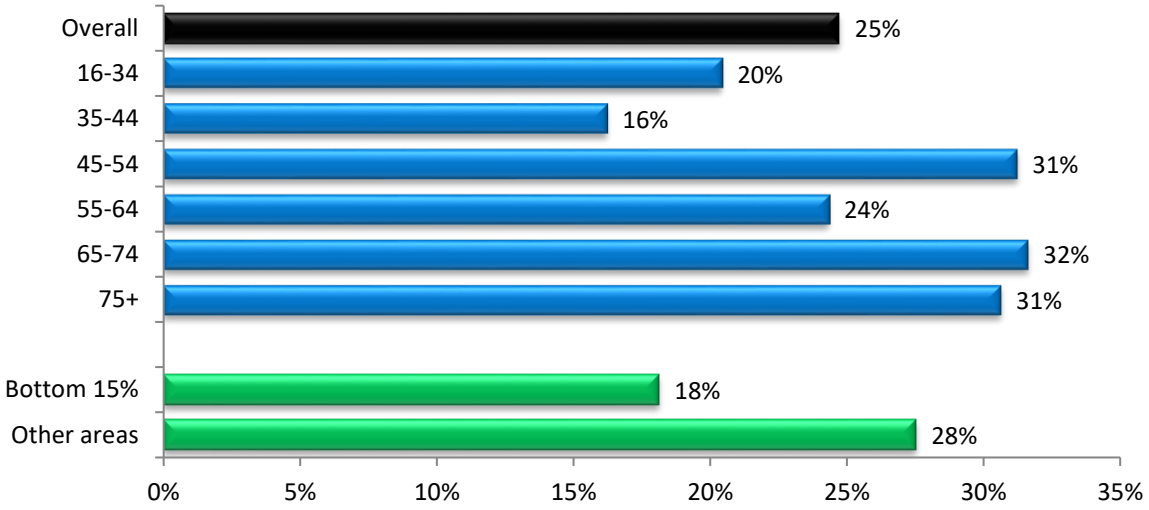
The national target for fruit and vegetable consumption is to have at least five portions of fruit and/or vegetables per day. Respondents were asked how many portions of fruit and how many portions of vegetables they had consumed on the previous day.

- One in four (25%) met the target of five portions.
- One in 11 (9%) had consumed no fruit or vegetables in the previous day.

There was no clear pattern by age group, but those aged 35-44 had the lowest proportion who met the target for fruit/vegetable consumption.

Those in the most deprived areas were less likely than others to consume five or more portions of fruit/vegetables per day.

Figure 3.8: Proportion who Met the Target of 5+ Portions of Fruit/Vegetables Per Day by Age and Deprivation



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to meet the target of consuming five or more portions of fruit/vegetables per day (25% West Dunbartonshire; 34% NHSGGC).

Evidence from Other Sources

- **The 2021 Scottish Health Survey**, which used a more detailed exploration of food intake and mean number of portions per day, found that 22% of adults meet the target for fruit/vegetable consumption - a rate which has remained fairly consistent since 2003. This may indicate that the rate measured by the NHSGGC survey based on self-reported numbers of 'portions' based on 'yesterday' may represent some over-estimating.

Policy Context: Diet

- In 2010 the Scottish Government published *Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight.* This was complemented by *The Obesity Route Map Action Plan*, which set out actions to address the increasing prevalence of obesity in Scotland.
  https://www.gov.scot/Publications/2010/02/17140721/0

- In January 2015, the Scottish Government launched *Eat Better Feel Better* to encourage and support people to make healthier choices to the way they shop, cook and eat. This is now known as Parent Club.
  Food & Eating | Parent Club

- Following a consultation from October 2017 to January 2018, the Scottish Government published its diet and healthy weight delivery plan in July 2018, 'A Healthier Future'. This recognises that eating habits are the second major cause (after smoking) of poor health in Scotland, and sets out approaches to address children's diet, ensure food environment supports healthier choices, provide access to weight management services, promote healthy diet and weight, and reduce diet-related health inequalities.
  https://beta.gov.scot/publications/healthier-future-scotlands-diet-healthy-weight-delivery-plan/pages/3/

- As part of *A Healthier Future*, the Scottish Government set out a framework for Type 2 Diabetes prevention, early detection and intervention in July 2018.
  https://www.gov.scot/publications/healthier-future-framework-prevention-early-detection-early-intervention-type-2/

- Turning the tide through prevention: Public Health Strategy (2018-2028) concentrates on improving public health in NHS Greater Glasgow and Clyde and sets out many programmes for action including, *applying a life- course approach, recognising the*

importance of early years and healthy ageing in relation to diet and physical activity.
Public Health Strategy 2018 - 2028 A4 - Landscape - 10-08-18-01.pdf (scot.nhs.uk)

- Food Standards Scotland have developed an online tool "Eat well your way" to help people in Scotland make healthier food and drink choices when planning and shopping, preparing food and eating out. https://www.foodstandards.gov.scot/consumers/healthy-eating/eat-well-your-way

3.4 Physical Activity

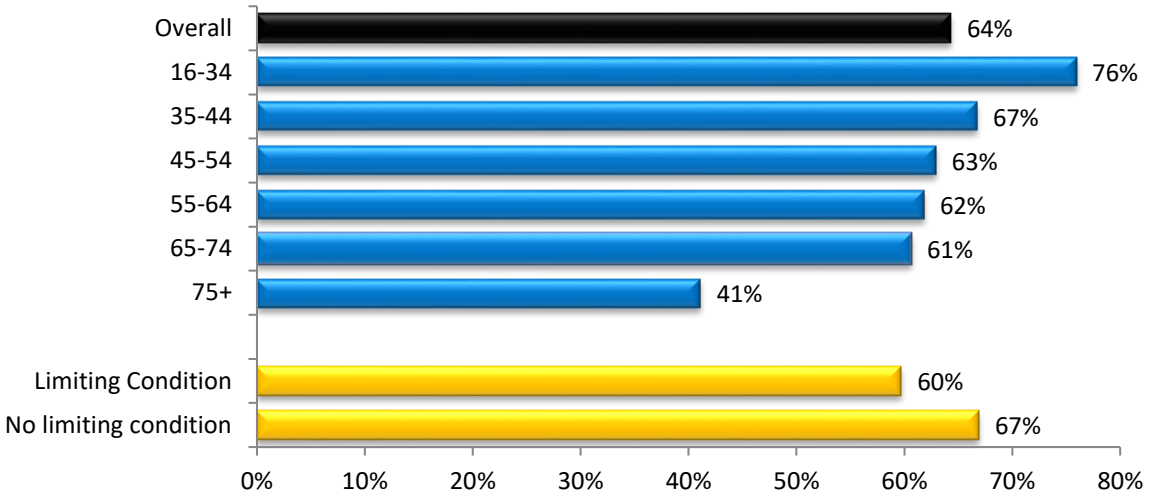
Respondents were asked on how many days in the last week had they taken a total of 30 minutes or more of physical activity which was enough to increase their heart rate, make them feel warmer and made them breathe a little faster. The 2022/23 survey for the first time included the instruction to count vigorous activity such as running as double. Overall, 17% said that they had not taken physical activity for 30 minutes on any day in the last week, but 44% has done this on five or more days in the last week. The mean number of days was 3.8.

Subsequently, respondents who had been active for 30 minutes or more on fewer than five days were asked whether they had done this type of activity for at least a total of two and a half hours (150 minutes) over the course of the last week, again with vigorous activity counting double. Combining the responses to both questions, 64% met the target of at least 150 minutes of exercise per week.

- Those aged under 35 were the most likely to meet the target for physical activity and those aged 75 or over were the least likely.

- Those with a limiting condition or illness were less likely to meet the physical activity target.

Figure 3.9: Proportion who met the Target of 150 Minutes of Exercise Per Week by Age and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to meet the target for physical activity (64% West Dunbartonshire; 70% NHSGGC).

Evidence from Other Sources

- **The 2021 Scottish Health Survey** found that nationally, 69% met the target for physical activity (higher than the rate measured by the NHSGGC survey for West Dunbartonshire in 2022/23). The Scottish Health Survey has seen a continual increase in the proportion meeting the physical activity target since 2012 when it was 62%.

Policy Context – Physical Activity

- In 2014, the Scottish Government published *A More Active Scotland – building a legacy from the Commonwealth Games* which set out a 10-year physical activity implementation plan which aimed to get the population more physically active through initiatives to increase uptake of sport, physical activity and active travel. The plan included efforts in education, work place settings, health and social care, and facilities and infrastructure. https://beta.gov.scot/publications/more-active-scotland-building-legacy-commonwealth-games/

- As part of this overall plan, a National Walking Strategy was launched. https://beta.gov.scot/publications/lets-scotland-walking-national-walking-strategy/

- Also in 2014, a revised Cycling Action Plan for Scotland was launched, and this was subsequently revised in the 2017-2020 plan published in January 2017. https://www.transport.gov.scot/publication/cycling-action-plan-for-scotland-2017-2020/

- Updated National Physical Activity Guidelines (2019) - Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK (www.gov.uk)

- Active Scotland Delivery Plan (2018) - Active Scotland Delivery Plan - gov.scot (www.gov.scot)

- WHO More Active People for a Healthier World (2018) - Global action plan on physical activity 2018–2030: more active people for a healthier world (who.int)

- Scotland Public Health Priorities: Priority 6 (2018) - Scotland's public health priorities - gov.scot (www.gov.scot)

- Public Health Scotland: Physical Activity Referral Standards - Physical activity referral standards - Publications - Public Health Scotland

Strength and Balance Activities

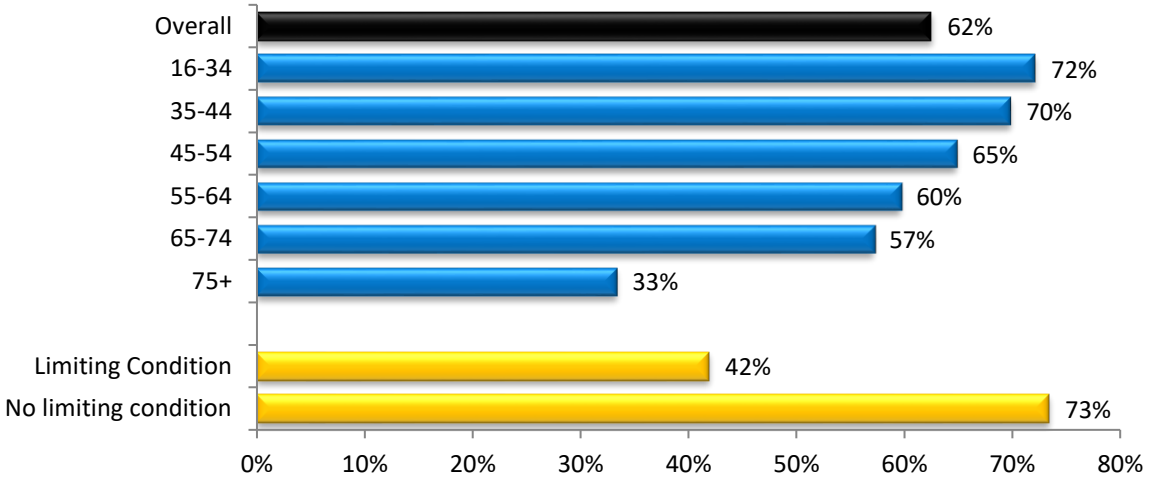
Respondents were asked how many days they had done strength and balance physical activities that made their muscles become warm, shake and/or burn. Examples are weight training, exercise, sport, heavy housework, DIY or gardening.

Overall, 62% had done any of these types of activity in the previous week, including 14% who had done so on five or more days in the previous week.

- Those aged under 45 were the most likely to participate in strength/balance activities and those aged 75 or over were the least likely.

- Those with a limiting condition or illness were less likely than others to participate in strength and balance activities.

Figure 3.10: Proportion who Participated in Strength and Balance Activities in the Previous Week by Age and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were more likely to participate in strength/balance activities (62% West Dunbartonshire; 55% NHSGGC).

Effects of the COVID Pandemic on Physical Activity Levels

Respondents were asked about their physical activity levels since the COVID pandemic started in March 2020. One in four (25%) said they were physically active more often, one in three (33%) said they were active less often and 42% said there was no change to their physical activity levels.

- Those aged under 45 were the most likely to say they were physically more active and those aged 75 or over were the least likely to say this.

- Those with a limiting condition were much more likely than others to say they had become physically less active.

Table 3.2: Physical Activity Levels Since the COVID Pandemic Began by Age and Limiting Conditions

	Physically active more often	Physically active less often	No change to physical activity
16-34	35%	25%	39%
35-44	33%	27%	40%
45-54	18%	36%	46%
55-64	23%	36%	41%
65-74	17%	39%	43%
75+	7%	45%	48%
Limiting Condition	14%	50%	36%
No limiting condition	30%	25%	45%
Overall	25%	33%	42%

3.5 Summary of Key Messages from This Chapter

Indicators where West Dunbartonshire Compared Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to have an AUDIT score indicating alcohol-related risk
- more likely to participate in strength/balance activities.

Indicators where West Dunbartonshire Compared Less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to meet the target of consuming five or more portions of fruit/vegetables per day
- less likely to meet the target of 150 minutes of physical activity per week.

Differences by Age and Gender

- Those aged under 35 were the most likely to be exposed to second hand smoke and to use e-cigarettes.

- Women were more likely than men to use e-cigarettes.

- Men were more likely than women to have an AUDIT score indicating alcohol-related risk, and among those who drank alcohol, men were more likely than women to binge drink. Drinkers aged 65 or over were the least likely to binge.

- Men were more likely than women to have an AUDIT score indicating alcohol-related risk, and among those who drank, more likely than women to binge.

- Those in the oldest age groups were the least likely meet the target for physical activity and the least likely to participate in strength/balance activities.

Differences by Deprivation

Those in the most deprived areas were:

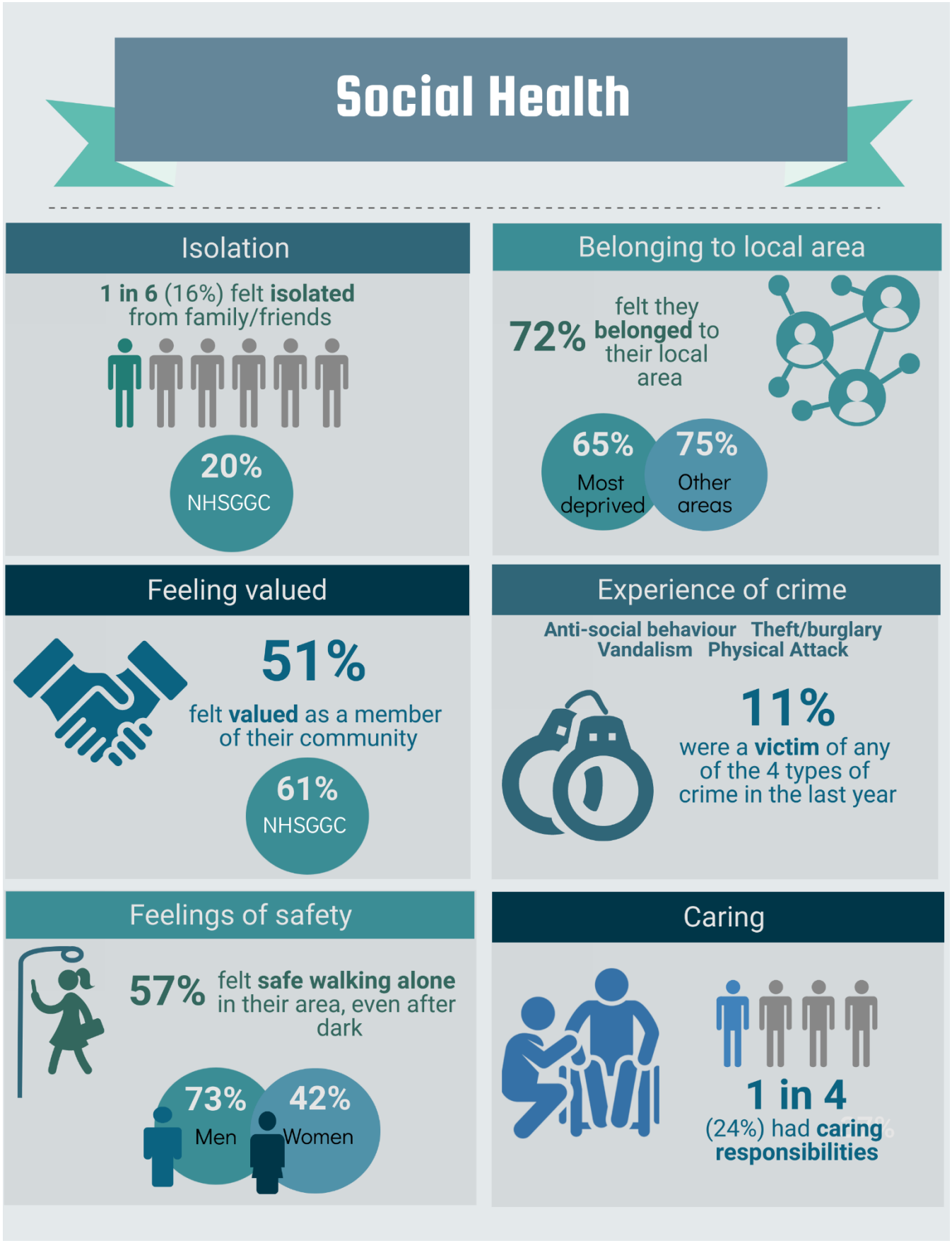
- more likely to smoke and more likely to be exposed to second hand smoke
- more likely to use e-cigarettes
- less likely to meet the target of consuming 5+ portions of fruit/vegetables per day.

Limiting Conditions

Those with a long-term limiting condition or illness were:

- more likely to smoke but less likely to use e-cigarettes
- (among those who drank) less likely to binge
- less likely to meet the target for physical activity and less likely to participate in strength/balance activities.

4 Social Health



4.1 Social Connectedness

Isolation from Family and Friends

One in six (16%) said they felt isolated from family and friends.

Those with a long-term limiting condition or illness were much more likely than others to feel isolated from family and friends (25% compared to 11%).

Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to feel isolated (16% West Dunbartonshire; 20% NHSGGC).

When asked whether feeling of isolation from family and friends had changed due to the COVID pandemic, 6% said it had changed for the better, 20% said it had changed for the worse and 74% said there had been no change.

Those with a long-term limiting condition or illness were more likely than others to say that their isolation from family/friends had changed for the worse due to the COVID pandemic (29% compared to 14%).

Feeling Lonely

Respondents were asked how often they had felt lonely in the past two weeks. Two percent said that had felt lonely all the time, 7% said often, 16% some of the time, 24% rarely and 51% never.

Thus, overall one in four (25%) said that they felt lonely at least some of the time in the previous two weeks.

Those with a long-term limiting condition or illness were more likely than others to say they had felt lonely at least some of the time in the previous two weeks (34% compared to 21%).

Respondents were asked how lonely they had felt compared to before the COVID pandemic which started in March 2020. One in nine (11%) said they felt more lonely and 6% felt less lonely. The remainder either said it was the same as before (49%) or that they never felt lonely (34%).

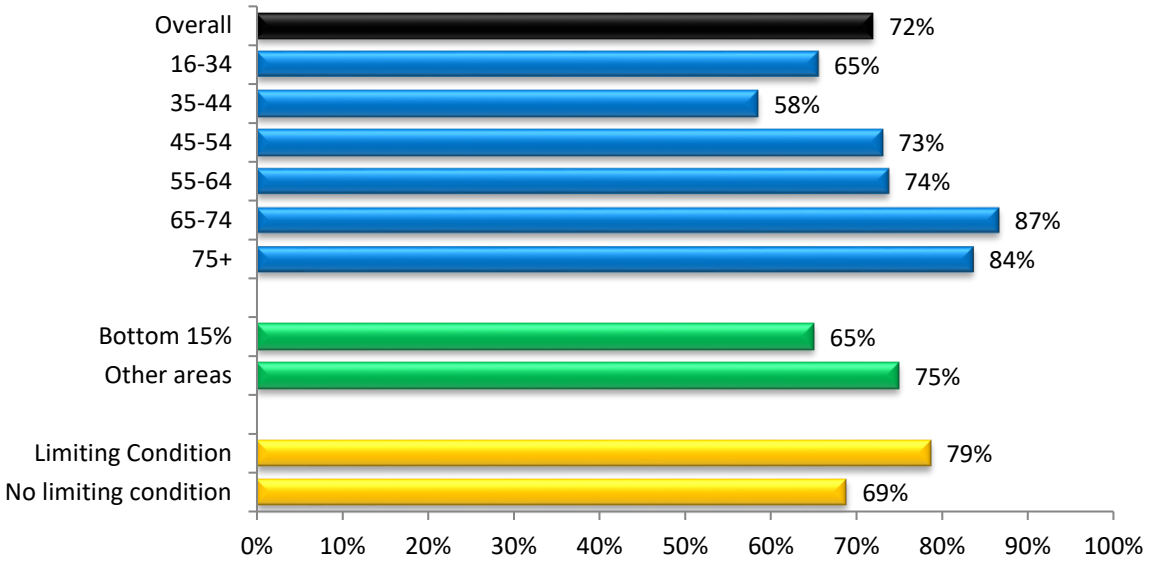
- **The 2022 Scottish Household Survey** found that nationally 23% had experienced feelings of loneliness in the previous week - similar to the 25% in West Dunbartonshire in the NHSGGC survey who who said they had felt lonely at least some of the time in the previous two weeks. Nationally, 29% of those aged 75 or over and 29% of those in the most deprived quintile had felt lonely in the last week.

Sense of Belonging to the Community

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement "I feel I belong to this local area". In total, 72% agreed with this (23% strongly agreed and 49% agreed), while 17% neither agreed nor disagreed and 11% disagreed (9% disagreed and 2% strongly disagreed).

- Those aged under 45 were the least likely to feel they belonged to their local area and those aged 65 or over were the most likely.
- Those in the most deprived areas were less likely than others to feel they belonged to their local area.
- Those with a long-term limiting condition or illness were more likely than others to feel they belonged to their local area.

Figure 4.1: Proportion who Agreed they Felt that they Belonged to their Local Area by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

The proportion in West Dunbartonshire who felt they belonged to their local area (72%) was lower than in the NHSGGC area as a whole (78%).

Evidence from Other Sources

- **The 2022 Scottish Household Survey** asked how strongly people felt they belonged to their community. Across Scotland, 83% said 'very strongly or 'fairly strongly' - higher than the 72% who agreed they belonged to the local community in West Dunbartonshire in the NHSGGC survey. As in West Dunbartonshire, nationally strength of feeling of belonging to the community was lower in the most deprived areas.

Feeling Valued as a Member of the Community

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement "I feel valued as a member of my community". Half (51%) agreed with this (9% strongly agreed and 43% agreed), while 31% neither agreed nor disagreed with this, and 18% disagreed (15% disagreed and 3% strongly disagreed).

Women were more likely than men to feel valued as a member of the community (57% female; 46% male).

Comparison with NHSGGC

The proportion in West Dunbartonshire who felt valued as a member of the community (51%) was lower than in the NHSGGC area as a whole (61%).

Influence in the Neighbourhood

Respondents were asked the extent to which they agreed or disagreed with the statement, "By working together people in my neighbourhood can influence decisions that affect my neighbourhood". Overall, 69% agreed with this (15% strongly agreed and 54% agreed), 23% neither agreed nor disagreed and 8% disagreed (5% disagreed and 2% strongly disagreed).

4.2 Experience of Crime

Respondents were asked whether they had been a victim of specific types of crime in the last year. Overall, 11% had been the victim of any of the four types of crime listed. The most common was anti-social behaviour.

Table 4.1: Proportion who had Been the Victim of Crime in the Last Year

	% Victim in last year
Anti-social behaviour	8.2%
Vandalism	3.0%
Any type of theft or burglary	1.6%
Physical attack	1.4%
Any of the above 4 types of crime	**10.6%**

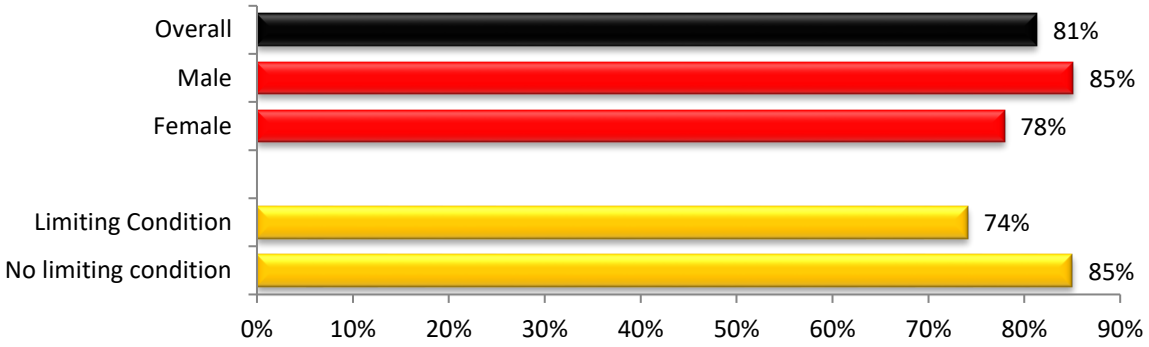
4.3 Feelings of Safety

Respondents were asked the extent to which they agreed or disagreed with the statement "I feel safe using public transport in this local area". In total, 81% agreed with this (17% strongly agreed and 65% agreed), 13% neither agreed nor disagreed and 5% disagreed (5% disagreed and 1% strongly disagreed).

- Men were more likely than women to feel safe using local public transport.

- Those with a limiting condition or illness were less likely than others to feel safe using public transport.

Figure 4.2: Proportion who Felt Safe Using Local Public Transport by Gender and Limiting Conditions



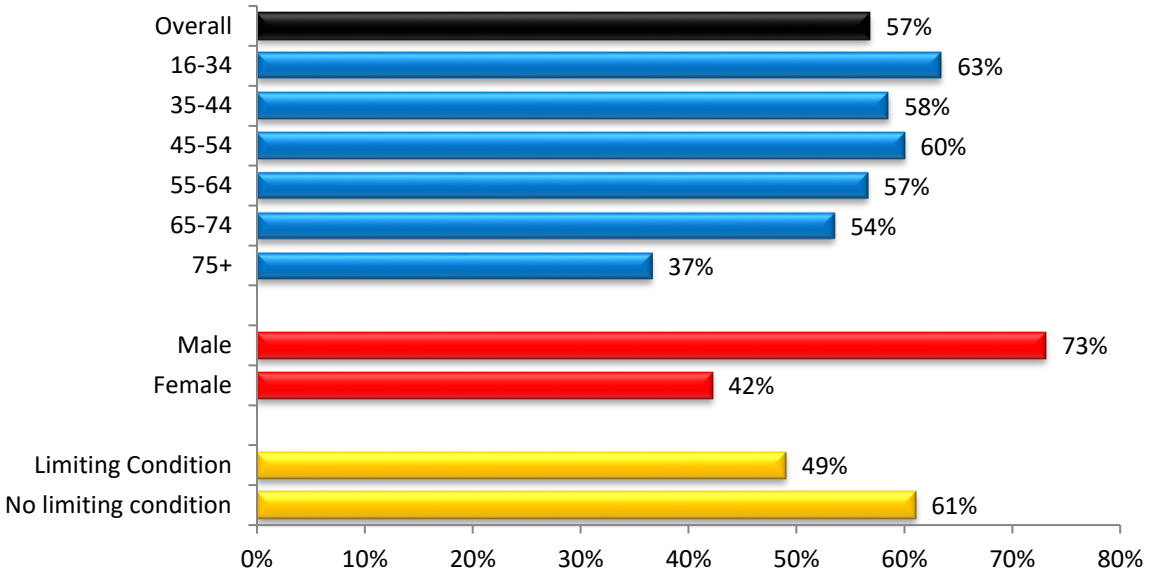
Respondents were also asked the extent to which they agreed or disagreed with the statement "I feel safe walking alone around this local area even after dark". In total, 57% agreed with this (6% strongly agreed and 51% agreed), 17% neither agreed nor disagreed and 26% disagreed (19% disagreed and 7% strongly disagreed).

- Those aged 75 or over were the least likely to feel safe walking alone.

- Women were much less likely than men to feel safe walking alone.

- Those with a limiting condition or illness were less likely to feel safe walking alone.

Figure 4.3: Proportion who Felt Safe Walking Alone in their Local Area Even After Dark by Age, Gender and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to feel safe:

- using local public transport (81% West Dunbartonshire; 88% NHSGGC)
- walking alone in their local area even after dark (57% West Dunbartonshire; 69% NHSGGC).

Evidence from Other Sources

- **The 2022 Scottish Household Survey** found that nationally 81% of people felt very or fairly safe walking alone in their neighbourhood after dark (92% for men; 72% for women), much higher than the 57% in West Dunbartonshire in the NHSGGC survey.

4.4 Perceived Quality of Services in the Area

Respondents were given a list of ten local services and asked to rate each one (excellent, good, adequate, poor or very poor).

Seven of the ten services showed variations in ratings by age. These are shown in Table 4.2. The other services were:

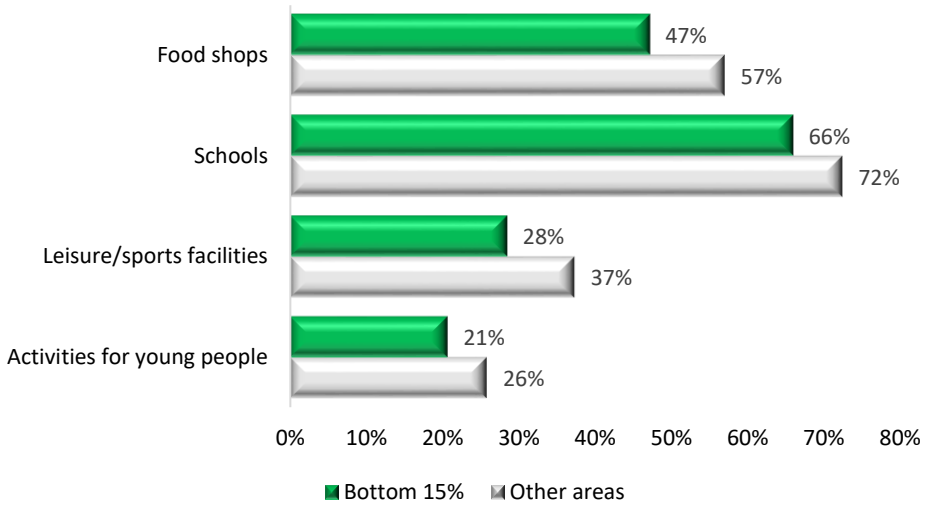
- Schools (for which 71% gave a positive rating)
- Public transport (for which 57% gave a positive rating)
- Childcare provision (for which 32% gave a positive rating).

Table 4.2: Proportion with Positive Perception of Quality of Local Services by Age

	Food shops	Nurse-led clinics	GP/doctor	Police	Out of hours medical service	Leisure/sports facilities	Activities for young people
16-34	65%	51%	55%	57%	42%	44%	32%
35-44	50%	43%	41%	37%	32%	30%	22%
45-54	45%	47%	36%	34%	33%	27%	17%
55-64	50%	50%	35%	23%	34%	27%	17%
65-74	53%	61%	34%	33%	39%	38%	27%
75+	54%	68%	49%	37%	53%	41%	30%
Overall	**54%**	**53%**	**43%**	**39%**	**38%**	**35%**	**24%**

As Figure 4.4 shows, those in the most deprived areas were less likely than others to have positive perceptions of four types of local service.

Figure 4.4: Proportion with a Positive Perception of Local Services by Deprivation



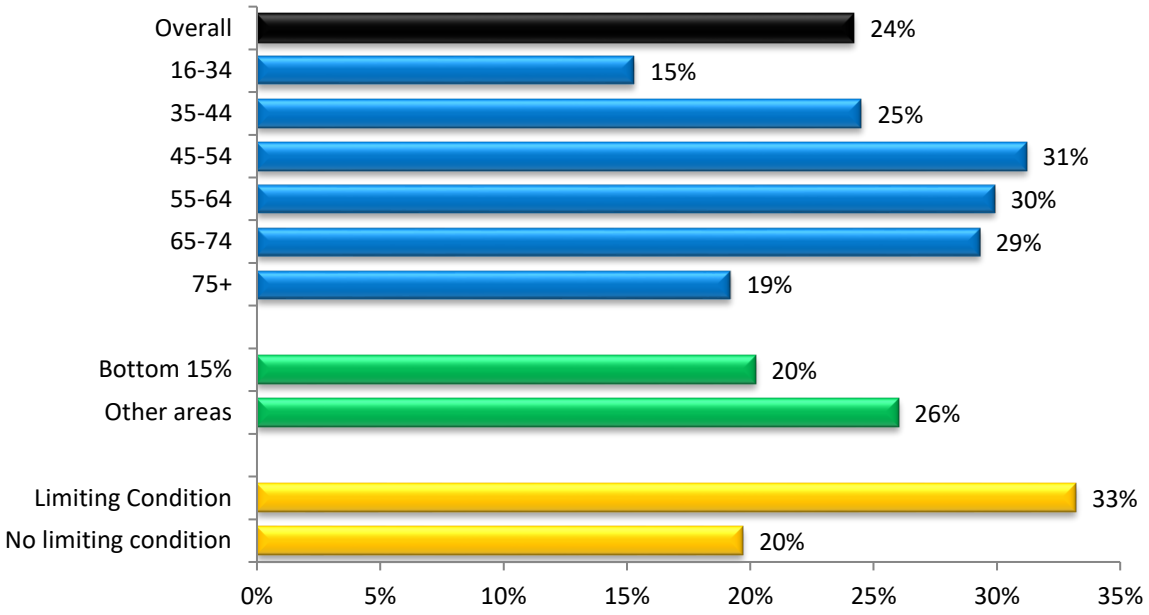
Those with a limiting condition were less likely than others to have positive perceptions of local police (30% compared to 44%) and nurse-led clinics (48% compared to 61%).

4.5 Caring Responsibilities

One in four (24%) said that they looked after, or gave regular help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability, or problems relating to old age.

- Those aged 45-74 were the most likely to have caring responsibilities.
- Those in the most deprived areas were less likely than others to be carers.
- Those with a long-term limiting condition or illness were more likely than others to be carers.

Figure 4.5: Proportion with Caring Responsibilities by Age, Deprivation and Limiting Conditions



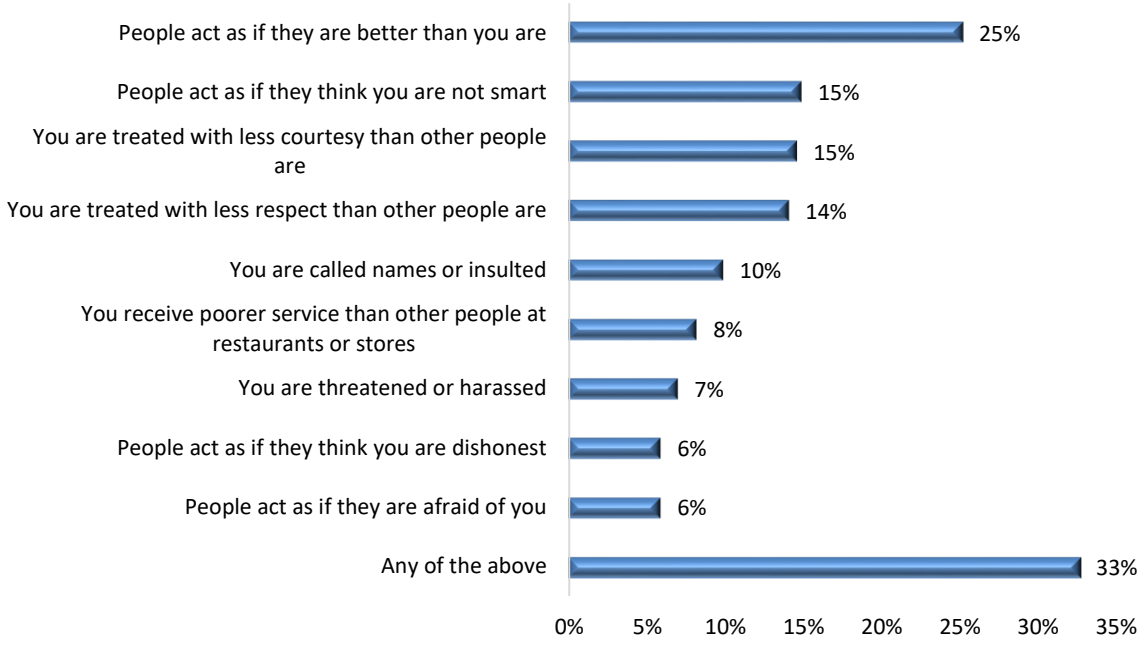
Comparison with NHSGGC

The proportion in West Dunbartonshire who were carers (24%) was higher than in the NHSGGC area as a whole (21%).

4.6 Discrimination

The main questionnaire (self-completion section) included The Everyday Discrimination Scale[6]. The proportion who reported each type of discrimination happening at least a few times a year is shown in Figure 4.6. Overall, one in three (33%) had experienced at least one type of discrimination at least a few times in the last year.

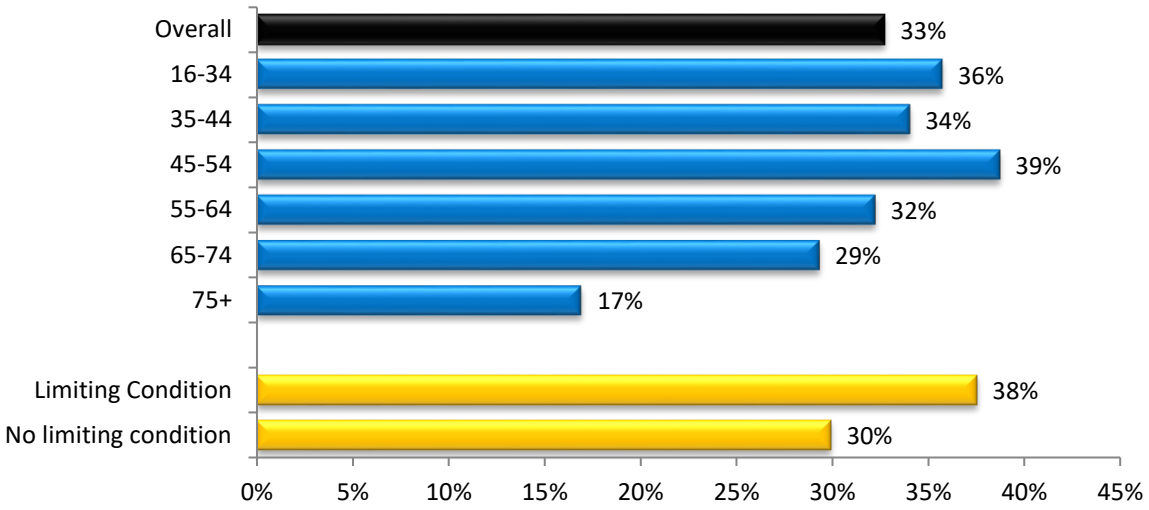
Figure 4.6: Proportion who Experienced Each Type of Discrimination at Least a Few Times Per Year



- Those aged 75 or over were the least likely to experience discrimination.
- Those with a limiting condition or illness were more likely than others to experience discrimination.

6 https://scholar.harvard.edu/files/davidrwilliams/files/discrimination_resource_dec._2020.pdf

Figure 4.7: Proportion who Experienced Discrimination by Age and Limiting Conditions



Comparison with NHSGGC

Compared to the NHSGGC area as a whole, those in West Dunbartonshire were less likely to report experiences of discrimination (33% West Dunbartonshire; 39% NHSGGC).

Those who experienced discrimination were asked what they thought were the main reasons for these experiences (with the option of selecting multiple reasons). The most common reasons given were:

- Age (40%)
- Gender (31%)
- Education or income level (24%)
- Weight (21%)
- Other aspects of physical appearance (18%)
- Height (16%)
- Physical disability (10%).

4.7 Summary of Key Messages from This Chapter

Indicators where West Dunbartonshire Compared Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to feel isolated from family and friends
- less likely to experience discrimination.

Indicators where West Dunbartonshire Compared Less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to feel they belonged to their local area
- less likely to feel valued as a member of their community
- less likely to feel safe using local public transport or walking alone in their area.

Other differences between West Dunbartonshire and NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- more likely to have caring responsibilities.

Differences by Age and Gender

- Those aged 65 or over were the most likely to feel they belonged to their local area.
- Women were more likely than men to feel valued as a member of the community.
- Men were more likely than women to feel safe using local public transport or walking alone in their local area. Those aged 75 or over were the least likely to feel safe using local public transport.
- Those aged 45-74 were the most likely to have caring responsibilities.
- Those aged 75 or over were the least likely to report experiences of discrimination.

Differences by Deprivation

Those in the most deprived areas were:

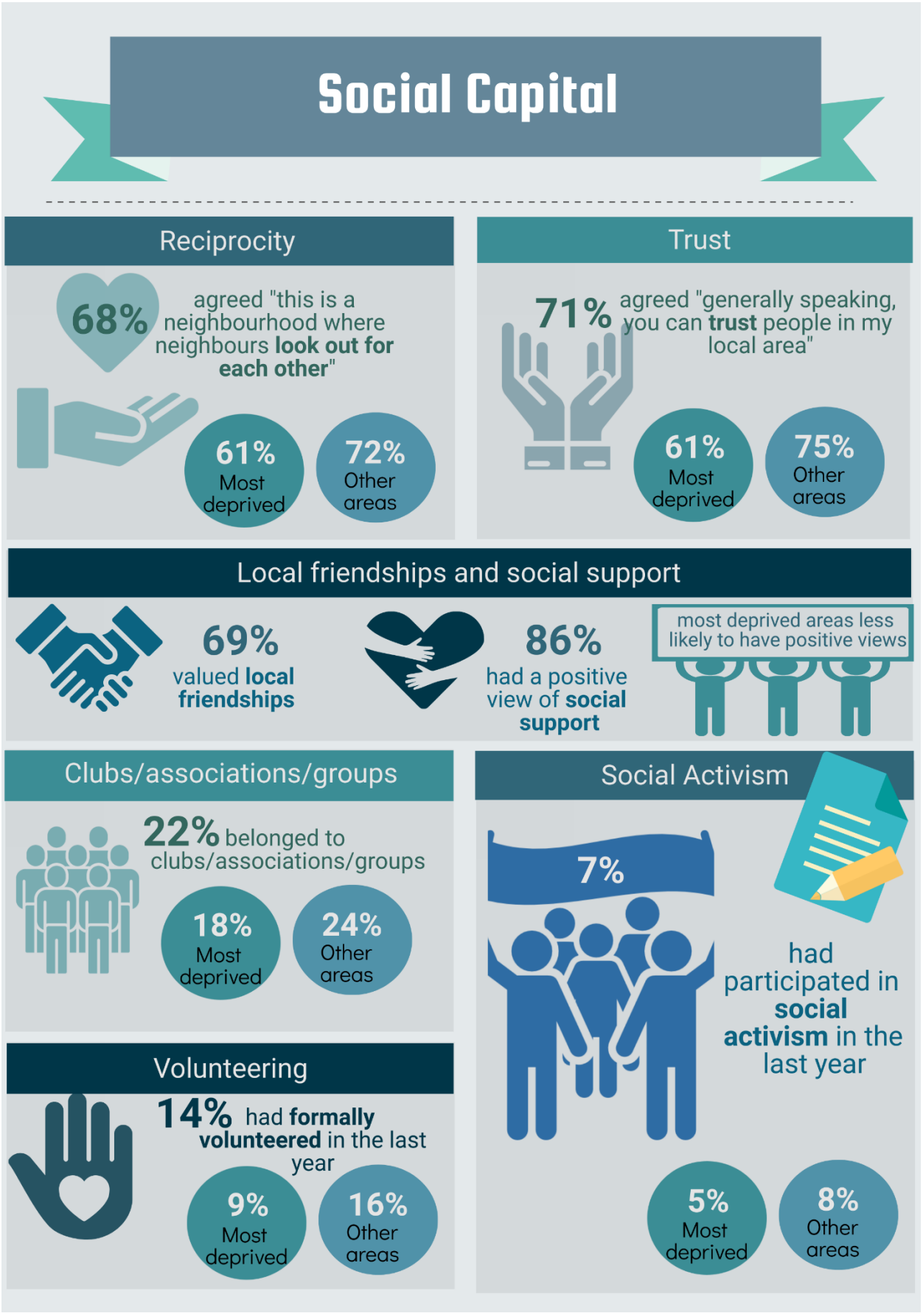
- less likely to feel they belonged to their local area
- less likely to be carers.

Differences by Limiting Conditions

Those with a long-term limiting condition or illness were:

- more likely to feel isolated or lonely
- more likely to be the victim of crime
- more likely to feel they belonged to their local area
- less likely to feel safe using local public transport or walking alone in their local area
- more likely to be carers
- more likely to experience discrimination.

5 Social Capital



5.1 Reciprocity and Trust

Respondents were asked to indicate the extent to which they agree with the following statements:

"This is a neighbourhood where neighbours look out for each other", and "Generally speaking, you can trust people in my local area".

Those agreeing with the first statement were categorised as having a positive view of reciprocity, and those agreeing with the second were categorised as having a positive view of trust. Overall, 68% were positive about reciprocity and 71% were positive about trust.

There was a high degree of crossover on these two questions; 86% of those who were positive about trust were also positive about reciprocity.

- Those aged 65 or over were the most likely to have a positive perception of reciprocity or trust.

- Those in the most deprived areas were less likely than others to have a positive perception of reciprocity or trust.

Figure 5.1: Proportion with a Positive Perception of Reciprocity by Age and Deprivation

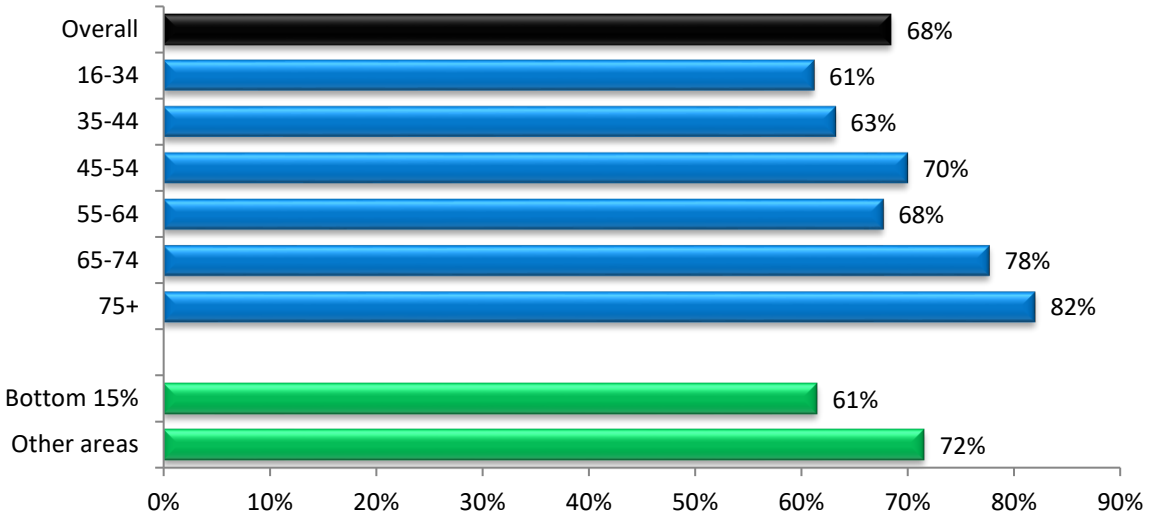
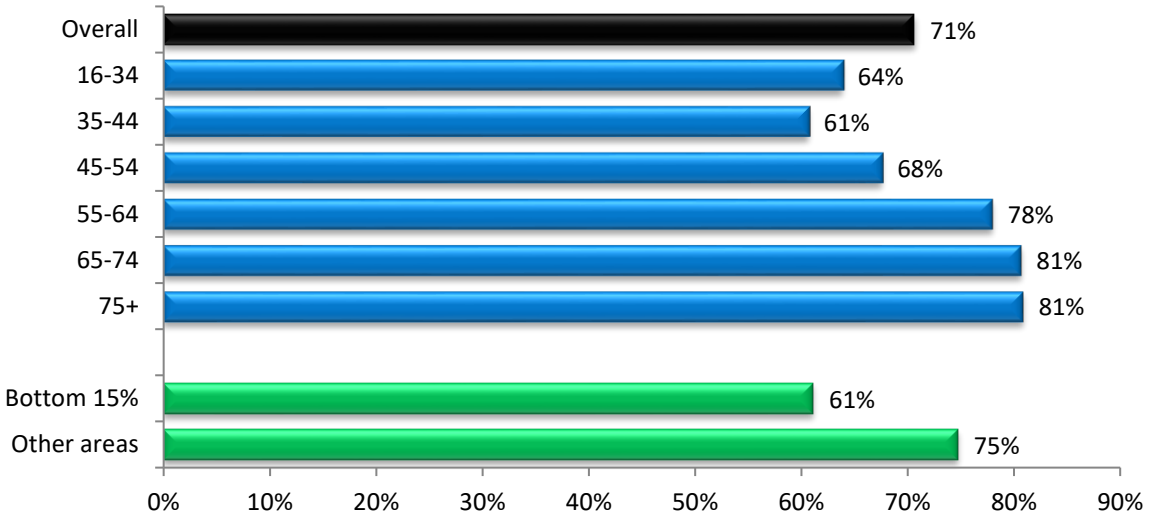


Figure 5.2: Proportion with a Positive Perception of Trust by Age and Deprivation



Comparison with NHSGGC

Compared to the NHSGGC area as a whole, those in West Dunbartonshire were less likely to have a positive perception of:

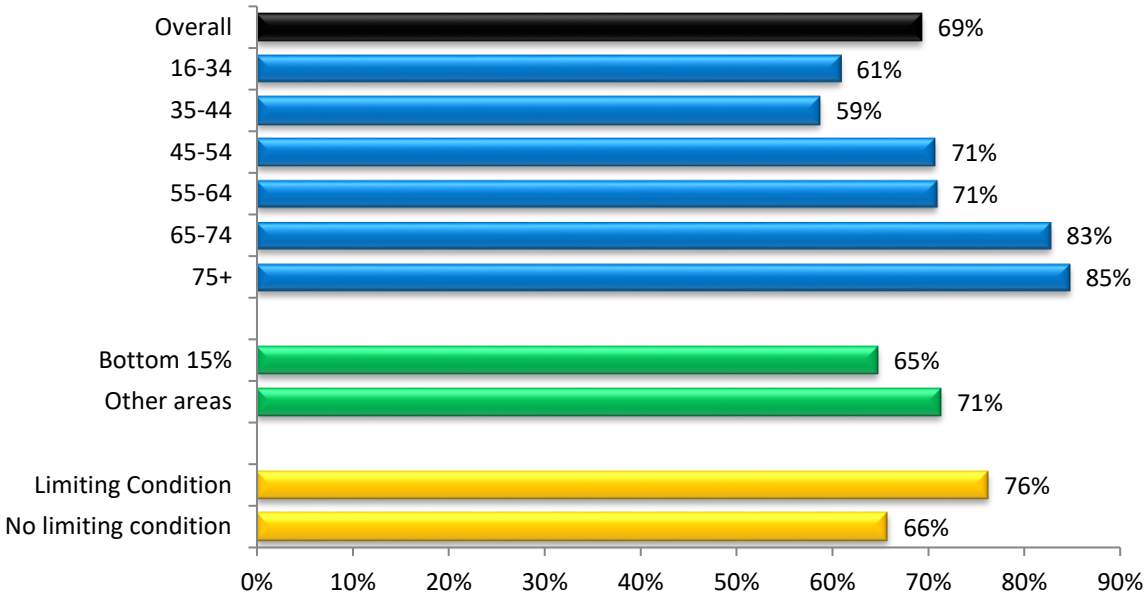
- reciprocity (68% West Dunbartonshire; 74% NHSGGC)
- trust (71% West Dunbartonshire; 76% NHSGGC).

5.2 Local Friendships

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement: *"The friendships and associations I have with other people in my local area mean a lot to me"*. Overall, 69% agreed with this, while 22% neither agreed nor disagreed and 8% disagreed.

- Those aged 65 or over were the most likely to value local friendships.
- Those in the most deprived areas were less likely to value local friendships.
- Those with a limiting condition or illness were more likely to value local friendships.

Figure 5.3: Proportion Value Local Friendships by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

Compared to the NHSGGC area as a whole, those in West Dunbartonshire were less likely to value local friendships (69% West Dunbartonshire; 73% NHSGGC).

5.3 Social Support

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement: *"If I have a problem, there is always someone to help me".* Those agreeing with this statement were categorised as having a positive view of social support. Responses showed that overall 86% had a positive view of social support.

Those in the most deprived areas were less likely than others to have a positive view of social support (82% compared to 88%).

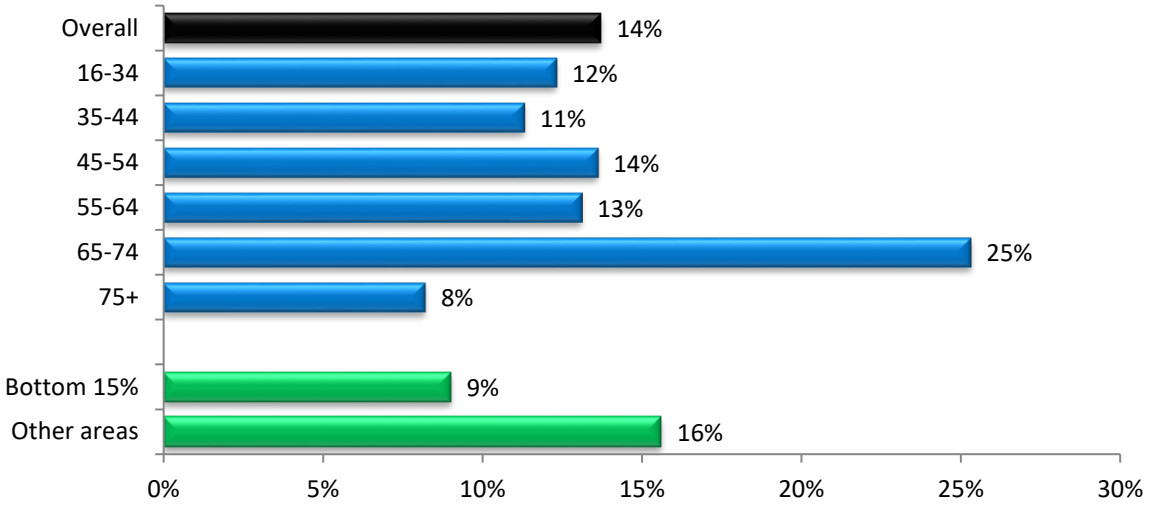
5.4 Volunteering

One in seven (14%) said they had given up any time to help any clubs, charities, campaigns or organisations in an unpaid capacity in the last year.

- The age group most likely to have formally volunteered was 65-74 year olds.

- Those in the most deprived areas were less likely than others to volunteer formally.

Figure 5.4: Proportion who Volunteered to help Clubs/Charities/Campaigns/Organisations in Last 12 Months by Age and Deprivation

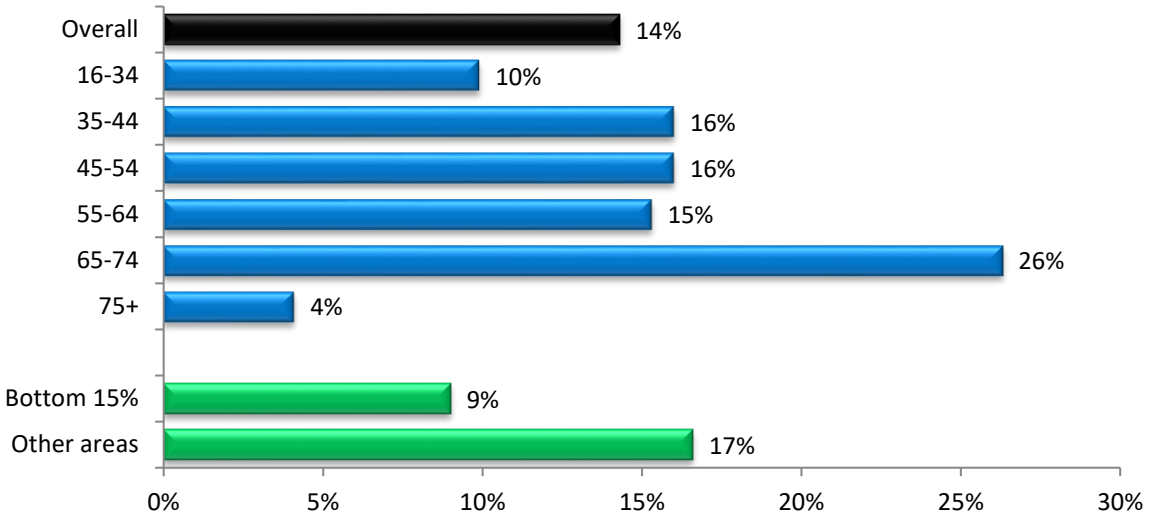


Respondents were also asked whether in the last 12 months they had given any voluntary unpaid help as an individual (not through a group or organisation) to help other people outside their family or to support their local environment (e.g. keeping in touch with someone at risk of being lonely, helping neighbours with shopping or chores, litter picking not part of an organised activity). One in seven (14%) had volunteered in this way.

- Again, those aged 65-74 were the most likely to informally volunteer.

- Those in the most deprived areas were less likely than those in other areas to volunteer in this way.

Figure 5.5: Proportion who Volunteered as an Individual in Last 12 Months by Age and Deprivation



Combining responses to both questions, overall 19% of people had volunteered in the last year. Overall rates of volunteering were 22% for those in the most deprived areas compared to 13% of those in other areas.

Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to volunteer:

- formally (14% West Dunbartonshire; 19% NHSGGC)
- informally (14% West Dunbartonshire; 20% NHSGGC)
- overall (19% West Dunbartonshire; 26% NHSGGC).

Evidence from Other Sources

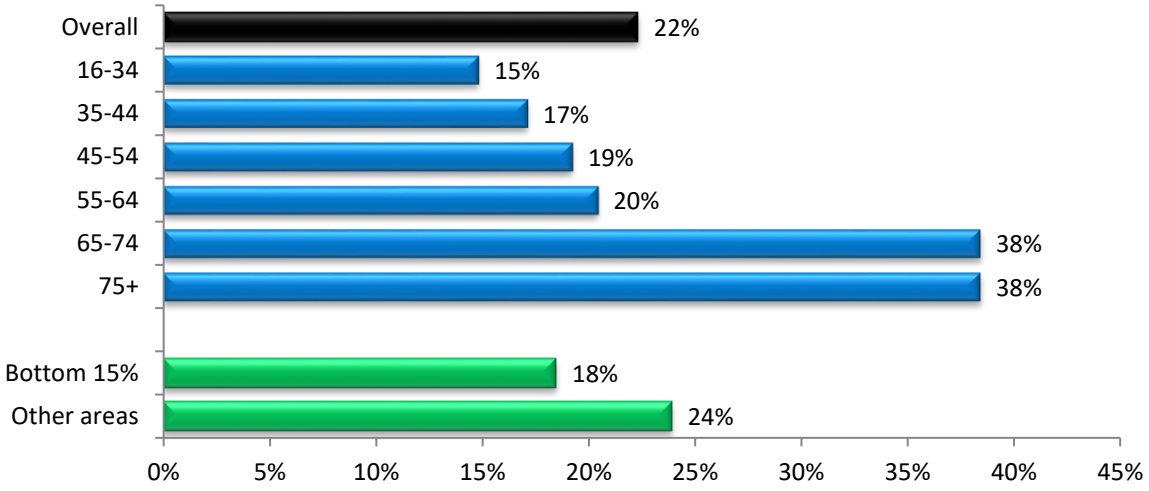
- **The 2022 Scottish Household Survey** showed that 22% of adults in Scotland had **formally** volunteered in the previous 12 months, higher than the 14% who had formally volunteered in West Dunbartonshire in the NHSGGC survey. Overall, the 2022 Household Survey showed that 46% had done any volunteering (formal or informal) - much higher than the 19% in West Dunbartonshire in the NHSGGC survey. As in West Dunbartonshire, volunteering measured in the Household Survey was less prevalent in the most deprived areas.

5.5 Belonging to Clubs, Associations and Groups

Just over one in five (22%) belonged to any social clubs, associations, church groups or similar.

- Those aged 65 or over were the most likely to belong to clubs/associations/groups.
- Those in the most deprived areas were less likely than others to belong to these types of groups or organisations.

Figure 5.6: Proportion Belong to Social Clubs, Associations, Church Groups or Similar by Age and Deprivation

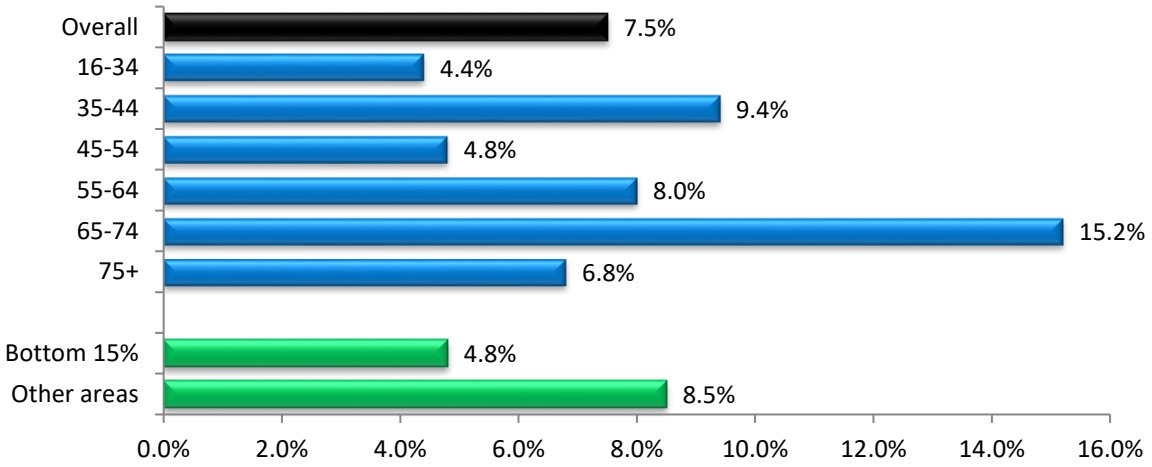


5.6 Social Activism

Respondents were asked whether, in the last 12 months, they had taken any actions in an attempt to solve a problem affecting people in their local area – e.g. contacted any media, organisation, council, councillor, MSP or MP; organised a petition. Overall, 7% had engaged in this type of social activism in the last year.

- Those aged 65-74 were the most likely to engage in social activism.
- Those in the most deprived areas were less likely than those in other areas to engage in social activism.

Figure 5.7: Proportion Engaged in Social Activism in Last 12 Months by Age and Deprivation



Comparison with NHSGGC

The proportion in West Dunbartonshire who had engaged in social activism (7.5%) was lower than in NHSGGC as a whole (11.4%).

5.7 Summary of Key Messages from This Chapter

Indicators were West Dunbartonshire Compared Less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to have positive views of reciprocity or trust
- less likely to value local friendships
- less likely to engage in social activism.

Differences by Age

- Those aged 65 or over were the most likely to have positive views of reciprocity or trust, the most likely to value local friendships and the most likely to belong to clubs/associations/groups.

- Those aged 65-74 were the most likely to volunteer formally or informally and the most likely to engage in social activism.

Differences by Deprivation

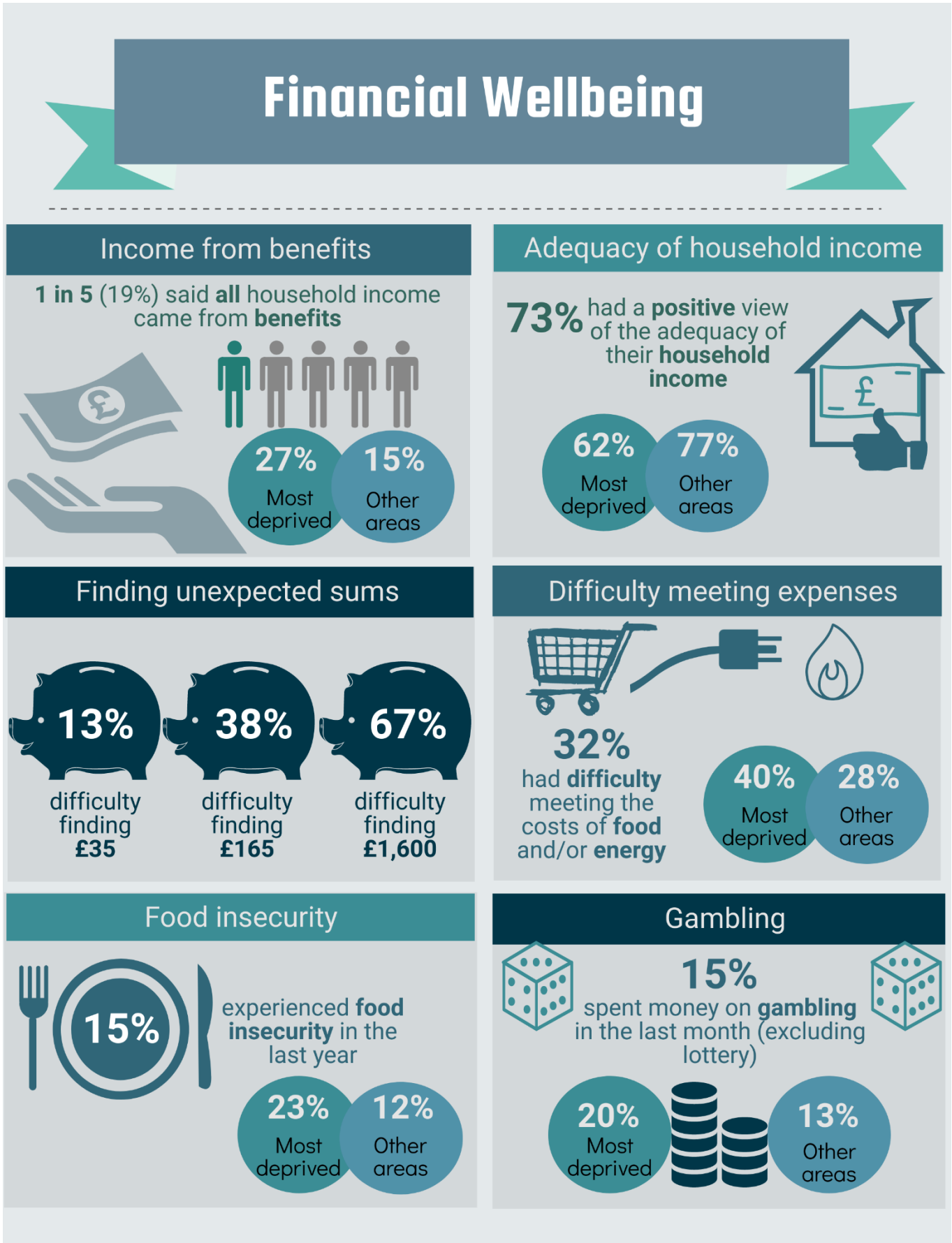
Those in the most deprived areas were:

- less likely to have positive views of reciprocity or trust

- less likely to value local friendships or have a positive view of social support

- less likely to volunteer or to belong to clubs/associations

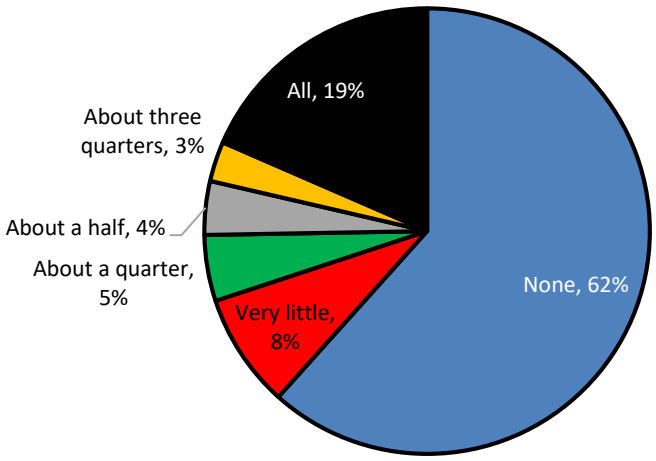
- less likely to engage in social activism.


Financial Wellbeing
Income from benefits
1 in 5 (19%) said all household income came from benefits
27% Most deprived
15% Other areas
Adequacy of household income
73% had a positive view of the adequacy of their household income
62% Most deprived
77% Other areas
Finding unexpected sums
13% difficulty finding £35
38% difficulty finding £165
67% difficulty finding £1,600
Difficulty meeting expenses
32% had difficulty meeting the costs of food and/or energy
40% Most deprived
28% Other areas
Food insecurity
15% experienced food insecurity in the last year
23% Most deprived
12% Other areas
Gambling
15% spent money on gambling in the last month (excluding lottery)
20% Most deprived
13% Other areas

6.1 Income from State Benefits

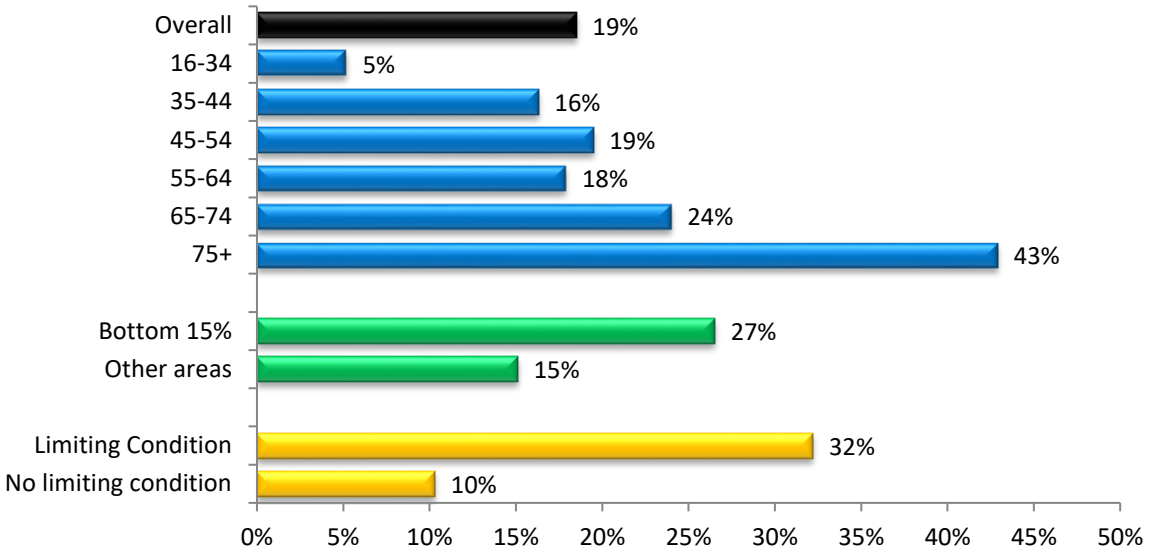
Just under two in five (38%) said that at least some of their household income came from state benefits, and 19% said that all their household income came from state benefits.

Figure 6.1: Proportion of Household Income from State Benefits



- Those aged under 35 were the least likely to receive all household income from benefits and those aged 75 or over were the most likely.
- Those in the most deprived areas were more likely than others to receive all household income from benefits.
- Those with a limiting condition or illness were more than three times as likely as others to say all their household income came from benefits.

Figure 6.2: Proportion who Received All Household Income from State Benefits by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

The proportion in West Dunbartonshire who received all household income from benefits (19%) was higher than in the NHSGGC area as a whole (13%).

Those who received any of their household income from benefits were asked whether they had experienced benefits sanctions of delays in benefits payments in the last year.

- 1.1% had experienced benefits sanctions
- 3.4% had experienced delays in benefits payments in the last year.

Those who received benefits were asked whether their household had been affected by benefit changes in the last 12 months (e.g. Universal Credit, Carer's Allowance, Disability Living Allowance/Adult Disability Payment, Child Disability Payment, Best Start payments).

Overall 8.4% of benefit recipients said they had been affected by benefit changes. Of those who had been affected by changes, 54% said their household was financially worse off as a result, 32% said their household was better off and 14% said it made no difference.

Policy Context: Financial Wellbeing

The impact of the COVID19 pandemic and the withdrawal of the United Kingdom from the European Union (Brexit) in 2020 have generated significant economic and welfare change since the last survey. There have also been significant changes to the welfare system in Scotland since the Social Security (Scotland) Act 2018 Social Security (Scotland) Act 2018 (legislation.gov.uk) and the establishment of Social Security Scotland Social Security Scotland - Homepage which enabled the devolution of aspects of the social security system and the introduction of Scotland specific welfare measures.

The Health and Wellbeing Survey asks questions about financial security and insecurity to continue to understand these impacts on residents. The survey has included an additional question on fuel insecurity as a consequence of the significant rise in fuel costs across the UK.

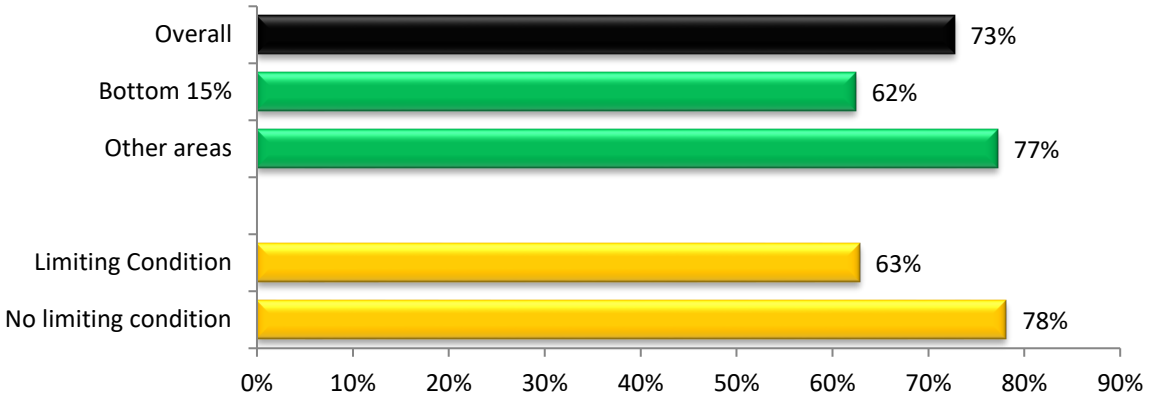
The Child Poverty Scotland Act, 2017 and the subsequent Scottish Government Child Poverty Action Plans – Every Child, Every Chance: the Tackling Child Poverty Delivery Plan 2018-2022, and Best Start, Bright Futures: Tackling Child Poverty Delivery Plan 2022-2026 identify the need for concerted partnership approaches and plans to tackle child poverty. While the targets seek to reduce child poverty levels, the Act and subsequent strategic plans provide a need to focus on Parents/ Carers in six priority family groups at highest risk of poverty: lone parent families, minority ethnic families, families with a disabled adult or child, families with a younger mother (under 25), families with a child under one, and larger families (3+ children). As a result of the Child Poverty Act, the Poverty and Inequality Commission was established. The Public Services Reform (Poverty and Inequality Commission) (Scotland) Order 2018 widened the scope of the Commission to advise the government on matters relating to poverty more broadly and promote the reduction of poverty and inequality across the population as a whole.

6.2 Adequacy of Income

Using the 'faces' scale (see Chapter 2), respondents were asked how they felt about the adequacy of their household income. Just under three in four (73%) expressed a positive perception of the adequacy of their household income, while 15% had a neutral perception and 12% had a negative perception.

- Those in the most deprived areas were less likely to give a positive view.
- Those with a limiting condition or illness were less likely to give a positive view.

Figure 6.3: Proportion with a Positive Perception of the Adequacy of their Household Income by Deprivation and Limiting Conditions



6.3 Views on Poverty

Respondents were asked what they felt was the main reason some people in their area lived in poverty. The most frequent responses were lack of jobs (27%) and an inevitable part of modern life (20%). All responses are shown in Table 6.1, together with the differing profile of responses for those living in the most deprived areas compared to those in other areas.

Those living in the most deprived areas were more likely to attribute poverty to lack of jobs or laziness/lack of willpower, and less likely to attribute poverty to injustice in society.

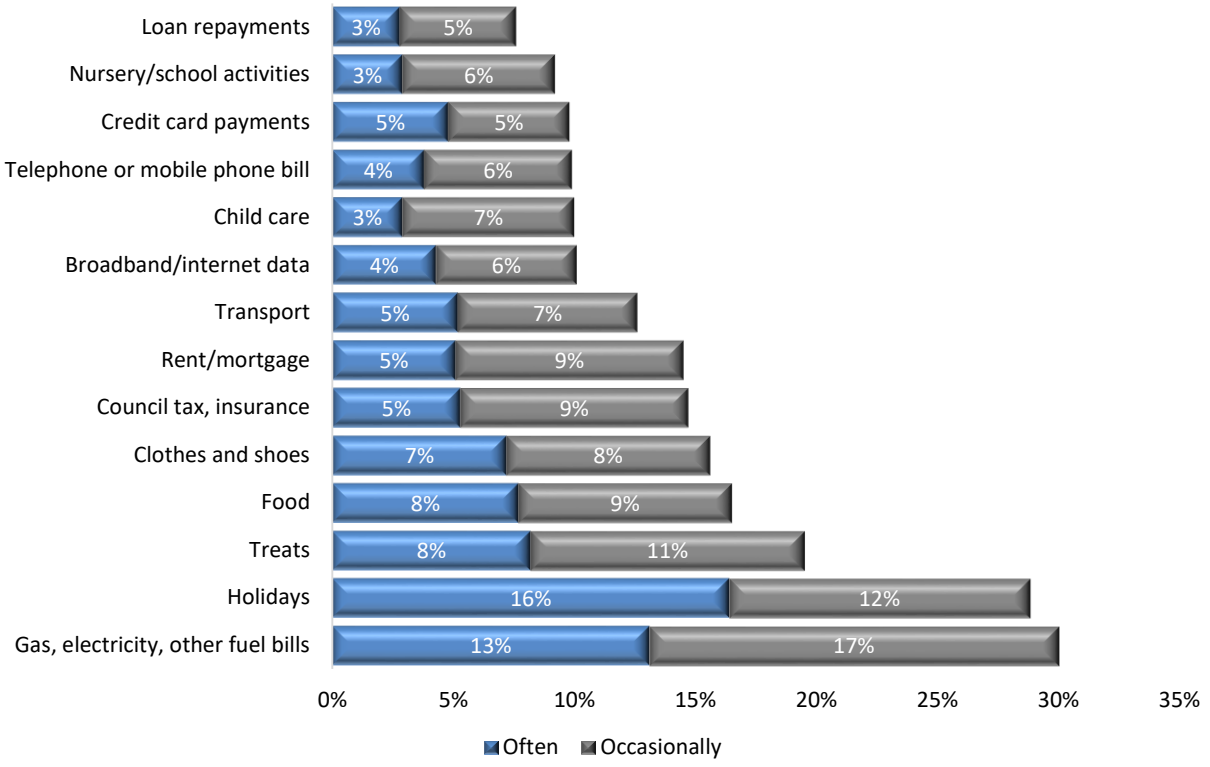
Table 6.1: Perceived Reasons for Poverty in Local Area by Deprivation

	Overall	Bottom 15%	Other areas
An inevitable part of modern life	20%	21%	19%
Laziness or lack of willpower	15%	17%	15%
Because they have been unlucky	7%	6%	8%
Because of injustice in society	12%	9%	13%
Lack of jobs	27%	32%	25%
There is no one living in poverty in this area	2%	2%	2%
Other	12%	12%	12%
None of the above	6%	1%	8%

6.4 Difficulty Meeting the Cost of Specific Expenses

Figure 6.4 shows the proportion of people who said they had difficulty meeting specific expenses often or occasionally.

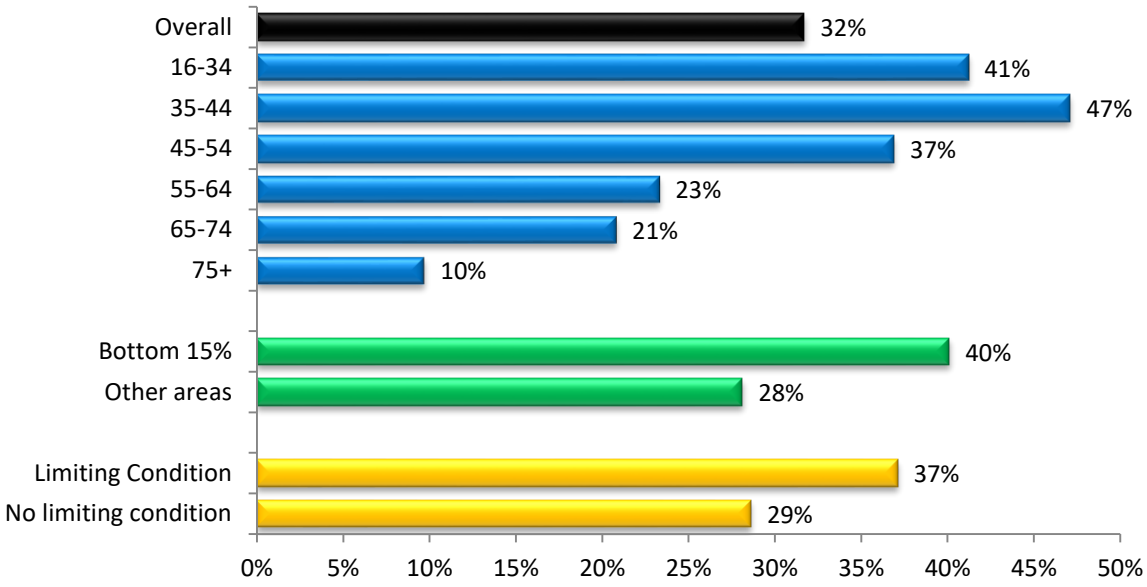
Figure 6.4: How Often Have Difficulty Meeting the Cost of Specific Expenses



Altogether, 32% said that they had difficulty meeting the cost of food and/or energy (at least occasionally).

- Those aged 75 and over were the least likely to have difficulty meeting the cost of food or energy and those aged 35-44 were the most likely.
- Those in the most deprived areas were more likely than others to have difficulty meeting the cost of food or energy.
- Those with a limiting condition or illness were more likely than others to have difficulty meeting the cost of food/energy.

Figure 6.5: Proportion who Had Difficulty Meeting the Cost of Food and/or Energy by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

The proportion in West Dunbartonshire who had difficulty meeting the cost of food and/or energy (32%) was lower than in the NHSGGC area as a whole (38%).

6.5 Difficulty Finding Unexpected Sums

Respondents were asked how their household would be placed if they suddenly had to find a sum of money to meet an unexpected expense such as a repair or new washing machine. Overall, 13% said it would be a problem to find £35, 38% said it would be a problem to find £165 and 67% said it would be a problem to find £1,600.

- Those aged 65 or over were the least likely to say they would have difficulty finding these sums.
- Women were more likely than men to say they would have difficulty meeting any of these sums.
- Those in the most deprived areas were more likely to have difficulty meeting any of these sums.
- Those with a limiting condition were more likely than others to have difficulty finding sums of £35 or £165.

Table 6.2: Proportion who would Find it Difficult Meeting Unexpected Sums of £35, £165 or £1,600 by Age, Gender, Deprivation and Limiting Conditions

	Problem finding £35	Problem finding £165	Problem finding £1,600
16-34	15%	50%	85%
35-44	15%	51%	84%
45-54	19%	41%	71%
55-64	10%	30%	53%
65-74	6%	22%	45%
75+	8%	17%	51%
Male	9%	35%	62%
Female	16%	40%	73%
Bottom 15%	18%	50%	81%
Other areas	10%	32%	62%
Limiting condition	21%	44%	NS
No limiting condition	9%	34%	NS
Overall	**13%**	**38%**	**67%**

NS= No significant difference

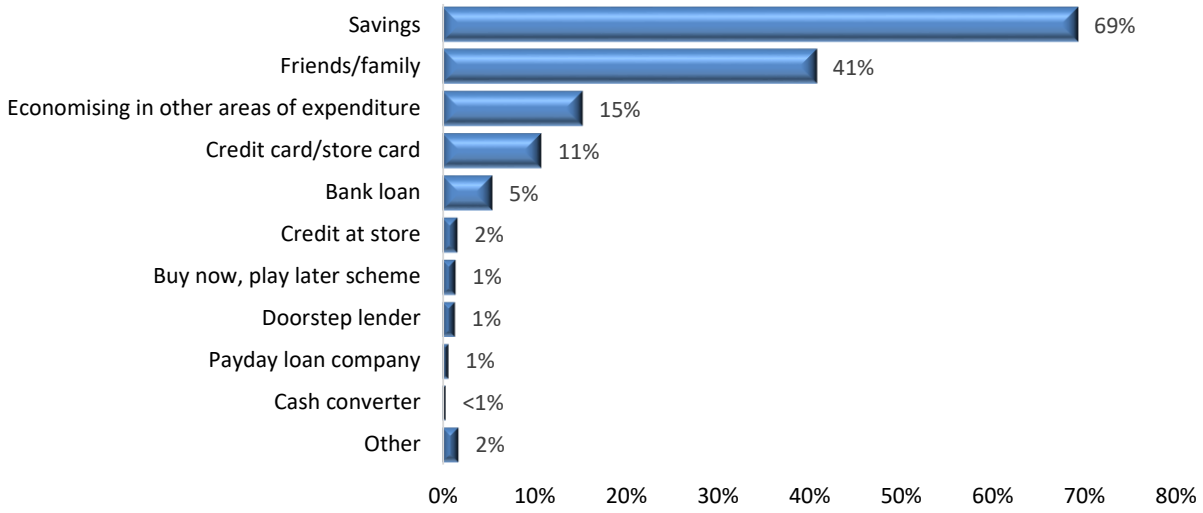
Comparison with NHSGGC

Those in West Dunbartonshire were less likely than those in the NHSGGC area as a whole to have difficulties finding:

- £35 (13% West Dunbartonshire; 15% NHSGGC)
- £165 (38% West Dunbartonshire; 41% NHSGGC)
- £1,600 (67% West Dunbartonshire; 74% NHSGGC)

Respondents were asked, if they suddenly had to find a sum of money to meet an unexpected bill, where would they get the money from (with the option of giving more than one response). The most common sources were savings (69%) and friends/family (41%). All responses are shown in Figure 6.6.

Figure 6.6: Where Would Find Sum of Money to Meet Unexpected Bill



The proportion who said they would use savings to pay unexpected bills rose with age from 55% of those aged under 35 to 85% of those aged 75 or over. Those aged under 35 were the most likely to say they would source money from friends/family (66%).

Women were more likely than men to say they would source money from friends/family (46% female; 35% male).

Those in the most deprived areas were:

- less likely to use savings to pay unexpected bills (60% most deprived; 73% other areas)
- more likely to get money from friends/family (56% most deprived; 34% other areas)
- more likely to use a bank loan (9% most deprived; 4% other areas).

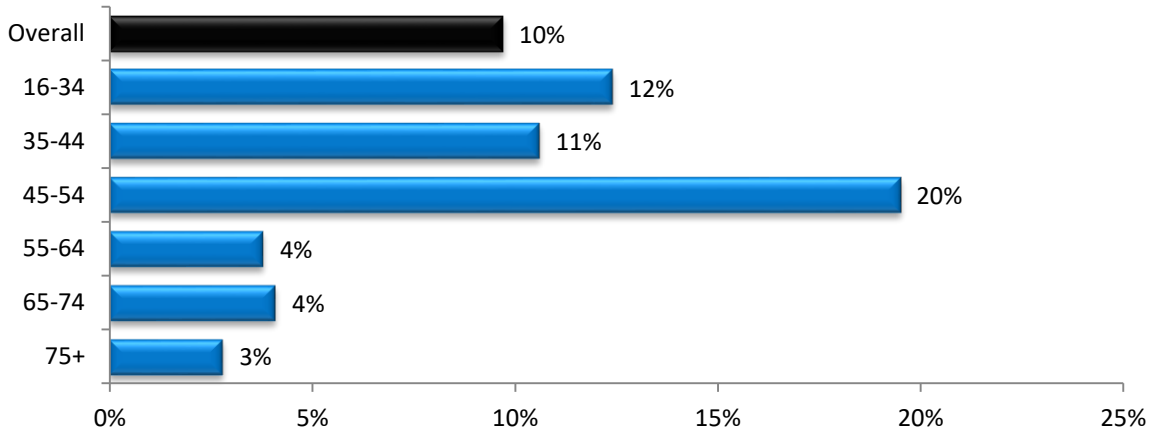
6.6 Credit

Respondents were asked how many months from the last six months they had to use a source of credit to cover essential living costs due to a lack of money that they may struggle to pay off.

Overall, 9.7% had used credit to cover essential living costs they may struggle to pay off during the previous six months, consisting of 3.2% who had done so in one month, 2.3% who had done so in two months, 1.8% who had done so in three months and 2.4% who had used credit in this way for three or more months.

Those aged 45-54 were the most likely to have used credit to cover essential living costs in the last six months.

Figure 6.7: Proportion who Used Credit to Cover Essential Living Costs in the Last Six Months by Age



6.7 Food Insecurities

Respondents were asked eight questions which comprise the Food Insecurity Experiences Scale[7]. The proportion who said 'yes' to each question is shown in Table 6.3. Altogether, 15% had experienced at least one event in the last year which was an indication of food insecurity.

[7] See: http://www.fao.org/in-action/voices-of-the-hungry/fies/en/

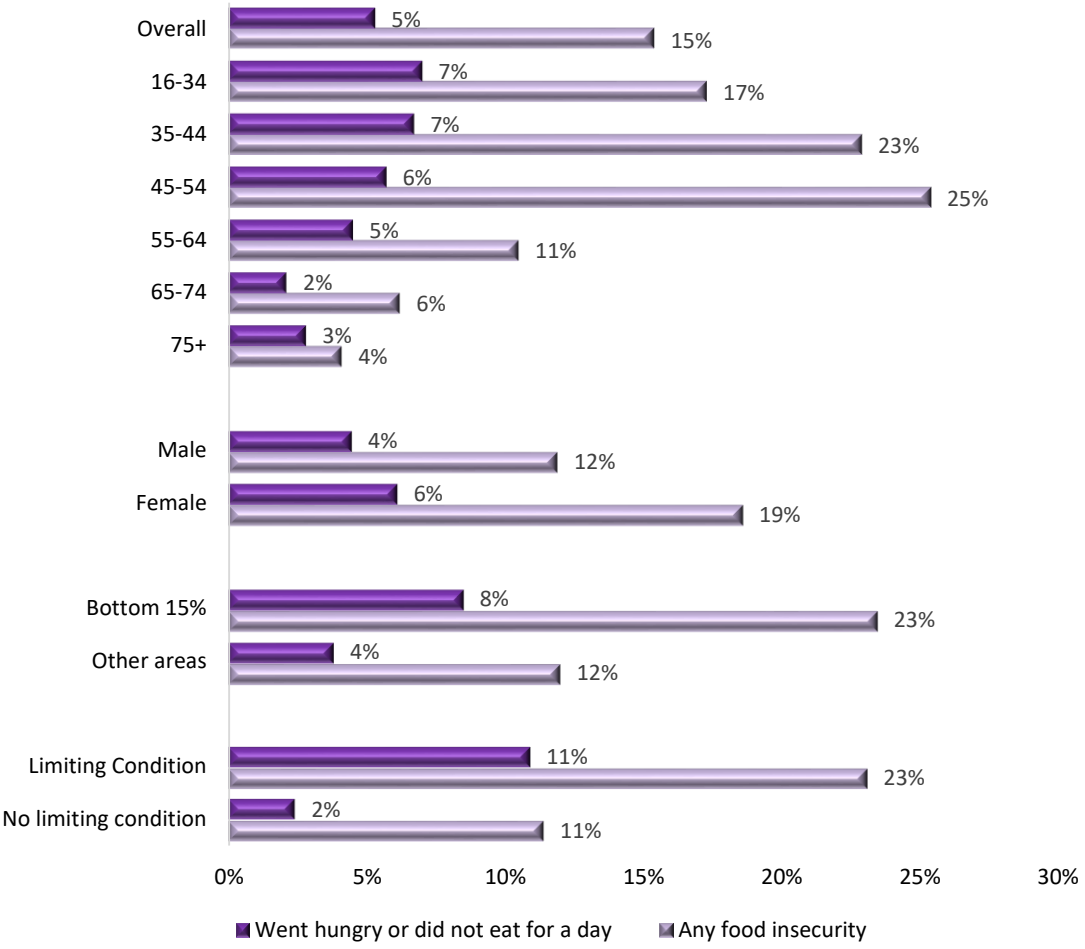
Table 6.3: Proportion who Experienced Each Event on the Food Insecurities Experience Scale in the Last 12 Months

	Proportion who answered 'yes'
You were worried you would run out of food because of a lack of money or other resources	10.7%
You were unable to eat healthy and nutritious food because of a lack of money or other resources	8.0%
You ate only a few kinds of food because of a lack of money or other resources	10.5%
You had to skip a meal because there was not enough money or other resources to get food	5.6%
You ate less than you thought you should because of a lack of money or other resources	9.8%
Your household ran out of food because of a lack of money or other resources	4.8%
You were hungry but did not eat because there was not enough money or other resources for food	4.7%
You went without eating for a whole day because of a lack of money or other resources	3.7%
Any of the above	**15.4%**

Overall, 5.3% of adults experienced **either** of the last two items, indicative of the most severe forms of food insecurity – going hungry because they could not afford food or going a whole day without eating because of lack of money/resources.

- Those aged 35-54 were the most likely to experience food insecurity.
- Women were more likely than men to experience food insecurity.
- Those in the most deprived areas were twice as likely as others to experience food insecurity.
- Those with a limiting condition or illness were twice as likely as others to experience food insecurity.

Figure 6.8: Food Insecurities Experience in the Last 12 Months by Age, Gender, Deprivation and Limiting Conditions



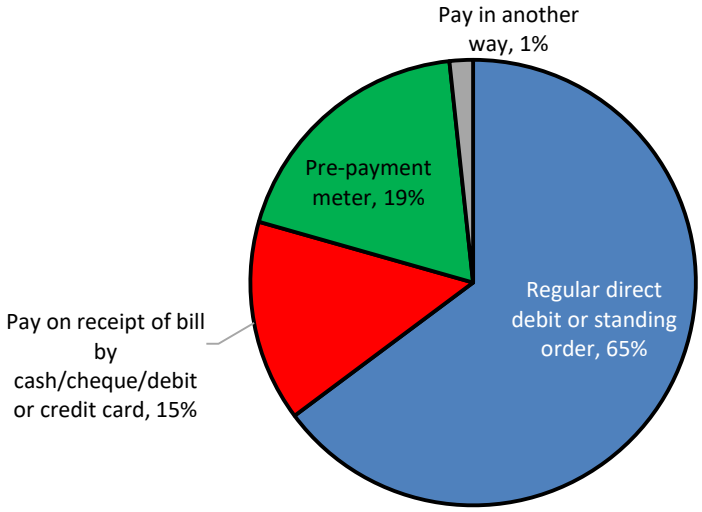
Evidence from Other Sources

- **The 2021 Scottish Household Survey** found that nationally 9% had, at some time in the previous 12 months worried that they would run out of food because of a lack of money or other resources, slightly lower than the 11% in West Dunbartonshire in the NHSGGC survey in 2022/23.

6.8 Energy Bills

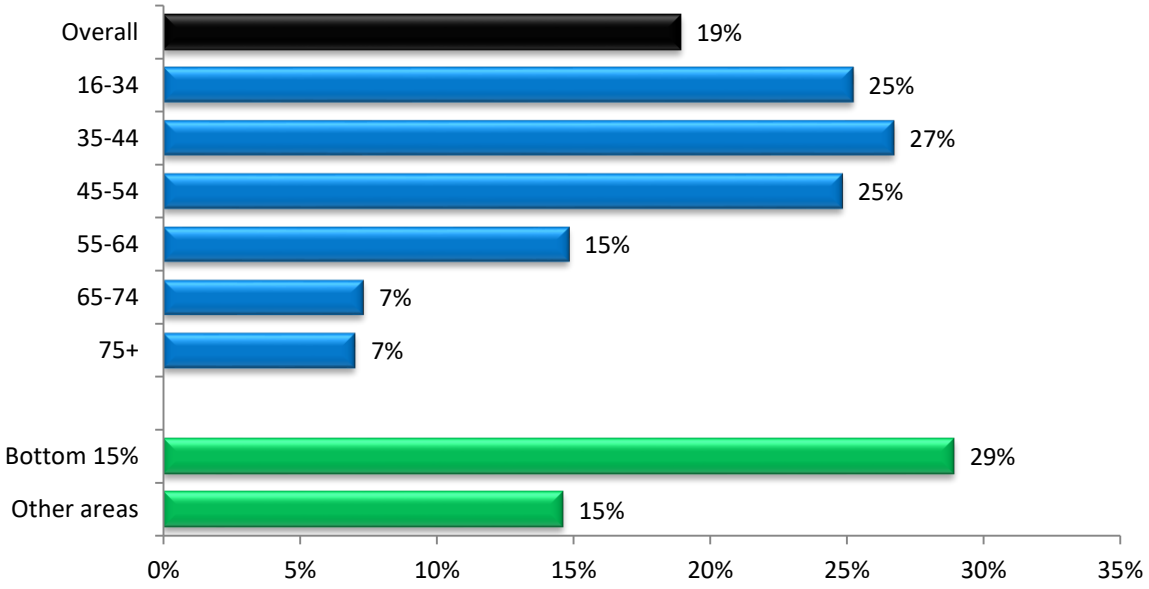
Just under two in three (65%) said they paid their energy bill by regular direct debit or standing order, 19% had a pre-payment meter and 15% paid on receipt of their bill.

Figure 6.9: Means of Paying for Energy



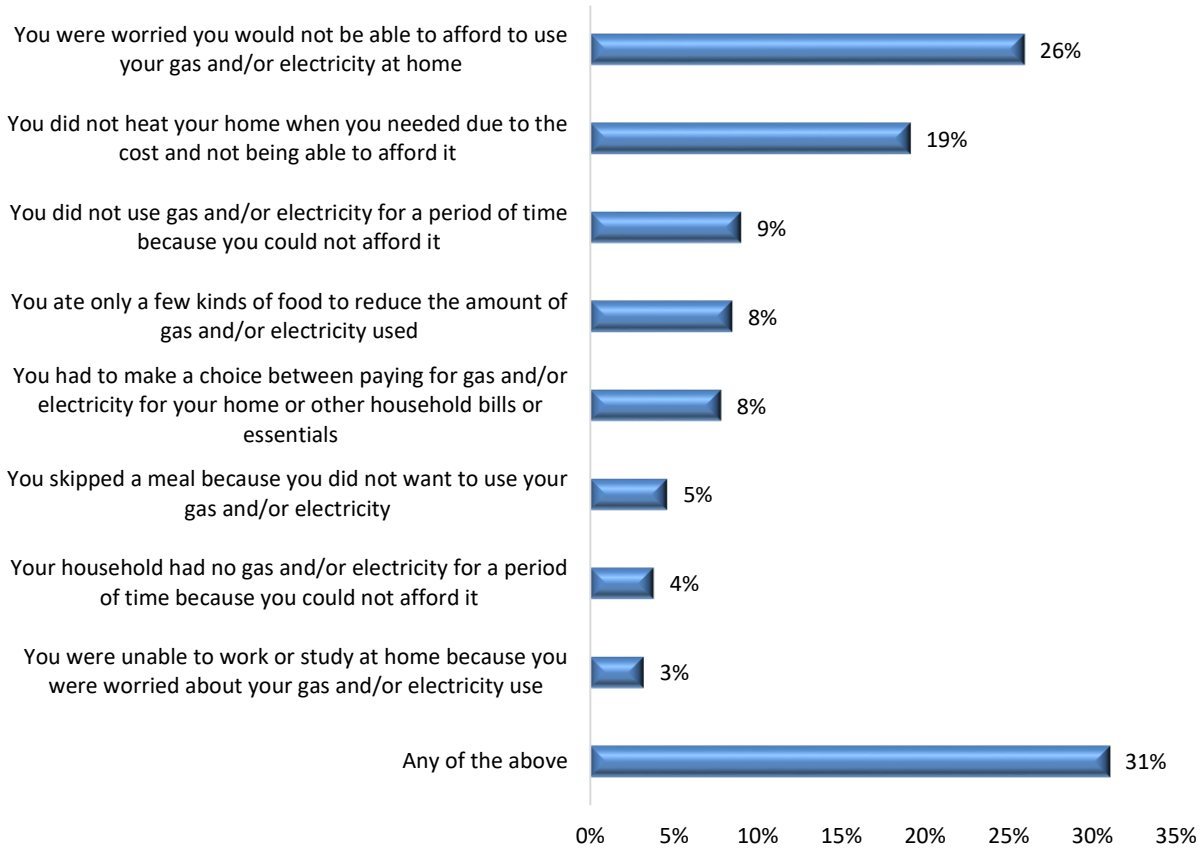
- Those in the youngest age groups were the most likely to have a pre-payment meter.
- Those in the most deprived areas were much more likely to have a pre-payment meter.

Figure 6.10: Proportion with a Prepaid Meter by Age and Deprivation



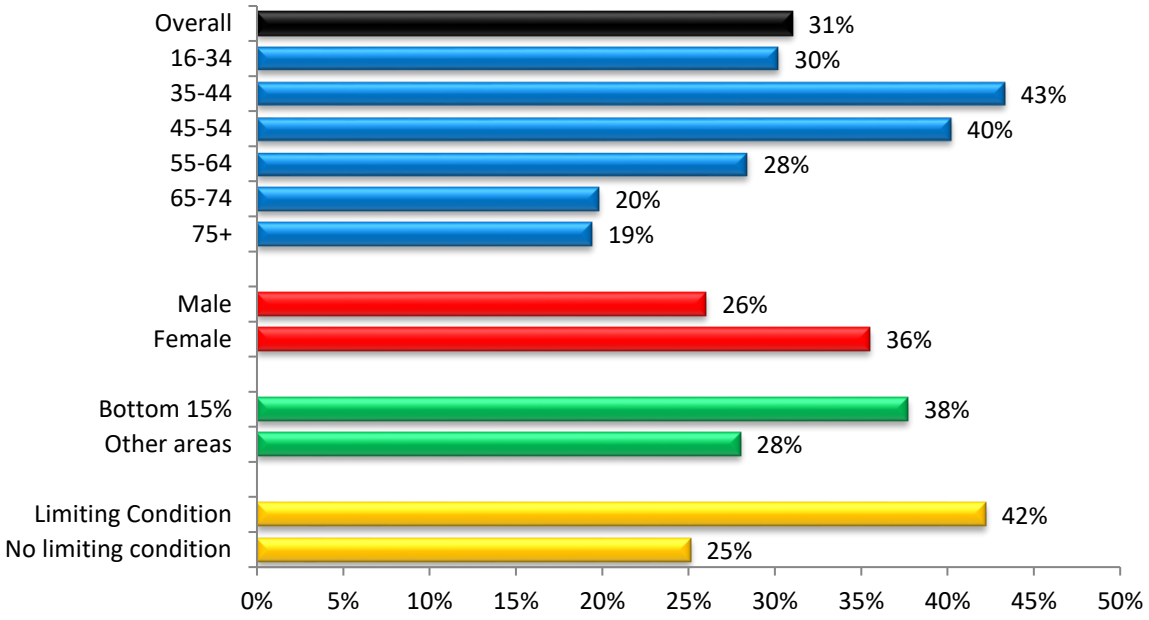
Respondents were asked whether any of eight things had happened in the last 12 months relating to energy affordability. Figure 6.11 shows the proportion who said each thing had happened. In total, 31% reported indicators of difficulties affording energy.

Figure 6.11: Proportion who said each Indicator of Difficulties with Energy Bills Occurred in the Last Year



- Those aged 35-54 were the most likely to say they had experienced any of these indicators of difficulty affording energy.
- Women were more likely than men to say they had experienced any of these indicators of difficulty affording energy.
- Those in the most deprived areas were more likely to have experienced any of the indicators of difficulties paying for energy.
- Those with a limiting condition or illness were more likely to have experienced any of these indicators.

Figure 6.12: Proportion who Had Experienced at Least One Indicator of Difficulties Affording Energy in the Last Year by Age, Gender, Deprivation and Limiting Conditions



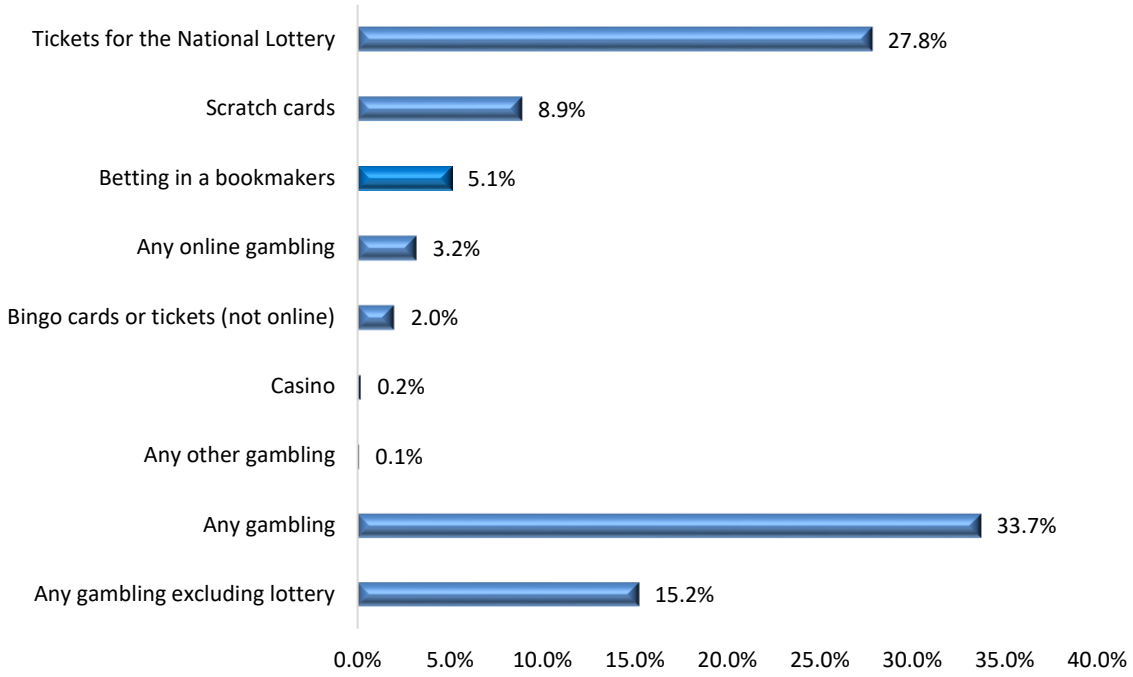
Comparison with NHSGGC

The proportion in West Dunbartonshire who had indicators of difficulties affording energy (31%) was lower than in the NHSGGC area as a whole (40%).

6.9 Gambling

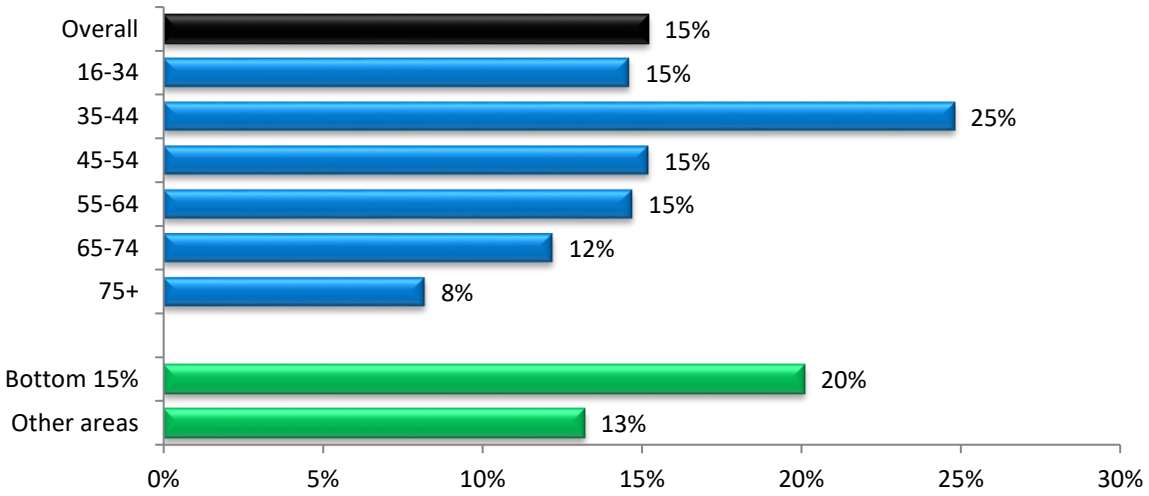
Respondents were asked whether they had spent money on different types of gambling activities in the last month. Overall, 34% had spent money on gambling in the last month. By far the most common type was lottery. In total, 15% had spent money on gambling which excluded lottery.

Figure 6.13: Proportion who Spent Money on Gambling Activities in the Previous Month



- Those aged 35-44 were the most likely to gamble and those aged 75 or over were the least likely.
- Those in the most deprived areas were more likely than others to gamble.

Figure 6.14: Proportion who Spent Money on Gambling Activities (Excluding National Lottery) in the Previous Month by Age and Deprivation



Comparison with NHSGGC

The proportion in West Dunbartonshire who spent money on gambling excluding the lottery (15%) was higher than in the NHSGGC area as a whole (12%).

6.10 Summary of Key Messages from This Chapter

Indicators where West Dunbartonshire Compared Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to say they had difficulty meeting the cost of food and/or energy
- less likely to say they would have difficulty finding sums to pay for unexpected expenses
- less likely to have indicators of difficulty affording energy.

Indicators where West Dunbartonshire Compared Less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- more likely to receive all household income from benefits
- more likely to spend money on gambling (excluding lottery).

Differences by Age and Gender

- Those aged 75 or over were the most likely to receive all household income from benefits.

- Those aged 35-44 were the most likely to have difficulty paying for food and/or energy, the most likely to experience food insecurity and the most likely to have indicators of difficulty affording energy.

- Those aged 65 or over were the least likely to have difficulty finding unexpected sums.

- Women were more likely than men to have problems finding unexpected sums, to experience food insecurity or to have experiences indicating difficulties affording energy.

- Those aged under 55 were the most likely to have a pre-paid meter.

- Those aged 35-44 were the most likely to spend money on gambling.

Differences by Deprivation

Those in the most deprived areas were:

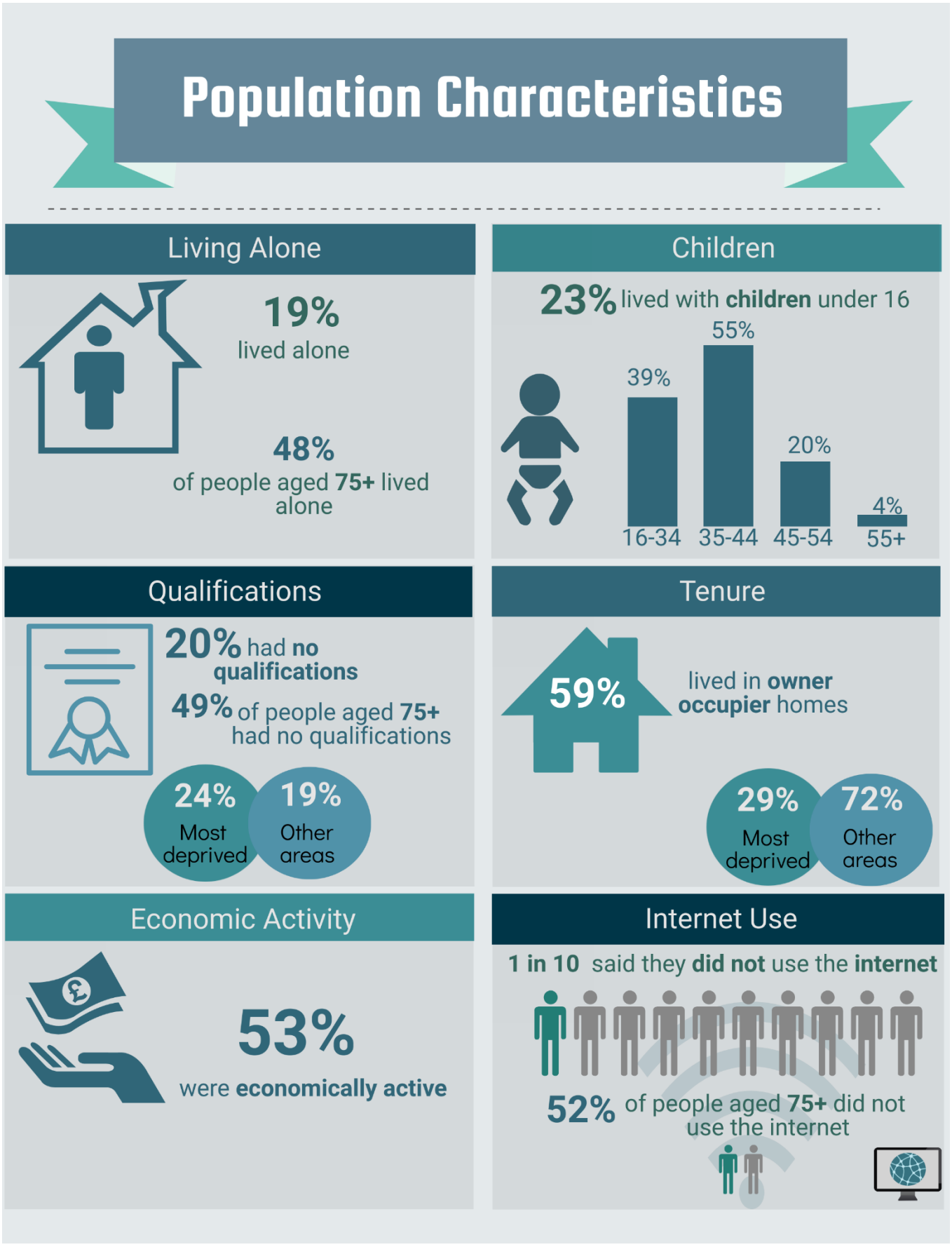
- more likely to receive all household income from state benefits
- less likely to have a positive view of the adequacy of their income
- more likely to report difficulties paying for food and/or energy, or finding money to meet unexpected costs
- more likely to report experiences indicating food insecurity
- more likely to have a pre-payment meter and more likely to report experiences indicating difficulties affording energy
- more likely to spend money on gambling.

Differences by Limiting Conditions

Those with a limiting illness or condition were:

- more likely to receive all household income from benefits
- less likely to have a positive view of the adequacy of their household income
- more likely to report difficulties meeting the cost of food/energy or meeting unexpected sums of £35 or £165
- more likely to experience food insecurity
- more likely to report experiences indicating difficulties affording energy.

7 Population Characteristics

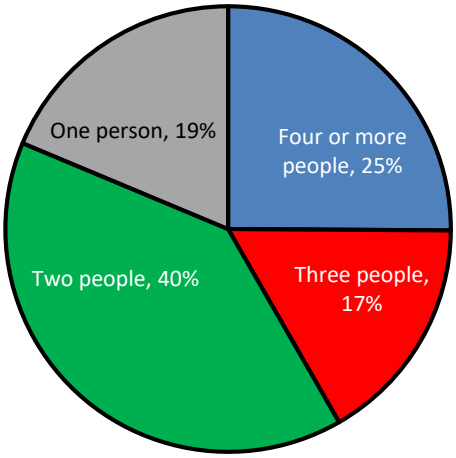


7.1 Household Composition

Household Size

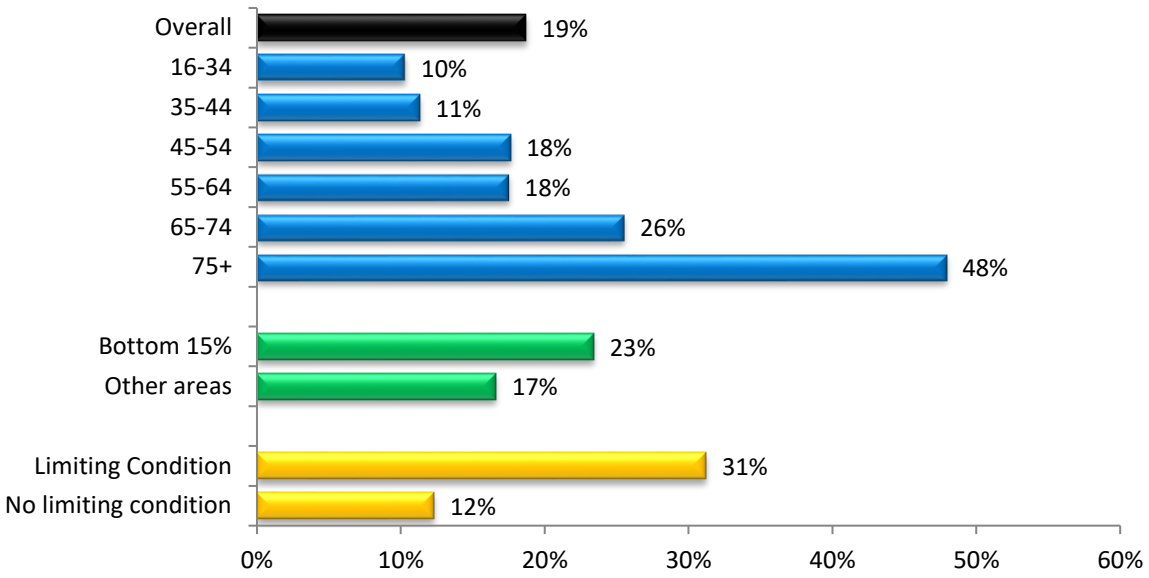
One in five (19%) lived alone. Figure 7.1 shows the breakdown of household size.

Figure 7.1: Household Size



- Those aged 75 or over were the most likely to live alone – nearly half (48%) of those aged 75 or over lived alone.
- Those in the most deprived areas and those with a limiting condition or illness were more likely to live alone.

Figure 7.2: Proportion who Live Alone by Age, Deprivation and Limiting Conditions



Although overall there was no gender difference for the proportion who lived alone, among those aged 65 or over, women were much more likely than men to live alone, as Table 7.1 shows.

Table 7.1: Proportion who Live Alone by Age and Gender

	Live Alone
Men 16-44	12%
Women 16-44	9%
Men 45-64	21%
Women 45-64	14%
Men 65+	21%
Women 65+	46%

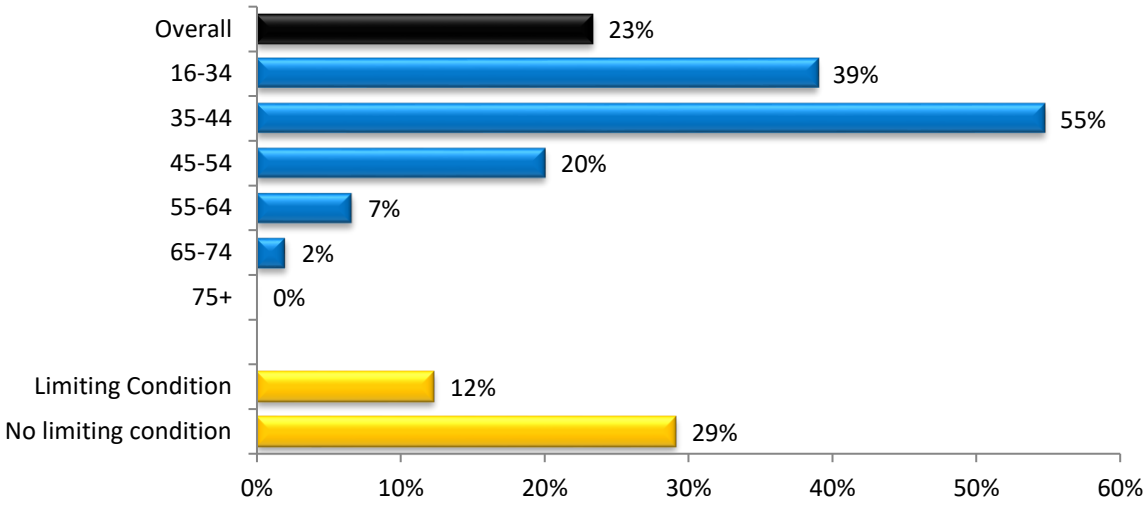
Children in the Household

Just under one in four (23%) adults lived in a home with at least one child under the age of 16.

- Those aged 35-44 were the most likely to live in a home with at least one child under the age of 16.

- Those with a limiting condition or illness were much less likely than others to live with children.

Figure 7.3: Proportion with a Child Aged Under 16 in their Household by Age and Limiting Conditions



Although overall there was no significant difference by gender, among those aged under 45, women were more likely than men to have children in their household.

Table 7.2: Proportion with a Child Aged Under 16 in their Household by Age and Gender

	Child in household
Men 16-44	38%
Women 16-44	51%
Men 45-64	13%
Women 45-64	13%
Men 65+	3%
Women 65+	1%

7.2 Trans Identities and Sexual Orientation

Of the 958 people who answered the self-completion component of the main questionnaire and answered the question about trans identities, less than 1% (N=<5) said they considered themselves to be trans or to have a trans history.

Most (97.6%) of those who answered the self-completion component described themselves as heterosexual or straight, while 0.6% described

themselves as gay, 1.5% described themselves as bisexual and 0.4% described themselves in another way. (This excludes the 2.4% who preferred not to say).

Those aged under 35 were the most likely to identify as gay, bisexual or other (6.3%).

Comparison with NHSGGC

The proportion in West Dunbartonshire who identified as gay/bisexual/other (2.4%) was lower than in the NHSGGC area as a whole (6.1%).

7.3 Ethnicity

Respondents were asked their ethnicity. Table 7.3 shows the proportion of respondents in each group (groups have been combined where sub-groups had less than 1.0% responses)[8].

Table 7.3: Ethnicity

Ethnicity	%
White:	
Scottish	85.8%
Other British	8.6%
Other White	3.4%
Total White	**97.8%**
Total Asian	**1.4%**
Mixed or any other ethnic group	**0.8%**
Total BME (Non-white)	**2.2%**

[8] The full Scottish Census 2022 categories were used – see Question T06 in the main questionnaire, Appendix F

Comparison with NHSGGC

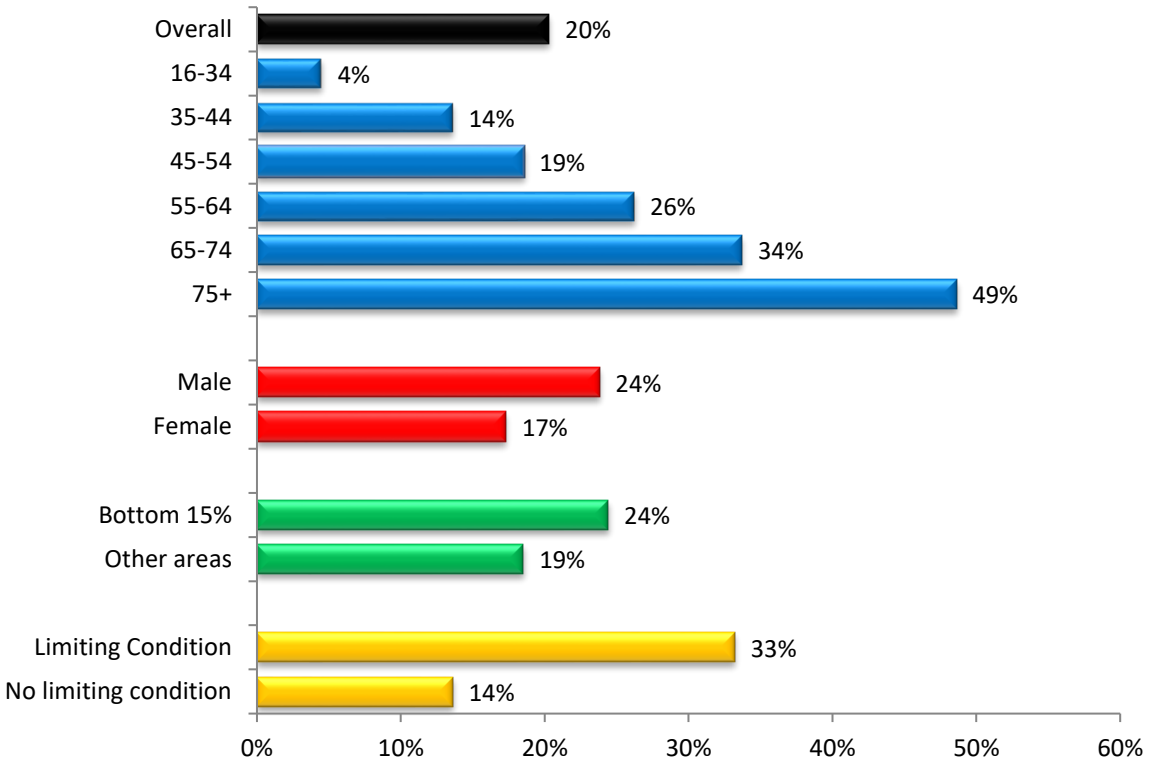
The proportion in West Dunbartonshire who had BME identities (2.2%) was lower than in the NHSGGC area as a whole (13.1%).

7.4 Educational Qualifications

One in five (20%) said they had no qualifications.

- The proportion who said they had no qualifications rose with age from 4% of those aged under 35 to 49% of those aged 75 or over.
- Men were more likely than women to say they had no qualifications.
- Those in the most deprived areas were more likely than those in other areas to say they had no qualifications.
- Those with a limiting condition or illness were more likely to say they had no qualifications.

Figure 7.4: Proportion with No Qualifications by Age, Gender, Deprivation and Limiting Conditions



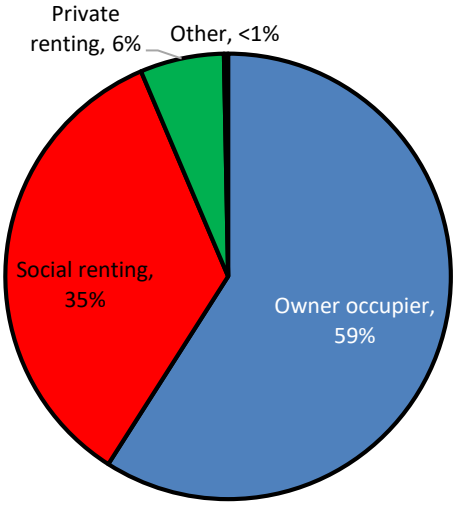
Comparison with NHSGGC

The proportion in West Dunbartonshire who had no qualifications (20%) was higher than in the NHSGGC area as a whole (14%).

7.5 Tenure

Three in five (59%) adults lived in owner-occupied homes (either owned outright or buying with a mortgage), 35% lived in homes rented from the council or a housing association, 6% lived in privately rented homes and less than 1% lived in homes with some other tenure.

Figure 7.5: Tenure



- Those aged under 45 were the least likely to live in owner-occupied homes and those aged under 35 were the most likely to live in privately rented homes.

- Three in ten (29%) of those in the most deprived areas lived in owner-occupied homes compared to 72% of those in other areas. Just under two thirds (64%) of those in the most deprived areas lived in socially rented homes.

- Those with a limiting condition or illness were more likely than others to live in socially rented homes and less likely to live in privately rented homes.

Table 7.4: Tenure by Age, Deprivation and Limiting Conditions

	Owner-occupier	Social renting	Private renting	Other
16-34	46%	40%	14%	1%
35-44	47%	48%	6%	0%
45-54	59%	35%	6%	1%
55-64	69%	29%	1%	1%
65-74	77%	22%	1%	0%
75+	69%	28%	3%	0%
Bottom 15%	29%	64%	6%	1%
Other areas	72%	22%	6%	0%
Limiting Condition	58%	38%	3%	0%
No limiting condition	59%	32%	8%	<1%

7.6 Economic Activity

Respondents were asked which category best described their employment situation, with the option of selecting more than one category. Responses, from most to least frequent were:

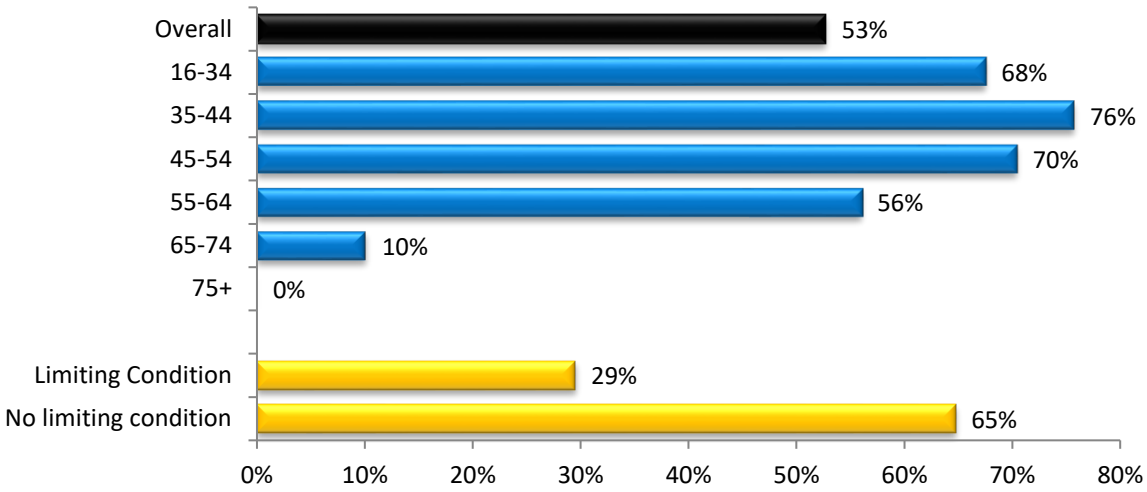
- Employee in full-time job (38%)
- Wholly retired from work (26%)
- Employee in part-time job (12%)
- Permanently sick/disabled (8%)
- Unemployed and available for work (6%)
- Full-time education (4%)
- Self-employed – full or part time (2%)
- Looking after the family/home (2%)
- Employed on a zero hours contract (<1%)
- Part-time education (<1%)
- Other (1%).

In total, 53% were economically active (in full-time or part-time employment, self-employed or on a zero hours contract).

- Rates of economic activity were highest among those aged 35-44.

- Those with a limiting condition or illness were much less likely than others to be economically active.

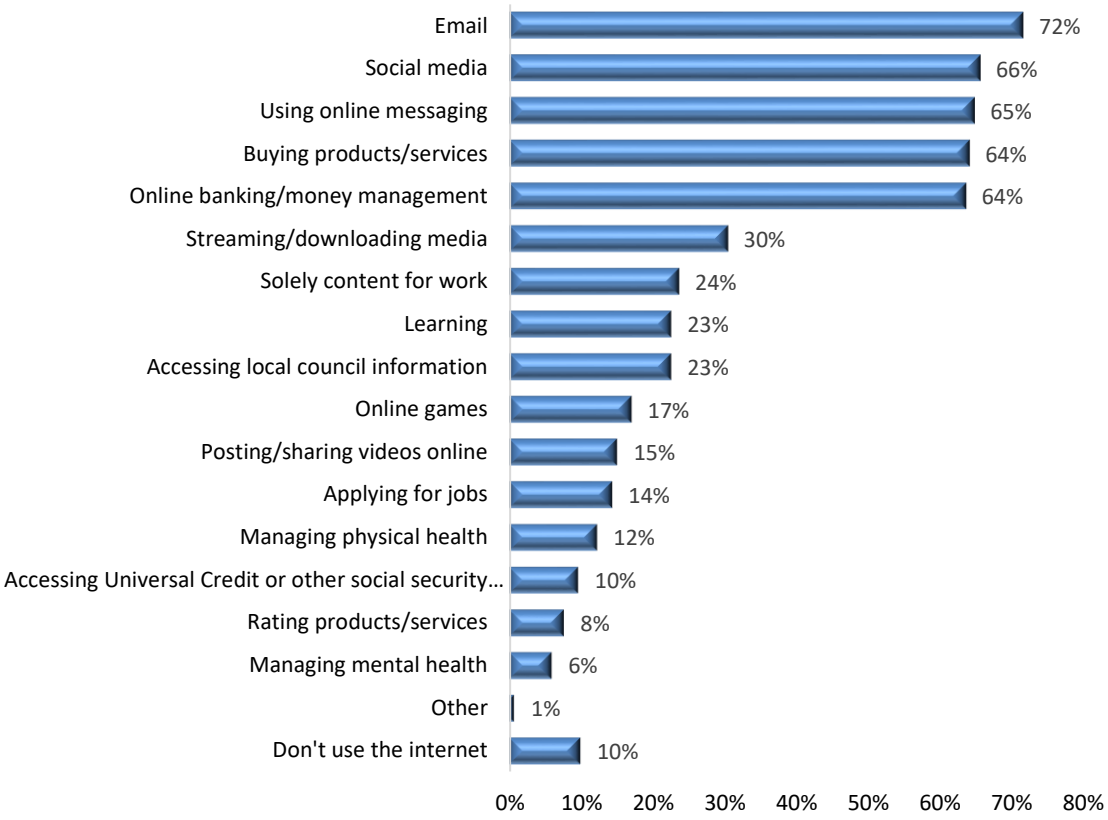
Figure 7.6: Proportion Economically Active by Age and Limiting Conditions



7.7 Internet Use

Respondents were asked about the purposes for which they used the internet. One in ten (10%) did not use the internet. The most common use of the internet was email (72%). All responses are shown in Figure 7.7.

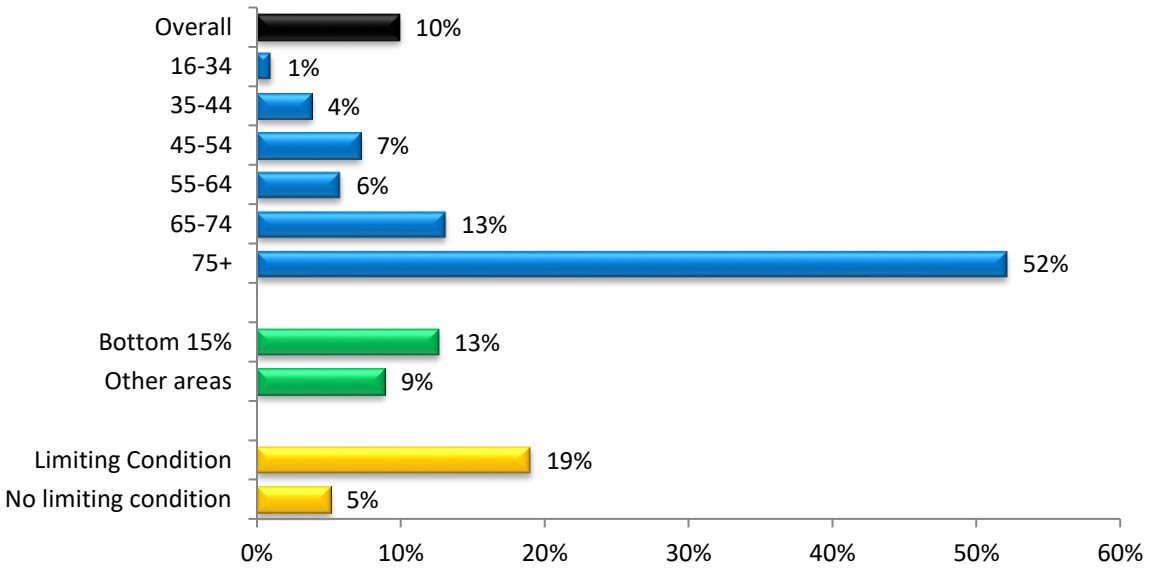
Figure 7.7: Purposes of Internet Use



- Nearly all (99%) of those aged under 35 used the internet, but just under half (48%) of those aged 75 or over used the internet.

- Those in the most deprived areas were less likely to use the internet.
- Those with a limiting condition or illness were much more likely than others to say they did not use the internet.

Figure 7.8: Proportion who Do Not Use the Internet by Age, Deprivation and Limiting Conditions

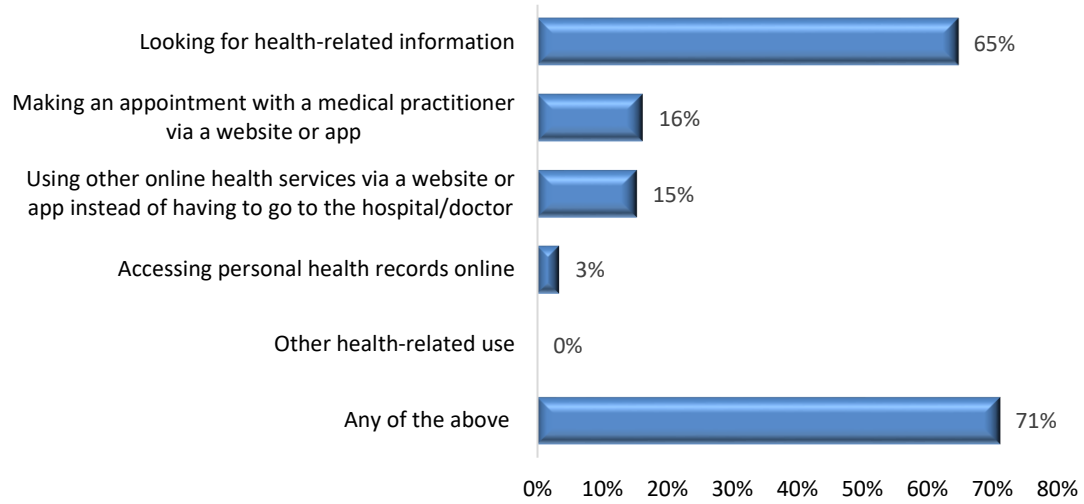


Evidence from Other Sources

- **The 2022 Scottish Household Survey** found that nationally 90% of people used the internet, dropping to 76% for those aged 75 or over. Although the question was asked in a different way, it indicates a similar prevalence of internet use in West Dunbartonshire compared to nationally (although use of the internet among those aged 75 or over was much lower in West Dunbartonshire).

Among those who ever used the internet, 71% had used the internet for health-related use, the most common being looking for health-related information.

Figure 7.9: Health-Related Use of the Internet (for those who ever used the internet)

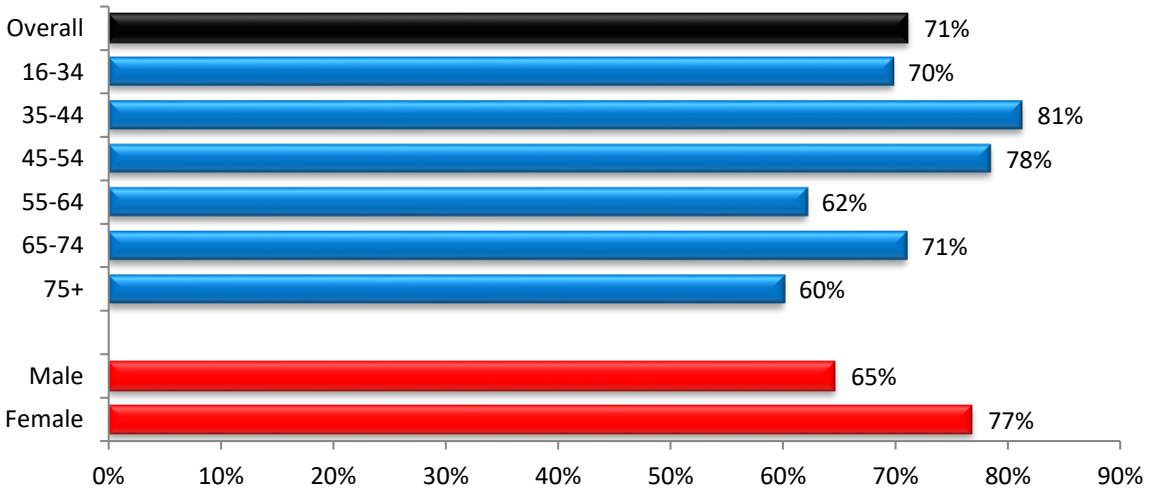


Base: All those who used the internet (unweighted N= 936)

Among those who used the internet:

- those aged 35-54 were the most likely to use the internet for health-related reasons
- women were more likely than men to use the internet for health-related reasons.

Figure 7.10: Proportion of Internet Users who Used the Internet for Health-Related reasons by Age and Gender



Base: All those who used the internet (unweighted N= 936)

Those who did not use the internet (N=138) were asked which of a number of statements applied to them when thinking about what would encourage them to improve their digital skills. Most (85%) said that nothing would encourage them to do so as they avoid adopting technology, but 13% said they would if devices were cheaper.

7.8 Summary of Key Messages from This Chapter

Indicators were West Dunbartonshire Differed Significantly to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to identify as gay/bisexual/other
- less likely to have BME identities
- more likely to say they had no qualifications.

Differences by Age and Gender

- Those aged 75 or over were the most likely to live alone.
- Those aged 35-44 were the most likely to have children in their household.
- Those aged 75 or over were the most likely to say they had no qualifications, and men were more likely than women to say they had no qualifications.
- Those in the youngest age groups were the least likely to live in owner occupied homes and the most likely to rent privately.
- Those aged 35-44 were the most likely to be economically active.
- Those aged 75 or over were the least likely to use the internet. Among those who did use the internet, those aged 35-54 were the most likely to use it for health-related reasons. Women were more likely than men to use the internet for health-related reasons.

Differences by Deprivation

Those in the most deprived areas were:

- more likely to live alone
- more likely to say they had no qualifications
- less likely to live in owner-occupied homes and more likely to live in socially rented homes
- less likely to use the internet.

Differences by Limiting Conditions

Those with a limiting condition or illness were:

- more likely to live alone and less likely to live with children
- more likely to say they had no qualifications
- more likely to live in socially rented homes
- less likely to be economically active
- less likely to use the internet.

APPENDIX A: SURVEY METHODOLOGY & RESPONSE

This Appendix has been prepared by BMG Research, who conducted the survey fieldwork. It details the collection of 10,346 interviews: Note this was subsequently reduced to 10,030 interviews as 316 could not be used due to missing age group and/or household size data. Appendix B details the profile of the 10,030 interviews in the final dataset.

Introduction

This technical report provides details of the methodology employed by BMG Research in the collection of the HWB 2022 data. A number of key response statistics will also be presented, such as response rates, quality checking outputs, interviewer metrics, and wave by wave interviewing numbers obtained.

All processes from sampling through to data collection and delivery were managed in-house at BMG Research.

Sampling

Introduction

All sampling was managed in-house at BMG Research, and the process that was adopted closely matched that used in previous years to ensure reliable comparisons could be made over time.

The overarching objective was to obtain a sample that is representative of each of the HSCP areas, particularly in terms of age, gender, economic status and deprivation. The targets per HSCP were also split into categories depending on the nature of the area and the type of boost it was defined as: including main sample, basic boost, neighbourhood boost and enhanced boost. The target grid is shown below, with an overall target of 10,335 interviews to achieve.

Table A1: Target number of interviews to achieve per HSCP

				Boosts Required Sample (+/- 4% MOE)				
	SAPE 2020	Main Sample *		Basic Boost	N'Hood Boost	Enhanced Boost		
HSCP	16 plus	15%	Others	All	All	MD **	Others	Total Sample
NE Glasgow	160765	190	201	207				598
Parkhead/Dalmarnock	8796				562			562
Garthamlock/Ruchazie	6720				552			552
NW Glasgow	184615	131	318	150				599
Ruchill & Possilpark	9637				566			566
South Glasgow	189782	156	305	138				599
Govanhill	122282				573			573
Greater Gorbals	8816				563			563
Glasgow City	535162	477	824	495	2816	0	0	4612
East Dunbartonshire	89250	8	208			505	389	1110
East Renfrewshire	76414	5	180			469	416	1070
Renfrewshire	149208	75	288			514	310	1187
Inverclyde	64647	55	103			530	489	1177
West Dunbartonshire	72856	53	124			532	470	1179
NHSGGC Total *	987537	673	1727	495	2816	2550	2074	10335

** MD = most deprived 15% (20% in East Dunbartonshire & East Renfrewshire)

Sampling process

NHSGGC provided BMG Research with a datazone definition file that identified the key criteria of each datazone within the study area, including SIMD 2020, HSCP, neighbourhood etc. Datazones formed the sampling points within each area, with their selection based on a stratification by SIMD within each of the target areas to ensure a representative datazone selection by deprivation. The postcode address file (PAF) was then used to randomly select 30 addresses per datazone to form the sampling frame, with a target of 10 interviews to achieve per datazone.

It was found that during this process, a number of target areas (for example, all the neighbourhood boosts and some of the enhanced boosts) did not have sufficient datazones to achieve the target using the principle of '30 addresses sampled to achieve 10 interviews'. In these instances, we increased the number of sample points within each datazone to achieve the sample, but at all times only 3 times the number of addresses were supplied to achieve the target, thus ensuring the response rates were protected and consistent.

Therefore, in summary:

1,033 datazones/sample points were sampled in total.

30,969 addresses were sampled in total across these datazones.

Each address received a pre-survey letter in the post prior to being approached for interview, which gave the household the opportunity to 'opt out', and responding households were left with an information leaflet on completion of the interview.

The next birthday rule was utilised to ensure the random selection of respondent per household.

The datazones were allocated to one of six 'survey waves' which ensured a broad spread of interviews. The resulting number of achieved interviews per HSCP per wave is shown in the table below. In total 3,605 interviews were undertaken during 2022.

Table A2: Number of interviews achieved per HSCP per wave

HSCP	Wave 1 inc pilot (09/22 & 10/22)	Wave 2 (10/22 – 12/22)	Wave 3 (12/22 – 02/23)	Wave 4 (02/23 – 03/23)	Wave 5 (03/23 – 04/23)	Wave 6 (04/23 – 05/23)	TOTAL
East Dunbartonshire	167	173	200	172	174	252	1138
East Renfrewshire	154	146	186	207	173	214	1080
Glasgow North East	248	232	328	331	313	256	1708
Glasgow North West	162	164	213	237	301	104	1181
Glasgow South	252	251	300	339	388	199	1729
Inverclyde	160	196	236	248	179	165	1184
Renfrewshire	170	186	213	226	197	193	1185
West Dunbartonshire	180	178	207	180	190	206	1141
TOTAL	1493	1526	1883	1940	1915	1589	10346

Fieldwork

Prior to fieldwork commencing, a pilot was conducted to test a number of aspects of the methodology, including sampling, questionnaire content/flow, CAPI script functionality, and contact management in terms of recording call outcomes at addresses. A total of 40 interviews were

conducted as part of the pilot, spread across HSCP and deprivation, as follows:

Table A3: Number of pilot interviews

HSCP	SIMD	No. of interviews
Glasgow North East – 15% SIMD	1	10
East Renfrewshire – Other	5	5
Glasgow North West – Other	4	10
Glasgow South – Other	3	6
Renfrewshire – Other	2	9

A total of 34 interviewers were briefed and worked on this project. The initial briefing session took place in September and was recorded for those who were unable to attend the initial briefing. The average number of interviews conducted per interviewer was 304. The interviews lasted an average of 24 minutes.

All interviewers were briefed that each address must be attempted up to six times before it is deemed exhausted. However, to effectively manage this, interviewers were briefed to make two attempts at an address at a weekend, two on a weekday after 5pm and two on a weekday before 5pm. This ensures the greatest opportunity for all resident groups to be captured, particularly those in work. The following table provides the breakdown of interviews achieved by time of day and weekday or weekend, and it can be seen that more than half of the interviews were completed at weekends or evenings.

Table A4: Number of achieved interviews by time of day and week

	No. of interviews	%
Weekday before 5pm	4751	46%
Weekday after 5pm	2900	28%
Weekend	2695	26%

Call outcomes and response rates

The following table provides a breakdown of the call outcomes and the resulting response rates by HSCP as well as at a total level. The response rate can be calculated as the number of interviews achieved from valid addresses issued (minus addresses found to be empty, businesses, derelict, or unable to locate), which is 40%, or as an adjusted response rate based on the number of achieved interviews where contact was actually made with the household, which is 69%.

Table A4: Call outcomes and response rates

	East Dunbartonshire HSCP	East Renfrewshire HSCP	Glasgow North East HSCP	Glasgow North West HSCP	Glasgow South HSCP	Inverclyde HSCP	Renfrewshire HSCP	West Dunbartonshire HSCP	TOTAL
Interview obtained	1138	1080	1708	1181	1729	1184	1185	1141	10346
Refused	264	288	535	396	363	431	339	404	3020
Opt out	488	354	288	264	371	425	390	446	3026
No reply	812	898	1322	899	1557	594	949	782	7813
Call back/appointment	122	141	117	71	202	67	96	79	895
Physically or mentally unable to complete interview	11	9	19	2	6	20	6	15	88
Away at hospital during survey period	6	4	18	17	8	25	0	32	110
Language issues	7	3	15	10	30	4	5	2	76
Contact exhausted	149	1	15	59	2	106	19	159	510
Non-valid contacts									
Non-residential address/institution/holiday home	33	10	64	12	19	17	13	31	199
Empty/derelict/under construction	35	15	37	36	147	136	40	57	503
Not attempted because target achieved	259	417	987	555	783	481	485	354	4321
Unable to locate address	0	5	5	8	3	20	13	8	62

Quality checking overview

In total, 1831 of the 10,346 cases were back checked (654 via telephone and 1177 online). The back checking procedure involves, predominantly, telephoning or emailing respondents to check the validity and conduct of the interview. The following types of information are checked with respondents:

Name and address.

Conduct of the interviewer (politeness, showed ID badge, whether the interviewer tried to influence the answers).

Other details concerning the interview (were showcards used, was the interview conducted in home or at the doorstep, was a leaflet left behind).

Four pieces of information provided by the respondent during the interview are re-checked for consistency. These were age, household tenure, employment status and whether they were asked to self-complete part of the survey.

In addition to these checks random GPS checks were also undertaken as well as checks on interview timings/length for additional verification.

Online Survey

This year the face-to-face survey asked if respondents would be willing to complete an online follow up survey to gather some further information. Email addresses were collected for those willing and an online survey invitation was sent via email followed by two reminders for those who had not completed.

Those aged 18 plus who completed the follow up online survey were entered in to a prize draw to win one of four £250 Love2Shop vouchers.

In total, 2647 respondents were invited to take part in the online follow up survey and 1196 responded giving an overall response rate of 45%.

Table A6: Online follow up survey response rates

	No. of invites sent	No. of responses	Response Rate
East Dunbartonshire	413	205	50%
East Renfrewshire	259	140	54%
Glasgow North East	260	92	35%
Glasgow North West	197	85	43%
Glasgow South	404	175	43%
Inverclyde	392	187	48%
Renfrewshire	370	150	41%
West Dunbartonshire	352	162	46%
TOTAL	2647	1196	45%

APPENDIX B: COMPARISON WITH PREVIOUS HEALTH AND WELLBEING SURVEYS, and KEY CHANGES TO THE SURVEY METHODOLOGY

Comparison with previous health and wellbeing surveys

The 2022/23 survey was affected by the following factors:

- It was delayed for two years due to the COVID pandemic.
- Staffing of the survey proved difficult as a result of the new context in which it was operating, and the fieldwork was therefore conducted over a longer period of time than previous surveys (from September 2022 to May 2023).
- The longer survey period, with responses being collected during the spring season for the first time, means that there will likely be some impact of seasonality when comparing responses.
- It should also be considered that societal and economic factors changed during the period of data collection which may affect survey responses. For example:
    - The beginning of the survey period was closer in time to the isolating effects of COVID restrictions which were in place until spring 2022.
    - The rising cost of living, including surges in the cost of energy and food, continued apace throughout the survey period and therefore the impact is likely to have been more keenly felt among those interviewed towards the end of the survey period.

Key changes to the survey methodology in 2022/23

A number of changes were introduced in the 2022/23 Health and Wellbeing Survey. The key changes implemented include:

- Increased sample size to cover all geographies in GGC allowing for analysis at HSCP level for Glasgow City, East Dunbartonshire, Renfrewshire, Inverclyde, West Dunbartonshire and East Renfrewshire.
- New questions introduced asked about 'effects of COVID on Health and Wellbeing', fuel poverty, internet use and 'Everyday Discrimination' scale.

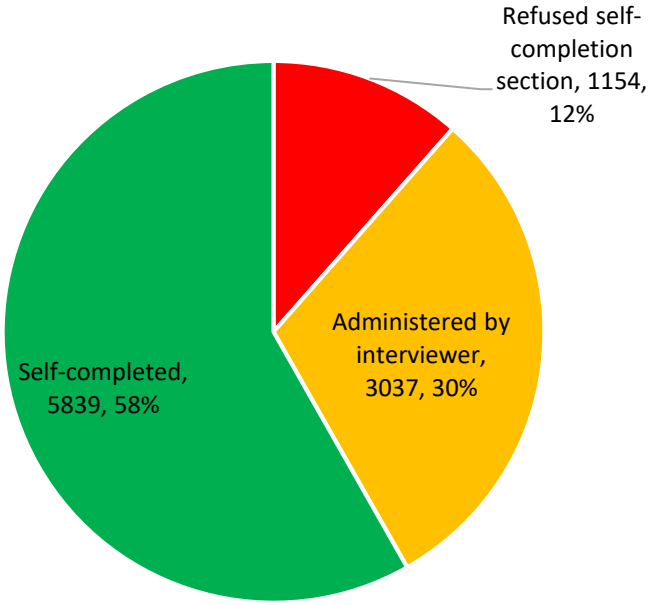
- An online survey component completed by a subset of respondents asking about mental health, dental health, diet, drugs and sexual health.

- A self-completion section asking about mental wellbeing, discrimination, domestic abuse, sexual orientation and the option to undertake the online survey.

Limitations of Self-Completion Component

All respondents were invited to participate in the self-completion section (see Section G of the main questionnaire, Appendix F). When considering the findings from the questions in this section, it should be noted that one in eight (N=1,154; 12%) respondents **refused** to answer the self-completion section and three in ten (N=3,037; 30%) respondents did not self-complete the section, but it was **administered by the interviewer**. Thus, only 58% self-completed the section. This is illustrated in Figure B1.

Figure B1: Responses to the Self-Completion Section of the Main Questionnaire



The high refusal rate and the large number of respondents answering the personal/sensitive questions directly to the interviewer may impact the reliability of these findings. Also, as the Table C2 in Appendix C shows, the proportion of respondents who responded and self-completed the section varied by age, deprivation group, limiting conditions and HSCP area.

APPENDIX C: DATA WEIGHTING AND SAMPLE PROFILE

Introduction

Data were weighted to ensure that they were as representative as possible of the adult population in the NHSGGC area. This appendix describes the weighting processes.

Household Size Weighting

In this survey, households were selected at random and therefore had equal probability of selection. However within the household the probability of an individual's selection is not necessarily equal to that of others, since it is inversely proportional to the number of people available to be selected. For example, in a single-person household the probability of selection is exactly 1 whereas in a four-person household the probability of selection is 1/4. The logic of this implies that the respondent from the single-person household represents one person (him/herself) while the respondent from the four-person household is in fact representing four people. It is normal to allow for this bias by 'weighting' the sample to give the respondent from the four-person household four times the 'weight' of the respondent from the one-person household. It is usual to calculate this weighting in such a way that the sum of the weights matches the sample size.

The formula for calculating the household size weight was:

$$Wf = F \times \frac{T}{A}$$

Where:

- *Wf* is the household size weighting factor for a respondent living in a household size F.
- *F* is the household size
- *T* is the total number of respondents
- *A* is the total number of adults in all households where a successful interview took place.

Weighting by Age/Gender/Bottom 15%/HSCP or Neighbourhood

Firstly the household size weighting was applied to the dataset. This produced the new 'actual' counts to which we applied the age/sex/bottom15%[9]/HSCP or Neighbourhood weighting frame to produce the final weighting factors. This ensured that the weighted data would reflect the overall Greater Glasgow and Clyde population in terms of age, gender, bottom 15%/other areas and

[9] Bottom 20% in the case of East Dunbartonshire and East Renfrewshire

HSCP areas (or neighbourhoods in the case of Glasgow City). The formula for this stage of the weighting process was:

$$Wi = \frac{ci}{C} \times \frac{T}{ti}$$

Where:

W_i is the individual weighting factor for a respondent in age/gender/bottom15% versus other areas/HSCP or neighbourhood group i

c_i is the known population in age/gender/bottom15% versus other areas/HSCP or neighbourhood group i

C is the total adult population in the NHS Greater Glasgow and Clyde area

T is the total number of interviews

t_i is the number of interviews (weighted by the household size weighting factor) for age/gender/bottom15% versus other areas/HSCP or neighbourhood group i

The 'known population' came from the Small Area Population Estimates (SAPE) provided by National Records of Scotland. SAPE records population by binary gender only, while the survey asked for self-identified gender, including the option to identify in other ways to male or female or to not disclose gender identity. Of the 10,030 respondents, there were 20 who did not give a binary identity (11 gave a non-binary identity and 9 preferred not to say). For the purposes of weighting only, they were randomly assigned male and female to allow weighting to be applied on the basis of age, deprivation group and HSCP/neighbourhood).

The application of the household weighting factor was multiplied by the individual weighting factor to provide the main weighting factor which was applied for all analysis of the main survey questions.

The unweighted and weighted sample profiles are shown in Table C1. This shows how the weighting process returned the profile to match the Small Area Population Estimates for 2020 in terms of gender, age, deprivation and HSCP/Neighbourhood for the main questionnaire.

Table C2 shows the differing levels of self-completion of the 'self-completion' section of the questionnaire.

Table C1: Main questionnaire sample before and after weighting, and Small Area Population Estimates (SAPE) comparison

	Sample Before Weighting N	Sample Before Weighting %	Sample After Weighting N	Sample After Weighting %	SAPE 2020 N	SAPE 2020 %
Male	4,634	46.2%	4,829	48.3%	475,238	48.1%
Female	5,375	53.6%	5,173	51.7%	512,299	51.9%
Other/no answer	21	0.2%	28	0.3%	N/A	N/A
16-24	674	6.7%	1,341	13.4%	132,368	13.4%
25-34	1,775	17.7%	1,999	19.9%	195,380	19.8%
35-44	1,765	17.6%	1,560	15.6%	153,625	15.6%
45-54	1,476	14.7%	1,558	15.5%	153,502	15.5%
55-64	1,685	16.8%	1,569	15.6%	155,349	15.7%
65-74	1,488	14.8%	1,102	11.0%	108,323	11.0%
75+	1,167	11.6%	901	9.0%	88,990	9.0%
Bottom 15% (or 20% in East Dun and East Ren)	5,128	51.1%	2,820	28.1%	276,573	28.0%
Other Areas	4,902	48.9%	7,210	71.9%	710,964	72.0%
East Dunbartonshire	1,088	10.8%	907	9.0%	89,250	9.0%
East Renfrewshire	1,058	10.5%	778	7.8%	76,414	7.7%
Glasgow NE	1,669	16.6%	1,633	16.3%	160,765	16.2%
Glasgow NW	1,171	11.7%	1,875	18.7%	184,615	18.7%
Glasgow South	1,678	16.7%	1,919	19.1%	189,782	19.2%
Inverclyde	1,138	11.3%	659	6.6%	64,647	6.6%
Renfrewshire	1,144	11.4%	1,518	15.1%	149,208	15.1%
West Dunbartonshire	1,084	10.8%	742	7.4%	72,856	7.4%

Table C2: Profile of responses to the self-completion section of the main questionnaire by age, deprivation, limiting conditions and HSPC (UNWEIGHTED DATA)

	Refused		Interviewer-Administered		Self-completed	
	N	%	N	%	N	%
16-24	42	6.2%	113	16.8%	519	77.0%
25-34	150	8.5%	267	15.0%	1,358	76.5%
35-44	191	10.8%	319	18.1%	1,255	71.1%
45-54	172	11.7%	370	25.1%	934	63.3%
55-64	207	12.3%	608	36.1%	870	51.6%
65-74	176	11.8%	662	44.5%	650	43.7%
75+	216	18.5%	698	59.8%	253	21.7%
Bottom 15% (or 20% in East Dun and East Ren)	588	11.5%	1,758	34.3%	2,782	54.3%
Other Areas	566	11.5%	1,279	26.1%	6,057	62.4%
Limiting condition	468	11.9%	1,572	40.1%	1,877	47.9%
No limiting condition	682	11.2%	1,462	24.0%	3,952	64.8%
East Dunbartonshire	144	13.2%	310	28.5%	634	58.3%
East Renfrewshire	102	9.6%	340	32.1%	616	58.2%
Glasgow NE	309	18.5%	521	31.2%	839	50.3%
Glasgow NW	86	7.3%	387	33.0%	698	59.6%
Glasgow South	139	8.3%	440	26.2%	1,099	65.5%
Inverclyde	147	12.9%	418	36.7%	573	50.4%
Renfrewshire	108	9.4%	246	21.5%	790	69.1%
West Dunbartonshire	119	11.0%	375	34.6%	590	54.4%
All	1,154	11.5%	3,037	30.3%	5,839	58.2%

APPENDIX D: INDEPENDENT VARIABLES

The table below lists the independent variables used for the analysis in this report, showing for each the number of categories and how these categories were formed.

Independent Variable	Number of categories	Categories
Gender	2	Male; Female
Age	6	16-34; 25-34; 35-44; 45-54; 55-64; 65-74; 75+
Age/Gender	6	Male 16-44; Female 16-44; Male 45-64; Female 45-64; Male 65+; Female 65+
Deprivation	2	20% most deprived datazones; other datazones
Limiting Conditions	2	Has a long-term limiting condition or illness; does not have a long-term limiting condition or illness

APPENDIX E: ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT) SCORING

AUDIT is a comprehensive 10 question alcohol harm screening tool. It was developed by the World Health Organisation (WHO) and modified for use in the UK and has been used in a variety of health and social care settings.

	Scoring system					
Questions	**0**	**1**	**2**	**3**	**4**	**Your score**
How often do you have a drink containing alcohol	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

- 0 to 7 indicates low risk
- 8 to 15 indicates increasing risk
- 16 to 19 indicates higher risk
- 20 or more indicates possible dependence

APPENDIX F: MAIN SURVEY QUESTIONNAIRE

NHSGGC Health & Wellbeing Survey 2022
Main Questionnaire

Survey introductions

CAPI INTRO [TO BE UPDATED]

Good morning/ afternoon, my name is … and I'm from BMG Research. BMG Research is an independent research company who work to the Market Research Society (MRS) code of conduct. We are carrying out research on behalf of the NHS Greater Glasgow and Clyde. The survey is about your health including issues such as diet, exercise and the area you live in and is a follow up to a similar study conducted in 2017.

The survey will take around 30 minutes to complete. [book appointment if not convenient now].

BMG Research will only use your details for the purpose of this survey, and for quality checking the interviews, unless your permission is otherwise sought.

The anonymised findings from the survey may be published. The data will only be used for the purposes specified and in terms of the Data Protection Act 1998. Please note that no individual will be identified through the data and findings from the survey, unless your permission is otherwise sought.

Just to confirm, your responses will be treated in the strictest confidence. BMG Research abides by the Market Research Society Code of Conduct and data protection laws at all times. Please note consent is audio recorded.

You can find out more information about our surveys and what we do with the information we collect in our Privacy Notice which is on our website.

I can give you the website address (https://www.bmgresearch.co.uk/privacy).

Ensure calling card provided if request more detail about BMG including about privacy notice

INTERVIEWER: Confirm respondent happy to proceed with the survey

✓ Informed consent provided **[TICK BOX, DO NOT ALLOW TO PROCEED WITHOUT TICKED]**

Section A: PERCEPTIONS OF HEALTH & ILLNESS

INTRO TEXT

I'd like to start by asking you some questions about your health.

Base: All respondents

SINGLE CODE

A01. How would you describe your health?

Please use showcard 1 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Very good		
2	Good		
3	Fair		
4	Bad		
5	Very bad		
97	Don't know	FIX, EXCLUSIVE	

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

A02. Looking at the faces on the card...?

Please use showcard 2 (with faces on) and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Which face best rates your overall quality of life?		
2	Which face best rates your general physical well-being?		
3	Which face best rates your general mental or emotional well-being?		

Column code	Column list	Scripting notes	Routing
1	1		
2	2		
3	3		

4	4		
5	5		
6	6		
7	7		
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE RESPONSE

A03. Do you feel in control of decisions that affect your life, such as planning your budget, moving house or changing job?

Read out and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Definitely		
2	To some extent		
3	No		
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE RESPONSE

A04. Do you have any long-term condition or illness that substantially interferes with your day-to-day activities?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		**GO TO A05**
2	No		
98	Prefer not to say		

ASK IF YES (CODE 1) AT A04 = YES

MULTICODE

A05. Thinking of these conditions and/or illnesses, would you describe yourself as having…?

Read out and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	A physical disability		
2	A mental or emotional health problem		
3	A long-term illness		
97	Don't know	FIX, EXCLUSIVE	

All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 30

A06. How many illnesses or conditions are you currently being treated for?

Please use showcard 3 (with list of illnesses/conditions) and type response in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
98	Prefer not to say	FIX, EXCLUSIVE	

Base: All respondents

SINGLE RESPONSE

A07. How would you describe the current state of the health of your mouth and teeth?

Please use showcard 4 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I feel my mouth and teeth are in good health		
2	I feel my mouth and teeth have some problems that need to be fixed		
3	I feel my mouth and teeth are in a poor state		
98	Prefer not to say		

Base: All respondents

MULTICODE

A08. Which of the following services have you attended with a dental problem in the last two years?

Please use showcard 5 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	High street dental practice		
2	Out of Hours/Emergency dental service		
3	Accident and Emergency Department		
4	Medical GP		
5	Pharmacist		
6	No services required	FIX, EXCLUSIVE	
97	Don't know	FIX, EXCLUSIVE	

INTRO TEXT

There is strong recent evidence and support from UK Chief Medical Officers that adding fluoride to water supplies will help reduce tooth decay. This question is only intended to explore your attitude towards this. The issue would be subject to formal public consultation before any future decisions were taken

Base: All respondents

SINGLE CODE

Please use showcard 6 and select one only

A09. Do you agree or disagree with the following statement: I am open to the possibility of water fluoridation in my local area?

Column code	Column list	Scripting notes	Routing
1	Agree		
2	Neither agree nor disagree		
3	Disagree		
4	Unsure/I don't know what water fluoridation is		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

A10. How has the following changed for you due to the COVID pandemic?

Please use showcard 7 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Quality of life		

2	General physical well- being		
3	General mental or emotional well-being		
4	Feel in control of decisions that affect your life		
5	Physical Disability		
6	Mental or emotional health problem		
7	Long-term illness		

Column code	Column list	Scripting notes	Routing
1	Improved a lot		
2	Improved a little		
3	Much the same		
4	Deteriorated a little		
5	Deteriorated a lot		
6	Changed, however, not due to Covid pandemic		
97	Don't know	**FIX, EXCLUSIVE**	

Section B: HEALTH BEHAVIOURS

INTRO TEXT

Now I would like to ask you some questions about your lifestyle.

Base: All respondents

MULTICODE

B01. Are you exposed to other people's tobacco smoke in any of these places?

Please use showcard 8 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	At own home		
2	At work		
3	In other people's homes		
4	In cars, vans etc		

5	Outside of buildings (e.g., pubs, shops, hospitals)		
6	In other public places		
7	No, none of these	**FIX, EXCLUSIVE**	
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE CODE

Please use showcard 9 and select one only

B02. How often are you in places where there is smoke from other people smoking tobacco?

Column code	Column list	Scripting notes	Routing
1	Most of the time		
2	Some of the time		
3	Seldom		
4	Never		
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE CODE

B03. Which of the following statements best describes you at present?

Please note, when answering this question please **DO NOT** include cigarettes without tobacco or electronic cigarettes/VAPES.

Please use showcard 10 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I have never smoked tobacco		
2	I have only tried smoking once or twice		
3	I have given up smoking		
4	I smoke some days		**GO TO B04**
5	I smoke every day		**GO TO B04**
98	Prefer not to say		

Base: Those who smoke some days or every day (code 4 or 5) at B03

SINGLE CODE

B04. Which of the following statements best describes you?

Please use showcard 11 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I REALLY want to stop smoking and intend to in the next month		
2	I REALLY want to stop smoking and intend to in the next 3 months		
3	I want to stop smoking and hope to soon		
4	I REALLY want to stop smoking but I don't know when I will		
5	I want to stop smoking but haven't thought about when		
6	I'm thinking I should stop smoking but don't really want to		
7	I don't want to stop smoking		
98	Prefer not to say		

Base: All respondents

SINGLE CODE

B05. Have you used an electronic cigarette or VAPES in the last year?

Please use showcard 12 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes – every day		
2	Yes – some days		
3	Once or twice		
4	No		
98	Prefer not to say		

https://patient.info/doctor/alcohol-use-disorders-identification-test-audit

INTRO TEXT

Now I am going to ask you some questions about your use of alcoholic drinks during the past year.

Base: All respondents

SINGLE CODE

B06. How often do you have a drink containing alcohol?

Please use showcard 13 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Never		
2	Monthly or less		**GO TO B07**
3	2-4 times per month (this includes once a week)		**GO TO B07**
4	2-3 times per week		**GO TO B07**
5	4+ times per week		**GO TO B07**
98	Prefer not to say		

ASK IF B06 = 2 TO 5

SINGLE CODE

B07. How many units of alcohol do you drink on a typical day when you are drinking?

Please use showcard 14 (which includes details of units) and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	0-2		
2	3-4		
3	5-6		
4	7-9		
5	10 or more		
98	Prefer not to say		

ASK IF B06 = 2 TO 5

GRID, SINGLE RESPONSE PER ROW

B08. How often in the last year has the following happened?

Please use showcard 15 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Had 6 or more units if female, or 8 or more if male, on a single occasion		
2	You have found that you were not able to stop drinking once you had started		

3	You have failed to do what was normally expected from you because of your drinking		
4	You have needed an alcoholic drink in the morning to get yourself going after a heavy drinking session		
5	You have had a feeling of guilt or remorse after drinking		
6	You have been unable to remember what happened the night before because you had been drinking		

Column code	Column list	Scripting notes	Routing
1	Never		
2	Less than monthly		
3	Monthly		
4	Weekly		
5	Daily or almost daily		
98	Prefer not to say		

IF B06 = 2 TO 5

SINGLE RESPONSE

B09. Have you or somebody else been injured as a result of your drinking?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	No		
2	Yes, but not in the last year		
3	Yes, during the last year		
98	Prefer not to say		

ASK IF B06 = 2 TO 5

SINGLE RESPONSE

B10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	No		
2	Yes, but not in the last year		
3	Yes, during the last year		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

B11A. Thinking about the number of places you can buy alcohol in your local area from off-licences, local grocers and supermarkets, in your opinion are there...?

Read out and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	The right amount		
2	Too many		
3	Too few		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

B11B. Now thinking about the number of places you can buy alcohol in your local area from pubs, bars and restaurants, in your opinion are there...?

Read out and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	The right amount		
2	Too many		
3	Too few		
97	Don't know		

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 30

B12. Now I'd like to ask you some questions about the food you eat. Yesterday, how many portions of fruit did you eat? Examples of a portion are one apple, one tomato, 3 tablespoons of canned fruit, one small glass of fruit juice.

Please record number in the box below if less than one, write '0'

[_____]

Fixed codes	Answer list	Scripting notes	Routing
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 30

B13. Yesterday, how many portions of vegetables or salad (not counting potatoes) did you eat? A portion of vegetables is 3 tablespoons.

Please record number in the box below if less than one, write '0'

[_____]

Fixed codes	Answer list	Scripting notes	Routing
97	Don't know	**FIX, EXCLUSIVE**	

INTRO TEXT

The next questions look at how active you are.

The next question is about the type of physical activity that increases your heart rate, makes you feel warmer and makes you breathe a little faster. This may include walking or cycling for recreation or to get to and from places; gardening; and exercise or sport.

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 7

B14. How many days in the past week have you been physically active for a total of 30 minutes or more?

Please use showcard 16

The types of activity included for this question are activities that increase your heart rate, make you feel warmer and make you breathe a little faster. This may include walking or cycling for recreation or to get to and from places; gardening; and exercise or sport. The 30 minutes can be obtained by adding smaller bouts of not less than 10 minutes.

Remember vigorous activity such as running counts for double. If the person is unable to sing, or needing to take breaths between words, they are likely to be doing vigorous physical activity. Every minute of vigorous activity equals 2 minutes of moderate activity.

Please record number in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
97	Don't know	**FIX, EXCLUSIVE**	

Base: Those active for four days or less at B14 (0 to 4)

SINGLE RESPONSE

B15. Have you been physically active for at least two and a half hours (150 minutes) over the course of the past week?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 7

B16. In the past week, on how many days have you done strength and balance physical activities that make your muscles become warm, shake and/or burn? This includes weight training; exercise; sport; heavy housework; DIY or gardening.

Please use showcard 17 (which shows examples)

Showcard list
Weight training (e.g., free weights, weight machines or resistance bands)
Bodyweight exercises (e.g., press-ups, sit-ups)
Yoga/Pilates/Gymnastics/Stretching sessions
Impact sports (e.g., Football/Rugby/Badminton/Tennis/Squash)
Heavy manual work (e.g., digging/moving heavy loads)

Gardening (e.g., mowing/digging/planting)
Heavy housework (e.g., moving heavy furniture/walking with heavy shopping)

Please record number in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
97	Don't know	**FIX, EXCLUSIVE**	

INTRO TEXT

The next question is about the impact COVID-19 has had on your Physical Activity Levels.

Base: All respondents

SINGLE RESPONSE

B17. Since the COVID-19 pandemic started in March 2020, which of the following statements best describes your physical activity levels?

Please use showcard 18 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Physically active more often		
2	Physically active less often		
3	No change to physical activity		

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC

B18. On an average day, in the last seven days, how long did you spend sitting, reclining or lying down?

Please estimate the time on an average (normal) day in the last seven days. We realise this will vary over the week, but try to give an estimate. We are interested in your sedentary behaviour, which is any time you spend sitting, reclining and lying down. This may include time spent sitting at a desk, sitting in a motor vehicle, reading, playing video games, sitting or lying down to watch television (please don't count the time asleep).

Please type your response in the box below HOURS/MINUTES

[_____

Section C: SOCIAL HEALTH

Base: All respondents

SINGLE RESPONSE

C01. Do you ever feel isolated from family and friends?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		**GO TO C03**

Base: Those who answered Yes or No to C01

SINGLE RESPONSE

C02. Has this changed due to the COVID pandemic?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes, changed for the better		
2	Yes, changed for the worse		
3	No change		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

C03. How often have you felt lonely in the past two weeks?

Please use Showcard 19 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	All of the time		
2	Often		
3	Some of the time		
4	Rarely		
5	Never		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

C04. Compared to before the COVID pandemic which started in March 2020 how lonely have you felt?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	More lonely		
2	Same as before		
3	Less lonely		
4	Never felt lonely		
98	Prefer not to say		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

C05. How much do you agree or disagree with the following statements about living in this local area?

Please use showcard 20 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	I feel I belong to this local area		
2	I feel valued as a member of my community		
3	By working together, people in my neighbourhood can influence decisions that affect my neighbourhood		

Column code	Column list	Scripting notes	Routing
1	Strongly agree		
2	Agree		
3	Neither agree nor disagree		
4	Disagree		
5	Strongly disagree		
97	Don't know	**FIX, EXCLUSIVE**	

BASE: ALL RESPONDENTS

GRID, SINGLE RESPONSE PER ROW

C06. Please look at the card I've given you and tell me what you think of the quality of services in your area

Please use showcard 21 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Food shops		
2	Local schools		
3	Public transport		
4	Activities for young people		
5	Leisure / sports facilities		
6	Childcare provision		
7	Police		
8	GP/Doctor		
9	Out of hours medical service		
10	Nurse Led clinics such as asthma clinic, flu vaccination, child healthcare		

Column code	Column list	Scripting notes	Routing
1	Excellent		
2	Good		
3	Adequate/Ok		
4	Poor		
5	Very poor		
97	Don't Know		

BASE: ALL RESPONDENTS

SINGLE RESPONSE PER ROW

C07. Could you tell me if you have been a victim of each of these crimes in the last year? Just to reiterate, your responses to this survey will remain confidential unless your permission is explicitly given.

Please use showcard 22 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Anti-social behaviour		
2	Any type of theft or burglary		
3	Vandalism		
4	Physical attack		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		
98	Refused		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

C08. How much do you agree or disagree with the following statements about safety in this local area?

Please use showcard 23 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	I feel safe using public transport in this local area		
2	I feel safe walking alone around this local area even after dark		

Column code	Column list	Scripting notes	Routing
1	Strongly agree		
2	Agree		

3	Neither agree nor disagree		
4	Disagree		
5	Strongly disagree		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

C09. Do you look after, or give any regular help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability, or problems related to old age?

Exclude any caring that is done as part of any paid employment or formal volunteering.

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Section D: Social Capital

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

D01. How much do you agree or disagree with the following statements about living in this local area?

Please use showcard 23 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	This is a neighbourhood where neighbours look out for each other		
2	Generally speaking, I can trust people in my local area		
3	The friendships and associations I have with other people in my local area mean a lot to me		
4	If I have a problem, there is always someone to help me		

Column code	Column list	Scripting notes	Routing
1	Strongly agree		
2	Agree		
3	Neither agree nor disagree		
4	Disagree		
5	Strongly disagree		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

D02. Thinking back over the last 12 months, have you given up any time to help any clubs, charities, campaigns or organisations in an unpaid capacity? (For example, helping out at schools, youth clubs, health and wellbeing charities, sport and exercise clubs, local community groups and faith-based organisations).

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Base: All respondents

SINGLE RESPONSE

D03. Thinking back over the last 12 months, have you given any voluntary unpaid help as an individual (not through a group or organisation) to help other people outside your family, or to support your local environment? (For example, keeping in touch with someone who is at risk of being lonely; helping a neighbour through shopping, collecting pension, household chores; or helping to improve your local environment e.g. litter picking but not as part of an organised activity)

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Base: All respondents

SINGLE RESPONSE

D04. Do you belong to any social clubs, associations, church groups or anything similar?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Base: All respondents

SINGLE RESPONSE

D05. In the last 12 months, have you taken any actions in an attempt to solve a problem affecting people in your local area? e.g., contacted any media, organisation, council, councillor MSP or MP; organised a petition.

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Section E: Financial Wellbeing

Base: All respondents

SINGLE RESPONSE

E01. What proportion of your household income comes from state benefits (e.g., Universal Credit, Carer's Allowance, Disability Living Allowance/Adult Disability Payment, Child Disability Payment, Best Start payments)?

Showcard 24 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	None		
2	Very little		
3	About a quarter		
4	About a half		
5	About three quarters		
6	All		
97	Don't know		

98	Prefer not to say		

E02. Thinking of the total income of your household, which face on the scale indicates how you feel about the adequacy of that income?

Please use Showcard 25 (with faces on) and select one answer only

Fixed codes	Answer list	Scripting notes	Routing
1	1 Happy		
2	2		
3	3		
4	4		
5	5		
6	6		
7	7 Unhappy		
97	Don't know	**FIX, EXCLUSIVE**	
98	Prefer not to say	**FIX, EXCLUSIVE**	

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

E03. How often, if at all, over the past year have you found it difficult to meet the cost of the following?

Please use showcard 26 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Rent/mortgage		
2	Gas, electricity and other fuel bills		
3	Telephone or mobile phone bill		
4	Broadband/internet data		
5	Council tax, insurance		
6	Food		
7	Clothes and shoes		
8	Transport		
9	Credit card payments		

10	Loan repayments		
11	Nursery/school activities		
12	Child care		
13	Treats		
14	Holidays		

Column code	Column list	Scripting notes	Routing
1	Very often		
2	Quite often		
3	Occasionally		
4	Never		
96	N/A – do not have that cost		
97	Don't know		
98	Prefer not to say		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

E04. How would your household be placed if you suddenly had to find a sum of money to meet an unexpected expense such as a repair or new washing machine? How much of a problem would it be if it was …

Please use showcard 27 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	£35		
2	£165		
3	£1,600		

Column code	Column list	Scripting notes	Routing
1	No problem		
2	A bit of a problem		
3	A big problem		

4	Impossible to find		
97	Don't know		

Base: All respondents

MULTICODE

E05. If you suddenly had to find a sum of money to meet an unexpected bill, where would you get the money from?

Please use showcard 28 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Savings		
2	Economising in other areas of expenditure		
3	Credit card/store card		
4	Cash Converter		
5	Payday loan company		
6	Bank loan		
7	Credit at store		
8	Buy now, pay later scheme' i.e. Clearpay, Klarna		
9	Doorstep Lender		
10	Friends/family		
95	Other (please specify) BACKCODE AND LIST		
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE RESPONSE

E06. In the last 6 months, for how many months have you had to use a source of credit (i.e., credit card) to cover essential living costs due to a lack of money that you may struggle to pay off?

Prompt if necessary: By essential living costs we mean things like household bills, food or fuel bills, school uniforms etc.

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	1 month		
2	2 months		

3	3 months		
4	More than 3 months		
5	None		
98	Prefer not to say		

Base: Those in receipt of benefits (E01 is not None)

GRID, SINGLE RESPONSE PER ROW

E07. In the last year have you experienced the following?

Select one per statement

Row Code	Row list	Scripting notes	Routing
1	Benefits Sanctions		
2	Delays in benefit payments		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		
98	Refused		

Base: Those in receipt of benefits (E01 is not None)

SINGLE RESPONSE

E08. Have you or your household been affected by benefit changes in the last 12 months (e.g., Universal Credit, Carer's Allowance, Disability Living Allowance/Adult Disability Payment, Child Disability Payment, Best Start payments)?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		**GO TO E09**
2	No		
97	Don't know		

ASK IF E08 CODE 1

SINGLE RESPONSE

E09. Is your household…?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Financially better off under benefit changes		
2	Financially worse off under benefit changes		
3	Made no difference		
97	Don't know		

Now I would like to ask you some questions about your food consumption in the last 12 months.

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

E10A. During the last 12 months was there a time when…?

Select one per statement

Row Code	Row list	Scripting notes	Routing
1	You were worried you would run out of food because of a lack of money or other resources?		
2	You were unable to eat healthy and nutritious food because of a lack of money or other resources?		
3	You ate only a few kinds of food because of a lack of money or other resources?		
4	You had to skip a meal because there was not enough money or other resources to get food?		
5	You ate less than you thought you should because of a lack of money or other resources?		
6	Your household ran out of food because of a lack of money or other resources?		
7	You were hungry but did not eat because there was not enough money or other resources for food?		

8	You went without eating for a whole day because of a lack of money or other resources?		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		
98	Prefer not to say		

We would now like to ask you some questions about your fuel consumption in the last 12 months.

Base : All respondents

SINGLE RESPONSE

E10B. How do you usually pay for your energy?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Pay by regular direct debit or standing order		
2	Pay on receive of a bill by cash/cheque/debit or credit card		
3	Have a pre-payment meter (i.e pay in advance by putting credit on a key, card or App)		
95	Pay in another way (please specify)		
97	Don't know		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

E10C. During the last 12 months was there a time when…?

Select one per statement

Row Code	Row list	Scripting notes	Routing
1	You were worried you would not be able to afford to use your gas and/or electricity at home?		

2	You had to make a choice between paying for gas and/or electricity for your home or other household bills or essentials?		
3	You were unable to work or study at home because you were worried about your gas and/or electricity use?		
4	You ate only a few kinds of food to reduce the amount of gas and/or electricity used?		
5	You skipped a meal because you did not want to use your gas and/or electricity?		
6	Your household had no gas and/or electricity for a period of time because you could not afford it?		
7	You did not heat your home when needed due to the cost and not being able to afford it?		
8	You did not use gas and/or electricity for a whole day due to the cost and not being able to afford it?		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

E11. What would you say is the main reason some people in this area live in poverty? In general terms, poverty is when the income available to an individual or household does not meet their needs. Poverty is not just about being able to heat a house or eat. It can mean that people are not able to participate in the routine activities expected in society. It can mean that people can't afford to buy birthday presents for their children or they can't afford to meet up with friends to socialise.

Please use showcard 29 and select one only

Fixed codes	Answer list	Scripting notes	Routing

1	An inevitable part of modern life		
2	Laziness or lack of willpower		
3	Because they have been unlucky		
4	Because of injustice in society		
5	Lack of jobs		
6	There is no one living in poverty in this area		
95	Other (please specify)	**ADD OPEN TEXT BOX**	
96	None of the above		
97	Don't know		

BASE: ALL RESPONDENTS

GRID, SINGLE RESPONSE PER ROW

E12. Have you spent money on any of the following in the last month?

Select one per statement

Row Code	Row list	Scripting notes	Routing
1	Tickets for the National Lottery, including Thunderball and Euromillions and tickets bought online		
2	Scratch cards (but not online or newspaper or magazine scratch cards)		
3	Bingo cards or tickets, including playing at a bingo hall (not online)		
4	Betting in a Bookmakers		
5	Casino		
6	Any online (internet) gambling (including bingo, poker etc)		
95	Any other gambling – please specify	**ADD TEXT BOX**	

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		

For the next set of questions about gambling, please indicate the extent to which each one has applied to you in the last 12 months.

ASK IF SPENT MONEY ON ANY ACTIVITIES AT E12 [Any code 1]. IF ONLY CODE 1 AT 'ANY LOTTERY/SCRATCHCARD', ROUTE TO E14

SINGLE RESPONSE

E13. When you gamble, how often do you go back another day to win back the money you lost?

Please use showcard 30 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Every time I lost		
2	Most of the time		
3	Some of the time (less than half the time I lost)		
4	Never		
98	Prefer not to say		

ASK IF SPENT MONEY ON ANY ACTIVITIES AT E12 [Any code 1].

GRID, SINGLE RESPONSE PER ROW

E14. In the last 12 months, how often...?

Please use showcard 31 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Have you needed to gamble with more and more money to get the excitement you are looking for?		
2	Have you felt restless or irritable when trying to cut down gambling?		
3	Have you gambled to escape from problems or when you are feeling depressed, anxious or bad about yourself?		
4	Have you made unsuccessful attempts to control, cut back or stop gambling?		
5	Have you risked or lost an important relationship, job, educational or work opportunity because of gambling?		

6	Have you asked others to provide money to help with a financial crisis caused by gambling?		

Column code	Column list	Scripting notes	Routing
1	Very often		
2	Fairly often		
3	Occasionally		
4	Never		
98	Prefer not to say		

Section F: INTERNET USE

Base: All respondents

MULTIPLE RESPONSE

F01. For which of the following do you use the Internet?

Please use showcard 32 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Accessing Universal Credit or other social security benefits		
2	Managing Mental Health		
3	Applying for jobs		
4	Managing physical health		
5	Online games		
6	Rating products/services		
7	Solely content for work		
8	Learning		
9	Accessing local council information		
10	Posting/sharing videos online		
11	Streaming/downloading media		
12	Social Media		

13	Using online messaging		
14	Buying products/services		
15	Online banking/money management		
16	Email		
95	Other (please specify)	**ADD TEXT BOX**	
96	Don't use the internet	**EXCLUSIVE**	**GO TO F03**

ASK IF CODES 1-16 OR 95 AT F01

MULTIPLE RESPONSE

F02. At any time, have you used the internet for?

Please use showcard 33 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Looking for health-related information (e.g. injury, disease, nutrition, improving health etc) (please note which sites are used or if search engine used)		
2	Making an appointment with a medical practitioner via a website or app		
3	Using other online health services via a website or app instead of having to go to the hospital or visit a doctor, for example getting a prescription or a consultation online		
4	Accessing personal health records online		
95	Other health-related use (please specify)		
96	Have not used the internet for any of the above		

Base: F01 = 96 Don't use the internet

MULTIPLE RESPONSE

F03. Which of the following statements apply to you if you were thinking about what would encourage you to improve your digital skills?

Please use showcard 34 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	I would if devices and Internet access were cheaper		

2	I would if it could help me progress in my job or secure a better role		
3	I would if I thought that it would directly help me with a day-to-day task or piece of work		
4	Nothing – I avoid adopting technology where I can	**EXCLUSIVE**	
5	I'm always interested in technology and will actively look to adopt it		
6	I would if I knew there was support available to help me as or when I needed it		
97	Don't know	**EXCLUSIVE**	

SECTION G : Self completion section

I am now going to hand over the survey to you, and I'd like you to complete the following questions yourself which ask about thoughts and feelings, whether certain things have happened to you and some other sensitive questions which are best completed by yourself due to their sensitive nature.

Interviewer record self completion outcome

Row Code	Row list	Scripting notes	Routing
1	Self completed by respondent	**PLEASE PASS TABLET TO RESPONDENT**	
2	Administered by interviewer		
3	Respondent refused to self complete and for interviewer to administer		**GO TO SECTION T**

Base: Those who are happy to self complete (self completion outcome = 1)

Before this, however, I would like you to do a quick task to get you used to the computer. This will require you to answer a simple question, getting you used to clicking the answer, and then moving to the next page.

SINGLE

GTEST. What is your favourite colour?

Please select one answer

Fixed codes	Answer list	Scripting notes	Routing
1	Red		
2	Blue		

3	Green		
4	Yellow		
5	Black		
6	White		
7	Pink		
8	Brown		
9	Grey		
10	Purple		
11	Orange		
12	Gold		
13	Silver		
95	Other		
97	Don't know		
98	Prefer not to say		

Some of the questions tell us more about you and helps us to make sure we have captured views from a cross section of people. We recognise that you might consider some of these questions to be personal or sensitive in which case you are free not to answer them.

Base: All respondents

GRID, SINGLE RESPONSE PER ROW, ROTATE

G01. Below are some statements about feelings and thoughts. Please select the box that best describes your experience of each over the last 2 weeks

Please select one answer per statement

Row Code	Row list	Scripting notes	Routing
1	I've been feeling optimistic about the future		
2	I've been feeling useful		
3	I've been feeling relaxed		
4	I've been interested in other people		
5	I've had energy to spare		
6	I've been dealing with problems well		
7	I've been thinking clearly		
8	I've been feeling good about myself		

9	I've been feeling close to other people		
10	I've been feeling confident		
11	I've been able to make up my own mind about things		
12	I've been feeling loved		
13	I've been interested in new things		
14	I've been feeling cheerful		

Column code	Column list	Scripting notes	Routing
1	None of the time		
2	Rarely		
3	Some of the time		
4	Often		
5	All of the time		
98	Prefer not to say		

BASE: ALL RESPONDENTS

GRID, SINGLE RESPONSE PER ROW, ROTATE

G02. In your day-to-day life, how often do any of the following things happen to you?

Please select one answer per statement

Row Code	Row list	Scripting notes	Routing
1	You are treated with less courtesy than other people are		
2	You are treated with less respect than other people are		
3	You receive poorer service than other people at restaurants or stores		
4	People act as if they think you are not smart		
5	People act as if they are afraid of you		
6	People act as if they think you are dishonest		

7	People act as if they're better than you are		
8	You are called names or insulted		
9	You are threatened or harassed		

Column code	Column list	Scripting notes	Routing
1	Almost everyday		
2	At least once a week		
3	A few times a month		
4	A few times a year		
5	Less than once a year		
6	Never		
98	Prefer not to say		

The Everyday Discrimination Scale.
https://scholar.harvard.edu/files/davidrwilliams/files/discrimination_resource_dec._2020.pdf

Base: Those who have said at least a few times a year or more to one of G02 (G02 = codes 1 to 4 to any)

MULTICODE, ROTATE

G03. What do you think are the main reasons for these experiences?

Please select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Your Ancestry or National Origins		
2	Your Gender		
3	Your Race		
4	Your Age		
5	Your Religion		
6	Your Height		
7	Your Weight		
8	Some other Aspect of Your Physical Appearance		
9	Your Sexual Orientation		
10	Your Education or Income Level		
11	A physical disability		
12	Your shade of skin colour		
95	Other (please specify)	**FIX, ADD OPEN TEXT BOX**	
97	Don't know	**FIX, EXCLUSIVE**	
98	Prefer not to say	**FIX, EXCLUSIVE**	

BASE: ALL RESPONDENTS

SINGLE RESPONSE

G04. Have you been a victim of domestic abuse in the last year? Just to reiterate, your responses to this survey will remain confidential unless your permission is explicitly given.

Please select one answer

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		

98	Prefer not to say		

BASE: ALL RESPONDENTS

SINGLE RESPONSE

G05. Do you consider yourself to be trans, or have a trans history?

Please select one only

Code	Answer list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

G06. Which of the following options best describes how you think of yourself?

Please select one only

Code	Answer list	Scripting notes	Routing
1	Heterosexual / Straight (attracted to opposite sex only)		
2	Gay (attracted to same sex only)		
3	Bisexual (attracted to same and opposite sex)		
95	Other		
98	Prefer not to say		

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC

G07. Please can you tell me your date of birth?

Please type your response in the box below DD/MM/YYYY

[_____]

Fixed codes	Answer list	Scripting notes	Routing

98	Prefer not to say	**FIX, EXCLUSIVE**	

Base: All respondents

OPEN RESPONSE

G08. NHS Greater Glasgow and Clyde would like to undertake a follow up online survey to this. This would involve collecting your email address for this purpose. The online survey would take around 10 minutes to complete and all those aged 18+ who complete this follow up survey have the opportunity to be entered in to a prize draw to win a £250 Love2Shop voucher.

Would you be interested in taking part and willing to provide your email address for this purpose?

Fixed codes	Answer list	Scripting notes	Routing
1	Yes	**COLLECT EMAIL ADDRESS**	
2	No		

Please type your email address in the box below

[_____]

Please retype your email address in the box below

[_____]

IF G08 = YES

Many thanks for your interest in taking part in this follow up survey and providing your email address. Please note you will be sent a link to an online survey via the email address provided within the next week from surveys@bmgresearch

Base: Those who are happy to self complete (self completion outcome = 1)

Thank you very much. Please pass the tablet back to the interviewer for the last section.

Closing demographics (Section T)

INTRO TEXT

The following questions tell us more about you and helps us to make sure we have captured views from a cross section of people. We recognise that you might consider some of these questions to be personal or sensitive in which case you are free not to answer them. The information you provide will be used to make sure NHS GGC understand the views of different groups of residents.

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP 20

T01. Now I'd like to ask you about the members of your household. How many people are there in this household (including yourself)?

Please record number in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
98	Prefer not to say	**FIX, EXCLUSIVE**	

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP 20 AND LESS THAN T01

T02. How many people living in your household are aged under 16?

Please record number in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
98	Prefer not to say	**FIX, EXCLUSIVE**	

BASE: ALL RESPONDENTS

SINGLE RESPONSE

T03. How do you describe your gender?

Please select one only

Code	Answer list	Scripting notes	Routing
1	Male		
2	Female		
3	Non-Binary		
95	Or do you describe yourself another way (Please specify)	**ADD OPEN TEXT BOX**	
98	Prefer not to say		

Base: Where do not want to provide exact age (G07 = 98)

SINGLE RESPONSE

T04. Would you mind indicating which age band you fit into?

Showcard 35 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	16-19		
2	20-24		
3	25-29		
4	30-34		
5	35-39		
6	40-44		
7	45-49		
8	50-54		
9	55-59		
10	60-64		
11	65-74		
12	75+		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

T05. Which of the following applies to your household?

Showcard 36 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Owner occupier / owned outright		
2	Owner occupier / buying with a mortgage		
3	Rented from council		
4	Rented from housing association		
5	Rented from a private landlord		
6	Shared ownership		
7	Accommodation comes with the job		
95	Other (please specify) BACKCODE AND LIST		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

T06. Which of the groups on this card best describes you?

Please use showcard 37 and select one only

Fixed codes	Answer list	Scripting notes	Routing
	White	**HEADING NOT CODE**	
1	Scottish		
2	Other British		
3	Irish		
4	Polish		
5	Gypsy/Traveller		
6	Roma		
7	Showman/showwoman		
8	Other White ethnic group, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	

	Mixed	**HEADING NOT CODE**	
9	Any mixed or multiple ethnic background, please specify LIST	**ADD A TEXT BOX**	
	Asian, Scottish Asian or British Asian	**HEADING NOT CODE**	
10	Pakistani, Scottish Pakistani or British Pakistani		
11	Indian, Scottish Indian or British Indian		
12	Bangladeshi, Scottish Bangladeshi or British Bangladeshi		
13	Chinese, Scottish Chinese or British Chinese		
14	Other, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
	African	**HEADING NOT CODE**	
15	African, Scottish African or British African		
16	Other, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
	Caribbean or Black	**HEADING NOT CODE**	
17	Caribbean, Scottish Caribbean or British Caribbean		
18	Other, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
	Other ethnic group	**HEADING NOT CODE**	
19	Arab, Scottish Arab or British Arab		
95	Other, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
97	Don't know		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

T07. Which of the following best describes your employment situation?

Showcard 38 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Employee in full-time job (35 or more hours per week)		

2	Employee in part-time job (less than 35 hours per week)		
3	Employed on a zero hours contract		
4	Self-employed – full or part time		
5	Government supported training or employment		
6	Unemployed and available for work		
7	Full-time education at school, college or university		
8	Part-time education at school, college or university		
9	Wholly retired from work		
10	Looking after the family/home		
11	Permanently sick/disabled		
95	Other, please specify BACKCODE AND LIST		
98	Refused		

Base: All respondents

SINGLE RESPONSE

T08. What is the highest level of educational qualifications you've obtained?

Please use showcard 39 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	School leaving certificate, National Qualification Access Unit		
2	'O' Grade, Standard Grade, GCSE, GCE O Level, CSE, National Qualification Access 3 Cluster, Intermediate 1 or 2 Senior Certificate or equivalent, National 4 or 5		
3	GNVQ/GSVQ Foundation or Intermediate, SVQ Level 1 or 2, SCOTVEC/National Certificate Module, City and Guilds Craft, RSA Diploma or equivalent		
4	Higher Grade, Advanced Higher, CSYS, 'A' Level, AS Level, Advanced Senior Certificate or equivalent		
5	GSVQ/GSVQ Advanced, SVQ Level 3, ONC, OND, Scotvec National Diploma, BTEC First Diploma, City and Guilds Advanced Craft, RSA Advanced Diploma or equivalent		

6	HNC, HND, SVQ Level 4, RSA Higher Diploma or equivalent		
7	First Degree, Higher Degree, SVQ Level 5		
8	Professional Qualifications e.g. teaching, accountancy		
9	Other school examinations not already mentioned		
95	Other post-school but pre-Higher education examinations/ Higher education qualifications not already mentioned, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
96	No qualifications		
98	Refused		

Base : Ask those that have provided DOB at G07

LINKING HEALTH RECORDS

T09.

- The National Health Service (NHS) maintains routine medical and other health records on all patients who use their services. These records include:
    - Inpatient and outpatient visits to hospital, length of stay and waiting time.
    - Information about specific medical conditions such as cancer, heart disease and diabetes.
    - Details about registration with a general practitioner, and when people pass away, the date and cause of their death.
- We would like to ask for your consent to link your NHS health records with your survey answers.
- To link this information we would need to send your name, address and date of birth to NHSGGC and the Information Services Division (ISD) of NHS Scotland so they can identify your health records.
- By linking this information with the interview data the research is more useful as we can look at how people's lifestyle and circumstances can have an impact on their future and use of hospital services.
- This information will be confidential and used for statistical and research purposes only. The information will not identify you so it cannot be used by anyone treating you as a patient.
- By checking this box you are only giving permission for the linking of this information to routine administrative data and nothing else.
- You can cancel this permission at any time in the future by contacting BMG Research on 0800 358 0337. You do not need to give a reason to cancel this.

By checking this box, I give consent to BMG Research to pass my name, address and date of birth to NHSGGC and the Information Services Division of NHS Scotland:

T10. May we have your permission to give NHS Greater Glasgow & Clyde or its partners your name and address so they can contact you in the future about similar research studies in relation to health and wellbeing? The partners are the Glasgow Centre for Population Health and the University of Glasgow. Should you agree, this follow-up research could take the form of a postal, telephone or face to face interview/questionnaire within the next 24 months.

Fixed codes	Answer list	Scripting notes	Routing
1	Yes, permission given		
2	No, permission not given		

THANK AND CLOSE

INSERT QC SECTION IE CAPTURE NAME AND NUMBER/EMAIL ADDRESS FOR BACKCHECKING

INTERVIEWER TO COMPLETE:

SINGLE RESPONSE

T17. Was the interview conducted in another language (other than English)?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	No		
2	Yes (specify language) …… LIST	**ADD TEXT BOX**	

APPENDIX G: ONLINE SURVEY QUESTIONNAIRE

Online survey invite

SUBJECT : NHS Greater Glasgow and Clyde would like your help with a follow-up health survey

Dear [INSERT NAME]

You recently completed a face-to face health survey on behalf of the NHS Greater Glasgow and Clyde. Firstly, thank you very much for completing that survey. NHS Greater Glasgow and Clyde would like to undertake a follow up survey to this. During the survey you agreed to do a follow up survey and provided your email address for this purpose.

Below is the link to the follow up online survey for you to complete. The survey should take around **10 minutes to complete.**

INSERT SURVEY LINK

Those who complete this follow up survey will have the opportunity to be entered in to a prize draw to win a £250 Love2Shop voucher. Further details along with terms and conditions can be found here [INSERT PRIZE DRAW LINK]

Just to confirm, your responses will be treated in the strictest confidence. BMG Research abides by the Market Research Society Code of Conduct and data protection laws at all times.

The survey can only be completed once and it is important that the person who completed the face-to-face survey completes the follow up so survey. We therefore ask that you do not pass this email or link on to anybody else.

Any queries about this survey please contact BMG Research on 0800 358 0337 or email healthandwellbeingsurvey@bmgresearch.com

Many thanks in advance,

BMG Research

Survey introduction

ONLINE INTRO

Many thanks for providing your details for this follow up survey which BMG Research are conducting on behalf of NHS Greater Glasgow and Clyde.

The survey will take around **10 minutes to complete** and builds on the survey you undertook recently face-to-face.

In order that we do not have to repeat questions that you have already been asked we will link the answers you provide to this survey to the survey you recently completed face-to-face.

Just to confirm, your responses will be treated in the strictest confidence. BMG Research abides by the Market Research Society Code of Conduct and data protection laws at all times.

You can find out more information about our surveys and what we do with the information we collect in our Privacy Notice which is here http://www.bmgresearch.co.uk/privacy

You can also find out more about NHS Greater Glasgow and Clyde and what they do with the results we provide to them via their Privacy Notice which is here https://www.nhsggc.org.uk/media/259281/nhsggc_gdpr_data_protection_notice-v4.pdf

Click **NEXT** to begin the survey

By clicking the **NEXT** button, you agree to participate in the survey and for BMG to process your results as outlined above.

Base: All respondents

SINGLE CODE

S01_A. This survey **requires** us to ask some questions that may be perceived as sensitive such as perceptions of health and illness, drug use, diet, sexual health and relationships and social health. Providing information in response to these questions is entirely voluntary and you may withdraw your consent at any time. Prefer not to say options are available for each question. The answers that you provide will be used only for market research analysis purposes.

Do we have your permission to ask you these questions?

Code	Answer list	Scripting notes	Routing
1	Yes		
2	No	**SCREENOUT**	

Section A: Perception of health and illness

INTRO TEXT

We would like to know if you have any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions shown simply by clicking on the answer which you think most closely applies to you. Remember that we want to know about present and recent complaints, not those you had in the past.

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

A01. Have you recently …

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	a) …been able to concentrate on whatever you're doing?		

Column code	Column list	Scripting notes	Routing
1	Better than usual		
2	Same as usual		
3	Less than usual		
4	Much less than usual		
98	Prefer not to say		

2	b) …lost much sleep over worry?		
5	e) …felt constantly under strain?		
6	f) …felt you couldn't overcome your difficulties?		
9	i) …been feeling unhappy and depressed?		
10	j) …been losing confidence in yourself?		
11	k) …been thinking of yourself as a worthless person?		

Column code	Column list	Scripting notes	Routing
1	Not at all		
2	No more than usual		
3	Rather more than usual		

4	Much more than usual		
98	Prefer not to say		

3	c) …felt that you are playing a useful part in things?		
4	d) …felt capable of making decisions about things?		
7	g) …been able to enjoy your normal day-to-day activities?		
8	h) …been able to face up to your problems?		
12	l) …been feeling reasonably happy, all things considered?		

Column code	Column list	Scripting notes	Routing
1	More so than usual		
2	Same as usual		
3	Less so than usual		
4	Much less than usual		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

A02. In the last two years, how many times have you had a problem with your teeth or mouth that has required you to seek the advice of a medical or dental professional?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Never		**GO TO B01**
2	Once		
3	Twice or more		
4	Had a problem however did not seek advice		
97	Don't know		
98	Prefer not to say		

Base: Those who said Once, Twice or more, or had a problem however did not seek advice at A02 (codes 2 to 4)

SINGLE RESPONSE

A03. In the last two years, how many times have you had to miss work or not attend a social occasion due to problems with your mouth or teeth?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Never		
2	Once		
3	Twice or more		
97	Don't know		
98	Prefer not to say		

Base: Those who said Once or Twice or more at A02 (codes 2 to 3)

SINGLE RESPONSE

A04. In the last two years, have you been able to get a dental appointment at your usual dentist when needed?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes, I had no problems arranging an appointment		
2	Yes, but I had to wait longer than I wanted to		
3	I was unable to get an appointment with my own dentist		
97	Don't know		
98	Prefer not to say		

Section B: Social Health

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

B01. Now some questions about things that may or may not be a problem in your local area. Which face best describes how you feel about…?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing

1	The level of unemployment in your area		
2	The amount of drug activity in your area		
3	The level of alcohol consumption in your area		
4	People being attacked or harrassed because of their skin colour, ethnic origin or religion		
5	The amount of troublesome neighbours in your area		

Column code	Column list	Scripting notes	Routing
1	Happy	**WILL NEED FACES SHOWN IN SCRIPT FOR 1 TO 7**	
2			
3			
4			
5			
6			
7	Unhappy		
8	Not a problem		
97	Don't know		
98	Prefer not to say		

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

B02. Now some questions about environmental issues that may or may not be a problem in your area. Which face best describes how you feel about…?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	The amount of rubbish lying about in your area		
2	The amount of dog's dirt in your area		
3	The availability of safe play spaces in your area		
4	The availability of pleasant places to walk in your area		

Column code	Column list	Scripting notes	Routing
1	Happy	**WILL NEED FACES SHOWN IN SCRIPT FOR 1 TO 7**	
2			
3			
4			
5			
6			
7	Unhappy		
97	Don't know		
98	Prefer not to say		

SECTION C: HEALTH BEHAVIOURS - DIET

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

C01. How often do you eat / drink the following?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	Lean meat such as poultry		
2	Fish and shellfish		
3	Wholegrains such as brown bread and pasta		
4	Nuts and seeds		
5	Low fat dairy or alternative such as milk, cheese and yoghurt		
6	Water and sugar free/diet drinks		
7	Pies, pastries, sausage rolls, chips		
8	Processed meat such as bacon, sausages and cold meats		
9	Cakes, sweets, chocolate, ice cream		
10	Savoury salted snacks such as Crisps, pretzels		
11	Sugary drinks (regular fizzy, energy drink, juice drinks)		
12	Takeaways (fast food, burgers, Indian, Chinese, pizza)		

13	Eating out in a café/ restaurant		
14	Eating from a food truck/van		
15	Homemade from fresh ingredients		
16	Readymade meals		
17	Food bank or food parcels		

Column code	Column list	Scripting notes	Routing
1	More than once a day		
2	Once a day		
3	At least weekly		
4	At least monthly		
5	A few times a year		
6	Less than once a year		
7	Never		
98	Prefer not to say		

Section D: Sexual health and relationships

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

D01. To the best of your recollection, when were you last tested for?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	HIV		
2	Hepatitis C		
3	Hepatitis B		

Column code	Column list	Scripting notes	Routing
1	Never		
2	More than 12 months ago		
3	In the last 12 months		
97	Don't know		

98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

D02. Which of these is true for you at the moment?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I am not currently in a sexual relationship		
2	I am currently in a sexual relationship with one person of the opposite sex		
3	I am currently in a sexual relationship with one person of the same sex		
4	I am currently in sexual relationships with more than one person of the opposite sex		
5	I am currently in sexual relationships with more than one person of the same sex		
6	I am currently in sexual relationship with more than one person of both sexes		
98	Prefer not to say		

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

D03. In the last year, have you been …?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	Humiliated or emotionally abused in other ways by a partner or ex-partner		
2	Afraid of a partner or ex-partner		
3	Forced to have any kind of sexual activity by a partner or ex-partner		
4	Kicked, hit, slapped or otherwise physically hurt by a partner or ex-partner without your consent		
5	Told by a partner who you could see and where you could go		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		

Base: Ask if Yes (code 1) to any of D03

SINGLE RESPONSE

D04. Is [IF MORE THAN ONE YES AT D03 : any of] this abuse new since the COVID pandemic started in March 2020 …?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes – started for the first time during the pandemic		
2	No – it already happened before the pandemic		
98	Prefer not to say		

Base: All respondents

MULTI RESPONSE

D05. Please tell us about the use of your or your partners use of pornography?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I do not view pornography		**SECTION E**
2	I do view pornography	**CANNOT SAY 1 & 2**	**GO TO D06**
3	My partner does not view pornography	**DO NOT SHOW IF CODE 1 AT D02**	**SECTION E**
4	My partner does view pornography	**DO NOT SHOW IF CODE 1 AT D02 CANNOT SAY 3 & 4**	**GO TO D06**
98	Prefer not to say	**EXCLUSIVE**	**SECTION E**

Base: If view pornography at D05 (code 2 or 4)

GRID MULTI RESPONSE PER ROW, RANDOMISE ROWS

D06. In the last year do you think pornography has affected any of the following aspects of your relationships?

Please select those that apply for each statement

Row Code	Row list	Scripting notes	Routing
1	Pornography viewed has made me or my partner feel less desirable		
2	Pornography has decreased how often my partner or I want to have sex		
3	Pornography has reduced the ability of my partner or me to have sex		
4	Pornography has increased the amount of screen time my partner or I spend		

Column code	Column list	Scripting notes	Routing
1	Yes for me		
2	Yes for my partner		
3	No	**EXCLUSIVE**	
98	Prefer not to say	**EXCLUSIVE**	

Section E: Health Behaviours - Drugs

Base: All respondents

SINGLE RESPONSE

E01. Have you ever taken illegal drugs, new psychoactive substances (NPS), solvents or prescription drugs that were not prescribed to you?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		**GO TO E02**
2	No		**SECTION T**
98	Prefer not to say		**SECTION T**

Base: Those who said Yes (code 1) to E01

SINGLE RESPONSE

E02. How often do you usually use drugs?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Only taken drugs once		

2	Used to take drugs sometimes but I don't take them anymore		
3	A few times a year		
4	Once or twice a month		
5	At least once a week		
6	Most days		
98	Prefer not to say		

Base: Those who said Yes (code 1) to E01

MULTI RESPONSE

E03. The last time you used drugs where did you use them?

Please select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	At home with friends		
2	At home alone		
3	At work		
4	At a friend's house		
5	Outside with friends		
6	Outside alone		
7	At a club, gig or festival		
95	Somewhere else (please specify where)	**OPEN TEXT BOX**	
98	Prefer not to say	**EXCLUSIVE**	

Base: Those who said Yes (code 1) to E01

MULTI RESPONSE

E04. Which, if any, of these drugs have you taken in the last year?

Please select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Cannabis (Weed, Skunk, Green, Hash, Blow, Joints, Marijuana)		
2	Gas, Glue or Other Solvents		
3	Amphetamines (Speed, Whizz, Sulph, Paste)		
4	Buprenorphine		

5	Ecstasy (E, Eccies, XTC, Pills)		
6	Cyroban (Cy, Cyber, CBan)		
7	Non prescribed Benzos (Diazepam, Valium, Etizolam, Blues, Whites, Yellows, Xanax)		
8	Heroin (Smack, Kit, H, Brown, Skag)		
9	Magic Mushrooms (Shrooms)		
10	Methadone (Physeptone, Meth)		
11	MDMA powder/crystals (Mandy, Molly, Madman)		
12	Cocaine (Coke, Charlie, C, Proper, Council)		
13	Anabolic Steroids (Roids)		
14	Unknown White Powders (Gear)		
15	Ketamine (Ket, K)		
16	Synthetic Cannabinoids (SPICE, Exodus, Black Mamba)		
17	LSD (Acid, Blotters)		
18	2C (2CB, 2CI, 2CE)		
19	Diet Pills		
20	Tanning Pills/Liquids/Powders		
21	None in the last year		
95	Other drugs including prescription drugs not prescribed to you (Please specify what)	**OPEN TEXT BOX**	
98	Prefer not to say	**EXCLUSIVE**	

Base: Those who said Yes (code 1) to E01

SINGLE RESPONSE

E05. Have you ever injected yourself with any non-prescribed drugs or other substances?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		

Base: Those who said Yes (code 1) to E05

SINGLE RESPONSE

E06. When was the last time you injected yourself with non-prescribed drugs or other substances?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	In the last 4 weeks		
2	Between 4 weeks and 1 year ago		
3	Over 1 year ago		
98	Prefer not to say		

Closing section (Section T)

INTRO TEXT

Thank you for your responses. That was the final question.

Base: All respondents

SINGLE RESPONSE

T01. Would you like to enter the prize draw to win the £250 Love2Shop voucher on the basis of these terms and conditions?

a) The prize draw will be administered by BMG Research

b) You confirm you are aged 18 or over and accept the prize is non-exchangeable, non-transferable and no cash alternatives will be offered

c) To administer the prize draw BMG Research needs your first name and surname and will use the email address previously provided. These details will only be used for this purpose and be kept confidential.

d) BMG Research selects and notifies a winner at random from all valid entries received before the survey closes at the end of February 2023. Winners will be notified and receive their voucher by the 10th March.

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes I would like to enter the prize draw		**GO TO T02**
2	No I DO NOT wish to enter the prize draw		**CLOSING TEXT**

Base: All respondents

SINGLE RESPONSE

T02. Please confirm your first name and surname. These will be handled as stated in the terms and conditions on the previous page.

Please type your first name in the box below

[_____]

Please type your surname in the box below

[_____]

CLOSING TEXT

You have reached the end of the survey. Thank you for taking the time to answer our questions. Your input is really appreciated.

Please **click next** to submit your responses.

NHS Greater Glasgow and Clyde

Working together to stem the tide

January 2024

DPH Report Forward

I am delighted to introduce the new Director of Public Health (DPH) Report; providing an update on the health and wellbeing of the population of NHS Greater Glasgow and Clyde (NHSGGC) against the backdrop of the Covid-19 pandemic and the current cost of living crisis. Whilst this has meant the NHS, our partners, and the community we serve has been through significant challenge and change, it has also served as a reminder of the importance and necessity for population health. The purpose of this report, therefore, is to re-mobilise and re-focus efforts on population health in order to reduce health inequalities and accelerate health improvement.

As in previous years, our understanding of the challenges experienced in our community is framed by the most recent NHSGGC Health and Wellbeing (HWB) Survey. Featuring interviews with over 10,000 patients, it represents the biggest single source of data about current health behaviours and perceptions of health and wellbeing across our population and provides valuable intelligence on where we need to work with partners and local communities to improve health.

The report shows, post pandemic, an overall worsening of health (particularly mental health and wellbeing) and persistent inequalities, but we know that concerted action at all levels can make a difference. There is further need for immediate and focused action for the most vulnerable in our population.

The successful delivery against the public health priorities within this report cannot be delivered in isolation or solely by one team; nor can they be delivered by continuing to do things the same way they have always been done. Our concerted efforts must be focused on innovating together, quickly and at scale, to support design and adoption of interventions that we know will make a difference to our community.

While the population health post pandemic shows significant challenge, together we can create a ‘can do’ attitude to mobilise efforts across population and wider partners. Public health remains everyone’s business. We need to seize all available opportunities to improve health. This report therefore aims to share and create understanding of the post pandemic health challenge and to create wide dialogue to strengthen effective action to address challenge, including enabling individual’s role in self-care and accessing healthcare in the virtual world.

I hope you find the public health priorities and actions identified in the report useful to inform the joint planning that is undertaken to improve the health of the population with a continued focus on addressing inequalities. I would like to extend my thanks to

all of those that contributed to this report. I look forward to further discussions with you all over the coming months as we work together to improve the lives of those living in NHSGGC.

Dr Emilia Crighton
Director of Public Health
NHS Greater Glasgow and Clyde

Executive Summary

This Director of Public Health (DPH) report sets out the contemporary public health challenge, recognising the impact of the Covid-19 pandemic and general reduction in standards of living as a result of increased cost of living. It continues to endorse the approach outlined in the existing NHSGGC Public Health Strategy (Turning the Tide through Prevention) that population health remains everyone's business.

It develops a collective understanding of our communities and demographic changes using population statistics (Chapter 2) before summarising factors which describe or influence health including life expectancy, burden of disease, self-reported health, and infectious disease incidence (Chapter 3). The main focus of the report is around the opportunities to work collectively to improve health, in relation to established public health priorities reconfirmed by the new evidence (Chapter 4 – children and young people, healthy weight, mental health, drug harms) and in relation to priorities emerging from the current health challenges (Chapter 5 – financial security, trauma informed response, access to digital health, transport, strengthening communities and places).

Against the background of the Covid-19 pandemic and the current cost of living crisis, this report sets out a stark reality of worsening health, with a particularly steep decline in mental health and wellbeing. It shows that those already worst off in our society are also worst affected by austerity and the pandemic. Any narrowing of inequalities in health and wellbeing were due to a 'levelling down effect', i.e. those formerly doing better seeing a steeper rate of decline in health, but those most disadvantaged still being pushed into further deterioration.

Addressing the priority areas (which are closely aligned to those set out in the Marmot report[2]) will require strong and coordinated collective action rooted in a human rights based approach, with a focus on equality of health and wellbeing. The application of proportionate universalism (providing the strongest support to those with the greatest needs) will improve equality in outcomes.

In summary, we call for:

Giving every child the best start in life

- The foundations for our physical and mental health, relationships, abilities and habits including diet and activity are laid in childhood. Our commitment to prevention and reduction in inequalities needs to have children's outcomes at its core.

Enabling all people to maximise their capabilities and have control over their lives and strengthening the role and impact of ill health prevention.

- Strengthen the factors that boost positive mental wellbeing, address root causes of poor mental health and ensure swift mental health support for those in distress.

- Enable all people to eat healthily, be physically active in their daily lives and maintain a healthy weight.
- Tackle the conditions that can give rise to or exacerbate drug use and drug harms, such as stigma, trauma, deprivation and homelessness and reduce the health impact of drug use through prevention, harm reduction, treatment and recovery services.

Ensuring a healthy standard of living for all, creating fair employment and good work for all, creating and developing healthy and sustainable places and communities

- Enable all people to access the financial support they need, ensure that all services contribute to mitigating the impacts of poverty, create fair employment and good work opportunities for all and ensure that all organisations and services contribute positively to their local communities.
- Tackle the conditions that can give rise to or exacerbate trauma, including gender based violence, stigma, deprivation and homelessness and ensure that all people who have experienced trauma are supported through trauma sensitive practice to access all services they need.
- Enable all people to gain the benefit of digital access and optimise digital opportunities for better health, whilst ensuring those who cannot or chose not to have digital access receive equally good services and support.
- Enable all people to use affordable, accessible and sustainable transport in a way that maximises health, environmental and economic benefits for individuals and communities.
- Bolster our communities and the places in which we live (with opportunities for children and young people at their heart), build on the strengths and assets of communities and organisations by working together to design support around the needs of those who are most vulnerable and ensure that all organisations and services contribute positively to their local communities, including through fair employment and work.

Contents

1. Introduction

The Director of Public Health (DPH) report is an important vehicle for the DPH to fulfil their role as independent advocate for the health of the population and to provide system leadership for its improvement and protection[1]. It is intended to provide advice and recommendations on population health to both professionals and the public.

The existing NHSGGC Public Health Strategy 2018-2028, Turning the Tide through Prevention, emphasises that achieving improved and equitable population health is everyone's business. The strategy established a clear direction of travel for a whole system approach to public health, working together across legislative, social, community and individual change programmes.

This DPH report underpinned by the 2022/23 HWB Survey results, provides an update on the health challenges for NHSGGC. It serves simultaneously as a review of the Public Health Strategy in the context of these health challenges, as a joint strategic needs assessment to inform planning across partnerships, and to mobilise efforts across the population and wider partners, by setting out the rationale for priorities for action.

Greater Glasgow and Clyde has had longstanding experience of deprivation, with poverty, discrimination and exclusion impacting on both overall population health and inequalities in health. This has been further intensified by a series of recent shocks, with the current cost of living crises and the impact of the Covid-19 pandemic compounding the adverse effects of austerity. These have resulted in a significant impact on the health of our population, with increases in premature mortality, chronic illness and many more residents experiencing difficulties in meeting essential costs.

Health inequalities remain unacceptable with the most vulnerable in our society affected the worst by the succession of recent crises. This report highlights priority areas for partnership action to help mitigate this impact and slow and reverse trends of increasing inequalities in the longer term. Human rights and equality need to be the guiding principles of this work. The priority areas for action are closely aligned to those set out in the Marmot report[2], which have been adopted as the conceptual foundation for health inequalities work within Scottish Government[3,4]:

- Giving every child the best start in life
- Enabling all people to maximise their capabilities and have control over their lives
- Ensuring a healthy standard of living for all
- Creating fair employment and good work for all
- Creating and developing healthy and sustainable places and communities
- Strengthening the role and impact of ill health prevention.

2. Understanding our communities

2.1 Current population and changes over time

The size and composition of any population is a fundamental indicator of need for health and other services in a community. Detailed profiles are available via ScotPHO[5].

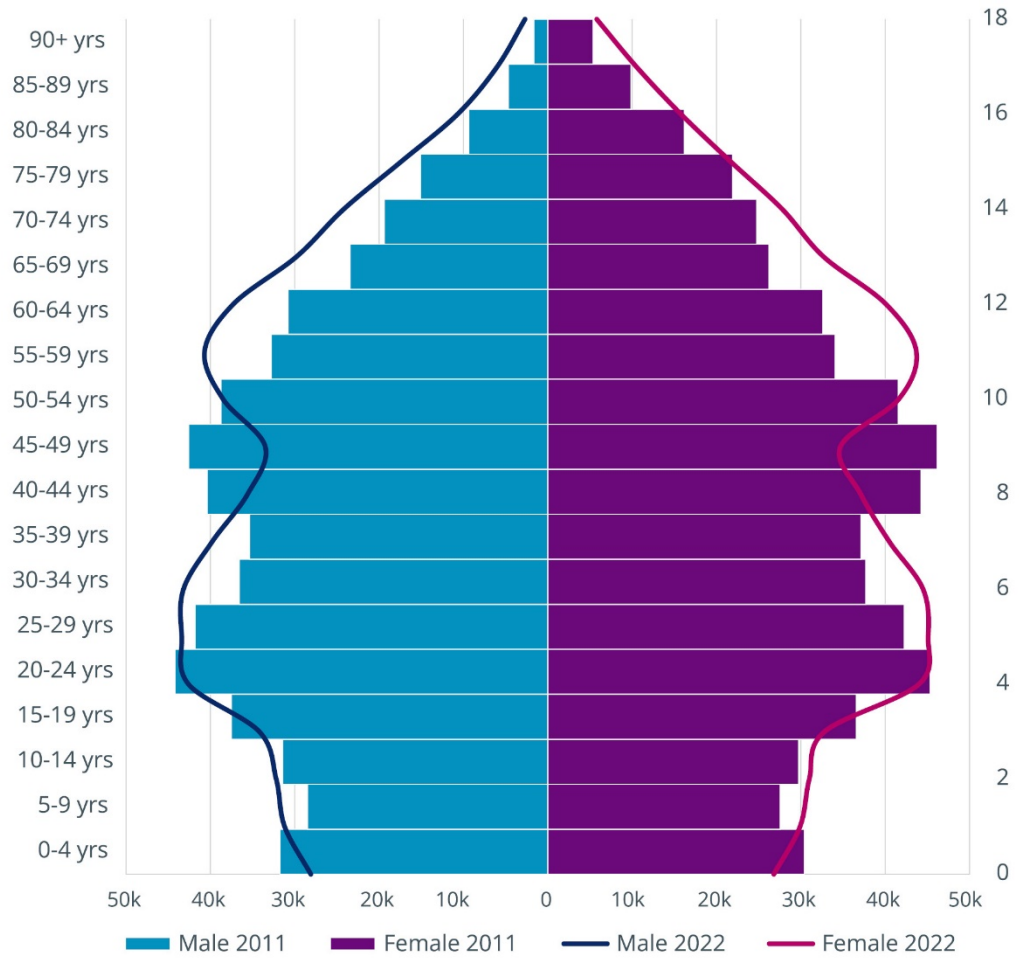
Size of the population

NHSGGC has the largest population of Scotland's Health Boards, accounting for over a fifth (21.7%) of the population. This is distributed across six Local Authorities (LAs), with wide demographic variations both between and within these areas. According to preliminary 2022 census data, the total population of NHSGGC comprised of 1,177,100 people - increasing faster than Scotland as a whole (3.6% since the previous census in 2011 compared to 2.7% for Scotland). Different patterns of change occurred across LAs. Population increases were seen in East Renfrewshire (6.9%), Renfrewshire (5.1%), Glasgow City (4.6%) and East Dunbartonshire (3.8%), whilst declines were seen in Inverclyde (3.8%) and West Dunbartonshire (2.6%)[6].

Age-structure

The age-structure of a population is an important indicator of population need, as the prevalence of chronic illness and the demand on health and social care services increases with age. The population of Scotland is ageing i.e. the number and proportion of the NHSGGC population who are in older age groups has increased over time (Figure 1). In 2022, 17.4% (205,100) people in NHSGGC were aged 65 years or older compared to 15.7% in 2011. Of these, 2.1% (25,100) were 85 years or older in 2022, compared to 1.9% in 2011. The proportion of the population in NHSGGC aged 65 years and older was lower than for Scotland overall (20.1%). However, there were marked differences in age structure by LA across NHSGGC, with the highest proportion of the population aged 65 years or older in East Dunbartonshire (24.0%), and the lowest in Glasgow City (14.0%)[6].

Figure 1: Population pyramid: population of NHSGGC by 5 year age band and sex, based on census data in 2011 and 2022.



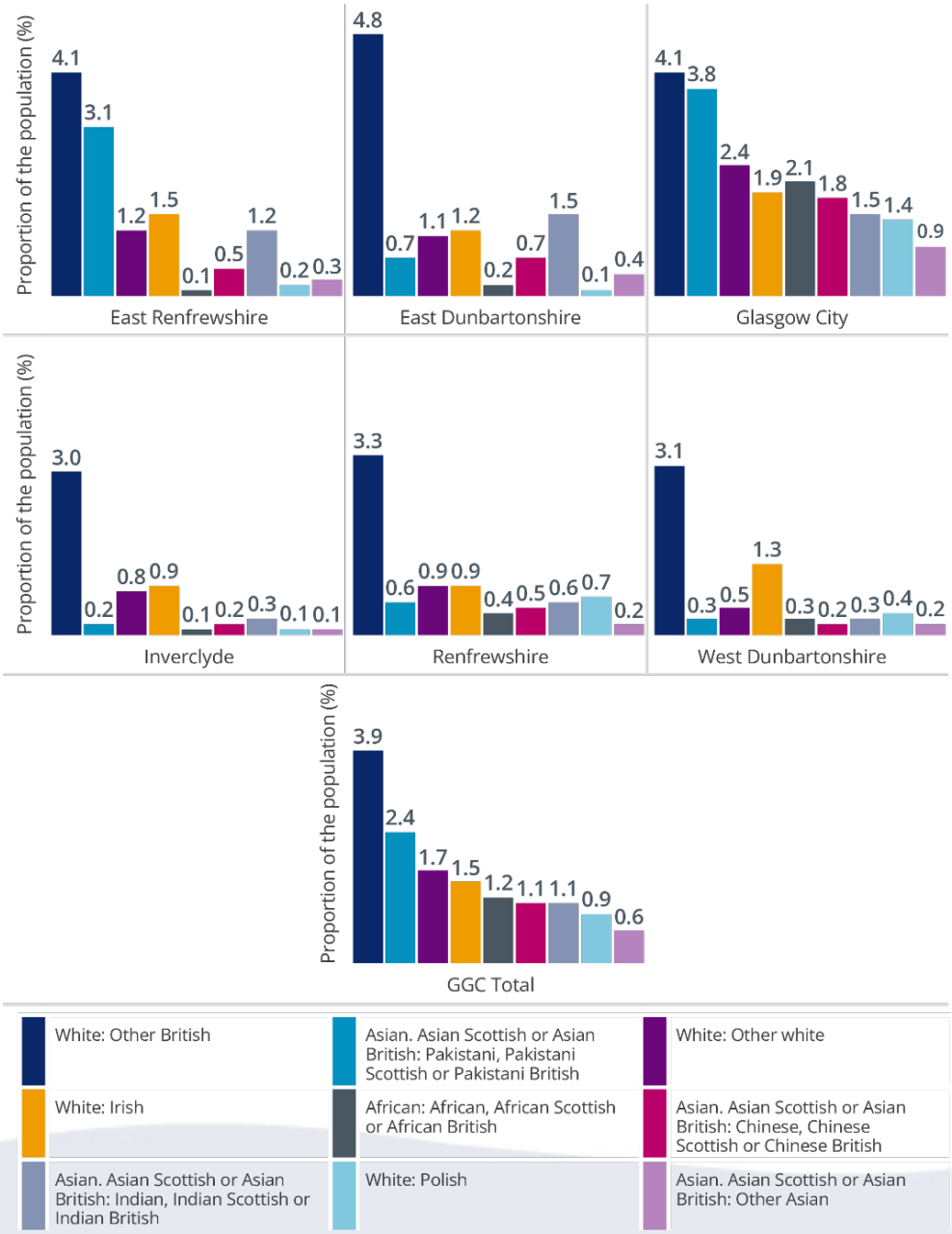
Material deprivation

Closely associated with population need, material deprivation is measured using the Scottish Index of Multiple Deprivation (SIMD) system, which allocates deprivation rankings to data zones. (A data zone is a small unit of population of approximately 1,000 people. The deprivation ranking of data zones is commonly grouped into quintiles, Quintile 1 represents the most deprived fifth of the population and Quintile 5 the least deprived fifth of the population). In 2021, more than one third (34.3%) of the total population of NHSGGC resided in the most deprived Scottish data zones (Quintile 1), compared with 19.7% across Scotland. Within NHSGGC, the proportion resident in the most deprived data zones (Quintile 1) varied from 4.0% in East Dunbartonshire to 44.9% in Glasgow City[7].

Ethnicity

Ethnicity is also an important indicator, as there are significant inequalities in health needs and outcomes between ethnic groups in Scotland. According to the 2011 Scottish census estimates, 84.4% of the NHSGGC population identified as white Scottish (ranging from 78.6% in Glasgow City to 93% in West Dunbartonshire)[8]. Figure 2 shows the distribution by LA over ethnic groups. The ethnic diversity of the population is likely to have increased since 2011, with international inward migration the main driver of population increase for NHSGGC and in particular for Glasgow City between 2011 and 2021[9].

Figure 2: Proportion of the population by LA, for ethnic groups accounting for 0.5% or more of the NHSGGC population (excluding white: Scottish), based on census 2011 results.



2.2 Demographic changes

Changes in size and structure of the population are determined by three fundamental demographic processes; birth rate, mortality rate and migration.

Births

There were 10,966 live births to residents of NHSGGC in 2022, a 16% decrease from 2011 (compared to a 20% decrease in births across Scotland over the same period). The birth rate in NHSGGC declined from 11.5 per 1,000 in 2011 to 9.3 per 1,000 in 2022. Whilst birth rates recovered again slightly since the low rate seen in the first year of the Covid-19 pandemic (8.8 per 1000 population in NHSGGC in 2020), the longstanding decline in birth rates is likely to persist for the foreseeable future.

Mortality

There were 13,092 deaths in residents of NHSGGC in 2022, an increase of 8% from 2011 (compared to a 17% increase across Scotland).

Mortality rates are one of the most commonly-used indicators of general health status. As mortality rates differ by age and sex, the standardised mortality rate (SMR) takes account for differences in age-structure and sex to allow comparison between different populations and changes over time. Reflecting the decline in mortality for some specific diseases, including vascular diseases, the SMR (all causes) was declining in most western countries until the middle of the last decade. The SMR in NHSGGC declined to 11.3 per 1,000 population in 2013 and 2014, after which it started to increase. This dramatic reversal in mortality trends, particularly associated with an increase in premature mortality in the most deprived areas, has been linked to the impacts of austerity[10].

A further large increase in mortality rate from 11.7 per 1,000 population in 2019 to 13.6 per 1,000 population in 2020 reflected the impact of Covid-19 on mortality before vaccination had become available. In 2021 and 2022, the SMR in NHSGGC declined to 12.9 and 12.5 per 1,000 population respectively, but this was still higher than observed in the ten years from 2004-2014. In 2022, the SMR ranged from 8.6 per 1,000 population in East Renfrewshire to 14.0 per 1,000 population in Glasgow City.

Migration

The latest available migration statistics (2021)[11] show the total net inward migration into NHSGGC as 2,740. This was almost sufficient to cover the demographic loss arising from the number of deaths in residents of NHSGGC exceeding the number of births by 2,934. This underlines the importance of inward migration as a mechanism of sustaining the Board's population. Net inward migration was high in the middle of the last decade but has declined in the last few years e.g. net migration to NHSGGC was 11,340 in year 2015-16. The probable reasons for this decline include the departure of the UK from the European Union and the Covid-19 pandemic.

2.3 Projections for the population of NHSGGC

Projected populations for NHSGGC and the individual LAs can be made by applying demographic processes to recent estimates of the populations. The most recent projections available for local areas (2018 based) show that to the year 2036, the overall population of NHSGGC is projected to increase by 2.5%[12]. The projections show different trends across LAs (largely reflective of historical trends). Projected population increases are expected in Glasgow City (3.3%), East Renfrewshire (8.9%), East Dunbartonshire (5.5%) and Renfrewshire (2.4%); whereas projected population declines are expected in Inverclyde (9.6%) and in West Dunbartonshire (3.3%).

Further ageing of the population is also projected. The number and proportion of people aged 65 years or older in NHSGGC are expected to increase substantially making up 21.3% of the population by the year 2036.

3. Identifying factors which influence health

3.1 Life expectancy and healthy life expectancy

Life expectancy at birth and healthy life expectancy are common indicators used to describe the overall health status in populations.

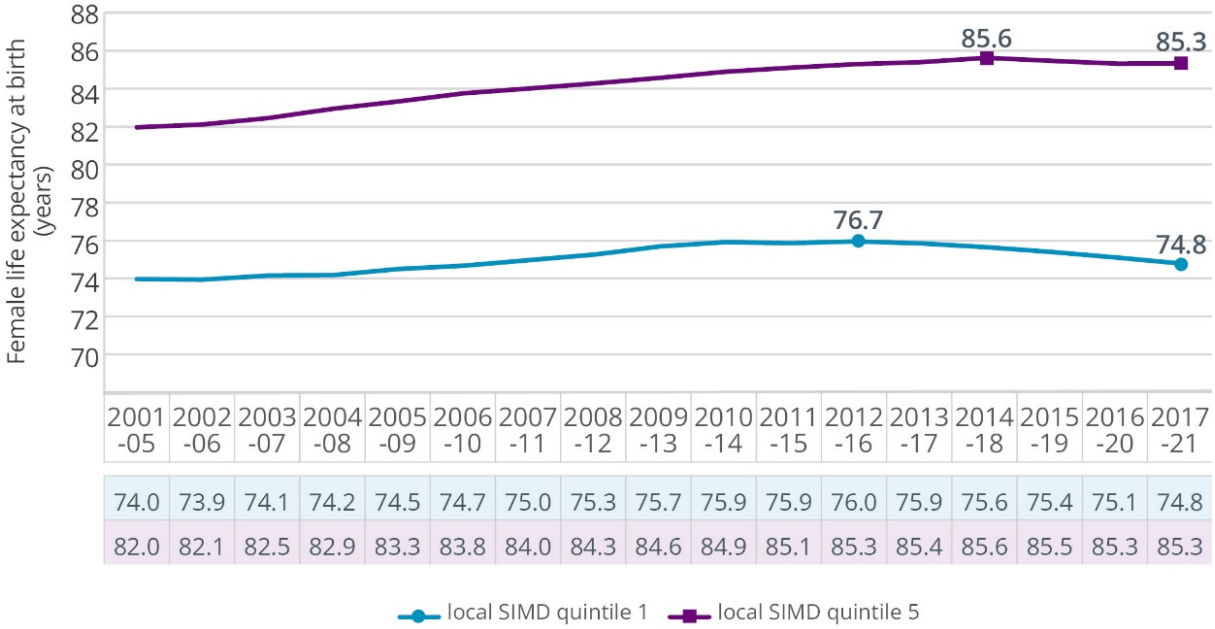
Life Expectancy

Life expectancy at birth is the number of years that a person born into a particular population might be expected to live, based on current mortality rates.

Life expectancy for male residents in NHSGGC, born in the years 2019-2021, was 74.8 years and for females, 79.5 years. The life expectancy for both males and females was less than that in Scotland generally - 76.6 years in males and 80.8 years in females. Life expectancy varied considerably by area of residence across NHSGGC, ranging from 79.4 years in males and 83.8 years in females in East Renfrewshire, to 72.9 years in males and 78.0 years in females in Glasgow City[13], reflecting differences in life expectancy associated with experience of deprivation.

Trends in life expectancy show that the long-standing increase in life expectancy in Scotland slowed and then reversed in the middle of the last decade. In NHSGGC, life expectancy increased to a maximum value of 75.4 in males (2014-16) and to 80.1 years in females (2013-15). Such a stagnation in trends for life expectancy was unprecedented outwith times of war or previous pandemics, and there is strong evidence that this was associated with the severe impacts of austerity on health[10]. For people living in the most deprived fifth of NHSGGC (local SIMD quintiles), a decline in life expectancy was already observed from the period estimates for 2012-2016, illustrating that the impacts were worst for those already most disadvantaged (data shown for females in Figure 3). Life expectancy at birth for both males and females for NHSGGC overall has fallen in more recent years. Covid-19 mortality contributed to an increase in mortality across the whole population, but caused significantly worse mortality in the more deprived areas, thus driving further exacerbation of inequalities in life expectancy.

Figure 3: Trends in female life expectancy at birth in NHSGGC for the most deprived local SIMD quintile (Q1) and the least deprived local SIMD quintile (Q5) by 5 year period, data labels for period of highest life expectancy, and for the most recent period.



Healthy Life Expectancy

Healthy life expectancy is the number of years from birth that a person could expect to live in a state of self-assessed good health.

Healthy life expectancy for males living in NHSGGC born in 2019-2021 was 58 years and for females, 58.7 years, lower than in Scotland generally (60.4 years in males and 61.1 years in females). Healthy life expectancy varied considerably by area of residence, ranging from 66.7 years in males and 67.2 years in females in East Renfrewshire, to 54.8 years in male and 56.0 years in females in Glasgow City, reflecting differences in health associated with deprivation.

The difference between life expectancy and healthy life expectancy underlines that many years of life are spent in states of poor health. Public health measures should thus not only consider effects on life expectancy, but also on closing the gap between life expectancy and healthy life expectancy.

3.2 Burden of disease

The Scottish Burden of Disease (SBoD) study[14] provides a summary about which diseases and injuries have the greatest impact on population health and wellbeing.

The most recent estimates (2019) illustrated stark inequalities in health. National data revealed the disease burden per person to be twice as high in the most deprived areas compared to the least deprived areas. This was largely driven by inequalities in premature mortality15. Many of the leading causes of disease burden in NHSGGC in 2019 – including heart disease, drug use disorders, lung cancer and

COPD – were also the leading drivers of absolute and relative inequalities in the disease burden at the national level (Table 1).

Table 1: Five leading causes of health loss for males and females in NHSGGC in 2019 (Scottish Burden of Disease Study).

Males	Females
1 Ischaemic heart disease	1 Alzheimer's and Dementia
2 Drug use	2 Ischaemic heart disease
3 Lung cancer	3 Lung cancer
4 Depression	4 COPD
5 Cerebrovascular disease	5 Drug use

There is a shift with age in the conditions most influential for health losses. For males and females who are 15–64 years of age, the top 5 causes of health loss include substance misuse (drugs and alcohol) and mental health conditions (depression/ anxiety), and also self-harm and violence in young people and younger working age males (males and females 15-24 years of age; males 25-44 years of age).

Cancers and circulatory diseases enter the top 5 causes of health loss for adults 45 years or older, and Alzheimer and Dementia enter the top 5 causes of health loss in those aged 65 years and older.

The total burden of disease for people aged 85 years or older is small compared to other age groups in NHSGGC, but there is a large burden per person. This means that the total burden will increase substantially, with an increase in the number of older people, as anticipated from population projections.

The burden of disease estimates confirm drug harms and mental health as priorities for public health. There is also a large overlap in the modifiable risk factors for cardiovascular diseases, COPD, cancers as well as dementia, including healthy diet and weight, physical activity, living smoke free, limiting alcohol consumption, and being able to avoid air pollution. Healthy and sustainable places are important to enable good physical and mental health. Increasing and retaining cognitive reserve, including through educational attainment and maintaining frequent social contact, are further important protective factors reducing the risk of dementia, reinforcing both the importance of supporting early years' development, as well as strong communities that reduce social isolation.

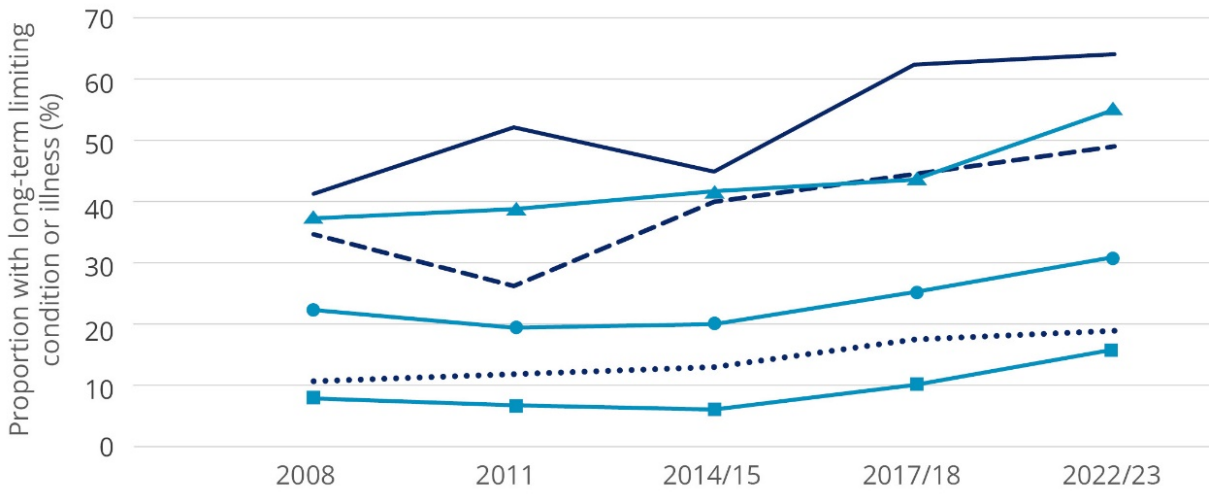
3.3 Long term condition or illness that substantially limits day to day activities

Conducted in the aftermath of Covid-19, the 2022/23 NHSGGC HWB Survey provides important insights into self-perceived health and ill-health of our population.

Three in ten adults in NHSGGC (31%) reported a long-term condition or illness that interfered with their day to day activities[16]. This increased with age, affecting nearly two thirds (61%) of those aged 75 years and over. Health inequalities remained large, with 37% of people living in the 15% most deprived data zones affected by a limiting condition, compared to 29% of people living in other areas.

The proportion of adults in NHSGGC with a long term limiting condition increased substantially over the last 15 years from just under a quarter (23.3%) in 2008, to over a third (35.8%) in 2022/23. This increase varied across age groups. For the middle aged (45-64 years) and older age (65 years and over) groups, the increase was steeper for those living in the 15% most deprived data zones, compare to other areas. However, a narrowing in inequalities was seen between 2017/18 and 2022/23, with a steeper increase in those living in less deprived data areas. This narrowing was least pronounced in the 45-64 year old age group.

Figure 4: Trends in proportion of the population with a long-term condition or illness limiting daily activities by deprivation (bottom 15% most deprived versus other areas) and age group (16-44 years, 45-64 years, 65 years or older) 2008 to 2022/23.



	2008	2011	2014/15	2017/18	2022/23
Bottom 15%: 16-44	10.8%	11.6%	13.1%	17.6%	19.0%
Bottom 15%: 45-64	34.7%	26.3%	40.0%	45.1%	49.0%
Bottom 15%: 65+	41.3%	52.1%	44.9%	62.3%	64.0%
Other areas: 16-44	8.0%	6.9%	6.2%	10.2%	16.0%
Other areas: 45-64	22.4%	19.5%	20.1%	25.3%	31.0%
Other areas: 65+	37.3%	38.8%	41.7%	43.6%	55.0%

The proportion of NHSGGC adults receiving treatment for at least one condition (not necessarily conditions affecting daily activities) also increased by nearly 10% over the last 15 years (36.5% to 45.9%), with the steepest increase seen between 2017/18 (39.2%) and 2022/23 (45.9%).

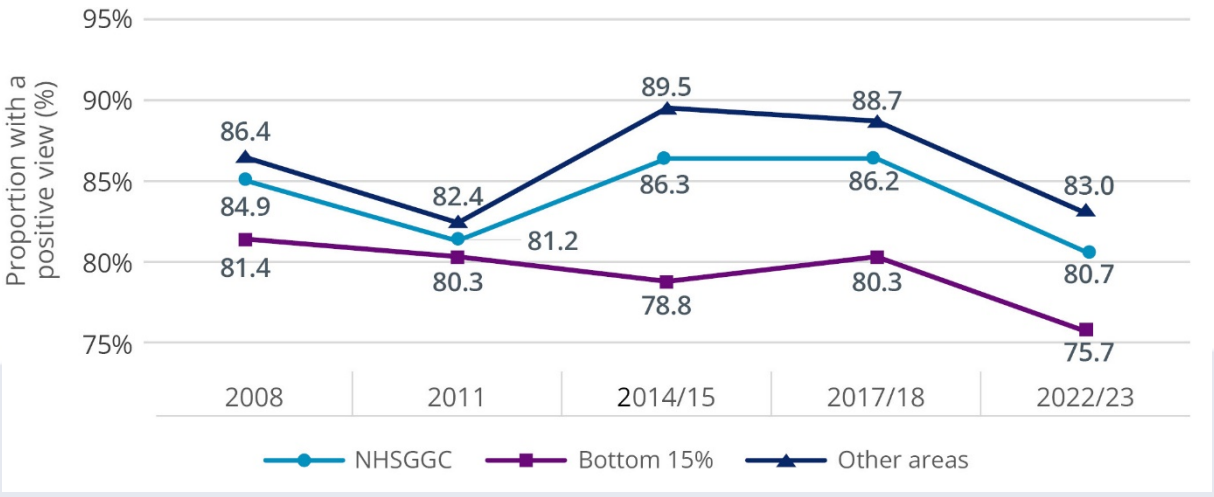
These stark trends in ill health over time, accelerated over the last 5 years since the last survey, represent an increasing need for health and social care, with a clear requirement for enabling self-management to support the substantial increase in people whose health directly impacts on the activities they carry out in their daily lives (which may include work and or caring commitments).

3.4 Positive views of mental and emotional wellbeing

Based on the most recent HWB Survey (2022/23), four out of five adults in NHSGGC (81%) had a positive view of their mental and emotional wellbeing, though this was lower in those living in the most deprived 15% data zones (75% compared to 83% for those living in other data zones). A much lower proportion of adults with a long term condition limiting their day to day activity rated their mental and emotional wellbeing positively (62%), compared to those without a limiting condition (89%). There was no clear trend by age group, though the proportion with positive views was generally higher in those groups under the age of 45 (range 82% to 84%), compared to older age groups (range 76% to 81%) with the lowest proportion rating their mental and emotional wellbeing positively those aged 45-54 years (76%).

Over the last 15 years, the proportion of adults reporting a positive view of their mental and emotional wellbeing fluctuated, with a previous fall in the 2011 survey. A steep decrease (by 5.5%) was seen since the most recent survey pre-pandemic (2017/18 versus 2022/23). This decrease was steeper in those living in the less deprived data zones (Figure 5). Young adults aged 16-24 year had the steepest decline in reporting a positive view of their mental and emotional wellbeing, decreasing by 12% (94% in 2017/18 to 82% in 2022/23). This compares to a decrease in positive views of 3%-6% for the other age groups.

Figure 5: Trends in positive view of mental and emotional wellbeing by deprivation, 2008 to 2022/23.



3.5 Infectious diseases in the context of the Covid-19 pandemic

3.5.1 Covid-19

The last three years have been dominated by the Covid-19 pandemic, the most significant health event worldwide since the 1919 influenza pandemic. The response to Covid-19 was a societal effort, requiring strong partnership working. The NHS worked together with a multitude of partners, including LAs, police, fire, and many other statutory and voluntary organisations, through resilience partnerships. Two areas of partnership work particularly deserve to be highlighted – work undertaken to deliver the largest mass vaccination drive in living memory, and the design, set up and running of community testing services.

The epidemiology of Covid-19 is described in detail elsewhere through national surveillance outputs, and dashboards that allow tracking of local trends[17]. The impact of Covid-19 has touched every aspect of our lives – individual and community health, delivery of services, education and economic growth. It has more severely affected the lives and health (higher morbidity and higher mortality) of older people, those living in more deprived areas, ethnic minorities, disabled people and those with underlying chronic conditions.

In the 2022/23 HWB survey 47% of respondents reported that the impact of the Covid-19 pandemic led to deterioration of at least one measure of their wellbeing (32% quality of life; 29% general mental or emotional wellbeing; 25% general physical wellbeing). These effects were disproportionally felt by those with limiting conditions, as well as women and older people.

Between 2% and 3% of the population are currently thought to be affected by long Covid, the syndrome when ongoing symptoms associated with Covid infection continue for at least 4 weeks after the start of infection[18,19]. This equates to approximately 20,000 individuals in NHSGGC (although this is likely to be an underestimation). Symptoms of long Covid can include fatigue, breathlessness, brain fog and limited capacity to engage in Activities of Daily Living. Referrals received by the NHSGGC long Covid service (a multidisciplinary service offering group and individual support) reflect findings around those most affected, with two-thirds female, and those being referred predominantly aged 30-64.

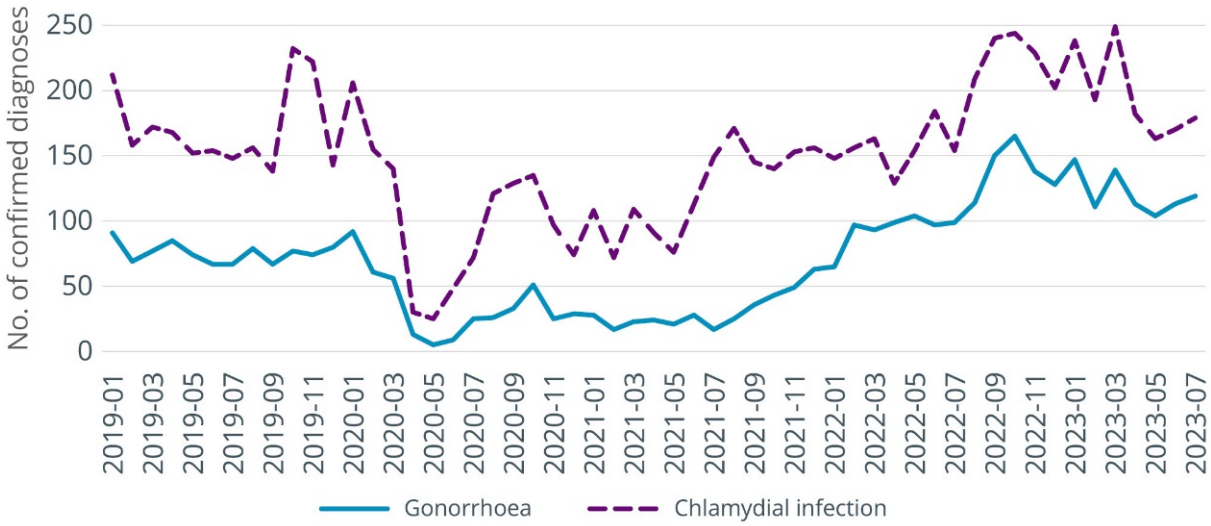
3.5.2 Sexual health including sexually transmitted Infections and blood-borne viruses

Sexually Transmitted Infections (STIs)

NHSGGC has seen changes in the number of sexually transmitted infections (STIs) since the start of the Covid-19 pandemic, likely to be a result of changing societal restrictions and behavioural changes during the pandemic. In the first year of the Covid-19 pandemic, both the numbers of tests for gonorrhoea and chlamydia, and the proportion of positive results fell, suggesting a reduction in STIs in our population

at that time. However, during 2021, newly diagnosed cases of chlamydia and gonorrhoea began to increase again, at first returning to pre-pandemic levels, and then continuing to rise to higher levels in 2022. Number of tests carried out had not recovered to pre-pandemic levels, suggesting that the increased diagnoses were due to a true rise in the number of these STIs, rather than due to increased testing. A national response was mounted including a Scotland-wide communication campaign focussing on social media channels and promoting behavioural change to reduce STI transmission risk.

Figure 6: Number of gonorrhoea and chlamydial infection diagnoses by month, NHSGGC, January 2019 – July 2023 (National Sexual Health System data).



Blood-Borne Viruses (BBVs)

NHSGGC accounts for over a third of cases of blood borne virus (BBV) infections diagnosed in Scotland. BBVs can affect anyone, but they disproportionately affect people who inject drugs (>90% of hepatitis C diagnoses in Scotland are linked to injecting drug use), gay and bisexual men, and men who have sex with men (who account for 45% of HIV diagnoses in Scotland).

There has been a fall in the number of new diagnoses of HIV in recent years and there are signs that the outbreak of HIV among people who inject drugs in NHSGGC (first identified in 2015) has stabilised. In addition, the prevalence of hepatitis C in NHSGGC fell by 60% between 2015-2016 and 2019-2020. These developments are likely to be the result of the scaling up of testing and treatment as well as outreach models to improve initiation and retention in care.

The Covid-19 pandemic, however, had a major and lasting impact on BBV prevention, diagnosis and treatment in NHSGGC, and progress towards the elimination of hepatitis C has slowed. Higher rates of testing and treatment as well as expansion of other control measures, including: injecting equipment provision (IEP); provision and promotion of condoms; HIV Pre Exposure Prophylaxis and Post Exposure Prophylaxis, vaccination for hepatitis B and outreach services to support

individuals into care will all be required if NHSGGC is to make further progress on BBVs and achieve elimination of hepatitis C and HIV transmission.

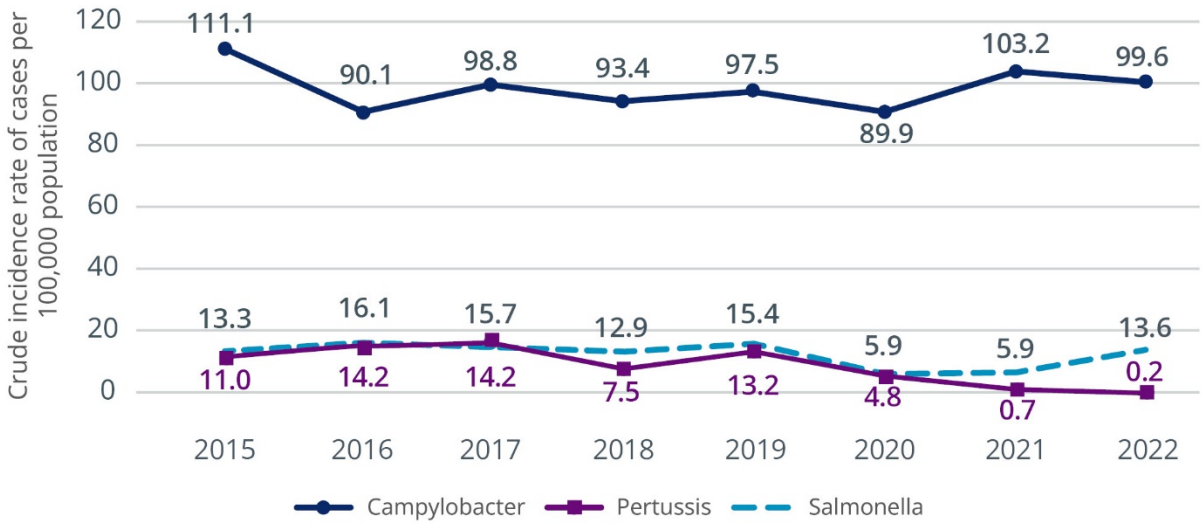
3.5.3 Changes in selected notifiable communicable diseases

The Covid-19 pandemic has greatly impacted the pattern of many communicable diseases. The countermeasures against Covid-19 and lifestyle changes encouraged by the pandemic response, might have contributed to this, but did not have the same effects across all diseases. This is illustrated here with reference to three specific pathogens – pertussis (whooping cough), salmonella and campylobacter.

There has been a strong and persistent reduction in pertussis cases compared to before the pandemic (Figure 7). Whilst a similar substantial decrease was recorded for salmonella in that time period, the number of salmonella cases has now returned to near pre-pandemic levels (Figure 7). This is likely to be due to resumption of travel patterns (with a significant proportion of all salmonella cases in NHSGGC residents are associated with foreign travel).

An example of a disease with levels remaining similar before, during and after the pandemic is campylobacter, which is the most common bacterial cause of gastrointestinal illness (Figure 7). Campylobacter is most associated with ingestion of undercooked poultry or other meat products, particularly with summer BBQ season and other holiday periods, which were less affected by the pandemic restrictions.

Figure 7: Crude incidence rate of Campylobacter/pertussis cases per 100,000 population by year, NHSGGC, 2015-2021 (HPZone).



The workload of the Public Health Protection Unit (PHPU) is a further indicator of the changes in burden of infectious diseases. PHPU is a multidisciplinary team of public health specialists, responsible for fulfilling the Health Board's obligations under the Public Health Act. For example, in 2022 there were 941 incidents or outbreaks managed by PHPU; a 779% increase compared to 2017.

3.5.4 Vaccine preventable diseases

After clean water, vaccinations are considered the single most important intervention for improving health and preventing disease. The NHSGGC vaccination programme is the largest NHS public health intervention in Scotland.

Due to the high vaccination rate, measles is rare (last confirmed measles cases in NHSGGC were in 2019) however, there is an ongoing resurgence of measles across Europe and the rest of the UK. Whilst measles, mumps and rubella (MMR) vaccination uptake is close to the WHO target of 95%, Public Health Scotland estimate that 9.4% of NHSGGC residents aged 19 and under remain susceptible to measles.

Other routine vaccination rates are comparable to rest of Scotland and close to or over the WHO targets. This includes the Human Papillomavirus (HPV) schools vaccination where NHSGGC has the highest coverage by S4 of all mainland Boards and is the only Board to achieve coverage above 90% across all five SIMD quintiles.

4. Opportunities to improve health

The burden of disease is projected to increase in coming years. Combined with the likely long term health impacts of the Covid-19 pandemic and the cost of living crisis, the urgency of concerted action for prevention and reduction in health inequalities is greater than ever. In line with the objectives outlined in the Marmot review, this requires **strengthening the role and impact of ill health prevention** (including mental health, drug harms, overweight, obesity and diabetes) whilst **enabling all people to maximise their capabilities and have control over their lives.** It also means **giving every child the best start in life**. Health and development in childhood influence a person's health over the rest of their life, and a commitment to prevention and reduction in inequalities needs to have children's outcomes at its core.

4.1 Ensuring the best start for life

The foundations for our physical and mental health, relationships, abilities and habits, including diet, are laid in childhood. The first 1,000 days from conception to age 2 is a critical period of body and brain development. Positive and negative impacts at this time directly influence future mental and physical health (including oral health and healthy weight) and life chances. These impacts include our nutrition, the 'emotional environment' and learning stimuli.

"The highest rate of economic returns comes from the earliest investments in children" (Heckman, Nobel Prize winning economist).[20]

Adolescence brings a further important stage in brain development. It is a time of rapid learning and vulnerability and important for developing resilience and mental wellbeing.

Childhood and adolescence is not just a route to adulthood, however, it is approximately a quarter of our lives. A fifth of our community are children and young people and they make a large contribution to that community, including in the role of carers. Public health outcomes for children are multifaceted and are not well represented by the 'need for healthcare', or measures such as life expectancy and burden of disease.

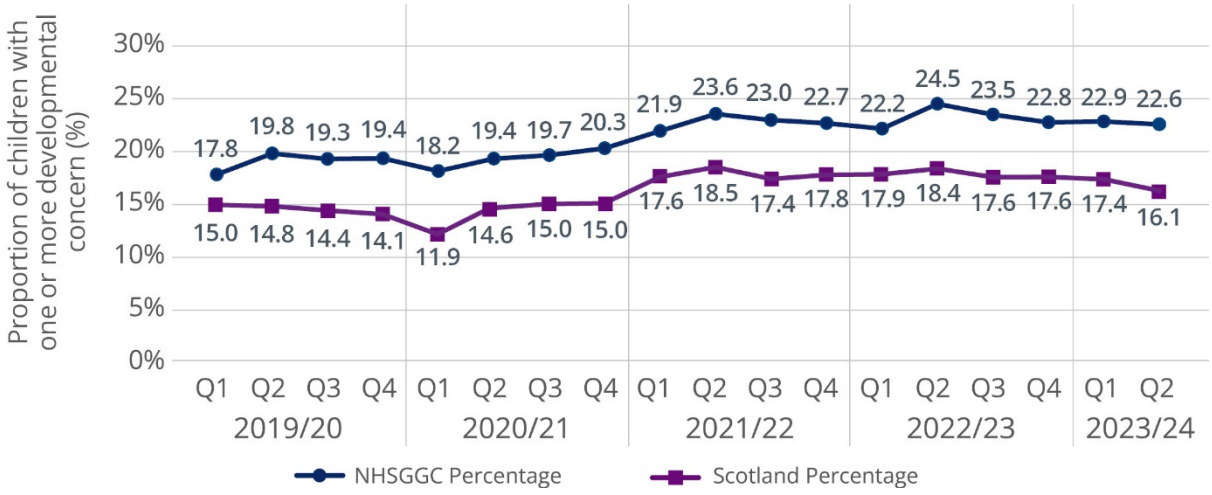
4.1.1 Child development – why immediate action is needed

The proportion of children with developmental concerns has remained high and has increased since Covid-19 (Figure 8). A proportion of these developmental concerns are preventable, whilst outcomes can be improved in others if there is early intervention. Without this, more children will require more support and have more challenges to overcome throughout life.

Children residing in deprived areas and children who have experience of care are more likely to have developmental concerns. Pre-Covid, there was some evidence

that the gap associated with deprivation was reducing, however this is widening again. Narrowing the gap in health outcomes must begin at this stage.

Figure 8: Percentage of children with one or more developmental concerns recorded at the 27-30 month review, NHSGGC and Scotland, quarter one (Q1) 2019/20 to quarter two (Q2) 2023/24.

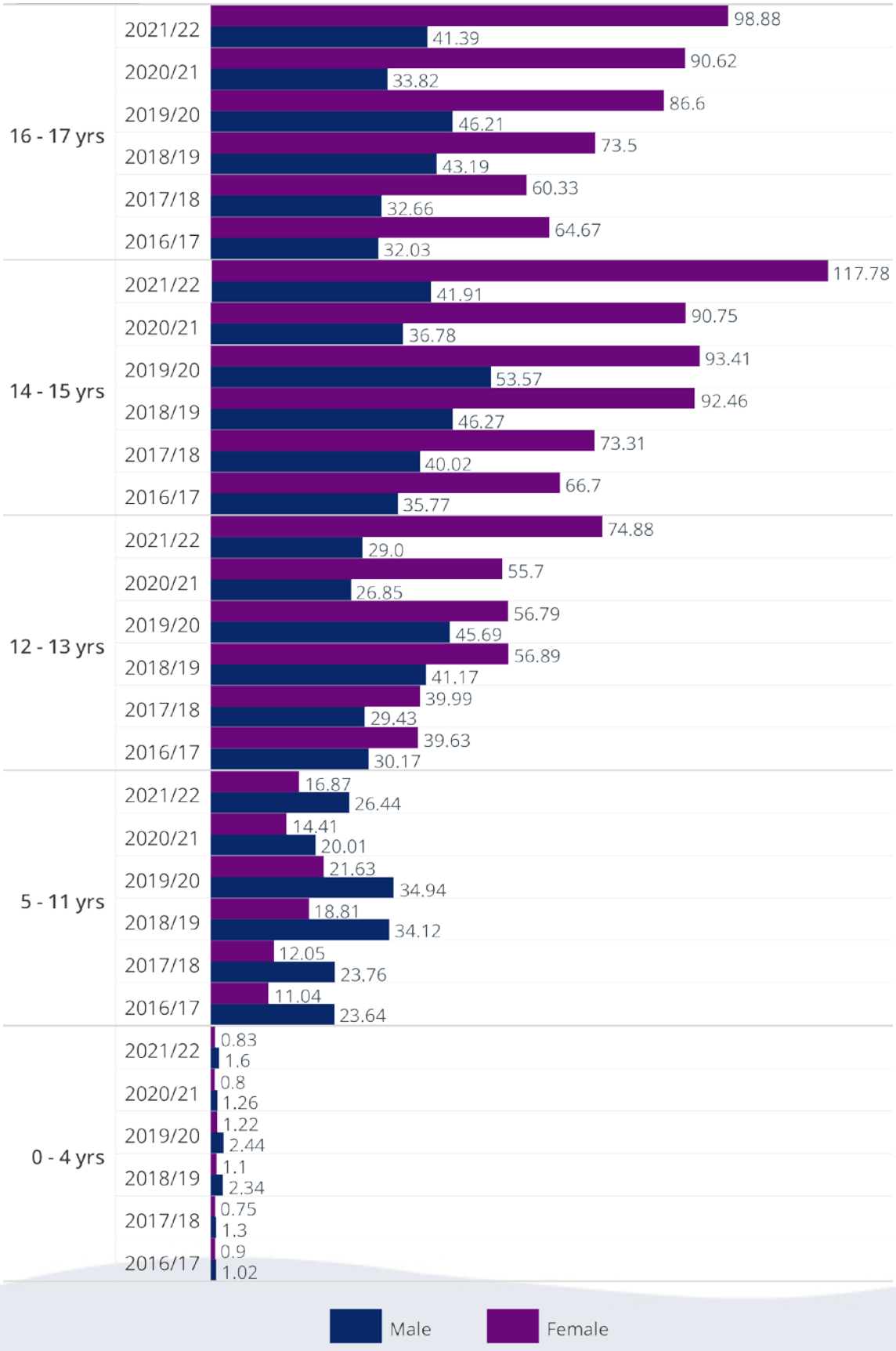


4.1.2 Children and young people's mental health – why immediate action is needed

The mental health and wellbeing of children and young people is deteriorating. This is reflected by increased referrals to Child and Adolescent Mental Health Services, increased presentations with self-harm to hospital and primary care and an increase in eating disorders. This is predominantly seen in females aged 12-17 (Figure 9). Conducted in 2021/22, the most recent Scottish Schools Health and Wellbeing Census[21] highlighted 3 in 10 secondary age/S2-S6 pupils with probable clinical depression and a similar proportion with a high level of emotional and behavioural difficulties (from local analysis of Glasgow City data). 14% often or always felt lonely, 30% had been bullied in the last year, 27% were not happy with their body or the way they looked, and around 7% had a social media disorder (problematic social media use). Suicide is the leading cause of death in children and young people.

Mental health and wellbeing is worse in particular groups including LGBTQ+ people, those from deprived areas and those with neurodevelopmental concerns. There are links with developmental concerns including increased risk of mental health problems in children with neurodevelopmental disorders, particularly if they are not supported early and provided with the environment and techniques to support them to thrive.

Figure 9: Accepted CAMHS referrals over time by gender and age (rates per 1,000 population)



4.1.3 Child oral health – why immediate action is needed

Dental decay is a preventable condition but remains the most common reason for a child to be admitted to hospital for a General Anaesthetic (GA) across the UK. Despite child oral health improving in Scotland and NHSGGC since 2005, there are persistent oral health inequalities. Just under 30% of Primary 1 and Primary 7 children were noted to have obvious decay, with higher levels in children living in more deprived areas. The impact of the Covid-19 pandemic is not fully understood, but the available data from the National Dental Inspection Programme conducted in 2022[22] suggests that those children who had decay were more likely to need urgent dental treatment (i.e. they were experiencing more severe disease) compared to previous years.

The Childsmile programme, a flagship programme which includes toothbrushing in schools, was severely disrupted by the pandemic. Whilst the proportion of schools engaging has improved (71% in June 2023 compared to 38% in November 2022), it is still lower than pre-pandemic levels (around 80% uptake). Toothbrushing with fluoride toothpaste remains the most effective and cost effective intervention to reduce tooth decay.

4.1.4 Ensuring the best start for life - Calls to action

As a society, in order to improve health and wellbeing, we need to significantly reduce child poverty and financial distress, drive out gender based violence and support families to flourish if we are to make the biggest impacts on children's outcomes. We know that a consistent drive to improve the first 1,000 days of life - from conception into the early years - including maintaining investment in this period, will give us the best return for the health and wellbeing of our population.

- Through maternity care, recognise and address the individual needs of women and families during pregnancy, including risk behaviour such as alcohol, preparation for parenting, mental health and financial challenges and risks of gender based violence.
- Maximise the role of the Universal Health Visiting Programme, providing support to all families, recognising children and families who need additional support to thrive and those with developmental problems. Intervene quickly and connect vulnerable children and families to effective, evidence based, preventative services and support programmes, building pathways of care centred around the needs of children and families.
- Strengthen support for early child development through strong early years learning; social opportunities supportive environments for play and early years child care providers.
- Protect the mental health of children and young people and promote development of resilience, recognising the impacts of sleep, social media, diet and exercise in mental wellbeing. This includes embedding children's rights within decision making, supportive learning and home environments, with

resilient youth services and opportunities for children and young people within our communities.

- Use our joint resources to build supportive and easy-to-navigate tiers of mental health support which prioritise early intervention when needed.
- Improve children's oral health by promoting dental registration and delivering new and innovative approaches to school/community based tooth brushing programmes (such as Childsmile).

4.2 Enabling Healthy Weight through healthy eating and active living

The proportion of the population who are overweight or obese continues to rise across Scotland. In NHSGGC, 67% of adults and 23% of children entering P1 are now overweight and/or obese[23]. Being overweight or obese increases the risk of developing conditions such as type 2 diabetes (T2DM), as well as cardiovascular disease, many types of cancers, liver and respiratory disease[24]. It can also impact on mental health[25]. The annual costs of overweight and obesity across Scotland is estimated to be £5.3 billion, which corresponds to 3% of Scotland's 2022 GDP[26].

Overweight, obesity and T2DM contribute to health inequalities, disproportionately impacting on people living in the more deprived areas (SIMD 1 and 2) and people from an Asian or Black ethnic origin.

4.2.1 Enabling healthy weight – why immediate action is needed

During the pandemic, childhood levels of obesity relative to overweight have increased in our most deprived communities[27]. Overweight and obesity is the single most important modifiable risk factor for T2DM and increasing prevalence is driving an alarming rise in the number of people being diagnosed with T2DM. In 2022, 66,677 patients had T2DM; this is a rise of 4,687 cases from the previous year. It represents 5.5% of the NHSGGC population, with approximately 150 new diagnoses every week.

The pandemic (where lockdown measures increased sedentary behaviours) followed by the cost of living crisis (increased food costs) exacerbated drivers of overweight and obesity[28]. Healthy foods now cost almost three times as much as unhealthy foods that are high in fats, salts and sugars[29]. The increase in levels of food insecurity described in chapter 5 are mirrored by the use of foodbanks. 1 in 20 of the NHSGGC population use foodbanks regularly, rising to 1 in 5 in the most deprived areas.

Recent HWB Survey data showed that eating habits are changing. Fruit and vegetable consumption is a reliable indicator of nutritional quality of the diet, but across all socio-economic groups, the proportion who ate the recommended daily amounts has decreased since the last survey. Those living in the most deprived areas were also less likely to consume nutritious and more expensive foods such as

lean meat or fish and more likely to consume cheaper processed convenience foods such as pies, pastries and chips.

Figure 10: Proportion of children in primary 1 of school in NHSGGC who were overweight or obese by Local Authority, 2021/22.

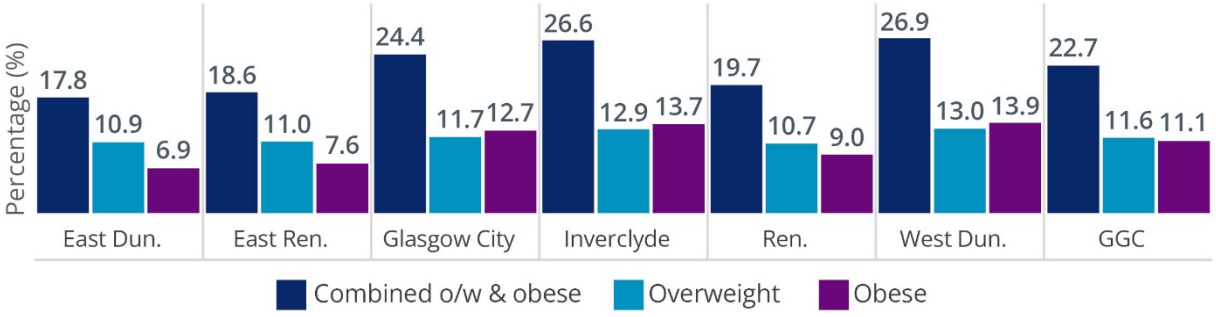
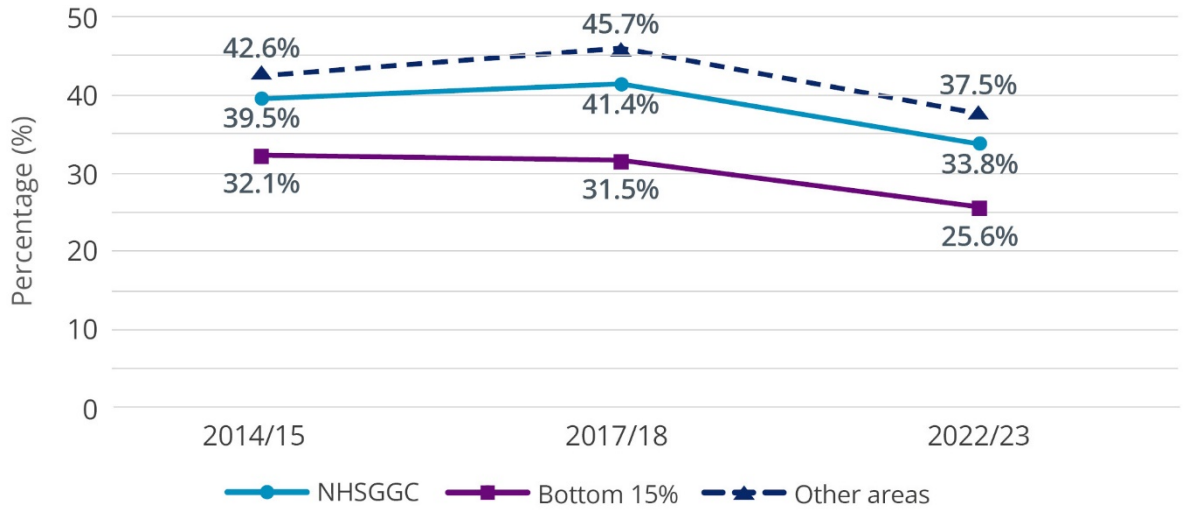


Figure 11: Trends for proportion meeting the target of consuming five or more portions of fruit/vegetables per day 2014/15 to 2022/23.



Food purchased outwith the home is more likely to be higher in fat, salt and sugars than home cooked options. However, 40% of the wider population did not eat home-made food daily (higher in deprived areas). The increased cost of healthy food coupled with the reduction in cooking from scratch and the associated loss of practical cooking skills[30], is undoubtedly having an impact on nutrition related health inequalities[31].

Additionally, HWB Survey data highlighted that those living in the most deprived circumstances, those over the age of 65 and those with a long term limiting condition were all less likely to be physically active. The recent schools census highlighted that less than a third of young people are active every day.

4.2.2 Enabling healthy weight - Calls to action

- Work across agencies to build a comprehensive universal approach to child healthy weight based on the HENRY programme32, which promotes holistic child development and wellbeing in a way which builds meaningful reductions overweight and obesity from a young age.
- Continue to develop weight management services to meet the needs of the NHSGGC population.
- Strengthen work with the national pantry network, Third Sector Organisations and partners to identify supply chains and distribution networks to widen access to affordable healthy food for those experiencing food insecurity. Collaborate to develop robust asset-based initiatives such as Thrive Under Five and local Community Food Networks to build community capacity, cookery skills and food literacy and reduce food insecurity.
- Strengthen partnerships with Third Sector Organisations, leisure and land services to incorporate safe, green spaces and play areas within existing communities and new developments to promote play and activity and community cohesion and offer a range of free and low-cost physical activity opportunities.

4.3 Boosting mental health and mental wellbeing

Good mental health and wellbeing are important foundations for positive general health, relationships, development and resilience. Our mental health is shaped by the social, physical and economic environments in which we are born, grow, live, work and age[33]. Therefore, good mental health is not experienced equally across society. Those who are experiencing the most disadvantage in life are also at highest risk of poor mental health.

4.3.1 Boosting mental health and wellbeing - why immediate action is needed

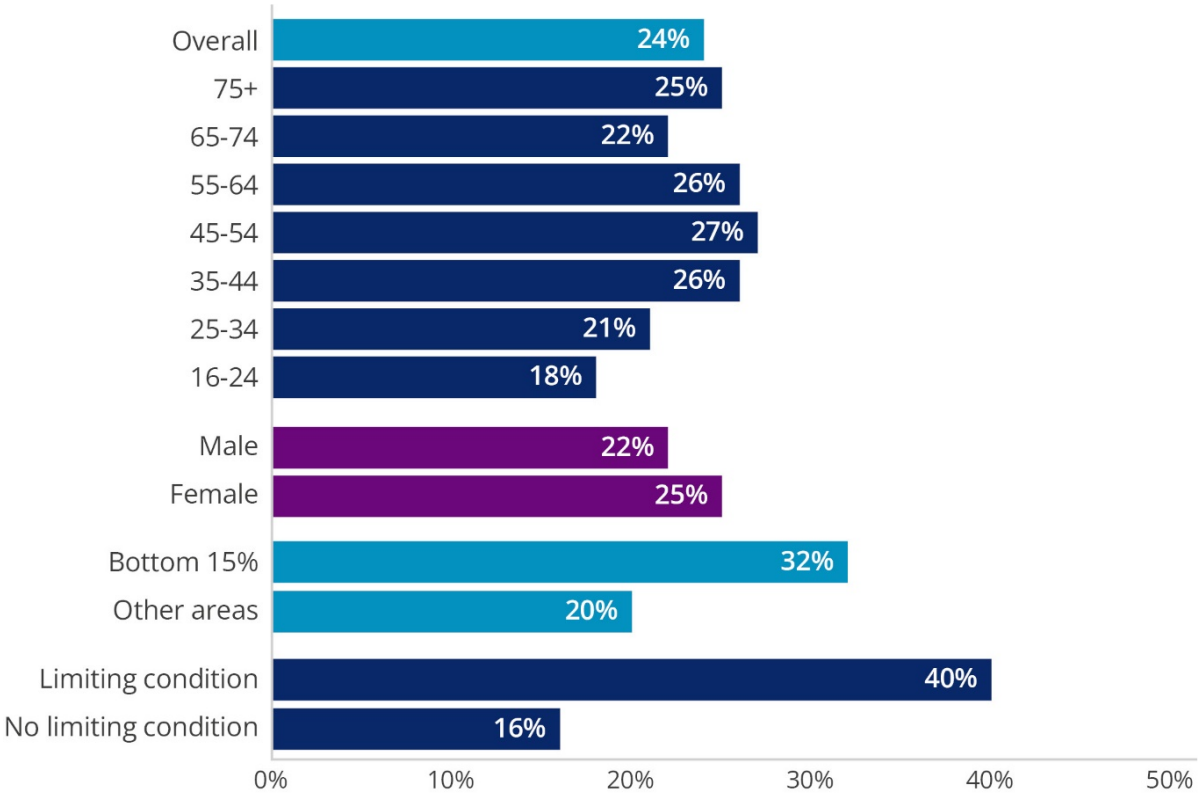
The pandemic lockdowns and cost of living crisis have, on the whole, negatively impacted on mental health and have disproportionately affected those who were already struggling. Overall trends show mental health and wellbeing has declined steeply across NHSGGC since the last HWB Survey in 2017/18 (see section 3.4).

Within the NHSGGC HWB Survey, participants were asked about the impact of the Covid-19 pandemic on various aspects of wellbeing. Whilst 64% stated that their general mental or emotional wellbeing had remained the same, 29% stated it had deteriorated. For all indicators of wellbeing, 67% of those with a limiting condition reporting deterioration of at least one wellbeing indicator due to the Covid-19 pandemic compared to 37% of those with no limiting condition.

The 2022/23 survey used the validated tool Warwick-Edinburgh Mental Well-being Scale (WEMWBS) to measure mental health and wellbeing. Using a score of 41 or below as an indicator of likely depression, significant inequalities were seen with

females, those living in the 15% most deprived areas and those with a limiting condition, more likely to have a score indicative of depression (Figure 12).

Figure 12: Proportion with a WEMWBS Score Indicating Depression by Age, Gender, Deprivation and Limiting Conditions. Source: NHSGGC Adult Health and Wellbeing Survey 2022/2023.



Other groups known to be disproportionately affected by poor mental health include people with disabilities, LGBTQ+ people, Black & Minority Ethnic (BME) people and those with a mental illness. Recent reports have identified issues such as high suicidal ideation, discrimination, micro-aggressions towards individuals in these groups, stigma and challenges seeking and accessing the support needed[33,34,35,36,37].

4.3.2 Boosting mental health and mental wellbeing – Calls to action

- Build on a 'public mental health' approach across NHSGGC, which means taking a systematic approach to addressing both the root causes of poor mental health and the factors that boost positive mental wellbeing, working in active partnership with relevant communities to achieve the best possible mental health for all, with a particular focus on groups disproportionately affected including disabled people, ethnic minorities, LGBTQ+ people and people with a mental illness.

- Learn from lived experience in our communities to drive improvements in relation to wellbeing support, finding the right support at the right time, suicide prevention and responding to those in most distress.

- Identify and spread innovative practice and service development across partnership structures, working closely with statutory partners and Third Sector Organisations to build capacity.

4.4 Concerted action to reduce drug harms

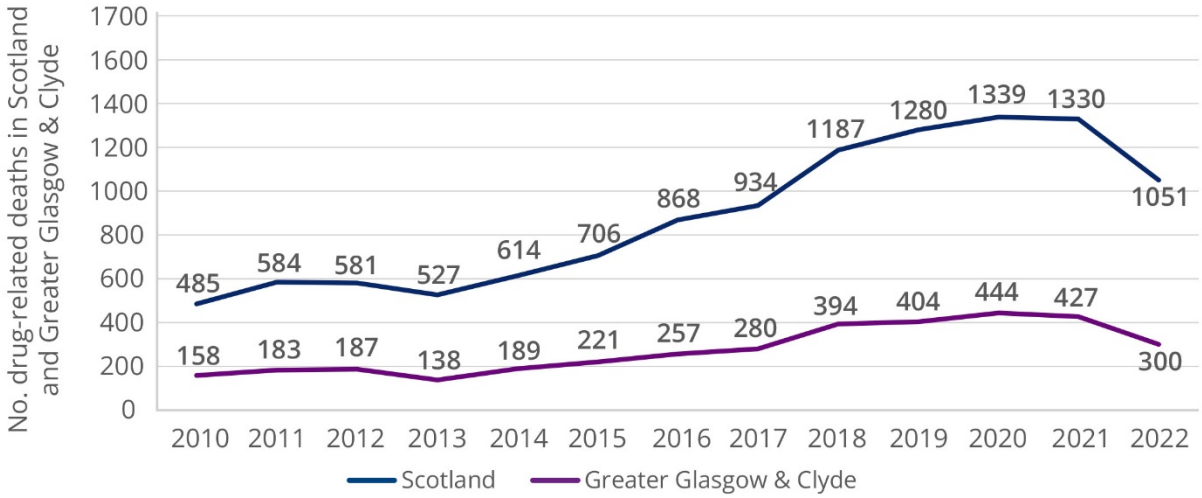
NHSGGC has a high prevalence of drug use and experiences a considerable burden of associated health harms. Those harms disproportionately affect those living in areas of greatest deprivation and include: drug-related deaths and non-fatal overdoses; injecting wound infections; blood-borne virus (BBV) transmission (see section 3.5.2), exacerbation of mental health conditions and other co-existing health problems and reduced access to services to meet health and wider needs (such as financial inclusion and housing) that in their own right have a bearing upon health.

Drug use also has the potential to harm the physical and mental health of not just the individual using drugs, but also their friends and family, including children. Stigma is commonly experienced by people who use drugs and their families and is both harmful in its own right as well as a powerful factor in generating other forms of harm such as impaired access to services.

4.4.1 Concerted action to reduce drug harms - why immediate action is needed

Drug-related deaths are the most extreme form of drug harms. For many years, the number of drug-related deaths has been steadily rising across Scotland, with NHSGGC consistently accounting for about a third of the deaths. In 2021 and 2022, the number of deaths fell for the first time in nearly a decade, with NHSGGC experiencing 30% fewer deaths in 2022 than in the previous year. Whilst this is encouraging, the number of deaths remains far too high, and there are no certainties that this recent decrease will be sustained into the coming years. Interventions on BBV were severely disrupted by the Covid-19 pandemic (see section 3.5.2). Ongoing efforts to prevent drug-related deaths and other drug harms are therefore as important as ever.

Figure 13: Number of drug-related deaths in Scotland and Greater Glasgow and Clyde by year, 2010-2022 (Source: National Records of Scotland).



4.4.2 Concerted action to reduce drug harms - Calls to action

The complexity of drug harms requires broad action to reduce the extent of drug use in our population and to prevent or mitigate the harms that can arise from it.

- Continue to deliver a comprehensive range of prevention, harm reduction and treatment services which meet Medication Assisted Treatment (MAT) Standards.
- Strengthen collaborative efforts to tackle the conditions that can give rise to or exacerbate drug use and drug harms, such as stigma, deprivation and homelessness.
- Facilitate a co-ordinated approach to reducing drug harm through the implementation of NHSGGC Framework for Addressing the Health Harms Associated with Drug Use, which reflects key national and local policies and strategies for tackling drug harms.
- Following the Lord Advocate's statement in September 2023, support the opening of a Safer Drug Consumption Facility in Glasgow City, and ensure robust evaluation to demonstrate this as a key component of a comprehensive approach to addressing drug harms in our population.

5. Shaping a better future, today

Following the Covid-19 pandemic, the remobilisation of public services is focussed on the immediate health and social needs of our society. Responding to the public health challenges is equally as time critical. As set out in the Marmot objectives, this will require both immediate and ongoing actions to achieve **a healthy standard of living for all, fair employment and good work for all, and healthy and sustainable places and communities**. Working closely with our communities, building financial security, and shaping local services to minimise the impact of further inequalities from trauma, digital exclusion and transport for health, are important to pave the way.

5.1 Building financial security for better health

The link between health and wealth is indisputable. Poverty makes leading a healthy lifestyle more difficult and can make prioritising health impossible. Being in ill health can both push people into poverty and make it harder to escape it.

Across Scotland, just over one in five adults and almost one in four children are living in poverty[38]. People most at risk of poverty include single parents, younger households, households with larger families (with three or more children), disabled people, Black and Minority Ethnic people, people experiencing homelessness and people that are unemployed and on low incomes.

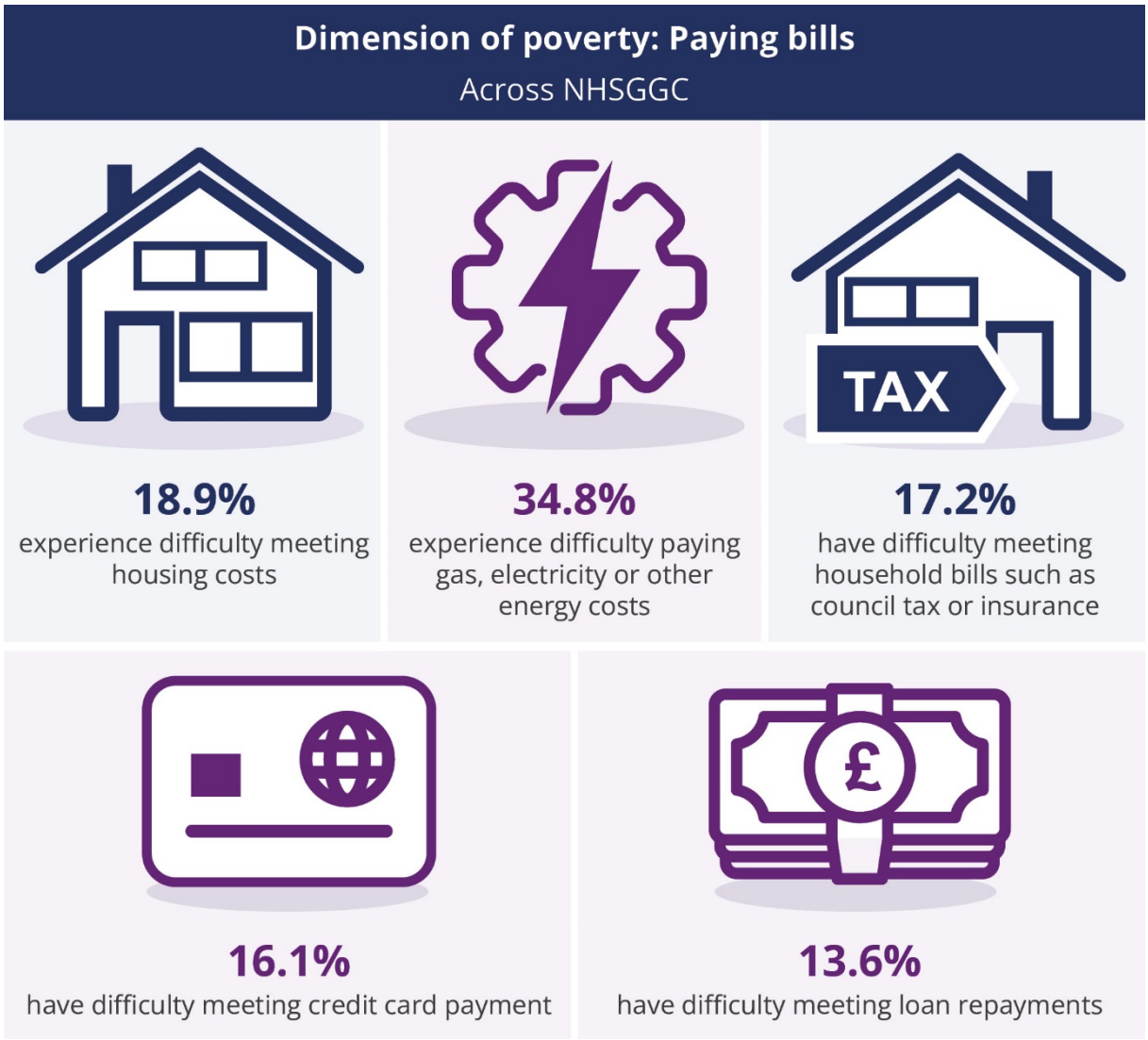
Evidence from the Joseph Rowntree Foundation highlighted that half of those in poverty have an income below 40% of the average income after housing costs[39]. 1 in 10 workers are locked in persistent low pay (of which 72% are women). More than two thirds of children in poverty live in working households.

Opportunities for families to escape the poverty trap are hampered through the existence of the ‘poverty premium’, where costs increase due to lower credit scores e.g. higher prices for home energy prepayment meters, increased interest rates when spreading payments and poorer choices for credit such as payday loans or credit cards. Within North East Glasgow, 30.2% of households experience this poverty premium, costing on average £448 per household per year, whilst in East Dunbartonshire 15.5% of households experience an additional cost of £365 a year[40].

5.1.1 Building financial security – why immediate action is needed

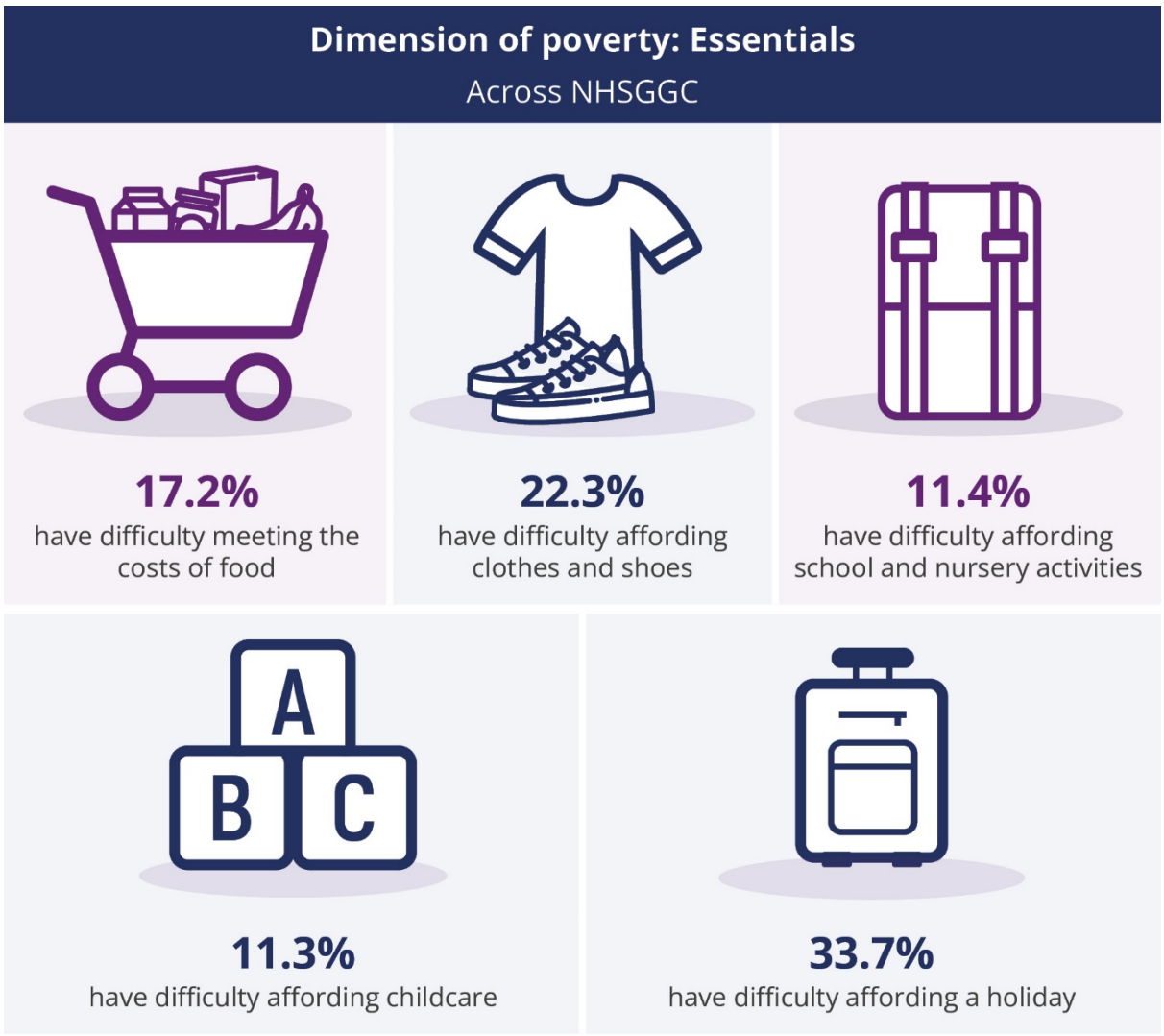
Years of austerity and other socioeconomic blows have been compounded by the wider impacts of the Covid-19 pandemic and the rising cost of living. Across society, people that may not have experienced money worries before are now cutting back due to arrears, rental increases above inflation and rising food and fuel costs41,42. The 2022/23 HWB survey starkly presents the impact of financial insecurity on ‘essentials for living’, with increases in the proportion of the population experiencing difficulty in meeting basic costs (as illustrated by Figure 14).

Figure 14: Summary of proportion of people experiencing difficulty paying bills (Source: Health and Wellbeing Survey, 2022-23).



Just under two in five people said they had difficulty meeting food and/or home energy costs at least occasionally, rising to one in two in the most deprived areas with those under 25 years old, women, and people with a limiting condition most likely to have difficulties. Most significant was the rise in food insecurity (from 8.6% to 17.2%), with under 55's, women, people with limiting condition and those in the most deprived areas all more likely to have experienced issues meeting the cost of food.

Figure 155: Summary of proportion of people experiencing difficulty covering essential living costs (Source: Health and Wellbeing Survey, 2022-23).



The ability to meet an unexpected cost of £35 decreased overall with deprived communities experiencing the biggest deterioration. The proportion of people who had used credit to cover essential living costs significantly increased (to one in nine in 2023 compared to one in thirty three in 2017).

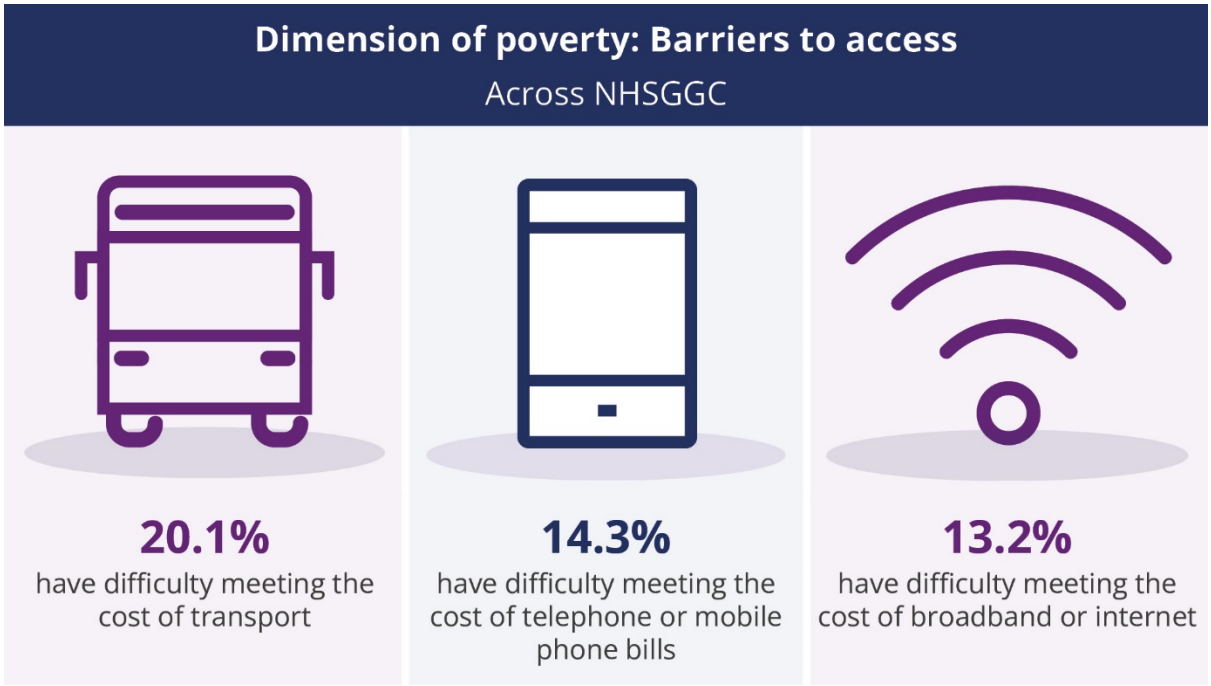
This rise in meeting the costs of essentials, as illustrated in Figure 15, is a significant concern, as lack of funds for one or more is a risk factor for destitution[43]. With a 9% rise in homelessness applications across Scotland in 2022/23, there is concern that this will further increase, resulting in more households with children living in temporary accommodation.

The economic potential of Glasgow City Region is limited by both the levels of unemployment and economic inactivity due to ill health within the population. In 2022, more than a third (34.9%) of the economically inactive working-age population was out of the labour market, primarily due to health-related reasons, equating to

100,300 residents. This is in line with the HWB Survey findings of 55% of NHSGGC residents who identified as economically active.

Across the region, almost a quarter of residents (23,750) who are inactive due to ill-health want a job[44]. These financial pressures can also directly create barriers to accessing healthcare due to inability to afford transport or make it less likely to engage with digital or telephone reminders, appointments or services. Figure 16 shows the proportion of people reporting difficulty accessing such services.

Figure 166: Summary of proportion of people experiencing barriers to accessing transport and other services (Source: Health and Wellbeing Survey, 2022-23).



When describing the relationship between poverty and health, quality of life and life expectancy, it is important to stress that deprivation is not inevitable and health inequalities remain unacceptable. Notwithstanding the national and UK policy context and scope there are opportunities within our local political, local authority and health systems to take actions to address wider environmental influences to mitigate the experience of poverty and inequalities within our population. By working together to target services for high-risk groups such as homeless people and promoting targeted employability opportunities to support wider economic regeneration, we can respond with both the short term and longer-term actions required to break the trend in deteriorating health outcomes within the NHSGGC population.

5.1.2 Building financial security for better health – Calls to action

Reduce the immediate impact of poverty on NHSGGC residents, with a particular focus on child poverty:

- Strengthen the network of Third Sector Organisations providing social welfare, legal and debt advice, including fuel and food poverty support linked to key settings such as healthcare (primary and secondary care), schools and workplaces.
- Continue to build local social prescribing networks to address 'essentials for living' including referrals for food and fuel security support and financial, legal, housing and debt advice.
- Work in partnership to explore the potential of auto-enrolment and shared data to facilitate systematic engagement and 'passported' access to available benefits for vulnerable families to adopt a cash first approach. Prioritise actions and pathways which will reduce child poverty.
- Commit to making Glasgow City Region (GCR) a Living Wage Place.
- Drive service improvement to better respond to socio-economic deprivation and wider health inequalities through the development of a poverty proofing tool for public sector services.

Build longer term capacity for financial security:

- Develop a regional approach to retaining employees in fair and healthy work, including support for those with mental and/or physical health conditions.
- Work together with local employability partnerships and private sector partners to strengthen recruitment practices, including provision of apprenticeships and in-work training from more deprived communities and key target groups.
- Collaborate as public sector partners to maximise local procurement impact through the development and sharing of supply chains to promote diversification and sustainability in the local economy; making commitment to GCR as a Living Wage Place a prerequisite for NHS and public sector contracts and optimising community benefits in line with investment.
- Continue to advocate for longer term policy change with policy makers in Scotland and the UK.

5.2 Creating a Trauma-Informed Response

Trauma is defined as “an event, a series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening”. There is increasing awareness that experience of trauma is common and can affect anyone at any stage of life.

The ‘Hard Edges Scotland’ report[45] found that severe and multiple disadvantage experienced in adulthood, such as substance use, offending, homelessness, mental ill health and domestic abuse, often has roots in childhood trauma and adversity. The prevalence of trauma is often higher for people with multiple vulnerabilities, including those with learning disabilities, people in inpatient mental health care, drug and alcohol services and the justice system.

5.2.1 Creating a trauma-informed response – why immediate action is needed

People experiencing multiple forms of trauma and adversity are more likely to experience greater inequalities in health outcomes. With four or more Adverse Childhood Experiences (ACEs), there is a greater likelihood of harmful health behaviour and poorer mental health[46,47]. The 2019 Scottish Health survey identified that 71% of Scottish adults had at least one ACE and 1 in 7 adults in Scotland have four or more.

However, poorer outcomes are not inevitable. Through a trauma-informed and responsive way of working, the negative impact can be mitigated and recovery is possible. This approach includes five key principles of practice: Safety, Trustworthiness, Choice, Collaboration, Empowerment[48]. For maximum impact, this approach should be developed alongside actions to address health inequalities, poverty, and the root causes of addiction and mental health problems.

5.2.2 Creating a trauma-informed response – Calls to action

- Continue to work with key partners to encourage a whole system approach building on local multi-disciplinary and multi-agency working groups across GGC, aligned to the national roadmap[49].

- As employers, invest in training for line managers to develop a safe and supportive organisational culture and allowing people to remain in work (e.g. recognising the signs and symptoms of trauma and ensuring support mechanisms are in place to address this).

- As service providers, ensure the voice of staff and service user experience is embedded in re-designing and improving access to services.

5.3 Broadening Access to Digital Health

Despite the acceleration of digital approaches to work, education and public services across Scotland since the Covid-19 pandemic (particularly as a result of lockdown) digital access remains unequal across society[50,51].

The HWB survey identified that within NHSGGC, 1 in 11 people do not use the internet (9%). This and other national surveys show that there are a number of groups most likely to be digitally excluded including older people; people in lower income groups and those without a job; people in social housing; people with disabilities; those whose first language is not English; and people with fewer educational qualifications or those that left school at 16.

The HWB Survey showed that digital exclusion was experienced in a number of different ways:

- **Internet access**: 1 in every 11 people (9%) do not use the internet. This rises to 1 in 8 people who live in our most deprived areas, 1 in 6 of those with a limiting condition and 2 out of 3 people over the age of 65 years.
- **Maintaining access**: 13% are finding it difficult to meet broadband/internet data costs and 16% are having difficulties meeting telephone/mobile costs.
- **Digital skills and confidence**: 69% of those using the internet had used it for health related use; 33% to access local council information.
- **Digital skills for health**: 61% had used the internet to access health information, 22% to make an appointment and 20% had accessed for other health service instead of having to go to doctor/hospital.
- **Motivation for uptake** of digital support - of those that do not use the internet, 88% said that nothing would encourage them to do so however 8% said they would if devices or broadband was cheaper.

The rapid growth in digital transformation risks widening inequalities between households further, particularly as those who could benefit most are the least likely to be online[52]. As more public services including healthcare offer digital contact as the primary route this risks further isolating the digitally excluded and will increase health inequalities. Just 1 in 11 people in NHSGGC are using the internet to access social security payments despite 3 in 10 relying on benefits for at least some of their income.

5.3.1 Broadening access to digital health – why immediate action is needed

As new digital innovations continually evolve, digital inclusion is not a static issue, with learning of new technologies required for all. This means the benchmark for digital inclusion will continually shift.

Those that can access and engage with the digital world benefit in a variety of ways such as instant access to information and online services, more convenient

appointments and shopping experiences, saving money through access to banking and price comparison, improved digital skills for education and the workplace and increased social connection[53].

Digital Poverty is described by the Digital Poverty Alliance (DPA) as: “the inability to interact with the online world fully, when, where, and how an individual needs” and has recently been defined as experiencing a lack of appropriate device or internet connection, a lack of digital skills or being unable to get online more than once per week (with severe digital poverty being a combination of two or more of these)[53].

Whilst there are variations in geographical internet connection speeds and coverage across NHSGGC, access to devices or internet connection is largely driven by financial barriers, with 1 in 3 people reporting difficulties in keeping up with costs and 1 in 9 people having cancelled a broadband or mobile contract in the past month. Housing status such as social renting, and temporary accommodation or homelessness can also impact on people’s ability to commit to mobile data or broadband contracts and relying on public Wi-Fi can have security and/or privacy issues[54,55,56].

Knowing where to get safe, quality and reliable health information and advice is important for self-care and self-management of health conditions. Connecting Scotland reported improved ability to find advice and guidance on important issues for those engaged in their digital access and skills programme during the pandemic, however health information sources such as NHS Inform compete with a huge volume of unverified health information sources[57].

5.3.2 Broadening access to digital health - Calls to action:

- Work in partnership to ensure online public services are clear for all whilst maintaining and improving existing offline services to prevent digital exclusion alongside the move to digitally-led service delivery models.

- Collaborate with key partners both within and outwith health services to develop social marketing campaigns to help influence motivation to get online for the ‘essentials of daily living’.

- Improve search engine optimisation for digital public services so that people are easily navigated to quality assured online health information.

- Collaborate to strengthen asset based community hubs in building digital capacity and explore opportunities to co-locate digital support alongside core community services utilised by most at risk groups such as money advice services.

5.4 Connecting people and health: affordable, accessible and sustainable transport

A good transport system provides a means of travelling safely, reliably, affordably, and accessibly from home to a range of everyday activities. There are well known health benefits if at least one part of a travel journey is active and the use of public transport is a sustainable travel option which can help reduce air pollution[58] - a major impactor on health.

Current transport policy prioritises sustainable transport[59], promoting active travel (walking, cycling and wheeling), followed by public transport and then private car travel as a last resort. Evidence suggests approaches such as 20-minute neighbourhoods, where residents can meet their day-to-day needs within a 20-minute walk of their home, have potential to decrease health inequalities, improve quality of life, improve the local economy and deliver climate action[60].

5.4.1 Affordable, accessible and sustainable transport – why immediate action is needed

Issues of affordability, reliability, access and safety mean that many people face barriers to travel and/or sustainable transport options.

Positive perceptions of public transport have dropped significantly in recent surveys (from 74% of respondents in 2017/18 to 61% in 2022/23). Those in older age groups, women and people with a limiting condition had less positive views. However, those living in most deprived communities, where car ownership is lowest, were significantly more positive (64%) about public transport.

Despite free travel for those under 22 in Scotland, the cost of public transport is a concern for more than 20% of young people (16–34-year-olds), as well as for people living in the most deprived areas and people with a limiting condition. Women, who often take on the main burden of caring and household tasks, are more dependent on public transport and often undertake complicated multi-modal multi-purpose journeys. The Scottish Women's Budget Group (SWBG) Women's Survey 2023[61] highlighted that 28% of respondents said they were struggling to manage transport costs, rising to 41% for disabled women and 54% for single parents.

Perceptions of safety on public transport were relatively high (88%) although women (85%) and people with limiting conditions (82%) felt slightly less safe.

Public transport that connects people to amenities is also crucial. A recent report on improving public transport in the Glasgow City Region[62] noted that a third of Glasgow residents stated access to healthcare was an in issue (linked to lack of direct public transport, frequency and cost)[63].

Whilst health services have adapted to provide more home-based support, virtual face to face appointing, telephone and email interventions reducing the need for

travel, this is not yet the norm and may pose in itself further barriers for those facing digital exclusion.

5.4.2 Affordable, accessible and sustainable transport – Calls to action

- Collaborate with partners to locate public sector services and interventions with proximity to well-connected public transport links.
- Take an active role in developing options to improve public transport services and better connections for communities in the SPT region.
- Work with employers to review and promote support available to increase active travel and use public transport to work.
- Collaborate with partners to identify opportunities to reduce impact of affordability on access to healthcare and where possible reduce the need for patient travel as part of planned service transformation workstreams.

5.5 Strengthening Communities and Places

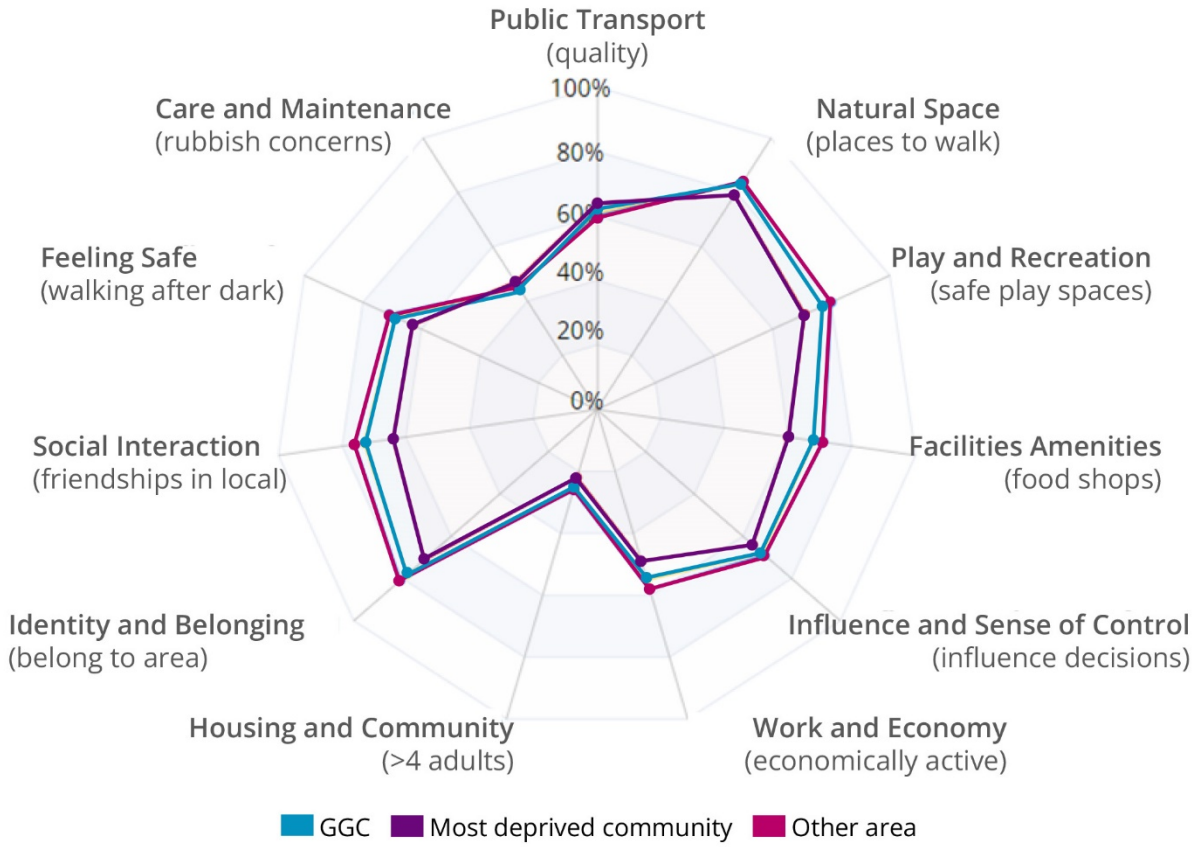
Assets within communities, such as the skills and knowledge, social networks and community organisations are the building blocks of good health. Community life, social connections and having a voice in local decisions are all factors that make a vital contribution to our health and wellbeing.

Healthy and sustainable places support good mental and physical health. This requires access to safe green spaces, clean air, opportunities for active travel, good quality housing and a range of amenities and community resources.

The evidence is growing for approaches that focus on communities, enable strong participation from members of the community, and build on their existing strengths (asset-based)[64,65,66,67,68]. The Kings Fund[69] describes work to develop social capital and local assets as one of the most promising ways of working to reduce health inequalities. Places can create and nurture health but can also be harmful to health. The right to feel safe, without discrimination or experience of crime is fundamental. The quality of the local environment and access to services all provide a sense of place and wellbeing for an individual.

The Place Standard[70] sets out indicators used to determine the quality of place. NHSGGC HWB survey indicators aligned to these are illustrated in Figure 17 below:

Figure 177: Assessment of quality of place using HWB survey indicators (Source: Health and Wellbeing Survey, 2022-23).



5.5.2 Strengthening Communities and Places – why immediate action is needed

Across NHSGGC, significant changes have been seen in relation to our social capital (i.e. our ability to work together to achieve a common purpose through shared values and/or resources). Indicators such as the levels of reciprocity and trust within local areas are viewed less positively than in 2017; the proportion of those who valued local friendships or who had a positive view of social support has also decreased. These changes vary with age, with older age groups more positive in relation to social connectedness and support. Women are more likely than men to be positive in relation to social capital. People living in the most deprived communities were more likely to be positive in relation trust, local friendships and support, but less likely to feel they belonged to their community or were able to influence decisions.

There has been an increase in the proportion of people feeling isolated from family and friends. Whilst almost two thirds of our population felt socially engaged and empowered, there has been a significant decrease in the number of people who felt they belonged to their local area, felt valued as members of their community and felt that local people could influence local decisions.

There have also been increasing concerns in relation to the four care and maintenance issues in the local environment of rubbish, dog dirt, safe play and pleasant places to walk, with more negative views in more deprived communities.

The overall changes in our population relating to social capital and social engagement/empowerment measures are worrying. After demonstrating improvement until 2014, the steep decline from 2017 suggests our communities are less equipped to be resilient in this post Covid era. Importantly, the decrease in positive perception of social capital and place related indicators across NHSGGC is attributable to areas out-with the most deprived communities. With less change in deprived communities this has resulted in a more equal perception across communities. However, this narrowing of the ‘gap’ between most deprived communities and other areas reflects a ‘levelling down’ rather than an improvement for the most deprived communities.

As the evidence base for strengthening communities grows, and in the context of limited public resources, there is a compelling case to adopt an explicit approach of targeting communities with the greatest need or highest levels of vulnerability, whereby the provision of universal services (such as health, education, employability support) are on a scale and intensity that is proportionate to the level of need (proportionate universal response) to ensure limited resources have the greatest impact.

5.5.3 Strengthening Communities and Places – Calls to action

Minimise the impact of reduced public funds on our most vulnerable communities by working together.

- Undertake engagement with local communities and community organisations in response to HWB Survey data to shape further action to improve health and reduce health inequalities.
- Ensure planning, decision making and system change is informed through local intelligence including lived experience with a particular focus on groups often marginalised.
- Design our communities, including streets and public spaces, to be more child friendly to facilitate play and exploration which will support children's rights under UNCRC, be beneficial to children's development, wellbeing and health, and benefits all people by aligning to commitments to liveable neighbourhoods and sustainability.
- Create a shared focus on community resourcing to build capacity, increase participation and mobilise community assets, prioritising those that will reduce social isolation, through cross-organisational working and community commissioning.
- Deliver community wealth building outcomes which benefit our local population through individual and collective effort as Anchor Organisations, working as part of Glasgow City Region Anchor Network (a group of public,

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) BOARD

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

27 June 2024

Subject: NHS Greater Glasgow and Clyde Health and Wellbeing (HWB) Survey

1. Purpose

1.1 The purpose of this report is to update the HSCP Board following a review of NHS Greater Glasgow and Clyde's Health and Wellbeing West Dunbartonshire Report, to identify any emerging areas of concern that West Dunbartonshire HSCP Board requires to consider from a strategic planning perspective.

1.2 The review was undertaken alongside consideration of the data used to form the West Dunbartonshire Strategic Needs Assessment which, in turn, informed the HSCP's Strategic Plan, Improving Lives Together, to consider any areas of convergence and divergence.

2. Recommendations

2.1 It is recommended that the HSCP Board notes:

2.1.1 The Health and Wellbeing Survey Report provided as Appendix 1;
2.1.2 The Health and Wellbeing Report reaffirms the strategic priorities identified within the HSCP Strategic Plan 2023-26: Improving Lives Together;
2.1.3 The identification of the low number of children registered with a dentist and the need for collaborative working in this area; and
2.1.4 The suggestions made for consideration when reviewing the HSCP Strategic Plan 2023-26: Improving Lives Together.

3. Background

3.1 In March 2023, West Dunbartonshire HSCP Board approved "Improving Lives Together" the HSCP's Strategic Plan for 2023 – 2026 and the associated delivery plan.

3.2 The strategy encompasses four strategic outcomes aimed at fostering community well-being. Improving Lives Together identifies four thematic areas with high level outcomes linked to each. These include:

- Caring Communities: Enhanced satisfaction among people who use our services, an increase in perceived quality of care and equitable access to services ensured;
- Safe and Thriving Communities: People are able to look after and improve their own health and wellbeing, and live in good health for longer, while ensuring that our citizens are safe from harm;
- Equal Communities: A reduction in the impact of the wider determinants of health;
- Healthy Communities: Improved health, an increase in independence and resilience, lower rates of hospital admissions, lower rates of re-admission and a reduction in reliance on health and social care services.

3.3 In January 2024, NHS Greater Glasgow and Clyde (NHSGGC) Health Board published their Health and Wellbeing Survey Report. The report contains the findings of a research survey on the health and wellbeing (HWB) of NHS Greater Glasgow and Clyde residents carried out in 2022/23. The survey has been conducted every three years since 1999 and is the eighth in the series of studies; initially covering the NHS Greater Glasgow area it was expanded in 2008 to cover the new NHS Greater Glasgow and Clyde area.

3.4 The health and wellbeing survey was due to be conducted between autumn 2020 and early 2021 but was postponed due to the COVID pandemic. Although a small sample of West Dunbartonshire residents have participated in the Greater Glasgow and Clyde survey previously, this is the first time sample size has been sufficient to allow for a West Dunbartonshire specific report. The focused analysis of West Dunbartonshire specific data permits a deeper understanding of the unique health challenges and needs of the local population, presenting an opportunity to consider the need for more targeted and effective strategies for enhancing the overall health and wellbeing of our community.

3.5 The HWB survey features a set of core questions that remained consistent until the 2022/23 survey. In preparation for the latest survey, an extensive consultation exercise occurred to modernize the questionnaire. New inquiries were added to address the impact of the COVID pandemic on health and illness, health behaviours, social health, social capital, financial wellbeing, fuel poverty, dental health, and internet use. A notable addition in 2022/23 was the introduction of an online component covering more sensitive topics such as sexual health, relationships, drugs, and various aspects of health and illness.

3.6 The 2022/23 survey allows for both an exploration of trends over time and insight into contemporary public health issues. It provides a flexible solution for monitoring population health across various geographies within NHSGGC. Sample boosts aimed at comparing the most deprived areas with the least deprived ones took place in Inverclyde, East Dunbartonshire,

Renfrewshire, West Dunbartonshire, and East Renfrewshire. These boosts contribute to a comprehensive understanding of health disparities across different regions.

4. Main Issues

4.1 Table 1 (below) and paragraph 4.2 provide a summary of the findings of the Health and Wellbeing report. The HWB report uses NHSGGC as the comparator for West Dunbartonshire; it does not consider the national picture. With NHSGGC comparing less favourably to the national data, caution is required when interpreting relatively positive comparisons between West Dunbartonshire and NHSGGC.

4.2 Appendix 2 demonstrates the comparison between NHSGGC and national data and suggests even comparatively good performance in the HWB survey between West Dunbartonshire and NHSGGC may fail to translate to a positive comparison at a national level. On the other hand, if West Dunbartonshire is performing poorly relative to NHSGGC, it is likely to be below the national average.

Table 1: Health and Wellbeing Report Summary Findings

Indicators where West Dunbartonshire Compared Favorably to NHSGGC	Indicators where West Dunbartonshire Compared Less Favorably to NHSGGC	Indicators with No Significant Difference
• Positive perception of mental/emotional wellbeing. • Less perceived negative effects of COVID on wellbeing. • Lower likelihood of AUDIT scores indicating alcohol-related risk. • Higher participation in strength/balance activities. • Lower difficulty meeting the cost of food and/or energy. • Lower difficulty finding sums for unexpected expenses. • Less likely to have indicators of difficulty affording energy. • Lower prevalence of identifying as gay/bisexual/other. • Lower prevalence of BME identities. • Higher likelihood of having qualifications.	• Less positive views of general health. • Higher prevalence of limiting long-term conditions. • Lower mean WEMWBS scores. • Less likely to rate mouth/teeth as in good health. • Lower likelihood of meeting fruit/vegetable consumption and physical activity targets. • Higher exposure to second-hand smoke. • Higher prevalence of smoking. • Higher prevalence of using e-cigarettes. • Lower sense of belonging to the local area. • Lower perceived value as a member of the community.	• Views of physical wellbeing. • Views of quality of life. • Views of physical wellbeing by gender. • Views of mental/emotional wellbeing by age and gender. • Views of physical wellbeing by age. • Views of mental/emotional wellbeing by age. • Views of quality of life by age. • Views of physical wellbeing by deprivation. • Views of mental/emotional wellbeing by deprivation. • Views of quality of life by deprivation.

4.3 The Health and Wellbeing Report underscores that individuals residing in socioeconomically disadvantaged regions exhibit poorer outcomes across various health and wellbeing indicators. These poorer outcomes are evident in overall health, physical and mental/emotional well-being, quality of life, and the manifestation of depression, as evidenced by The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) scores. These findings align with the results of the Strategic Needs Assessment (SNA), and is reflected throughout Improving Lives Together, specifically in the "Equal Communities" and "Health Communities" outcomes.

4.4 Relative to the entirety of the NHSGGC area, West Dunbartonshire demonstrates poorer results in health and wellbeing measures, encompassing assessments of general health, dental health, and the prevalence of limiting conditions. Within West Dunbartonshire, one-third (34%) of adults have a limiting condition or illness (e.g. physical disability), a figure that rises significantly to nearly three in four (73%) for individuals aged 75 or older. Approximately 46% of all adults are undergoing treatment for at least one condition, surging to 88% among those aged 75 or above. The data (34%) exceeds the result for a similar indicator outlined in the SNA, where 26% of adults disclosed experiencing a 'long-term physical or mental health condition'.

4.5 It should be noted that although there a similarity between these indicators they are not the same and caution should be used when comparing the results. Comparable 2019 data from the Scottish Health Survey (same questions as HWB report) showed that 38% of West Dunbartonshire adults reported having a limiting condition or illness.

4.6 Dental Health data was not included within the SNA and consequently not considered in terms of whether it should be a priority within Improving Lives Together. The HWB report highlights that those in West Dunbartonshire were less likely than those in the NHSGGC area as a whole to rate their mouth/teeth as in good health (66% West Dunbartonshire; 70% NHSGGC). In addition, just over half (53%) of adults indicated that in the last two years they had required services for a dental problem. Of these, most (90%) had used a high street dental practice. Other services used were pharmacist (10%), medical GP (6%), out of hours/emergency dental service (4%), and Accident and Emergency Department (2%).

4.7 A focus on dental health is further supported by Public Health Scotland data. Table 2 (below) illustrates that prior to the pandemic (September 2019), the registration of children with an NHS dentist in NHSGGC was good, with some variation across HSCP areas; West Dunbartonshire performed below the national average, the NHSGGC average and lower than the other HSCP areas within the GGC area.

4.8 The data in Table 2 demonstrates there has been a chronic and sustained reduction in capacity during the Pandemic and during the recovery period, which has limited access to dental services for young children and resulted in significant reductions in dental registrations. The most profound impact is on the cohort born during the pandemic, those aged 0-2 years. Less than a third of children in this age group were able to be registered with an NHS dentist. A significant effect is also seen for children aged 3-5 years.

Table 2: Dental registrations of young children by HSCP between 2019-22. Data published by Public Health Scotland (Jan 2023)

	Sep 2019		Sep 2021		Mar 2022		Sep 2022	
	0-2 yrs old	3-5 yrs old	0-2 yrs old	3-5 yrs old	0-2 yrs old	3-5 yrs old	0-2 yrs old	3-5 yrs old
East Dun	52.0%	90.6%	27.1%	82.0%	28.7%	80.8%	36.6%	80.2%
East Ren	53.9%	92.2%	25.2%	79.7%	25.8%	77.1%	36.8%	77.8%
Glas City	53.6%	91.3%	26.5%	84.5%	24.0%	79.8%	29.7%	77.0%
Inver	57.5%	93.6%	30.1%	84.9%	29.9%	82.9%	42.2%	78.5%
Ren	54.8%	93.2%	29.3%	86.8%	29.0%	83.5%	36.3%	78.7%
West Dun	47.4%	87.0%	18.9%	78.0%	16.1%	72.5%	24.9%	68.2%
GGC	53.4%	91.4%	26.5%	83.7%	25.1%	75.4%	32.2%	77.1%
Scotland	48.8%	89.8%	22.6%	79.8%	22.1%	75.4%	28.1%	73.1%

4.9 The evidence presented indicates the necessity of establishing robust engagement with key departments, namely Health Visiting Teams, Dental Health Support Workers, and Dental Practices. This collaborative effort is aimed at enhancing dental registrations for children under the age of 5, with a specific focus on children aged 0 to 2 years.

4.10 Concerning health-related behaviours, the overall prevalence of smoking among adults in West Dunbartonshire stands at 17%, with 23% reporting exposure to second-hand smoke. These indicators exhibit markedly higher prevalence in areas characterized by heightened deprivation. Notably, individuals under the age of 35 demonstrate the highest exposure to second-hand smoke, with a prevalence of 36%.

4.11 Similarly, e-cigarette usage is more prevalent among young adults and

those residing in economically disadvantaged areas, mirroring the findings within the SNA (19%) that also highlight the increasing trend in e-cigarette use among residents.

4.12 Furthermore, only one in four individuals (25%) achieves the recommended goal of consuming five or more servings of fruits and vegetables daily, while just under two in three (64%) achieve the target of engaging in 150 minutes of physical activity per week. Both of these metrics fall below the corresponding benchmarks for the NHSGGC area as a whole. Physical activity was explicitly considered in the SNA, with 62% of adults meeting the recommended levels of 150 minutes per week.

4.13 Conversely, fruit and vegetable consumption was not assessed in the SNA, but these behaviours have been designated as focal points within the Strategic Plan. The SNA highlighted that over two-thirds (71%) of West Dunbartonshire residents are overweight or obese, a figure higher than both NHSGGC (63%) and Scotland (65%).

4.14 Gender disparities are evident in alcohol-related risk, with men being twice as likely as women to register an AUDIT score indicative of such risk (20% for men compared to 10% for women). The 2021 Scottish Health Survey found that nationally, 14% of adults had AUDIT scores indicating risk (18% for men and 9% for women), akin to the levels measured in West Dunbartonshire in 2022/23.

4.15 Alcohol prevalence was not included in the SNA as local data was not available although it did highlight alcohol-related harm and alcohol-related deaths in West Dunbartonshire are among the highest in Scotland.

4.16 Indicators of social capital consistently reveal less favourable outcomes for West Dunbartonshire compared to the NHSGGC area as a whole. This includes perceptions of reciprocity and trust, appreciation of local friendships, and involvement in social activism. Individuals aged 65 or older are notably more inclined to exhibit positive indicators of social capital.

4.17 Conversely, those situated in the most deprived areas consistently demonstrate poorer metrics in terms of social capital measures. Specifically, they are less prone to harbour positive views of reciprocity, trust, or social support, less likely to value local friendships, and exhibit reduced likelihoods of volunteering or participating in clubs/associations.

4.18 It is worth noting that none of these areas were reviewed within the SNA, something worth considering for future assessments. Additionally, there is an emerging concern regarding the increasing number of West

Dunbartonshire residents living alone, potentially facing social isolation (Victor et al., 2002). Research by Patterson and Veenstra (2010), establishes a connection between social isolation and adverse outcomes such as depression, cognitive decline, and poor health.

4.19 Notably, Patterson and Veenstra (2010), argue that the risks to well-being associated with segregation and loneliness are comparable to the well-established adverse effects of smoking and obesity. Therefore, it is advisable for stakeholders to give due consideration to this data during the upcoming second and third-year reviews of the Improving Lives Together Strategic Plan.

4.20 A fifth of the population (19%) relies entirely on benefits for their household income, surpassing the NHSGGC area as a whole (13%). In the most deprived areas, this proportion rises to one in four (27%), and among those with a limiting condition, it increases further to one in three (32%). On the whole, 15% of individuals experience signs of food insecurity.

4.21 Those more susceptible to food insecurity include individuals aged 35-54, women, residents of deprived areas, and those contending with a limiting condition. In comparison to the NHSGGC area, residents of West Dunbartonshire are less prone to encountering challenges in paying for food and/or energy, less likely to confront difficulties in securing funds for unforeseen expenses and exhibit lower indicators of struggling to afford energy.

4.22 The financial pressures on West Dunbartonshire residents are extensively detailed in the Strategic Needs Assessment (SNA), with 41% of households estimated to be in fuel poverty. This pressing issue is duly acknowledged within the framework of Improving Lives Together, which underscores a dedicated focus on poverty, particularly through targeted efforts aimed at addressing the wider determinants of health.

5. Options Appraisal

5.1 An options appraisal is not required for this report.

6. People Implications

6.1 There are no direct people implications associated with the recommendations contained in this report.

7. Financial and Procurement Implications

7.1 There are no financial or procurement implications associated with the recommendations contained in this report.

8. Risk Analysis

8.1 As noted within the report, areas requiring attention will be taken forward by the relevant operational stakeholders. The relevant governance structures are in place to support the implementation the recommendations.

9. Equalities Impact Assessment (EIA)

9.1 An EIA is not required for this report.

10. Environmental Sustainability

10.1 A Strategic Environmental Assessment (SEA) is not required in this instance.

11. Consultation

11.1 The HSCP Senior Management Team, Chief Financial Officer, Monitoring Solicitor and Head of HR, have been consulted in the preparation of this report. Further consultation is planned with Third Sector partners to better understand their perspective on the issues raised within the Health and Wellbeing Survey and the work undertaken by partners addressing these issues.

12. Strategic Assessment

12.1 The recommendations within this report support the delivery of the strategic outcomes within the HSCP Strategic Plan 2023 – 2026 Improving Lives Together. In particular and drawing upon the Main Issues section, the HWB survey analysis should provide reassurance to the HSCP Board and stakeholders regarding the effective use of data which formed the HSCP Strategic Needs Assessment which went on to inform Improving Lives Together.

12.2 Notwithstanding the two issues identified above (dental health and social isolation), the HWB survey data clearly converge with the HSCP SNA, demonstrating that the concerns for citizens in West Dunbartonshire identified in the latter persist and require to be addressed with urgency

13. Directions

13.1 A Direction is not required for this report.

Margaret –Jane Cardno

Head of Strategy and Transformation

21 February 2024

Person to Contact:	Margaret-Jane Cardno Head of Strategy and Transformation
Appendices:	Appendix 1: West Dunbartonshire Health and Wellbeing Survey Report Appendix 2: Scottish Public Health Observatory Profile: Health and Wellbeing
Background Papers:	West Dunbartonshire HSCP Strategic Needs Assessment West Dunbartonshire HSCP Strategic Plan 2023-26: Improving Lives Together

Summary

Introduction
This summary provides an overview of the key findings for West Dunbartonshire from the Health and Wellbeing survey conducted through face-to-face interviews with adult residents across the NHS Greater Glasgow and Clyde area between September 2022 and May 2023. There were 1,058 interviews conducted in West Dunbartonshire. The survey has been conducted every three years since 1999 in the Greater Glasgow area, and in the expanded Greater Glasgow and Clyde area since 2008. The COVID pandemic caused a postponement to the survey in 2020/21, meaning there has been a five-year gap since the previous NHS Greater Glasgow and Clyde survey in 2017/18.

Data were weighted to ensure they are representative of age, gender and deprivation groups.

General Health
Across a range of health and wellbeing indicators, those in the most deprived areas had poorer findings – this included views of general health, physical and mental/emotional wellbeing and quality of life, and having WEMWBS scores indicating depression.

West Dunbartonshire fared poorer than the NHSGGC area as a whole for health and wellbeing indicators including views of general health and dental health and having limiting conditions. One in three adults in West Dunbartonshire had a long-term limiting condition or illness, rising to nearly three in four (73%) of those aged 75 or over. Just under half (46%) of all adults were receiving treatment for at least one condition, rising to 88% of those aged 75 or over. However, adults in West Dunbartonshire were more likely than those in the NHSGGC area as a whole to rate their mental/emotional wellbeing positively.

Health Behaviours
Overall, 17% of adults in West Dunbartonshire were smokers and 23% were exposed to second hand smoke. Rates for both indicators were much higher in the most deprived areas. Exposure to second hand smoke was highest among adults aged under 35 (36%). Use of e-cigarettes was also most common among young adults and those in the most deprived areas.

Men were twice as likely as women to have an AUDIT score which indicated alcohol-related risk (20% of men and 10% of women).

One in four (25%) met the target of consuming five or more portions of fruit in vegetables per day, and just under two in three (64%) met the target of 150 minutes of physical activity per day. Both measures were lower than in the NHSGGC area as a whole.

Social Health

One in six felt isolated from family and friends – lower than the finding for the NHSGGC area as a whole.

The proportion who felt they belonged to their local area or who felt valued as a member of their community was lower in West Dunbartonshire than in the NHSGGC area as a whole. For both these measures, older people showed the most positive findings and those in the most deprived areas fared worse.

Men were more likely than women to feel safe using local public transport or walking alone in their area. Overall, those in West Dunbartonshire were less likely than those in the NHSGGC area as a whole to feel safe doing either of these things.

One in four adults in West Dunbartonshire had caring responsibilities – higher than the proportion in the NHSGGC area as a whole.

Social Capital

Measures of social capital consistently showed less favourable findings for West Dunbartonshire compared to the NHSGGC area as a whole including perceptions of reciprocity and trust, valuing local friendships and engagement in social activism.

Those aged 65 or over were the most likely to have positive indicators of social capital. Those in the most deprived areas consistently had poorer indicators for measures of social capital – e.g. they were less likely to have positive views of reciprocity, trust or social support, less likely to value local friendships, and less likely to volunteer or belong to clubs/associations.

Financial Wellbeing

One in five (19%) received all household income from benefits – higher than in the NHSGGC area as whole (13%). One in four (27%) of those in the most deprived areas and one in three (32%) of those with a limiting condition received all household income from benefits.

Overall, 15% experienced indicators of food insecurity. Groups more likely to experience food insecurity were those aged 35-54, women, those in the deprived areas and those with a limiting condition.

Compared to the NHSGGC area as a whole, adults in West Dunbartonshire were less likely to have difficulty paying for food and /or energy, less likely to have a problem finding sums for unexpected expenses and less likely to have indicators of difficulty affording energy.

Demographics

Overall, one in five adults lived alone, but this rose to nearly half (48%) among those aged 75 or over.

One in five said they had no qualifications, which was higher than the proportion in the NHSGGC area as a whole.

In the most deprived areas, three in ten lived in owner-occupied homes compared to seven in ten of those in other areas.

Just over half (53%) of adults were economically active.

Contents

1 Introduction

1.1 Introduction[1]

This report contains the findings of a research survey on the health and wellbeing (HWB) of NHS Greater Glasgow and Clyde (NHSGGC) residents carried out in 2022/23. The fieldwork and data entry were performed by BMG on behalf of NHSGGC, and the analysis and reporting were performed by Traci Leven Research.

The survey has been conducted every three years since 1999 and is the eighth in the series of studies; initially covering the NHS Greater Glasgow area it was expanded in 2008 to cover the new NHS Greater Glasgow and Clyde area. The health and wellbeing survey was due to be conducted between autumn 2020 and early 2021 but was postponed due to the COVID pandemic.

This report presents the findings for the West Dunbartonshire Health and Social Care Partnership area.

Background

The aims of the survey:

- to provide intelligence to inform Board wide planning e.g. Public Health priorities, Health and Social Health Partnerships and local Community Planning Partnerships;
- to explore the different experience of health and wellbeing in our most deprived communities compared to other areas;
- to provide intelligence on the impact of the COVID pandemic on health behaviours; health and illness; social health; social capital; financial wellbeing; and
- to provide information that would be useful for monitoring health improvement interventions.

There have been many policy changes since the first HWB survey was conducted in 1999. Social Inclusion Partnership areas (SIPs) were in place until around 2005 as a focus of tackling area-based deprivation. The Scottish Index of Multiple Deprivation (SIMD) was established as the main tool for measuring area-based deprivation and focusing of resources. Various structures (some dictated by policy) have been in place during the last 24 years; Community Health & Care Partnerships, Community Health Partnerships and more recently Health and Social Care Partnerships (HSCPs) as a vehicle for integrated planning and delivery of health and social care services at a local authority level. The introduction of Local Outcome Improvement Plans have led to a recognition of the breadth of influencing

[1] This section has been prepared by NHSGGC

factors on health. Locality planning has become a key requirement of local government. There have been many policies and strategies over this time relating to factors which impact on health and wellbeing. These include areas such as: child poverty; mental health; employability; loneliness and isolation; drugs and alcohol; community empowerment and many more. The factors which impact on health and wellbeing are complex and the political and strategic landscape is ever-changing in relation to this.

The HWB survey is formed around a set of core questions which have remained the same since 1999. Prior to the 2022/23 survey an extensive consultation exercise took place to modernise the questionnaire. New questions were included on the impact of the COVID pandemic on health and illness; health behaviours; social health; social capital and financial wellbeing, fuel poverty, dental health and internet use. An online component to the HWB survey was introduced in 2022/23 that covered more sensitive topics on sexual health and relationships, drugs, aspects of health and illness and social health. The 2022/23 survey provides an opportunity to explore trends over time while also exploring some contemporary public health issues.

The survey continues to offer flexible solutions for monitoring the health of the population in a range of geographies within NHSGGC. Again in 2022/23 we conducted neighbourhood level boosts. Intensive interviewing took place in Govanhill; Ruchill/Possilpark; Gorbals; Parkhead/Dalmarnock and Garthamlock/Ruchazie (to provide intelligence for monitoring the Thriving Places Programme). Boosts which enable the exploration of our most deprived areas compared to least deprived areas have taken place in Inverclyde, East Dunbartonshire, Renfrewshire, West Dunbartonshire and East Renfrewshire.

Thanks are due to the working group that led the survey:

Margaret McGranachan	Public Health Researcher
Heather Jarvie	Programme Manager
Katy Levin	Senior Researcher
Rebecca Campbell	Consultant in Public Health

For further information, please contact:
margaret.mcgranachan@ggc.scot.nhs.uk

We would also like to thank our partners for their feedback and comments during the questionnaire consultation.

1.2 Summary of Methodology

The 2022/23 survey comprises 10,030 interviews conducted face-to-face at homes with adults aged 16 or over throughout the NHSGGC area. Of these, 1,084 interviews were conducted in West Dunbartonshire.

The fieldwork was conducted between September 2022 and May 2023. A full account of the sampling procedures, fieldwork and survey response can be found in Appendix A. A comparison with previous survey methods and key changes for the 2022/23 survey are presented in Appendix B. The overall sample profile is in Appendix C. The survey questionnaires are in Appendices F and G.

The sample profile of the 1,084 interviews conducted in West Dunbartonshire is shown in Table 1.1.

Table 1.1: Main questionnaire sample before and after weighting, and Small Area Population Estimates (SAPE) comparison for West Dunbartonshire

	Sample Before Weighting N	Sample Before Weighting %	Sample After Weighting %	SAPE 2020 %
Male	490	45.2%	47.2%	47.0%
Female	594	54.8%	52.8%	53.0%
Other/no answer	0	0.0%	0.0%	N/A
16-24	57	5.3%	11.7%	11.7%
25-34	155	14.3%	15.7%	15.7%
35-44	153	14.1%	14.2%	14.2%
45-54	161	14.9%	16.8%	16.7%
55-64	235	21.7%	18.4%	18.5%
65-74	207	19.1%	13.3%	13.4%
75+	116	10.7%	9.8%	9.8%
Bottom 15%	553	51.0%	30.0%	30.0%
Other Areas	531	49.0%	70.0%	70.0%

Note that the methodology and survey response described in Appendix A details the initial dataset of 10,346 interviews obtained across the whole GGC area. However, this was subsequently reduced to 10,030 when cases with missing compulsory data of age group and/or household size (required for data weighting) were removed.

Social and Economic Context

It is important to consider the very significant social and economic changes that occurred since the previous survey in 2017/18 and continued to change during the survey period. Those surveyed in 2022/23 were living in a very different context to those in 2017/18, not least those associated with:

- **the UK's withdrawal from the European Union** (formally initiated in January 2020)

- **the COVID pandemic** since March 2020 and its impacts on physical health, mental health, isolation, financial wellbeing and other factors. Beyond the period of restrictions (Spring 2022), some lasting changes in lifestyle (e.g. working patterns/home working), long-lasting physical effects (e.g. long Covid), longer term impacts on mental health and knock-on effects (e.g. on hospital waiting lists) etc. should be considered as contextual factors of the 2022/23 survey

- the very significant rise in the **cost of living**, including steep rises in energy costs from October 2021, exacerbated by the war in Ukraine from February 2022. Inflation has been consistently over 5% since January 2022, and was over 10% during most of the survey period.

In addition, the continuing effects of pre-pandemic austerity have been explored by work led by Glasgow Centre of Population Health and University of Glasgow which have linked **austerity** to life expectancy plateauing (or decreasing in the most deprived areas) in Scotland and across the UK since 2012[2], and healthy life expectancy showing a two-year decrease in Scotland between 2011 and 2019[3].

1.3 This Report

Chapters 2-7 report on all the survey findings, with each subject chapter containing its own infographic summary at the start, and a 'key messages' summary at the end. For each indicator, figures and/or tables are presented showing the proportion of the sample which met the criteria, broken down by demographic (independent) variables. Comparisons are also made with the findings for the NHSGGC area as a whole. **Only comparisons with NHSGGC as a whole and findings by independent variables which were found to be significantly different ($p \leq 0.05$) are reported.** The independent variables which were tested were:

- Age group

- Gender

[2] McCartney G, Walsh D, Fenton L, Devine R. Resetting the course for population health: evidence and recommendations to address stalled mortality improvements in Scotland and the rest of the UK. Glasgow; Glasgow Centre for Population Health/University of Glasgow:2022. https://www.gcph.co.uk/assets/0000/8723/Stalled_Mortality_report_FINAL_WEB.pdf

[3] Walsh D, Wyper GMA, McCartney G: Trends in healthy life expectancy in the age of austerity *J Epidemiol Community Health 2022*;76:743-745.https://jech.bmj.com/content/76/8/743

- Age and gender[4]
- Most deprived 20% datazones versus other areas
- Presence versus absence of a long-term limiting condition or illness

An explanation of how the independent variables were derived is in Appendix D.

Data Weighting

Findings are all based on **weighted data**, ensuring that the sample was representative of the geography, population profile and deprivation groups of the NHSGGC area as a whole. An explanation of the weighting process is in Appendix C.

Missing and 'Don't Know' Responses

Unless otherwise stated, all findings exclude 'don't know' and 'prefer not to say' responses.

Online Survey

A much smaller subset of respondents across GGC (N=1,194) responded to an additional online survey. The findings for this are reported in the main report, but not explored for individual HSCPs due to the small sample size.

A Note on Rounding and Interpreting Percentages

Most percentages are presented to the nearest whole number. However, there are some instances where a small proportion gave a particular response and it is helpful to examine statistics to one decimal place. Where whole numbers are used, the convention of '<1%' is used to represent a value greater than 0% but less than 0.5%.

Due to rounding, not all questions recoded into positive or negative type responses will necessarily appear to add up to the quoted overall figure. For example, in Chapter 4 the overall proportion who disagreed that local people could influence local decisions was 8% comprising 5% who disagreed and 2% who strongly disagreed. These appear to sum 7%, but the more precise figures were 5.4% and 2.3% which total 7.7%, thus rounded to 8%.

[4] Findings by the variable 'age and gender' are only reported if they provide additional insight beyond the findings for the separate variables 'age group' and 'gender' – e.g. if gender differences are only observed in some age groups, or more marked in some age groups compared to others.

Columns and bars presented in charts are built with statistics to one decimal place, but the figures on the charts are usually rounded to the nearest whole number.

Some questions, for example experience of crime (reported in Table 4.1), allow the respondent to select more than one category, so total responses can add up to more than proportion who say 'any of the above'.

Unreported Findings

One question from the main survey questionnaire is not reported due to errors/difficulties in data collection. This was question B18 in the main questionnaire (sedentary behaviour) where respondents appeared to misunderstand the question and data parameters were not applied - respondents frequently gave responses outside of expected limits (hours appear to have been given per week rather than per day in many cases).

Other Surveys Cited in This Report

For context and comparison, findings from other surveys are cited in this report. These are:

- The 2022 Scottish Household Survey https://www.gov.scot/collections/scottish-household-survey-publications/

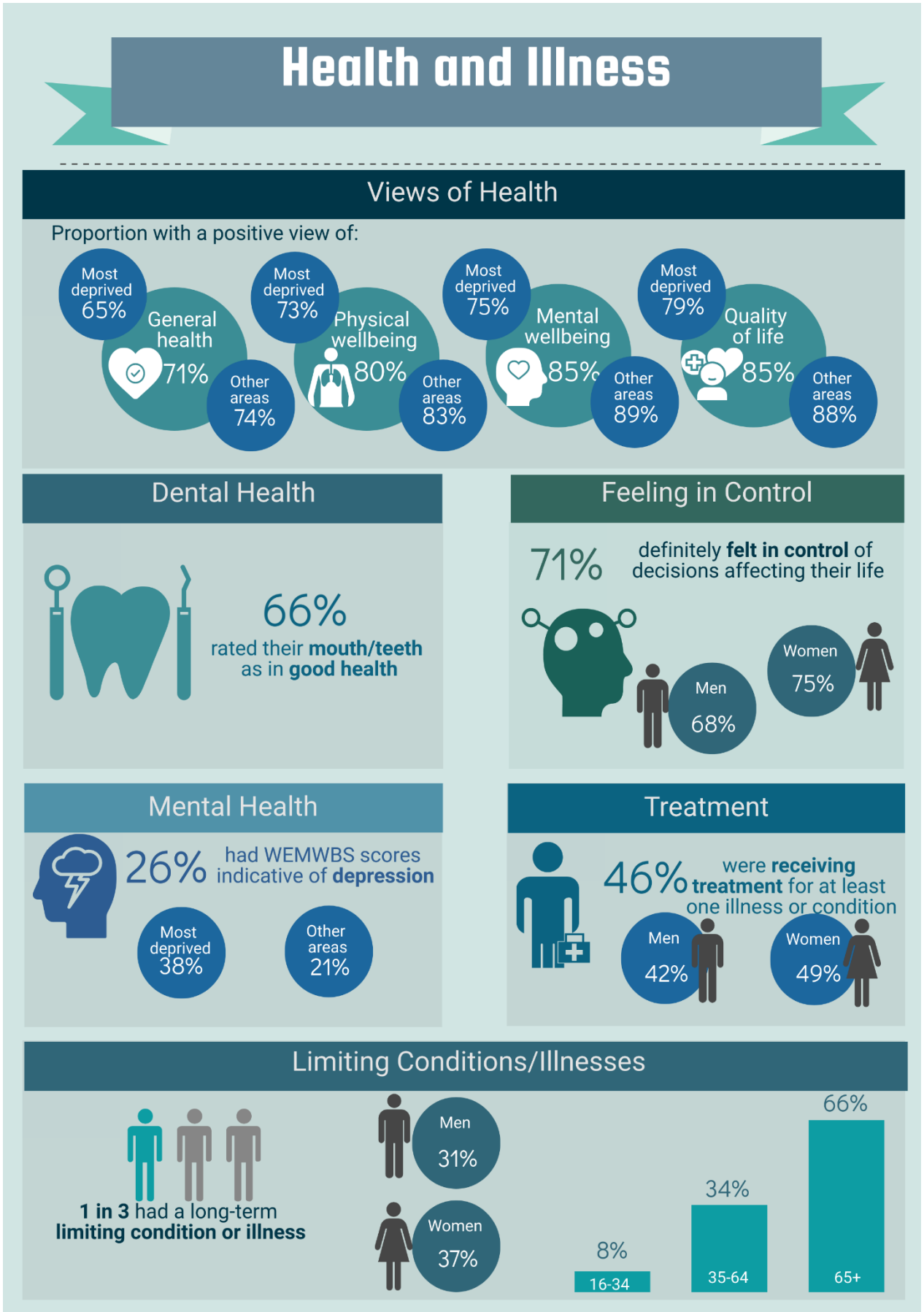
- The 2021 and 2022 Scottish Health Surveys[5] https://www.gov.scot/publications/scottish-health-survey-2021-volume-1-main-report/ https://www.gov.scot/publications/scottish-health-survey-2022-volume-1-main-report/

- Previous NHS Greater Glasgow & Clyde Health and Wellbeing Surveys https://www.stor.scot.nhs.uk/ggc/

Policy Context

Policy context is provided for some of the topics within the findings chapters. These are shown in shaded boxes, and have been prepared by policy colleagues in NHSGGC.

[5] 2022 Scottish Health Survey findings are used for comparisons where available, but relevant 2021 findings are used for indicators not included in the 2022 survey.


Health and Illness
Views of Health
Proportion with a positive view of:
General health
Most deprived 65%
71%
Other areas 74%
Physical wellbeing
Most deprived 73%
80%
Other areas 83%
Mental wellbeing
Most deprived 75%
85%
Other areas 89%
Quality of life
Most deprived 79%
85%
Other areas 88%
Dental Health
66%
rated their mouth/teeth as in good health
Feeling in Control
71%
definitely felt in control of decisions affecting their life
Men 68%
Women 75%
Mental Health
26%
had WEMWBS scores indicative of depression
Most deprived 38%
Other areas 21%
Treatment
46%
were receiving treatment for at least one illness or condition
Men 42%
Women 49%
Limiting Conditions/Illnesses
1 in 3 had a long-term limiting condition or illness
Men 31%
Women 37%
8%
16-34
34%
35-64
66%
65+

2.1 Self-Perceived Health and Wellbeing

General Health

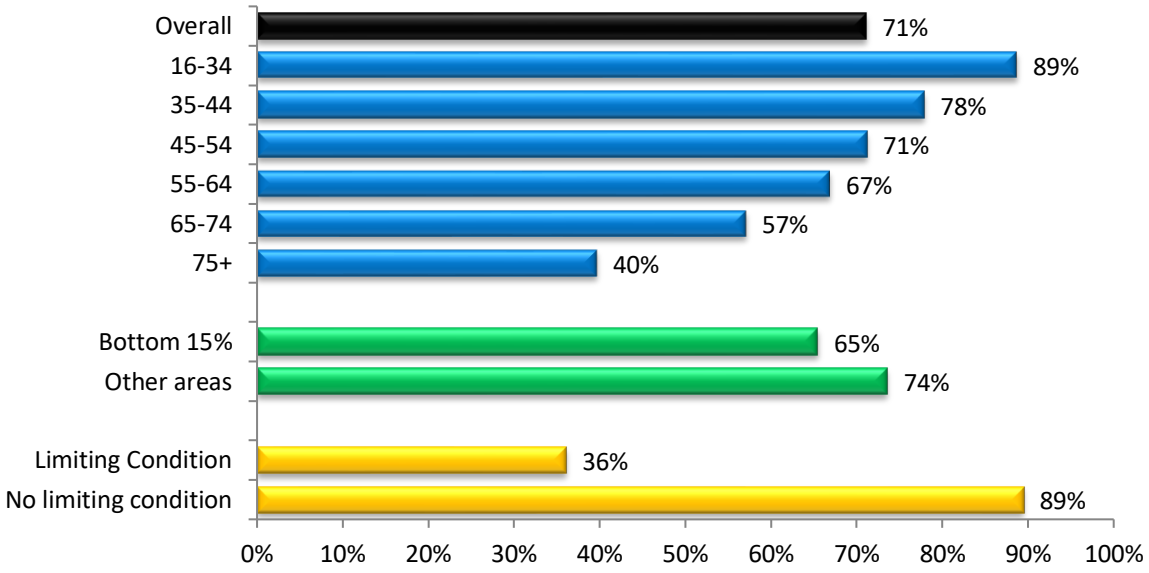
Respondents were asked to describe their general health over the last year on a five point scale (very good, good, fair, bad or very bad). Overall, seven in ten (71%) gave a positive view of their health, with 21% saying their health was very good and 50% saying their health was good. However, 29% gave a negative view of their health, with 19% saying their health was fair, 8% saying it was bad and 2% saying it was very bad.

As Figure 2.1 shows, the likelihood of having a positive view of general health decreased with age, ranging from 89% of those aged under 35 to 40% of those aged 75 or over.

Those in the most deprived areas were less likely than those in other areas to have a positive view of their general health.

As would be expected, those who had a long-term limiting condition or illness were much less likely than others to rate their general health positively.

Figure 2.1: Positive View of General Health by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

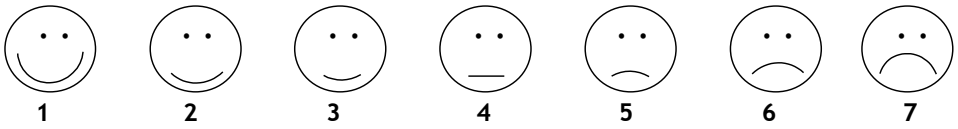
The proportion in West Dunbartonshire who had a positive view of their general health (71%) was lower than in the NHSGGC area as a whole (74%).

Evidence from Other Sources

The finding of 71% for West Dunbartonshire is similar to the national findings of the **Scottish Health Survey (2022**) which found that overall 70% of adults in Scotland had a positive view of their general health, declining with age from 85% of 16-24 year olds to 52% of those aged 75+.

Physical Wellbeing and Mental/Emotional Wellbeing

Respondents were presented with a 7-point 'faces' scale, with the expressions on the faces ranging from very happy to very unhappy:



Using this scale, they were asked to rate their general physical wellbeing and general mental or emotional wellbeing. Those selecting any of the three 'smiling' faces (1-3) were categorised as having a positive perception.

In total, 80% gave a positive view of their physical wellbeing, and 85% gave a positive view of their mental/emotional wellbeing.

- Those in the youngest age groups were the most likely to have a positive perception of their physical wellbeing and those in the oldest age groups were the least likely.
- Men were more likely than women to have a positive perception of their physical wellbeing.
- Those in the most deprived areas were less likely than others to have positive ratings of either physical or mental/emotional wellbeing.
- As would be expected, positive ratings of both measures were higher for those without limiting conditions or illnesses.

Figure 2.2: Positive Perception of Physical Wellbeing by Age, Gender, Deprivation and Limiting Conditions

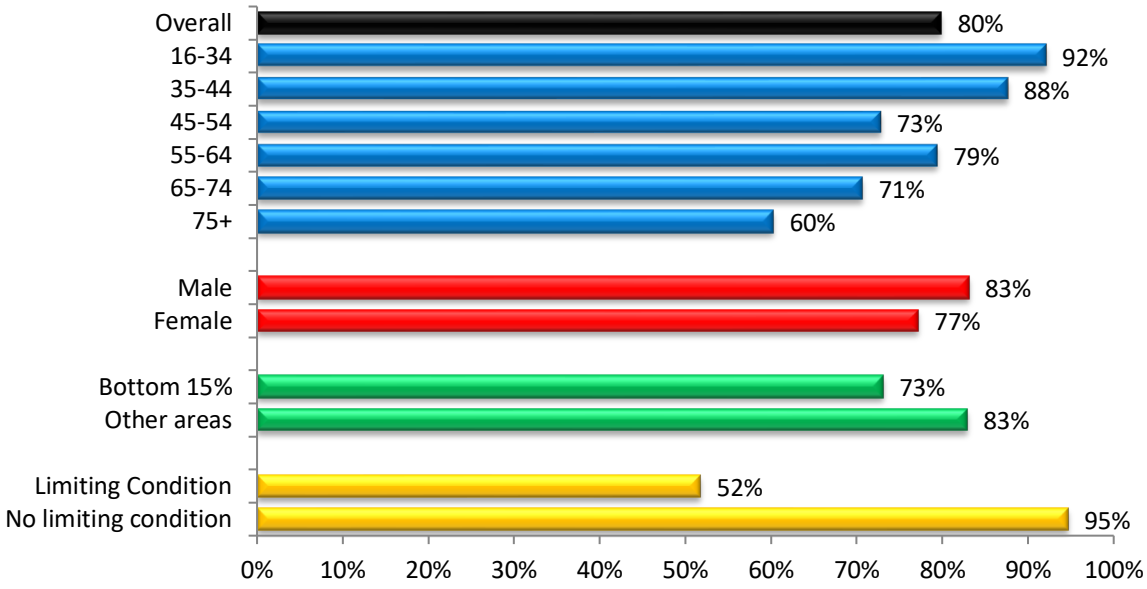
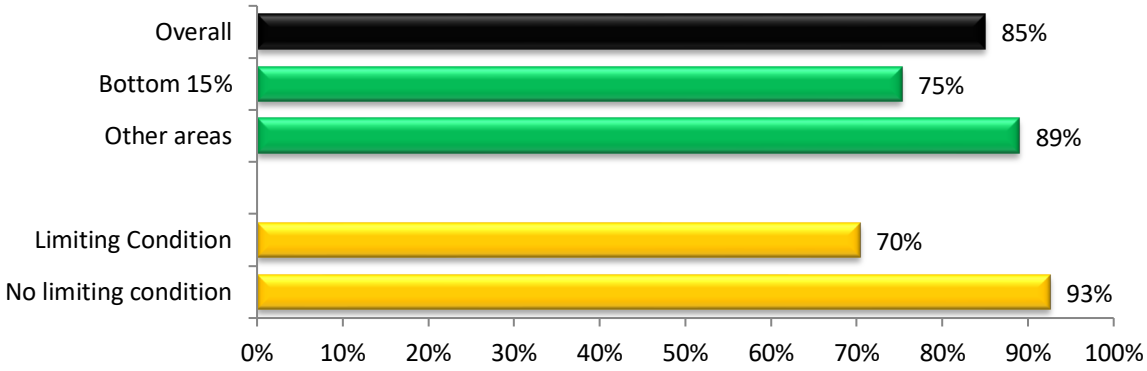


Figure 2.3: Positive Perception of Mental/Emotional Wellbeing by Deprivation and Limiting Conditions



Comparison with NHSGGC

The proportion in West Dunbartonshire who had a positive view of their mental/emotional wellbeing (85%) was higher than in the NHSGGC area as a whole (81%).

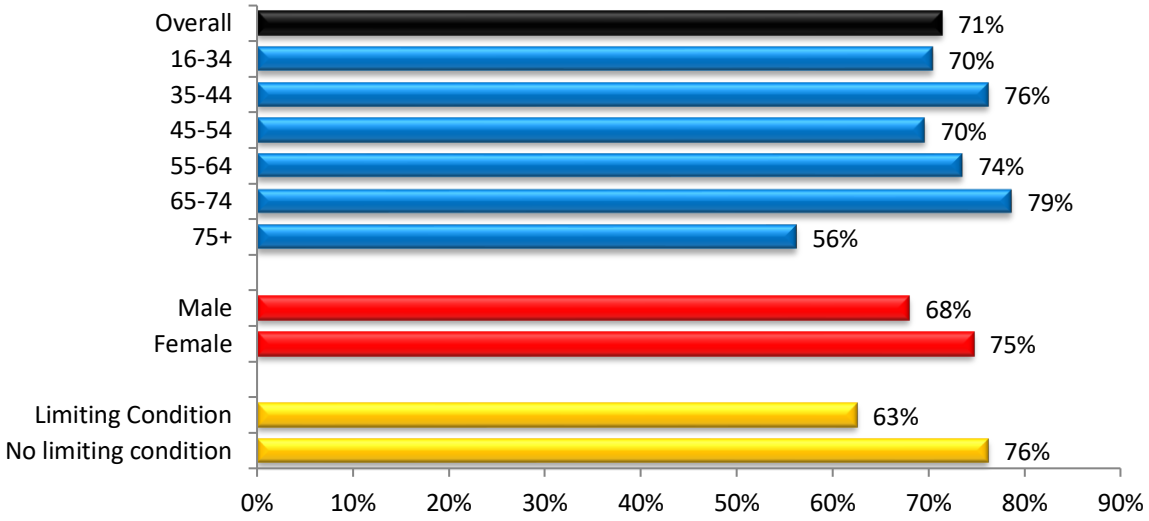
Feeling in Control of Decisions Affecting Life

Respondents were asked whether they feel in control of decisions that affect their life, such as planning their budget, moving house or changing job. Seven in ten (71%) said that they 'definitely' felt in control of these decisions,

while 23% said that they felt in control 'to some extent' and 6% did not feel in control of these decisions.

- Those aged 75 or over were the least likely to say they definitely felt in control of the decisions affecting their life.
- Women were more likely than men to say they definitely felt in control of the decisions affecting their life.
- Those with a limiting condition or illness were less likely than others to feel in control of the decisions affecting their life.

Figure 2.4: 'Definitely' Feel in Control of Decisions Affecting Life by Age, Gender and Limiting Conditions

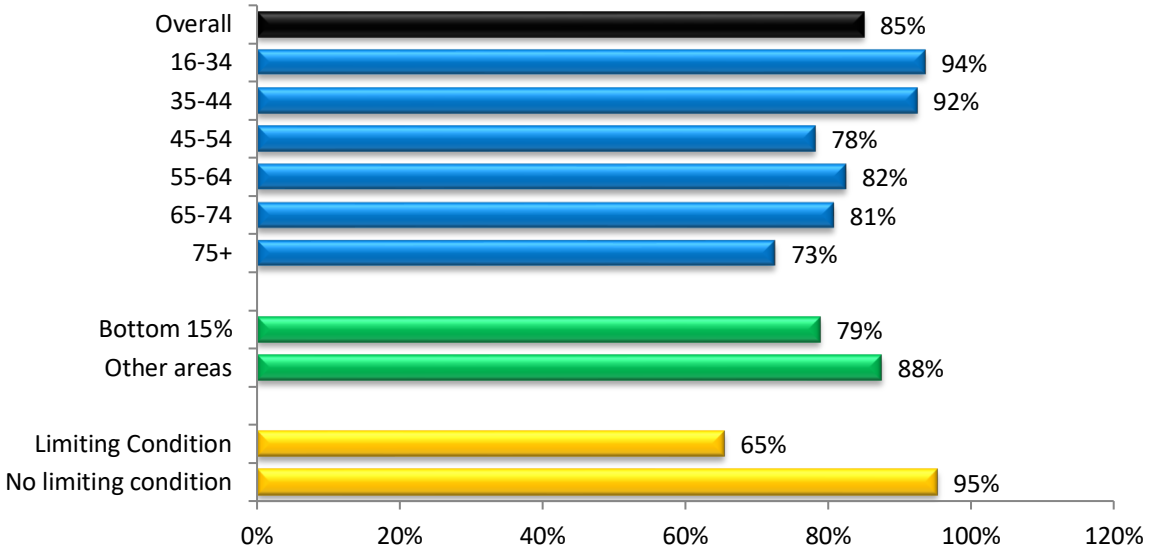


2.2 Self-Perceived Quality of Life

Using the 'faces' scale, respondents were asked to rate their overall quality of life. Overall, 85% gave a positive rating of their quality of life.

- Those aged 75 or over were the least likely to give a positive rating of their overall quality of life, and those aged under 45 were the most likely.
- Those in the most deprived areas were less likely to have a positive perception of their overall quality of life.
- Those with a long-term limiting condition or illness were less likely than others to have a positive view of their quality of life.

Figure 2.5: Positive Perception of Quality of Life by Age, Deprivation and Limiting Conditions



2.3 Long Term Conditions or Illness

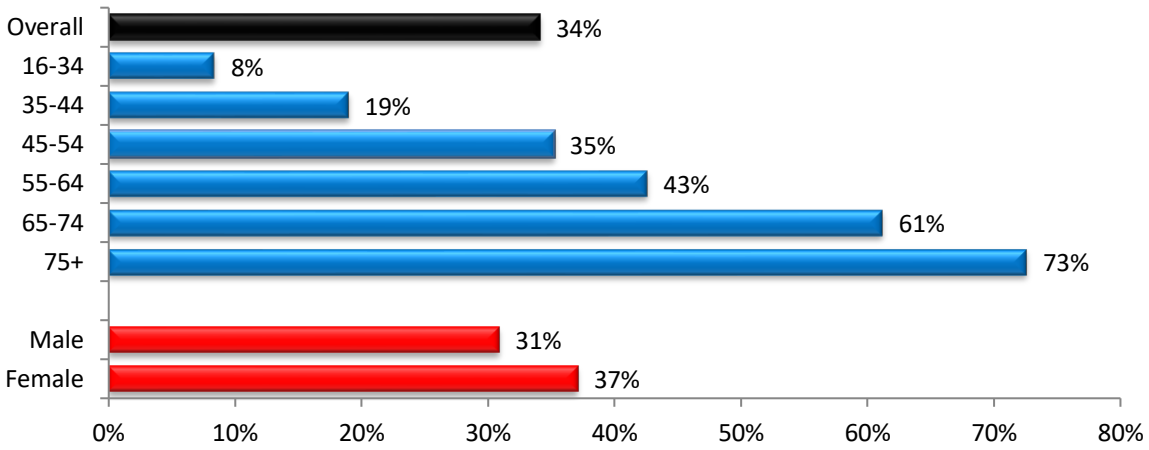
One in three (34%) said they had a long-term condition or illness that substantially interfered with their day to day activities. Of those who had a long-term limiting condition or illness:

- 46% had a physical disability
- 16% had a mental or emotional health problem
- 65% had a long-term illness.

The likelihood of having a long-term limiting condition or illness increased with age from 8% of those aged under 35 to 73% of those aged 75 or over.

Women were more likely than men to have a long-term limiting condition or illness.

Figure 2.6: Limiting Long-Term Condition or Illness by Age and Gender



Although overall women were more likely than men to have a long-term limiting condition or illness, this was mostly attributable to those aged 65 or over, as Table 2.1 shows.

Table 2.1: Limiting Long-Term Condition or Illness by Age and Gender

	Limiting Long-Term Condition or Illness
Men 16-44	11%
Women 16-44	13%
Men 45-64	38%
Women 45-64	40%
Men 65+	57%
Women 65+	73%

Comparison with NHSGGC

The proportion in West Dunbartonshire who had a limiting long-term condition or illness (34%) was higher than in the NHSGGC area as a whole (31%).

Evidence from Other Sources

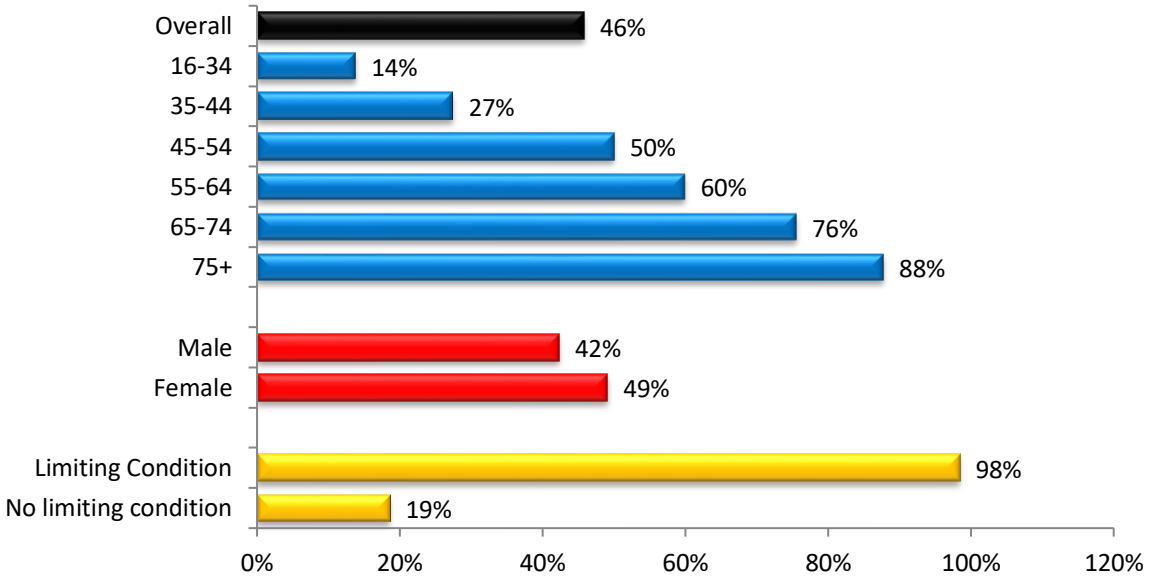
- The proportion who reported having a limiting long-term condition/illness (34%) was slightly lower than the national figure from the **Scottish Health Survey (2022)** which found that overall 37% had a limiting condition/illness, showing an overall increase from 26% in 2008 and from 34% in 2021.

Illnesses/Conditions for Which Treatment is Being Received

Just under half (46%) of respondents said they had one or more illness or condition for which they were currently being treated (not necessarily 'limiting' illnesses/conditions) – 20% were being treated for one condition, and 26% were being treated for two or more.

- The proportion being treated for any conditions/illnesses increased with age from 14% of those aged under 35 to 88% of those aged 75 or over.
- Women were more likely than men to be receiving treatment.
- Most (98%) of those who had a long-term limiting condition or illness said they were receiving treatment.

Figure 2.7: Proportion Receiving Treatment for at Least One Condition by Age, Gender and Limiting Conditions



The overall gender difference was largely attributable to the gender difference observed for those aged 65 and over.

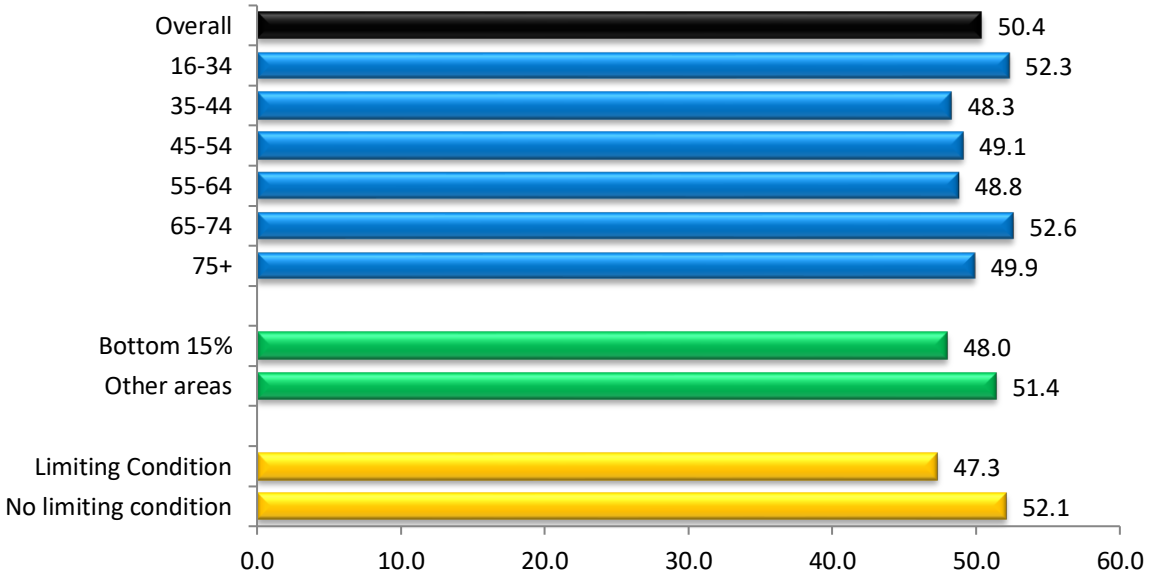
Table 2.2: Proportion Receiving Treatment for at Least One Condition by Age and Gender

	Receiving treatment
Men 16-44	18%
Women 16-44	20%
Men 45-64	54%
Women 45-64	57%
Men 65+	73%
Women 65+	86%

2.4 Mental Health

The self-completion section of the main survey questionnaire included the fourteen questions of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS). This measures mental wellbeing. The mean WEMWBS score was 50.4. Mean WEMWBS scores varied significantly by age, deprivation and limiting conditions, as Figure 2.8 shows.

Figure 2.8: Mean WEMWBS Scores by Age, Deprivation and Limiting Conditions (Higher Scores = better mental wellbeing)



Validated categorisations of WEMWBS scores are:

- Score under 41: Probable clinical depression
- Score 41-44: Possible/mild depression
- Score 45+: No depression

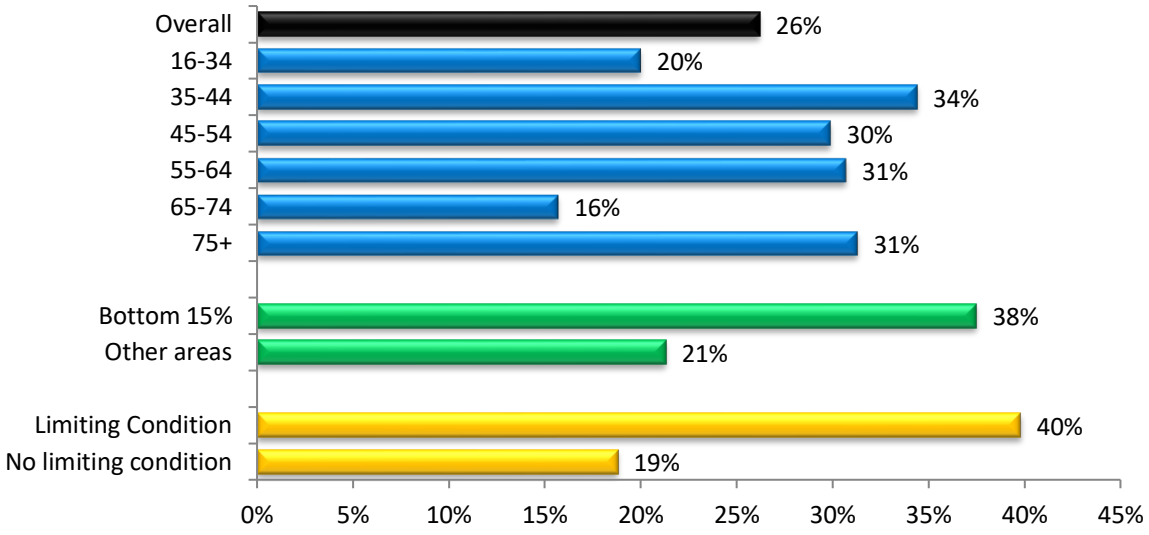
Using these categories, 26% had a WEMWBS score indicating depression – either probable clinical depression (14%) or possible mild/depression (12%).

- Those aged 35-64 were the most likely to have a score indicating depression.

- Just under two in five (38%) of those in the most deprived areas had a score indicating depression, compared to one in five (21%) of those in other areas.

- Those with a limiting condition or illness were much more likely than others to have a score indicating depression.

Figure 2.9: Proportion with WEMWBS Scores Indicating Depression by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire had a lower mean WEMWBS score (50.4 West Dunbartonshire; 51.2 NHSGGC).

Evidence from Other Sources

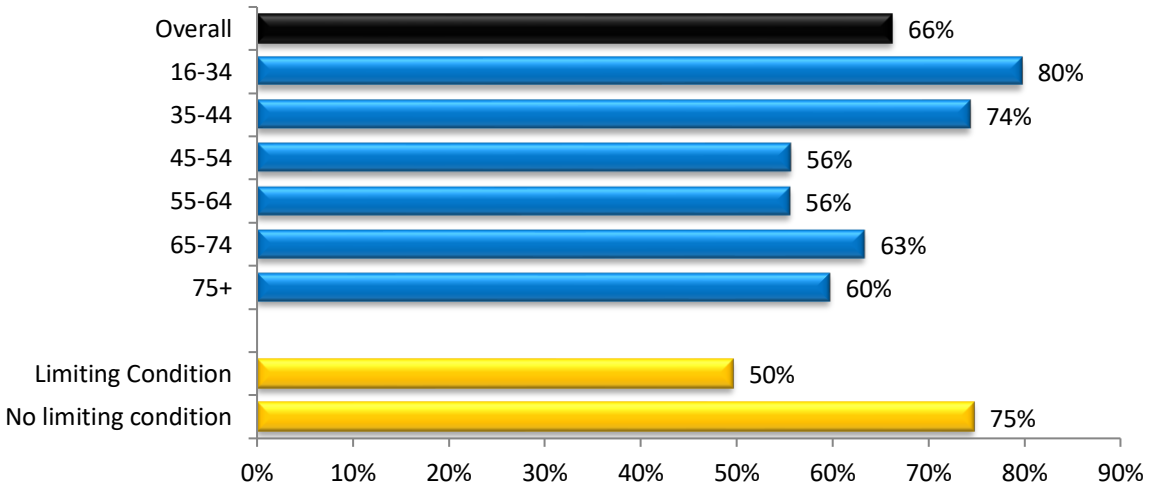
- The **Scottish Health Survey (2022)** found, after a decade of fairly constant mean WEMWBS scores, there was a decrease between 2019 and 2021 from 49.8 to 48.6, and a further decrease to 47.0 in 2022 - lower than the mean of 50.4 in West Dunbartonshire measured by the NHSGGC survey. The mean SHS WEMWBS score in 2022 for the most deprived quintile was 44.7.

2.5 Dental Health

Respondents were asked how they would describe the current state of the health of their mouth and teeth. Two in three (66%) said they felt their mouth and teeth were in good health, while 25% said they felt that their mouth and teeth had some problems that need to be fixed and 9% said they felt their mouth and teeth were in a poor state.

- Those aged under 35 were the most likely to rate their mouth/teeth as being in good health.
- Those with a long-term limiting condition or illness were less likely than others to say they felt their mouth/teeth were in good health.

Figure 2.10: Proportion Rating Mouth/Teeth as in Good Health by Age and Limiting Conditions



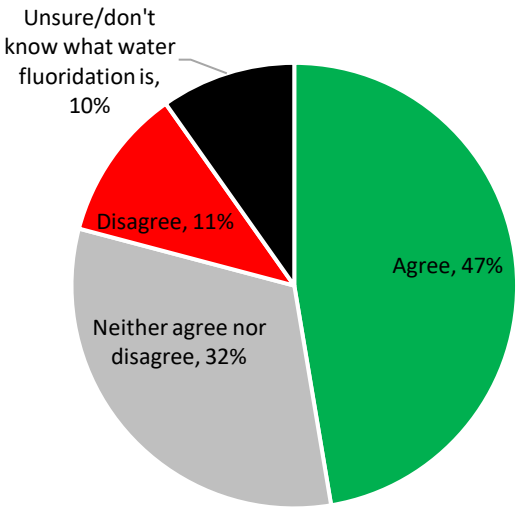
Comparison with NHSGGC

Those in West Dunbartonshire were less likely than those in the NHSGGC area as a whole to rate their mouth/teeth as in good health (66% West Dunbartonshire; 70% NHSGGC).

Just over half (53%) of adults indicated that in the last two years they had required services for a dental problem. Of these, most (90%) had used a high street dental practice. Other services used were: pharmacist (10%), medical GP (6%), out of hours/emergency dental service (4%), and Accident and Emergency Department (2%).

Respondents were asked the extent to which they agreed or disagreed with the statement: 'I am open to the possibility of water fluoridation in my local area'. Overall, 47% agreed with this, while 11% disagreed and 42% either said they did not agree nor disagree or that they were unsure/did not know what fluoridation is.

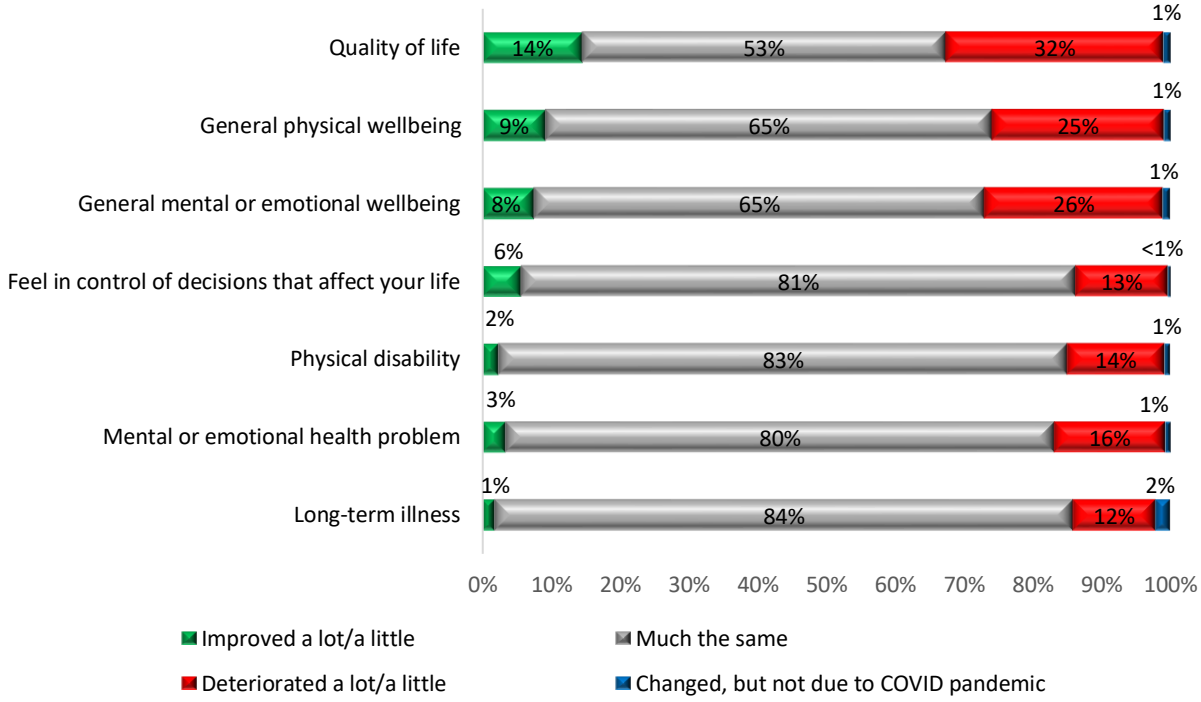
Figure 2.11: Responses to the statement 'I am open to the possibility of water fluoridation in my local area'



2.6 Effects of COVID on Health and Wellbeing

Respondents were asked how a number of health and wellbeing indicators had changed for them due to the COVID pandemic. Responses are shown in Figure 2.12. For each indicator, most said they were 'much the same'. However, 32% said their quality of life had deteriorated due to the pandemic; 26% said their general mental or emotional wellbeing had deteriorated and 25% said their general physical wellbeing had deteriorated due to the pandemic.

Figure 2.12: Perceived Effects of the COVID Pandemic on Wellbeing

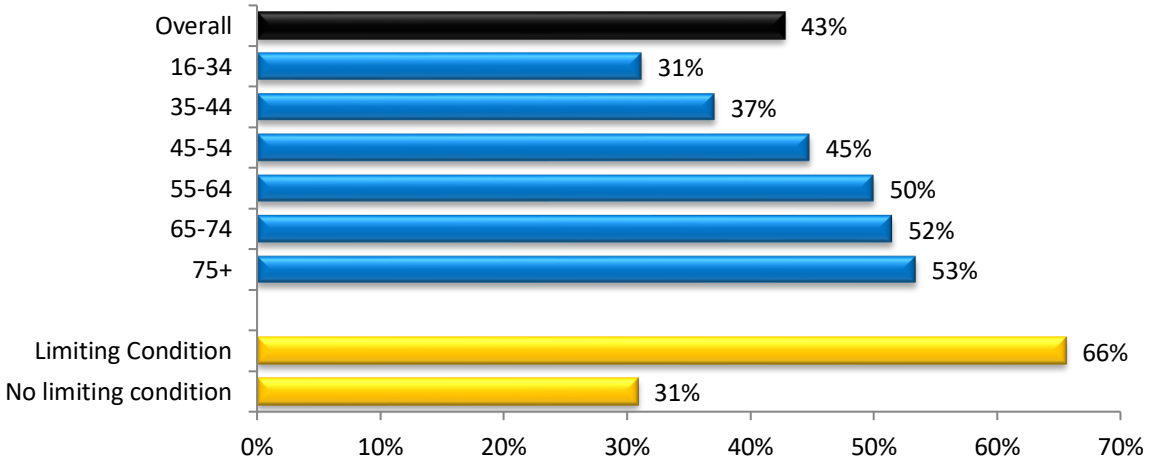


Overall, 43% said that at least one of the health and wellbeing indicators had deteriorated due to the COVID pandemic.

- The likelihood of having perceived negative effects of COVID on health and wellbeing indicators was lowest for the youngest age groups and higher for the oldest groups.

- Those with a limiting condition or illness were much more likely than others to report negative effects of the pandemic on wellbeing.

Figure 2.13: Proportion Reporting Deterioration of at Least One Wellbeing Indicator due to the COVID Pandemic by Age and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to report negative effects of COVID on wellbeing (43% West Dunbartonshire; 47% NHSGGC).

2.7 Summary of Key Messages from This Chapter

Indicators where West Dunbartonshire Compared Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- more likely to have a positive perception of their mental/emotional wellbeing
- less likely to have perceived negative effects of COVID on wellbeing indicators.

Indicators where West Dunbartonshire Compared less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire:

- were less likely to have a positive view of their general health
- were more likely to have a limiting long term condition or illness
- had lower mean WEMWBS scores
- were less likely to rate their mouth/teeth as in good health.

Differences by Age and Gender

- Those aged 75 or over were the least likely to have positive views of their general health, physical wellbeing and quality of life, and the least likely to definitely feel in control of the decisions affecting their life.

- Men were more likely than women to have positive views of their physical wellbeing.

- Women were more likely than men to definitely feel in control of the decisions affecting their life.

- Those aged 75 or over were the most likely to have a limiting long-term condition or to be receiving treatment.

- Women were more likely than men to have a limiting long-term condition or to be receiving treatment.

- Those aged 35-44 were the age group most likely to have a WEMWBS score indicating depression.

- Those aged under 35 were the most likely to rate their mouth/teeth as in good health.

Differences by Deprivation

Those living in the most deprived areas were:

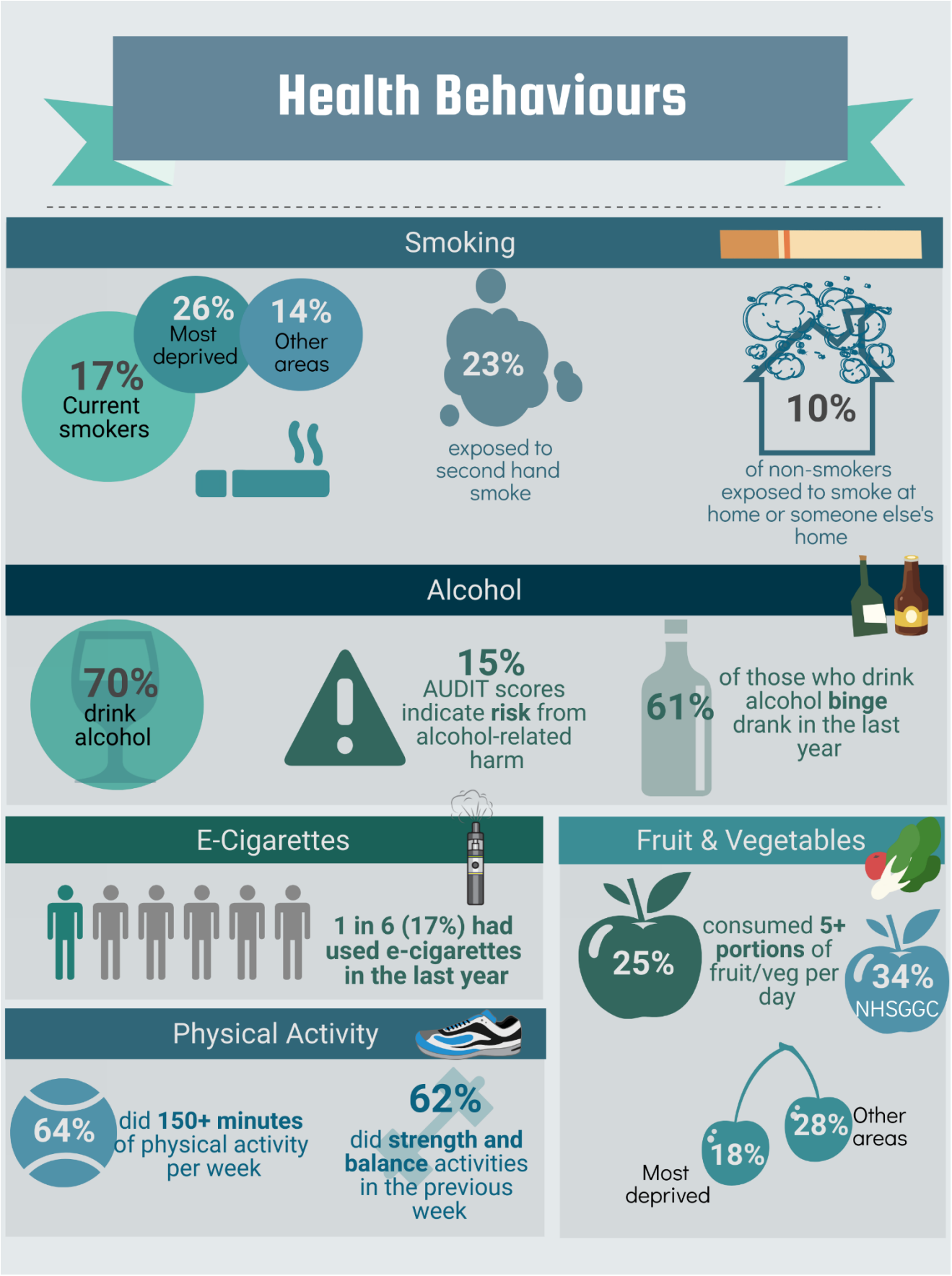
- less likely to have a positive view of their general health, physical wellbeing, mental/emotional wellbeing or quality of life
- more likely to have a WEMWBS score indicating depression.

Differences by Limiting Conditions

Those with a long-term limiting condition or illness were:

- less likely to have positive views of their general health, physical wellbeing, mental/emotional wellbeing and quality of life
- less likely to definitely feel in control of the decisions affecting their life
- more likely to be receiving treatment for at least one condition
- more likely to have a WEMWBS score indicating depression
- less likely to feel their mouth/teeth were in good health
- more likely to report deterioration of wellbeing indicators due to the COVID pandemic.

3 Health Behaviours

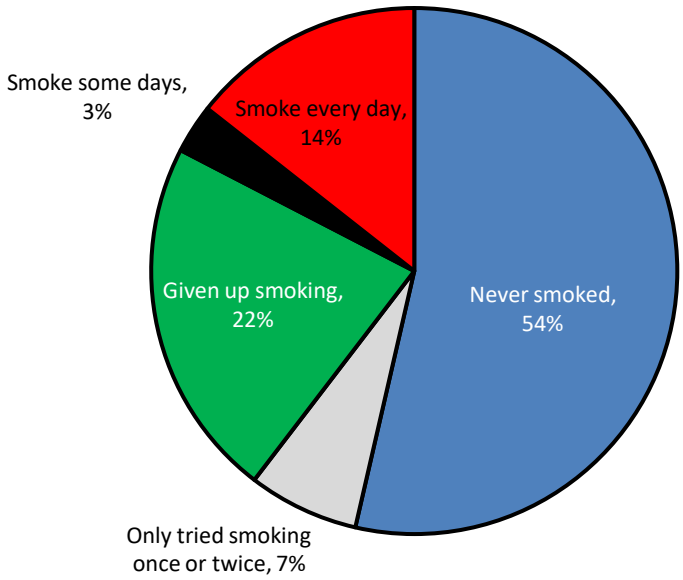


3.1 Smoking

Smoking

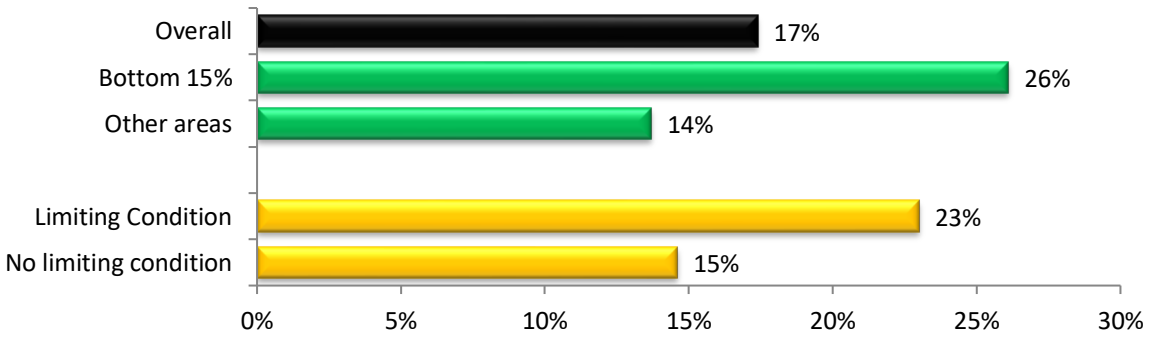
One in six (17%) were smokers, smoking either every day (14%) or some days (3%).

Figure 3.1: Current Smoking Status



- Those in the most deprived areas were much more likely than those in other areas to be smokers.
- Those with a limiting condition or illness were more likely than others to be smokers.

Figure 3.2: Proportion of Current Smokers by Deprivation and Limiting Conditions



Among current smokers, 29% indicated they wanted to stop smoking soon, 40% did not want to stop smoking and a further 31% wanted to stop or felt they should but did not plan to do so soon.

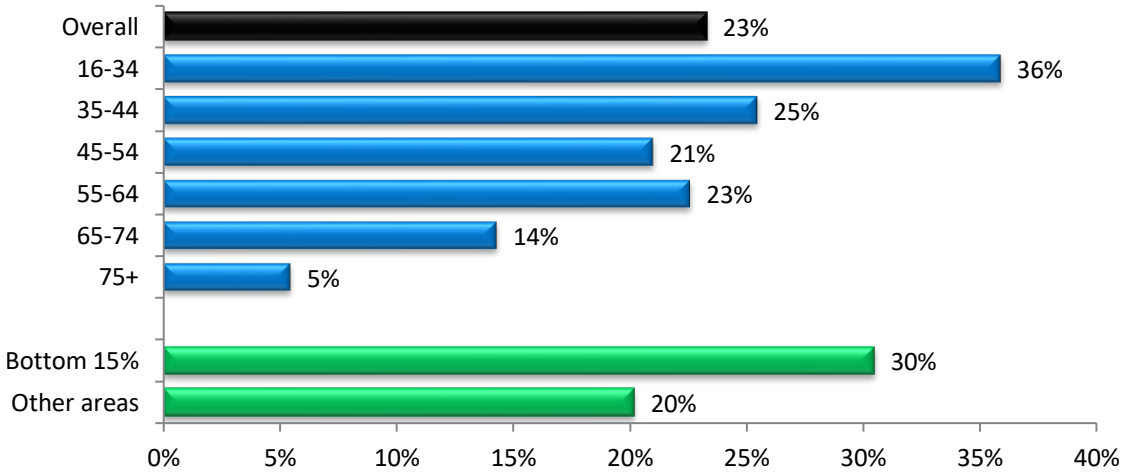
Exposure to Second Hand Smoke

Respondents were asked how often they were in places where there is smoke from other people smoking tobacco. Overall, 23% said that this happened most of the time (8%) or some of the time (15%). A further 23% said that they were seldom exposed to second hand smoke and 53% said they were never exposed.

- Those aged under 35 were the most likely to be exposed to second hand smoke and those aged 75 or over were the least likely.

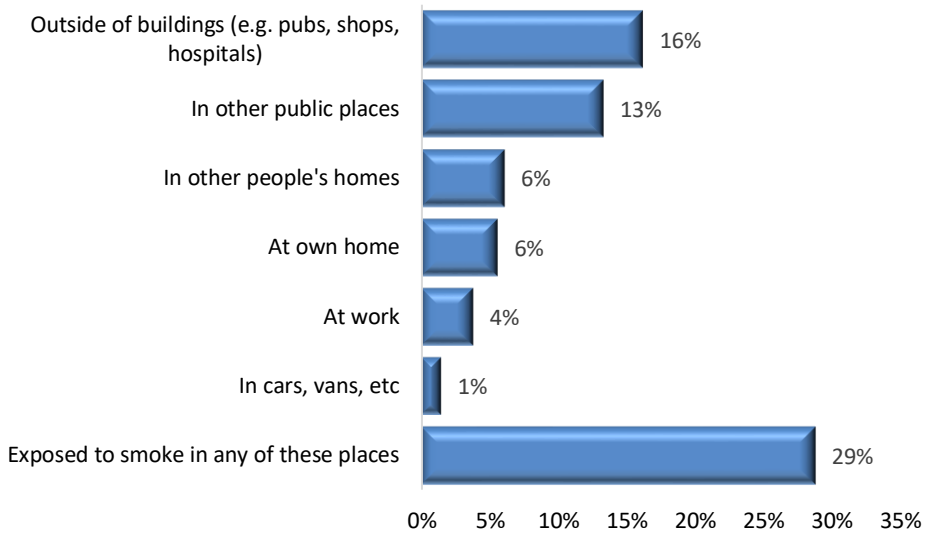
- Those in the most deprived areas were more likely to be exposed to second hand smoke.

Figure 3.3: Exposure to Second Hand Smoke (most/some of the time) by Age and Deprivation



Respondents were also asked whether they were exposed to other people's smoke in any of a number of places. Responses are shown in Figure 3.4 for non-smokers. Overall, 29% of non-smokers were exposed to smoke in at least one of these places, the most common being outside of buildings (16%).

Figure 3.4: Proportion of Non-Smokers Exposed to Second Hand Smoke in Specific Places



Base: Non-smokers (unweighted N=839)

In total, 10% of non-smokers were exposed to cigarette smoke in their own or someone else's home.

Policy Context – Smoking

Legislation and policy in Scotland had sought to decrease smoking and exposure to second hand smoke over the last 15 years as follows.

- In 2006, the Smoking Health and Social Care (Scotland) Act was introduced which banned smoking in enclosed public spaces. https://www.legislation.gov.uk/asp/2005/13/contents
  National evaluation of Scotland's smoke free legislation https://www.ashscotland.org.uk/what-we-do/supply-information-about-tobacco-and-health/resources/national-evaluation-of-scotlands-smoke-free-legislation/
- In 2007, the minimum age for the sale or purchase of tobacco was raised from 16 to 18.
- The Tobacco and Primary Medical Services Act 2010 made provision about the retailing of tobacco products, including provision prohibiting the display of tobacco products and establishing a register of tobacco retailers https://www.legislation.gov.uk/asp/2010/3/contents
- In 2013, the Scottish Government published its strategy on tobacco *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland.* This set a target to reduce smoking rates to 5% or less among the adult population by 2034. https://www.gov.scot/resource/0041/00417331.pdf
- The above strategy contained a specific action that 'all NHS Boards will implement and enforce smoke-free grounds by March 2015'. The Prohibition of Smoking in Certain Premises (Scotland) Regulations 2006 allowed for certain exemptions within mental health units, so a phased approach was taken. https://www.legislation.gov.uk/ssi/2006/90/contents/made
- CEL 01(2012) sets out the expectation of all NHS grounds being smoke-free, including mental health units. In 2016 all mental health units in NHS GGC became smokefree.

- The Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill was passed in 2016 which made provisions for the sale and purchase of Nicotine Vapour Products and introduced smoke-free perimeters around NHS hospitals. http://www.parliament.scot/parliamentarybusiness/Bills/89934.aspx
- At the end of 2016, a ban on smoking in cars carrying anyone aged under 18 was introduced Smoking Prohibition (Children in Motor Vehicles) (Scotland) Act 2016 https://www.legislation.gov.uk/asp/2016/3/contents
- A 5-year action plan was produced in June 2018, *Raising Scotland's Tobacco Free Generation,* the new plan for 2023 onwards is in development. https://www.gov.scot/publications/raising-scotlands-tobacco-free-generation-tobacco-control-action-plan-2018/
- In 2022 Scottish Government launched a consultation on *Tightening rules on advertising and promoting vaping products* to seek views on proposed regulations which aim to strike a balance between protecting non-smokers and making information available to smokers. https://www.gov.scot/publications/tightening-rules-advertising-promoting-vaping-products-consultation-paper-2022/documents/
- The *Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022* made it an offence to smoke within 15 metres of a hospital building. This applies to everyone, including staff, visitors, and patients and applies to all NHS hospital buildings in Scotland. https://www.legislation.gov.uk/sdsi/2022/9780111053843?view=plain

• **The 2022 Scottish Health Survey** showed that 15% of adults in Scotland were current smokers, slightly lower than the rate of 17% in West Dunbartonshire as measured by the NHSGGC survey in 2022/23. As in West Dunbartonshire, nationally smoking was more prevalent in the most deprived areas - 25% in the most deprived quintile were smokers.

E-Cigarettes/Vaping

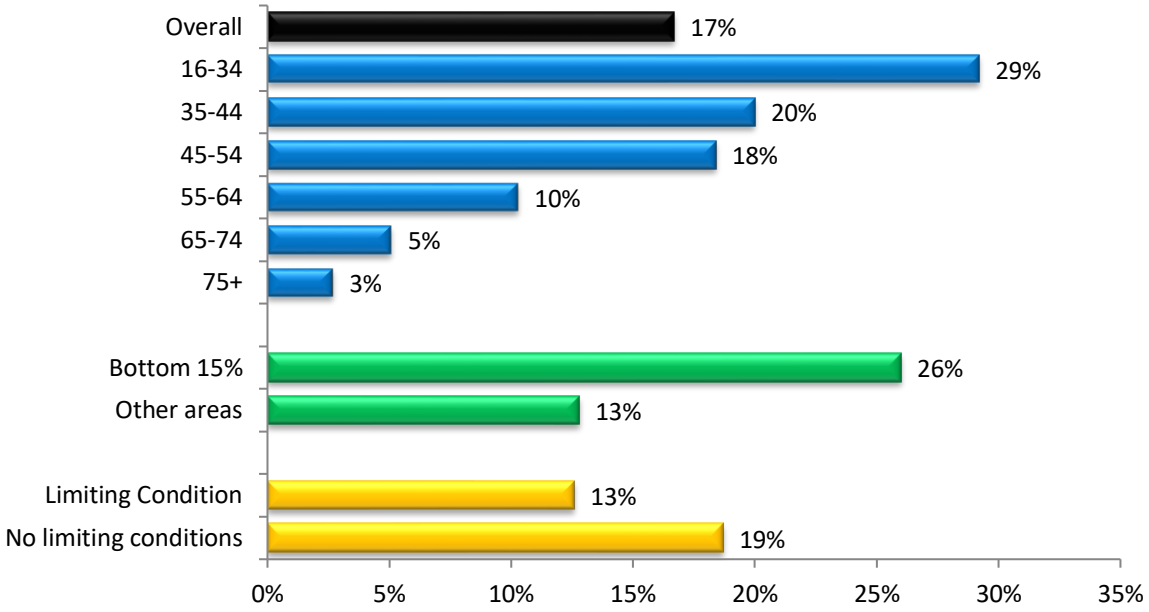
In total, 17% had used e-cigarettes at least some days in the last year. These comprised 6% who had used e-cigarettes every day in the last year, 6% who had done so on some days and 4% who had done so just once or twice in the last year.

- The likelihood of using e-cigarettes decreased with age from 29% of those aged under 35 to 3% of those aged 75 or over.

- Those in the most deprived areas were twice as likely as others to have used e-cigarettes on at least some days in the last year.

- Those with a limiting condition or illness were less likely than others to have used e-cigarettes in the last year.

Figure 3.5: Proportion who had used E-Cigarettes in the Last Year by Age, Deprivation and Limiting Conditions



3.2 Alcohol

AUDIT Scores

The survey used a series of 10 questions which comprise the Alcohol Use Disorders Identification Test (AUDIT). The AUDIT scoring is shown in Appendix E. Together, responses to these questions allow scores to be calculated for each respondent and categorised according to a level of risk. The proportion which fell into each category is shown in Table 3.1.

Table 3.1: Proportion in each Alcohol Use Disorders Identification Test (AUDIT) Category

	%
Low Risk (AUDIT score 0-7)	85.3%
Increasing Risk (AUDIT score 8-15)	14.0%
Higher Risk (AUDIT score 16-19)	0.3%
Possible Dependence (AUDIT score 20+)	0.4%

Those with a score greater than 7 indicates increased risk (15%).

Men were twice as likely as women to have a score indicating risk (20% male; 10% female).

Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to have an AUDIT score indicating risk (15% West Dunbartonshire; 17% NHSGGC).

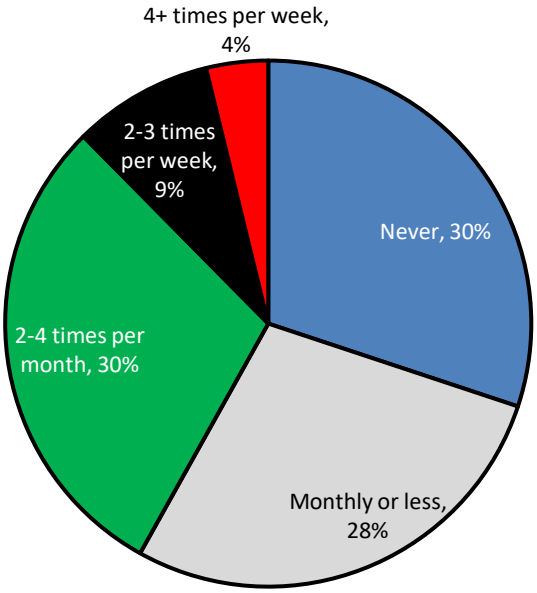
Evidence from Other Sources

- **The 2021 Scottish Health Survey** found that nationally, 14% of adults had AUDIT scores indicating risk (18% for men and 9% for women), similar to the levels measured in West Dunbartonshire in 2022/23.

Frequency of Drinking

Respondents were asked how often they drank alcohol. Three in ten (30%) said they never drank alcohol, but 12% drank alcohol at least twice per week.

Figure 3.6: How Often Drank Alcohol



Those with a limiting condition or illness were less likely than others to drink alcohol (64% compared to 73%)

Evidence from Other Sources

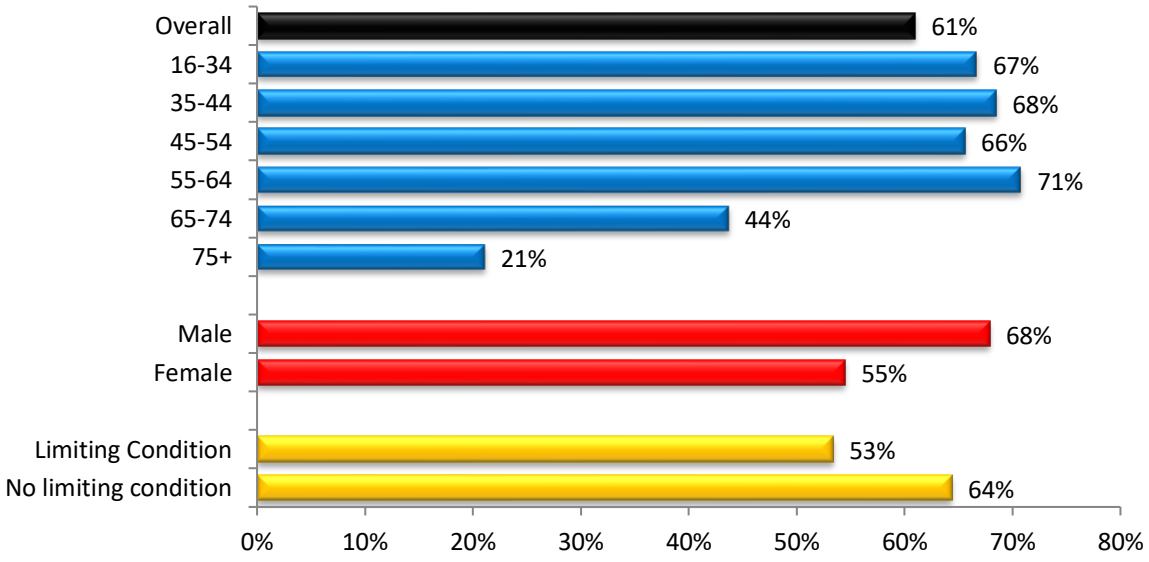
- **The 2022 Scottish Health Survey** found that nationally, 81% of adults drank alcohol (83% of men and 79% of women) - much higher than the 70% in West Dunbartonshire measured by the NHSGGC survey.

Binge Drinking

Those who drank alcohol were asked how often they had 6 or more units if female, or 8 or more if male on a single occasion in the last year. In total, 61% of drinkers had drunk alcohol at this level in the last year – 2% had done so daily/almost daily, 16% weekly, 13% monthly, and 30% less than monthly.

- Drinkers aged under 65 were more likely than older drinkers to binge.
- Male drinkers were more likely than female drinkers to binge.
- Among drinkers, those with a limiting condition or illness were less likely than others to binge.

Figure 3.7: Proportion of Alcohol Drinkers who had Consumed 6+ Units (if female) or 8+ units (if male) on a Single Occasion in the Last Year by Age, Gender and Limiting Conditions



Base: Those who drank alcohol (unweighted N=708).

Policy Context – Alcohol

- The Scottish Government published *Changing Scotland's Relationship with Alcohol: a Framework for Action* in 2009 which set out measures to reduce alcohol consumption, support families and communities, promote positive attitudes and positive choices and improve treatment and support.
  https://www.gov.scot/Publications/2009/03/04144703/0

- Initiatives introduced since the framework was implemented include the delivery of alcohol brief interventions and the establishment of Alcohol and Drug Partnerships. Since ADP's have been formed they have developed strategies, most recently covering 2020 - 2023, with the aims of reducing the harms and health inequalities caused by alcohol and drugs.

- Legislation implemented has included the quantity discount ban and the introduction of a lower drink-drive limit.

- Alcohol Minimum pricing legislation was introduced in 2018 (after the NHSGGC health and wellbeing survey fieldwork concluded)
  http://www.legislation.gov.uk/asp/2012/4/contents/enacted

- In November 2018, The Scottish Government published *Rights, Respect and Recovery – Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths*
  https://www.gov.scot/publications/rights-respect-recovery/

Attitudes to Places Selling Alcohol

Three in four (76%) adults felt that there was the right amount of off-licences, local grocers and supermarkets selling alcohol in their local area, while 18% felt there were too many and 5% felt there were too few.

When considering the amount of pubs, bars and restaurants selling alcohol in their local area, 74% felt there was the right amount, 17% felt there was too many and 9% felt there was too few. The proportion saying there were too many was higher for those with a limiting condition or illness (24% limiting condition; 14% others).

3.3 Diet

Fruit and Vegetables

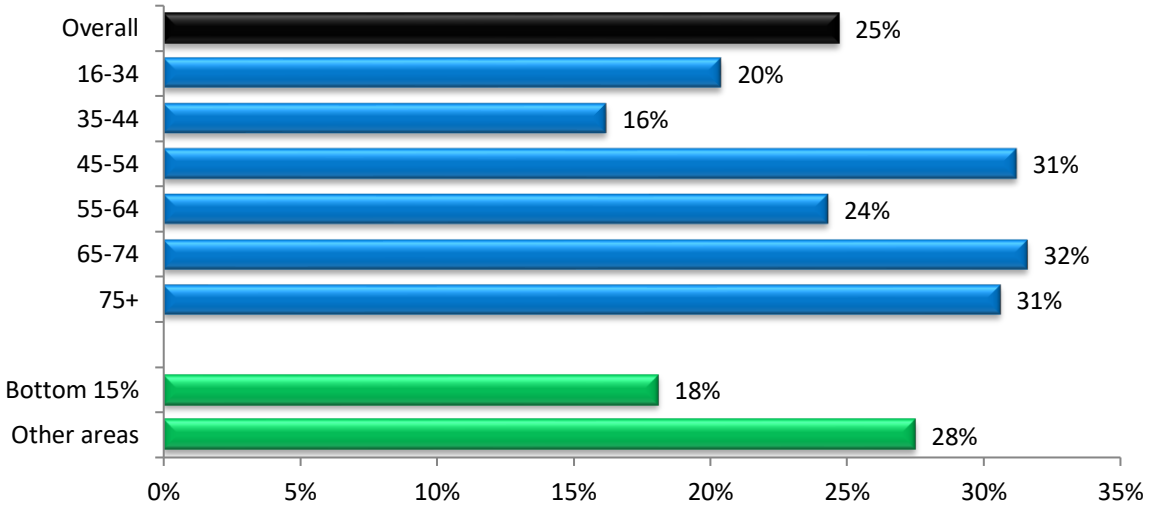
The national target for fruit and vegetable consumption is to have at least five portions of fruit and/or vegetables per day. Respondents were asked how many portions of fruit and how many portions of vegetables they had consumed on the previous day.

- One in four (25%) met the target of five portions.
- One in 11 (9%) had consumed no fruit or vegetables in the previous day.

There was no clear pattern by age group, but those aged 35-44 had the lowest proportion who met the target for fruit/vegetable consumption.

Those in the most deprived areas were less likely than others to consume five or more portions of fruit/vegetables per day.

Figure 3.8: Proportion who Met the Target of 5+ Portions of Fruit/Vegetables Per Day by Age and Deprivation



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to meet the target of consuming five or more portions of fruit/vegetables per day (25% West Dunbartonshire; 34% NHSGGC).

Evidence from Other Sources

- **The 2021 Scottish Health Survey**, which used a more detailed exploration of food intake and mean number of portions per day, found that 22% of adults meet the target for fruit/vegetable consumption - a rate which has remained fairly consistent since 2003. This may indicate that the rate measured by the NHSGGC survey based on self-reported numbers of 'portions' based on 'yesterday' may represent some over-estimating.

Policy Context: Diet

- In 2010 the Scottish Government published *Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight.* This was complemented by *The Obesity Route Map Action Plan*, which set out actions to address the increasing prevalence of obesity in Scotland.
  https://www.gov.scot/Publications/2010/02/17140721/0

- In January 2015, the Scottish Government launched *Eat Better Feel Better* to encourage and support people to make healthier choices to the way they shop, cook and eat. This is now known as Parent Club.
  Food & Eating | Parent Club

- Following a consultation from October 2017 to January 2018, the Scottish Government published its diet and healthy weight delivery plan in July 2018, 'A Healthier Future'. This recognises that eating habits are the second major cause (after smoking) of poor health in Scotland, and sets out approaches to address children's diet, ensure food environment supports healthier choices, provide access to weight management services, promote healthy diet and weight, and reduce diet-related health inequalities.
  https://beta.gov.scot/publications/healthier-future-scotlands-diet-healthy-weight-delivery-plan/pages/3/

- As part of *A Healthier Future*, the Scottish Government set out a framework for Type 2 Diabetes prevention, early detection and intervention in July 2018.
  https://www.gov.scot/publications/healthier-future-framework-prevention-early-detection-early-intervention-type-2/

- Turning the tide through prevention: Public Health Strategy (2018-2028) concentrates on improving public health in NHS Greater Glasgow and Clyde and sets out many programmes for action including, *applying a life- course approach, recognising the*

importance of early years and healthy ageing in relation to diet and physical activity.
Public Health Strategy 2018 - 2028 A4 - Landscape - 10-08-18-01.pdf (scot.nhs.uk)

- Food Standards Scotland have developed an online tool "Eat well your way" to help people in Scotland make healthier food and drink choices when planning and shopping, preparing food and eating out.

  Diet and healthy weight: out of home action plan - gov.scot (www.gov.scot)

3.4 Physical Activity

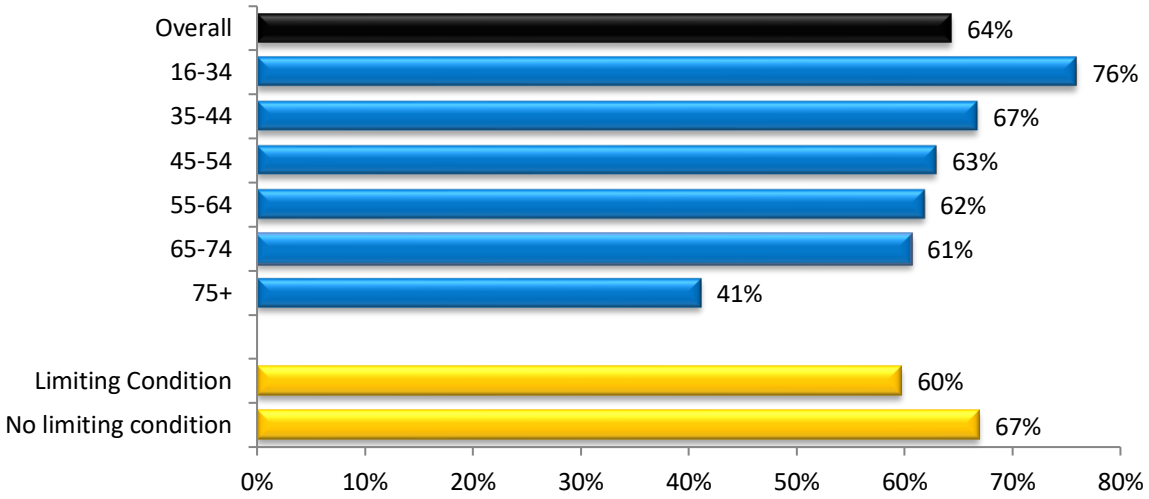
Respondents were asked on how many days in the last week had they taken a total of 30 minutes or more of physical activity which was enough to increase their heart rate, make them feel warmer and made them breathe a little faster. The 2022/23 survey for the first time included the instruction to count vigorous activity such as running as double. Overall, 17% said that they had not taken physical activity for 30 minutes on any day in the last week, but 44% has done this on five or more days in the last week. The mean number of days was 3.8.

Subsequently, respondents who had been active for 30 minutes or more on fewer than five days were asked whether they had done this type of activity for at least a total of two and a half hours (150 minutes) over the course of the last week, again with vigorous activity counting double. Combining the responses to both questions, 64% met the target of at least 150 minutes of exercise per week.

- Those aged under 35 were the most likely to meet the target for physical activity and those aged 75 or over were the least likely.

- Those with a limiting condition or illness were less likely to meet the physical activity target.

Figure 3.9: Proportion who met the Target of 150 Minutes of Exercise Per Week by Age and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to meet the target for physical activity (64% West Dunbartonshire; 70% NHSGGC).

Evidence from Other Sources

- **The 2021 Scottish Health Survey** found that nationally, 69% met the target for physical activity (higher than the rate measured by the NHSGGC survey for West Dunbartonshire in 2022/23). The Scottish Health Survey has seen a continual increase in the proportion meeting the physical activity target since 2012 when it was 62%.

Policy Context – Physical Activity

- In 2014, the Scottish Government published *A More Active Scotland – building a legacy from the Commonwealth Games* which set out a 10-year physical activity implementation plan which aimed to get the population more physically active through initiatives to increase uptake of sport, physical activity and active travel. The plan included efforts in education, work place settings, health and social care, and facilities and infrastructure. https://beta.gov.scot/publications/more-active-scotland-building-legacy-commonwealth-games/

- As part of this overall plan, a National Walking Strategy was launched. https://beta.gov.scot/publications/lets-scotland-walking-national-walking-strategy/

- Also in 2014, a revised Cycling Action Plan for Scotland was launched, and this was subsequently revised in the 2017-2020 plan published in January 2017. https://www.transport.gov.scot/publication/cycling-action-plan-for-scotland-2017-2020/

- Updated National Physical Activity Guidelines (2019) - Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK (www.gov.uk)

- Active Scotland Delivery Plan (2018) - Active Scotland Delivery Plan - gov.scot (www.gov.scot)

- WHO More Active People for a Healthier World (2018) - Global action plan on physical activity 2018–2030: more active people for a healthier world (who.int)

- Scotland Public Health Priorities: Priority 6 (2018) - Scotland's public health priorities - gov.scot (www.gov.scot)

- Public Health Scotland: Physical Activity Referral Standards - Physical activity referral standards - Publications - Public Health Scotland

Strength and Balance Activities

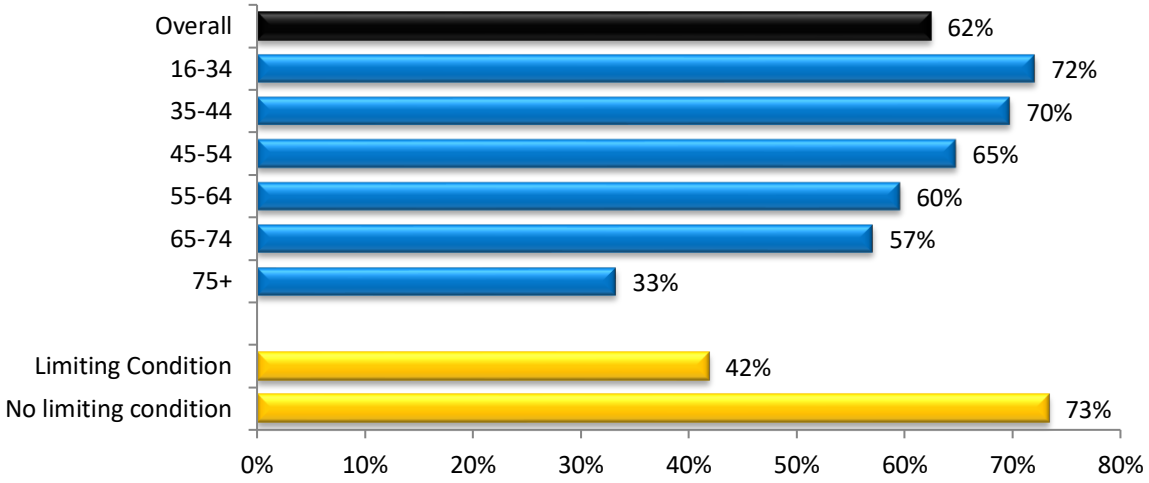
Respondents were asked how many days they had done strength and balance physical activities that made their muscles become warm, shake and/or burn. Examples are weight training, exercise, sport, heavy housework, DIY or gardening.

Overall, 62% had done any of these types of activity in the previous week, including 14% who had done so on five or more days in the previous week.

- Those aged under 45 were the most likely to participate in strength/balance activities and those aged 75 or over were the least likely.

- Those with a limiting condition or illness were less likely than others to participate in strength and balance activities.

Figure 3.10: Proportion who Participated in Strength and Balance Activities in the Previous Week by Age and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were more likely to participate in strength/balance activities (62% West Dunbartonshire; 55% NHSGGC).

Effects of the COVID Pandemic on Physical Activity Levels

Respondents were asked about their physical activity levels since the COVID pandemic started in March 2020. One in four (25%) said they were physically active more often, one in three (33%) said they were active less often and 42% said there was no change to their physical activity levels.

- Those aged under 45 were the most likely to say they were physically more active and those aged 75 or over were the least likely to say this.

- Those with a limiting condition were much more likely than others to say they had become physically less active.

Table 3.2: Physical Activity Levels Since the COVID Pandemic Began by Age and Limiting Conditions

	Physically active more often	Physically active less often	No change to physical activity
16-34	35%	25%	39%
35-44	33%	27%	40%
45-54	18%	36%	46%
55-64	23%	36%	41%
65-74	17%	39%	43%
75+	7%	45%	48%
Limiting Condition	14%	50%	36%
No limiting condition	30%	25%	45%
Overall	25%	33%	42%

3.5 Summary of Key Messages from This Chapter

Indicators where West Dunbartonshire Compared Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to have an AUDIT score indicating alcohol-related risk
- more likely to participate in strength/balance activities.

Indicators where West Dunbartonshire Compared Less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to meet the target of consuming five or more portions of fruit/vegetables per day
- less likely to meet the target of 150 minutes of physical activity per week.

Differences by Age and Gender

- Those aged under 35 were the most likely to be exposed to second hand smoke and to use e-cigarettes.

- Women were more likely than men to use e-cigarettes.

- Men were more likely than women to have an AUDIT score indicating alcohol-related risk, and among those who drank alcohol, men were more likely than women to binge drink. Drinkers aged 65 or over were the least likely to binge.

- Men were more likely than women to have an AUDIT score indicating alcohol-related risk, and among those who drank, more likely than women to binge.

- Those in the oldest age groups were the least likely meet the target for physical activity and the least likely to participate in strength/balance activities.

Differences by Deprivation

Those in the most deprived areas were:

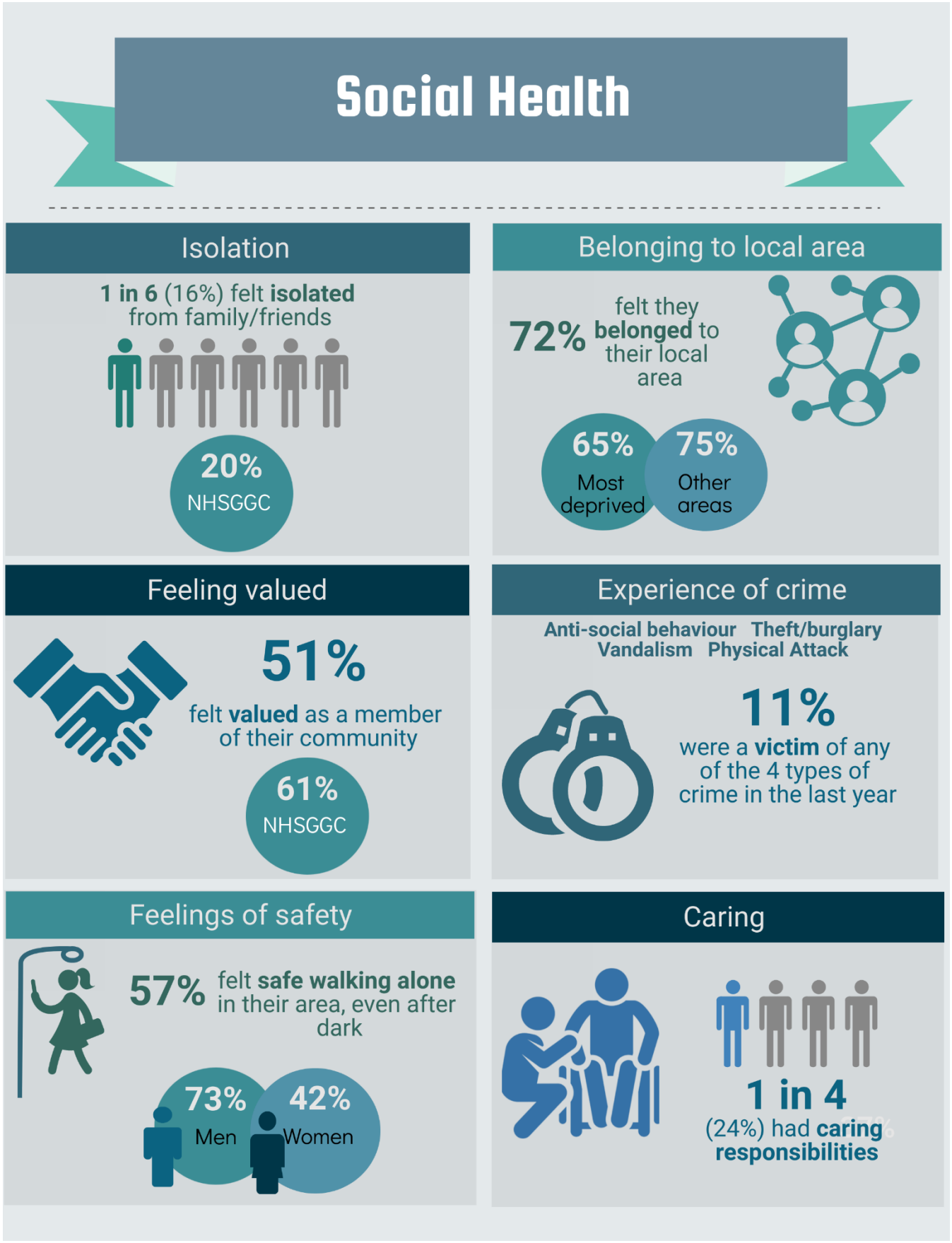
- more likely to smoke and more likely to be exposed to second hand smoke
- more likely to use e-cigarettes
- less likely to meet the target of consuming 5+ portions of fruit/vegetables per day.

Limiting Conditions

Those with a long-term limiting condition or illness were:

- more likely to smoke but less likely to use e-cigarettes
- (among those who drank) less likely to binge
- less likely to meet the target for physical activity and less likely to participate in strength/balance activities.

4 Social Health



4.1 Social Connectedness

Isolation from Family and Friends

One in six (16%) said they felt isolated from family and friends.

Those with a long-term limiting condition or illness were much more likely than others to feel isolated from family and friends (25% compared to 11%).

Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to feel isolated (16% West Dunbartonshire; 20% NHSGGC).

When asked whether feeling of isolation from family and friends had changed due to the COVID pandemic, 6% said it had changed for the better, 20% said it had changed for the worse and 74% said there had been no change.

Those with a long-term limiting condition or illness were more likely than others to say that their isolation from family/friends had changed for the worse due to the COVID pandemic (29% compared to 14%).

Feeling Lonely

Respondents were asked how often they had felt lonely in the past two weeks. Two percent said that had felt lonely all the time, 7% said often, 16% some of the time, 24% rarely and 51% never.

Thus, overall one in four (25%) said that they felt lonely at least some of the time in the previous two weeks.

Those with a long-term limiting condition or illness were more likely than others to say they had felt lonely at least some of the time in the previous two weeks (34% compared to 21%).

Respondents were asked how lonely they had felt compared to before the COVID pandemic which started in March 2020. One in nine (11%) said they felt more lonely and 6% felt less lonely. The remainder either said it was the same as before (49%) or that they never felt lonely (34%).

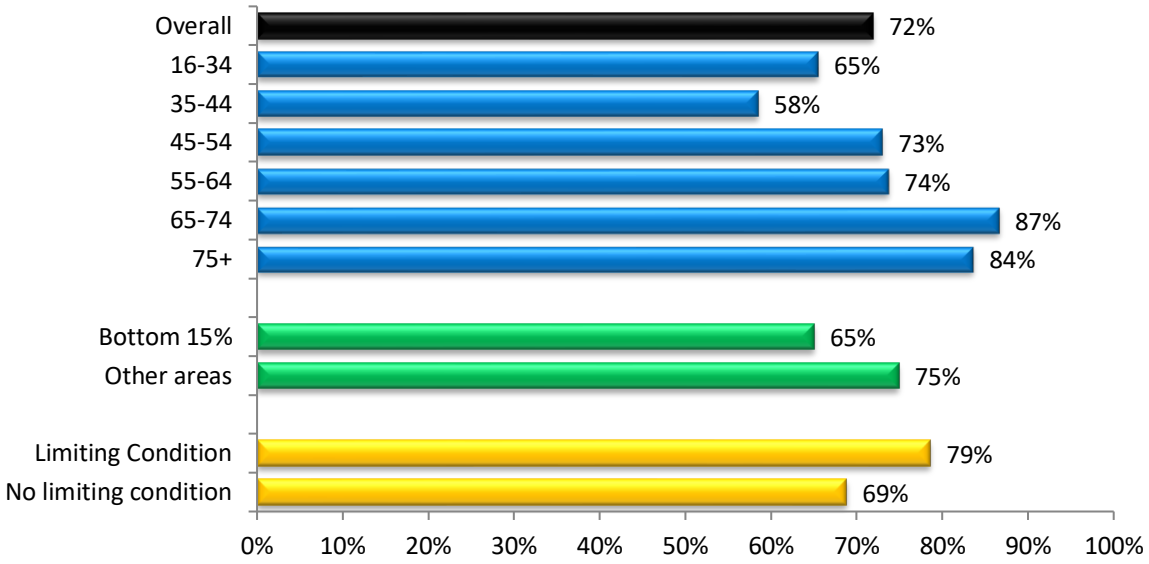
- **The 2022 Scottish Household Survey** found that nationally 23% had experienced feelings of loneliness in the previous week - similar to the 25% in West Dunbartonshire in the NHSGGC survey who who said they had felt lonely at least some of the time in the previous two weeks. Nationally, 29% of those aged 75 or over and 29% of those in the most deprived quintile had felt lonely in the last week.

Sense of Belonging to the Community

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement "I feel I belong to this local area". In total, 72% agreed with this (23% strongly agreed and 49% agreed), while 17% neither agreed nor disagreed and 11% disagreed (9% disagreed and 2% strongly disagreed).

- Those aged under 45 were the least likely to feel they belonged to their local area and those aged 65 or over were the most likely.
- Those in the most deprived areas were less likely than others to feel they belonged to their local area.
- Those with a long-term limiting condition or illness were more likely than others to feel they belonged to their local area.

Figure 4.1: Proportion who Agreed they Felt that they Belonged to their Local Area by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

The proportion in West Dunbartonshire who felt they belonged to their local area (72%) was lower than in the NHSGGC area as a whole (78%).

Evidence from Other Sources

- **The 2022 Scottish Household Survey** asked how strongly people felt they belonged to their community. Across Scotland, 83% said 'very strongly or 'fairly strongly' - higher than the 72% who agreed they belonged to the local community in West Dunbartonshire in the NHSGGC survey. As in West Dunbartonshire, nationally strength of feeling of belonging to the community was lower in the most deprived areas.

Feeling Valued as a Member of the Community

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement "I feel valued as a member of my community". Half (51%) agreed with this (9% strongly agreed and 43% agreed), while 31% neither agreed nor disagreed with this, and 18% disagreed (15% disagreed and 3% strongly disagreed).

Women were more likely than men to feel valued as a member of the community (57% female; 46% male).

Comparison with NHSGGC

The proportion in West Dunbartonshire who felt valued as a member of the community (51%) was lower than in the NHSGGC area as a whole (61%).

Influence in the Neighbourhood

Respondents were asked the extent to which they agreed or disagreed with the statement, "By working together people in my neighbourhood can influence decisions that affect my neighbourhood". Overall, 69% agreed with this (15% strongly agreed and 54% agreed), 23% neither agreed nor disagreed and 8% disagreed (5% disagreed and 2% strongly disagreed).

4.2 Experience of Crime

Respondents were asked whether they had been a victim of specific types of crime in the last year. Overall, 11% had been the victim of any of the four types of crime listed. The most common was anti-social behaviour.

Table 4.1: Proportion who had Been the Victim of Crime in the Last Year

	% Victim in last year
Anti-social behaviour	8.2%
Vandalism	3.0%
Any type of theft or burglary	1.6%
Physical attack	1.4%
Any of the above 4 types of crime	**10.6%**

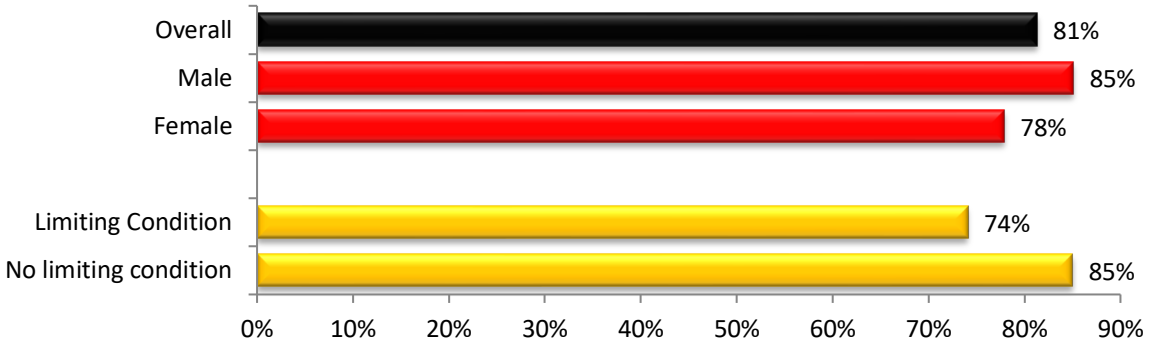
4.3 Feelings of Safety

Respondents were asked the extent to which they agreed or disagreed with the statement "I feel safe using public transport in this local area". In total, 81% agreed with this (17% strongly agreed and 65% agreed), 13% neither agreed nor disagreed and 5% disagreed (5% disagreed and 1% strongly disagreed).

- Men were more likely than women to feel safe using local public transport.

- Those with a limiting condition or illness were less likely than others to feel safe using public transport.

Figure 4.2: Proportion who Felt Safe Using Local Public Transport by Gender and Limiting Conditions



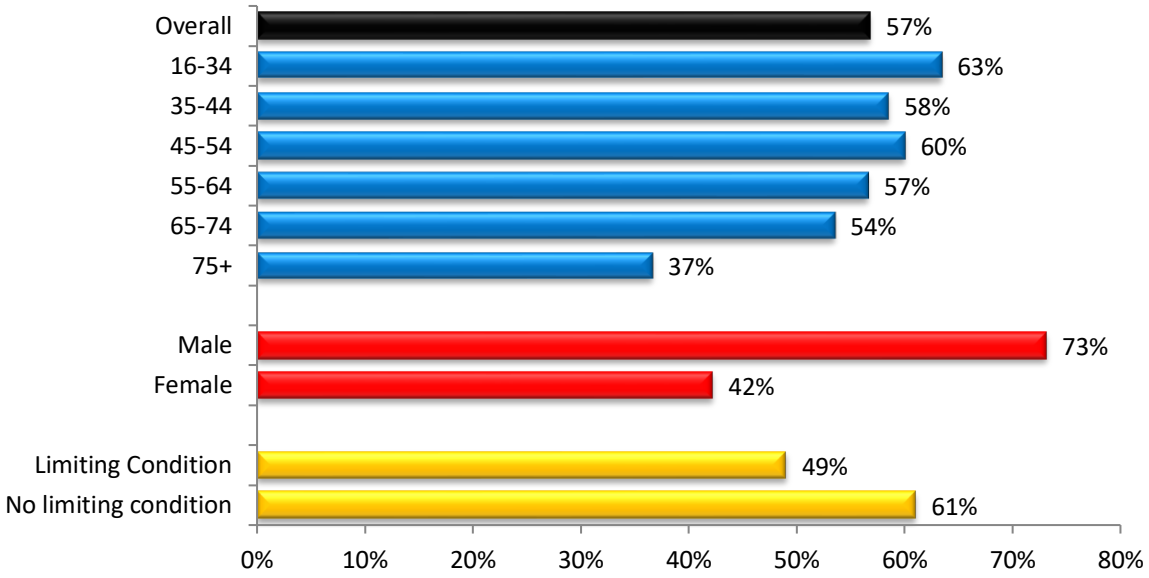
Respondents were also asked the extent to which they agreed or disagreed with the statement "I feel safe walking alone around this local area even after dark". In total, 57% agreed with this (6% strongly agreed and 51% agreed), 17% neither agreed nor disagreed and 26% disagreed (19% disagreed and 7% strongly disagreed).

- Those aged 75 or over were the least likely to feel safe walking alone.

- Women were much less likely than men to feel safe walking alone.

- Those with a limiting condition or illness were less likely to feel safe walking alone.

Figure 4.3: Proportion who Felt Safe Walking Alone in their Local Area Even After Dark by Age, Gender and Limiting Conditions



Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to feel safe:

- using local public transport (81% West Dunbartonshire; 88% NHSGGC)
- walking alone in their local area even after dark (57% West Dunbartonshire; 69% NHSGGC).

Evidence from Other Sources

- **The 2022 Scottish Household Survey** found that nationally 81% of people felt very or fairly safe walking alone in their neighbourhood after dark (92% for men; 72% for women), much higher than the 57% in West Dunbartonshire in the NHSGGC survey.

4.4 Perceived Quality of Services in the Area

Respondents were given a list of ten local services and asked to rate each one (excellent, good, adequate, poor or very poor).

Seven of the ten services showed variations in ratings by age. These are shown in Table 4.2. The other services were:

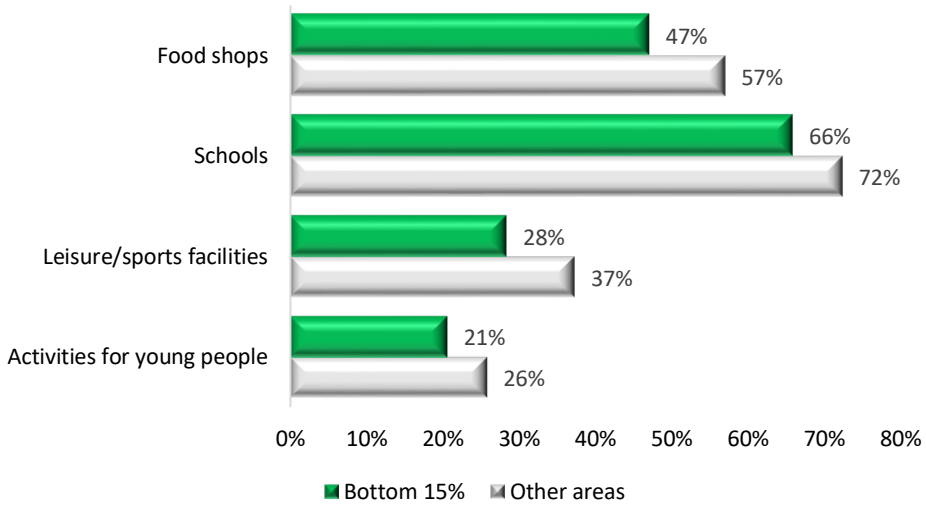
- Schools (for which 71% gave a positive rating)
- Public transport (for which 57% gave a positive rating)
- Childcare provision (for which 32% gave a positive rating).

Table 4.2: Proportion with Positive Perception of Quality of Local Services by Age

	Food shops	Nurse-led clinics	GP/doctor	Police	Out of hours medical service	Leisure/sports facilities	Activities for young people
16-34	65%	51%	55%	57%	42%	44%	32%
35-44	50%	43%	41%	37%	32%	30%	22%
45-54	45%	47%	36%	34%	33%	27%	17%
55-64	50%	50%	35%	23%	34%	27%	17%
65-74	53%	61%	34%	33%	39%	38%	27%
75+	54%	68%	49%	37%	53%	41%	30%
Overall	**54%**	**53%**	**43%**	**39%**	**38%**	**35%**	**24%**

As Figure 4.4 shows, those in the most deprived areas were less likely than others to have positive perceptions of four types of local service.

Figure 4.4: Proportion with a Positive Perception of Local Services by Deprivation



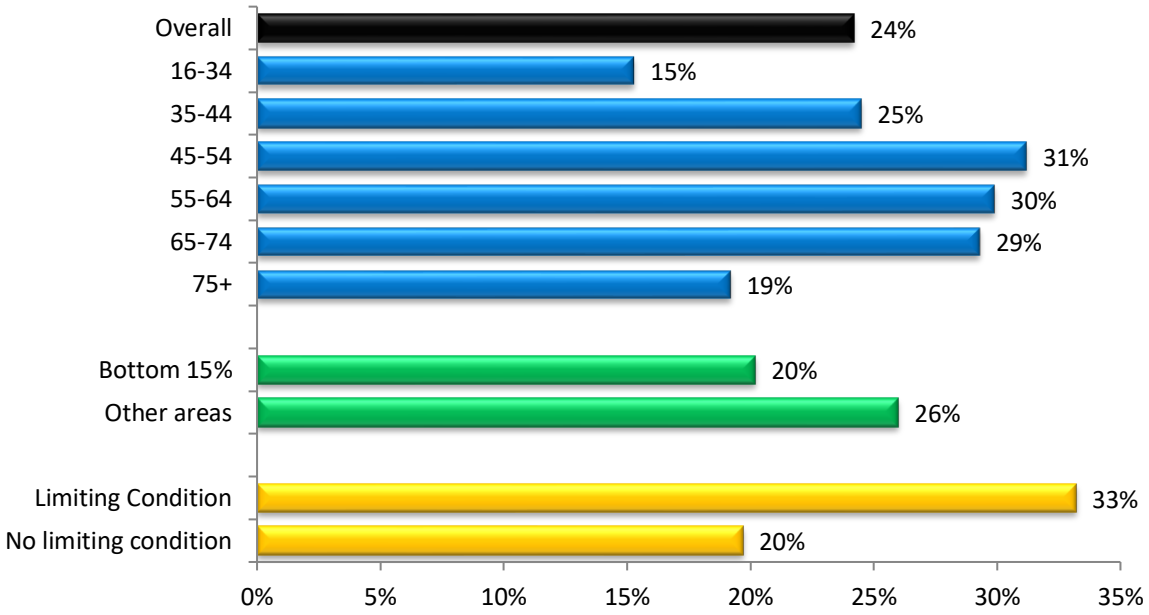
Those with a limiting condition were less likely than others to have positive perceptions of local police (30% compared to 44%) and nurse-led clinics (48% compared to 61%).

4.5 Caring Responsibilities

One in four (24%) said that they looked after, or gave regular help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability, or problems relating to old age.

- Those aged 45-74 were the most likely to have caring responsibilities.
- Those in the most deprived areas were less likely than others to be carers.
- Those with a long-term limiting condition or illness were more likely than others to be carers.

Figure 4.5: Proportion with Caring Responsibilities by Age, Deprivation and Limiting Conditions



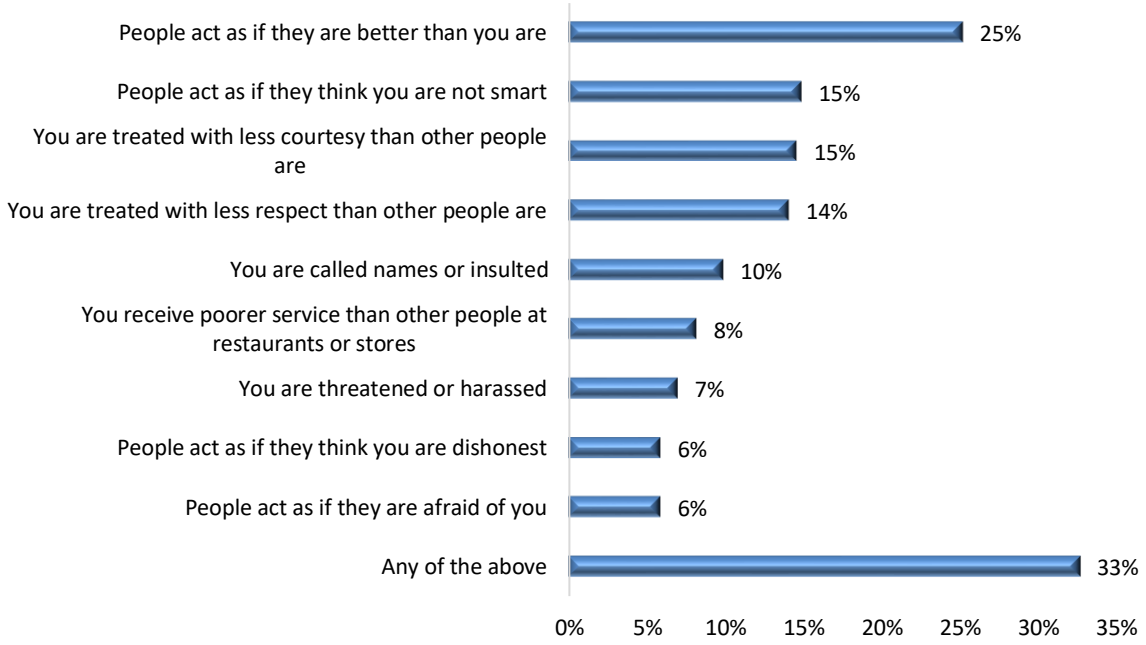
Comparison with NHSGGC

The proportion in West Dunbartonshire who were carers (24%) was higher than in the NHSGGC area as a whole (21%).

4.6 Discrimination

The main questionnaire (self-completion section) included The Everyday Discrimination Scale[6]. The proportion who reported each type of discrimination happening at least a few times a year is shown in Figure 4.6. Overall, one in three (33%) had experienced at least one type of discrimination at least a few times in the last year.

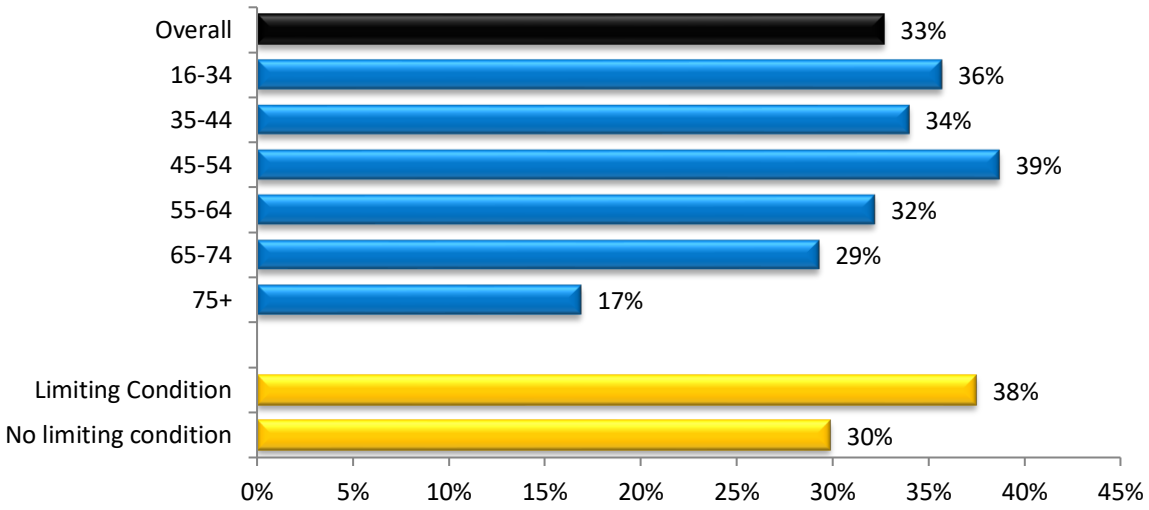
Figure 4.6: Proportion who Experienced Each Type of Discrimination at Least a Few Times Per Year



- Those aged 75 or over were the least likely to experience discrimination.
- Those with a limiting condition or illness were more likely than others to experience discrimination.

6 https://scholar.harvard.edu/files/davidrwilliams/files/discrimination_resource_dec._2020.pdf

Figure 4.7: Proportion who Experienced Discrimination by Age and Limiting Conditions



Comparison with NHSGGC

Compared to the NHSGGC area as a whole, those in West Dunbartonshire were less likely to report experiences of discrimination (33% West Dunbartonshire; 39% NHSGGC).

Those who experienced discrimination were asked what they thought were the main reasons for these experiences (with the option of selecting multiple reasons). The most common reasons given were:

- Age (40%)
- Gender (31%)
- Education or income level (24%)
- Weight (21%)
- Other aspects of physical appearance (18%)
- Height (16%)
- Physical disability (10%).

4.7 Summary of Key Messages from This Chapter

Indicators where West Dunbartonshire Compared Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to feel isolated from family and friends
- less likely to experience discrimination.

Indicators where West Dunbartonshire Compared Less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to feel they belonged to their local area
- less likely to feel valued as a member of their community
- less likely to feel safe using local public transport or walking alone in their area.

Other differences between West Dunbartonshire and NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- more likely to have caring responsibilities.

Differences by Age and Gender

- Those aged 65 or over were the most likely to feel they belonged to their local area.

- Women were more likely than men to feel valued as a member of the community.

- Men were more likely than women to feel safe using local public transport or walking alone in their local area. Those aged 75 or over were the least likely to feel safe using local public transport.

- Those aged 45-74 were the most likely to have caring responsibilities.

- Those aged 75 or over were the least likely to report experiences of discrimination.

Differences by Deprivation

Those in the most deprived areas were:

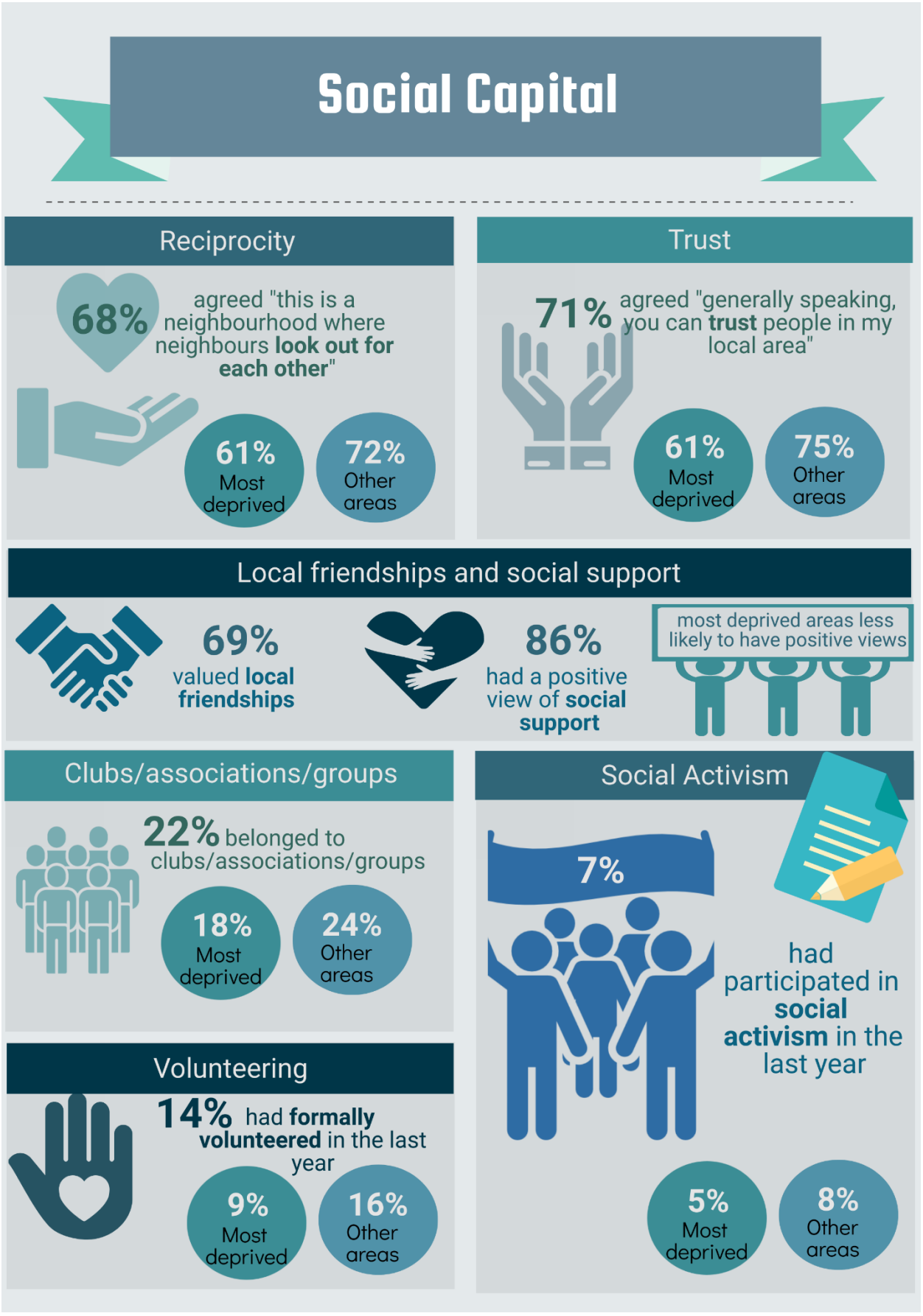
- less likely to feel they belonged to their local area
- less likely to be carers.

Differences by Limiting Conditions

Those with a long-term limiting condition or illness were:

- more likely to feel isolated or lonely
- more likely to be the victim of crime
- more likely to feel they belonged to their local area
- less likely to feel safe using local public transport or walking alone in their local area
- more likely to be carers
- more likely to experience discrimination.

5 Social Capital



5.1 Reciprocity and Trust

Respondents were asked to indicate the extent to which they agree with the following statements:

"This is a neighbourhood where neighbours look out for each other", and "Generally speaking, you can trust people in my local area".

Those agreeing with the first statement were categorised as having a positive view of reciprocity, and those agreeing with the second were categorised as having a positive view of trust. Overall, 68% were positive about reciprocity and 71% were positive about trust.

There was a high degree of crossover on these two questions; 86% of those who were positive about trust were also positive about reciprocity.

- Those aged 65 or over were the most likely to have a positive perception of reciprocity or trust.

- Those in the most deprived areas were less likely than others to have a positive perception of reciprocity or trust.

Figure 5.1: Proportion with a Positive Perception of Reciprocity by Age and Deprivation

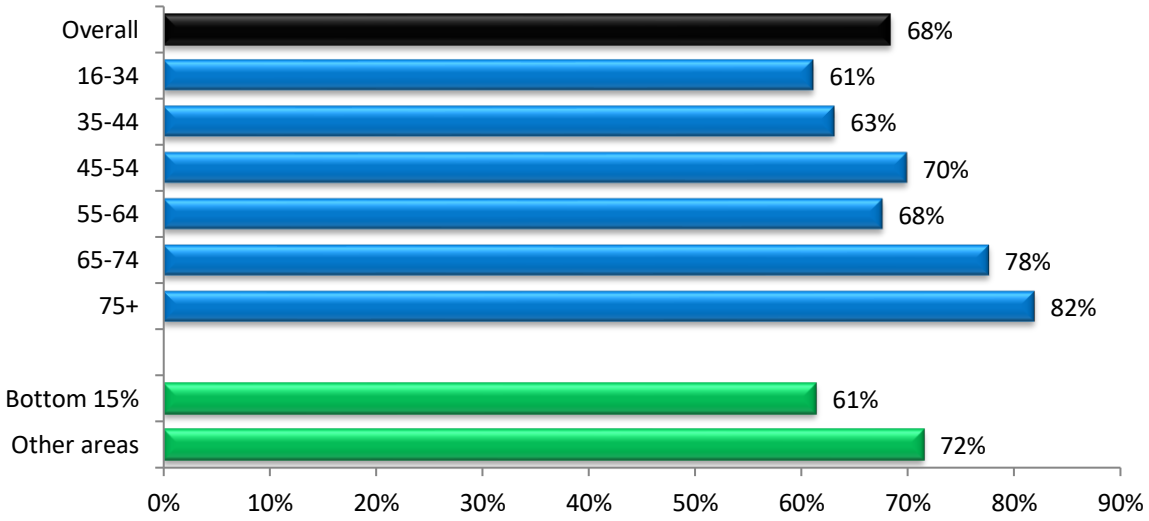
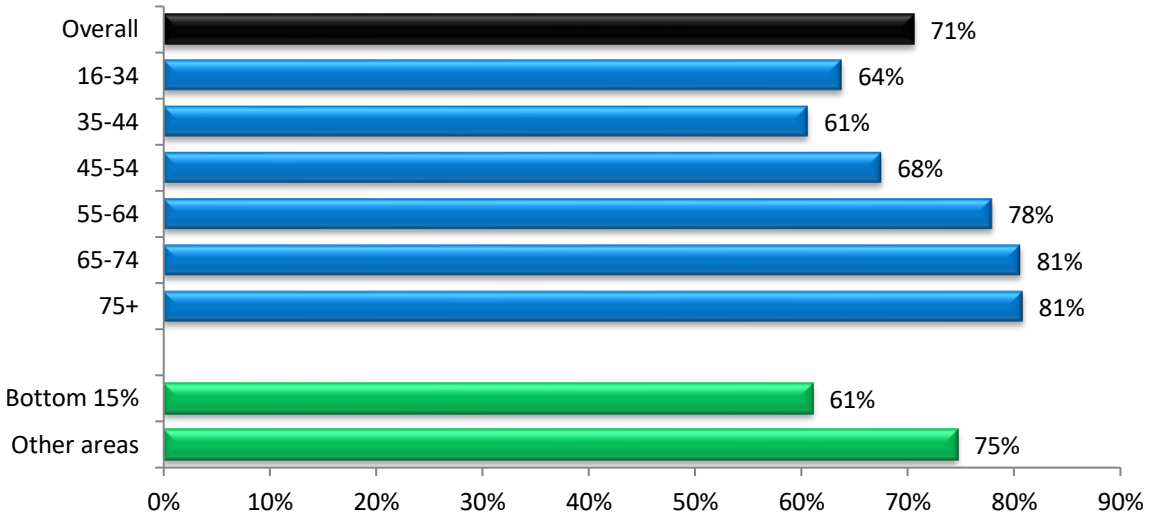


Figure 5.2: Proportion with a Positive Perception of Trust by Age and Deprivation



Comparison with NHSGGC

Compared to the NHSGGC area as a whole, those in West Dunbartonshire were less likely to have a positive perception of:

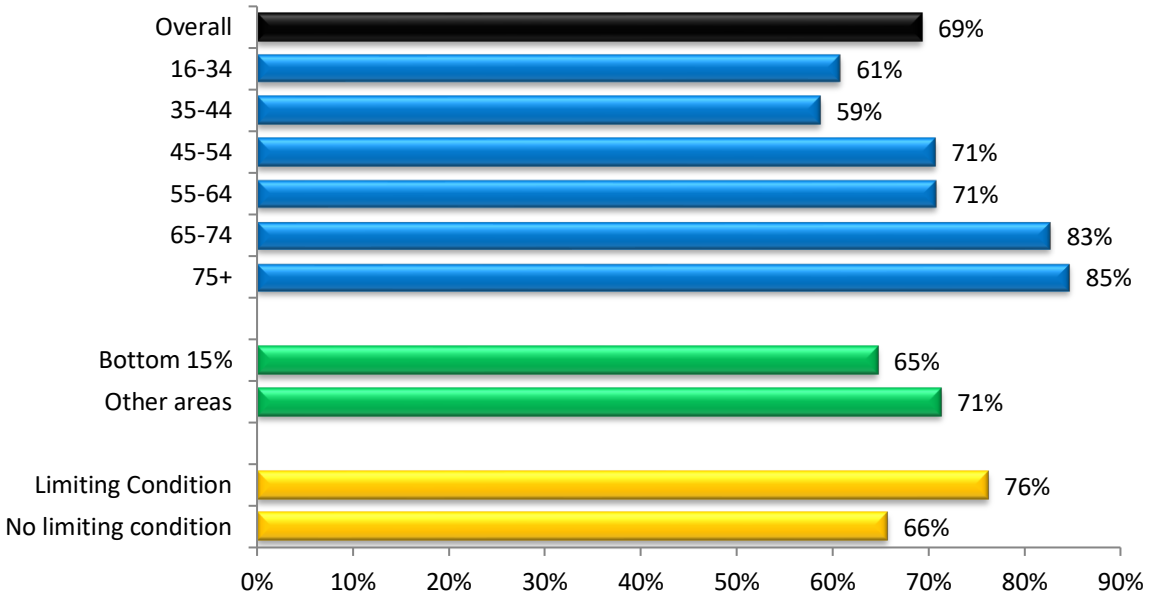
- reciprocity (68% West Dunbartonshire; 74% NHSGGC)
- trust (71% West Dunbartonshire; 76% NHSGGC).

5.2 Local Friendships

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement: *"The friendships and associations I have with other people in my local area mean a lot to me"*. Overall, 69% agreed with this, while 22% neither agreed nor disagreed and 8% disagreed.

- Those aged 65 or over were the most likely to value local friendships.
- Those in the most deprived areas were less likely to value local friendships.
- Those with a limiting condition or illness were more likely to value local friendships.

Figure 5.3: Proportion Value Local Friendships by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

Compared to the NHSGGC area as a whole, those in West Dunbartonshire were less likely to value local friendships (69% West Dunbartonshire; 73% NHSGGC).

5.3 Social Support

Respondents were asked to indicate the extent to which they agreed or disagreed with the statement: *"If I have a problem, there is always someone to help me".* Those agreeing with this statement were categorised as having a positive view of social support. Responses showed that overall 86% had a positive view of social support.

Those in the most deprived areas were less likely than others to have a positive view of social support (82% compared to 88%).

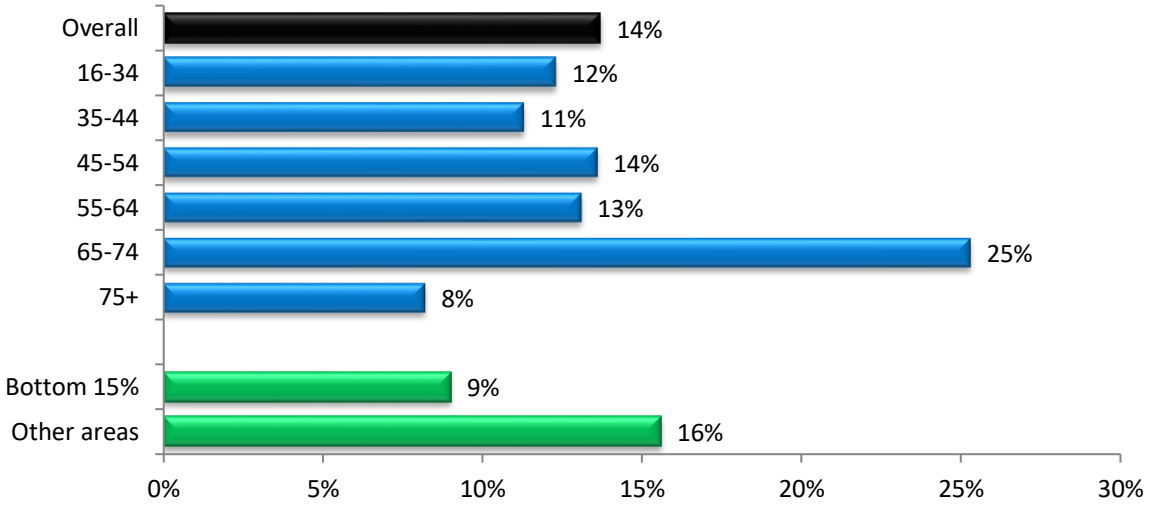
5.4 Volunteering

One in seven (14%) said they had given up any time to help any clubs, charities, campaigns or organisations in an unpaid capacity in the last year.

- The age group most likely to have formally volunteered was 65-74 year olds.

- Those in the most deprived areas were less likely than others to volunteer formally.

Figure 5.4: Proportion who Volunteered to help Clubs/Charities/Campaigns/Organisations in Last 12 Months by Age and Deprivation

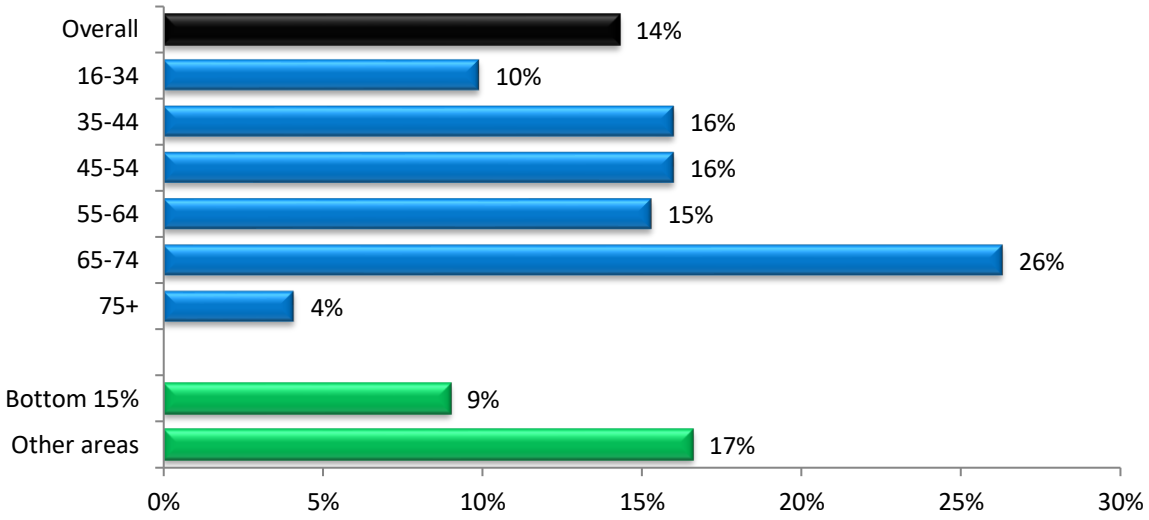


Respondents were also asked whether in the last 12 months they had given any voluntary unpaid help as an individual (not through a group or organisation) to help other people outside their family or to support their local environment (e.g. keeping in touch with someone at risk of being lonely, helping neighbours with shopping or chores, litter picking not part of an organised activity). One in seven (14%) had volunteered in this way.

- Again, those aged 65-74 were the most likely to informally volunteer.

- Those in the most deprived areas were less likely than those in other areas to volunteer in this way.

Figure 5.5: Proportion who Volunteered as an Individual in Last 12 Months by Age and Deprivation



Combining responses to both questions, overall 19% of people had volunteered in the last year. Overall rates of volunteering were 22% for those in the most deprived areas compared to 13% of those in other areas.

Comparison with NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were less likely to volunteer:

- formally (14% West Dunbartonshire; 19% NHSGGC)
- informally (14% West Dunbartonshire; 20% NHSGGC)
- overall (19% West Dunbartonshire; 26% NHSGGC).

Evidence from Other Sources

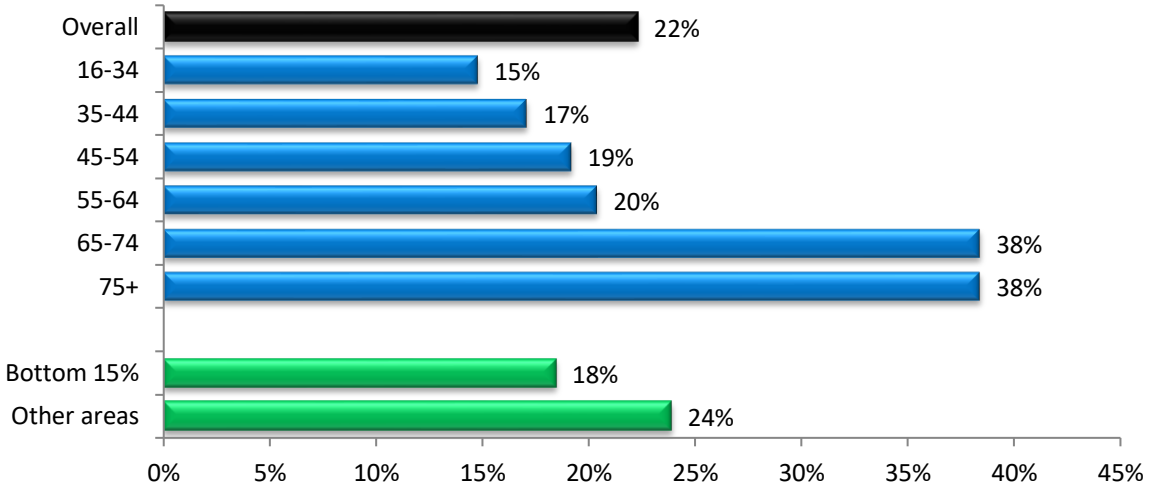
- **The 2022 Scottish Household Survey** showed that 22% of adults in Scotland had **formally** volunteered in the previous 12 months, higher than the 14% who had formally volunteered in West Dunbartonshire in the NHSGGC survey. Overall, the 2022 Household Survey showed that 46% had done any volunteering (formal or informal) - much higher than the 19% in West Dunbartonshire in the NHSGGC survey. As in West Dunbartonshire, volunteering measured in the Household Survey was less prevalent in the most deprived areas.

5.5 Belonging to Clubs, Associations and Groups

Just over one in five (22%) belonged to any social clubs, associations, church groups or similar.

- Those aged 65 or over were the most likely to belong to clubs/associations/groups.
- Those in the most deprived areas were less likely than others to belong to these types of groups or organisations.

Figure 5.6: Proportion Belong to Social Clubs, Associations, Church Groups or Similar by Age and Deprivation

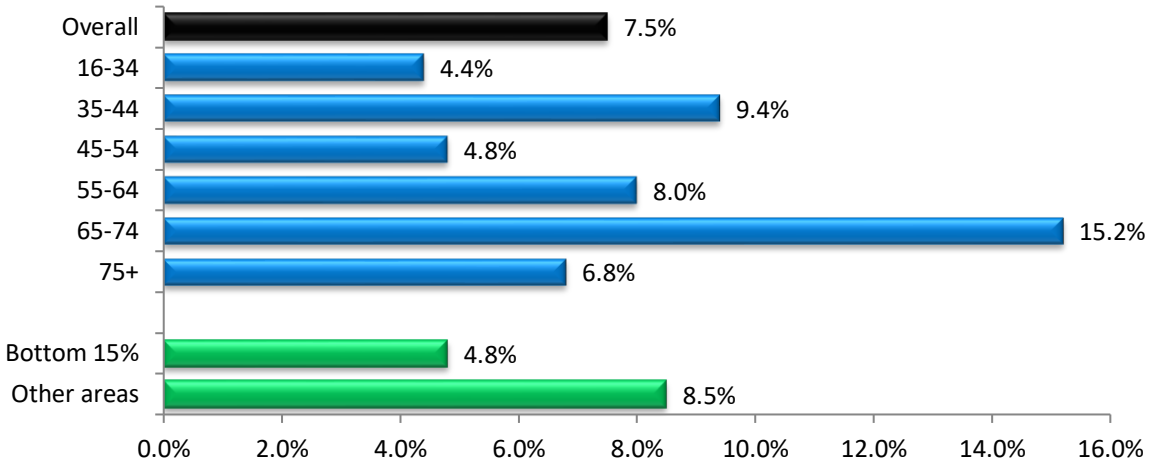


5.6 Social Activism

Respondents were asked whether, in the last 12 months, they had taken any actions in an attempt to solve a problem affecting people in their local area – e.g. contacted any media, organisation, council, councillor, MSP or MP; organised a petition. Overall, 7% had engaged in this type of social activism in the last year.

- Those aged 65-74 were the most likely to engage in social activism.
- Those in the most deprived areas were less likely than those in other areas to engage in social activism.

Figure 5.7: Proportion Engaged in Social Activism in Last 12 Months by Age and Deprivation



Comparison with NHSGGC

The proportion in West Dunbartonshire who had engaged in social activism (7.5%) was lower than in NHSGGC as a whole (11.4%).

5.7 Summary of Key Messages from This Chapter

Indicators were West Dunbartonshire Compared Less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to have positive views of reciprocity or trust
- less likely to value local friendships
- less likely to engage in social activism.

Differences by Age

- Those aged 65 or over were the most likely to have positive views of reciprocity or trust, the most likely to value local friendships and the most likely to belong to clubs/associations/groups.

- Those aged 65-74 were the most likely to volunteer formally or informally and the most likely to engage in social activism.

Differences by Deprivation

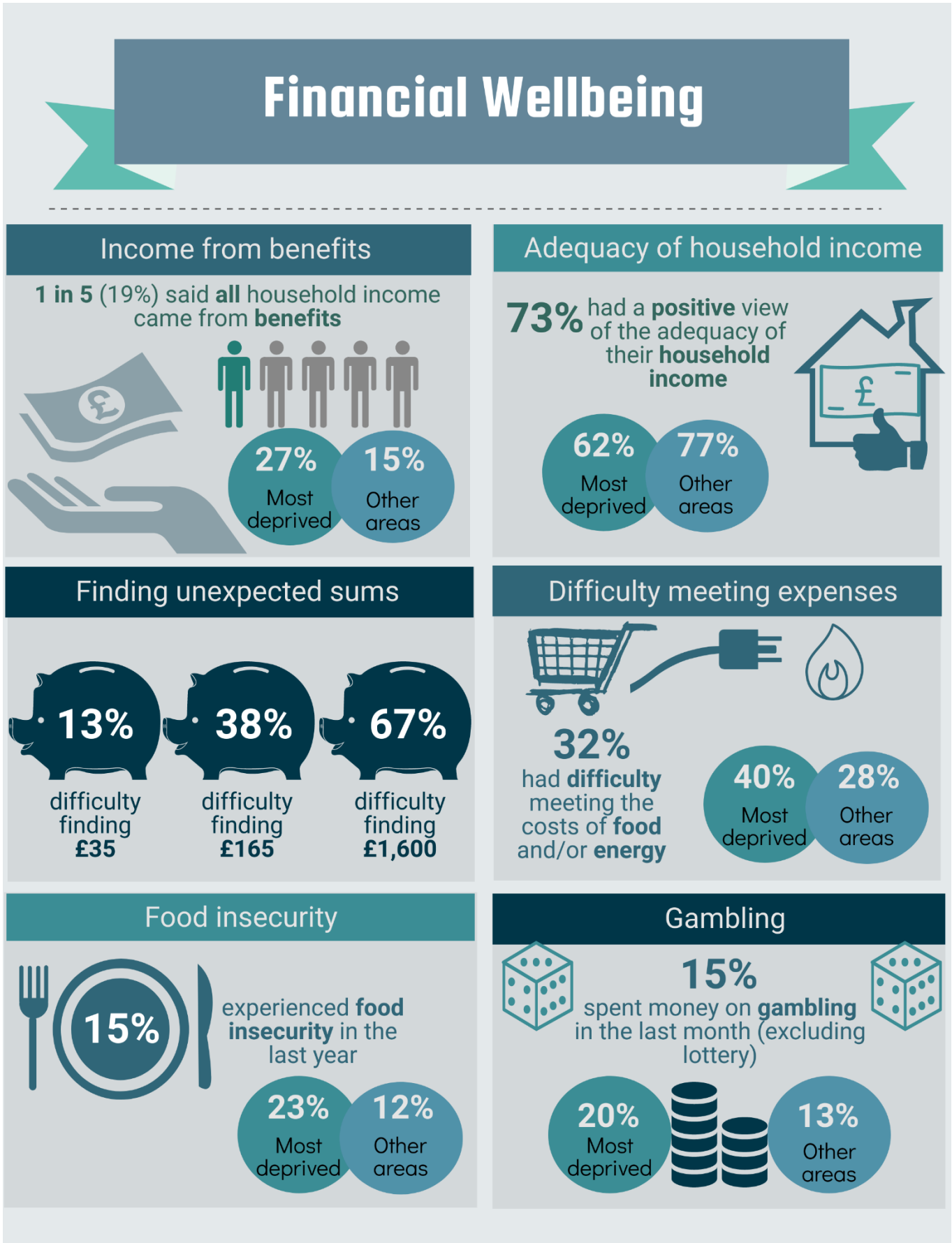
Those in the most deprived areas were:

- less likely to have positive views of reciprocity or trust

- less likely to value local friendships or have a positive view of social support

- less likely to volunteer or to belong to clubs/associations

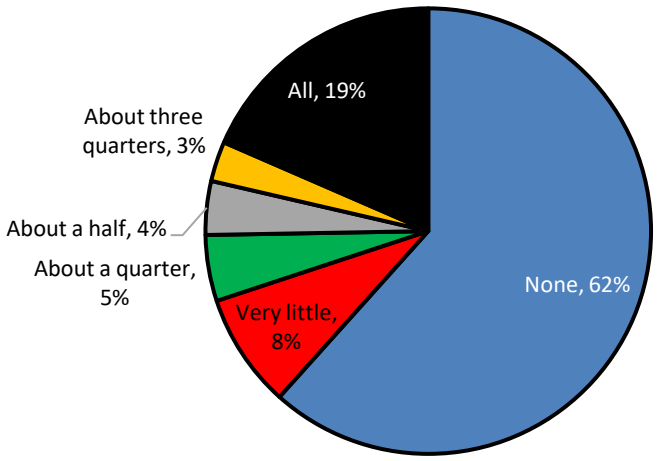
- less likely to engage in social activism.


Financial Wellbeing
Income from benefits
1 in 5 (19%) said all household income came from benefits
27% Most deprived
15% Other areas
Adequacy of household income
73% had a positive view of the adequacy of their household income
62% Most deprived
77% Other areas
Finding unexpected sums
13% difficulty finding £35
38% difficulty finding £165
67% difficulty finding £1,600
Difficulty meeting expenses
32% had difficulty meeting the costs of food and/or energy
40% Most deprived
28% Other areas
Food insecurity
15% experienced food insecurity in the last year
23% Most deprived
12% Other areas
Gambling
15% spent money on gambling in the last month (excluding lottery)
20% Most deprived
13% Other areas

6.1 Income from State Benefits

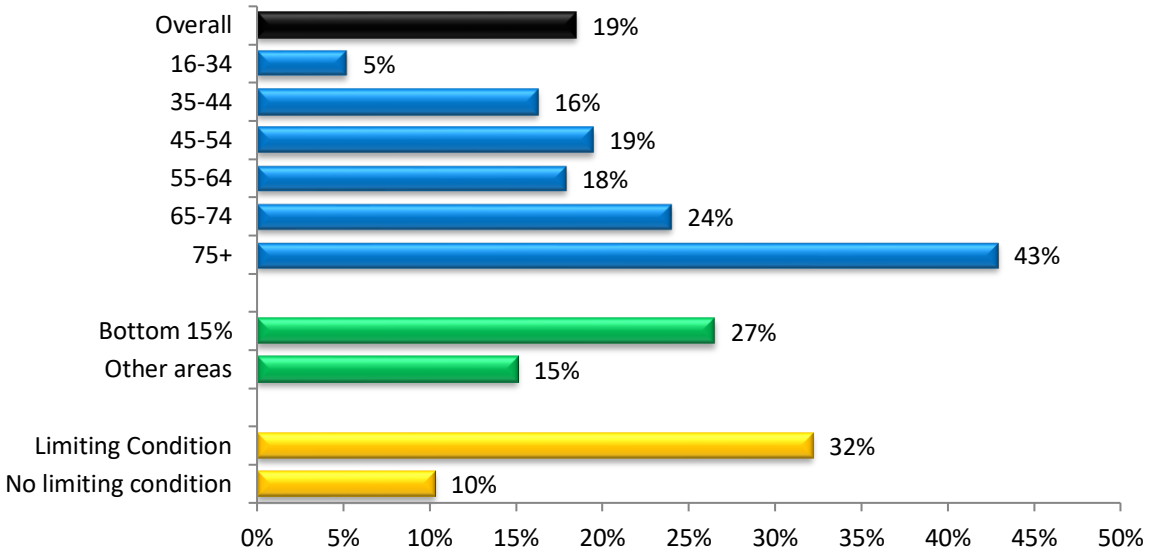
Just under two in five (38%) said that at least some of their household income came from state benefits, and 19% said that all their household income came from state benefits.

Figure 6.1: Proportion of Household Income from State Benefits



- Those aged under 35 were the least likely to receive all household income from benefits and those aged 75 or over were the most likely.
- Those in the most deprived areas were more likely than others to receive all household income from benefits.
- Those with a limiting condition or illness were more than three times as likely as others to say all their household income came from benefits.

Figure 6.2: Proportion who Received All Household Income from State Benefits by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

The proportion in West Dunbartonshire who received all household income from benefits (19%) was higher than in the NHSGGC area as a whole (13%).

Those who received any of their household income from benefits were asked whether they had experienced benefits sanctions of delays in benefits payments in the last year.

- 1.1% had experienced benefits sanctions
- 3.4% had experienced delays in benefits payments in the last year.

Those who received benefits were asked whether their household had been affected by benefit changes in the last 12 months (e.g. Universal Credit, Carer's Allowance, Disability Living Allowance/Adult Disability Payment, Child Disability Payment, Best Start payments).

Overall 8.4% of benefit recipients said they had been affected by benefit changes. Of those who had been affected by changes, 54% said their household was financially worse off as a result, 32% said their household was better off and 14% said it made no difference.

Policy Context: Financial Wellbeing

The impact of the COVID19 pandemic and the withdrawal of the United Kingdom from the European Union (Brexit) in 2020 have generated significant economic and welfare change since the last survey. There have also been significant changes to the welfare system in Scotland since the Social Security (Scotland) Act 2018 Social Security (Scotland) Act 2018 (legislation.gov.uk) and the establishment of Social Security Scotland Social Security Scotland - Homepage which enabled the devolution of aspects of the social security system and the introduction of Scotland specific welfare measures.

The Health and Wellbeing Survey asks questions about financial security and insecurity to continue to understand these impacts on residents. The survey has included an additional question on fuel insecurity as a consequence of the significant rise in fuel costs across the UK.

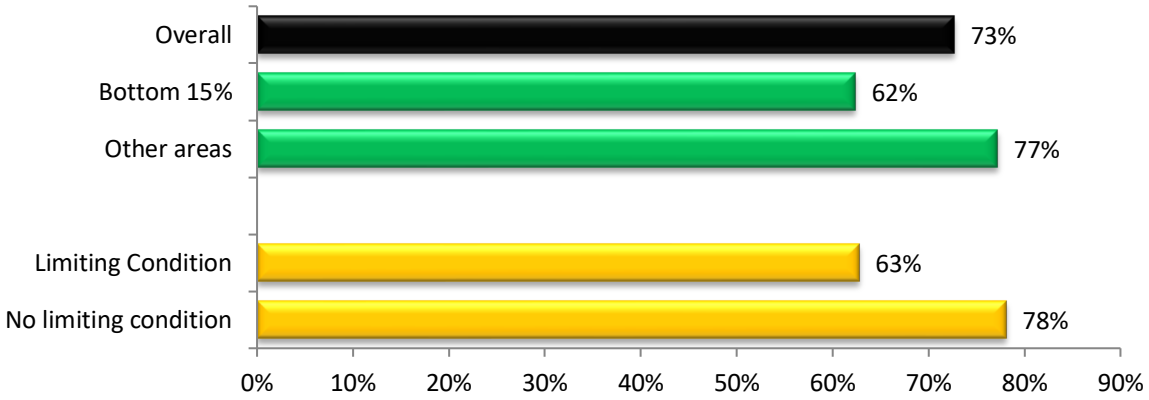
The Child Poverty Scotland Act, 2017 and the subsequent Scottish Government Child Poverty Action Plans – Every Child, Every Chance: the Tackling Child Poverty Delivery Plan 2018-2022, and Best Start, Bright Futures: Tackling Child Poverty Delivery Plan 2022-2026 identify the need for concerted partnership approaches and plans to tackle child poverty. While the targets seek to reduce child poverty levels, the Act and subsequent strategic plans provide a need to focus on Parents/ Carers in six priority family groups at highest risk of poverty: lone parent families, minority ethnic families, families with a disabled adult or child, families with a younger mother (under 25), families with a child under one, and larger families (3+ children). As a result of the Child Poverty Act, the Poverty and Inequality Commission was established. The Public Services Reform (Poverty and Inequality Commission) (Scotland) Order 2018 widened the scope of the Commission to advise the government on matters relating to poverty more broadly and promote the reduction of poverty and inequality across the population as a whole.

6.2 Adequacy of Income

Using the 'faces' scale (see Chapter 2), respondents were asked how they felt about the adequacy of their household income. Just under three in four (73%) expressed a positive perception of the adequacy of their household income, while 15% had a neutral perception and 12% had a negative perception.

- Those in the most deprived areas were less likely to give a positive view.
- Those with a limiting condition or illness were less likely to give a positive view.

Figure 6.3: Proportion with a Positive Perception of the Adequacy of their Household Income by Deprivation and Limiting Conditions



6.3 Views on Poverty

Respondents were asked what they felt was the main reason some people in their area lived in poverty. The most frequent responses were lack of jobs (27%) and an inevitable part of modern life (20%). All responses are shown in Table 6.1, together with the differing profile of responses for those living in the most deprived areas compared to those in other areas.

Those living in the most deprived areas were more likely to attribute poverty to lack of jobs or laziness/lack of willpower, and less likely to attribute poverty to injustice in society.

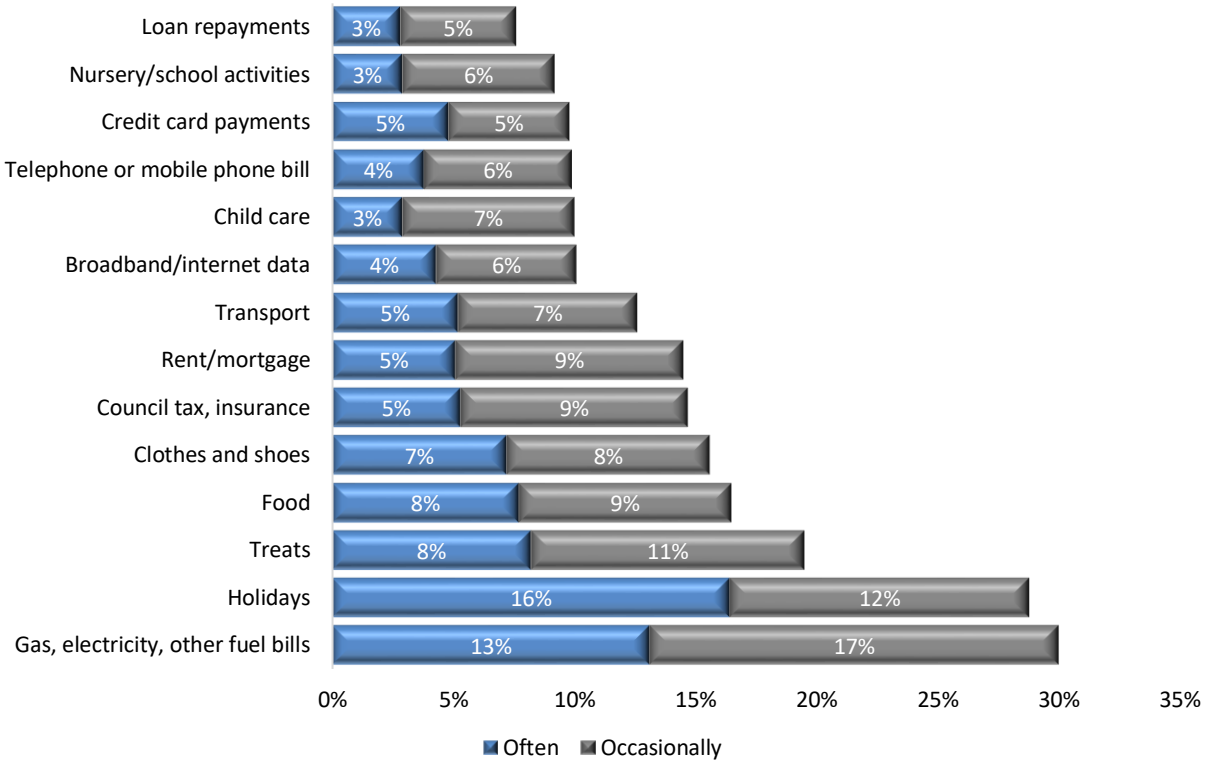
Table 6.1: Perceived Reasons for Poverty in Local Area by Deprivation

	Overall	Bottom 15%	Other areas
An inevitable part of modern life	20%	21%	19%
Laziness or lack of willpower	15%	17%	15%
Because they have been unlucky	7%	6%	8%
Because of injustice in society	12%	9%	13%
Lack of jobs	27%	32%	25%
There is no one living in poverty in this area	2%	2%	2%
Other	12%	12%	12%
None of the above	6%	1%	8%

6.4 Difficulty Meeting the Cost of Specific Expenses

Figure 6.4 shows the proportion of people who said they had difficulty meeting specific expenses often or occasionally.

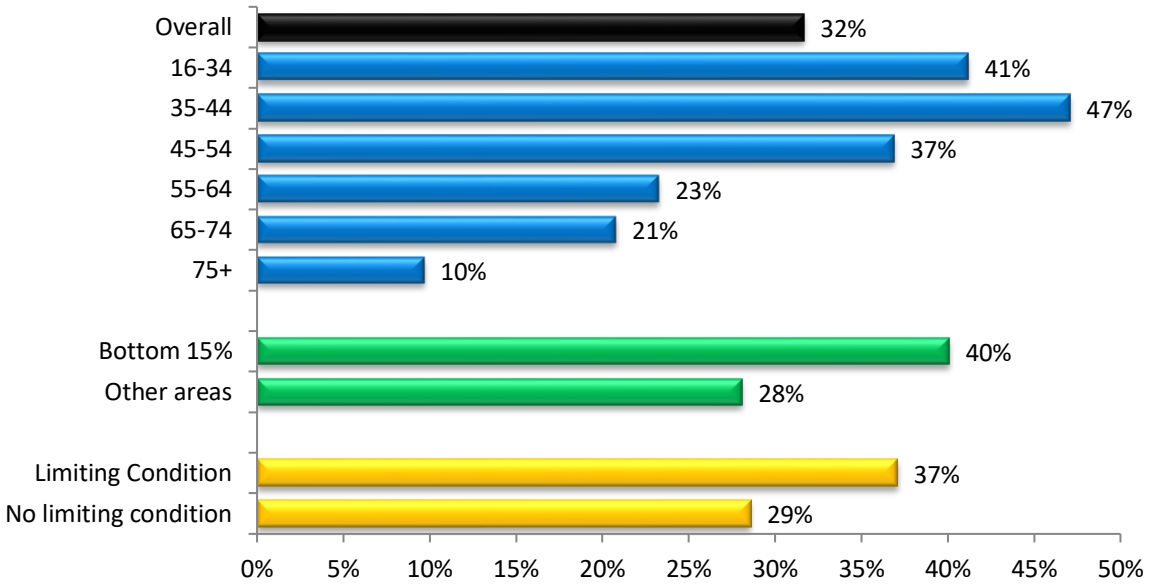
Figure 6.4: How Often Have Difficulty Meeting the Cost of Specific Expenses



Altogether, 32% said that they had difficulty meeting the cost of food and/or energy (at least occasionally).

- Those aged 75 and over were the least likely to have difficulty meeting the cost of food or energy and those aged 35-44 were the most likely.
- Those in the most deprived areas were more likely than others to have difficulty meeting the cost of food or energy.
- Those with a limiting condition or illness were more likely than others to have difficulty meeting the cost of food/energy.

Figure 6.5: Proportion who Had Difficulty Meeting the Cost of Food and/or Energy by Age, Deprivation and Limiting Conditions



Comparison with NHSGGC

The proportion in West Dunbartonshire who had difficulty meeting the cost of food and/or energy (32%) was lower than in the NHSGGC area as a whole (38%).

6.5 Difficulty Finding Unexpected Sums

Respondents were asked how their household would be placed if they suddenly had to find a sum of money to meet an unexpected expense such as a repair or new washing machine. Overall, 13% said it would be a problem to find £35, 38% said it would be a problem to find £165 and 67% said it would be a problem to find £1,600.

- Those aged 65 or over were the least likely to say they would have difficulty finding these sums.
- Women were more likely than men to say they would have difficulty meeting any of these sums.
- Those in the most deprived areas were more likely to have difficulty meeting any of these sums.
- Those with a limiting condition were more likely than others to have difficulty finding sums of £35 or £165.

Table 6.2: Proportion who would Find it Difficult Meeting Unexpected Sums of £35, £165 or £1,600 by Age, Gender, Deprivation and Limiting Conditions

	Problem finding £35	Problem finding £165	Problem finding £1,600
16-34	15%	50%	85%
35-44	15%	51%	84%
45-54	19%	41%	71%
55-64	10%	30%	53%
65-74	6%	22%	45%
75+	8%	17%	51%
Male	9%	35%	62%
Female	16%	40%	73%
Bottom 15%	18%	50%	81%
Other areas	10%	32%	62%
Limiting condition	21%	44%	NS
No limiting condition	9%	34%	NS
Overall	**13%**	**38%**	**67%**

NS= No significant difference

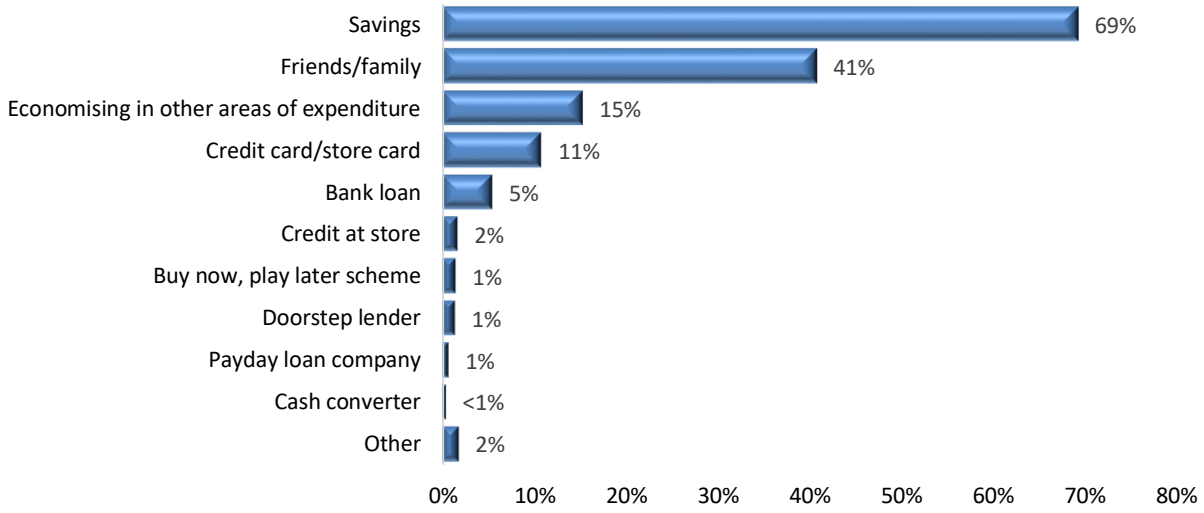
Comparison with NHSGGC

Those in West Dunbartonshire were less likely than those in the NHSGGC area as a whole to have difficulties finding:

- £35 (13% West Dunbartonshire; 15% NHSGGC)
- £165 (38% West Dunbartonshire; 41% NHSGGC)
- £1,600 (67% West Dunbartonshire; 74% NHSGGC)

Respondents were asked, if they suddenly had to find a sum of money to meet an unexpected bill, where would they get the money from (with the option of giving more than one response). The most common sources were savings (69%) and friends/family (41%). All responses are shown in Figure 6.6.

Figure 6.6: Where Would Find Sum of Money to Meet Unexpected Bill



The proportion who said they would use savings to pay unexpected bills rose with age from 55% of those aged under 35 to 85% of those aged 75 or over. Those aged under 35 were the most likely to say they would source money from friends/family (66%).

Women were more likely than men to say they would source money from friends/family (46% female; 35% male).

Those in the most deprived areas were:

- less likely to use savings to pay unexpected bills (60% most deprived; 73% other areas)
- more likely to get money from friends/family (56% most deprived; 34% other areas)
- more likely to use a bank loan (9% most deprived; 4% other areas).

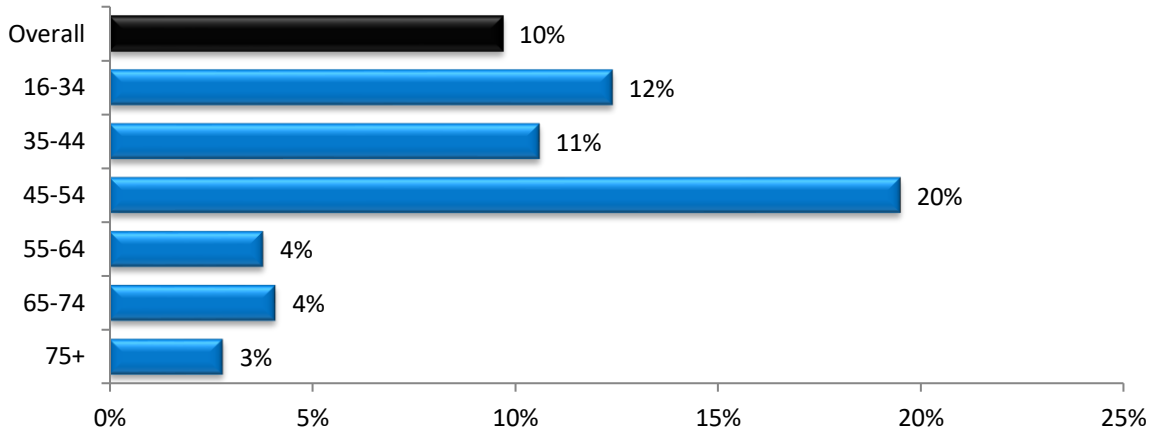
6.6 Credit

Respondents were asked how many months from the last six months they had to use a source of credit to cover essential living costs due to a lack of money that they may struggle to pay off.

Overall, 9.7% had used credit to cover essential living costs they may struggle to pay off during the previous six months, consisting of 3.2% who had done so in one month, 2.3% who had done so in two months, 1.8% who had done so in three months and 2.4% who had used credit in this way for three or more months.

Those aged 45-54 were the most likely to have used credit to cover essential living costs in the last six months.

Figure 6.7: Proportion who Used Credit to Cover Essential Living Costs in the Last Six Months by Age



6.7 Food Insecurities

Respondents were asked eight questions which comprise the Food Insecurity Experiences Scale[7]. The proportion who said 'yes' to each question is shown in Table 6.3. Altogether, 15% had experienced at least one event in the last year which was an indication of food insecurity.

[7] See: http://www.fao.org/in-action/voices-of-the-hungry/fies/en/

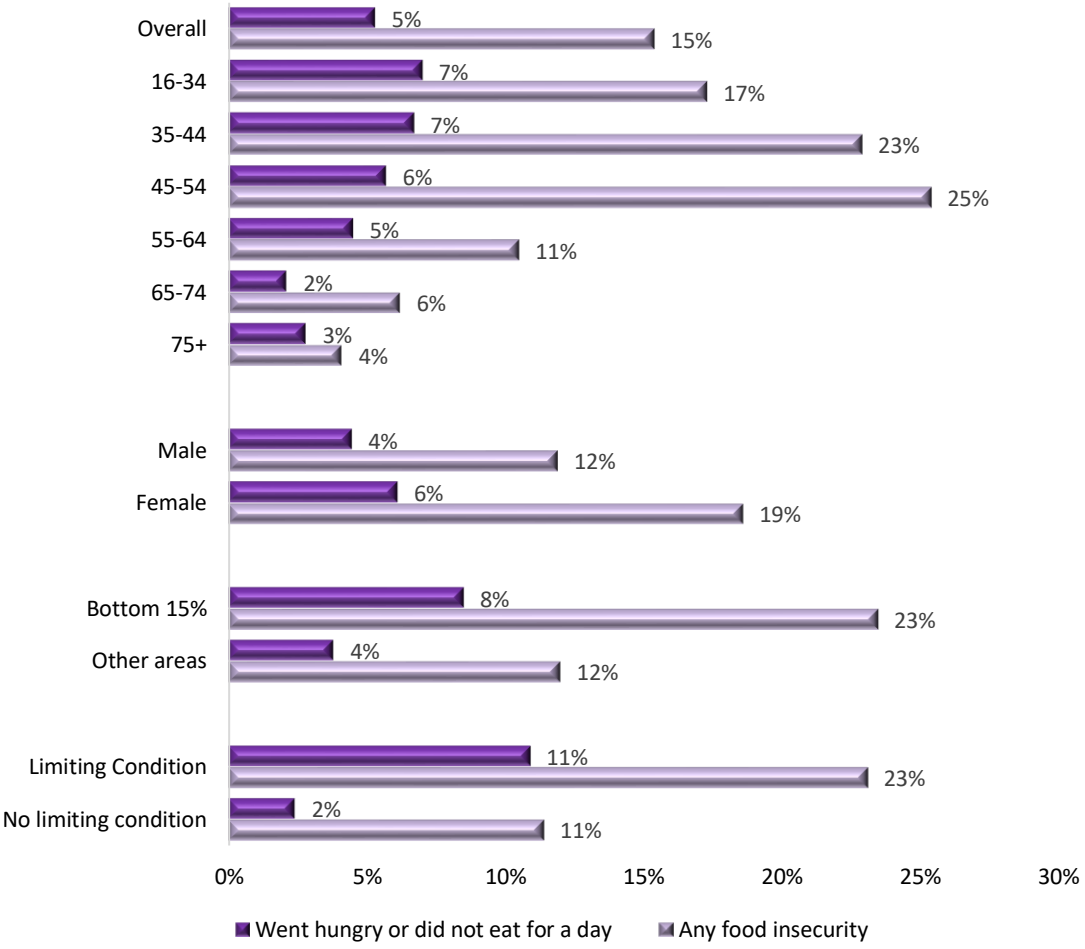
Table 6.3: Proportion who Experienced Each Event on the Food Insecurities Experience Scale in the Last 12 Months

	Proportion who answered 'yes'
You were worried you would run out of food because of a lack of money or other resources	10.7%
You were unable to eat healthy and nutritious food because of a lack of money or other resources	8.0%
You ate only a few kinds of food because of a lack of money or other resources	10.5%
You had to skip a meal because there was not enough money or other resources to get food	5.6%
You ate less than you thought you should because of a lack of money or other resources	9.8%
Your household ran out of food because of a lack of money or other resources	4.8%
You were hungry but did not eat because there was not enough money or other resources for food	4.7%
You went without eating for a whole day because of a lack of money or other resources	3.7%
Any of the above	**15.4%**

Overall, 5.3% of adults experienced **either** of the last two items, indicative of the most severe forms of food insecurity – going hungry because they could not afford food or going a whole day without eating because of lack of money/resources.

- Those aged 35-54 were the most likely to experience food insecurity.
- Women were more likely than men to experience food insecurity.
- Those in the most deprived areas were twice as likely as others to experience food insecurity.
- Those with a limiting condition or illness were twice as likely as others to experience food insecurity.

Figure 6.8: Food Insecurities Experience in the Last 12 Months by Age, Gender, Deprivation and Limiting Conditions



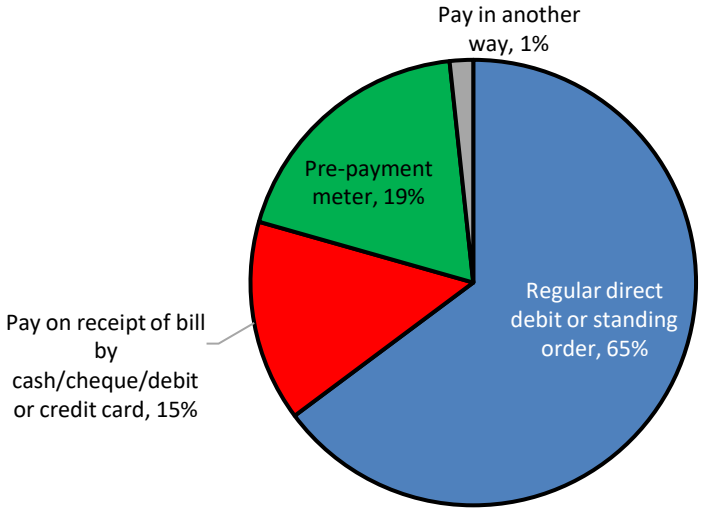
Evidence from Other Sources

- **The 2021 Scottish Household Survey** found that nationally 9% had, at some time in the previous 12 months worried that they would run out of food because of a lack of money or other resources, slightly lower than the 11% in West Dunbartonshire in the NHSGGC survey in 2022/23.

6.8 Energy Bills

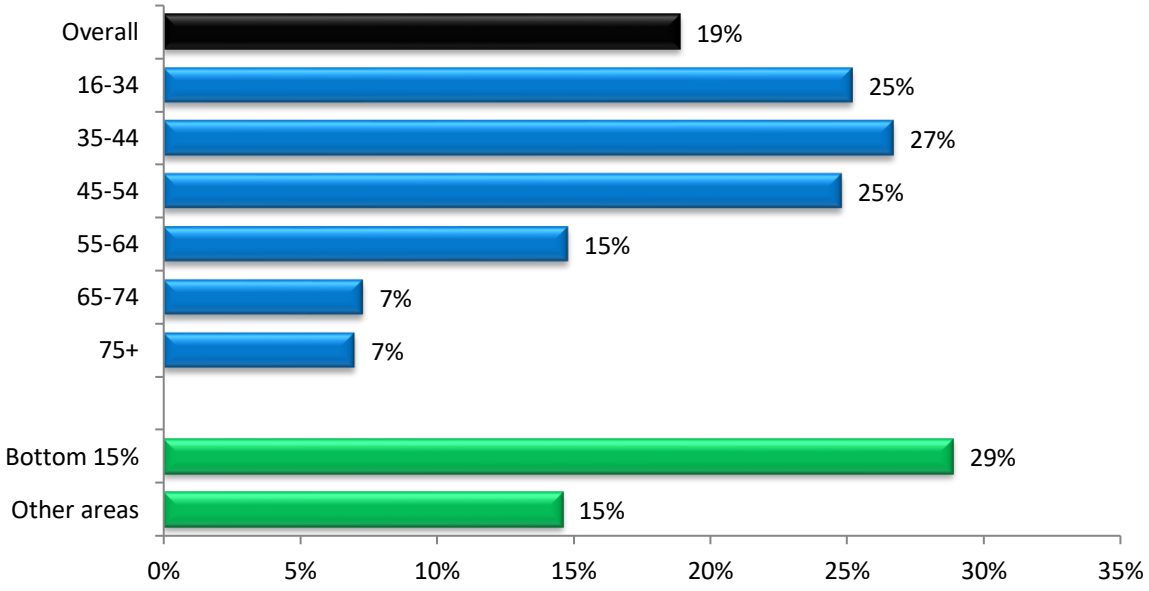
Just under two in three (65%) said they paid their energy bill by regular direct debit or standing order, 19% had a pre-payment meter and 15% paid on receipt of their bill.

Figure 6.9: Means of Paying for Energy



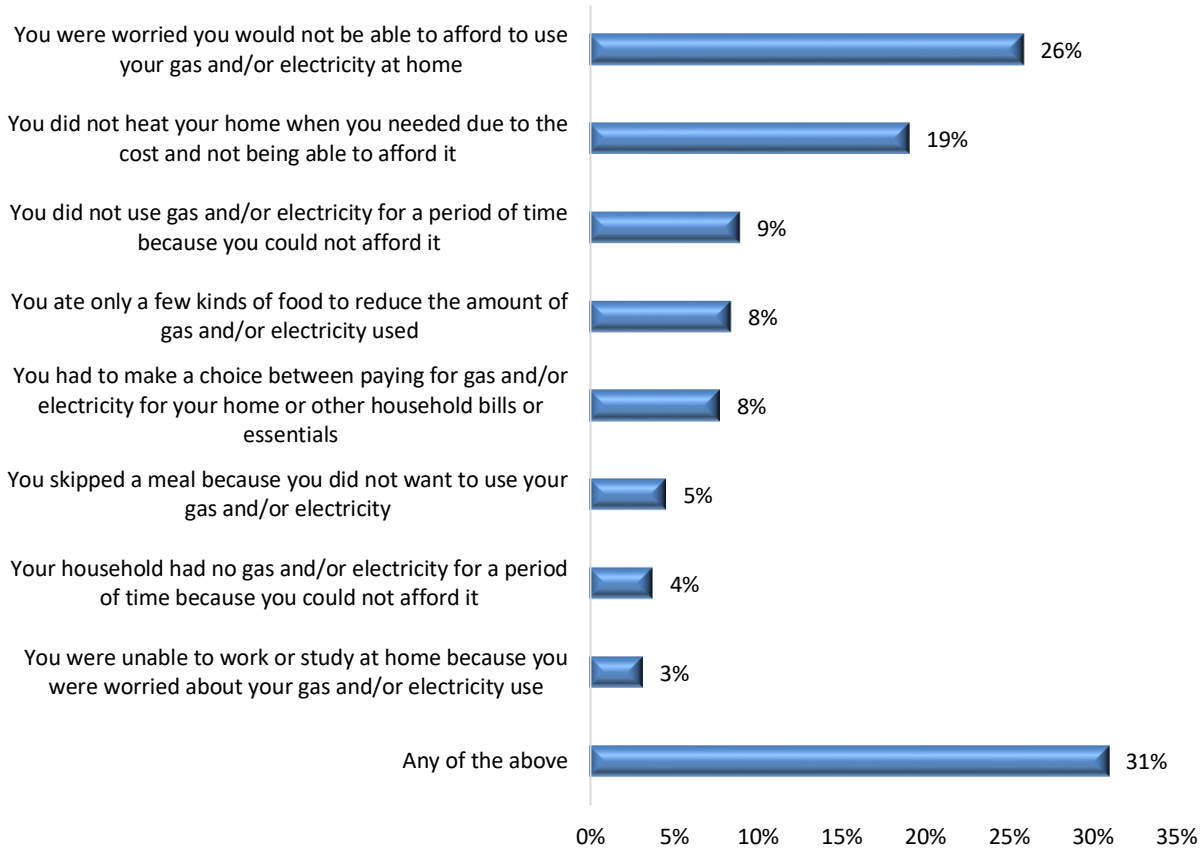
- Those in the youngest age groups were the most likely to have a pre-payment meter.
- Those in the most deprived areas were much more likely to have a pre-payment meter.

Figure 6.10: Proportion with a Prepaid Meter by Age and Deprivation



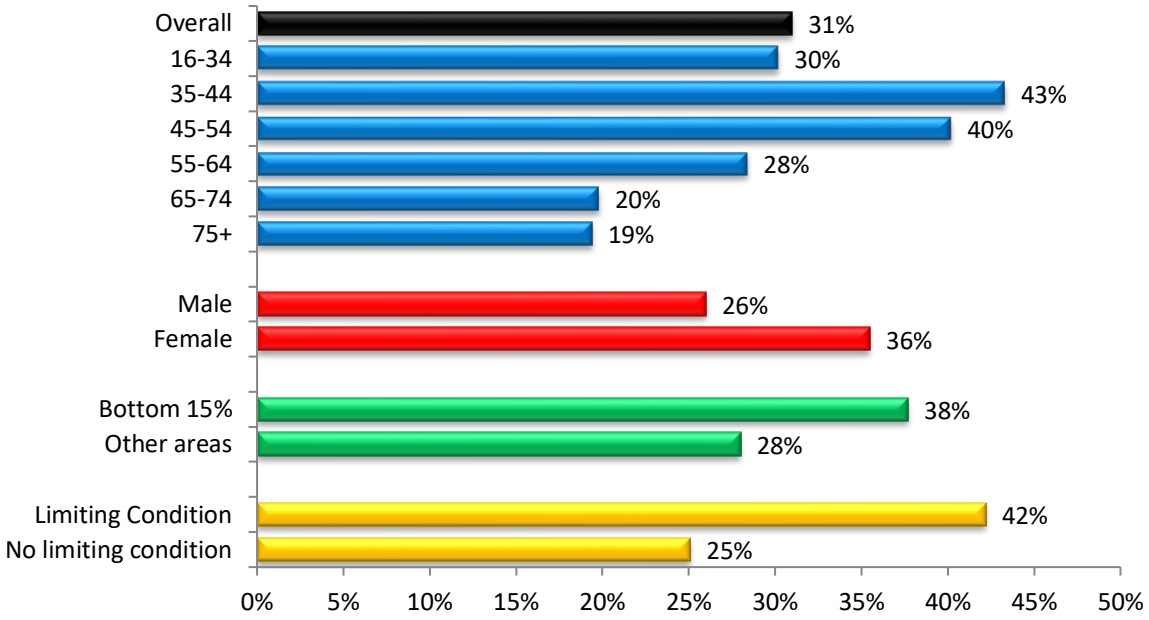
Respondents were asked whether any of eight things had happened in the last 12 months relating to energy affordability. Figure 6.11 shows the proportion who said each thing had happened. In total, 31% reported indicators of difficulties affording energy.

Figure 6.11: Proportion who said each Indicator of Difficulties with Energy Bills Occurred in the Last Year



- Those aged 35-54 were the most likely to say they had experienced any of these indicators of difficulty affording energy.
- Women were more likely than men to say they had experienced any of these indicators of difficulty affording energy.
- Those in the most deprived areas were more likely to have experienced any of the indicators of difficulties paying for energy.
- Those with a limiting condition or illness were more likely to have experienced any of these indicators.

Figure 6.12: Proportion who Had Experienced at Least One Indicator of Difficulties Affording Energy in the Last Year by Age, Gender, Deprivation and Limiting Conditions



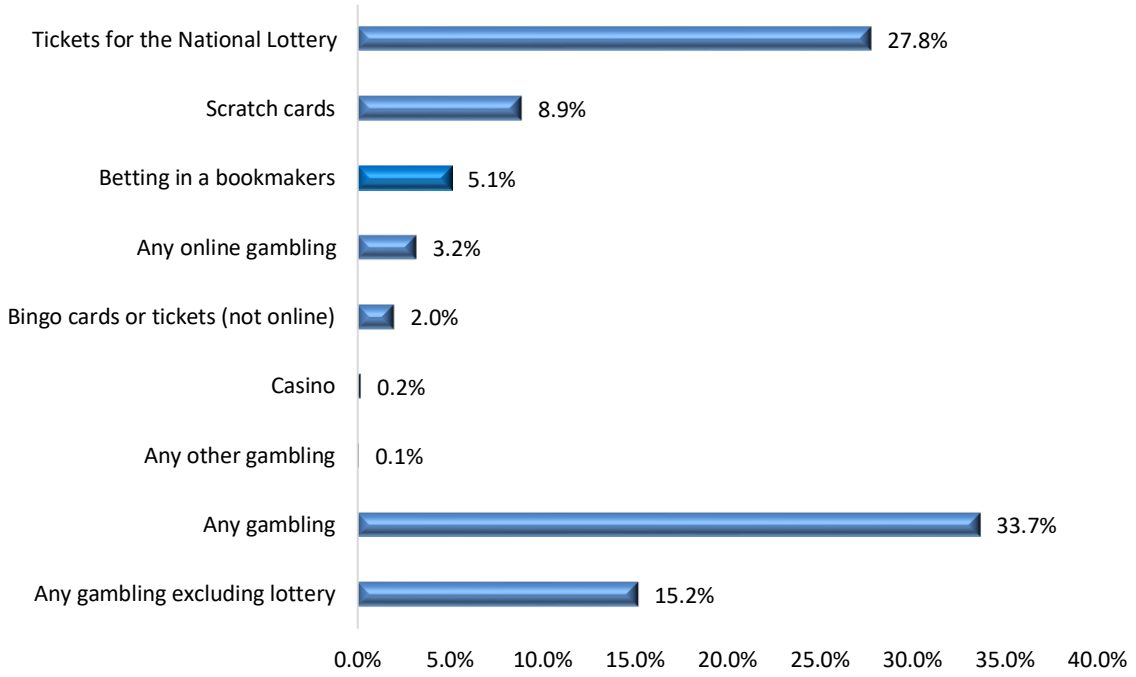
Comparison with NHSGGC

The proportion in West Dunbartonshire who had indicators of difficulties affording energy (31%) was lower than in the NHSGGC area as a whole (40%).

6.9 Gambling

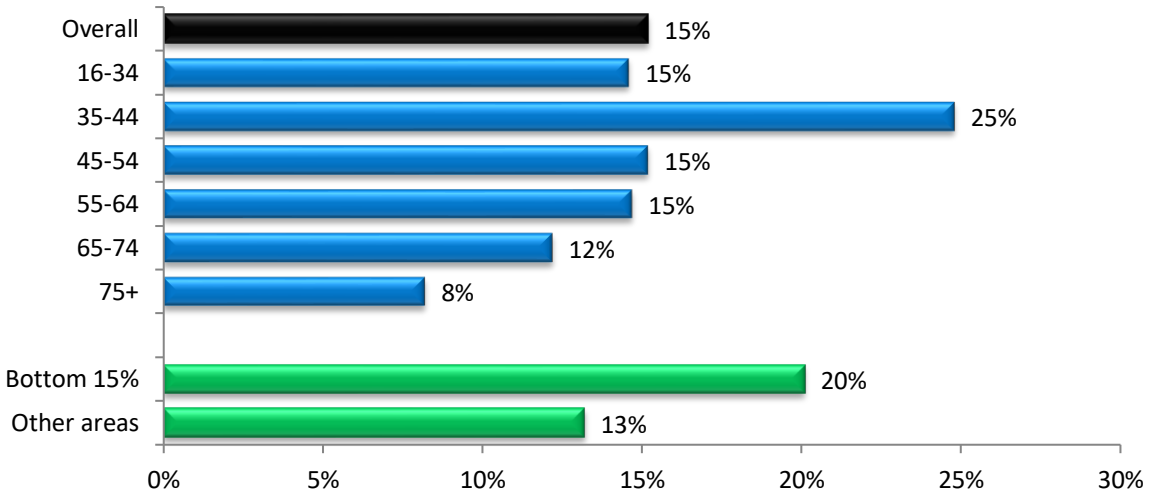
Respondents were asked whether they had spent money on different types of gambling activities in the last month. Overall, 34% had spent money on gambling in the last month. By far the most common type was lottery. In total, 15% had spent money on gambling which excluded lottery.

Figure 6.13: Proportion who Spent Money on Gambling Activities in the Previous Month



- Those aged 35-44 were the most likely to gamble and those aged 75 or over were the least likely.
- Those in the most deprived areas were more likely than others to gamble.

Figure 6.14: Proportion who Spent Money on Gambling Activities (Excluding National Lottery) in the Previous Month by Age and Deprivation



Comparison with NHSGGC

The proportion in West Dunbartonshire who spent money on gambling excluding the lottery (15%) was higher than in the NHSGGC area as a whole (12%).

6.10 Summary of Key Messages from This Chapter

Indicators where West Dunbartonshire Compared Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to say they had difficulty meeting the cost of food and/or energy
- less likely to say they would have difficulty finding sums to pay for unexpected expenses
- less likely to have indicators of difficulty affording energy.

Indicators where West Dunbartonshire Compared Less Favourably to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- more likely to receive all household income from benefits
- more likely to spend money on gambling (excluding lottery).

Differences by Age and Gender

- Those aged 75 or over were the most likely to receive all household income from benefits.

- Those aged 35-44 were the most likely to have difficulty paying for food and/or energy, the most likely to experience food insecurity and the most likely to have indicators of difficulty affording energy.

- Those aged 65 or over were the least likely to have difficulty finding unexpected sums.

- Women were more likely than men to have problems finding unexpected sums, to experience food insecurity or to have experiences indicating difficulties affording energy.

- Those aged under 55 were the most likely to have a pre-paid meter.

- Those aged 35-44 were the most likely to spend money on gambling.

Differences by Deprivation

Those in the most deprived areas were:

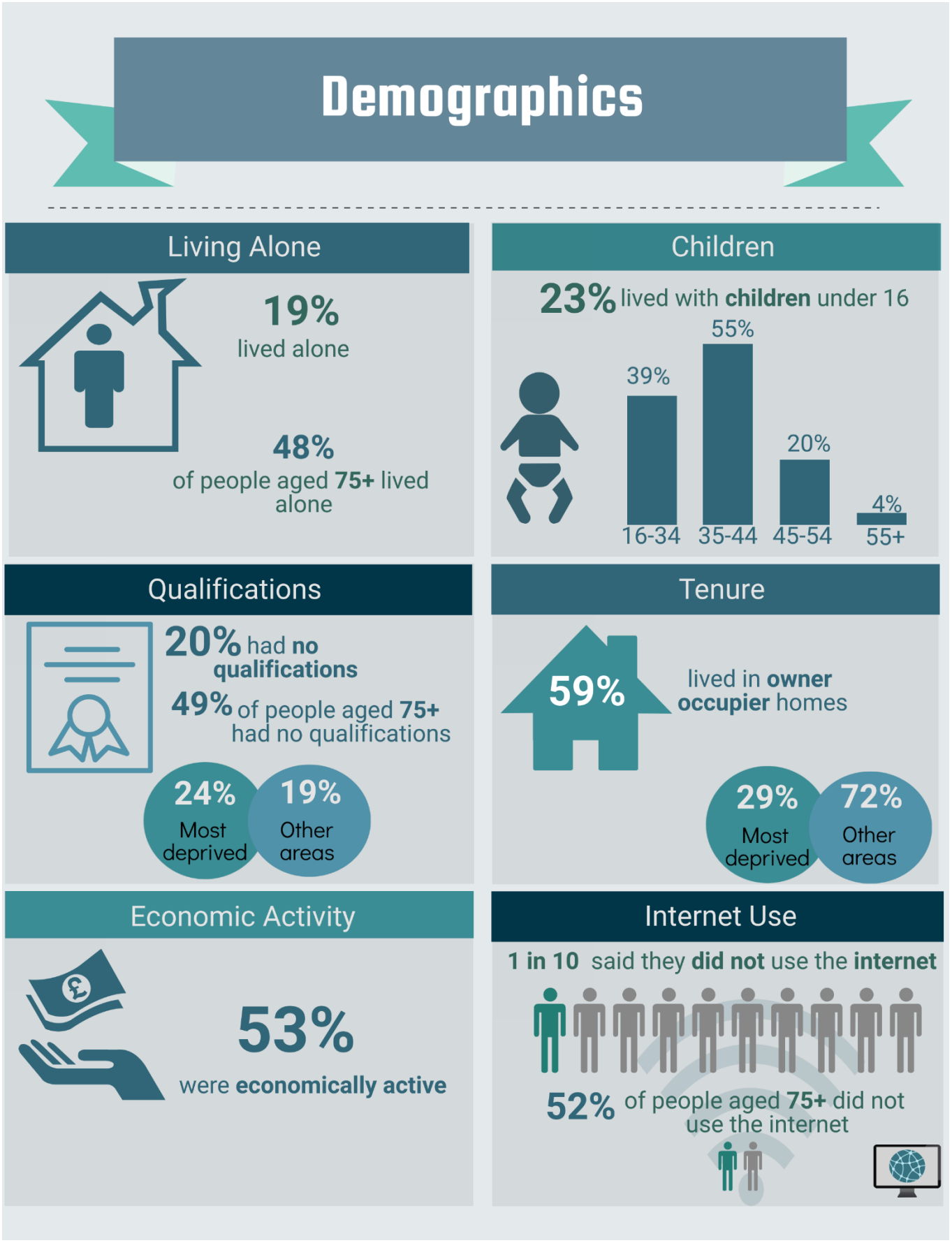
- more likely to receive all household income from state benefits
- less likely to have a positive view of the adequacy of their income
- more likely to report difficulties paying for food and/or energy, or finding money to meet unexpected costs
- more likely to report experiences indicating food insecurity
- more likely to have a pre-payment meter and more likely to report experiences indicating difficulties affording energy
- more likely to spend money on gambling.

Differences by Limiting Conditions

Those with a limiting illness or condition were:

- more likely to receive all household income from benefits
- less likely to have a positive view of the adequacy of their household income
- more likely to report difficulties meeting the cost of food/energy or meeting unexpected sums of £35 or £165
- more likely to experience food insecurity
- more likely to report experiences indicating difficulties affording energy.

7 Demographics

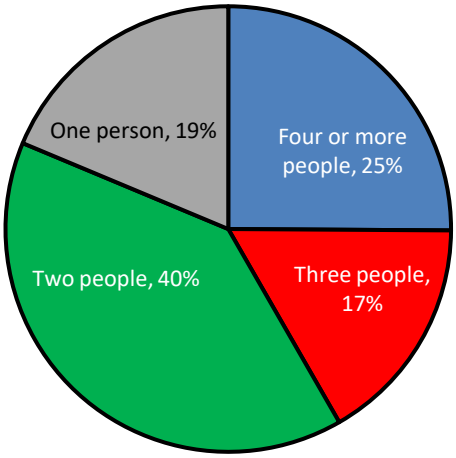


7.1 Household Composition

Household Size

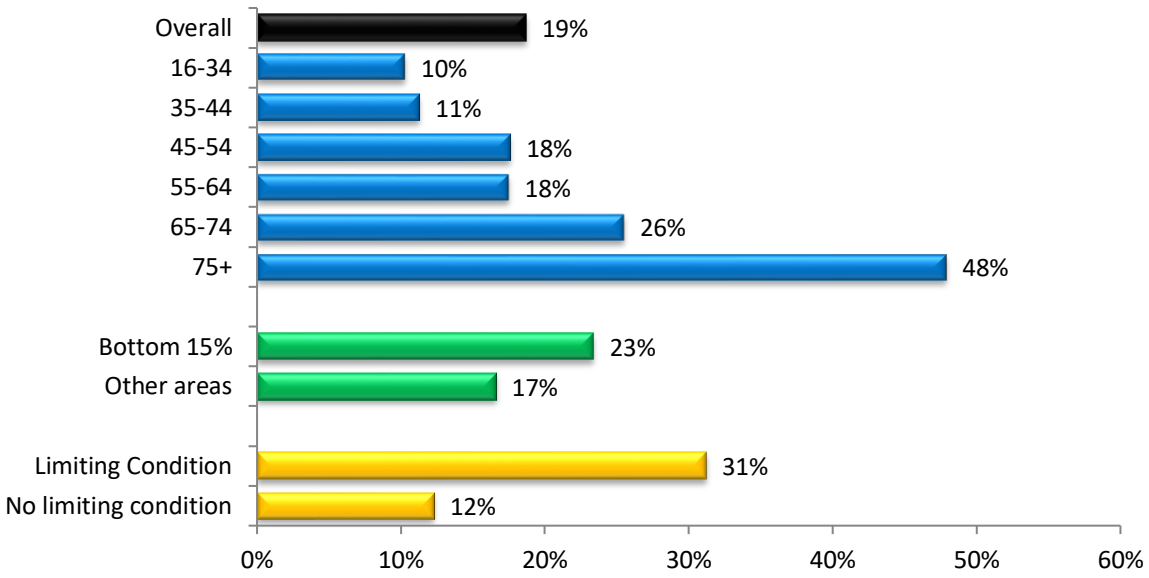
One in five (19%) lived alone. Figure 7.1 shows the breakdown of household size.

Figure 7.1: Household Size



- Those aged 75 or over were the most likely to live alone – nearly half (48%) of those aged 75 or over lived alone.
- Those in the most deprived areas and those with a limiting condition or illness were more likely to live alone.

Figure 7.2: Proportion who Live Alone by Age, Deprivation and Limiting Conditions



Although overall there was no gender difference for the proportion who lived alone, among those aged 65 or over, women were much more likely than men to live alone, as Table 7.1 shows.

Table 7.1: Proportion who Live Alone by Age and Gender

	Live Alone
Men 16-44	12%
Women 16-44	9%
Men 45-64	21%
Women 45-64	14%
Men 65+	21%
Women 65+	46%

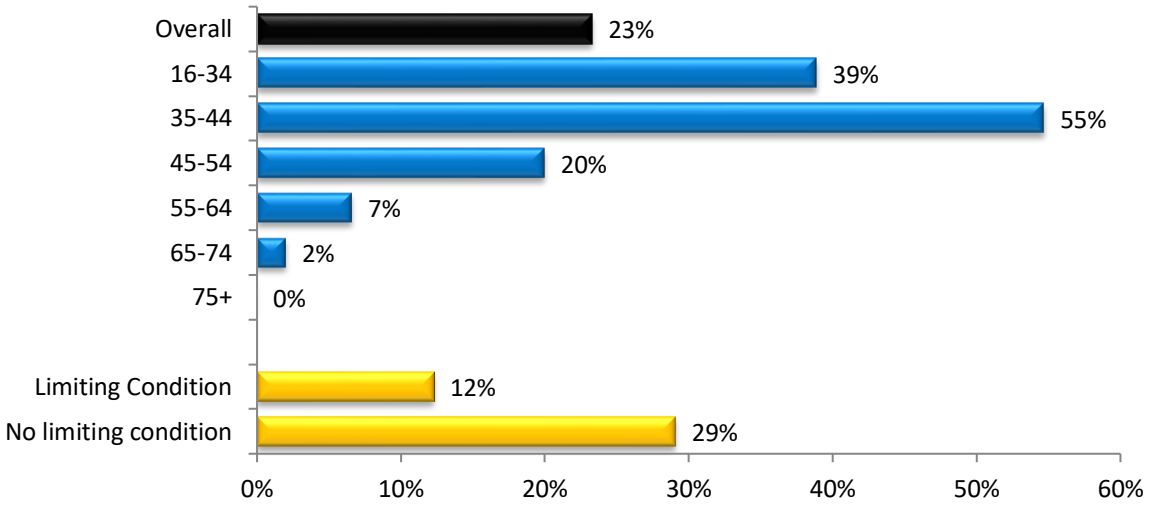
Children in the Household

Just under one in four (23%) adults lived in a home with at least one child under the age of 16.

- Those aged 35-44 were the most likely to live in a home with at least one child under the age of 16.

- Those with a limiting condition or illness were much less likely than others to live with children.

Figure 7.3: Proportion with a Child Aged Under 16 in their Household by Age and Limiting Conditions



Although overall there was no significant difference by gender, among those aged under 45, women were more likely than men to have children in their household.

Table 7.2: Proportion with a Child Aged Under 16 in their Household by Age and Gender

	Child in household
Men 16-44	38%
Women 16-44	51%
Men 45-64	13%
Women 45-64	13%
Men 65+	3%
Women 65+	1%

7.2 Trans Identities and Sexual Orientation

Of the 958 people who answered the self-completion component of the main questionnaire and answered the question about trans identities, less than 1% (N=<5) said they considered themselves to be trans or to have a trans history.

Most (97.6%) of those who answered the self-completion component described themselves as heterosexual or straight, while 0.6% described

themselves as gay, 1.5% described themselves as bisexual and 0.4% described themselves in another way. (This excludes the 2.4% who preferred not to say).

Those aged under 35 were the most likely to identify as gay, bisexual or other (6.3%).

Comparison with NHSGGC

The proportion in West Dunbartonshire who identified as gay/bisexual/other (2.4%) was lower than in the NHSGGC area as a whole (6.1%).

7.3 Ethnicity

Respondents were asked their ethnicity. Table 7.3 shows the proportion of respondents in each group (groups have been combined where sub-groups had less than 1.0% responses)[8].

Table 7.3: Ethnicity

Ethnicity	%
White:	
Scottish	85.8%
Other British	8.6%
Other White	3.4%
Total White	**97.8%**
Total Asian	**1.4%**
Mixed or any other ethnic group	**0.8%**
Total BME (Non white)	**2.2%**

[8] The full Scottish Census 2022 categories were used – see Question T06 in the main questionnaire, Appendix F

Comparison with NHSGGC

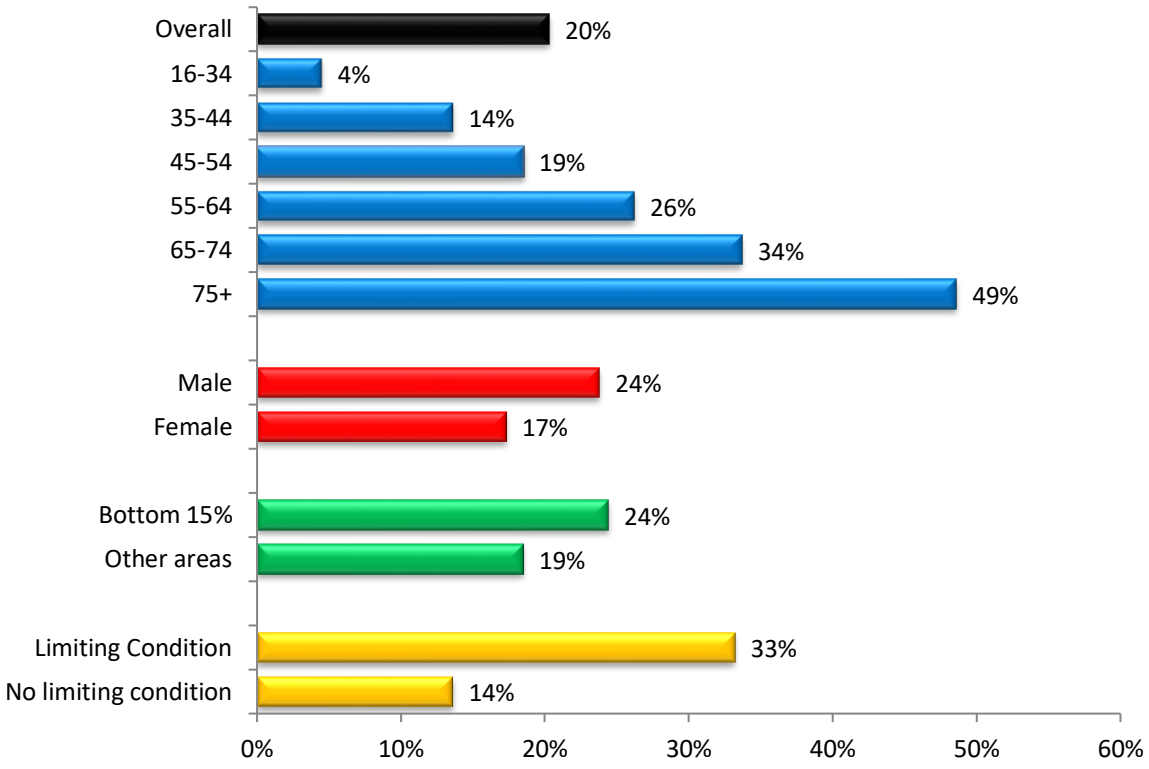
The proportion in West Dunbartonshire who had BME identities (2.2%) was lower than in the NHSGGC area as a whole (13.1%).

7.4 Educational Qualifications

One in five (20%) said they had no qualifications.

- The proportion who said they had no qualifications rose with age from 4% of those aged under 35 to 49% of those aged 75 or over.
- Men were more likely than women to say they had no qualifications.
- Those in the most deprived areas were more likely than those in other areas to say they had no qualifications.
- Those with a limiting condition or illness were more likely to say they had no qualifications.

Figure 7.4: Proportion with No Qualifications by Age, Gender, Deprivation and Limiting Conditions



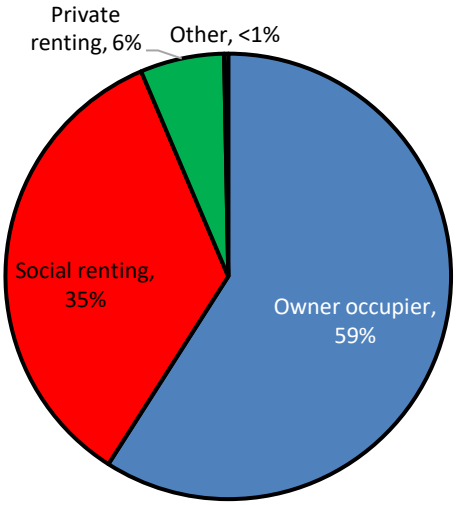
Comparison with NHSGGC

The proportion in West Dunbartonshire who had no qualifications (20%) was higher than in the NHSGGC area as a whole (14%).

7.5 Tenure

Three in five (59%) adults lived in owner-occupied homes (either owned outright or buying with a mortgage), 35% lived in homes rented from the council or a housing association, 6% lived in privately rented homes and less than 1% lived in homes with some other tenure.

Figure 7.5: Tenure



- Those aged under 45 were the least likely to live in owner-occupied homes and those aged under 35 were the most likely to live in privately rented homes.

- Three in ten (29%) of those in the most deprived areas lived in owner-occupied homes compared to 72% of those in other areas. Just under two thirds (64%) of those in the most deprived areas lived in socially rented homes.

- Those with a limiting condition or illness were more likely than others to live in socially rented homes and less likely to live in privately rented homes.

Table 7.4: Tenure by Age, Deprivation and Limiting Conditions

	Owner-occupier	Social renting	Private renting	Other
16-34	46%	40%	14%	1%
35-44	47%	48%	6%	0%
45-54	59%	35%	6%	1%
55-64	69%	29%	1%	1%
65-74	77%	22%	1%	0%
75+	69%	28%	3%	0%
Bottom 15%	29%	64%	6%	1%
Other areas	72%	22%	6%	0%
Limiting Condition	58%	38%	3%	0%
No limiting condition	59%	32%	8%	<1%

7.6 Economic Activity

Respondents were asked which category best described their employment situation, with the option of selecting more than one category. Responses, from most to least frequent were:

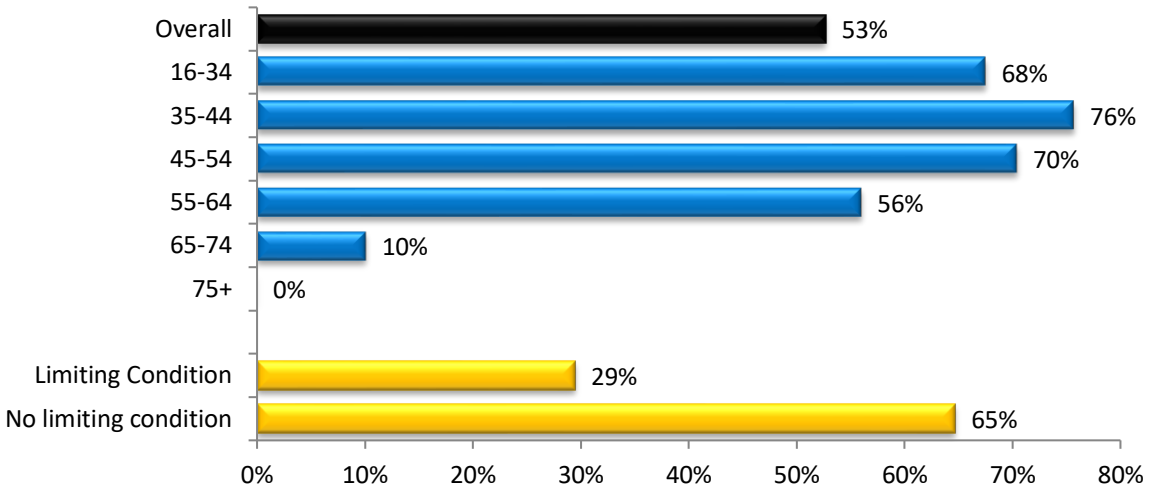
- Employee in full-time job (38%)
- Wholly retired from work (26%)
- Employee in part-time job (12%)
- Permanently sick/disabled (8%)
- Unemployed and available for work (6%)
- Full-time education (4%)
- Self-employed – full or part time (2%)
- Looking after the family/home (2%)
- Employed on a zero hours contract (<1%)
- Part-time education (<1%)
- Other (1%).

In total, 53% were economically active (in full-time or part-time employment, self employed or on a zero hours contract).

- Rates of economic activity were highest among those aged 35-44.

- Those with a limiting condition or illness were much less likely than others to be economically active.

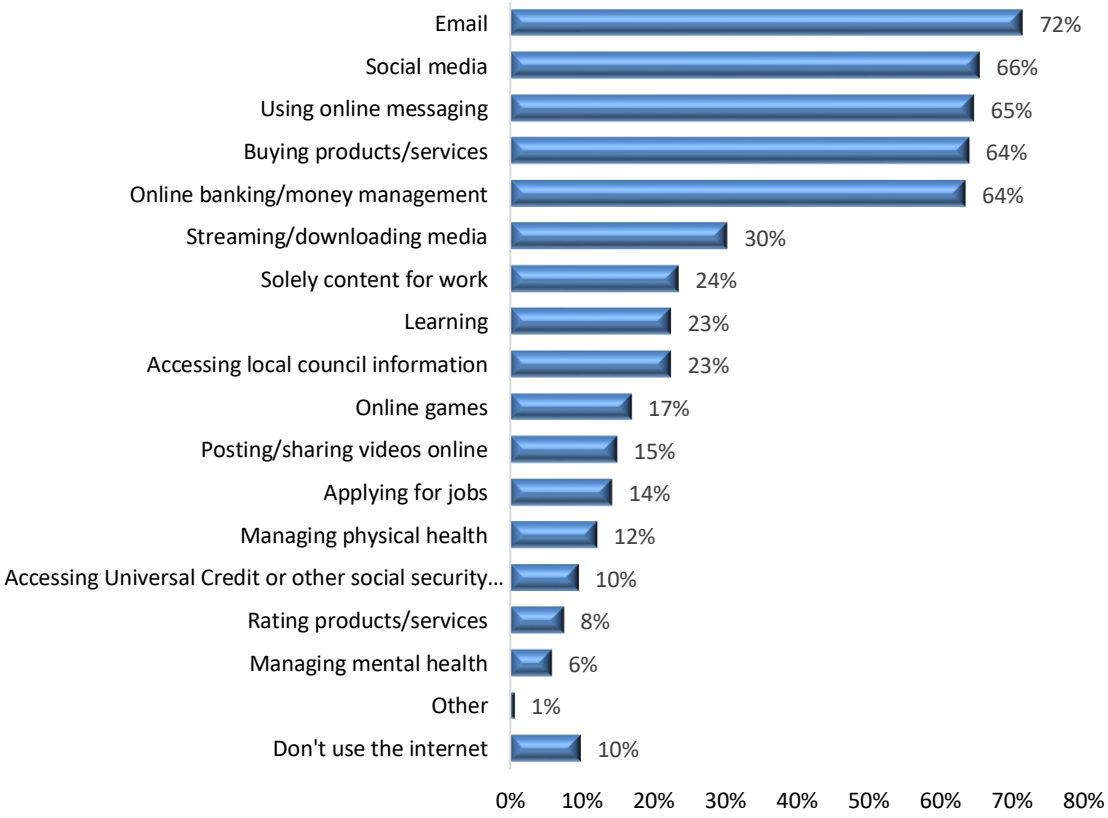
Figure 7.6: Proportion Economically Active by Age and Limiting Conditions



7.7 Internet Use

Respondents were asked about the purposes for which they used the internet. One in ten (10%) did not use the internet. The most common use of the internet was email (72%). All responses are shown in Figure 7.7.

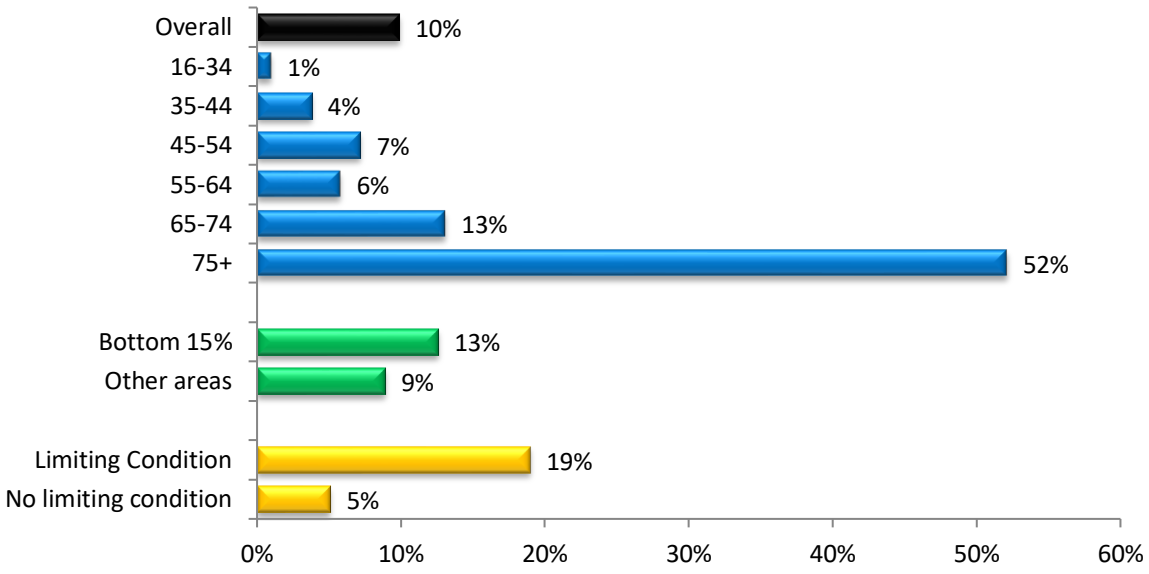
Figure 7.7: Purposes of Internet Use



- Nearly all (99%) of those aged under 35 used the internet, but just under half (48%) of those aged 75 or over used the internet.

- Those in the most deprived areas were less likely to use the internet.
- Those with a limiting condition or illness were much more likely than others to say they did not use the internet.

Figure 7.8: Proportion who Do Not Use the Internet by Age, Deprivation and Limiting Conditions

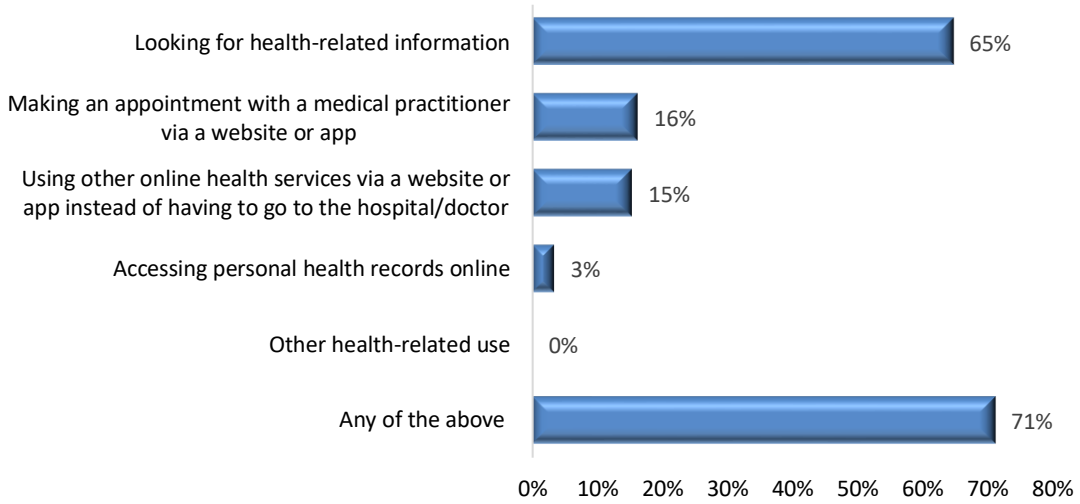


Evidence from Other Sources

- **The 2022 Scottish Household Survey** found that nationally 90% of people used the internet, dropping to 76% for those aged 75 or over. Although the question was asked in a different way, it indicates a similar prevalence of internet use in West Dunbartonshire compared to nationally (although use of the internet among those aged 75 or over was much lower in West Dunbartonshire).

Among those who ever used the internet, 71% had used the internet for health-related use, the most common being looking for health-related information.

Figure 7.9: Health-Related Use of the Internet (for those who ever used the internet)

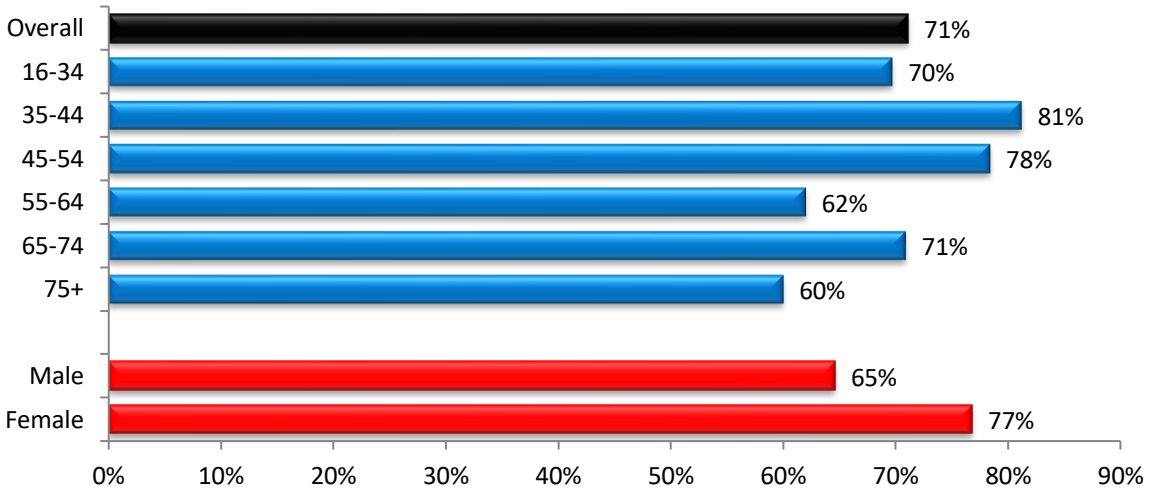


Base: All those who used the internet (unweighted N= 936)

Among those who used the internet:

- those aged 35-54 were the most likely to use the internet for health-related reasons
- women were more likely than men to use the internet for health-related reasons.

Figure 7.10: Proportion of Internet Users who Used the Internet for Health-Related reasons by Age and Gender



Base: All those who used the internet (unweighted N= 936)

Those who did not use the internet (N=138) were asked which of a number of statements applied to them when thinking about what would encourage them to improve their digital skills. Most (85%) said that nothing would encourage them to do so as they avoid adopting technology, but 13% said they would if devices were cheaper.

7.8 Summary of Key Messages from This Chapter

Indicators were West Dunbartonshire Differed Significantly to NHSGGC

Compared to those in the NHSGGC area as a whole, those in West Dunbartonshire were:

- less likely to identify as gay/bisexual/other
- less likely to have BME identities
- more likely to say they had no qualifications.

Differences by Age and Gender

- Those aged 75 or over were the most likely to live alone.
- Those aged 35-44 were the most likely to have children in their household.
- Those aged 75 or over were the most likely to say they had no qualifications, and men were more likely than women to say they had no qualifications.
- Those in the youngest age groups were the least likely to live in owner occupied homes and the most likely to rent privately.
- Those aged 35-44 were the most likely to be economically active.
- Those aged 75 or over were the least likely to use the internet. Among those who did use the internet, those aged 35-54 were the most likely to use it for health-related reasons. Women were more likely than men to use the internet for health-related reasons.

Differences by Deprivation

Those in the most deprived areas were:

- more likely to live alone
- more likely to say they had no qualifications
- less likely to live in owner-occupied homes and more likely to live in socially rented homes
- less likely to use the internet.

Differences by Limiting Conditions

Those with a limiting condition or illness were:

- more likely to live alone and less likely to live with children
- more likely to say they had no qualifications
- more likely to live in socially rented homes
- less likely to be economically active
- less likely to use the internet.

APPENDIX A: SURVEY METHODOLOGY & RESPONSE

This Appendix has been prepared by BMG Research, who conducted the survey fieldwork. It details the collection of 10,346 interviews: Note this was subsequently reduced to 10,030 interviews as 316 could not be used due to missing age group and/or household size data. Appendix B details the profile of the 10,030 interviews in the final dataset.

Introduction

This technical report provides details of the methodology employed by BMG Research in the collection of the HWB 2022 data. A number of key response statistics will also be presented, such as response rates, quality checking outputs, interviewer metrics, and wave by wave interviewing numbers obtained.

All processes from sampling through to data collection and delivery were managed in-house at BMG Research.

Sampling

Introduction

All sampling was managed in-house at BMG Research, and the process that was adopted closely matched that used in previous years to ensure reliable comparisons could be made over time.

The overarching objective was to obtain a sample that is representative of each of the HSCP areas, particularly in terms of age, gender, economic status and deprivation. The targets per HSCP were also split into categories depending on the nature of the area and the type of boost it was defined as: including main sample, basic boost, neighbourhood boost and enhanced boost. The target grid is shown below, with an overall target of 10,335 interviews to achieve.

Table A1: Target number of interviews to achieve per HSCP

				Boosts Required Sample (+/- 4% MOE)				
	SAPE 2020	Main Sample *		Basic Boost	N'Hood Boost	Enhanced Boost		
HSCP	16 plus	15%	Others	All	All	MD **	Others	Total Sample
NE Glasgow	160765	190	201	207				598
Parkhead/Dalmarnock	8796				562			562
Garthamlock/Ruchazie	6720				552			552
NW Glasgow	184615	131	318	150				599
Ruchill & Possilpark	9637				566			566
South Glasgow	189782	156	305	138				599
Govanhill	122282				573			573
Greater Gorbals	8816				563			563
Glasgow City	535162	477	824	495	2816	0	0	4612
East Dunbartonshire	89250	8	208			505	389	1110
East Renfrewshire	76414	5	180			469	416	1070
Renfrewshire	149208	75	288			514	310	1187
Inverclyde	64647	55	103			530	489	1177
West Dunbartonshire	72856	53	124			532	470	1179
NHSGGC Total *	987537	673	1727	495	2816	2550	2074	10335

** MD = most deprived 15% (20% in East Dunbartonshire & East Renfrewshire)

Sampling process

NHSGGC provided BMG Research with a datazone definition file that identified the key criteria of each datazone within the study area, including SIMD 2020, HSCP, neighbourhood etc. Datazones formed the sampling points within each area, with their selection based on a stratification by SIMD within each of the target areas to ensure a representative datazone selection by deprivation. The postcode address file (PAF) was then used to randomly select 30 addresses per datazone to form the sampling frame, with a target of 10 interviews to achieve per datazone.

It was found that during this process, a number of target areas (for example, all the neighbourhood boosts and some of the enhanced boosts) did not have sufficient datazones to achieve the target using the principle of '30 addresses sampled to achieve 10 interviews'. In these instances, we increased the number of sample points within each datazone to achieve the sample, but at all times only 3 times the number of addresses were supplied to achieve the target, thus ensuring the response rates were protected and consistent.

Therefore, in summary:

1,033 datazones/sample points were sampled in total.

30,969 addresses were sampled in total across these datazones.

Each address received a pre-survey letter in the post prior to being approached for interview, which gave the household the opportunity to 'opt out', and responding households were left with an information leaflet on completion of the interview.

The next birthday rule was utilised to ensure the random selection of respondent per household.

The datazones were allocated to one of six 'survey waves' which ensured a broad spread of interviews. The resulting number of achieved interviews per HSCP per wave is shown in the table below. In total 3,605 interviews were undertaken during 2022.

Table A2: Number of interviews achieved per HSCP per wave

HSCP	Wave 1 inc pilot (09/22 & 10/22)	Wave 2 (10/22 – 12/22)	Wave 3 (12/22 – 02/23)	Wave 4 (02/23 – 03/23)	Wave 5 (03/23 – 04/23)	Wave 6 (04/23 – 05/23)	TOTAL
East Dunbartonshire	167	173	200	172	174	252	1138
East Renfrewshire	154	146	186	207	173	214	1080
Glasgow North East	248	232	328	331	313	256	1708
Glasgow North West	162	164	213	237	301	104	1181
Glasgow South	252	251	300	339	388	199	1729
Inverclyde	160	196	236	248	179	165	1184
Renfrewshire	170	186	213	226	197	193	1185
West Dunbartonshire	180	178	207	180	190	206	1141
TOTAL	1493	1526	1883	1940	1915	1589	10346

Fieldwork

Prior to fieldwork commencing, a pilot was conducted to test a number of aspects of the methodology, including sampling, questionnaire content/flow, CAPI script functionality, and contact management in terms of recording call outcomes at addresses. A total of 40 interviews were

conducted as part of the pilot, spread across HSCP and deprivation, as follows:

Table A3: Number of pilot interviews

HSCP	SIMD	No. of interviews
Glasgow North East – 15% SIMD	1	10
East Renfrewshire – Other	5	5
Glasgow North West – Other	4	10
Glasgow South – Other	3	6
Renfrewshire – Other	2	9

A total of 34 interviewers were briefed and worked on this project. The initial briefing session took place in September and was recorded for those who were unable to attend the initial briefing. The average number of interviews conducted per interviewer was 304. The interviews lasted an average of 24 minutes.

All interviewers were briefed that each address must be attempted up to six times before it is deemed exhausted. However, to effectively manage this, interviewers were briefed to make two attempts at an address at a weekend, two on a weekday after 5pm and two on a weekday before 5pm. This ensures the greatest opportunity for all resident groups to be captured, particularly those in work. The following table provides the breakdown of interviews achieved by time of day and weekday or weekend, and it can be seen that more than half of the interviews were completed at weekends or evenings.

Table A4: Number of achieved interviews by time of day and week

	No. of interviews	%
Weekday before 5pm	4751	46%
Weekday after 5pm	2900	28%
Weekend	2695	26%

Call outcomes and response rates

The following table provides a breakdown of the call outcomes and the resulting response rates by HSCP as well as at a total level. The response rate can be calculated as the number of interviews achieved from valid addresses issued (minus addresses found to be empty, businesses, derelict, or unable to locate), which is 40%, or as an adjusted response rate based on the number of achieved interviews where contact was actually made with the household, which is 69%.

Table A4: Call outcomes and response rates

	East Dunbartonshire HSCP	East Renfrewshire HSCP	Glasgow North East HSCP	Glasgow North West HSCP	Glasgow South HSCP	Inverclyde HSCP	Renfrewshire HSCP	West Dunbartonshire HSCP	TOTAL
Interview obtained	1138	1080	1708	1181	1729	1184	1185	1141	10346
Refused	264	288	535	396	363	431	339	404	3020
Opt out	488	354	288	264	371	425	390	446	3026
No reply	812	898	1322	899	1557	594	949	782	7813
Call back/appointment	122	141	117	71	202	67	96	79	895
Physically or mentally unable to complete interview	11	9	19	2	6	20	6	15	88
Away at hospital during survey period	6	4	18	17	8	25	0	32	110
Language issues	7	3	15	10	30	4	5	2	76
Contact exhausted	149	1	15	59	2	106	19	159	510
Non-valid contacts									
Non-residential address/institution/holiday home	33	10	64	12	19	17	13	31	199
Empty/derelict/under construction	35	15	37	36	147	136	40	57	503
Not attempted because target achieved	259	417	987	555	783	481	485	354	4321
Unable to locate address	0	5	5	8	3	20	13	8	62

Quality checking overview

In total, 1831 of the 10,346 cases were back checked (654 via telephone and 1177 online). The back checking procedure involves, predominantly, telephoning or emailing respondents to check the validity and conduct of the interview. The following types of information are checked with respondents:

Name and address.

Conduct of the interviewer (politeness, showed ID badge, whether the interviewer tried to influence the answers).

Other details concerning the interview (were showcards used, was the interview conducted in home or at the doorstep, was a leaflet left behind).

Four pieces of information provided by the respondent during the interview are re-checked for consistency. These were age, household tenure, employment status and whether they were asked to self-complete part of the survey.

In addition to these checks random GPS checks were also undertaken as well as checks on interview timings/length for additional verification.

Online Survey

This year the face-to-face survey asked if respondents would be willing to complete an online follow up survey to gather some further information. Email addresses were collected for those willing and an online survey invitation was sent via email followed by two reminders for those who had not completed.

Those aged 18 plus who completed the follow up online survey were entered in to a prize draw to win one of four £250 Love2Shop vouchers.

In total, 2647 respondents were invited to take part in the online follow up survey and 1196 responded giving an overall response rate of 45%.

Table A6: Online follow up survey response rates

	No. of invites sent	No. of responses	Response Rate
East Dunbartonshire	413	205	50%
East Renfrewshire	259	140	54%
Glasgow North East	260	92	35%
Glasgow North West	197	85	43%
Glasgow South	404	175	43%
Inverclyde	392	187	48%
Renfrewshire	370	150	41%
West Dunbartonshire	352	162	46%
TOTAL	2647	1196	45%

APPENDIX B: COMPARISON WITH PREVIOUS HEALTH AND WELLBEING SURVEYS, and KEY CHANGES TO THE SURVEY METHODOLOGY

Comparison with previous health and wellbeing surveys

The 2022/23 survey was affected by the following factors:

- It was delayed for two years due to the COVID pandemic.
- Staffing of the survey proved difficult as a result of the new context in which it was operating, and the fieldwork was therefore conducted over a longer period of time than previous surveys (from September 2022 to May 2023).
- The longer survey period, with responses being collected during the spring season for the first time, means that there will likely be some impact of seasonality when comparing responses.
- It should also be considered that societal and economic factors changed during the period of data collection which may affect survey responses. For example:
    - The beginning of the survey period was closer in time to the isolating effects of COVID restrictions which were in place until spring 2022.
    - The rising cost of living, including surges in the cost of energy and food, continued apace throughout the survey period and therefore the impact is likely to have been more keenly felt among those interviewed towards the end of the survey period.

Key changes to the survey methodology in 2022/23

A number of changes were introduced in the 2022/23 Health and Wellbeing Survey. The key changes implemented include:

- Increased sample size to cover all geographies in GGC allowing for analysis at HSCP level for Glasgow City, East Dunbartonshire, Renfrewshire, Inverclyde, West Dunbartonshire and East Renfrewshire.
- New questions introduced asked about 'effects of COVID on Health and Wellbeing', fuel poverty, internet use and 'Everyday Discrimination' scale.

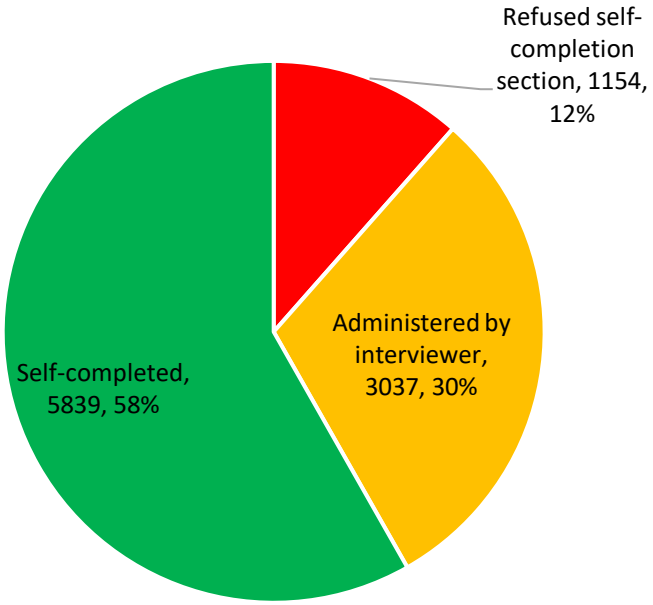
- An online survey component completed by a subset of respondents asking about mental health, dental health, diet, drugs and sexual health.

- A self-completion section asking about mental wellbeing, discrimination, domestic abuse, sexual orientation and the option to undertake the online survey.

Limitations of Self-Completion Component

All respondents were invited to participate in the self-completion section (see Section G of the main questionnaire, Appendix F). When considering the findings from the questions in this section, it should be noted that one in eight (N=1,154; 12%) respondents **refused** to answer the self-completion section and three in ten (N=3,037; 30%) respondents did not self-complete the section, but it was **administered by the interviewer**. Thus, only 58% self-completed the section. This is illustrated in Figure B1.

Figure B1: Responses to the Self-Completion Section of the Main Questionnaire



The high refusal rate and the large number of respondents answering the personal/sensitive questions directly to the interviewer may impact the reliability of these findings. Also, as the Table C2 in Appendix C shows, the proportion of respondents who responded and self-completed the section varied by age, deprivation group, limiting conditions and HSCP area.

APPENDIX C: DATA WEIGHTING AND SAMPLE PROFILE

Introduction

Data were weighted to ensure that they were as representative as possible of the adult population in the NHSGGC area. This appendix describes the weighting processes.

Household Size Weighting

In this survey, households were selected at random and therefore had equal probability of selection. However within the household the probability of an individual's selection is not necessarily equal to that of others, since it is inversely proportional to the number of people available to be selected. For example, in a single-person household the probability of selection is exactly 1 whereas in a four-person household the probability of selection is 1/4. The logic of this implies that the respondent from the single-person household represents one person (him/herself) while the respondent from the four-person household is in fact representing four people. It is normal to allow for this bias by 'weighting' the sample to give the respondent from the four-person household four times the 'weight' of the respondent from the one-person household. It is usual to calculate this weighting in such a way that the sum of the weights matches the sample size.

The formula for calculating the household size weight was:

$$Wf = F \times \frac{T}{A}$$

Where:

- *Wf* is the household size weighting factor for a respondent living in a household size F.
- *F* is the household size
- *T* is the total number of respondents
- *A* is the total number of adults in all households where a successful interview took place.

Weighting by Age/Gender/Bottom 15%/HSCP or Neighbourhood

Firstly the household size weighting was applied to the dataset. This produced the new 'actual' counts to which we applied the age/sex/bottom15%[9]/HSCP or Neighbourhood weighting frame to produce the final weighting factors. This ensured that the weighted data would reflect the overall Greater Glasgow and Clyde population in terms of age, gender, bottom 15%/other areas and

[9] Bottom 20% in the case of East Dunbartonshire and East Renfrewshire

HSCP areas (or neighbourhoods in the case of Glasgow City). The formula for this stage of the weighting process was:

$$Wi = \frac{ci}{C} \times \frac{T}{ti}$$

Where:

W_i is the individual weighting factor for a respondent in age/gender/bottom15% versus other areas/HSCP or neighbourhood group i

c_i is the known population in age/gender/bottom15% versus other areas/HSCP or neighbourhood group i

C is the total adult population in the NHS Greater Glasgow and Clyde area

T is the total number of interviews

t_i is the number of interviews (weighted by the household size weighting factor) for age/gender/bottom15% versus other areas/HSCP or neighbourhood group i

The 'known population' came from the Small Area Population Estimates (SAPE) provided by National Records of Scotland. SAPE records population by binary gender only, while the survey asked for self-identified gender, including the option to identify in other ways to male or female or to not disclose gender identity. Of the 10,030 respondents, there were 20 who did not give a binary identity (11 gave a non-binary identity and 9 preferred not to say). For the purposes of weighting only, they were randomly assigned male and female to allow weighting to be applied on the basis of age, deprivation group and HSCP/neighbourhood).

The application of the household weighting factor was multiplied by the individual weighting factor to provide the main weighting factor which was applied for all analysis of the main survey questions.

The unweighted and weighted sample profiles are shown in Table C1. This shows how the weighting process returned the profile to match the Small Area Population Estimates for 2020 in terms of gender, age, deprivation and HSCP/Neighbourhood for the main questionnaire.

Table C2 shows the differing levels of self-completion of the 'self-completion' section of the questionnaire.

Table C1: Main questionnaire sample before and after weighting, and Small Area Population Estimates (SAPE) comparison

	Sample Before Weighting N	Sample Before Weighting %	Sample After Weighting N	Sample After Weighting %	SAPE 2020 N	SAPE 2020 %
Male	4,634	46.2%	4,829	48.3%	475,238	48.1%
Female	5,375	53.6%	5,173	51.7%	512,299	51.9%
Other/no answer	21	0.2%	28	0.3%	N/A	N/A
16-24	674	6.7%	1,341	13.4%	132,368	13.4%
25-34	1,775	17.7%	1,999	19.9%	195,380	19.8%
35-44	1,765	17.6%	1,560	15.6%	153,625	15.6%
45-54	1,476	14.7%	1,558	15.5%	153,502	15.5%
55-64	1,685	16.8%	1,569	15.6%	155,349	15.7%
65-74	1,488	14.8%	1,102	11.0%	108,323	11.0%
75+	1,167	11.6%	901	9.0%	88,990	9.0%
Bottom 15% (or 20% in East Dun and East Ren)	5,128	51.1%	2,820	28.1%	276,573	28.0%
Other Areas	4,902	48.9%	7,210	71.9%	710,964	72.0%
East Dunbartonshire	1,088	10.8%	907	9.0%	89,250	9.0%
East Renfrewshire	1,058	10.5%	778	7.8%	76,414	7.7%
Glasgow NE	1,669	16.6%	1,633	16.3%	160,765	16.2%
Glasgow NW	1,171	11.7%	1,875	18.7%	184,615	18.7%
Glasgow South	1,678	16.7%	1,919	19.1%	189,782	19.2%
Inverclyde	1,138	11.3%	659	6.6%	64,647	6.6%
Renfrewshire	1,144	11.4%	1,518	15.1%	149,208	15.1%
West Dunbartonshire	1,084	10.8%	742	7.4%	72,856	7.4%

Table C2: Profile of responses to the self-completion section of the main questionnaire by age, deprivation, limiting conditions and HSPC (UNWEIGHTED DATA)

	Refused		Interviewer-Administered		Self-completed	
	N	%	N	%	N	%
16-24	42	6.2%	113	16.8%	519	77.0%
25-34	150	8.5%	267	15.0%	1,358	76.5%
35-44	191	10.8%	319	18.1%	1,255	71.1%
45-54	172	11.7%	370	25.1%	934	63.3%
55-64	207	12.3%	608	36.1%	870	51.6%
65-74	176	11.8%	662	44.5%	650	43.7%
75+	216	18.5%	698	59.8%	253	21.7%
Bottom 15% (or 20% in East Dun and East Ren)	588	11.5%	1,758	34.3%	2,782	54.3%
Other Areas	566	11.5%	1,279	26.1%	6,057	62.4%
Limiting condition	468	11.9%	1,572	40.1%	1,877	47.9%
No limiting condition	682	11.2%	1,462	24.0%	3,952	64.8%
East Dunbartonshire	144	13.2%	310	28.5%	634	58.3%
East Renfrewshire	102	9.6%	340	32.1%	616	58.2%
Glasgow NE	309	18.5%	521	31.2%	839	50.3%
Glasgow NW	86	7.3%	387	33.0%	698	59.6%
Glasgow South	139	8.3%	440	26.2%	1,099	65.5%
Inverclyde	147	12.9%	418	36.7%	573	50.4%
Renfrewshire	108	9.4%	246	21.5%	790	69.1%
West Dunbartonshire	119	11.0%	375	34.6%	590	54.4%
All	1,154	11.5%	3,037	30.3%	5,839	58.2%

APPENDIX D: INDEPENDENT VARIABLES

The table below lists the independent variables used for the analysis in this report, showing for each the number of categories and how these categories were formed.

Independent Variable	Number of categories	Categories
Gender	2	Male; Female
Age	6	16-34; 25-34; 35-44; 45-54; 55-64; 65-74; 75+
Age/Gender	6	Male 16-44; Female 16-44; Male 45-64; Female 45-64; Male 65+; Female 65+
Deprivation	2	20% most deprived datazones; other datazones
Limiting Conditions	2	Has a long-term limiting condition or illness; does not have a long-term limiting condition or illness

APPENDIX E: ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT) SCORING

AUDIT is a comprehensive 10 question alcohol harm screening tool. It was developed by the World Health Organisation (WHO) and modified for use in the UK and has been used in a variety of health and social care settings.

	Scoring system					
Questions	**0**	**1**	**2**	**3**	**4**	**Your score**
How often do you have a drink containing alcohol	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 times or more per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:

- 0 to 7 indicates low risk
- 8 to 15 indicates increasing risk
- 16 to 19 indicates higher risk
- 20 or more indicates possible dependence

APPENDIX F: MAIN SURVEY QUESTIONNAIRE

NHSGGC Health & Wellbeing Survey 2022
Main Questionnaire

Survey introductions

CAPI INTRO [TO BE UPDATED]

Good morning/ afternoon, my name is … and I'm from BMG Research. BMG Research is an independent research company who work to the Market Research Society (MRS) code of conduct. We are carrying out research on behalf of the NHS Greater Glasgow and Clyde. The survey is about your health including issues such as diet, exercise and the area you live in and is a follow up to a similar study conducted in 2017.

The survey will take around 30 minutes to complete. [book appointment if not convenient now].

BMG Research will only use your details for the purpose of this survey, and for quality checking the interviews, unless your permission is otherwise sought.

The anonymised findings from the survey may be published. The data will only be used for the purposes specified and in terms of the Data Protection Act 1998. Please note that no individual will be identified through the data and findings from the survey, unless your permission is otherwise sought.

Just to confirm, your responses will be treated in the strictest confidence. BMG Research abides by the Market Research Society Code of Conduct and data protection laws at all times. Please note consent is audio recorded.

You can find out more information about our surveys and what we do with the information we collect in our Privacy Notice which is on our website.

I can give you the website address (https://www.bmgresearch.co.uk/privacy).

Ensure calling card provided if request more detail about BMG including about privacy notice

INTERVIEWER: Confirm respondent happy to proceed with the survey

✓ Informed consent provided **[TICK BOX, DO NOT ALLOW TO PROCEED WITHOUT TICKED]**

Section A: PERCEPTIONS OF HEALTH & ILLNESS

INTRO TEXT

I'd like to start by asking you some questions about your health.

Base: All respondents

SINGLE CODE

A01. How would you describe your health?

Please use showcard 1 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Very good		
2	Good		
3	Fair		
4	Bad		
5	Very bad		
97	Don't know	FIX, EXCLUSIVE	

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

A02. Looking at the faces on the card...?

Please use showcard 2 (with faces on) and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Which face best rates your overall quality of life?		
2	Which face best rates your general physical well-being?		
3	Which face best rates your general mental or emotional well-being?		

Column code	Column list	Scripting notes	Routing
1	1		
2	2		
3	3		

4	4		
5	5		
6	6		
7	7		
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE RESPONSE

A03. Do you feel in control of decisions that affect your life, such as planning your budget, moving house or changing job?

Read out and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Definitely		
2	To some extent		
3	No		
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE RESPONSE

A04. Do you have any long-term condition or illness that substantially interferes with your day-to-day activities?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		**GO TO A05**
2	No		
98	Prefer not to say		

ASK IF YES (CODE 1) AT A04 = YES

MULTICODE

A05. Thinking of these conditions and/or illnesses, would you describe yourself as having…?

Read out and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	A physical disability		
2	A mental or emotional health problem		
3	A long-term illness		
97	Don't know	**FIX, EXCLUSIVE**	

All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 30

A06. How many illnesses or conditions are you currently being treated for?

Please use showcard 3 (with list of illnesses/conditions) and type response in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
98	Prefer not to say	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE RESPONSE

A07. How would you describe the current state of the health of your mouth and teeth?

Please use showcard 4 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I feel my mouth and teeth are in good health		
2	I feel my mouth and teeth have some problems that need to be fixed		
3	I feel my mouth and teeth are in a poor state		
98	Prefer not to say		

Base: All respondents

MULTICODE

A08. Which of the following services have you attended with a dental problem in the last two years?

Please use showcard 5 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	High street dental practice		
2	Out of Hours/Emergency dental service		
3	Accident and Emergency Department		
4	Medical GP		
5	Pharmacist		
6	No services required	**FIX, EXCLUSIVE**	
97	Don't know	**FIX, EXCLUSIVE**	

INTRO TEXT

There is strong recent evidence and support from UK Chief Medical Officers that adding fluoride to water supplies will help reduce tooth decay. This question is only intended to explore your attitude towards this. The issue would be subject to formal public consultation before any future decisions were taken

Base: All respondents

SINGLE CODE

Please use showcard 6 and select one only

A09. Do you agree or disagree with the following statement: I am open to the possibility of water fluoridation in my local area?

Column code	Column list	Scripting notes	Routing
1	Agree		
2	Neither agree nor disagree		
3	Disagree		
4	Unsure/I don't know what water fluoridation is		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

A10. How has the following changed for you due to the COVID pandemic?

Please use showcard 7 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Quality of life		

2	General physical well- being		
3	General mental or emotional well-being		
4	Feel in control of decisions that affect your life		
5	Physical Disability		
6	Mental or emotional health problem		
7	Long-term illness		

Column code	Column list	Scripting notes	Routing
1	Improved a lot		
2	Improved a little		
3	Much the same		
4	Deteriorated a little		
5	Deteriorated a lot		
6	Changed, however, not due to Covid pandemic		
97	Don't know	**FIX, EXCLUSIVE**	

Section B: HEALTH BEHAVIOURS

INTRO TEXT

Now I would like to ask you some questions about your lifestyle.

Base: All respondents

MULTICODE

B01. Are you exposed to other people's tobacco smoke in any of these places?

Please use showcard 8 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	At own home		
2	At work		
3	In other people's homes		
4	In cars, vans etc		

5	Outside of buildings (e.g., pubs, shops, hospitals)		
6	In other public places		
7	No, none of these	**FIX, EXCLUSIVE**	
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE CODE

Please use showcard 9 and select one only

B02. How often are you in places where there is smoke from other people smoking tobacco?

Column code	Column list	Scripting notes	Routing
1	Most of the time		
2	Some of the time		
3	Seldom		
4	Never		
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE CODE

B03. Which of the following statements best describes you at present?

Please note, when answering this question please **DO NOT** include cigarettes without tobacco or electronic cigarettes/VAPES.

Please use showcard 10 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I have never smoked tobacco		
2	I have only tried smoking once or twice		
3	I have given up smoking		
4	I smoke some days		**GO TO B04**
5	I smoke every day		**GO TO B04**
98	Prefer not to say		

Base: Those who smoke some days or every day (code 4 or 5) at B03

SINGLE CODE

B04. Which of the following statements best describes you?

Please use showcard 11 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I REALLY want to stop smoking and intend to in the next month		
2	I REALLY want to stop smoking and intend to in the next 3 months		
3	I want to stop smoking and hope to soon		
4	I REALLY want to stop smoking but I don't know when I will		
5	I want to stop smoking but haven't thought about when		
6	I'm thinking I should stop smoking but don't really want to		
7	I don't want to stop smoking		
98	Prefer not to say		

Base: All respondents

SINGLE CODE

B05. Have you used an electronic cigarette or VAPES in the last year?

Please use showcard 12 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes – every day		
2	Yes – some days		
3	Once or twice		
4	No		
98	Prefer not to say		

https://patient.info/doctor/alcohol-use-disorders-identification-test-audit

INTRO TEXT

Now I am going to ask you some questions about your use of alcoholic drinks during the past year.

Base: All respondents

SINGLE CODE

B06. How often do you have a drink containing alcohol?

Please use showcard 13 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Never		
2	Monthly or less		**GO TO B07**
3	2-4 times per month (this includes once a week)		**GO TO B07**
4	2-3 times per week		**GO TO B07**
5	4+ times per week		**GO TO B07**
98	Prefer not to say		

ASK IF B06 = 2 TO 5

SINGLE CODE

B07. How many units of alcohol do you drink on a typical day when you are drinking?

Please use showcard 14 (which includes details of units) and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	0-2		
2	3-4		
3	5-6		
4	7-9		
5	10 or more		
98	Prefer not to say		

ASK IF B06 = 2 TO 5

GRID, SINGLE RESPONSE PER ROW

B08. How often in the last year has the following happened?

Please use showcard 15 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Had 6 or more units if female, or 8 or more if male, on a single occasion		
2	You have found that you were not able to stop drinking once you had started		

3	You have failed to do what was normally expected from you because of your drinking		
4	You have needed an alcoholic drink in the morning to get yourself going after a heavy drinking session		
5	You have had a feeling of guilt or remorse after drinking		
6	You have been unable to remember what happened the night before because you had been drinking		

Column code	Column list	Scripting notes	Routing
1	Never		
2	Less than monthly		
3	Monthly		
4	Weekly		
5	Daily or almost daily		
98	Prefer not to say		

IF B06 = 2 TO 5

SINGLE RESPONSE

B09. Have you or somebody else been injured as a result of your drinking?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	No		
2	Yes, but not in the last year		
3	Yes, during the last year		
98	Prefer not to say		

ASK IF B06 = 2 TO 5

SINGLE RESPONSE

B10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	No		
2	Yes, but not in the last year		
3	Yes, during the last year		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

B11A. Thinking about the number of places you can buy alcohol in your local area from off-licences, local grocers and supermarkets, in your opinion are there...?

Read out and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	The right amount		
2	Too many		
3	Too few		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

B11B. Now thinking about the number of places you can buy alcohol in your local area from pubs, bars and restaurants, in your opinion are there...?

Read out and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	The right amount		
2	Too many		
3	Too few		
97	Don't know		

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 30

B12. Now I'd like to ask you some questions about the food you eat. Yesterday, how many portions of fruit did you eat? Examples of a portion are one apple, one tomato, 3 tablespoons of canned fruit, one small glass of fruit juice.

Please record number in the box below if less than one, write '0'

[_____]

Fixed codes	Answer list	Scripting notes	Routing
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 30

B13. Yesterday, how many portions of vegetables or salad (not counting potatoes) did you eat? A portion of vegetables is 3 tablespoons.

Please record number in the box below if less than one, write '0'

[_____]

Fixed codes	Answer list	Scripting notes	Routing
97	Don't know	**FIX, EXCLUSIVE**	

INTRO TEXT

The next questions look at how active you are.

The next question is about the type of physical activity that increases your heart rate, makes you feel warmer and makes you breathe a little faster. This may include walking or cycling for recreation or to get to and from places; gardening; and exercise or sport.

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 7

B14. How many days in the past week have you been physically active for a total of 30 minutes or more?

Please use showcard 16

The types of activity included for this question are activities that increase your heart rate, make you feel warmer and make you breathe a little faster. This may include walking or cycling for recreation or to get to and from places; gardening; and exercise or sport. The 30 minutes can be obtained by adding smaller bouts of not less than 10 minutes.

Remember vigorous activity such as running counts for double. If the person is unable to sing, or needing to take breaths between words, they are likely to be doing vigorous physical activity. Every minute of vigorous activity equals 2 minutes of moderate activity.

Please record number in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
97	Don't know	**FIX, EXCLUSIVE**	

Base: Those active for four days or less at B14 (0 to 4)

SINGLE RESPONSE

B15. Have you been physically active for at least two and a half hours (150 minutes) over the course of the past week?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP AT 7

B16. In the past week, on how many days have you done strength and balance physical activities that make your muscles become warm, shake and/or burn? This includes weight training; exercise; sport; heavy housework; DIY or gardening.

Please use showcard 17 (which shows examples)

Showcard list
Weight training (e.g., free weights, weight machines or resistance bands)
Bodyweight exercises (e.g., press-ups, sit-ups)
Yoga/Pilates/Gymnastics/Stretching sessions
Impact sports (e.g., Football/Rugby/Badminton/Tennis/Squash)
Heavy manual work (e.g., digging/moving heavy loads)

Gardening (e.g., mowing/digging/planting)
Heavy housework (e.g., moving heavy furniture/walking with heavy shopping)

Please record number in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
97	Don't know	**FIX, EXCLUSIVE**	

INTRO TEXT

The next question is about the impact COVID-19 has had on your Physical Activity Levels.

Base: All respondents

SINGLE RESPONSE

B17. Since the COVID-19 pandemic started in March 2020, which of the following statements best describes your physical activity levels?

Please use showcard 18 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Physically active more often		
2	Physically active less often		
3	No change to physical activity		

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC

B18. On an average day, in the last seven days, how long did you spend sitting, reclining or lying down?

Please estimate the time on an average (normal) day in the last seven days. We realise this will vary over the week, but try to give an estimate. We are interested in your sedentary behaviour, which is any time you spend sitting, reclining and lying down. This may include time spent sitting at a desk, sitting in a motor vehicle, reading, playing video games, sitting or lying down to watch television (please don't count the time asleep).

Please type your response in the box below HOURS/MINUTES

[_____

Section C: SOCIAL HEALTH

Base: All respondents

SINGLE RESPONSE

C01. Do you ever feel isolated from family and friends?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		**GO TO C03**

Base: Those who answered Yes or No to C01

SINGLE RESPONSE

C02. Has this changed due to the COVID pandemic?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes, changed for the better		
2	Yes, changed for the worse		
3	No change		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

C03. How often have you felt lonely in the past two weeks?

Please use Showcard 19 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	All of the time		
2	Often		
3	Some of the time		
4	Rarely		
5	Never		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

C04. Compared to before the COVID pandemic which started in March 2020 how lonely have you felt?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	More lonely		
2	Same as before		
3	Less lonely		
4	Never felt lonely		
98	Prefer not to say		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

C05. How much do you agree or disagree with the following statements about living in this local area?

Please use showcard 20 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	I feel I belong to this local area		
2	I feel valued as a member of my community		
3	By working together, people in my neighbourhood can influence decisions that affect my neighbourhood		

Column code	Column list	Scripting notes	Routing
1	Strongly agree		
2	Agree		
3	Neither agree nor disagree		
4	Disagree		
5	Strongly disagree		
97	Don't know	**FIX, EXCLUSIVE**	

BASE: ALL RESPONDENTS

GRID, SINGLE RESPONSE PER ROW

C06. Please look at the card I've given you and tell me what you think of the quality of services in your area

Please use showcard 21 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Food shops		
2	Local schools		
3	Public transport		
4	Activities for young people		
5	Leisure / sports facilities		
6	Childcare provision		
7	Police		
8	GP/Doctor		
9	Out of hours medical service		
10	Nurse Led clinics such as asthma clinic, flu vaccination, child healthcare		

Column code	Column list	Scripting notes	Routing
1	Excellent		
2	Good		
3	Adequate/Ok		
4	Poor		
5	Very poor		
97	Don't Know		

BASE: ALL RESPONDENTS

SINGLE RESPONSE PER ROW

C07. Could you tell me if you have been a victim of each of these crimes in the last year? Just to reiterate, your responses to this survey will remain confidential unless your permission is explicitly given.

Please use showcard 22 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Anti-social behaviour		
2	Any type of theft or burglary		
3	Vandalism		
4	Physical attack		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		
98	Refused		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

C08. How much do you agree or disagree with the following statements about safety in this local area?

Please use showcard 23 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	I feel safe using public transport in this local area		
2	I feel safe walking alone around this local area even after dark		

Column code	Column list	Scripting notes	Routing
1	Strongly agree		
2	Agree		

3	Neither agree nor disagree		
4	Disagree		
5	Strongly disagree		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

C09. Do you look after, or give any regular help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability, or problems related to old age?

Exclude any caring that is done as part of any paid employment or formal volunteering.

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Section D: Social Capital

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

D01. How much do you agree or disagree with the following statements about living in this local area?

Please use showcard 23 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	This is a neighbourhood where neighbours look out for each other		
2	Generally speaking, I can trust people in my local area		
3	The friendships and associations I have with other people in my local area mean a lot to me		
4	If I have a problem, there is always someone to help me		

Column code	Column list	Scripting notes	Routing
1	Strongly agree		
2	Agree		
3	Neither agree nor disagree		
4	Disagree		
5	Strongly disagree		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

D02. Thinking back over the last 12 months, have you given up any time to help any clubs, charities, campaigns or organisations in an unpaid capacity? (For example, helping out at schools, youth clubs, health and wellbeing charities, sport and exercise clubs, local community groups and faith-based organisations).

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Base: All respondents

SINGLE RESPONSE

D03. Thinking back over the last 12 months, have you given any voluntary unpaid help as an individual (not through a group or organisation) to help other people outside your family, or to support your local environment? (For example, keeping in touch with someone who is at risk of being lonely; helping a neighbour through shopping, collecting pension, household chores; or helping to improve your local environment e.g. litter picking but not as part of an organised activity)

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Base: All respondents

SINGLE RESPONSE

D04. Do you belong to any social clubs, associations, church groups or anything similar?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Base: All respondents

SINGLE RESPONSE

D05. In the last 12 months, have you taken any actions in an attempt to solve a problem affecting people in your local area? e.g., contacted any media, organisation, council, councillor MSP or MP; organised a petition.

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		

Section E: Financial Wellbeing

Base: All respondents

SINGLE RESPONSE

E01. What proportion of your household income comes from state benefits (e.g., Universal Credit, Carer's Allowance, Disability Living Allowance/Adult Disability Payment, Child Disability Payment, Best Start payments)?

Showcard 24 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	None		
2	Very little		
3	About a quarter		
4	About a half		
5	About three quarters		
6	All		
97	Don't know		

98	Prefer not to say		

E02. Thinking of the total income of your household, which face on the scale indicates how you feel about the adequacy of that income?

Please use Showcard 25 (with faces on) and select one answer only

Fixed codes	Answer list	Scripting notes	Routing
1	1 Happy		
2	2		
3	3		
4	4		
5	5		
6	6		
7	7 Unhappy		
97	Don't know	**FIX, EXCLUSIVE**	
98	Prefer not to say	**FIX, EXCLUSIVE**	

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

E03. How often, if at all, over the past year have you found it difficult to meet the cost of the following?

Please use showcard 26 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Rent/mortgage		
2	Gas, electricity and other fuel bills		
3	Telephone or mobile phone bill		
4	Broadband/internet data		
5	Council tax, insurance		
6	Food		
7	Clothes and shoes		
8	Transport		
9	Credit card payments		

10	Loan repayments		
11	Nursery/school activities		
12	Child care		
13	Treats		
14	Holidays		

Column code	Column list	Scripting notes	Routing
1	Very often		
2	Quite often		
3	Occasionally		
4	Never		
96	N/A – do not have that cost		
97	Don't know		
98	Prefer not to say		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

E04. How would your household be placed if you suddenly had to find a sum of money to meet an unexpected expense such as a repair or new washing machine? How much of a problem would it be if it was …

Please use showcard 27 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	£35		
2	£165		
3	£1,600		

Column code	Column list	Scripting notes	Routing
1	No problem		
2	A bit of a problem		
3	A big problem		

4	Impossible to find		
97	Don't know		

Base: All respondents

MULTICODE

E05. If you suddenly had to find a sum of money to meet an unexpected bill, where would you get the money from?

Please use showcard 28 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Savings		
2	Economising in other areas of expenditure		
3	Credit card/store card		
4	Cash Converter		
5	Payday loan company		
6	Bank loan		
7	Credit at store		
8	Buy now, pay later scheme' i.e. Clearpay, Klarna		
9	Doorstep Lender		
10	Friends/family		
95	Other (please specify) BACKCODE AND LIST		
97	Don't know	**FIX, EXCLUSIVE**	

Base: All respondents

SINGLE RESPONSE

E06. In the last 6 months, for how many months have you had to use a source of credit (i.e., credit card) to cover essential living costs due to a lack of money that you may struggle to pay off?

Prompt if necessary: By essential living costs we mean things like household bills, food or fuel bills, school uniforms etc.

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	1 month		
2	2 months		

3	3 months		
4	More than 3 months		
5	None		
98	Prefer not to say		

Base: Those in receipt of benefits (E01 is not None)

GRID, SINGLE RESPONSE PER ROW

E07. In the last year have you experienced the following?

Select one per statement

Row Code	Row list	Scripting notes	Routing
1	Benefits Sanctions		
2	Delays in benefit payments		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		
98	Refused		

Base: Those in receipt of benefits (E01 is not None)

SINGLE RESPONSE

E08. Have you or your household been affected by benefit changes in the last 12 months (e.g., Universal Credit, Carer's Allowance, Disability Living Allowance/Adult Disability Payment, Child Disability Payment, Best Start payments)?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		**GO TO E09**
2	No		
97	Don't know		

ASK IF E08 CODE 1

SINGLE RESPONSE

E09. Is your household...?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Financially better off under benefit changes		
2	Financially worse off under benefit changes		
3	Made no difference		
97	Don't know		

Now I would like to ask you some questions about your food consumption in the last 12 months.

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

E10A. During the last 12 months was there a time when…?

Select one per statement

Row Code	Row list	Scripting notes	Routing
1	You were worried you would run out of food because of a lack of money or other resources?		
2	You were unable to eat healthy and nutritious food because of a lack of money or other resources?		
3	You ate only a few kinds of food because of a lack of money or other resources?		
4	You had to skip a meal because there was not enough money or other resources to get food?		
5	You ate less than you thought you should because of a lack of money or other resources?		
6	Your household ran out of food because of a lack of money or other resources?		
7	You were hungry but did not eat because there was not enough money or other resources for food?		

8	You went without eating for a whole day because of a lack of money or other resources?		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		
98	Prefer not to say		

We would now like to ask you some questions about your fuel consumption in the last 12 months.

Base : All respondents

SINGLE RESPONSE

E10B. How do you usually pay for your energy?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Pay by regular direct debit or standing order		
2	Pay on receive of a bill by cash/cheque/debit or credit card		
3	Have a pre-payment meter (i.e pay in advance by putting credit on a key, card or App)		
95	Pay in another way (please specify)		
97	Don't know		

Base: All respondents

GRID, SINGLE RESPONSE PER ROW

E10C. During the last 12 months was there a time when…?

Select one per statement

Row Code	Row list	Scripting notes	Routing
1	You were worried you would not be able to afford to use your gas and/or electricity at home?		

2	You had to make a choice between paying for gas and/or electricity for your home or other household bills or essentials?		
3	You were unable to work or study at home because you were worried about your gas and/or electricity use?		
4	You ate only a few kinds of food to reduce the amount of gas and/or electricity used?		
5	You skipped a meal because you did not want to use your gas and/or electricity?		
6	Your household had no gas and/or electricity for a period of time because you could not afford it?		
7	You did not heat your home when needed due to the cost and not being able to afford it?		
8	You did not use gas and/or electricity for a whole day due to the cost and not being able to afford it?		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

E11. What would you say is the main reason some people in this area live in poverty? In general terms, poverty is when the income available to an individual or household does not meet their needs. Poverty is not just about being able to heat a house or eat. It can mean that people are not able to participate in the routine activities expected in society. It can mean that people can't afford to buy birthday presents for their children or they can't afford to meet up with friends to socialise.

Please use showcard 29 and select one only

Fixed codes	Answer list	Scripting notes	Routing

1	An inevitable part of modern life		
2	Laziness or lack of willpower		
3	Because they have been unlucky		
4	Because of injustice in society		
5	Lack of jobs		
6	There is no one living in poverty in this area		
95	Other (please specify)	**ADD OPEN TEXT BOX**	
96	None of the above		
97	Don't know		

BASE: ALL RESPONDENTS

GRID, SINGLE RESPONSE PER ROW

E12. Have you spent money on any of the following in the last month?

Select one per statement

Row Code	Row list	Scripting notes	Routing
1	Tickets for the National Lottery, including Thunderball and Euromillions and tickets bought online		
2	Scratch cards (but not online or newspaper or magazine scratch cards)		
3	Bingo cards or tickets, including playing at a bingo hall (not online)		
4	Betting in a Bookmakers		
5	Casino		
6	Any online (internet) gambling (including bingo, poker etc)		
95	Any other gambling – please specify	**ADD TEXT BOX**	

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		

For the next set of questions about gambling, please indicate the extent to which each one has applied to you in the last 12 months.

ASK IF SPENT MONEY ON ANY ACTIVITIES AT E12 [Any code 1]. IF ONLY CODE 1 AT 'ANY LOTTERY/SCRATCHCARD', ROUTE TO E14

SINGLE RESPONSE

E13. When you gamble, how often do you go back another day to win back the money you lost?

Please use showcard 30 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Every time I lost		
2	Most of the time		
3	Some of the time (less than half the time I lost)		
4	Never		
98	Prefer not to say		

ASK IF SPENT MONEY ON ANY ACTIVITIES AT E12 [Any code 1].

GRID, SINGLE RESPONSE PER ROW

E14. In the last 12 months, how often...?

Please use showcard 31 and select one per statement

Row Code	Row list	Scripting notes	Routing
1	Have you needed to gamble with more and more money to get the excitement you are looking for?		
2	Have you felt restless or irritable when trying to cut down gambling?		
3	Have you gambled to escape from problems or when you are feeling depressed, anxious or bad about yourself?		
4	Have you made unsuccessful attempts to control, cut back or stop gambling?		
5	Have you risked or lost an important relationship, job, educational or work opportunity because of gambling?		

6	Have you asked others to provide money to help with a financial crisis caused by gambling?		

Column code	Column list	Scripting notes	Routing
1	Very often		
2	Fairly often		
3	Occasionally		
4	Never		
98	Prefer not to say		

Section F: INTERNET USE

Base: All respondents

MULTIPLE RESPONSE

F01. For which of the following do you use the Internet?

Please use showcard 32 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Accessing Universal Credit or other social security benefits		
2	Managing Mental Health		
3	Applying for jobs		
4	Managing physical health		
5	Online games		
6	Rating products/services		
7	Solely content for work		
8	Learning		
9	Accessing local council information		
10	Posting/sharing videos online		
11	Streaming/downloading media		
12	Social Media		

13	Using online messaging		
14	Buying products/services		
15	Online banking/money management		
16	Email		
95	Other (please specify)	**ADD TEXT BOX**	
96	Don't use the internet	**EXCLUSIVE**	**GO TO F03**

ASK IF CODES 1-16 OR 95 AT F01

MULTIPLE RESPONSE

F02. At any time, have you used the internet for?

Please use showcard 33 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Looking for health-related information (e.g. injury, disease, nutrition, improving health etc) (please note which sites are used or if search engine used)		
2	Making an appointment with a medical practitioner via a website or app		
3	Using other online health services via a website or app instead of having to go to the hospital or visit a doctor, for example getting a prescription or a consultation online		
4	Accessing personal health records online		
95	Other health-related use (please specify)		
96	Have not used the internet for any of the above		

Base: F01 = 96 Don't use the internet

MULTIPLE RESPONSE

F03. Which of the following statements apply to you if you were thinking about what would encourage you to improve your digital skills?

Please use showcard 34 and select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	I would if devices and Internet access were cheaper		

2	I would if it could help me progress in my job or secure a better role		
3	I would if I thought that it would directly help me with a day-to-day task or piece of work		
4	Nothing – I avoid adopting technology where I can	**EXCLUSIVE**	
5	I'm always interested in technology and will actively look to adopt it		
6	I would if I knew there was support available to help me as or when I needed it		
97	Don't know	**EXCLUSIVE**	

SECTION G : Self completion section

I am now going to hand over the survey to you, and I'd like you to complete the following questions yourself which ask about thoughts and feelings, whether certain things have happened to you and some other sensitive questions which are best completed by yourself due to their sensitive nature.

Interviewer record self completion outcome

Row Code	Row list	Scripting notes	Routing
1	Self completed by respondent	**PLEASE PASS TABLET TO RESPONDENT**	
2	Administered by interviewer		
3	Respondent refused to self complete and for interviewer to administer		**GO TO SECTION T**

Base: Those who are happy to self complete (self completion outcome = 1)

Before this, however, I would like you to do a quick task to get you used to the computer. This will require you to answer a simple question, getting you used to clicking the answer, and then moving to the next page.

SINGLE

GTEST. What is your favourite colour?

Please select one answer

Fixed codes	Answer list	Scripting notes	Routing
1	Red		
2	Blue		

3	Green		
4	Yellow		
5	Black		
6	White		
7	Pink		
8	Brown		
9	Grey		
10	Purple		
11	Orange		
12	Gold		
13	Silver		
95	Other		
97	Don't know		
98	Prefer not to say		

Some of the questions tell us more about you and helps us to make sure we have captured views from a cross section of people. We recognise that you might consider some of these questions to be personal or sensitive in which case you are free not to answer them.

Base: All respondents

GRID, SINGLE RESPONSE PER ROW, ROTATE

G01. Below are some statements about feelings and thoughts. Please select the box that best describes your experience of each over the last 2 weeks

Please select one answer per statement

Row Code	Row list	Scripting notes	Routing
1	I've been feeling optimistic about the future		
2	I've been feeling useful		
3	I've been feeling relaxed		
4	I've been interested in other people		
5	I've had energy to spare		
6	I've been dealing with problems well		
7	I've been thinking clearly		
8	I've been feeling good about myself		

9	I've been feeling close to other people		
10	I've been feeling confident		
11	I've been able to make up my own mind about things		
12	I've been feeling loved		
13	I've been interested in new things		
14	I've been feeling cheerful		

Column code	Column list	Scripting notes	Routing
1	None of the time		
2	Rarely		
3	Some of the time		
4	Often		
5	All of the time		
98	Prefer not to say		

BASE: ALL RESPONDENTS

GRID, SINGLE RESPONSE PER ROW, ROTATE

G02. In your day-to-day life, how often do any of the following things happen to you?

Please select one answer per statement

Row Code	Row list	Scripting notes	Routing
1	You are treated with less courtesy than other people are		
2	You are treated with less respect than other people are		
3	You receive poorer service than other people at restaurants or stores		
4	People act as if they think you are not smart		
5	People act as if they are afraid of you		
6	People act as if they think you are dishonest		

7	People act as if they're better than you are		
8	You are called names or insulted		
9	You are threatened or harassed		

Column code	Column list	Scripting notes	Routing
1	Almost everyday		
2	At least once a week		
3	A few times a month		
4	A few times a year		
5	Less than once a year		
6	Never		
98	Prefer not to say		

The Everyday Discrimination Scale.
https://scholar.harvard.edu/files/davidrwilliams/files/discrimination_resource_dec._2020.pdf

Base: Those who have said at least a few times a year or more to one of G02 (G02 = codes 1 to 4 to any)

MULTICODE, ROTATE

G03. What do you think are the main reasons for these experiences?

Please select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Your Ancestry or National Origins		
2	Your Gender		
3	Your Race		
4	Your Age		
5	Your Religion		
6	Your Height		
7	Your Weight		
8	Some other Aspect of Your Physical Appearance		
9	Your Sexual Orientation		
10	Your Education or Income Level		
11	A physical disability		
12	Your shade of skin colour		
95	Other (please specify)	**FIX, ADD OPEN TEXT BOX**	
97	Don't know	**FIX, EXCLUSIVE**	
98	Prefer not to say	**FIX, EXCLUSIVE**	

BASE: ALL RESPONDENTS

SINGLE RESPONSE

G04. Have you been a victim of domestic abuse in the last year? Just to reiterate, your responses to this survey will remain confidential unless your permission is explicitly given.

Please select one answer

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		
97	Don't know		

98	Prefer not to say		

BASE: ALL RESPONDENTS

SINGLE RESPONSE

G05. Do you consider yourself to be trans, or have a trans history?

Please select one only

Code	Answer list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

G06. Which of the following options best describes how you think of yourself?

Please select one only

Code	Answer list	Scripting notes	Routing
1	Heterosexual / Straight (attracted to opposite sex only)		
2	Gay (attracted to same sex only)		
3	Bisexual (attracted to same and opposite sex)		
95	Other		
98	Prefer not to say		

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC

G07. Please can you tell me your date of birth?

Please type your response in the box below DD/MM/YYYY

[_____]

Fixed codes	Answer list	Scripting notes	Routing

98	Prefer not to say	**FIX, EXCLUSIVE**	

Base: All respondents

OPEN RESPONSE

G08. NHS Greater Glasgow and Clyde would like to undertake a follow up online survey to this. This would involve collecting your email address for this purpose. The online survey would take around 10 minutes to complete and all those aged 18+ who complete this follow up survey have the opportunity to be entered in to a prize draw to win a £250 Love2Shop voucher.

Would you be interested in taking part and willing to provide your email address for this purpose?

Fixed codes	Answer list	Scripting notes	Routing
1	Yes	**COLLECT EMAIL ADDRESS**	
2	No		

Please type your email address in the box below

[_____]

Please retype your email address in the box below

[_____]

IF G08 = YES

Many thanks for your interest in taking part in this follow up survey and providing your email address. Please note you will be sent a link to an online survey via the email address provided within the next week from surveys@bmgresearch

Base: Those who are happy to self complete (self completion outcome = 1)

Thank you very much. Please pass the tablet back to the interviewer for the last section.

Closing demographics (Section T)

INTRO TEXT

The following questions tell us more about you and helps us to make sure we have captured views from a cross section of people. We recognise that you might consider some of these questions to be personal or sensitive in which case you are free not to answer them. The information you provide will be used to make sure NHS GGC understand the views of different groups of residents.

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP 20

T01. Now I'd like to ask you about the members of your household. How many people are there in this household (including yourself)?

Please record number in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
98	Prefer not to say	**FIX, EXCLUSIVE**	

Base: All respondents

OPEN RESPONSE, FORCE NUMERIC, CAP 20 AND LESS THAN T01

T02. How many people living in your household are aged under 16?

Please record number in the box below

[_____]

Fixed codes	Answer list	Scripting notes	Routing
98	Prefer not to say	**FIX, EXCLUSIVE**	

BASE: ALL RESPONDENTS

SINGLE RESPONSE

T03. How do you describe your gender?

Please select one only

Code	Answer list	Scripting notes	Routing
1	Male		
2	Female		
3	Non-Binary		
95	Or do you describe yourself another way (Please specify)	**ADD OPEN TEXT BOX**	
98	Prefer not to say		

Base: Where do not want to provide exact age (G07 = 98)

SINGLE RESPONSE

T04. Would you mind indicating which age band you fit into?

Showcard 35 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	16-19		
2	20-24		
3	25-29		
4	30-34		
5	35-39		
6	40-44		
7	45-49		
8	50-54		
9	55-59		
10	60-64		
11	65-74		
12	75+		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

T05. Which of the following applies to your household?

Showcard 36 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Owner occupier / owned outright		
2	Owner occupier / buying with a mortgage		
3	Rented from council		
4	Rented from housing association		
5	Rented from a private landlord		
6	Shared ownership		
7	Accommodation comes with the job		
95	Other (please specify) BACKCODE AND LIST		
97	Don't know		

Base: All respondents

SINGLE RESPONSE

T06. Which of the groups on this card best describes you?

Please use showcard 37 and select one only

Fixed codes	Answer list	Scripting notes	Routing
	White	**HEADING NOT CODE**	
1	Scottish		
2	Other British		
3	Irish		
4	Polish		
5	Gypsy/Traveller		
6	Roma		
7	Showman/showwoman		
8	Other White ethnic group, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	

	Mixed	**HEADING NOT CODE**	
9	Any mixed or multiple ethnic background, please specify LIST	**ADD A TEXT BOX**	
	Asian, Scottish Asian or British Asian	**HEADING NOT CODE**	
10	Pakistani, Scottish Pakistani or British Pakistani		
11	Indian, Scottish Indian or British Indian		
12	Bangladeshi, Scottish Bangladeshi or British Bangladeshi		
13	Chinese, Scottish Chinese or British Chinese		
14	Other, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
	African	**HEADING NOT CODE**	
15	African, Scottish African or British African		
16	Other, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
	Caribbean or Black	**HEADING NOT CODE**	
17	Caribbean, Scottish Caribbean or British Caribbean		
18	Other, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
	Other ethnic group	**HEADING NOT CODE**	
19	Arab, Scottish Arab or British Arab		
95	Other, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
97	Don't know		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

T07. Which of the following best describes your employment situation?

Showcard 38 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Employee in full-time job (35 or more hours per week)		

2	Employee in part-time job (less than 35 hours per week)		
3	Employed on a zero hours contract		
4	Self-employed – full or part time		
5	Government supported training or employment		
6	Unemployed and available for work		
7	Full-time education at school, college or university		
8	Part-time education at school, college or university		
9	Wholly retired from work		
10	Looking after the family/home		
11	Permanently sick/disabled		
95	Other, please specify BACKCODE AND LIST		
98	Refused		

Base: All respondents

SINGLE RESPONSE

T08. What is the highest level of educational qualifications you've obtained?

Please use showcard 39 and select one only

Fixed codes	Answer list	Scripting notes	Routing
1	School leaving certificate, National Qualification Access Unit		
2	'O' Grade, Standard Grade, GCSE, GCE O Level, CSE, National Qualification Access 3 Cluster, Intermediate 1 or 2 Senior Certificate or equivalent, National 4 or 5		
3	GNVQ/GSVQ Foundation or Intermediate, SVQ Level 1 or 2, SCOTVEC/National Certificate Module, City and Guilds Craft, RSA Diploma or equivalent		
4	Higher Grade, Advanced Higher, CSYS, 'A' Level, AS Level, Advanced Senior Certificate or equivalent		
5	GSVQ/GSVQ Advanced, SVQ Level 3, ONC, OND, Scotvec National Diploma, BTEC First Diploma, City and Guilds Advanced Craft, RSA Advanced Diploma or equivalent		

6	HNC, HND, SVQ Level 4, RSA Higher Diploma or equivalent		
7	First Degree, Higher Degree, SVQ Level 5		
8	Professional Qualifications e.g. teaching, accountancy		
9	Other school examinations not already mentioned		
95	Other post-school but pre-Higher education examinations/ Higher education qualifications not already mentioned, please specify BACKCODE AND LIST	**ADD A TEXT BOX**	
96	No qualifications		
98	Refused		

Base : Ask those that have provided DOB at G07

LINKING HEALTH RECORDS

T09.

- The National Health Service (NHS) maintains routine medical and other health records on all patients who use their services. These records include:
    - Inpatient and outpatient visits to hospital, length of stay and waiting time.
    - Information about specific medical conditions such as cancer, heart disease and diabetes.
    - Details about registration with a general practitioner, and when people pass away, the date and cause of their death.
- We would like to ask for your consent to link your NHS health records with your survey answers.
- To link this information we would need to send your name, address and date of birth to NHSGGC and the Information Services Division (ISD) of NHS Scotland so they can identify your health records.
- By linking this information with the interview data the research is more useful as we can look at how people's lifestyle and circumstances can have an impact on their future and use of hospital services.
- This information will be confidential and used for statistical and research purposes only. The information will not identify you so it cannot be used by anyone treating you as a patient.
- By checking this box you are only giving permission for the linking of this information to routine administrative data and nothing else.
- You can cancel this permission at any time in the future by contacting BMG Research on 0800 358 0337. You do not need to give a reason to cancel this.

By checking this box, I give consent to BMG Research to pass my name, address and date of birth to NHSGGC and the Information Services Division of NHS Scotland:

T10. May we have your permission to give NHS Greater Glasgow & Clyde or its partners your name and address so they can contact you in the future about similar research studies in relation to health and wellbeing? The partners are the Glasgow Centre for Population Health and the University of Glasgow. Should you agree, this follow-up research could take the form of a postal, telephone or face to face interview/questionnaire within the next 24 months.

Fixed codes	Answer list	Scripting notes	Routing
1	Yes, permission given		
2	No, permission not given		

THANK AND CLOSE

INSERT QC SECTION IE CAPTURE NAME AND NUMBER/EMAIL ADDRESS FOR BACKCHECKING

INTERVIEWER TO COMPLETE:

SINGLE RESPONSE

T17. Was the interview conducted in another language (other than English)?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	No		
2	Yes (specify language) …… LIST	**ADD TEXT BOX**	

APPENDIX F: ONLINE SURVEY QUESTIONNAIRE

Online survey invite

SUBJECT : NHS Greater Glasgow and Clyde would like your help with a follow-up health survey

Dear [INSERT NAME]

You recently completed a face-to face health survey on behalf of the NHS Greater Glasgow and Clyde. Firstly, thank you very much for completing that survey. NHS Greater Glasgow and Clyde would like to undertake a follow up survey to this. During the survey you agreed to do a follow up survey and provided your email address for this purpose.

Below is the link to the follow up online survey for you to complete. The survey should take around **10 minutes to complete.**

INSERT SURVEY LINK

Those who complete this follow up survey will have the opportunity to be entered in to a prize draw to win a £250 Love2Shop voucher. Further details along with terms and conditions can be found here [INSERT PRIZE DRAW LINK]

Just to confirm, your responses will be treated in the strictest confidence. BMG Research abides by the Market Research Society Code of Conduct and data protection laws at all times.

The survey can only be completed once and it is important that the person who completed the face-to-face survey completes the follow up so survey. We therefore ask that you do not pass this email or link on to anybody else.

Any queries about this survey please contact BMG Research on 0800 358 0337 or email healthandwellbeingsurvey@bmgresearch.com

Many thanks in advance,

BMG Research

Survey introduction

ONLINE INTRO

Many thanks for providing your details for this follow up survey which BMG Research are conducting on behalf of NHS Greater Glasgow and Clyde.

The survey will take around **10 minutes to complete** and builds on the survey you undertook recently face-to-face.

In order that we do not have to repeat questions that you have already been asked we will link the answers you provide to this survey to the survey you recently completed face-to-face.

Just to confirm, your responses will be treated in the strictest confidence. BMG Research abides by the Market Research Society Code of Conduct and data protection laws at all times.

You can find out more information about our surveys and what we do with the information we collect in our Privacy Notice which is here http://www.bmgresearch.co.uk/privacy

You can also find out more about NHS Greater Glasgow and Clyde and what they do with the results we provide to them via their Privacy Notice which is here https://www.nhsggc.org.uk/media/259281/nhsggc_gdpr_data_protection_notice-v4.pdf

Click **NEXT** to begin the survey

By clicking the **NEXT** button, you agree to participate in the survey and for BMG to process your results as outlined above.

Base: All respondents

SINGLE CODE

S01_A. This survey **requires** us to ask some questions that may be perceived as sensitive such as perceptions of health and illness, drug use, diet, sexual health and relationships and social health. Providing information in response to these questions is entirely voluntary and you may withdraw your consent at any time. Prefer not to say options are available for each question. The answers that you provide will be used only for market research analysis purposes.

Do we have your permission to ask you these questions?

Code	Answer list	Scripting notes	Routing
1	Yes		
2	No	**SCREENOUT**	

Section A: Perception of health and illness

INTRO TEXT

We would like to know if you have any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions shown simply by clicking on the answer which you think most closely applies to you. Remember that we want to know about present and recent complaints, not those you had in the past.

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

A01. Have you recently …

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	a) …been able to concentrate on whatever you're doing?		

Column code	Column list	Scripting notes	Routing
1	Better than usual		
2	Same as usual		
3	Less than usual		
4	Much less than usual		
98	Prefer not to say		

2	b) …lost much sleep over worry?		
5	e) …felt constantly under strain?		
6	f) …felt you couldn't overcome your difficulties?		
9	i) …been feeling unhappy and depressed?		
10	j) …been losing confidence in yourself?		
11	k) …been thinking of yourself as a worthless person?		

Column code	Column list	Scripting notes	Routing
1	Not at all		
2	No more than usual		
3	Rather more than usual		

4	Much more than usual		
98	Prefer not to say		

3	c) …felt that you are playing a useful part in things?		
4	d) …felt capable of making decisions about things?		
7	g) …been able to enjoy your normal day-to-day activities?		
8	h) …been able to face up to your problems?		
12	l) …been feeling reasonably happy, all things considered?		

Column code	Column list	Scripting notes	Routing
1	More so than usual		
2	Same as usual		
3	Less so than usual		
4	Much less than usual		
98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

A02. In the last two years, how many times have you had a problem with your teeth or mouth that has required you to seek the advice of a medical or dental professional?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Never		**GO TO B01**
2	Once		
3	Twice or more		
4	Had a problem however did not seek advice		
97	Don't know		
98	Prefer not to say		

Base: Those who said Once, Twice or more, or had a problem however did not seek advice at A02 (codes 2 to 4)

SINGLE RESPONSE

A03. In the last two years, how many times have you had to miss work or not attend a social occasion due to problems with your mouth or teeth?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Never		
2	Once		
3	Twice or more		
97	Don't know		
98	Prefer not to say		

Base: Those who said Once or Twice or more at A02 (codes 2 to 3)

SINGLE RESPONSE

A04. In the last two years, have you been able to get a dental appointment at your usual dentist when needed?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes, I had no problems arranging an appointment		
2	Yes, but I had to wait longer than I wanted to		
3	I was unable to get an appointment with my own dentist		
97	Don't know		
98	Prefer not to say		

Section B: Social Health

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

B01. Now some questions about things that may or may not be a problem in your local area. Which face best describes how you feel about…?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing

1	The level of unemployment in your area		
2	The amount of drug activity in your area		
3	The level of alcohol consumption in your area		
4	People being attacked or harrassed because of their skin colour, ethnic origin or religion		
5	The amount of troublesome neighbours in your area		

Column code	Column list	Scripting notes	Routing
1	Happy	**WILL NEED FACES SHOWN IN SCRIPT FOR 1 TO 7**	
2			
3			
4			
5			
6			
7	Unhappy		
8	Not a problem		
97	Don't know		
98	Prefer not to say		

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

B02. Now some questions about environmental issues that may or may not be a problem in your area. Which face best describes how you feel about…?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	The amount of rubbish lying about in your area		
2	The amount of dog's dirt in your area		
3	The availability of safe play spaces in your area		
4	The availability of pleasant places to walk in your area		

Column code	Column list	Scripting notes	Routing
1	Happy	**WILL NEED FACES SHOWN IN SCRIPT FOR 1 TO 7**	
2			
3			
4			
5			
6			
7	Unhappy		
97	Don't know		
98	Prefer not to say		

SECTION C: HEALTH BEHAVIOURS - DIET

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

C01. How often do you eat / drink the following?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	Lean meat such as poultry		
2	Fish and shellfish		
3	Wholegrains such as brown bread and pasta		
4	Nuts and seeds		
5	Low fat dairy or alternative such as milk, cheese and yoghurt		
6	Water and sugar free/diet drinks		
7	Pies, pastries, sausage rolls, chips		
8	Processed meat such as bacon, sausages and cold meats		
9	Cakes, sweets, chocolate, ice cream		
10	Savoury salted snacks such as Crisps, pretzels		
11	Sugary drinks (regular fizzy, energy drink, juice drinks)		
12	Takeaways (fast food, burgers, Indian, Chinese, pizza)		

13	Eating out in a café/ restaurant		
14	Eating from a food truck/van		
15	Homemade from fresh ingredients		
16	Readymade meals		
17	Food bank or food parcels		

Column code	Column list	Scripting notes	Routing
1	More than once a day		
2	Once a day		
3	At least weekly		
4	At least monthly		
5	A few times a year		
6	Less than once a year		
7	Never		
98	Prefer not to say		

Section D: Sexual health and relationships

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

D01. To the best of your recollection, when were you last tested for?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	HIV		
2	Hepatitis C		
3	Hepatitis B		

Column code	Column list	Scripting notes	Routing
1	Never		
2	More than 12 months ago		
3	In the last 12 months		
97	Don't know		

98	Prefer not to say		

Base: All respondents

SINGLE RESPONSE

D02. Which of these is true for you at the moment?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I am not currently in a sexual relationship		
2	I am currently in a sexual relationship with one person of the opposite sex		
3	I am currently in a sexual relationship with one person of the same sex		
4	I am currently in sexual relationships with more than one person of the opposite sex		
5	I am currently in sexual relationships with more than one person of the same sex		
6	I am currently in sexual relationship with more than one person of both sexes		
98	Prefer not to say		

Base: All respondents

GRID SINGLE RESPONSE PER ROW, RANDOMISE ROWS

D03. In the last year, have you been …?

Please select one for each statement

Row Code	Row list	Scripting notes	Routing
1	Humiliated or emotionally abused in other ways by a partner or ex-partner		
2	Afraid of a partner or ex-partner		
3	Forced to have any kind of sexual activity by a partner or ex-partner		
4	Kicked, hit, slapped or otherwise physically hurt by a partner or ex-partner without your consent		
5	Told by a partner who you could see and where you could go		

Column code	Column list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		

Base: Ask if Yes (code 1) to any of D03

SINGLE RESPONSE

D04. Is [IF MORE THAN ONE YES AT D03 : any of] this abuse new since the COVID pandemic started in March 2020 …?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes – started for the first time during the pandemic		
2	No – it already happened before the pandemic		
98	Prefer not to say		

Base: All respondents

MULTI RESPONSE

D05. Please tell us about the use of your or your partners use of pornography?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	I do not view pornography		**SECTION E**
2	I do view pornography	**CANNOT SAY 1 & 2**	**GO TO D06**
3	My partner does not view pornography	**DO NOT SHOW IF CODE 1 AT D02**	**SECTION E**
4	My partner does view pornography	**DO NOT SHOW IF CODE 1 AT D02 CANNOT SAY 3 & 4**	**GO TO D06**
98	Prefer not to say	**EXCLUSIVE**	**SECTION E**

Base: If view pornography at D05 (code 2 or 4)

GRID MULTI RESPONSE PER ROW, RANDOMISE ROWS

D06. In the last year do you think pornography has affected any of the following aspects of your relationships?

Please select those that apply for each statement

Row Code	Row list	Scripting notes	Routing
1	Pornography viewed has made me or my partner feel less desirable		
2	Pornography has decreased how often my partner or I want to have sex		
3	Pornography has reduced the ability of my partner or me to have sex		
4	Pornography has increased the amount of screen time my partner or I spend		

Column code	Column list	Scripting notes	Routing
1	Yes for me		
2	Yes for my partner		
3	No	**EXCLUSIVE**	
98	Prefer not to say	**EXCLUSIVE**	

Section E: Health Behaviours - Drugs

Base: All respondents

SINGLE RESPONSE

E01. Have you ever taken illegal drugs, new psychoactive substances (NPS), solvents or prescription drugs that were not prescribed to you?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		**GO TO E02**
2	No		**SECTION T**
98	Prefer not to say		**SECTION T**

Base: Those who said Yes (code 1) to E01

SINGLE RESPONSE

E02. How often do you usually use drugs?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Only taken drugs once		

2	Used to take drugs sometimes but I don't take them anymore		
3	A few times a year		
4	Once or twice a month		
5	At least once a week		
6	Most days		
98	Prefer not to say		

Base: Those who said Yes (code 1) to E01

MULTI RESPONSE

E03. The last time you used drugs where did you use them?

Please select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	At home with friends		
2	At home alone		
3	At work		
4	At a friend's house		
5	Outside with friends		
6	Outside alone		
7	At a club, gig or festival		
95	Somewhere else (please specify where)	**OPEN TEXT BOX**	
98	Prefer not to say	**EXCLUSIVE**	

Base: Those who said Yes (code 1) to E01

MULTI RESPONSE

E04. Which, if any, of these drugs have you taken in the last year?

Please select all that apply

Fixed codes	Answer list	Scripting notes	Routing
1	Cannabis (Weed, Skunk, Green, Hash, Blow, Joints, Marijuana)		
2	Gas, Glue or Other Solvents		
3	Amphetamines (Speed, Whizz, Sulph, Paste)		
4	Buprenorphine		

5	Ecstasy (E, Eccies, XTC, Pills)		
6	Cyroban (Cy, Cyber, CBan)		
7	Non prescribed Benzos (Diazepam, Valium, Etizolam, Blues, Whites, Yellows, Xanax)		
8	Heroin (Smack, Kit, H, Brown, Skag)		
9	Magic Mushrooms (Shrooms)		
10	Methadone (Physeptone, Meth)		
11	MDMA powder/crystals (Mandy, Molly, Madman)		
12	Cocaine (Coke, Charlie, C, Proper, Council)		
13	Anabolic Steroids (Roids)		
14	Unknown White Powders (Gear)		
15	Ketamine (Ket, K)		
16	Synthetic Cannabinoids (SPICE, Exodus, Black Mamba)		
17	LSD (Acid, Blotters)		
18	2C (2CB, 2CI, 2CE)		
19	Diet Pills		
20	Tanning Pills/Liquids/Powders		
21	None in the last year		
95	Other drugs including prescription drugs not prescribed to you (Please specify what)	**OPEN TEXT BOX**	
98	Prefer not to say	**EXCLUSIVE**	

Base: Those who said Yes (code 1) to E01

SINGLE RESPONSE

E05. Have you ever injected yourself with any non-prescribed drugs or other substances?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes		
2	No		
98	Prefer not to say		

Base: Those who said Yes (code 1) to E05

SINGLE RESPONSE

E06. When was the last time you injected yourself with non-prescribed drugs or other substances?

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	In the last 4 weeks		
2	Between 4 weeks and 1 year ago		
3	Over 1 year ago		
98	Prefer not to say		

Closing section (Section T)

INTRO TEXT

Thank you for your responses. That was the final question.

Base: All respondents

SINGLE RESPONSE

T01. Would you like to enter the prize draw to win the £250 Love2Shop voucher on the basis of these terms and conditions?

a) The prize draw will be administered by BMG Research

b) You confirm you are aged 18 or over and accept the prize is non-exchangeable, non-transferable and no cash alternatives will be offered

c) To administer the prize draw BMG Research needs your first name and surname and will use the email address previously provided. These details will only be used for this purpose and be kept confidential.

d) BMG Research selects and notifies a winner at random from all valid entries received before the survey closes at the end of February 2023. Winners will be notified and receive their voucher by the 10th March.

Please select one only

Fixed codes	Answer list	Scripting notes	Routing
1	Yes I would like to enter the prize draw		**GO TO T02**
2	No I DO NOT wish to enter the prize draw		**CLOSING TEXT**

Base: All respondents

SINGLE RESPONSE

T02. Please confirm your first name and surname. These will be handled as stated in the terms and conditions on the previous page.

Please type your first name in the box below

[_____]

Please type your surname in the box below

[_____]

CLOSING TEXT

You have reached the end of the survey. Thank you for taking the time to answer our questions. Your input is really appreciated.

Please **click next** to submit your responses.

Appendix 2: Scottish Public Health Observatory Profile: Health and Wellbeing

Health board: NHS Greater Glasgow & Clyde
ScotPHO Profile: Health and Wellbeing

ScotPHO

indicator	NHS Greater Glasgow & Clyde	Scotland	Spine chart
Smoking prevalence, aged 16-34 years *2019 survey year . Percentage*	18.10	18.60	
Active travel to work *2020 survey year . Percentage*	15.36	16.93	
Alcohol-specific deaths *2017 to 2021 calendar years; 5-year aggregates . EASR per 100,000*	27.18	21.11	
Alcohol-related hospital admissions *2021/22 financial year . EASR per 100,000*	845.39	611.05	
Drug-related hospital admissions *2019/20 to 2021/22 financial years; 3-year aggregates . EASR per 100,000*	297.03	228.36	
Smoking attributable deaths *2020 to 2021 calendar years; 2-year aggregates . EASR per 100,000*	324.34	270.02	
Smoking during pregnancy *2019/20 to 2021/22 financial years; 3-year aggregates . Percentage*	10.26	12.92	
Domestic abuse *2021/22 financial year . Crude rate per 10,000*	125.49	118.26	
Violent crime *2020/21 financial year . Crude rate per 10,000*	19.69	16.41	
Drug crimes recorded *2021/22 financial year . Crude rate per 10,000*	67.88	50.59	
Crime rate *2017 calendar year . Crude rate per 1,000*	34.79	28.82	
Children referred to the Children's Reporter for offences *2021/22 financial year . Crude rate per 1,000 , 8-15 years*	6.12	4.97	
Prisoner population *31st March 2014 snapshot . EASR per 100,000*	239.15	161.86	
Children in low income families *2016 August snapshot . Percentage*	21.59	16.66	
Working age population employment deprived *2017 calendar year . Percentage*	11.81	9.29	
Population income deprived *2017 calendar year . Percentage*	15.97	12.07	
People claiming pension credits, aged >60 years *2016 May snapshot . Percentage*	7.94	5.49	

(continued)

indicator	NHS Greater Glasgow & Clyde	Scotland	Spine chart
Working age population claiming out-of-work benefits *2016 May snapshot . Percentage*	13.46	10.56	
Secondary school attendance by looked after children *2016/17 school year . Percentage*	88.67	87.42	
Annual participation (in education, training or employment) measure for 16 – 19 year olds *2023 calendar year . Percentage*	94.15	94.27	
School leavers in positive destinations *2021/22 school year . Percentage*	97.01	95.73	
School leavers with 1 or more qualification at SCQF Level 6 *2021/22 school year . Percentage*	51.73	44.09	
School leavers with 1 or more qualification at SCQF Level 4 *2021/22 school year . Percentage*	66.31	61.27	
Working age adults with low or no educational qualifications *2019 calendar year . Percentage*	14.70	11.64	
Secondary school attendance *2014/15 school year . Percentage*	91.70	91.79	
Adults rating neighbourhood as a very good place to live *2020 survey year . Percentage*	48.20	59.10	
People living in 15% most 'access deprived' areas *2017 calendar year . Percentage*	4.79	15.00	
Population within 500 metres of a derelict site *2022 calendar year . Percentage*	41.54	26.64	
Asthma patient hospitalisations *2019/20 to 2021/22 financial years; 3-year aggregates . EASR per 100,000*	69.07	68.44	
Cancer registrations *2019 to 2021 calendar years; 3-year aggregates . EASR per 100,000*	682.82	630.34	
Chronic obstructive pulmonary disease (COPD) patient hospitalisations *2019/20 to 2021/22 financial years; 3-year aggregates . EASR per 100,000*	280.01	207.45	
Emergency patient hospitalisations *2019 to 2021 calendar years; 3-year aggregates . EASR per 100,000*	7554.62	7236.08	
Emergency admissions, aged 65+ years *2019/20 to 2021/22 financial years; 3-year aggregates . EASR per 100,000*	7243.15	6824.16	
Coronary heart disease (CHD) patient hospitalisations *2019/20 to 2021/22 financial years; 3-year aggregates . EASR per 100,000*	363.10	341.63	

(continued)

indicator	NHS Greater Glasgow & Clyde	Scotland	Spine chart
Multiple emergency hospital admissions, aged >65 years *2019 to 2021 calendar years; 3-year aggregates . EASR per 100,000*	5489.87	5000.91	
Road traffic accident casualties *2019 to 2021 calendar years; 3-year aggregates . EASR per 100,000*	51.91	54.70	
Bowel screening uptake *2019 to 2021 calendar years; 3-year aggregates . Percentage*	61.18	65.56	
Immunisation uptake at 24 months - 6 in 1 *2020 to 2022 calendar years; 3-year aggregates . Percentage*	97.31	96.98	
Immunisation uptake at 24 months - MMR *2020 to 2022 calendar years; 3-year aggregates . Percentage*	94.79	94.39	
Breast screening uptake *2010 to 2012 calendar years; 3-year aggregates . Percentage*	67.69	72.48	
Drug-related deaths, males *2017 to 2021 calendar years; 5-year aggregates . EASR per 100,000*	48.38	33.15	
Deaths, aged 15-44 years *2019 to 2021 calendar years; 3-year aggregates . EASR per 100,000*	128.32	117.14	
Deaths all ages *2019 to 2021 calendar years; 3-year aggregates . EASR per 100,000*	1325.70	1180.65	
Early deaths from coronary heart disease (CHD), aged <75 years *2019 to 2021 calendar years; 3-year aggregates . EASR per 100,000*	61.57	52.59	
Early deaths from cancer, aged <75 years *2019 to 2021 calendar years; 3-year aggregates . EASR per 100,000*	168.45	149.58	
Healthy life expectancy, females *2019-2021 (3 year aggregate) . Years*	58.67	61.07	
Healthy life expectancy, males *2019-2021 (3 year aggregate) . Years*	57.95	60.39	
Life expectancy, females *2020 to 2022 (3 year aggregate) . Years*	79.35	80.72	
Life expectancy, males *2020 to 2022 (3 year aggregate) . Years*	75.25	76.54	
Deaths from suicide *2017 to 2021 calendar years; 5-year aggregates . EASR per 100,000*	14.12	14.13	
Population prescribed drugs for anxiety/depression/psychosis *2021/22 financial year . Percentage*	21.22	20.14	
Psychiatric patient hospitalisations *2019/20 to 2021/22 financial years; 3-year aggregates . EASR per 100,000*	277.52	230.66	

(continued)

indicator	NHS Greater Glasgow & Clyde	Scotland	Spine chart
People aged 65+ with high levels of care needs who are cared for at home *2021/22 financial year . Percentage*	35.60	35.31	
Children looked after by local authority *2021 July snapshot . Crude rate per 1,000 , 0-17 years*	17.41	12.93	
Single adult dwellings *2022 calendar year . Percentage*	41.35	38.45	
Adults claiming incapacity benefit/severe disability allowance *2016 May snapshot . Percentage*	8.14	6.07	
Babies exclusively breastfed at 6-8 weeks *2018/19 to 2020/21 financial years; 3-year aggregates . Percentage*	29.79	31.82	
Child dental health in primary 1 *2021/22 school year . Percentage*	69.25	73.11	
Child dental health in primary 7 *2019/20 school year . Percentage*	70.17	74.96	
Child healthy weight in primary 1 *2020/21 financial year . Percentage*	70.37	69.76	
Healthy birth weight *2019/20 to 2021/22 financial years; 3-year aggregates . Percentage*	86.18	84.14	
Teenage pregnancies *2019 to 2021 calendar years; 3-year aggregates . Crude rate per 1,000 females aged 15-19*	26.23	24.95	

Source: https://scotland.shinyapps.io/ScotPHO_profiles_tool/

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) BOARD

Report by Margaret-Jane Cardno, Head of Strategy and Transformation

27 June 2024

Subject: HSCP Digital Strategy 2024 - 2027

1. Purpose

1.1 The purpose of this report is to present the HSCP Digital Strategy 2024 – 2027, and the associated Delivery Plan and Equalities Impact Assessment to the West Dunbartonshire Health and Social Care Partnership Board.

2. Recommendations

It is recommended that the HSCP Audit and Performance Committee:

2.1 Approve the Digital Strategy 2024 – 2027 (Appendix 1) and note the Digital Strategy Delivery Plan (Appendix 2) and Equalities Impact Assessment (Appendix 3).

3. Background

3.1 The HSCP Digital Strategy 2024-2027 is an ambitious approach to developing digital services and structures, and to deliver successful change for employees, service users and other stakeholders.

3.2 The HSCP Digital Strategy aligns with the HSCP Strategic Plan 2023-2026, and links to national strategies such as Scotland's Digital Health and Care Strategy and the Health and Social Care Data Strategy. This approach would allow the HSCP to link specific programmes and projects to digital aims and objectives at a national and local level.

3.3 The HSCP participated in the Scottish Government Digital Maturity 2023 assessment, which identified areas of digital maturity and good practice. Specific areas of improvement and development highlighted by this exercise are focused upon within the strategy to ensure improvement in the digital maturity of the HSCP.

3.4 A delivery plan for the HSCP Digital Strategy has been created, which links directly to the Strategic Plan 2023-2027: Improving Lives Together Delivery Plan and the HSCP Workforce Plan. In addition, several digital workstreams that will be evaluated against the aims of Scotland's Digital Health and Care Strategy have been identified.

3.5 Digital will become central to everything the HSCP does and will be key in making services more person-centred, leading to significant changes in how health and social care is managed and delivered. Digital by default aims to make services more accessible, efficient, and user-friendly, while maintaining alternatives to include those who cannot use digital services.

3.6 Existing governance structures which as the HSCP PMO Board will be key to the success of the digital strategy through ensuring any projects identify areas where digital technologies would support the success of the project. The PMO Board will also have a role in providing guidance and direction to digital projects to ensure they are successful and following the aims of the digital strategy.

3.7 The Digital Strategy identifies several specific areas which will require focus through the duration of the strategy, which will bring opportunities for digital transformation across systems and technologies used, alongside the development of digital skills and supporting digital inclusion. In addition, a continual process of evaluating emerging technologies will be undertaken through the duration of the strategy.

4. Main Issues

4.1 As HSCP digital technologies and services are provided by West Dunbartonshire Council and NHS Greater Glasgow & Clyde, the HSCP has limited influence over wider strategic developments on priorities. The HSCP will need to ensure clarity is given around digital requirements.

4.2 Information systems used within the HSCP have been live for several years and are close to a point when their replacement will need to be considered. Outdated functionality, including the inability to integrate key systems, has led to issues with duplication of processes, recording and led to data issues between systems.

4.3 Replacement of existing systems with modern, cloud-based systems would bring significant benefits in streamlining processes, reducing duplication, and ensuring systems were able to share information which would improve data quality.

4.4 Funding would be required to allow any system replacement project to progress, whether in terms of costs associated with the procurement and implementation of a new system or implementation and resource costs to successfully go live. Existing systems would also need to be maintained during an implementation project.

4.5 It should be recognised that increased use of digital technologies will have an impact on our communities. Indications are that a high number of people have no concerns in using digital technologies, and the digital strategy will support digital inclusion, however traditional ways of seeking information or access to

services, such as telephone lines, will be maintained for those who are unable to engage with digital technologies.

4.6 The Digital Strategy will bring focus to the development of digital skills within the HSCP, ensuring appropriate training and support is available both to ensure employees have a good baseline level of digital literacy and to ensure those who require more advanced digital skills to support their roles receive suitable training, linking to the Workforce Plan and development of a Digitally Enabled Workforce.

5. Options Appraisal

5.1 Not required for this report.

6. People Implications

6.1 Training and support provision to improve digital skills within the HSCP will require teams to make employees available for training, supporting them to engage with any training content and support provided.

6.2 Digital technologies can transform the way members of our communities can access information and services, including giving people control of their own information through secure digital channels.

6.3 Digital inclusion will be considered, particularly where alternative digital channels are being considered. However, the strategy makes clear that these will be in addition to existing contact methods for engaging with the HSCP rather than replacing existing services.

7. Financial and Procurement Implications

7.1 Although the Digital Strategy does not have direct financial implications, there would be financial and procurement implications of some of the programmes and projects identified in the delivery plan such as the replacement of core HSCP systems where funding would be required for one off and recurring costs related to the implementation following procurement advice on testing the market.

8. Risk Analysis

8.1 The Digital Strategy aims to help position West Dunbartonshire HSCP as a digital by default organisation, able to utilise technology to support change within the partnership, support employees and support services and information provided by service users.

8.2 Current systems used within HSCP are essentially legacy systems which are limited in technology used and functionality available when compared to modern systems. Reliance on on-premise systems could post a risk around information security and resilience when compared to cloud-based systems.

8.3 All systems used are currently support by their suppliers, however over time there is a risk that for any legacy system a supplier will set a date to withdraw support. As more customers move to newer systems, this risk is likely to increase.

8.4 Current systems used within the partnership are likely to face additional barriers which could prevent taking full advantage of developments around the National Digital Platform.

9. Equalities Impact Assessment (EIA)

9.1 An Equalities Impact Assessment (EIA) was completed within the West Dunbartonshire Council Corporate EIA system on 15th January 2024 and approved in April 2024. The EIA can be found in Appendix 3.

9.2 The recommendation was to introduce the Digital Strategy, taking the view that the strategy will provide HSCP with a focus on digital developments across several areas, support change and setting out areas where focus will be required.

9.3 Although digital exclusion was noted as an issue, and identified in the strategy itself, existing routes to access HSCP services would remain in place.

10. Environmental Sustainability

10.1 Not required for this report.

11. Consultation

11.1 A consultation group was established to review and comment on the HSCP Digital Strategy, with comments sought from interested partners.

11.2 The HSCP Digital Strategy has been reviewed and confirmed by the Health and Social Care Partnership Senior Management Team.

11.3 Relevant Monitoring Officers, including internal auditors, have been consulted in the preparation of this report.

12. Strategic Assessment

12.1 The HSCP Digital Strategy is ambitious across several area in its aim to make digital technologies central to the delivery of services across the HSCP, including a focus on technology and digital skills within the organisation.

12.2 Approval of the Digital Strategy will allow the HSCP to engage with national digital and data strategies, including areas such as the National Digital Platform which would allow the partnership to be fully part of national initiatives.

12.3 Improvements in use of technology and systems will bring significant benefits to HSCP employees, with modern systems being accessible from different devices and offering improved functionality to simplify processes and reduce duplication in recording.

12.4 Technology Enabled Care will provide additional help to support vulnerable people to be safe and supported in their own homes, alongside Digital Telecare devices, and can be an established way of improving service user uptake of Self Directed Support.

13 Directions

Not required for this report.

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Appendices: HSCP Digital Strategy 2024-2017 (Appendix 1)
HSCP Digital Strategy Delivery Plan (Appendix 2)
Equalities Impact Assessment (Appendix 3)

NHS Greater Glasgow and Clyde

West Dunbartonshire Health and Social Care Partnership

Digital Strategy 2024-2027

Document Management Details

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Trades Union consultation (if applicable)	
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Contents

Introduction

Purpose of this document

The West Dunbartonshire Health and Social Care Partnership (WDHSCP) Digital Strategy 2024-2027 is an ambitious approach to developing digital services and structures, and to deliver successful change for employees, service users and other stakeholders. The Digital Strategy will support the WDHSCP Strategic Plan 2023-2026 Improving Lives Together, and the digital strategy itself and use of digital technologies will support the Strategic Delivery Plan.

Scotland's Digital Health and Care Strategy and the Health and Social Care Data Strategy provide the strategic direction that the Scottish Government and COSLA are making to improve the care and wellbeing of people in Scotland by increasing the use of digital technologies and using data in the design and delivery of services.

This strategy will reflect on how the impact of the Covid-19 pandemic has influenced the approach to digital within the partnership. The pandemic, and move into lockdown, made effective digital services critical to WDHSCP and supported moves to new ways of working. The strategy will aim to build on these positive developments.

The strategy will provide a framework for developing digital technologies to support service transformation, using the Scottish Approach to Service Design, introduce digital channels offering a secure and convenient option for accessing information and services, countering digital exclusion in communities and ensuring employees have the skills and knowledge required.

Digital technologies are key in making services person-centred, leading to significant changes in how health and social care can be arranged, managed, and delivered. Digital by Default aims to make services more accessible, efficient, and user-friendly, while maintaining alternatives to include those who cannot use digital services.

This will include how people engage with services, empowering service users to have greater choice and control in the delivery of their care. This will help people maintain their health and wellbeing, support people to live safely within their own homes and achieve best value through the delivery of more efficient and effective services.

The strategy will support engagement with communities to make sure the use of technology is accessible, promote digital inclusion and ensure that even with a focus on digital technologies no-one in our communities is affected by digital exclusion.

We will engage with communities and other partners to establish ways to improve access to information and support. As part of our plans to promote digital skills and inclusion within our communities, improvements to support and develop health literacy will be identified. Health literacy is the ability to find, understand and use information and services to make decisions about health and wellbeing. Health literacy involves personal skills and confidence, as well as the quality and accessibility of health information and services. Health literacy affects a person's health status and their ability to form effective partnerships with health care providers.

The Digital Strategy will align with the digital strategies of both West Dunbartonshire Council and NHS Greater Glasgow & Clyde, with each organisation having their own Digital strategies related to their wider organisations. With ICT services used by WDHSCP being managed by both organisations, technology, and devices available will be heavily influenced by decisions made within those corporate ICT services. WDHSCP will need to ensure that any requirements around applications or devices are clearly identified and shared with each ICT department.

Vision

Our vision is to become digital by default, shifting from traditional models of care delivery to a new model of patient-centred, value-based care with the help of digital technologies. We will support digital skills development within our teams and improve digital inclusion in our communities while continuing to provide services and support that meet the needs of our service users.

Mission

We will empower our service users and employees by utilising digital technologies and information, to support reliable, consistent, and responsive services, improving outcomes in line with the HSCP Strategic Plan Improving Lives Together 2023 - 2026.

Aims

The aims of the WDHSCP Digital Strategy 2024 – 2027 are to:

- Support the vision and delivery of the Strategic Plan 2023 – 2026 Improving Lives Together.
- Evaluate and improve digital maturity within WDHSCP.
- Ensure best use of modern, secure systems and technologies which help streamline processes, and improve quality and usage of our data.
- Reduce costs within our services by implementing digital tools and streamlining processes.
- Improve outcomes for service users by introducing technology enabled care and supporting the transition from analogue to digital telecare.
- Introduce high quality, innovative, accessible digital services which bring benefits to service users, carers, families, and employees.
- Focus on the development of digital skills for employees, ensuring confidence in using digital technologies.
- Ensure any digital technologies introduced by the partnership consider equalities, inclusion, and any environmental impacts before approval.
- Ensure governance of digital work streams support the digital strategy, and link appropriately to national and local strategies which influence the partnership.
- Support digital inclusion within our communities, working with partners and providers to increase digital skills and access to technologies.

The Digital Strategy will also support the six main priorities of Scotland's Digital Health and Care Strategy which are:

Digital access

- People have flexible digital access to information, their own data and services which support their health and wellbeing, wherever they are.

Digital services

- Digital options are increasingly available as a choice for people accessing services and staff delivering them.

Digital foundations

- The infrastructure, systems, regulation, standards, and governance are in place to ensure robust and secure delivery.

Digital skills and leadership

- Digital skills are seen as core skills for the workforce across the health and care sector.

Digital Futures

- Our wellbeing and economy benefit as Scotland remains at the heart of digital innovation and development.

Data-driven services and insight

- Data is harnessed to the benefit of citizens, services and innovation.

The aims of the strategy, alongside national priorities, will be considered when projects with a digital element are being started up and progress monitored through the duration of individual projects.

Background

Current Position

Within WDHSCP, several areas where effective use is made of digital technologies have been identified. WDHSCP participated in the Digital Health & Care Scotland Digital Maturity Assessment 2023, which identified areas of digital maturity and good practice, and will help focus attention on areas where change and improvement can be supported. Developments in those areas will have a positive impact on the 2024 Digital Maturity Assessment outcomes.

There are well established digital technologies within WDHSCP, including the ability for many employees to work remotely or begin and end their days from their own homes. Following on from its introduction during the Covid-19 pandemic, MS Teams has become a key communication platform used across the partnership for messaging, calls and online meetings which has led to less travelling for meetings reducing our carbon footprint. Recent developments have allowed WDHSCP employees employed by West Dunbartonshire Council or NHS Greater Glasgow & Clyde to share calendars, availability status, and call and chat functionality within MS Teams. Future developments will expand the features available within MS Teams.

Established information systems are in place, with a central service user information system linked to an electronic document management system. Within the Care at Home service a separate system for scheduling care visits is used. The use of these systems has enabled increased paperless working and use of digital files across the organisation. Internally, there is a focus on the use of management information from these systems, including improving access to information, setting up automated scheduled reports to reduce manual processes and improving accuracy of data.

Specific governance structures have been put in place to support digital transformation, including a Programme Management Office (PMO) Board allowing standardisation of process and guidance to be given, and a Change Board to ensure any changes made to information systems are controlled and meet WDHSCP and service requirements.

A WDHSCP website is available and provides information on what we do, how to make contact, key information around structures and sharing of documentation. Contact details are provided on the website, although it should be noted that opportunities for direct contact through the website are limited. In addition, other websites which meet specific requirements are available, such as the West Dunbartonshire Wellbeing website which provides information to support the wellbeing of children, young people, and their families.

The Digital Strategy will focus on where areas of improvement are available while also recognising progress made to date in those areas identified.

Challenges

There are several challenges associated with implementing a Digital Strategy for WDHSCP. As ICT and digital services are provided by West Dunbartonshire Council

and NHS GGC, WDHSCP has limited influence over wider strategic developments and priorities and there are specific challenges where employee work across separate networks, systems, and different devices. NHS systems are designed to meet NHS GG&C or national requirements, and Council systems are designed to meet WDHSCP or Council requirements which can mean it is difficult to find solutions that work specifically for the full partnership.

National drivers also need to be considered, including any preparatory work relating to the National Care Service as well as relevant national strategies, both directly and indirectly, linked to digital developments. Although the planned implementation date of the National Care Service is outside of the period covered by the digital strategy, the potential for preparatory work involving digital technologies will need to be considered.

Service user information systems used within WDHSCP have now been live for several years and are close to a point where their replacement will need to be considered whether to improve systems used or as suppliers move their support efforts to their newer systems. Integration between the main systems has not been possible which has led to duplication in processes and manual input into multiple systems.

The systems used are lacking in functionality available in more modern systems that would better support simplified recording processes, improved functionality for users, reduction in duplication and potential for integrating with other systems without the need for specific adaptors. Continued use of these systems will impact on the ability of WDHSCP to meet the aims of this strategy and will continue to embed inefficient recording processes.

Given the current financial climate, finding available funding for replacing current systems is likely to be a significant challenge both in terms of costs associated with implementing new systems or for additional resource to support new system implementation. It should be noted that throughout any implementation, there will still be a need to support current systems until go live. However, replacing existing systems would bring significant benefits to the partnership and should be seen as a priority area.

Consideration also needs to be given to the impact of digital technologies on our communities. Although indications are that a high number of people have no concerns in using digital technologies, other factors could impact on an individual’s ability to use digital technology. It is important to note that non-digital ways of contacting WDHSCP, accessing information and receiving services will be maintained to ensure the digital approach does not bring any negative impacts on those who, for whatever reason, are not able to engage with digital technologies. Where possible we should support digital inclusion while recognising that for some people digital is not an option.

Strategic Opportunities

HSCP Strategic Plan 2023-2026

The Digital Strategy 2024-2027 will be reviewed in line with the WDHSCP Strategic Plan 2023-2026 and associated delivery plan as the Digital Strategy will support the implementation of the Strategic Plan. As well as managing the ongoing impacts of the Covid-19 pandemic, the cost of living crisis, and financial restraints within the public sector will all impact on both the Strategic Plan and Digital Strategy. However, digital transformation can support service change and provide opportunities for preventing ill health, streamlining processes, and reducing duplication all of which will have a positive impact on WDHSCP and people of West Dunbartonshire.

Governance

WDHSCP is going through a period of significant change, with several large-scale projects ongoing within services which will change the way the partnership operates in key areas. Service improvement projects following the Scottish Approach to Service Design are ongoing within individual services and many of these projects will have a digital element to them. To improve outcomes and ensure success of change projects, there is a need for greater awareness of digital and clarity around the digital and data implications of individual programmes and projects.

To ensure the successful implementation of organisational change projects within the partnership, the PMO will support individual managers who are responsible for individual projects. A PMO Board is in place, with representatives from the WDHSCP Senior Management Team as members, which will have oversight on change projects with responsibilities including approving start-up of projects, monitoring progress, providing guidance and direction, and approving the closure of completed projects.

As part of this overall governance structure digital aspects of all projects should be captured and considered at the initiation stage and through ongoing project reporting even if those areas are either part of a phase or are likely to only be available once the project is live. It's also clear that individual project managers need a raised level of digital awareness so that these requirements and potential solutions are identified as part of the project work.

The success of these projects will have a significant impact on the HSCP and its strategic objectives. Therefore, a governance framework that ensures only suitable projects are given approval and supports them to a point where they are successful will have a significant impact on digital developments.

Information Systems

WDHSCP makes effective use of information systems across the organisation, using case management systems which enable recording of client, carer, and service information, including assessment forms, case notes, financial information, and specific areas such as Child Protection and Criminal Justice. A document management system is in place and linked to the case management system to support

a paperless approach and to improve accessibility of case record information. The Care at Home service uses a separate system to schedule and monitor care services which sits separately to other systems.

The systems used within the partnership have all been in place for a significant period, with the main case management system having been live for around 15 years. Although the systems continue to support the organisation, they are at a point where they should be considered legacy systems which have been or are being replaced in other partnerships.

The main impact of ongoing use of these systems is the lack of development to improve functionality to match what is available in newer systems which would support recording, reduce duplication, and improve accuracy of information stored on the system.

In addition, moving forward opportunities to integrate these systems, either with each other or with wider systems to support information sharing, will be limited when compared to more modern systems as current systems do not support an Open Application Programming Interface (API) approach. An Open API is an application programming interface made available by system providers which allows more straightforward integration between systems and will be required moving forward both for integrating systems within the partnership and to take full advantage of developments around the National Digital Platform.

Although the focus is currently on making best use of current systems with ongoing development projects taking place to support organisational change and improve access to information across teams and services, it is clear that replacement systems projects will need to be considered to support the aims of the digital strategy both in terms of improving digital tools for staff but also for enabling service user access to information and supporting national strategies and the National Care Service. Solutions which can be integrated will be key to linking up systems to reduce duplication, improve accuracy of data and ensure that key information can be captured once and recorded on all required systems.

Data Utilisation

The Scottish Government and COSLA strategy for data-driven care in the digital age seeks to empower the people of Scotland by giving individuals clear and easy access to, and the ability to manage and contribute to, their own health and social care data where it is safe and appropriate to do so. The National Digital Platform developments are likely to support access in this way, however the key for the partnership will be ensuring that systems used are able to integrate with national systems in a suitable way to enable this. This area may be a significant driver in the decision to start up a replacement systems project to ensure a suitable cloud-based solution is in place to support this integration.

Data held within the partnership should be developed as a business asset, with better use of systems ensuring information is recorded once, is accurate and is used to support services delivered to our communities. Where possible usage of a single

standard identifier such as the Community Health Index (CHI) number should become the main identifier across systems to allow integration and data linking to further reduce duplication, improve information quality, and support fuller management information.

Business intelligence tools will be used to extract information to support management information reporting, analysis and inform decision making. Real time access to data using dashboards to support service knowledge, identification of issues, budget management and decision making supported by business intelligence applications will support managers across WDHSCP to ensure delivery of a high quality, efficient service to all service users.

Microsoft Power BI is an enterprise-class data analytics and business intelligence platform that users connect to for data analysis, visualisation, collaboration, and distribution. The introduction of Power BI would improve reporting functionality available to the partnership, allowing us to move towards a more live dashboard approach rather than the existing use of excel as a way of outputting and reporting on our data.

Information sharing with partners will also be a key approach to the strategy, including building on existing arrangements to share health and social care information. New cloud-based systems with well-developed security models may enable access to partner agencies on a tightly controlled basis to allow them to access information and contribute to multi-agency working and assessments. This would reduce duplication and manual processes, improve data quality, and reduce recording time for staff across all partner agencies.

Information can also support equality outcomes, identifying areas where community engagement may be required, promoting health improvement across the area, and giving indications of where preventative work can be done either directly with client groups or more generally.

Technology Enabled Care

The national switchover of telephone lines from analogue to digital, due for completion by the end of 2025, will bring both challenges and opportunities to the WDHSCP Telecare Service. As the current analogue community alarm units are not fully compatible with the new digital lines, the analogue alarms will need to be replaced by new digital alarms for all service users.

The Digital Office and Scotland Excel have led on a national procurement exercise, creating a framework for a shared digital Alarm Receiving Centre (ARC) system with Chubb Cloud Care Control being the selected system.

The new ARC system will be a cloud solution offered as a Software as a Service (SaaS) model supporting the rollout of digital devices. The new system will bring benefits around accessibility of information, reporting and use of mobile apps to improve communications with responders. WDHSCP will work with partners in East Dunbartonshire to ensure the successful implementation of the ARC system and to review other functionality that could bring benefits to staff and service users.

New digital devices that can connect to digital alarms and may bring additional functionality to better support people at home, allowing them to remain independent for longer, will be evaluated and introduced where appropriate. In addition, wider use of Technology Enabled Care to support services users will be considered, including potential for standalone digital devices, which may be off the shelf products, to have a positive impact on outcomes and ensure people are safe, connected and supported.

Digital Skills

The focus on enhancing digital capabilities with the partnership has underscored the necessity of fostering both general digital literacy among all staff while also providing targeted, job-specific digital upskilling. Recognising that digital literacy forms the foundation of modern professional competencies, it is essential to equip every employee with basic digital skills, ensuring they can navigate digital tools and platforms effectively, including core systems, and understand data and how it can be used to support them.

Specialised digital upskilling is crucial for roles that demand more than just basic digital proficiency, requiring in-depth knowledge of specific software, systems, or technologies. By addressing both the digital literacy baseline and the more nuanced, role-specific digital skill requirements the partnership can develop and support a workforce that not only achieves a baseline level of digital literacy but can also hand the specific digital demands of their individual roles. This dual approach is integral to the continuous improvement and efficiency of services, reflecting a commitment to excellence in delivery in the digital age.

The recent Scottish Government Digital Maturity Assessment exercise helped identify a lack of digital skills linked to posts across the HSCP. Digital skills are not part of most standard job descriptions, including those where there is a requirement to use systems.

Through the duration of this digital strategy, an evaluation will take place on how digital skills could be reflected in roles within the HSCP and what training and support would be required to improve digital literacy for all staff, while also focusing on more job specific needs for advanced skills. The aim would be for digital skills to become a standard part of developmental discussions between managers and employees to ensure all employees are empowered to use digital systems and technologies in their roles where required.

The Digital Skills Support Framework launched within West Dunbartonshire Council alongside nominated Digi Champs would support HSCP employees develop their digital skills through sharing resources and offering digital skills support. Raising awareness of this framework alongside increased the number of HSCP Digi Champs would support improvements in digital skills. Potential for use of online training resources which can be accessed at any time will be explored.

Digital Inclusion

Digital Inclusion will be a significant factor in the ability of WDHSCP to move towards being a digital by default partnership. Digital inclusion ensures equal access to and proficiency in using digital technology and services. Addressing this aligns with broader goals of health equalities, community engagement and service optimisation. The disparities in access and literacy, especially among marginalised groups, elderly, and lower socioeconomic communities, can lead to inequitable outcomes. Therefore, it's essential to integrate digital inclusion into this Digital Strategy to maintain a commitment to equitable and comprehensive care.

To effectively address digital inclusion, the partnerships strategic goals should focus on supporting a multi-agency approach to enhancing digital literacy and access, particularly in vulnerable populations, through community-based programs. Inclusive service design, involving diverse community input, is crucial for creating accessible, secure, and user-friendly digital health and social care services.

Collaborative efforts with Council, Third Sector, Independent and Community sectors are key to implementing these strategies. Community organisations offering support within communities can help develop and support digital skills and increase confidence in using digital technologies. Challenges in this endeavour include securing funding, managing digital privacy and data security, and catering to the diverse needs of the population. WDHSCP will work with partners to support digital inclusion across our communities. Our clear commitment will be to balance the advancement of digital services with the maintenance of traditional access points is essential for inclusive digital health and social care.

Digital Customer Experience

The current WDHSCP website is a useful resource for providing information to our communities which includes clear pathways supporting people to access information related to their area of interest, including ways of contacting the partnership. Development of the website to offer additional information, signposting to partners and alternative ways of making contact, which are easy to use and available 24/7, will be considered.

In addition to offering digital channels for making direct contact with the partnership, people within our communities should be empowered to share their experience of health and care services, good or bad, that they have received. The partnership will evaluate the use of Care Opinion to encourage patients, service users and carers to share their experience of services which will further inform choice and allow the WDHSCP to gather information relating to direct experience of services delivered which will allow improvements to be identified.

As the online presence is developed to include digital channels, with encouragement given to service users and anyone needing to contact the partnership to use these channels, care must be taken to ensure alternative contact routes remain available rather than introducing technological barriers.

The Scottish Household Survey 2021 indicated that the proportion of households with internet access had risen across all households, however there are several factors impacting on access particularly around age, lower incomes, Scottish Index of Multiple Deprivation (SIMD) measure and social housing. This means that while there has been growing uptake of digital technologies there are still substantial numbers of people without internet access who could not make best use of digital channels.

While there needs to be a focus on improving digital channels, citizen engagement to reduce digital exclusion needs to be considered with a particular focus on ideas around how to increase digital skills to empower people and allowing them digital access to information, including their own data where it's appropriate.

The use of tools such as Near Me, which allows people to attend appointments from home or wherever is convenient rather than having to travel to appointments in a specific office, was taken up widely as a response to Covid-19 restrictions. Near Me is widely used across NHS Scotland and is a secure form of providing video consultations approved for use by the Scottish Government and NHS Scotland which will continue to be used and developed within the partnership.

WDHSCP currently uses a dedicated Twitter/X account to share information with our communities and could explore the potential for other channels to communicate with our communities. Given how comfortable many people are with social media, this would be a key route to sharing news, information, raising awareness of health conditions and opportunities for communities to share experiences with us.

An agreed approach to utilisation of social media, including potential for training and enabling staff from different services to be able to post content to social media as used in other HSCPs may allow an expanded WDHSCP social media presence to support sharing of information, service details and signposting to additional resources including web content.

Robotic Process Automation (RPA)

The partnership will explore the potential for Robotic Process Automation (RPA) to support change, reduce duplication and improve data quality across all systems used. RPA is well established within West Dunbartonshire and can be utilised to automate processes, reducing manual effort and duplication and will perform certain data tasks much faster than a user can update a system.

RPA will become a key tool which will enable efficiencies in processes, support systems and improve data quality within systems, with specific processes identified as suitable for automation which can then run as and when required to reduce duplication or enable information to be distributed from one system to another without requiring manual processes or full integrations.

Looking Forward

Throughout the duration of the Digital Strategy, the partnership will be committed to a continual process of evaluating emerging technologies with applications across health and social care, whether identified at a national or local level. There are likely to be

technological developments that will have to be considered in the implementation of this digital strategy, with progress across health and social care systems, Artificial Intelligence (AI) and automation likely to continue through the duration of the strategy.

Developments of AI applications within health and social care are likely to take place through the duration of the strategy, and the availability of Generative AI applications such as ChatGPT will lead to increasing use by individual users within the partnership, so this is an area that will need attention. Moving forward as this area develops it will be important for all organisations, including WDHSCP, to develop and introduce appropriate guidance and governance around the use of AI, ensuring use of trustworthy, ethical and inclusive AI as outlined in Scotland's AI Strategy.

At a national level there will also be further developments, including the introduction of the National Digital Platform and an increased focus on individuals having access to and control over their own information potentially through the introduction of a 'digital wallet' approach where individuals have control over their own information and who can have access to it. As the approach taken to national developments of this nature becomes clearer the partnership will need to be able to support this level of access and control.

Delivery Plan and Measuring Success

The HSCP Digital Strategy is ambitious across several areas and aims to make digital central to the delivery of services across the partnership, including a focus on technology and digital skills within the organisation, and to ensure the introduction of functionality that will support our staff, service users and communities as we move forward into an ever more digitally engaged world. The strategy will be delivered across the next 3 years with a recognition that in certain areas such as AI there is likely to be significant developments and progress made across that period.

While there is a baseline already achieved for digital within WDHSCP, with widely used systems and appropriate governance structures in place, there is much to be done to embed digital within employee groups and to ensure that new technology is made available to support our workforce.

This West Dunbartonshire HSCP Digital Strategy is supported by a clear delivery plan, which details actions that we will take over the next 3 years to achieve strategic and digital outcomes. This delivery plan provides a framework that will allow the Health and Social Care Partnership Board to monitor progress.

The delivery plan provides details on strategic plan delivery plan programmes of work and individual projects that have a digital element which should be supported by the digital strategy and demonstrates where individual projects will support the digital strategy itself and the workforce strategy.

Reporting on progress of programmes or projects under the digital strategy will be managed, and receive guidance and direction through the PMO, with the PMO responsible for ensuring digital aspects are captured at an early stage and that any projects have a robust business case.

Appendix 1 – References

Referenced Document	Web Address
West Dunbartonshire HSCP Strategic Plan 2023-20206: Improving Lives Together	http://www.wdhscp.org.uk/media/2666/wdhscp-strategic-plan.pdf
West Dunbartonshire HSCP Strategic Delivery Plan 2023-2026	http://www.wdhscp.org.uk/media/2665/wdhscp-delivery-plan.pdf
West Dunbartonshire Council Information & Communications (ICT) Strategy 2023-2028	https://www.west-dunbarton.gov.uk/media/r2vpw44q/ict-strategy-2023-28.docx
West Dunbartonshire Council People First Strategy 2022-2027	https://www.west-dunbarton.gov.uk/media/cr2lhspx/people-first-strategy-2022-2027.pdf
NHS Greater Glasgow and Clyde Digital on demand 2023-28	https://www.nhsggc.scot/downloads/digital-health-care-strategy-digital-on-demand-2023-2028/
Scotland's Digital Health and Care Strategy – Care in the Digital Age	https://www.gov.scot/publications/scotlands-digital-health-care-strategy/
Care in the Digital Age Delivery Plan 2023-24	https://www.gov.scot/publications/care-digital-age-delivery-plan-2023-24/
Scottish Government and CoSLA Strategy for data-driven care in the digital age	https://www.gov.scot/publications/data-strategy-health-social-care-2/
Scotland's AI Strategy	https://www.scotlandaistrategy.com/the-strategy
Scottish Approach to Service Design	https://www.gov.scot/publications/the-scottish-approach-to-service-design/
National Digital Platform	https://www.nationaldigitalplatform.scot/
Digital Maturity Assessment	https://www.digihealthcare.scot/digital-maturity-assessment-2023/

NHS Greater Glasgow and Clyde

West Dunbartonshire Health and Social Care Partnership

Digital Strategy 2024 – 2027 Delivery Plan

Introduction

The West Dunbartonshire Health & Social Care Partnership (WDHSCP) is pleased to present a delivery plan accompanying its Digital Strategy 2024-2027. The Digital Strategy and this delivery plan will support the HSCP Strategic Plan 2023-2026: Improving Lives Together and its associated Strategic Plan Delivery Plan through a focus on the projects identified within the delivery plan which have a digital dimension.

This delivery plan will support the WDHSCP Workforce Plan specifically around the development of a digitally enabled workforce where the workforce plan set out a vision stating 'We will review on an ongoing basis the need for investment in new technology to support both staff who will be working in a different way and to support service delivery going forward and will continue to work on the application of remote and digital services where appropriate e.g. attend anywhere appointments with clinical services.'.

In addition, specific digital projects will support the partnership in meeting the aims of Scotland's Digital Health and Care Strategy, focusing on the 6 priorities which support the main aims of the national strategy.

Moving forward the digital strategy and the delivery plan will provide the foundation for the partnership to improve digital skills across the organisation, improve systems and data quality, provide digital channels which support lean processes and reduce duplication are in place for our communities, support digital inclusion and improve WDHSCP digital maturity.

Within this delivery plan we present actions that WDHSCP will take to implement the Digital Strategy including areas where partnership working will be required. Clear links will be made to projects identified through the Strategic Plan which are relevant to and meet requirements of the implementation of the digital strategy. The digital strategy will support a number of projects, to varying degrees depending on the scope of the project, throughout its timeframe with digital becoming a key consideration for any project being undertaken within the partnership. It should also be noted that an exercise was undertaken to match areas identified within the strategic delivery plan to programmes that would be monitored and directed through the partnership Programme Management Office (PMO) Board.

Strategic Plan 2023-2026: Improving Lives Together Delivery Plan

Within the Strategic Delivery Plan several individual areas were identified that are of direct relevance to the Digital Strategy and this delivery plan. Within the Strategic Enables for the Strategic Plan Delivery Plan several individual programmes/projects are identified which have a defined digital component through their focus on technology, or a digital element likely required to meet their objectives.

Strategic Enablers

National Health and Wellbeing Outcomes

O8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

O9. Resources are used effectively and efficiently in the provision of health and social care services

Strategic Measures: National Indicators (NI) and intended direction of change

NI2. Percentage of adults supported at home who agree that they are supported to live as independently as possible (increase).

NI3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided (increase).

NI10. Percentage of staff who say they would recommend their workplace as a good place to work (increase).*

Programmes/Projects with a focus on digital, data and systems

Technology						
Programme/Project	Responsible Officer	Year 1 2023-2024	Year 2 2024-2025	Year 3 2025-2026	Strategic outcomes and measures	Measure of output
Develop and implement a project plan for the replacement of the CareFirst Information System	Head of Strategy and Transformation			March 2026	O9	Implementation of replacement system
Increase our focus on the provision of good-quality data, to enable services to monitor and provide effective and efficient health and social care.	Head of Strategy and Transformation	March 2024	March 2025	March 2026	O9	Enhancement of strategic, tactical and operational reporting.
Support the implementation of appropriate technology-based improvements, including the federation of NHS and council systems	Head of Strategy and Transformation			March 2026	O9 NI2	Implementation of federation of NHS and council systems.
Expand the use of technology-enabled care (TEC) throughout West Dunbartonshire.	Head of Strategy and Transformation	March 2024	March 2025	March 2026	O9	TEC usage statistics.
Address digital exclusion by exploring ways to assist access to digital systems and promote automation.	Head of Strategy and Transformation	March 2024	March 2025	March 2026	O9	Development and implementation of digital strategy.
Develop and implement the Analogue to Digital Implementation Plan.	Head of Strategy and Transformation		March 2025		O9 NI2	Development and implementation of plan.

Programmes/Projects where the digital strategy will have an input.

Programme/Project	Responsible Officer	Year 1 2023-2024	Year 2 2024-2025	Year 3 2025-2026	Strategic outcomes and measures	Measure of output
Develop and implement our workforce plan, focusing on staff recruitment, retention, training and health and wellbeing.	Head of HR	March 2024	March 2025	March 2026	O8, O9 NI10	Implementation of workforce plan.
Undertake workforce modelling to inform ICT needs, in the context of a blend of office-based, hybrid and home working	Head of HR	July 2023			O8, O9 NI10	Completion of workforce modelling.
Review and implement our Participation and Engagement Strategy.	Head of Strategy and Transformation	September 2023			O8 NI3	Review and implementation of strategy.

Alongside the Technology section, several other specific Programmes/Projects will be considered within this Delivery Plan for potential Digital opportunities.

Caring Communities

National Health and Wellbeing Outcomes

O3. People who use health and social care services have positive experiences of those services, and their dignity is respected.

O4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

O5. Health and social care services contribute to reducing health inequalities.

O8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

O9. Resources are used effectively and efficiently in the provision of health and social care services

Strategic Measures: National Indicators (NI) and intended direction of change

NI4. Percentage of adults supported at home who agree that their health and care services seem to be well coordinated (increase).

NI5. Percentage of adults receiving any care or support who rate it as excellent or good (increase).

NI6. Percentage of people with a positive experience of care at their General Practice (increase)

Programme/Project	Responsible Officer	Year 1 2023-2024	Year 2 2024-2025	Year 3 2025-2026	Strategic outcomes and measures	Measure of output
Review and update the HSCP Participation and Engagement Strategy.	Head of Strategy and Transformation	September 2023			O3, O4 NI5 NI6	Approval of updated strategy by HSCP Board.
Promote the use of Care Opinion to encourage patients, clients, carers and people who use our services to share their experiences of services, further informing choice.	Head of Strategy and Transformation		April 2024		O3, O4 NI5 NI6	Number of engagements with Care Opinion.
Strengthen the voice and include the views of the people who use our services in our individual care planning approach using My Assessment tools.	Head of Children's Health, Care and Justice	March 2024	March 2025	March 2026		Reporting and capturing of the views of children who are the subject of Looked After Reviews.
Undertake service design and improvement activity regarding how partners and people who use our services access HSCP services.	Head of Strategy and Transformation	December 2023			O3, O5, O9 NI4	Implementation of pathway to HSCP services plan, improving accessibility and coordination.
Develop and implement a Children's Services initial response team.	Head of Children's Health, Care and Justice	February 2024			O3, O4, O5	Development of key performance indicators to evaluate impact, including referral rates, pending services, wait times and service and staff satisfaction

Programme/Project	Responsible Officer	Year 1 2023-2024	Year 2 2024-2025	Year 3 2025-2026	Strategic outcomes and measures	Measure of output
Implement the HSCP Quality improvement Policy across all teams and, as part of a wider quality framework, develop a quality assurance policy. Identify mechanisms to share good practice and benchmarking information routinely and systematically	Head of Strategy and Transformation	September 2023			O8 NI5	Approval and implementation of the HSCP Quality Improvement Policy and Service Design Policy.
Develop and implement a five-year strategic approach – What Would it Take? – across Children's Services, underpinned by a medium-term financial plan and defined work streams for Children's Services. This will include commissioning child-centred services; supported accommodation for care leavers; best practice in child protection; children at the centre of residential care; and fostering for the future.	Head of Children's Health, Care and Justice	March 2024	March 2025	March 2026		Development of impact measures. HSCP Board approval of strategic plan.

Safe and thriving communities

National Health and Wellbeing Outcomes

O1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

O2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

O3. People who use health and social care services have positive experiences of those services, and their dignity is respected.

O4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

O5. Health and social care services contribute to reducing health inequalities.

O9. Resources are used effectively and efficiently in the provision of health and social care services

Strategic Measures: National Indicators (NI) and intended direction of change.

NI1. Percentage of adults able to look after their health very well or quite well (increase).

NI2. Percentage of adults supported at home who agree that they are supported to live as independently as possible (increase).

NI3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided (increase).

Programme/Project	Responsible Officer	Year 1 2023-2024	Year 2 2024-2025	Year 3 2025-2026	Strategic outcomes and measures	Measure of output
Work in partnership with stakeholders and people who use our services to develop pathways of care that promote and support self-management of long-term conditions. This will be facilitated by the establishment of a Greater Glasgow and Clyde primary care strategy and the progression of Moving Forward Together and the unscheduled care agenda.	Head of Health and Community Care	September 2023	September 2024	September 2025	O1, O2, O3, O4, O5, O9 NI1, NI2, NI3	Implementation of relevant strategies.

Equal communities

National Health and Wellbeing Outcomes

O1. People are able to look after and improve their own health and wellbeing and live in good health longer.

O2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

O3. People who use health and social care services have positive experiences of those services, and their dignity is respected.

O4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

O5. Health and social care services contribute to reducing health inequalities.

Strategic measures: National Indicators (NI) and intended direction of change

NI1. Percentage of adults able to look after their health very well or quite well (increase).

NI2. Percentage of adults supported at home who agree that they are supported to live as independently as possible (increase).

NI3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided (increase).

NI4. Percentage of adults supported at home who agree that their health and care services seem to be well coordinated (increase).

NI5. Percentage of adults receiving any care or support who rate it as excellent or good (increase).

NI7. Percentage of adults supported at home who agree that the services and support they receive have had an impact in improving or maintaining their quality of life (increase).

NI9. Percentage of adults supported at home who agree that they feel safe (increase).

Programme/Project	Responsible Officer	Year 1 2023-2024	Year 2 2024-2025	Year 3 2025-2026	Strategic outcomes and measures	Measure of output
Focus on improving quality of care for people living with dementia and their families, and develop strategies to reduce the risk of people developing dementia.	Head of Mental Health, Learning Disability and Addictions	March 2024	March 2025	March 2026	O1, O2, O3, O4, O5 NI1, NI2, NI3, NI4, NI5, NI7, NI9	Implementation of a dementia strategy.

Healthy communities

National Health and Wellbeing Outcomes

O1. People are able to look after and improve their own health and wellbeing and live in good health longer.

Strategic measures: National Indicators (NI) and intended direction of change

NI1. Percentage of adults able to look after their health very well or quite well (increase).

NI11. Premature mortality rate (reduction).

Programme/Project	Responsible Officer	Year 1 2023-2024	Year 2 2024-2025	Year 3 2025-2026	Strategic outcomes and measures	Measure of output
Through the Health Improvement Team, develop a range of interventions linked to cancer prevention, sexual health, physical activity and substance use – the leading risk factors driving West Dunbartonshire's high burden of preventable ill health and premature mortality.	Head of Strategy and Transformation	March 2024	March 2025	March 2026	O1 NI1, NI11	Improvement in engagement data.

Digital Strategy Delivery Plan

The WDHSCP PMO Board will provide governance on individual workstreams supporting the aims of the Digital Strategy, as well as supporting the delivery of the HSCP Strategic Plan. Through the duration of the strategy it is expected that other workstreams will start up that have not been identified at this point.

National Health and Wellbeing Outcomes

O8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

O9. Resources are used effectively and efficiently in the provision of health and social care services

Strategic measures: National Indicators (NI) and intended direction of change

NI2. Percentage of adults supported at home who agree that they are supported to live as independently as possible (increase).

NI10. Percentage of staff who say they would recommend their workplace as a good place to work (increase).*

Scotland's Digital Health & Care Strategy Priorities

P1 Digital access – people have flexible digital access to information, their own data and services which support their health and wellbeing wherever they are.

P2 Digital services – Digital options are increasingly available as a choice for people accessing services and staff delivering them.

P3 Digital foundations – the infrastructure, systems, regulation, standards, and governance are in place to ensure robust and secure delivery

P4 Digital skills and leadership – digital skills are seen as core skills for the workforce across the health and care sector

P5 Digital futures – our wellbeing and economy benefits as Scotland remains at the heart of digital innovation and development

P6 Data-driven services and insight – data is harnessed to the benefit of citizens, services and innovation.

Information Systems						
Programme/Project	Responsible Officer	Year 1 2024-2025	Year 2 2025-2026	Year 3 2026-2027	Strategic outcomes and measures	Measure of output
Digital Telecare	Head of Strategy and Transformation	March 2025	March 2026	March 2027	O2, O9, NI2, P2, P3, P5, P6	Digital transition across systems and devices complete Digital technologies to improve experience of service users, responders and telecare staff.

Information Systems						
Programme/Project	Responsible Officer	Year 1 2024-2025	Year 2 2025-2026	Year 3 2026-2027	Strategic outcomes and measures	Measure of output
Case Management System Replacement	Head of Strategy and Transformation	March 2025	March 2026	March 2027	O8, O9, P2, P3, P6	Business case for system replacement including requirements and options for procurement. If agreed implementation of replacement case management system.
Care at Home Scheduling Systems Replacement	Head of Health and Community Care	March 2025	March 2026	March 2027	O8, 09, P2, P3, P6	Business case for system replacement including requirements and procurement options. If agreed implementation of replacement system.
Data Quality Improvement including RPA	Head of Strategy and Transformation	March 2025	March 2026	March 2027	O8, O9, P3, P6	Information stored on main HSCP systems reviewed and updated. Missing information recorded, any out of date service information closed down. RPA to resolve data issues and streamline processes.

Information Systems						
Programme/Project	Responsible Officer	Year 1 2024-2025	Year 2 2025-2026	Year 3 2026-2027	Strategic outcomes and measures	Measure of output
Business Intelligence	Head of Strategy and Transformation	March 2025	March 2026	March 2027	O9, P3, P5, P6	Improving use of information, including management information reports, dashboard type development using existing applications and Power BI.
Staff digital skills developments	Head of HR	March 2025	March 2026	March 2027	O9, NI10, D4	Improving HSCP Digital Maturity. Identifying areas of development and how best to offer training and development opportunities.
HSCP website development	Head of Strategy and Transformation	March 2025	March 2026	March 2027	O9, D1, D2, D3	Including increased use of online forms to support and provision of detailed information and signposting to support communities.
Care Opinion evaluation	Head of Strategy and Transformation	March 2025			O9, D1, D2	Potential implementation of Care Opinion to be explored, including cost benefit analysis and business case.

Several specific areas with the aim of improving digital literacy within the HSCP have been identified and detailed below. This will consider available training resources to support a baseline level of digital skills and literacy as identified in the Workforce Plan, as well as more advanced training for specific job requirements which covers systems, processes, and wider requirements to develop and improve the understanding, interpreting and utilising of performance information within services.

Digitally Enabled Workforce – training and support						
Programme/Project	Responsible Officer	Year 1 2024-2025	Year 2 2025-2026	Year 3 2026-2027	Strategic outcomes and measures	Measure of output
Developing Digital Literacy	Head of Strategy and Transformation	March 2025	March 2026	March 2027	O9, NI10, D4	Aiming to improve general levels of digital literacy across the workforce on an ongoing basis. Identification of appropriate baseline training
Advanced Digital Skills	Head of HR	March 2025	March 2026	March 2027	O9, NI10, D4	Specialist roles where specific training would be beneficial identified and suitable training identified and delivered. An example could be PowerBI training for Information Team or specific systems training provision for individual services.
Online training resources – either currently existing or potential for ad hoc development	Head of Strategy and Transformation	March 2025	March 2026	March 2027	O9, D4	Supporting development of digital literacy, skills and offering additional options for training to support new systems implementations.

Digitally Enabled Workforce – training and support						
Programme/Project	Responsible Officer	Year 1 2024-2025	Year 2 2025-2026	Year 3 2026-2027	Strategic outcomes and measures	Measure of output
Performance Management – understanding and using information	Head of Strategy and Transformation	March 2025	March 2026	March 2027	O8, O9, D4, D6	Focus on increased provision of management information. Need to ensure that leaders within the HSCP are offered support and development in how to interpret, utilise and apply change based on a well-developed understanding of information.
Widen engagement with WDC Digital Skills Support Framework including encouraging people to become Digi Champs within the partnership to provide support and demonstrate new digital ways of working	Head of Strategy and Transformation	March 2025	March 2026	March 2027	O9, D4	Existing WDC framework offers opportunities to be involved in provision of digital support within Teams.

AssessmentNo	872	**Owner**	Alastair.Handley	
Resource	HSCP		**Service/Establishment**	Joint
	First Name	Surname	**Job title**	
Head Officer	Alastair	Handley	Systems, Digital &Information Governance Manager	
	(include job titles/organisation)			
Members	Alastair Handley (Systems, Digital &Information Governance Manager) Robert Sullivan (Digital Business Lead) Bob Purdon (Health Improvement Lead) Fraser Downie (Mental Health IOM)			
	***(Please note: the word 'policy' is used as shorthand for stategy policy function or financial decision*)**			
Policy Title	West Dunbartonshire Health &Social Care Partnership Digital Strategy 2024 - 2027			
	The aim, objective,purpose and intended out come of policy			
	HSCP Digital Strategy covering 2024-2027, aim is to set out a number of key areas which the HSCP will focus on over the duration of the strategy to become a more digitally mature organisation. The strategy has an internal focus, identifying areas where progress would be required to improve digital maturity, linking back to a recent national digital maturity assessment exercise. Looks at structures in place to support change, identifying areas which will require focus and looking at opportunities moving forward. Outcomes will be in the enablement of individual projects that will support the strategy and changes to how digital skills are considered, developed and supported.			
	Service/Partners/Stakeholders/service users involved in the development and/or implementation of policy.			
	Across the HSCP including both parent organisations.			

Does the proposals involve the procurement of any goods or services?	**Yes**
If yes please confirm that you have contacted our procurement services to discuss your requirements.	**No**
SCREENING	
You must indicate if there is any relevance to the four areas	
Duty to eliminate discrimination (E), advance equal opportunities (A) or foster good relations (F)	**Yes**
Relevance to Human Rights (HR)	**Yes**
Relevance to Health Impacts (H)	**Yes**
Relevance to Social Economic Impacts (SE)	**Yes**
Who will be affected by this policy?	
The HSCP Digital Strategy will have an impact across both staff and service users. Internally whether through a focus on digital skills, using new systems or becoming more digitally aware as an organisation there will be an impact on staff. This isn't anything new as there are already systems in use along with use of digital technologies but would be supportive and offer solutions that should have a positive impact. For service users any digital strategy that would focus on the digital customer experience, digital channels and inclusion/exclusion will have an effect, and will bring benefits such as improved access to information and simplified processes for contacting HSCP including online forms, however should be clear that current means of accessing services e.g. telephone calls to duty services will be maintained. In addition and project that would support the digital strategy would be responsible for its own specific equality impact assessment.	

Who will be/has been involved in the consultation process?

Alastair Handley (Systems, Digital &Information Governance Manager) Robert Sullivan (Digital Business Lead) Bob Purdon (Health Improvement Lead) Fraser Downie (Mental Health IOM)

Please outline any particular need/barriers which equality groups may have in relation to this policy list evidence you are using to support this and whether there is any negative impact on particular groups.

	Needs	Evidence	Impact
Age	Barrier - numbers of people without internet access who could not make best use of digital channels, suggestion that this has a higher impact on older age groups.	The Scottish Household Survey 2021 indicated that the proportion of households with internet access had risen across all households, however there are a number of factors impacting on access including age.	Retaining existing non-digital routes will ensure no negative impact. For all age groups, possibly younger more engaged in particular although exclusion can still be an issue, potential for positive impact of digital access to information and / or resources 24/7. In addition potential positive impact on families of older people who have other routes to access information.
Cross Cutting	Barrier - identified through Citizens Panel 2023, barriers around online safety, low level of digital skills, poor mobile reception were identified alongside costs of broadband and devices/	Citizens Panel 2023 identified barriers around online safety, poor mobile reception alongside cost of broadband and devices. Should be noted that 71% noted no barriers to digital communications and 80% of responders were aware of sources of digital support.	Retaining existing non-digital routes will ensure no negative impact. Similar to socio-economic impact. If HSCP can play a role in raising awareness of available digital support with service users both awareness and barriers may become less of an issue.
Disability	Barrier - specific accessibility type software may be required to support digital access.	Based on experience of supporting users who used Jaws screen reader	Retaining existing non-digital routes will ensure no negative impact. Don't think this would act as a further exclusion given alternative routes. Many people affected may already be digitally aware

			and have software in place to support general use but this could form part of any focus on digital inclusion.
Social & Economic Impact	Barrier - cost of being online and accessing equipment. Need - explore potential of facilitating use of reconditioned laptops and tablets for all groups. Provision of devices and free WiFi in libraries and other community venues.	Feedback captured at World Cafe Mental Health events in this area, similar issues arise across all client groups. As detailed above, digital strategy will look at areas such as improving digital channels however current non-digital routes will be maintained. Opportunities for improving digital inclusion through partners is a key element of the digital strategy to support inclusion.	Retaining existing non-digital routes will ensure no negative impact. Focus on digital inclusion may have a positive impact on this area given focus on devices and potential for identifying needs to training and support within communities
Sex			
Gender Reassign			
Health			
Human Rights			
Marriage & Civil Partnership			
Pregnancy & Maternity			
Race			
Religion and Belief			
Sexual Orientation			

Actions

Policy has a negative impact on an equality group,but is still to be implemented, please provide justification for this.

Will the impact of the policy be monitored and reported on an ongoing bases?

Delivery plan will be written up alongside the strategy focusing on individual projects which can then be monitored and reported on through HSCP Governance including reporting to Senior Management Team and HSCP Board/Audit &Performance.

Q7 What is you recommendation for this policy?

Intoduce

Please provide a meaningful summary of how you have reached the recommendation

The HSCP Digital Strategy will help provide the HSCP, including its Senior Management Team and Board, with a focus on the potential for digital developments across a number of areas that will

bring together change projects within the HSCP with digital focus and set out areas where attention, focus and developments will be required. The strategy will allow the HSCP to improve its digital maturity, which is a key Scottish Government focus, by looking to improve position across systems used, digital skills, access to information and governance structures. It should also serve to increase awareness and visibility of digital within the HSCP. The hope would be that a number of areas identified would bring benefits both within the HSCP and for members of the public looking to engage either for information or services and have a positive impact on inclusion, engagement and support provided. Although digital exclusion is clearly an issue, which has been identified and will be actioned through the strategy, the strategy itself will not impact on access to HSCP services through existing routes.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Report by Val Tierney, Chief Nurse

27 June 2024

Subject: Clinical and Care Governance - Annual Report 2023

1. Purpose

1.1 The Clinical and Care Governance Annual Report 2023 describes the clinical and care governance oversight arrangements in West Dunbartonshire HSCP and the progress made in assuring and improving the quality of health and social care. The purpose of this report is to provide assurance that health and care governance systems are in place to support the HSCP in monitoring and improving the quality of health and care that it provides. This includes services that are hosted, provided jointly with partner organisations, or commissioned from external providers. Key achievements and any risks and challenges to care quality are reflected in the report.

2. Recommendations

2.1 Members of the IJB are asked to approve the report. This report will also be sent to NHS Greater Glasgow and Clyde Health Board (NHSGGC) as all HSCPs are requested to provide an Annual Report covering the role and remit of the group and any future plans for review and evaluation of care quality.

3. Background

3.1 Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured and that staff are supported in continuously improving the quality and safety of care. This ensures that good performance is highlighted and poor performance is identified and addressed.

3.2 The aim in monitoring clinical and care quality aligned to the principles of good governance, is to engage and involve people in ensuring clinical and care quality is associated with public transparency, meaningful accountability requirements and robust organisational arrangements for clinical governance.

3.3 The report is structured around the three main domains set out in the National Quality Strategy: Safe, Effective, and Person-Centred Care.

3.4 Each HSCP is requested by NHSGGC to provide an Annual Report of the clinical and care governance activity.

4. Main Issues

4.1 The report describes West Dunbartonshire HSCP Clinical and Care Governance arrangements confirming these are in accordance with the Clinical and Care Governance Framework as set out by the Public Bodies (Joint Working) (Scotland) Act 2014, which details 'Five Process Steps to Support Clinical and Care Governance'

1. Information on the safety and quality of care is received
2. Information is scrutinised to identify areas for action
3. Actions arising from scrutiny and review of information are documented
4. The impact of actions is monitored, measured and reported
5. Information on impact is reported against agreed priorities

These align with the seven core components of Clinical and Care Governance as set out by NHS Greater Glasgow & Clyde:

1. Client-centred services
2. Developing and applying the knowledge base for professional practice
3. Safe and reliable services
4. Enhancing clinical effectiveness
5. Quality assurance and accreditation
6. Supporting and developing practitioners
7. Information, communication and co-ordination

4.2 The approach to clinical and care governance within the HSCP is maturing in alignment with NHS Greater Glasgow and Clyde Health Board's statutory duty for care quality (The Health Act 1999) and West Dunbartonshire Council Social Work and Social Care governance framework. This approach recognises the complex interdependencies in delivering safe effective person centred care in an integrated context.

4.3 This annual Clinical and Care Governance report illustrates the progress made in re-establishing and developing our care assurance processes. It details how care governance arrangements have been strengthened across services, and describes ongoing developments to ensure we have the same level of maturity in terms of scrutiny, reporting capability, and robust quality control and assurance processes across all service areas including those services commissioned by the HSCP. Selected examples demonstrate the significant efforts deployed to achieve continuous improvement and support the delivery of value based health and social care services, focussed on achieving the best outcomes for our service users while using resources wisely.

4.4 Selected examples from service have been used to demonstrate the quality of service provision. These are not exhaustive, but illustrate the range of activity ongoing to realise the three quality ambitions of safe, effective, and person centred and reflect our efforts to strive for continuous quality improvement.

4.5 The report also highlights key priorities for 2024 -25.

5. Options Appraisal

5.1 N/A

6. People Implications

6.1 There are no human resource implications

7. Financial and Procurement Implications

7.1 N/A

8. Risk Analysis

8.1 NHSGGC duty for care quality applies to all services provided with respect to prevention, diagnosis and treatment of illness and includes services that are provided jointly with partner organisations. This legal responsibility for quality of care is equal in measure to their other statutory duties.

8.2 Within the Health and Social Care Partnership the Chief Officer is accountable for ensuring the clinical and care governance requirements specified in the approved integration schemes are appropriately discharged.

8.3 Clinical and care governance is the mechanism by which that responsibility is discharged. Failure to discharge these responsibilities risks breaching a statutory duty for care quality, and could also result in reputational risk to the organisation. Failure to assure clinical and care governance across the new integrated arrangements could result in poor standards of care, poor outcomes for service users and their families.

8.4 Staff recruitment, retention and financial challenges all pose a credible risk to care quality making it critically important that we continued to strengthen our assurance and oversight arrangements to secure assurance and mitigate emerging threats.

8.5 The Care Home sector remains vulnerable. Enhanced support, oversight and assurance arrangements for local care homes ensured that emerging risks were identified early, robustly managed and care quality maintained. This has provided a solid foundation for partnership working to support ongoing quality improvement ambitions.

8.6 Care governance arrangements have been strengthened across services, and work is ongoing to ensure we have the same level of maturity in terms of scrutiny, reporting capability, and robust quality control and assurance processes across all service areas including those services commissioned by the HSCP.

9. Equalities Impact Assessment (EIA)

9.1 Not required as the report does not introduce new policy or strategy. Robust clinical and care governance ensures that the needs of protected groups are considered. All aspects of clinical and care governance seek to address avoidable variations in outcomes for service users.

10. Environmental Sustainability

10.1 N/A

11. Consultation

11.1 All service areas contributed to the report. The report was also submitted to HSCP Audit and Performance Committee 20.06.2024.

12. Strategic Assessment

12.1 Robust clinical and care governance contributes to the achievement of National Wellbeing Outcomes and West Dunbartonshire HSCP's strategic priorities and, the national quality ambitions of the delivery of safe, effective person centred care.

13. Directions

13.1 No directions required.

Name
Valerie Tierney

Designation
Chief Nurse

Date 18.06.2024

Person to Contact: Val.Tierney@ggc.scot.nhs.uk

Appendices:

Appendix 1: West Dunbartonshire HSCP Annual Clinical and Care Governance Report 2023 - 24

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire

Health and Social Care Partnership

Annual Clinical & Care Governance Report

2023

Contents

1. Introduction

1.1 Each Health and Social Care Partnership is requested by NHS Greater Glasgow and Clyde to provide an Annual Clinical and Care Governance Report. The Health Act 1999 requires that NHSGGC "put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals".

1.2 This report demonstrates West Dunbartonshire Health and Social Care Partnerships (WDHSCP) approach to assuring and improving the quality of health and care services we provide. Recognising the complex interdependencies in delivering safe effective person centred care in an integrated context it is also cognisant of West Dunbartonshire Council Social Work and Social Care governance framework.

1.3 The report outlines arrangements for Clinical and Care governance in WDHSCP and is framed around the three Quality ambitions outlined in NHS Scotland Quality Strategy; Safe, Effective, Person Centred Care. The Healthcare Quality Strategy sits within the context of the Patients' Rights Act which became law in Scotland in 2011. This provides a legal basis requiring the NHS in Scotland to provide care, which is person centred, safe and effective.

1.4 This report describes West Dunbartonshire HSCPs arrangements for scrutiny of care quality, within the services which the HSCP provides, and those that it commissions. A selection of activities and interventions are also highlighted to demonstrate our strong focus on quality improvement, these are illustrative rather than comprehensive.

2. West Dunbartonshire Health and Social Care Partnership

2.1 West Dunbartonshire Health and Social Care Partnership (HSCP) was established on 1st July 2015 as the Integration Authority for West Dunbartonshire in response to the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

2.2 The Vision of West Dunbartonshire Health and Social Care Partnership is '*Improving lives with the people of West Dunbartonshire'* through achievement of our strategic outcomes.

2.3 West Dunbartonshire HSCP employs over 900 health, social work and social care staff. There is also a significant workforce in the independent NHS contractor service for example, GPs, Dentists, Optometrists, and Community Pharmacists and third sector and independent social care providers. West Dunbartonshire HSCP hosts Musculoskeletal Physiotherapy and Diabetic Retinopathy services on behalf of NHSGGC.

2.4 Between 2018 and 2028, the population of West Dunbartonshire is projected to decrease from 89,130 to 87,141. This is due to fewer babies being born each year and more people moving out of the area than moving in. 18% of the population are aged 0-15, and 9.7% of the population are aged 16-24. In terms of overall size, the 45 to 64 age group remains the largest at 25, 6646 (29%).People aged 65 and over make up 19% of West Dunbartonshire's population, which is similar to Scottish population.

2.5 West Dunbartonshire contains the third equal highest share of the most deprived data zones out of Scotland's 32 local authority areas. 22.6% of children live in low income families. Life expectancy is lower than the Scottish average with those living in the most deprived communities spending, on average 24 years fewer in good health than those

living in the least deprived areas. With those in the most deprived areas also dying younger, they spend more than one third of their lives in poor health. Healthy life expectancy has decreased in West Dunbartonshire to 58.1 years for males and 58.5 for females.

2.6 The World Health Organization ended the global emergency status for COVID-19 on 5th May 2023 more than three years after its original declaration. However for our service users and their families the impact of the pandemic and the cost of living crises have exacerbated inequalities. Access to some health and care services has proved challenging, and led to longer wait for services at a time of increased need for support within the community. This has resulted in pressure for both staff and service users.

2.7 Budget Setting has highlighted the financial pressures the Partnership is facing. There is evidence that poor quality increases costs through harm, waste and variation. It is imperative therefore that we remain assured of our ability to deliver high quality care whilst overcoming the financial challenges.

2.8 Delivering the best possible outcomes for the people of West Dunbartonshire is contingent on, supporting our staff to deliver high quality care and optimising the use of resources to deliver high quality community-based services, particularly for those with higher levels of need, while keeping more people safe at home. Equally we need to adopt a collaborative approach that ensures people have choice and control over the services they receive.

3. Clinical Governance Arrangements

3.1 Clinical and Care Governance is the framework through which the Health and Social Care Partnership (HSCP) provides accountability for safe guarding high quality care and of continuously improving the quality of service provision.

3.2 The Public Bodies (Joint Working) (Scotland) Act 2014 requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. West Dunbartonshire HSCP Clinical and Care Governance Group (WDHSCP CCGG) works in accordance with the Clinical and Care Governance Framework set out by the Public Bodies (Joint Working) (Scotland) Act 2014, which details 'Five Process Steps to Support Clinical and Care Governance',

1. Information on the safety and quality of care is received
2. Information is scrutinised to identify areas for action
3. Actions arising from scrutiny and review of information are documented
4. The impact of actions is monitored, measured and reported
5. Information on impact is reported against agreed priorities

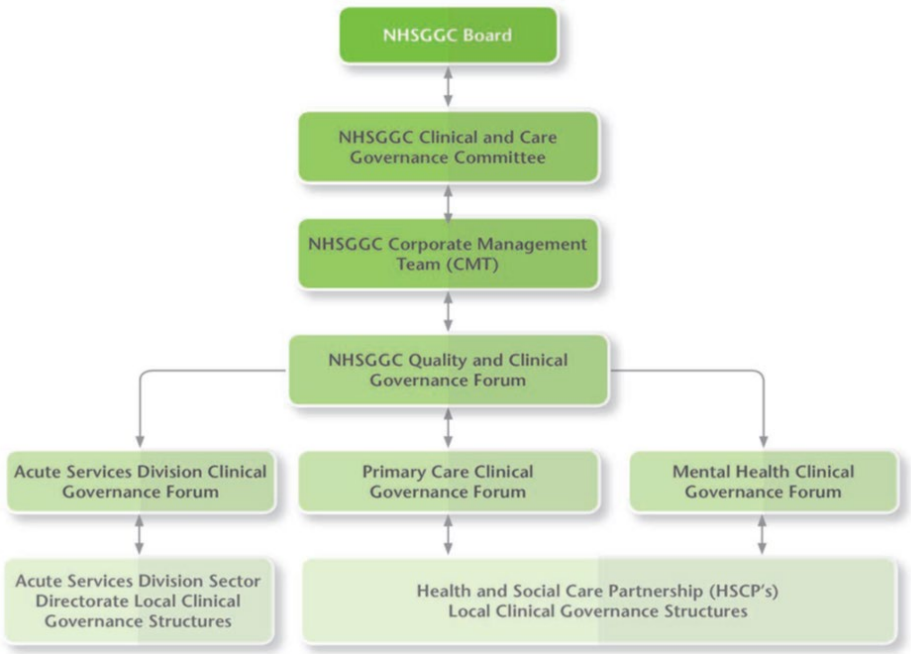
These are complementary to the seven core components of Clinical and Care Governance as set out by NHS Greater Glasgow & Clyde:

1. Client-centred services
2. Developing and applying the knowledge base for professional practice
3. Safe and reliable services
4. Enhancing clinical effectiveness
5. Quality assurance and accreditation
6. Supporting and developing practitioners
7. Information, communication and co-ordination

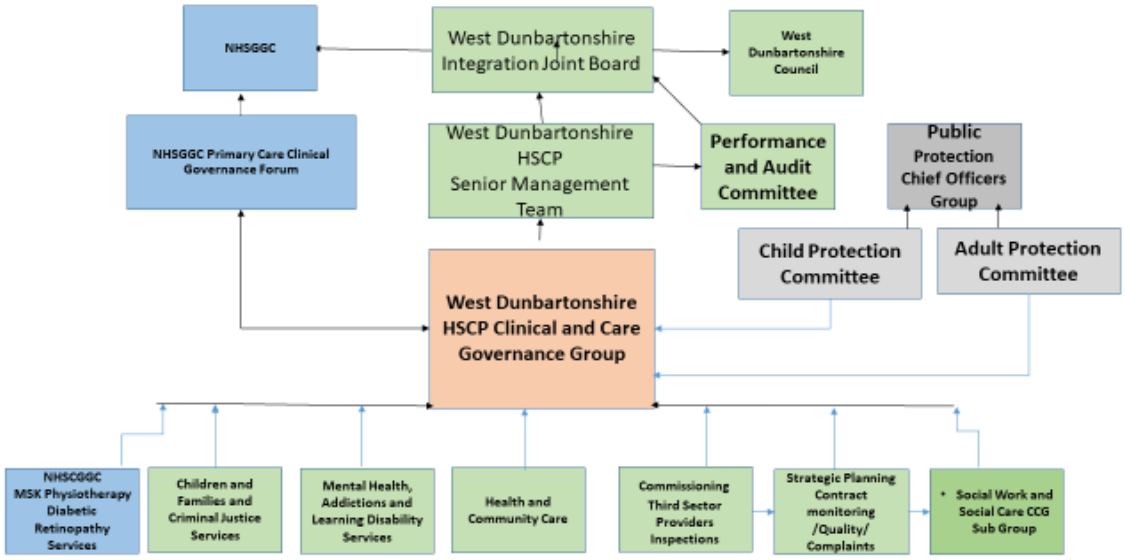
3.3 The Public Services Reform (Scotland) Act 2010 places a duty on a range of scrutiny bodies to co-operate and coordinate their activities with each other, and to work together to improve the efficiency, effectiveness and economy of their scrutiny of public services in Scotland. A number of scrutiny bodies have an interest in how the health and social care agenda is developing including the Care Inspectorate, Accounts Commission, Health Improvement Scotland and the Auditor General for Scotland. Each have distinct statutory responsibilities for the audit, scrutiny and improvement of organisations providing health and care services in Scotland. This external scrutiny provides assurance and supports our internal contract monitoring arrangements with our external partner providers. The Health and Care Partnership work jointly with external scrutiny bodies and our external partner providers to participate in any regulation or scrutiny activity. Care services in Scotland must be registered with the Care Inspectorate.

3.4 During 2023 our approach to clinical and care governance continued to evolve. Scrutiny and assurance was strengthened with the wider inclusion of social work and social care services within Clinical and care Governance arrangements. Oversight of social work and social care quality has been enhanced and fully incorporated into our clinical and care governance activity and a Social Care and Social Work CCG sub group led by CSWO has been established. Our contract monitoring team work closely with senior managers to maintain close working relationships with care home providers and commissioned services providers to enhance scrutiny and oversight of any complaints or concerns raised.

3.5 Figure 1 NHSGGC Corporate Level Clinical and Care Governance Arrangements



3.6 Figure 2: West Dunbartonshire HSCP Clinical and Care Governance Arrangements



3.7 The Role of West Dunbartonshire HSCP Clinical & Care Governance Group

a) Consider matters relating to strategic plan development, governance, risk management, service user feedback, complaints, standards, care assurance, education, professional registration, validation, learning, continuous improvement and inspection activity.

b) Provide assurance to the Health & Social Care Partnership Board, the Council and NHSGGC, via the Chief Officer, that the professional standards of staff working in Integrated Services are maintained and that appropriate professional leadership is in place.

c) Review significant and adverse events and ensure learning is applied. Support staff in continuously improving the quality and safety of care. Ensure that service user / patient views on their health and care experiences are actively sought and listened to by services.

d) Create a culture of quality improvement and ensure that this is embedded in the organisation by facilitating improvement activity including self-evaluation and clinical governance actions. Provide oversight and assurance regarding the quality and safety of care including public protection, inspections and contract monitoring.

e) The Clinical Director chairs the HSCP CCG group and the Chief Social Work Officer is Co- Chair. The membership includes the Chief Nurse, the Heads of Service from all HSCP services areas including hosted services and a representative form NHSGG&C Clinical Risk Department.

f) The Chief Social Work Officer has a core responsibility to provide professional oversight and leadership regarding the provision of social work services and to ensure that the social services workforce practices within the standards and codes of

practice as set out by the Scottish Social Services Council (SSSC). This complementary activity is captured within the Chief Social Work Officers Annual Report which is shared with the Clinical and Care Group to provide assurance on statutory social work functions.

g) The Clinical Director completes an exception report four times per year to submit to the Primary Care Clinical and Care Governance Forum (PCCCGF). The exception report is shared with the HSCP Senior Management Team as per local governance arrangement's to ensure all pertinent matters are reported from respective services. HSCP Services also report to NHSGGC board wide Mental Health, Learning Disability, and Specialist Children's Services Clinical and Care Governance Systems.

h) There has been ongoing reflection on the purpose and direction of the group and the role of clinical and care governance, and the quality agenda within the Strategic Plan.

3.8 West Dunbartonshire HSCP is committed to moving away from transactional based commissioning to a more outcomes focused collaborative commissioning underpinned by ethical commissioning standards. Standardising our approach to commissioning supports the future implementation of the Service Improvement and Quality Assurance Frameworks in line with WD HSCPs strategic plan.

4. **Safe: '***There will be no avoidable injury or harm to people from the care they receive, and an appropriate, clean and safe environment will be provided for the delivery of all services at all times'*.

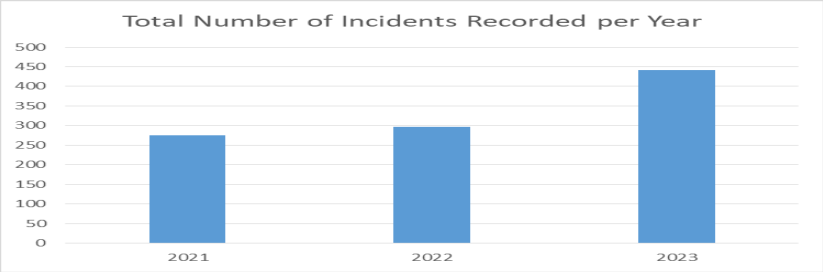
Clinical and Care Risk Management

4.1 Datix is the NHS Greater Glasgow & Clyde incident risk management and patient safety system used to capture clinical incident activity within health services delivered by West Dunbartonshire HSCP including Board Wide Musculoskeletal (MSK) Physiotherapy and Diabetic Retinal Screening Services (DRSS). The system is used to systematically identify and measures risks faced by the organisation with the focus on learning so that we might reduce or eliminate future risk.

4.2 NHSGCC Incident Management Policy mandates 28 calendar days from the date of reporting an incident to final approval. Improvement activity in 2021 resulted in a significant decrease in the number of overdue incidents awaiting approval. This improvement has not been sustained throughout 2023 and will require further focussed activity.

Number of Clinical and Care Incidents Reported

4.3 The total number of recorded incidents recorded continues to increase year on year as shown in Table 1.



Incident Category

4.4 Incidents were reported across twenty two incident categories. The top incident categories are shown in Table 2. Pressure ulcers accounted for the highest recorded category This is a reflection of more effective use of the Datix system following general awareness raising sessions and to targeted quality improvement activity e.g. recording of pressure ulcer incidents increased by 69% Jan – June 2023 compared to the previous six month period. The majority of slips trips and falls occurred in older adult mental health services and most resulted in minor or no harm to the patient.

Table 2:

Categories	C&F	Clyde Sector	Corporate Services	Community	Retinal Screen	MSK Physio	MHS	PPSU	PH	SCS	Total
Pressure Ulcer Care	0	0	0	97	0	0	0	0	0	0	97
Slips. Trips and Falls	0	11	1	5	0	1	65	0	0	0	83
Other	1	0	0	20	0	4	41	1	0	0	67
Violence and Aggression	0	0	0	0	0	0	27	0	0	0	27
Medication Prescribing	0	0	0	0	0	0	2	22	0	2	26
Information Governance	1	0	0	11	0	1	8	0	0	0	21
Medication dispensing Supply	0	1	0	1	0	0	8	5	0	0	15
Challenging Behaviour	0	0	0	4	0	0	9	0	0	0	13
Treatment Problem	0	0	1	8	0	4	0	0	0	0	13
Medication Administration	0	0	0	5	0	0	3	1	2	0	11
Communication	1	0	2	5	0	0	2	0	0	0	10
Health records	0	0	1	1	0	3	0	0	0	0	5
Suicide	0	0	0	0	0	0	2	0	0	1	3
Medical devices /Equipment	0	0	0	2	0	0	1	0	0	0	3
Total	3	12	5	159	0	13	168	29	2	3	394

Severity of Clinical and Care Incidents

4.5 Table 3:

Severity	1- Negligible	2 - Minor	3 – Moderate	4 – Major	5- Extreme	Not Recorded	Total
Children & Families	0	3	2	0	0	0	5
Clyde Sector	4	9	0	0	0	4	17
Corporate	2	3	0	0	0	0	5
HCC	35	96	17	2	5	19	174
MHS	50	92	16	2	27	3	190
MSK	6	6	1	0	0	1	14
PPSU	19	9	3	0	0	1	32
Public Health	0	0	0	0	0	2	2
Retinal Screening	0	0	0	0	0	0	0
SCS	1	0	1	0	1	0	3
Total	117	218	40	4	33	30	442

4.6 All incidents are ascribed a severity score using NHSGGC risk matrix and severity impact assessment. Minor and negligible incidents may require to be investigated in addition to the review and approval process. This is at the discretion of the line manager who receives the report. If the severity is minor or low this does not mean that the incident can be ignored. These incidents represent small failures and vulnerabilities that may signal action to avoid repeat or escalation of a situation. The opportunity for learning exists at times without a significant adverse outcome for the patient, e.g. a near miss or a lower impact incident which exposes potential clinical system weaknesses that could lead to further significant harm.

4.7 Moderate rated incidents are reviewed by the Local Management Teams and action plans drawn up to eliminate or reduce the risk of recurrence. If the rating is a 4-Major, or 5- Extreme, there must be an investigation of causation. For all incidents severity graded 4 or 5 there is discussion and with the Clinical Risk Team, Clinical Director and Manager to determine whether the severity of the incident is such that it merits formal classification as a 'Significant Incident' requiring a Significant Adverse Event review. This is not necessarily the case for all category 4/5 incidents. Most category 4/5 incidents occur in mental health and addiction services. Incidents are rarely due to a single act or omission. Usually an incident occurs because of a combination of actions, events and the surrounding circumstances.

Significant Adverse Event Reviews (SAER)

4.8 From the full range of clinical incidents reported there is a smaller set of instances where there is a risk of significant harm to patients. We ensure these incidents are appropriately investigated to minimise the risk of recurrence by applying lessons learned. These events are referred to as Significant Adverse Events (SAE). These are usually incidents that have been categorised as severity 4 or 5. These may lead to a significant adverse event review (SAER).

4.9 The purpose of the review is to determine whether there are learning points or improvements for the service and wider organisation. It is then our responsibility to implement those improvements that are identified as producing a greater level of safety for those we care for.

4.10 SAERs Commissioned January – December 2023 - Table 4
There were eight SAERs commissioned

Table 4

Speciality	No. of SAERs Commissioned
Addiction Services	
Learning Disability (Community Team)	1
MH - Crisis team (Mental Health)	1
MH - Community Mental Health Team	3
MH – Older Adults Community Mental Health Team	2
HCC - District Nursing	1
Total	8

4.11 SAERs Concluded January – December 2023 – Conclusion Codes

Eleven SAERs were concluded during 2023. Nine by Mental Health Services and, and two by HCC. On completion a conclusion code is allocated to reflect findings.

Table 5

SAER Conclusion Code		No.
1.	Appropriate Care Well Planned	2
2.	Issues Identified but they did not contribute to the event	3
3.	Issues Identified which may have contributed to or caused the event	5
4.	Issues identified that directly related to the cause of the event	1
	Total	11

4.12 Learning from SAERs

a) The learning from all reviews is shared within WDHSCP and across NHSGGC. Actions plans are created to address findings. Completion of SAER actions is monitored via the Clinical and Care Governance Group. A common theme identified across all SAERs was the need for enhanced assessment, analysis and management of risk, and service areas have reflected and acted upon findings introducing new risk assessment tools, strengthening audit to provide assurance around compliance with policy and practice guidance.

The SAER with a conclusion code 4 (Issues identified that directly related to the cause of the event) related to weight management and management of chronic low body weight in Learning Disability Teams. Actions were identified for the team to support improvement and review of weight management processes. These included

- Audit of use of the Multidisciplinary Universal Screening tool (MUST) and weight management recording on EMIS.
- Development of a Standard Operating Procedure for weight management within the team.
- Attendance of senior social work and duty social worker at health allocations meetings and note of meeting recorded on CareFirst.
- Completion of face to face MUST training and Food Fluid and Nutrition (FFN) modules.
- Audit of allocations meetings regarding attendance compliance with processes.

b) All healthcare staff in the Community Learning Disability Team participated in a face-to-face session regarding MUST completion in the last quarter of 2023. Monthly FFN audits have been completed within the team with December reporting at 60% compliance and then increasing to 91% compliance in February. There has also been the development of a Weight Management standing operating procedure for the team and our Health Care Support Workers (HCSW) now run a weight management clinic weekly at our local day service, and any concerns are raised and discussed through the weekly team allocations meeting. Plans are also in place to trial an initial appointment clinic to support triaging of referrals on waiting list and allow the team to gain weight and nutrition information at the point of referrals being accepted.

b) Adult mental Health and Addiction services have established an incident review group which meets fortnightly to establish concerns subsequently leading to a full review of the care provided in the year prior to any patient's death from suicide. This ensures lessons learned are actioned and crucially identifies good practice and areas where practice could be improved. Investigations of this nature are undertaken by clinicians in other sectors of the board to ensure impartiality. This helps identify areas for improvement in caring for the highest risk patients and is yielding encouraging results.

c) There were 32 open SAER actions West Dunbartonshire 11 of which were overdue (Dec 2023). This remains a focus for ongoing improvement.

d) A cross HSCP Child Protection Quality group was established in 2022. This group discuss and disseminate the learning from all Child Protection SAERs across the six HSCPs in NHSGGC and to seek assurance from all HSCPs that the requisite actions have been implemented. Between April 23 and March 24 there were 15 CP SAERs concluded across NHSGGC. Learning and associated actions related to strengthening documentation and assessment, learning and development to support more effective management of neglect, developing trauma informed practice and enhancing supervision and audit processes. Work has been progressed in relation to all identified actions.

4.13 SAERs – Key performance Indicators

NHSGGC Policy on the Management of Significant Adverse Events was refreshed in 2023. There is recognition of the risk to individuals' practitioners and the organisation that drift in the SAER process introduces. Key performance indicators were introduced to support improvement in this area. These state that reviews should be commissioned within ten days of the incident being reported and concluded within three months of the event.

None of our SAERs have been commissioned or completed within these time frames. Of the SAERs concluded in 2023 all were active for a period of more than 12 months. To date in order to secure the requisite improvement efforts have been made to increase the number of staff trained to undertake and lead a SAER. Improvement in adherence to SAER KPI will feature in the HSCP CCG Action plan 2024-25.

<u>Duty of Candour</u>

4.14 The organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (The Act) and The Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm)

.

Six of the SAERS met the threshold for organisational duty of candour and all necessary steps were taken to fulfil the duty.

Public Protection

4.15 Through the wider Public Protection agenda, the Health and Social Care Partnership work to ensure that people, particularly those at risk, are kept safe from harm and risks to individuals and groups are identified and managed appropriately. The Public Protection Chief Officers Group (PPCOG) holds responsibility for strategic leadership, scrutiny, and accountability in respect of public protection services. This incorporates a range of measures including multi agency strategic planning and operational services providing protections to children, young people and adults at risk. Management of high risk offenders through Multi Agency Public Protection arrangements (MAPPA), Alcohol and drugs Partnership, Violence Against Women Group, and Community Safety.

4.16 PPCOG continue to strengthen their assurance and risk management processes. This includes quarterly review of multiagency, operational and strategic risk registers. The PPCOG Performance and Assurance Reporting Framework data set continues to be developed.

4.17 NHS GGC Public Protection Unit developed a Public Protection Strategy and Quality Assurance Framework during 2023. This will support and enhance oversight of corporate and local HSCP monitoring of compliance with requisite standards.

Learning Reviews

4.18 National Lead Review Guidance was published by the Scottish Government in Sept 2021 for Child Protection Committees, and in May 2022 for the Adult Protection Committees, replacing Initial and Significant Case Review Guidance.

4.19 A Learning Review is multi-agency, bringing practitioners together with the review team in a structured process in order to reflect, increase understanding and identify key learning. They provide a means for public bodies and office holders with responsibilities relating to the protection of adults and children at risk of harm to learn lessons by considering the circumstances where an adult or child at risk has died or been significantly harmed. They are carried out by the Adult / Child Protection Committees under their functions of keeping procedures and practices under review, giving information and advice to public bodies and helping or encouraging improvement.

4.20 During 2023 West Dunbartonshire Adult Protection Committee commissioned and concluded one themed learning review. One further individual learning review was commissioned.

4.21 West Dunbartonshire Child Protection Committee commissioned one Child Learning review. Another Learning review is currently on hold due to an ongoing criminal investigation.

5. **Effective: '***care at the right time, right place by right person and no unnecessary variance in quality of care and outcomes for service users'.*

The Health and Social Care Standards published in 2018, set out what individuals can expect when using health, social work or social care services in Scotland. They aim to ensure better outcomes for everyone, that people are treated with respect and dignity, and that basic human rights are upheld. The Care Inspectorate, Health Improvement Scotland and other scrutiny bodies all take cognisance of these standards in relation to their work around inspection and registration of health and care services.

Older Peoples Care Homes

5.1 Maintaining high quality care in Care Homes remains a key priority within the partnership. Care homes environments continue to be susceptible to the coronavirus with elderly residents at risk of poorer outcomes due to pre-existing conditions, However the success of the Covid booster programme and high uptake achieved (>95% of those residents eligible) means that our residents are protected and the impact of Covid 19 has been successfully reduced. Nonetheless the care home sector continues to face challenges in terms of recruitment and retention of staff and commercial viability.

5.2 West Dunbartonshire HSCP Collaborative Care Home Support Team (CCHST) continues to work in collaboration with care homes, to focus on improvement, sustainability and viability. This ensures that local assurance and support arrangements link effectively with, rather than duplicate, wider regulation activity by the Care Inspectorate.

5.3 Care assurance visits are one part of the supportive framework around care homes and sit alongside HSCP commissioning relationships with individual care homes and daily care home huddle reports via TURAS.

5.4 Care Assurance Visits are undertaken by the CCHST twice per year for each care home and more often if required. Visits provide the opportunity to discuss with care homes areas of strength as well as key improvement priorities. Following visits liaison with NHGGC Care Home Collaborative (CHC) supports access to support for care homes to help them secure identified improvements in care equality. The visits focus on four key themes:

- Theme 1 - Infection Prevention Control; Environment, Cleaning, PPE, Handwashing Laundry and waste Management.
- Theme 2 – Resident Health Care Needs; Anticipatory Care Planning, Caring for People at end of life, Caring for People with Cognitive Impairment
- Theme *3* – Workforce Leadership and Culture; Staffing resource and Staff Wellbeing
- Theme 4- Action Planning for Assurance and Continuous Improvement

5.5 The Collaborative Care Home Support Team (CCHST) is focusing on implementation of the Healthcare Framework for Care Homes, with multidisciplinary support to care home residents and a quality management approach based on the Health and Social Care Standards.

5.6 Crosslet and Queens Quay Local Authority residential care homes have worked with NHSGGC Care Home Collaborative to introduce Project Milkshake. The milkshake project is a pilot programme led by NHSGGC Care Home Collaborative team to measure effectiveness of nutritional value of fortified drinks and approved recipes by dieticians. This has had a positive impact for residents. Five residents commenced the project and over a four week period their Multidisciplinary universal screening tool for malnutrition (MUST) scores improved.

External Scrutiny - Care Inspectorate Inspection West Dunbartonshire Care Homes

5.7 The Care Inspectorate is responsible for inspecting standards of care in Scotland. They use a quality framework that sets out key elements to help answer key questions about the difference care is making to people, and the quality and effectiveness of the things that contribute to that. The primary purpose of a quality framework is to support services to self-evaluate their own performance. The same framework is then used by inspectors to provide independent assurance about the quality of care and support.

5.8 The Care Inspectorate now use Key Questions rather than Quality Themes in their inspections. Key Questions:-

KQ1 – How well we do we support people's wellbeing;
KQ2 – How good is our Leadership;
KQ3 – How good is our staff team;
KQ4 – How good is our setting;
KQ5 – How well is our care and support plan
KQ6 – Capacity for improvement

They still use the six point scale of 1 – Unsatisfactory, 2 – Weak, 3 – Adequate, 4- Good, 5- Very Good, to 6 – Excellent in grades awarded against each quality indicator.

5.9 The Care Inspectorate uses requirements and recommendations to help regulated care services improve. A requirement is a statement which sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in the Public Services Reform (Scotland) Act 2010t, its regulations, or orders made under the Act, or a condition of registration. Requirements are enforceable in law. A recommendation is a statement that sets out actions that a care service provider should take to improve or develop the quality of the service, but where failure to do so would not directly result in enforcement.

5.10 Six of the ten care homes in West Dunbartonshire were inspected between April 2023 and March 2024. The grades awarded are depicted in Table 6. Of these four had requirements and had areas for improvement identified.

Table 6

Care Home	Date of Inspection	Inspection Grades					No of Requirements	No of Areas for Improvement
		KQ 1	KQ 2	KQ 3	KQ 4	KQ 5		
Clyde Court	25.05.23	2	2	3	2	N/A	8	5
Clyde Court	24.08.23	3	3	3	3	N/A	0	0
Kingsacre	19.06.23	4	4	4	5	3	0	4
Castle View	27.06.23	3	3	3	3	3	7	9
Castle View	21.09.23	4	4	4	N/A	4	0	2
Hill View	07.08.23	4	3	N/A	N/A	4	1	0
Hill View	23.11.23	N/A	4	N/A	N/A	N/A	0	0
Edinbarnet	04.09.23	4	4	N/A	N/A	N/A	0	3
Alderwood House	13.11.23	2	2	2	2	2	8	0
Alderwood House	23.01.24	3	3	3	3	3	0	0

5.11 Due to grades awarded at the inspection on 25.05.23 it was agreed with the Provider that a Moratorium on admissions would be placed on Clyde Court until sufficient progress had been made to meet the 8 requirements detailed within the inspection report. At the inspection in August 2023 the Care Inspectorate confirmed that all 8 requirements had been met. This was a result of the hard work of the Management and staff team and their willingness to embrace the support offered from the HSCP and Care Home Collaborative teams. The moratorium on placements was removed on 25 August 2023. Work is ongoing with HSCP and Care Home Collaborative to ensure improvement is sustained and the service continues to improve.

5.12 Due to the grades awarded and nature of the requirements highlighted following the inspection in Oct/Nov 2023 it was agreed with the Provider that a Moratorium on admissions would be placed on Alderwood House until sufficient progress had been made meet the 8 requirements. The HSCP also took the decision to undertake an Adult Protection Large Scale Investigation (LSI) due to the number and nature of the Adult Protection referrals which had been submitted following the Inspection. The LSI required officers from the HSCP to undertake reviews for all WDC clients within the service to ensure clients were safe and receiving the appropriate level of care. This request was also made to all other HSCPs who had clients placed in Alderwood House. All reviews were complete and any issues highlighted were addressed. The HSCP staff held weekly meetings with the Management Team at Alderwood to offer support and

guidance. The Care Home Collaborative also provided training and support. At the inspection visit in January 2024 Inspectors confirmed that all 8 requirements had been met and grades would be increasing. The Moratorium on placements was removed and the LSI process was concluded on 1 March 2024. Work is ongoing with HSCP and Care Home Collaborative to ensure the service continues to improve.

External Scrutiny Commissioned Care Services April 2023 – March 2024

5.13 The following commissioned services were inspected during this period.

- Joan's Carers – Adults & Older People Care at Home Service (based in Argyll and Bute);
- Ben View Community Bathing Service – Adults and Older People Support Service;
- Hands-on Home Care Limited - Adults & Older People Care at Home Service (based in East Dunbartonshire);
- Baxter View (Cornerstone) – Adult Support Service

Table 7

Care Home	Date of Inspection	Inspection Grades					No of Requirements	No of Areas for Improvement
		KQ 1	KQ 2	KQ 3		KQ 5		
Joan's Carers	02.10.23	4	4	5		3	2	0
Joan's Carers	02.02.24	N/A	N/A	N/A		3	1	0
Ben View	20.10.23	5	5	N/A		N/A	2	0
Hands-On Homecare	11.12.23	4	4	4		4	0	5
Baxter View (Cornerstone)	16.11.23	2	2	2		2	4	0

5.14 Following the inspection in November 2023, the Care Inspectorate assessed that changes in management and staffing within Baxter View service had impacted adversely on service delivery. The provider responded timeously to concerns raised in relation to the service and identified areas of service delivery which required substantial improvement. The managerial structure has changed, and a robust action plan is now in place which clearly identifies the work required to improve outcomes for service users. Inspectors highlighted 4 requirements for action in relation to care planning, assessment and monitoring of care plans, staff training and quality assurance – all requirements had a timescale of 12 March 2024. At a follow-up visit 12 March 2024 Inspectors did not feel sufficient progress had been made to meet any of the four requirements. These requirements remain in place with an extended timescale to be confirmed when the final report is published. HSCP officers have reviewed the care of all people living at Baxter View. Meetings have also taken place the Management Team at Baxter View to offer support and guidance which has been welcomed by the service.

Mental Health Services - Attention Deficit Disorder

5.15 The number of individuals suspected by Primary Care Services to have Attention Deficit Hyperactivity Disorder (ADHD) and subsequently referred to Adult Mental Health services for assessment confirmation has increased by 700% since 2019 across NHS Greater Glasgow and Clyde.

5.16 The three Adult Community Mental Health Teams (CMHTs) in West Dunbartonshire and Helensburgh receive approximately 50 referrals per month in total. In February 2024, this increased demand and the valuable feedback received through our suggestion and complaints process, led to a review of service delivery for this client group. Nursing roles were enhanced to create a Specialist Nurse Practitioner role. The role is to undertake assessment of individuals with ADHD symptoms and provides guidance to both patients and colleagues. As a result of these changes waiting time for new ADHD referrals to be assessed has significantly decreased, from six months to between six and eight weeks.

Diabetic Retinopathy Services (DRS) – Hosted Service

5.17 Post Covid 19 DRS has re- established screening in 16 locations and continues to progress accessibility in another 4 locations. For locations not yet re-established patients are called to the one most convenient to them.

5.18 Optical Coherence Tomography (OCT) has now been introduced as part of the retinal screening outcome pathway. This was established to more effectively identify patients who require Ophthalmology intervention, versus those patients who could be safely monitored as part of the Screening Programme. OCT clinics have now been introduced in Greenock, Gartnavel General Hospital and Vale of Leven Hospital. The introduction of these clinics has reduced the travelling for patients who require further examination. Further work is proposed to introduce another OCT clinic in south side of the city

5.19 Specialised software supports inbuilt quality assurance (IQA). This IQA monitors a set number of grading completed by staff each day and pulls a section to be quality assured by a second screener.

5.20 Regular Audits to detect where images have been incorrectly labelled by the screener reveal that from the 1st April 2023 to 31 March 2024 four patient images were attributed to the wrong case file out of 40 331 screened (0.009%).
The service also participates in and external quality assurance (EQA) process twice per year. Each grader grades 100 sets of images and their results are compared with their peers in NHSGGC and nationally. All GGC graders met the required standards within the acceptable threshold for sensitivity and specificity.

Health and Community Care – Focused Intervention Team (FIT)

5.21 The FIT Team sought to improve outcomes for patients who experienced a fall to avoid unnecessary conveyances and admission to hospital. A new falls pathway was introduced across NHSGG&C, due to recognition of lack of alternatives to conveyances for Scottish Ambulance Service (SAS). The pathway for West Dunbartonshire allows SAS to contact or refer directly to Focused Intervention Team who will visit within two hours and carry out full assessment aimed at maintaining the patient safely within their own home. Fifty patients were maintained at home safely over a twelve 12 month period. The FIT Team rapid response means we support

patients safely at home where appropriate who previously would have been conveyed to hospital.

Case Study

'Falls Referral Case Study 78 year old patient who had experienced several falls at home. SAS were called by neighbour after a fall and patient was taken to the Emergency Department (ED) where assessment revealed no serious injury or need for admission. ED staff at the hospital telephoned a referral to West Dun FIT Team as they were concerned the patient was like to fall again on return to home. The referral was triaged and patient contacted same day. The patient had experienced three recent falls, and were mobile with a walking stick. There was no other equipment in the house and no regular help nor care at home input. The patient was visited - two day delay as they went to stay with their daughter for two days out with the area. The initial visit identified a falls risks mobilising out of bed and working on food preparation in kitchen. · Discussed equipment and walking frame, a kitchen trolley and perching stool were provided. FIT staff carried out short visits daily for 7 days to ensure suitability of equipment and provide short period or rehabilitation and support.

· *Carer support discussed, but they declined at this time. Further check visits on day 8 and on day 11 revealed no further falls. Case closed to FIT Team. Check in four weeks after case closure revealed no hospital admissions, no further presentations at any hospital front door departments, and no HSCP referrals'.*

Excellence in Care

5.22 Excellence in Care is a national approach which aims to ensure people have confidence they will receive a consistent standard of high-quality of care no matter where they receive treatment in NHS Scotland.

5.23 Work to develop our quality management and assurance approach across our nursing teams progressed well during 2023. West Dunbartonshire nursing teams have been contributing to the development of cross NHSGGC combined care assurance assessment tools (CCAT) and implementing these in practice. These report on core nursing and midwifery family specific quality indicators. The CCAT Care Assurance and Improvement tool allows staff to view and understand their data over time, respond appropriately and plan improvement. These will inform quality of care reviews and drive quality improvement in nursing and midwifery.

5.24 CCAT self-evaluation cycles are now well established across our nursing teams. This involves elements of self- evaluation and external evaluation provided by a Senior Nurse from out-with West Dunbartonshire. Results have provided assurance regarding care quality and also identified areas that require to be strengthened e.g. – in Mental Health and Learning Disability - assessment and legislation standards require to be strengthened, Family Nurse Partnership are strengthening engagement with clients in the ante natal period, while Health visitors identified that although there is sharing of information they are not being specific enough when recording what information they are sharing and why.

5.25 Table 8: CCAT Results West Dunbartonshire

Team	RAG Rate /Date	RAG Rate / Date	RAG Rate / Date
WDHSCP Learning disability	Amber 01.11.2022	December 2023 Amber	
HCC ; District Nursing VOL	Amber December 2022	October 2023	March 2024 Peer
HCC District Nurse Dumbarton	Green November 2022	October 2023	March 2024 Gold
HCC District Nurse Clydebank	Green November 2022	Gold October 2023 (corporate Audit)	March 2024
FNP (NW)	October 2023 62%	Green February 2023	
SCS West Dunbartonshire	Gold April 2023	April 2024	
Helens burgh CMHT	Green April 2023	Amber 73% October 2023	Amber 78%March 2024
Riverview CMHT	Green April 2023		
Goldenhill CMHT	Gold April 2024		
Glenarn OPMH Inpatient	Gold January 2023	Gold March 2024	
Friuin / Katrine OPMH	Green April 2023	Green October 2023	April 2024 Gold
WD ADRS	Green April 2023	Green October 2023	
WD Health Visitor Record Keeping Audit	Green July 2023		
WD School Nurse Record Keeping Audit	Green July 2023		
WD HSCP School Nurse CCAT	Amber October 2023		
WDHSCP HV CB	September 2024	March 2024	
WDHSCP HV DUM	September 2024	March 2024	
WDHSCP HV CB	September 2024	March 2024	
West Dunbartonshire CAHMS Nursing Team	Red - June 2023	October 2023 Amber	March 2024 – being collated

Health and community Care - District Nursing – Key Quality Indicators

5.26 Pressure Ulcer Prevention improvement activity has yielded positive results, against a background of increasing caseload acquired pressure ulcer rates (Caseload Acquired Pressure Ulcer Rates per 1000 caseload March 2024 - we are seeing an upward trend from Dec 2021 n= 6/1000 – 11.5/1000 - NHSGGG 12/1000/ WDHSCP 11/1000) reflecting the increased frailty in caseloads, West Dunbartonshire rate for avoidable pressure ulcer rates per /1000 caseload West Dunbartonshire has seen sustained improvement with a rate = 0/1000 against NHSGGC 0.34/1000.

5.27 Palliative and End of Life Care – Key Quality Indicators

Direct enquiry and identification of preferences for end-of-life care is associated with patients achieving their preference for place of death. Patients whose preferred place of death is unknown are more likely to be admitted to hospital for end-of-life care. The majority of people would prefer to die at home and the stated aim of our District Nursing Team is to identify and support patients to achieve their preference.

Table 9: Preferred Place of Death Recorded

	Jan 24	Feb 24	March 24
WDHSCP	81% (n=17)	77% (n=13)	100% (n=24)

Table 10: Preferred Place of Death Achieved

	Jan 2024	Feb 2024	March 2024
WDHSCP	81% (n =17)	100% (n=13)	87% (n=21)

Distress Brief Intervention Service

5.28 Continuous improvement within the distress brief intervention (DBI) service for young people in West Dunbartonshire enables provision of fast, compassionate support to young people in distress aged 14 –24yrs or 26years (if care experienced). The service was launched in January 2022 with Scottish Action for Mental Health (SAMH) commissioned by the Health & Social Care Partnership on behalf of Community Planning Partners to deliver an associate DBI service for young people in West Dunbartonshire. The local delivery group provides leadership and is focused on continuous service improvement. Initially patient pathways were established in Primary Care and Education settings for those aged 16years and over. Consultation with partners highlighted a need for access to the service for those under 16 years. Agreement to pilot a referral pathway for 14-15year olds in line with the national pilot was given for West Dunbartonshire to be the 5th pilot site contributing to the national evaluation to understand the effectiveness of DBI in young people under 16 years. A tri-partite pathway linking School Pupil Support Teams, CAMHS and DBI Level 2 services supported fast and effective communication of a young person's needs, ensuring they receive the right support, from the right people at a time when they need it. The patient pathway for 14 and 15 year olds launched in January 2023.

5.29 Demand for the service continues to increase averaging 18 per month. Of the closed cases up to September 2023, the majority of service users completed between 6-8 sessions with the median number of sessions for both male and female being 6 sessions. The numbers of referrals (as of September 2023) are relatively low (and therefore inferences should be treated with caution) service outcome measures

indicate that of the closed cases between October 2022 and September 2023 young people reported an improvement of 5 points in their distress rating post intervention compared to their rating when referral made. When asked about their ability to meet their own goals in relation to their distress a median rating from 0 (not at all) -10 (completely) a score of 9 was given. When asked about their ability to manage immediate distress and future distress post intervention a median score of 9 was given each time. The data suggests that young people accessing the service have an improved ability to manage their distress and also feel more able to manage future distress post intervention. Next steps are underway to expand the patient pathway for 14 and 15 year olds to primary care settings

NHSGGC- Community Optometry – Hosted

5.30 The Community Glaucoma Service was implemented in NHS Greater Glasgow and Clyde in 2023. NHS Greater Glasgow and Clyde are the first board to roll out the community service. Eleven optometrists across three HSCPs in NHS Greater Glasgow and Clyde have received NHS Education for Scotland Glaucoma Award Training (NESGAT) training enabling them to receive referrals for low risk glaucoma patients. NHS Greater Glasgow and Clyde Hospital Eye care service aim to transfer the care of 1,000 patients per year to Community Optometry services in line with the principles Right Care, Right Person Right Place. Further Training of Optometrists will ensure this services is available in all HSCPs in 2024 and community optometry will have the expertise to deliver this community service in NHS Greater Glasgow and Clyde.

NHSGGC Musculoskeletal Physiotherapy Service – Hosted

5.31 Advanced Practice Physiotherapists (APPs) were recruited to support GP practices as part of the Multidisciplinary team within the Primary Care Improvement Plan. This was with a view to releasing GP time and providing expert and timely MSK advice for patients. There are now almost 30 w.t.e. APPs in GP practices across NHSGGC covering 44% of the GGC population. The resource was based on the recommended national model of one whole time equivalent APP per 16 -18,000 head of population. In 2023/24, APPs provided 62,943 new patient appointments across GGC (an increase of 4361 appointments on 2022/23). Impact data from the Board area can be accessed via this hyperlink;
https://create.piktochart.com/output/63829958-nhsggc-app-in-primary-care-activity-report-mar23-apr24

Primary Care – General Practice

5.32 Efforts to improve patient access to Intrauterine Device (IUD) contraception were deployed following identification of high rates of Termination of Pregnancy in West Dunbartonshire with poor local access to long acting reversible contraception (LARC) in particular IUDs. The cluster agreed to set up a Coil Training hub locally where a local GP acts as a trainer for local GPs and Practice nurses. Patients from the locality can book into the Coil Hub clinic and these clinics are used to train GPs/PNs and provide appointments for coil insertion. Once the GP/PN is trained they are then able to provide the service in their own practices. It is planned that in Year 1 all practices in Alexandria will have a staff member trained in IUD insertion, and in Year 2 practices in Dumbarton will access the training. From October –March 2023 76

appointments for coil insertion have been offered by the Hub, 68 appointments have been taken and 65 coils have been fitted. One Healthcare professional completed training with two further trainees in progress. A follow up patient questionnaire was completed by 39 patients. Of these 82% of patients were appointed within two weeks of contacting the service and the average patient satisfaction rating for the service provided was 4.95/5 indicating high patient satisfaction rates.

Primary Care - Nursing – Advanced Nurse Practitioners

5.33 The integration of health and social care in Scotland calls for new models of care, delivered by multidisciplinary, integrated teams. The Chief Nursing Officer (CNO) is committed to maximising the contribution of the Nursing Midwifery and Allied Health Professional (NMAHP) workforce and pushing the traditional boundaries of professional roles. The Transforming Roles paper on Advanced Nursing Practice (ANP) set out core competencies, education priorities and supervision requirements for ANP roles in Scotland. Trainee ANPs were introduced to West Dunbartonshire HSCP as part of the General Medical Services Contract to support Urgent Care in Primary Care. In 2021 we introduced 2 trainee ANPs and we have expanded this workforce, over the three years to 6 ANPs. The ANP and trainee ANP resource provide additional capacity within General Practice to respond to Urgent Care presentations. During 2023/24 our ANPs provided approximately 146.25 hours capacity in direct support of patient care per week. This provided approximately 292 patient appointments per week. In addition we have developed workforce data collection which provides the HSCP with data on the conditions treated by ANPs, outcomes for patients, and the support requirements from GP and wider multidisciplinary Team. Two qualified ANPs have completed their Fit note training.

Alcohol and Drug Recovery Service (ADRS)

5.34 Medication Assisted Treatment Standards (MAT) were introduced in 2021 and came into force in 2022 to improve access, choice and support for those affected by drug related harms. Through effective implementation of these standards each year we can evidence that West Dunbartonshire is supporting individuals, families and communities to reduce drug harms and drug deaths. A key priority is to ensure people receive high quality treatment and care. An experiential programme was introduced alongside the implementation of the MAT Standards as a qualitative measure designed to explore how people accessing services evaluate their experience. This measure and approach was designed by lived and living experienced individuals alongside family members. The programme was to ensure that the MAT Standards were meeting the aims and objectives of those they were designed to help.

5.35 It has been evidenced that those who enter into a program of substitute prescribing have increased chances of better health outcomes. That is why this critical intervention helps to support people through problematic drug use.

5.36 Each year the MAT Implementation Support Team (MIST) sends out the benching marking report from the evidence that has been submitted through numerical data and process documentation. Once they have received this information they can then score each of the standards accordingly producing a RAG rating. The objective for all the standards is to achieve a green in West Dunbartonshire we have progressed each year, demonstrating our commitment to delivering the highest standard in treatment and care to all service users. Through each standard we incorporate a

holistic approach that covers all services and organisations that are responsible for the delivery of care in a Recovery Orientated System.

5.37 In support of MAT Standard 9, improving joint working with ADRS and Mental health services, several steps have been taken to improve working and to improve overall mental health support available to patients of ADRS, addressing the divide identified by Mental Welfare Commissions report – Ending the exclusion. We know the impact of trauma, often leads to poor mental health and addiction. However, for the first time, we are now seeing the benefits of joint working with our patients, giving them the appropriate support to address mental health needs and reduce dependency at the same time. Having introduced this change to clinical practice we anticipate a reduction in relapse and self-harm and suicide among our patient group.

Family Nurse Partnership

5.38 Family Nurse Partnership (FNP) is a preventive licensed voluntary programme for first time mothers aged 19 years and under. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two years old. It is an intensive, structured intervention for young first time mothers and their children to maximise their potential. The programme aims to modify behavioural risk factors and enhance protective factors through regular home visits, using motivational interviewing techniques and strengths based approach. Our current workforce capacity continues to offer the programme to all eligible ≤19 year old clients and as an addition offers this to care experienced first-time mothers aged up to 20years old.

5.39 The recruitment pathway in West Dunbartonshire has been successful

- A total of 177 clients have enrolled in programme in West Dunbartonshire
- High engagement rate of entitled clients = 82%
- Very low attrition for disengaged clients = 3%
- SIMD – 83% of clients from most deprived quintiles so reaching the clients with most need

5.39 FNP continue to deliver the programme in West Dunbartonshire in accordance with NHS GGC board and Scottish Government guidance.

5.40 A key focus on the impact of poverty was supported by training accessed through Queens Nurse Catalyst for Change Project and training was provided by GEMAP money advice organisation for FNP. FNP staff were also trained in Home Energy training to alleviate fuel poverty implications.

5.41 Partnership working with Sandyford Services is underway to progress a test of change in relation to Family Nurses administering contraceptive implants to clients at home, this commenced in February 2024. Partnership working with Sandyford Clinic ensures fast-track to sexual health appointments for FNP clients. Additionally, an ongoing programme of training for Family Nurses supporting clients' self-efficacy with self-administration of subcutaneous contraception.

6. Person Centred: '*compassion, continuity, communication, co-production and shared decision making'*

Complaints

6.1 Table 11 General Practice - The Annual Summary of Practice Complaints

Outcome	Upheld	Partially upheld	Not Upheld	P	Total
Stage 1	56	23	46		125
Stage 2	8	15	14		

Themes relate to access to appointments, prescription issues and telephone access as well as patient expectation not being met. Practices have responded to all complaints and have reflected on some by means of significant event analysis where appropriate.

HSCP Complaints

6.2 From 1st April 2023 to 31st March 2024 there were a total of 214 stage 1 complaints and 76 Stage 2 complaints received within the Partnership. There were no Integration Joint Board complaints.

6.3 Performance targets state that 70% of complaints should be dealt with within the specified time period for each stage. That is a standard of 5 working days for Stage 1 (or up to 10 working days with management approved extension). Stage 2 is up to 20 working days. There is no set timescale for resolution at Stage 3 as that is a matter for SPSO. There are set timescales for WDHSCP to respond to enquiries from SPSO and to implement recommendations set by them. HSCP response times are detailed in Table 13.

Table 12

	Value	Target
Percentage of complaints received and responded to within 20 working days (NHS)	58%	70%
Percentage of complaints received which were responded to within 28 days (WDC)	42%	70%

6.4 Summary of main themes evident from lessons learnt:

- Importance of reviewing processes to ensure they are efficient and fit for purpose.
- Any changes to service packages should be communicated to family members.
- Importance of staff communicating timeously, clearly and respectfully with service users and family members.
- More effective partnership working with families/carers and timeous completion of assessment following allocation to a social worker.

Health and community care - Primary Care Improvement Plan – Treatment Rooms

6.5 A Patient Satisfaction Survey was carried out across all Health and Care Centres for Treatment Room Services. Patient feedback indicated they would like a direct pathway to Treatment Room Services instead of requiring referral from their GP Practice which resulted in delays in treatment. Consultation with GP practices identified which referrals could safely be directly referred. Treatment Room and Community Administration Staff worked collaboratively to construct a self-referral process which provides timeous access to the service, whilst ensuring patient safety. Consideration was given to ensure all patients and disability groups could access the new pathway. Where appropriate this has achieved speedier access to the treatment room service and removed the need for GP assessment and referral.

NHSGGC- Community Optometry – Hosted

6.6 West Dunbartonshire HSCP are the Lead HSCP for Community Optometry Services. Annually the Lead Community Optometrists and Eye care Service collaborate to provide an education and Learning event for our Optometry providers. These events provide the opportunity to educate and share learning across the 6 HSCPs and are accredited. As part of Community Optometry contractual responsibility, practices are required to report to Primary Care Services on patient complaints and whistleblowing. During 2023/24. One complaint was recorded for West Dunbartonshire's Community Optometry providers, with no instances of whistleblowing.

Mental Health

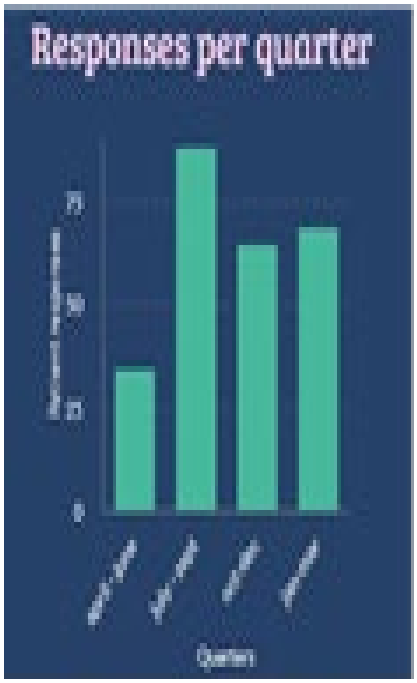
6.7 All Mental health services in West Dun undertake patient feedback on the care and service they received. Team Leaders review and plan actions around feedback given by the patients and their carers. The service has developed a range of feedback opportunities including digitally and traditional letters with return envelopes. The aim is to improve engagement in feedback targeting all age groups.

NHSGGC Musculoskeletal Physiotherapy Service – Hosted Service

6.8 Patient Reported Experience (PREMS) of MSK Service. Pre pandemic each staff member collected twenty five PREMS using the CARE measure. This previously provided the service with over 3000 PREMS each year. CARE measure will be reintroduced within 2024/25 but at present we continue to seek feedback from all patients electronically through our webropol survey, and more recently through the introduction of Care Opinion and through individual project work.

6.9 Infographic Flash reports from webropol are prepared quarterly and circulated to all staff. In addition to the quantitative data, we also communicate the qualitative themes to support all staff to appreciate what matters most to our patients. Any feedback that identifies a named therapist is shared with them, their manager, and the head of service. Summaries of feedback are included in the regular service newsletter. Any constructive learning points from the feedback are brought to the Extended Management Team and shared with staff.

6.10 On webropol, patients were asked about a range of aspects of care and their overall recommendation. In 2022/23, 119 patients responded and this more than doubled in 23/24, to 261, a 219 % increase. The feedback, as always, was very positive and shows little variation form one quarter to another. A summary for the whole year is presented here with a few highlights below.



6.11 Regular qualitative feedback is now received via Care Opinion from patients who receive care on acute sites. An examples of feedback received via Care Opinion is shown below

Posted by Orthopatient2023 (as a service user), 2 days ago

I want to thank NHS GGC staff for the excellent treatment that I have received as a patient suffering from severe leg pain as a result of a large lumbar disc bulge.

I was assessed and treated in MSK Physiotherapy (NVIC) by Morven who, with her highly specialist experience, was able to guide me on the right pathway for rehab with empathy and compassion. I was referred for an MRI and then on to Orthopaedics for surgical opinion.

The Radiology department were so professional and made me feel at ease when I was struggling to move. The Orthopaedic staff which included Mr Brownson and his surgical team, pre-op staff and the Advanced Practice Ortho physios (Martijn and Jenny) were all outstanding in supporting me through a very difficult time offering reassurance and hope.

The QEUH Orthopaedic ward staff which included domestic staff, support workers, physios, nurses and the medical team were amazing and treated me with dignity and respect.

The care and attention that I have received could not be faulted - Thank you!

Children and Families Health Visiting Service

6.12 As part of Health Visitor's efforts to continually improve the quality of care they deliver, a service user feedback survey was undertaken during the first quarter of 2024. Health visitors asked service users to complete the survey online using a QR code or via a paper copy completed at the time of the visit to the family home. A very small number of clients responded n = 17. This revealed that 94% of respondents were happy with HV service they had received. Continuity of HV is important and 82% reported they had the same HV for all contacts to date with a further 11.8% indicating mostly the same HV, and one respondent replying she never got the same HV. Making contact with the service was easy for 88% of respondents. This is an area for improvement as access should always be simple and straight forward with contingency arrangements identified. All respondents recorded a positive response and agreed that HV encourage parental involvement in assessments and that their views were listened to. 66% of respondents reported they believed the assessments were helpful with a further 31 % saying quite helpful. Encouragingly 93% felt able to discuss sensitive issues with their Health Visitors reporting that they had a good enough rapport to share child/family issues. 97% of respondents were fairly happy with the service and could not make any suggestions on how to improve the service. However one comment revealed a less helpful experience prompting consideration of staff learning and development opportunities around managing challenging conversations.

7. HSCP Clinical and Care governance Action Plan

7.1 Work has progressed throughout 2023 on delivery of the clinical and care governance work plan. Progress is tracked via the HSCP Clinical and Care Governance Group.

7.2 The HSCP CCG action plan is developed around the main quality ambitions Safe Effective Person Centred Care.

Safe Care

7.3 Some progress has been made mapping activity across service areas to ensure there is evidence of systematic monitoring, assessment and management of risk to care quality.

7.4 Heads of service have mechanisms in place to monitor assessment and risk to care quality. Work continues on more systemic development required to capture reportable incidents across social work and social care services. This will remain a priority within next year's action plan.

7.5 Work with Clinical Risk colleagues to develop packaged reports ensures we have effective reporting and oversight of Datix reporting and SAER activity.

7.6 Learning and development sessions with our extended management team has yielded positive results with increased Datix reporting, recording and review and clearer understanding of process for consideration of the requirement for SAE review.

Effective Care

7.7 The mapping of Quality Improvement Capability across West Dunbartonshire HSCP has proved challenging alongside the mapping out of all improvement activity for the entire HSCP. This will remain as a priority for 2024 – 2025

7.8 We are increasingly able to evidence learning and change from SAERs and related improvements in our processes and outcomes for service users and their families.

7.9 We continue to strengthen our arrangements for Enhanced Collaborative Clinical and Care Support for Care Homes to build on our local approach to support the sector.

7.10 We require to develop our HSCP Quality Assurance Framework and identify prioritised quality improvement programmes, which will improve and sustain the delivery of services during 2024- 25.

7.11 We have made significant progress developing our care assurance programmes across nursing services. The challenge going forward is to extend this across all teams and disciplines and to use the Health and Social care Standards as a common means against which we benchmark progress.

Person Centred Care

7.11 Some progress has taken place around development of a Duty of Candour process for the HSCP.

Assurance

7.12 This reports provides assurance about the robust Clinical and Care Governance arrangement in place across the HSCP and the quality of care being delivered. Throughout 2024 -2025 we will continue to strengthen the adequacy of our controls, developing data and reporting capabilities particularly across social care and social work services. We will work in an integrated way to support teams through health and care inspection and strengthen our oversight of improvement plans related to inspections and progress against agreed timescales. We will continue to promote, support and review evidence of improvement and learning in areas of challenge or risk, that have been identified through local governance mechanisms and external scrutiny, in order to provide assurance to external agencies and the integration joint board on the quality of our services.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD (HSCP)

Report by: Margaret-Jane Cardno, Head of Strategy and Transformation

27 June 2024

Subject: Strategic Risk Register Six Month Review

1. Purpose

1.1 The purpose of this report is to present the Strategic Risk Register to the West Dunbartonshire Health and Social Care Partnership (HSCP) Board.

2. Recommendations

It is recommended that the HSCP Board:

2.1 Consider and approve the Strategic Risk Register (Appendix A).

3. Background

3.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) states that an Integration Joint Board (IJB) must have effective governance arrangements in place, which includes systems for managing strategic risks.

3.2 The Integration Scheme confirms that a key element of the required risk management process is the preparation, scrutiny, approval and then annual review of the strategic risk register for the Health and Social Care Partnership.

3.3 The Chief Officer is responsible for ensuring that suitable and effective arrangements are in place to manage both strategic and operational risks relating to the Health and Social Care Partnership.

3.4 The HSCP Board's Financial Regulations reflect the recommendations of the national Integrated Resources Advisory Group which confirms the responsibility of the Chief Officer to develop a West Dunbartonshire Health and Social are Partnership Risk Management policy and strategy. The current Risk Management Policy and Strategy was approved by the HSCP Board on the 20 September 2021.

3.5 On the 19 March 2024 the HSCP Board Audit and Performance Committee approved the Risk Appetite Statement, this provides officers with clear guidance in respect of the amount of risk that the Partnership is prepared to accept, tolerate, or be exposed to at any point in time and is used as a point of reference when reviewing the strategic risk register.

4. Main Issues

4.1 Risk Management is about the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects. It is pro-active in understanding risk and uncertainty, it learns and builds upon existing good practice and is a continually evolving process that has an important role in ensuring that beneficial and defensible decisions are made.

4.2 The attached Strategic Risk Register (Appendix A) has been prepared in accordance with the Risk Management Policy and Strategy, approved by the HSCP Board on the 20 September 2021. Similarly, in accordance with that Policy and Strategy, standard procedures are applied across all areas of activity within the Health and Social Care Partnership in order to achieve consistent and effective implementation of good risk management.

4.3 Strategic risks represent the potential for the HSCP Board to achieve (opportunity) or fail to meet (threat) its desired outcomes and objectives as set out within the Strategic Plan, and typically these risks require strategic leadership in the development of activities and application of controls to manage the risk. These are distinct from operational risks, which represent the potential for impact (opportunity or threat) within or arising from the activities of an individual service area or team operating within the scope of the Health and Social Care Partnership's activities.

4.4 The Chief Officer has responsibility for managing operational risks as those are more 'front-line' in nature and the development of activities and controls to respond to these risks can be led by local managers and team leaders. Operational risk registers are maintained by Heads of Service on behalf of the Chief Officer; and are the "building blocks" for the Strategic Risk Register.

4.5 Where a number of operational risks impact across multiple service areas or, because of interdependencies, require more strategic leadership, then these can be proposed for escalation to 'strategic risk' status for the HSCP Board.

4.6 Existing Strategic Risks on the risk register were reviewed by the appropriate Risk Owner.

4.7 One risk was assessed as requiring an increase in the assessed risk level, moving from Low to Medium.

4.8 Five risks were assessed as requiring a decrease in their risk level, with all 5 moving from High to Medium.

4.9 Following the review, the number of strategic risks identified by risk level are as follows: Very High - 1, High - 9, Medium - 11, Low - 1.

5. Options Appraisal

5.1 Not required for this report.

6. People Implications

6.1 Key people implications associated with the identified strategic risks are addressed within the mitigating actions of the Strategic Risk Register.

6.2 The Risk Management Policy and supporting strategy affirms that risk management needs to be integrated into daily activities, with everyone involved in identifying current and potential risks where they work.

6.2 Individuals have a responsibility to make every effort to be aware of situations which place them, or others at risk, report identified hazards and implement safe working practices developed within their service areas.

7. Financial and Procurement Implications

7.1 Key financial implications associated with the identified strategic risks are addressed within the mitigating actions of the Strategic Risk Register.

7.2 The Risk Management Policy and supporting strategy affirms that financial decisions in respect of these risk management arrangements rest with the Chief Financial Officer.

8. Risk Analysis

8.1 Failure to comply with the legislative requirement in respect of risk management would place the HSCP Board in breach of its statutory duties.

8.2 The Strategic Risk Register has been reviewed by the appropriate risk owner which has included the addition of new risks, updates to existing risks including risk levels and closure of risks that no longer apply.

8.3 The Chief Officer and Senior Management Team reviewed the updated Strategic Risk Register on 29 May 2024.

9. Equalities Impact Assessment (EIA)

9.1 An equality impact assessment is not required as the recommendations within this report will not have a differential impact on any of the protected characteristics.

10. Environmental Sustainability

10.1 Not required for this report.

11. Consultation

11.1 The Strategic Risk Register has been reviewed and confirmed by the Health and Social Care Partnership Senior Management Team.

11.2 Relevant Monitoring Officers, including internal auditors, have been consulted in the preparation of this report.

11.3 The Strategic Risk Register was scrutinised by the HSCP Board Audit and Performance Committee on 27 June 2024. A verbal update will be provided to the HSCP Board in respect of their deliberations.

12. Strategic Assessment

12.1 Effective risk management will support local and strategic priorities and national health and wellbeing outcomes. It will prevent or mitigate the effects of loss or harm; and will increase success in delivery of the HSCP Strategic Plan, improving lives with the people of West Dunbartonshire.

13 Directions

13.1 Not required for this report.

Name:	Margaret-Jane Cardno
Designation:	Head of Strategy and Transformation
Date:	27 June 2024

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Appendices: Strategic Risk Register (Appendix 1)

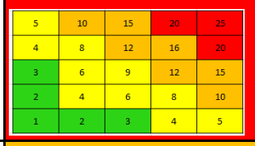
Background Paper: WDHSCP Audit and Performance Committee 19 March 2024

Description	Cause	Risk level (initial)	Controls in place	Risk level (current)	Risk level (Target)	Status
Risk Owner: Margaret-Jane Cardno Failure to deliver contract monitoring and management of commissioned services; creates a risk to the financial management of the HSCP and there is a risk to delivery of high quality services and the delivery of quality assurance across all areas of service delivery	Poor commissioning can have several underlying causes. 1. Insufficient Needs Assessment: Issue: Inadequate understanding of the health and care needs of the population. 2. Lack of Strategic Planning: Issue: Commissioning without a clear long-term vision or strategic direction. 3. Inadequate Stakeholder Engagement: Issue: Failing to involve key stakeholders (such as patients, carers, and community representatives) in decision-making. 4. Financial Constraints: Issue: Budget limitations and financial pressures. 5. Fragmented Systems and Silos: Issue: Lack of coordination between health and social care providers. 6. Inadequate Performance Monitoring: Issue: Insufficient monitoring of service quality and outcomes. 7. Short-Term Focus: Issue: Prioritizing immediate needs over long-term sustainability.	4x4 High = 16	1. Commissioning Work Plan agreed and monitored by Head of Service for Strategy and Transformation. 2. Commissioning Reviews linked to medium term financial plan. 3. Development and monitoring of Contract Risk Register. 4. Contracts Risk Register reported to HSCP Board. 5. Commissioning Team represented at an appropriate level across the HSCP. 6. Establish provider networks/forums across all HSCP areas. Engagement of stakeholders throughout the commissioning process to ensures inclusivity and responsiveness. 7. Develop and implement IRISS Change Makers Project. 8. Develop a quality assurance framework across HSCP service areas including, registered and non-registered services and in-house and 3rd party providers. 9. Trend analysis and reporting by exception programmed into HSCP Board reports. This enables the HSCP to regularly assess performance, collect feedback, and adjust commissioning strategies accordingly. 10. Strategic Plan "Improving Lives Together" approved by IJB. The development of this robust strategic plan ensures alignment with local and national priorities. 11. Care Pay and Care Finance roll out. 12. Balance financial constraints with the need for effective and sustainable services. 13. Promote integrated working, breaking down silos, and fostering collaboration. 14. Balance short-term goals with a forward-looking perspective. 15. Rigorous assessment processes, involving community engagement and data analysis, are essential.	3x3 Medium = 9	2x2 Medium = 4	Live/Active
Risk Owner: Margaret-Jane Cardno Failure to manage contracting arrangements; there is a risk that the HSCP has commissioned services which may be out-with contract or contracts are not fit for purpose.	Poor contract management can have several underlying causes such as: 1. Inadequate Record-Keeping Techniques. 2. Too Many Manual Processes. 3. Misalignment between Legal Teams and Stakeholders. 4. Misunderstandings about contract terms and expectations. 5. Inefficient collaboration and decision-making. 6. Limited Expertise. 7. Insufficient knowledge or expertise in contract management practices. 8. Lack of training for contract managers. 9. Inability to identify and address potential risks. 10. Inadequate Technology.	4x4 High = 16	1. Commissioning Work Plan agreed and monitored by Head of Service for Strategy and Transformation. 2. Commissioning Reviews linked to medium term financial plan. 3. Development and monitoring of Contract Risk Register. 4. Contracts Risk Register reported to HSCP Board. 5. Commissioning Team represented at an appropriate level across the HSCP. 6. Establish provider networks/forums across all HSCP areas. 7. Develop and implement IRISS Change Makers Project. 8. Develop a quality assurance framework across HSCP service areas including, registered and non-registered services and in-house and 3rd party providers. 9. Trend analysis and reporting by exception programmed into HSCP Board reports. 10. Roll out of Care Pay and Care Finance.	3x4 High = 12	2x2 Medium = 4	Live/Active

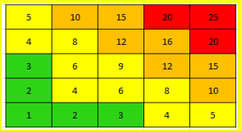
Risk Owner: Margaret-Jane Cardno Failure to manage contracting arrangements; there is a risk that the HSCP is unable to demonstrate Best Value.	Poor contract management can have several underlying causes such as: 1. Inadequate Record-Keeping Techniques. 2. Too Many Manual Processes. 3. Misalignment between Legal Teams and Stakeholders. 4. Misunderstandings about contract terms and expectations. 5. Inefficient collaboration and decision-making. 6. Limited Expertise. 7. Insufficient knowledge or expertise in contract management practices. 8. Lack of training for contract managers. 9. Inability to identify and address potential risks. 10. Inadequate Technology.	4x4 High = 16	1. Commissioning Work Plan agreed and monitored by Head of Service for Strategy and Transformation. 2. Commissioning Reviews linked to medium term financial plan. 3. Development and monitoring of Contract Risk Register. 4. Contracts Risk Register reported to HSCP Board. 5. Commissioning Team represented at an appropriate level across the HSCP. 6. Establish provider networks/forums across all HSCP areas. 7. Develop and implement IRISS Change Makers Project. 8. Develop a quality assurance framework across HSCP service areas including, registered and non-registered services and in-house and 3rd party providers. 9. Trend analysis and reporting by exception programmed into HSCP Board reports. 10. Roll out of Care Pay and Care Finance.	3x4 High = 12	2x2 Medium = 4	Live/Active
Risk Owner: Margaret-Jane Cardno Failure to adhere to Financial Regulations and Standing Financial Instructions when commissioning services from external providers.	Failure to adhere to financial regulations can have significant consequences for individuals, the HSCP, and the overall stability of the financial system. Underlying causes can be: 1. A poor understanding of legal obligations and contractual agreements. 2. Ignorance or Lack of Awareness. 3. Intentional Non-Compliance: 4. Financial Reporting Irregularities. 5. Culture and Incentives: Organizational culture that prioritizes efficiency or short term interventions over compliance. 6. Complexity and Opaqueness.	4x4 High = 16	1. Restructure and implementation of a Transactional Team. 2. Training on financial regulation and standing orders. 3. Care Pay and Care Finance roll out. 4. Review of Scheme of Delegation. 5. Implementation of Strategic Plan “Improving Lives Together”	3x3 Medium = 9	1x1 Low = 1	Live/Active

Risk Owner: Margaret-Jane Cardno Failure to maintain a secure information management network; there is a risk for the HSCP that the confidentiality of information is not protected from unauthorised disclosures or losses.	Maintaining a secure information management network is crucial for the HSCP and its parent bodies. Some common systemic causes are: 1. Misconfigurations of network devices. 2. Network disruptions. 3. Line Damage. 4. Human damage. 5. Sudden Hardware Failure. 6. Poor Visibility and Fundamentals in Cybersecurity. 7. Failure to implement basic security practices. 8. Outdated Software.	3x3 Medium = 9	1. Data breach management policy in place for both NHS and WDC data. This includes internal e-form reporting procedure for staff. Data breach registers for both partner organisations are kept and analysed for trends and where relevant mitigation put in place. 2. Breaches are reported to ICO and data subjects where required. 3. Ongoing monitoring and management required including relevant training. 4. Records management plan in place and lodged with National Records of Scotland. 5. Cyber security recognised as a strategic risk by both parent bodies.	2x2 Medium = 4	1x1 Low = 1	Tolerated
Risk Owner: Margaret-Jane Cardno Failure to maintain a secure information management network; there is a risk for the HSCP if this is unmanaged of breaches as a result of a GDPR breach; power/system failure; cyber-attack; lack of shared IT/recording platforms; as such being unable to manage and deliver services. Inability to provide service.	Maintaining a secure information management network is crucial for the HSCP and its parent bodies. Some common systemic causes are: 1. Misconfigurations of network devices. 2. Network disruptions. 3. Line Damage. 4. Human damage. 5. Sudden Hardware Failure. 6. Poor Visibility and Fundamentals in Cybersecurity. 7. Failure to implement basic security practices. 8. Outdated Software.	3x3 Medium = 9	1. Data breach management policy in place for both NHS and WDC data. This includes internal e-form reporting procedure for staff. Data breach registers for both partner organisations are kept and analysed for trends and where relevant mitigation put in place. 2. Breaches are reported to ICO and data subjects where required. 3. There remains an ongoing risk that despite procedures a breach may occur. 4. Ongoing monitoring and management required including relevant training. 5. Records management plan in place and lodged with National Records of Scotland. 6. Contingency planning underway in respect of planned power outages and black start events. 7. Cyber security recognised as a strategic risk by both parent bodies.	2x2 Medium = 4	1x1 Low = 1	Tolerated

Risk Owner: Margaret-Jane Cardno Failure to review and scrutinise performance management information; creates a risk of the HSCP being unable to manage demand analysis, service planning and budget management across totality of the organisational responsibilities.	1. Inadequate Leadership and Culture. 2. Lack of Clear Goals and Objectives. 3. Absence of basic management systems.	4x4 High = 16 	1. Regular performance reports are presented to the HSCP Chief Officer and Heads of Services. 2. Regular Organisational Performance Review meetings are held with Chief Executives of WDC and NHSGGC. 3. Regular performance reports are presented to the Audit and Performance Committee and HSCP Board. 4. NHSGGC has established a monthly performance board in order to further scrutinise high risk areas in relation to waiting time directives. 5. The Senior Management Team reviews performance data at both SMT meetings and via the Programme Management Office. 6. Roll out of data literacy training.	3x4 High = 12 	1x1 Low = 1 	Tolerated
Risk Owner: Margaret-Jane Cardno Failure to monitor commissioned and other partnership services which could impact on an individual's safety or risk to themselves or others.	Failure to monitor commissioned and other partnership services which could impact on an individual's safety or risk to themselves or others.	4x4 High = 16 	1. Commissioning Work Plan agreed and monitored by Head of Service for Strategy and Transformation. 2. Commissioning Reviews linked to medium term financial plan. 3. Development and monitoring of Contract Risk Register. 4. Contracts Risk Register reported to HSCP Board. 5. Commissioning Team represented at an appropriate level across the HSCP. 6. Establish provider networks/forums across all HSCP areas. 7. Develop and implement IRISS Change Makers Project. 8. Develop a quality assurance framework across HSCP service areas including, registered and non-registered services and in-house and 3rd party providers. 9. Quality Assurance reporting to HSCP Board and relevant sub committees for example Clinical & Care Governance. 10. Trend analysis and reporting by exception programmed into HSCP Board reports.	3x3 Medium = 9 	2x1 Low = 2 	Tolerated

Risk Owner: Julie Slavin West Dunbartonshire HSCP Board (IJB) being unable to achieve and maintain financial sustainability within the approved budget in the short to medium term due to the financial challenge of delivering services with increasing costs and demographic pressures against a backdrop of flat-cash allocations from partners	1. Insufficient funding allocations from partner bodies that fail to reflect demographic pressures, the impacts of poverty, the impacts of heath inequalities or inflationary cost of delivering health and social care services. 2. Unable to deliver on all approved savings from current and previous years. 3. Unable to fully mitigate the financial impacts of wider economic issues, in particular UK and global inflation. Financial risks to staffing costs, commissioning of care services, GP prescribing costs (inflation, import challenges and short supply), utilities, food and equipment costs. 4. New demand across services e.g. legacy impacts of COVID-19 on general health, increase in secure placements and impact of cost of living pressures on families. 5. Impact of NRAC and GAE allocations from the Scottish Government to deliver on a range of policy commitments and requirement to use earmarked reserves for core delivery. 6. Increasing resilience on use of non-recurring savings options and use of reserves to close the financial gap.	5x5 Very High = 25 	Active engagement with all partner bodies in budget planning process and throughout the year. This includes HSCP senior officers being active members of both council and health board corporate management teams. Working in partnership across the 6 GGC HSCPs. Also working collectively in local and national forums for health and social care e.g. National Chief Officers Group, CIPFA Chief Financial Officers Section, Scottish Government Sustainability and Value Groups. Local and NHSGGC Prescribing Efficiency Programmes. CIPFA CFO Section working with Scottish Government and COSLA officials on the importance of timely notification of funding, the need to have recurring allocations that attract inflationary uplifts to support full delivery and financial sustainability of policies. The regular financial reports to the HSCP Board. Budget monitoring reports are prepared and informed by the range of actions, controls and mitigations. These reports support the HSCP Board to agree on any corrective actions required to support financial sustainability. All actions are predicated on the adherence to Financial Regulations, Standing Financial Instructions, Procurement Regulations and implementation of Directions issued by the Board. Service Redesign Programmes managed by Project Boards and scrutinised by the Project Management Office (PMO). Regular analysis of performance and financial data with updates to SMT. Regular meetings with operational budget holders to monitor progress of savings as well as overall budgetary performance and corrective action taken as required. Focus on service redesign programmes and regular programme of review that support the outcomes of service users and patients. Weekly Vacancy Management Panel to scrutinise and challenge recruitment requests. Balanced against reduction in use of agency staff. Review and update the Medium Term Financial Plan (MTFP). The MTFP, the annual budget setting report and the regular financial performance reports update on key financial risks and any mitigating actions. Robust Reserves Policy and protection of earmarked reserves to support short to medium term financial planning. This includes, the creation, maintenance and application of some key earmarked reserves for GP Prescribing, Redesign and Transformation, Unachievement of Savings and Fair Work Practices. Robust commissioning processes linked to strategic priorities and eligibility and self-directed support. Strengthening of governance processes including a refreshed Area Resource Group. Robust application of Eligibility Criteria in completion of new My Life Assessments and regular reviews of current packages of care. Further supported by Supervision Policy.	5x4 Very High = 20 	3x3 Medium = 9 	Tolerated
Risk Owner: Gillian Gall Inability to develop and deliver sufficient workforce capacity to deliver strategic objectives. Insufficient workforce will impact ability to meet service demands, caused by the inability to recruit, retain or deploy the workforce with necessary skills, which could potentially lead to disruption of services.	Failure to attract people to work for the organisation and the unavailability of labour market.	3x4 High = 12 	Workforce Plan. HR/strategic policy mirrors national guidance and policy on terms and conditions. Workforce planning oversight locally. Local recruitment drives ongoing to support delivery of workforce plans and shortage occupational gaps. Recruitment stats monitored through workforce team and assessed through vacancy control group.	3x3 Medium = 9 	3x3 Medium = 9 	Tolerated

Risk Owner: Gillian Gall Staff dissatisfaction due to increased workload pressure; increasing risk of staff absence and turnover, leading to further loss of skills and knowledge.	Increasing risk of staff absence and turnover, leading to further loss of skills and knowledge. Training and development infrastructure not effectively monitored and implemented.	1x2 Low = 2	Data reported through performance reporting frameworks provided and improvement measures identified where data is below the required standard. This presents opportunity for any workforce risks to be highlighted or escalated. A robust, proactive approach to analysis and triangulation of this data could support management teams in monitoring the workforce to identify areas where support can be given. Completion of core statutory and mandatory training. Internal profession based career pathways development as identified in the workforce plan.	2x2 Medium = 4	1x2 Low = 2	Tolerated
Risk Owner: Fiona Taylor Failure to support timely discharge and minimise delayed discharge; creates risk for the HSCP to effectively manage patient, client and carer care	Increasing complexity of people admitted to hospital. This impacts on increased bed days plus higher number of people requiring Guardianship applications. Pathways of care across the Acute sites and the HSCP CHDT can vary.	3x3 Medium = 9	Quality improvement activities are ongoing to address a range of issues impacting on the ability to discharge people in a timely manner. Includes: Partnership working with Vale of Leven Hospital for high referral wards; staff awareness in identified areas such as AWI legislation; effective leadership. Increasing awareness of Power of Attorney and Future care Planning underway. Daily HSCP huddles to scrutinise the HSCP daily delays list, Effective dialogue between HSCP and Acute Hospital Discharge team to facilitate speedy resolution to operational issues impacting on bed days lost.	3x3 Medium = 9	2x3 Medium = 6	Live/Active
Risk Owner: Fiona Taylor Failure to plan and adopt a balanced approach to manage the unscheduled care pressures and related business continuity challenges that are faced in winter; creates risk for the HSCP to effectively manage patient, client and carer care	Impact is unpredictable, can be dependent e.g. weather, communicable diseases such as flu. Public messaging is central to ensure citizens understand and comply with pathways for care available in the community before attending Acute sites.	3x3 Medium = 9	Greater Glasgow and Clyde whole system co-ordinated approach for Winter Planning starts June 2024. Adult Vaccination programme Business Continuity Plans in place for all Health and Community care Services, inclusive of adverse weather events. Annual leave monitored to reduce risk of lack of staff availability at key points. Integrated approach across Health and Community Care services to target shared care opportunities if increased demand is experienced.	2x3 Medium = 6	2x3 Medium = 6	Tolerated

Risk Owner: Fiona Taylor Failure to monitor and ensure the wellbeing of adults in independent or WDC residential care facilities. Failure of staff to recognise, report and manage risk.	Lack of managerial scrutiny of a high standard of care in external and internal care homes. Lack of ASP awareness in external and internal care homes.	2x4 Medium = 8 	Mandatory ASP training for Local Authority Residential Care staff. Care Home Collaborative and Clinical care Governance process have oversight of risks. Care Home Collaborative and Clinical care Governance process have oversight of risks Care Homes accountability to the Care Inspectorate.	2x4 Medium = 8 	2x4 Medium = 8 	Tolerated
Risk Owner: Sylvia Chatfield Failure to meet waiting times targets - Psychological Therapies	Increase in referral numbers, staffing absence, or inability to fill vacant posts	4x4 High = 16 	Full data cleanse has taken place with ongoing admin support around accurate data recording. Continue to maximise staff capacity and use of peripatetic psychology for additional weekly session. Impact has been substantially due to vacancies and absence however staffing position is improving.	3x3 Medium = 9 	1x2 Low = 2 	Live/Active
Risk Owner: Sylvia Chatfield Failure to meet waiting times targets - Drug and Alcohol Treatment.	Increase in referral numbers, staffing absence, or inability to fill vacant posts	1x2 Low = 2 	Target continues to be reached and maintained. Only impact would be due to substantial absences. Staff team stable with minimum vacancies	1x2 Low = 2 	1x1 Low = 1 	Live/Active

Risk Owner: Lesley James There is a risk that failure to ensure compliance with relevant assessments such as My Life Assessments and My Assessment and plan will cause disparity within service user groups and in service access and result in incomplete assessments of risk's and needs and will not comply with statutory requirements.	Failure to embed My Life assessment and My Life Assessment screening across adult services. The implementation of My Assessment and Plan was fully implemented in July 2023. An evaluation on the implementation and quality of assessments is underway. Self evaluation activity is required to determine quality beyond implementation.	4x4 High = 16	Group improvement project is documenting the end-to-end process for adult assessments along with a new Adult Area Resource Group standard operational guide which defines the roles and responsibilities across the team and ensures there is consistence governance across the adult services. In addition, the project is reviewing any common tasks across the services which could be centralised. The ARG is being reinstated in Children's in addition to the social work Education panel for screening of shared placement provision service. An evaluation is being progressed of roll out of My life Assessment and Plan within Children's services . There is a concern that the duty to assess for report requests form the reporter is not being fully met due to staffing shortages and the required assessment provision not being able to be undertaken. Ongoing liaison with SCRA and Panel Chairs is in place to implement range of shared solutions to initial enquiry requests. Close working with Children's reporter in relation to the duty to carry out enquires is in place with agreed processes and solution being developed to ensure information is shared appropriately with the reporter.	4x4 High = 16	2x4 Medium = 8	Live/Active
Risk Owner: Lesley James Failure to ensure that staff are appropriately trained and adhere to standards for risk assessment and risk management across child, adult and public protection work.	Resources to support Learning and development opportunities for staff have not been recruited to (temporary resource funding). Skills passports for council staff are not being routinely reported on or further developed.	4x4 High = 16	Reporting mechanisms are at early stages to ensure both Training needs analysis of staff and training delivered and attended is both captured and able to be reported within social work and social care. The appointment of two learning and developments officers will ensure this can be effectively progressed. The learning and development officers have recently been approved by SSRG and are being recruited to. On an interim basis training and development opportunities are being promoted through a range of commissioned training and through ilearn modules and scheduled management training.	4x4 High = 16	4x2 Medium = 8	Live/Active
Risk Owner: Lesley James Failure to meet legislative duties in relation to child protection.	Capacity workforce risk due to vacancies and absence . Gaps in data oversight Training and development in National child Protection Guidance required	4x4 High = 16	Oversight by the Child Protection Committee is currently in place with an independent chair to ensure objective support and challenge. The national data set for CP is in place and a data analysis groups meets regularly to consider local performance. Time scales aligned to national guidance are routinely reported on as part of children's services data set. Visits to children on the CP register. With required timescales are routinely reported. Self-evaluation activity in relation to areas for improvement are informed by the data. Mechanisms for recording staff core and mandated training is an early stages of developments and this requires to be strengthened to ensure oversight and assurance. Use of agency staff to manage vacancies.	3x4 High = 12	2x4 Medium = 8	Live/Active

Risk Owner: Lesley James Failure to meet legislative duties in relation to adult support & protection.	Learning and development aligned to capacity and data oversight	4x4 High = 16	A national data set is being implemented by April 2023 and routine reporting to the Adult Protection Committee is in place with an independent chair to ensure objective scrutiny. Performance and conversion rates in relation to case conferencing is regularly reported and identified improvement in timescales is progressing. Further development is required to report on staff core and mandated training to ensure training compliance in ASP is in place for Social Work and Social Care.	4x4 High = 16	4x2 Medium = 8	Live/Active
Risk Owner: Lesley James Failure to meet legislative duties in relation to multi-agency public protection arrangements (MAPPA).	Rising demand of MAPPA activity Capacity in relation to rising demand within Justice services both in relation to MAPPA and court orders with flat cash settlement section 27 budget 22/23 and 23/24	4x3 High = 12	West Dunbartonshire is part of the North Strathclyde Partnership and oversight reporting structures namely the SOG and MOG meet regularly in relation to all MAPPA activity where reporting of MAPPA activity and the associated risk register is in place. MAPPA activity forms part of reporting to PPCOG to ensure effective oversight and scrutiny. Training to all staff in relation to risk management is supported nationally with justice services. strengthening of reporting is required to ensure improved oversight of learning and development including completion mandatory training is met.	4x3 High = 12	4x2 Medium = 8	Live/Active
Risk Owner: Lesley James Failure to ensure that Guardianship cases are appropriately monitored, supported and reviewed by social workers.	Data oversight of all guardianship cases is being developed but not currently available. Some adults subject to guardianship orders are not routinely allocated. Statutory reviews are not always taking place within required timeframes.	4x4 High = 16	Clinical and Care Governance oversight is being strengthened in this area with Guardianship oversight data to be reported form CareFirst with performance being reported quarterly. The data set is in early stages of development to ensure effective assurance is in place as is data to ensure effective reviewing timeline are in place . Data has been collated and reported to the Mental Welfare Commission who have an external scrutiny role.	4x4 High = 16	4x2 Medium = 8	Live/Active

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Meeting: **Meeting of Joint Staff Forum**

Date: **Thursday 7th March 2024, 10.30am – 12.30pm**

Venue: **Room 2, Clydebank Health & Care Centre & MSTeams**

MINUTE

Present: Beth Culshaw, (Chair); Diana McCrone; Fiona Taylor; Margaret Jane Cardno; Moira Wilson; Michelle McAloon; Gillian Gall; Sylvia Chatfield; Julie Slavin; Helen Little; Davy Smith; David Scott; Andrew McCready; Ricki Sheriff Short; Susan Walker; Morag Weir; Joyce Habo (Minutes)

Apologies: Shirley Furie; Paul Carey; Lesley James; Leanne Galasso

Item	Description	Action
1.	**Welcome, Introduction, Apologies**	Chair
2.	**Standing Agenda Items**	
	a) Minutes of Last Meeting ..\January\2024 01 18 DRAFT JSF Minute.docx	Chair
	Minute agreed as an accurate record.	
	b) Rolling Action List ..\JSF ROLLING ACTION LIST.xlsx	Chair
	Gillian advised Attendance Management training was delivered on 28th Feb, no TU colleagues attended but there will be further mop up sessions available. Susan advised she was not aware of this.	
	Beth noted that absence is higher than we have ever seen, some of it linked to winter, but we need to support staff to return to work.	
	Beth queried comments made at JCF re not following policy and requested any further information. David advised it was organisational change, Davy gave an example of organisers not completing back to work interviews face to face but via phone call which isn't good practice, however this has now been resolved via Jacqui Carson at JCF.	
	c) Chief Officer Update	BC
	Beth advised the main area to update on is the Budget. There was a separate JSF on finance and a further date is planned.	

Council set the budget 06/03 and we need to review where we are in terms of the financial gap, within the IJB on 28th March.

The decision taken was for the 2nd year that Council are not passing over monies from ScotGov for the pay award to HSCP. We have received a flat cash settlement and this is a real cause for concern as we cannot utilise our reserves to address recurring pressures.

Additional funding allocated to education for residential care and costs associated were passed to education but not to HSCP. In terms of Education the split is 72-Educ vs 28-HSCP and there has been a lot of debate highlighting our additional costs are three times what education experience.

David queried if there was anything we can take today as an action point in this forum to debate this decision, as it appears this is not the fairest outcome if HSCP are bearing the burden last year as well as this year, this is not the best way to work.

Beth noted there was TU attendance at the council meeting, but the decision has now been made, however if TU choose to write it would be their call.

d) HR & OD Update
   i. Report — MM/LG
   ii. Recruitment & Retention — GG

WDC Update - Gillian advised absence overall is 11.24% with long term absence remaining a concern. Reasons are minor illness, personal stress and MSK injuries.

We need to ensure the sickness process is following policy, prompt conversations are needed when patterns emerge, a recent absence audit was completed and this will go to Audit Committee.

Planned training for new managers and also for managers with less experience is available, HSCP are looking to implement more focussed action plans, and ensure managers are getting the right support as well as the workforce.

Davy noted at the council meeting they have cancelled physio for staff, which is a false saving. Helen noted this will impact via MSK routes as it will increase demand. Current demand is up with 72k referrals.

NHS Update – Michelle advised absence was 7.99% in January which is an increase. Long term absence is concerning as it has risen from 4.7% to 5.38%. Main reasons are anxiety, stress/depression, cough, cold, flu or cardiac problems. 18 long term and 5 short term have now returned. In line with the Once for Scotland policy, a manager's toolkit has been developed.

The KSF/PDP compliance rate has decreased. Statutory mandatory is exceptional at 95% compliance. Seven leavers in January. NHS reasonable adjustment guidance has been updated. The staff bursary scheme and Active bystander training is available. Retirement courses for NHS staff are also on eESS, pre-retirement awareness courses also available.

Gillian noted that ScotGov have now issued guidance re Covid special leave, from 1st April it will be treated as a normal absence as Covid is no longer notifiable.

e) Service Updates

I. Mental Health, Addictions and Learning Disabilities SC

Sylvia advised MH wards are a challenge re: staffing and there is an ongoing issue with vacancies, bank staff are covering. We are looking for an additional post for 1 year, a professional nurse advisor to boost development work.

HR support has been required re incidents in wards and specific HR issues, 2 nurse team leads have left and it has been a challenge to fill the posts.

LD review paper going to the Board in March to start the review process, as well as a consultation phase re: pavilion café and 1:1's are happening today and tomorrow.

J McGinley soon leaves for maternity leave – cover options are currently being looked at.

Sylvia is supporting duty work in community care and ASP duty alongside Theresa Connor, Anne Kane, and Gail McEwan. This has been challenging due to feedback from learning reviews. Management action had to be taken recently to ensure there was cover on a shift. We require strong governance and a senior to sit in on the decision making which has caused some uncertainty. This was an operational decision for safety reason.

An audit took place of adult support and protection and Val Tierney has been leading on this, staff have been involved and the learning review information will return to the adult protection committee.

David advised staff were frustrated because of an SRA and part of that was involving staff in decisions. Sylvia advised she met with staff to ensure they were aware of what was happening noting there are times when a management decision is required, no processes have been changed, only the governance has changed and this is to ensure service users and staff are safe.

II. Health and Community Care FT

Home care staffing remains a challenge and Fiona will update numbers at JCC today. The Care at Home redesign consultation feedback has been shared with JTU and given the depth of the information circulated it was agreed a further meeting invite would be sent for 14th March to meet with JTU to discuss and take forward any gaps in information that informed decision making.

Currently focussing on the Care Inspectorate to complete the inspection in 2024 and working with the team to review the 4 requirements. There are challenges re absence, with 20% in Clydebank and 14% in Dumbarton.

Fiona delivered training to front line carers this week and attendance was 85 which was a great opportunity to meet with staff, there is a plan for drop-ins going forward.

Diana queried OOH district nursing services re standardised rotas, Fiona advised there are a historical range of shift patterns as some staff had weekends off. We are keen to pilot this and Fiona has linked with RCN to take forward, Ricky advised he is the link, so Fiona will forward the email to him.

David thanked Fiona for acknowledging the pressure that staff are working under as this matches feedback TU are receiving.

III. Children's, Health, Care and Criminal Justice **C/F** LJ

IV. Strategy & Transformation MJC

Margaret Jane advised she has a service manager who is moving on.

The budget proposal in March may impact on commissioning services. She has 3 posts going up, 2 of which are vacant, but there may be staffing implications for 1 post holder.

Current issues managing COPT and ACT administrative staff, with some emerging issues, David has been part of this.

Sickness and vacancies are both stable.

HL

V. MSK

Helen has met with CSP colleagues as national CSP are canvassing members to lobby ScotGov. Not enough physios to meet workforce requirements and physios are being asked to write to local MP's.

Recent capital planning meeting and hopeful of getting VOL space returned for MSK, the other 2 clinics will move and we are waiting timescales.

More complex cases are coming through and we invested £80k in training to reflect the case load for staff, this training followed international research and included 8 staff becoming mentors to embed this practice, we are also encouraging staff to apply for the staff bursary.

200 responses to the wellbeing at work survey. Clinical notes have moved to a digital record and 70% of staff believe this has made work easier.

Accommodation pressure at RAH as space is required for a clinical research facility. There is a large area where staff go at lunch time which means staff will use the clinical area for lunches. Comms will be circulated and shared with CSP colleagues first, then meeting RAH staff next week.

Diana queried staff eating meals in a clinical space, Helen confirmed this is what currently happens as the department closes at lunch time. Beth also noted there are other catering facilities in the building and also one outside the physio department.

JS

VI. Finance

Julie advised they met in February to review the funding gap and set out the various pressures we have, half of which is coming from 2 years of unfunded pay awards. We have also had flat cash since 2019, and every inflationary increase, we've had to fund the difference. Last year it was 2% this year its 4%, the shortfall budgeting was at 4% but for HSCP its closer to 7%. ScotGov gave this share out, but this has not been passed over and calculates to £3.5m.

Pay is the largest element of the budget gap in terms of pressure, also the increasing demand for services i.e. care at home, children and families, older people and paying a 70% share of educational places and for some covering 100% of the costs.

The most recent report to the board changed by ¾ million due to 2 new emergency placements going in. These emergencies can't be built in or budgeted for, but it's for the Board to decide on the level of risk.

Overspent already by £1.6m due to staff pay awards and there are inflationary pressures re: prescribing. To close this gap we use reserves or via staff turnover and the health board's new process is to address their financial gap, we have our vacancy panel every Monday and then it goes to health. There is also SRRG at council and the benefit of this is you make turnover saving to assist with the financial year end.

In terms of reserves we are below our target as we need to hold 2% in reserves or we're not sustainable which means we need to find other savings to address this. Superannuation saving will be

a big element to close the gap next year.

David queried if we're taking savings over 3 years. Julie advised we could phase it but not getting the pay award means we cannot take it over 4 years. Davy queried the amount, Julie confirmed they are receiving £11m over 4 years.

Julie clarified that children and families receive funding for UASC which is a daily amount which does not cover the cost of the accommodation needed, however for any young people not coming via the Government scheme (spontaneous arrivals) we receive no funding for them. We may have to place them in children's houses or residential placements out with WDun which will also impact on the end of the financial year for them.

Diana queried if the council give flat cash, are we funding 2 years of pay awards, also who sets the target for reserves. Julie confirmed that we are funding 2 years of pay awards and the reserves target is seen as good practice, Audit look this to show financial sustainability. David thanked Julie for updating in an easy to understand way.

Beth confirmed we are in a very financially challenging position and the savings we need to come up with are the ones which are the least worst, via assessing what's deliverable against what's desirable.

Julie noted we cannot continue to receive flat cash as it gives no recognition of the cost of living as you're unable to deliver the same level of service. At the last presentation Julie highlighted the cumulative position which was stark, this will not change unless we review services. We have to come up with options and the Board make the decisions.

David requested clarity: - even before additional pressures e.g. children and families, overspend in HSCP is significant as of 1st April 2024? Julie confirmed this and noted if we review all people we are supporting residentially vs the budget, it's not sufficient and needs to be managed. Every manager needs to manage within their budget and we need to come forward with solutions, if using reserves that are not recurring we need to review how to deliver services.

David queried how this information will be shared with front line staff, when it's an insurmountable task that's excessively challenging. Beth advised we will contain costs and minimise risks, for example if we hold vacancies for some savings, but some are harder to achieve, there is increasing demand and we need to track the budget throughout.

Noting a £20m prescribing budget and flat cash means in terms of inflation our budget stays the same and with demand increasing

we have to work with local GP's and clinical directors to track and monitor the impact which emphasises how challenging this is and we can only do our best to achieve and deliver this.

Julie noted in terms of delivering the priorities of the Board, ultimately it's about partner organisations to fund appropriately, we need to review packages and have regular conversations with colleagues if we are unable to deliver services.

Diana queried staff turnover which is the biggest variable, NHS have frozen recruitment, are HSCP doing this. Gillian advised our approach has been to have a vacancy control process in place which we've had since 2022, we have weekly meetings where all vacancies are discussed. Additionally the Board added a new process re: justification so far all have been taken forward. Diana queried if staff side participate in this decision making. Susan advised that staff side are involved in vacancy management groups which allows them to challenge if required, it is right and proper that staff side are involved in this process.

Susan agreed it would be helpful and for the purpose of transparency it would support consistency. Both Inverclyde and East Ren currently do this. It was agreed that the invite would be shared with Diana.

3. Health & Care (Staffing) (Scotland) Act GG/VT

Gillian advised that a local group is now in place and met within the last 2 weeks. The mapping exercise is being undertaken.

4. Trade Union Updates

Diana queried the working week being reduced by 30 minutes from 1st April which isn't a lot of notice.

Gillian advised there was a statement last Friday and an implementation plan should follow over the next week as there are a lot of practical implications.

Helen noted it is concerning as MSK diaries are booked well into April, noting payment being an alternative, therefore budget implications, work life balance is at the heart of this but timescales will be tight.

5. National Care Service MJC

The Bill went through - 1st reading, no briefings since then, there will be a key stakeholders meeting soon and Margaret Jane will provide feedback following this.

6. Any Other Business

a) Three key elements for Area Partnership Forum

Budget – Continued focus on budget setting
Good performance re statutory mandatory training
Vacancies looking at the process to embrace both council and NHS colleagues

7. Papers for Information/For Noting

- JCF Minutes – 14 December 23
  JCF Minutes 14 12 23.pdf
- NHS Workforce Analytics Storyboard – December & January
  12. Workforce Analytics Storyboard WEST DUN Dec 23.pptx

- APF Information Exchange document – 17.01.2024 & 14.02.2024
  APF Info Exchange Doc 17.01.24.docx
  APF Info Exchange 14.02.24.docx

- APF Minutes – 15.11.2023 & 17.01.2024
  APF Minutes 15.11.23.docx
  APF Agenda 17.01.24.doc

- APF Agenda - 17.01.2024 & 14.02.2024
  APF Agenda 17.01.24.doc
  APF Agenda 14.02.24.doc

8. Date of Next Meeting

Thursday 11th April, 2.00pm to 4.00pm, Ballantines, Ground Floor, Church Street, Dumbarton

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Meeting: **Monthly Meeting of Joint Staff Forum**

Date: Thursday 11th April 2024, 2.00pm to 4.00pm

Venue: Ballantine, Ground Floor, Church Street, Dumbarton

Present: Shirley Furie (Chair); Beth Culshaw; Diana McCrone; Fiona Taylor; Margaret Jane Cardno; Moira Wilson; Michelle McAloon; Gillian Gall; Conner Farmer; David Smith; Ricki Sheriff Short; Lesley James; Leanne Galasso; Davy Scott; Fraser Downie; Joyce Habo (Minutes)

Apologies: Susan Walker; Sylvia Chatfield; Helen Little; Julie Slavin; Andrew McCready

DRAFT MINUTE

Item	Description	Action
1.	**Welcome, Introduction, Apologies**	Chair
	Apologies noted. Shirley Furie agreed to Chair today's meeting. Review of circulation list to be updated.	
2.	**Standing Agenda Items**	
	a) Minutes of Last Meeting Minute was agreed as an accurate record. ..\3 March\JSF Agreed Minute 07 03 2024.docx	Chair
	b) Rolling Action List Updated	Chair
	c) Chief Officer Update IJB met in March to discuss the proposals for savings and set the budget. The budget has now been set and savings proposals need to be delivered this year. The IJB highlighted concerns around savings on a non-recurring basis that need to be achieved on a recurring basis. This needs to be taken forward to release recurring efficiencies. Children and Families 5 year strategy was approved by the IJB along with the redesign of LD services to be considered in June. There remains ongoing challenges with staff absence.	BC

Industrial action from GMB on 10th and 11th April is being managed across the service. Discussions with GMB have been positive, action short of a strike action surrounding medication has been removed.

d) HR & OD Update

MM/LG
GG/MW

Leanne gave an overview of absence for Council staff. In Feb 24 has decreased in some service areas from 11.42% to 10.85%. Community health and care have had significant absences, main reasons: minor illness, health and stress, MSK. The HR team are continuing to work with services in terms of supporting wellbeing and any additional training to support newer managers.

Leavers were recorded as 29 for the period. The majority were resignations, no concerns were highlighted on exit questionnaires, noting not everyone completed this. Following a query from David, it was noted that 29.9% of staff completed the exit questionnaire.

David requested a link to the wellbeing roundups is circulated to Managers as this may be helpful, Leanne agreed to circulate. LG

Davy queried if any of these leavers were linked to budget cuts noting that some other service areas were impacted, for example access to both physio and counselling for staff are now being added to NHS waiting lists, this is potentially a false economy. Leanne felt it was too early to see any impact of this. Davy advised he's getting feedback that staff are considering other career options e.g. retail staff have higher salaries, querying how we can stop this sliding further.

Beth advised we do have a recruitment and retention group to look at local ways to recruit staff. Gillian highlighted we are linking into schools with 3 recent events, reviewing apprenticeships options and scoping with local colleges.

David noted a high number of staff leavers were from health and care teams, and felt we are losing a lot of experienced staff which will result in a huge skills gap, although it's positive we're going into schools and have this R&R group. Further discussion at JCC was suggested.

Michelle advised NHS absence is reducing at 7.25% in March. Main reasons are anxiety, stress, depression, colds, injuries and gastro intestinal issues.

KSF compliance shows an increase from January-February and a decrease from February-March due to staff using annual leave. Trajectory for 2024 is 64%.

StatMan training is positive at 94%, above 90% for all modules. Leavers were 4; 1 retirement, 1 voluntary resignation and 2 other reasons. Michelle highlighted NHS workforce messages, Pension contribution changes are in place for NHS. Staff bursary is now live. April is stress awareness month. Current review of Band 5 nursing role via the agenda for change pay deal, and advised a group has been set up but we're waiting national guidance.

Reduced working week – Gillian advised the 30 minute reduced working week has generated a lot of questions and meetings are taking place with NHSGG/HR/Operational teams to review the recording of this as there are 3 systems requiring input. There is no detriment to staff by this reduction and teams have implemented this positively. Gillian advised TU have been involved, noting this is not yet implemented for a small number of areas including in-patient staff as there is currently significant absence in ward settings. Fraser added there are a high number of part time staff and every day requires planning, Julie Campbell has been meeting team leads and senior charge nurses and the feedback is they will come up with a plan. Some teams are averaging this over the rota period or reducing weekly.

Moira updated the iMatter process is now live via Webropol with a start date of 22nd April for managers to confirm their teams. Support sessions are in place and have been promoted. The Intranet has a QR code to log this information and key themes will be added, a YouTube clip is also available highlighting the process.

Action planning support sessions are available and managers should plan ahead to meet their teams. Moira reminded the forum that iMatter is about staff experience as we all have an influence on each other, ownership and responsibility is on everyone who need to consider what part they play in this. David requested a report would be helpful on completion rates to keep track of this. Moira circulated the Link Below:
iMatter Participation Rates 2018-2023 (1).doc

e) Service Updates

I. Mental Health, Addictions and Learning Disabilities — FD

Fraser advised there are challenges around staffing but it is an improving picture with 1 person acting up and some nursing posts being recruited to. The service has vacancies in community health and at Goldenhill, along with nurse team lead post. Pavilion café is currently in the 45 day consultation period. All staff have had 121's completed, the process is planned to end on 31st May. Staff who have length of service are entitled to move to the Switch process.

There is currently 1 stress risk assessment, 1 grievance and 1 disciplinary in health.

II. Health and Community Care

Fiona confirmed the opening of 14 additional beds in Queens Quay, these are likely to be filled quickly. In adult nursing they are progressing with the spring vaccination programme. The care at home implementation group starts on 15/04 and attendees include TU members and employee reps. FT

Ricky advised Stephanie Dunn has not been in contact with him, Fiona advised she would connect them.

III. Children's, Health, Care and Criminal Justice

Lesley advised the change to a 37hr working week for health staff will be implemented from 15/04. All were in agreement that this time needs to be meaningful for staff.

Lesley reported a concern with absence in Clydebank across health visiting and school nursing. Confirming the RAG status will be updated to amber due to short term and long term absences. LJ

Children's Services 5 year Strategy was agreed at IJB in March which is good news for the service and this will create efficiencies when we re-balance care services for looked after children. The medium term financial plan underpins the £1.9m overspend in care provision as we are unable to balance that out until 2026/2027. This document is now in the public domain.

There are currently 18 vacancies in children's services. 53 SW posts are being reviewed to align some of this across services, along with the approach to recruitment.

There are currently 2 inspections taking place; one in fostering and adoption which has been inspected recently with a current action plan/improvement plan in place to evidence the work. The other is a thematic inspection of care for children transitioning or continuing care. Inspections do create anxiety for staff and leads to additional work and pressure for them.

Justice services are fully staffed. The Caledonia programme have moved in the last 6 months with some additionality from children's services to allow justice to oversee these areas. Domestic violence is currently a real concern.

There is a new requirement for SSSC registration and we're working to develop a manager's and employee guide to strengthen this oversight aligned to registration. The current practice relies on manual spreadsheets, however, HR21 has now been amended to log this on individual employee records and this will ensure all annual checks are completed.

The Permanence Team have been recruited to, 4 posts were realigned from the locality team.

Ricky noted high absence in HV's is concerning but this seems to be consistent across the area. Lesley confirmed they have moved the RAG status (red/amber/green) to amber and this relates to staffing levels, particularly in the Clydebank team.

IV. Strategy & Transformation
Margaret Jane confirmed there is no issues with staff absence. Noting the end of the financial year means several annual reports are required. Within the Transformation team, there is a lot of activity with major change projects. A key one for the service is the admin review, the first meeting next week includes TU representation. MJC

V. MSK
No Update

VI. Finance
No Update

3. Health & Care (Staffing) (Scotland) Act GG
Gillian advised the next meeting is taking place on 23/04 and a TOR has been agreed. Reviewing learning and templates requires a large volume of reading including reviewing the landscape for social care and also a mapping tool, YouTube videos are also available.

Overall there is a GGC programme group as well as an HSCP oversight working group that Gillian and Val attend. Gillian will circulate the papers and infographics.

4. Trade Union Updates

Diana queried vacancy management, Beth clarified this was not to slow down the process as we are quick to respond, but this was part of budget setting and achieving staff turnover, we will continue to monitor this. Gillian added that the vacancy replacement form was driven by GG&C who are requesting additional information, which can slow things down at times but is unavoidable.

Diana queried the reasonable adjustments presentation, Michelle advised this is important for staff with a disability or health issue to ensure they feel valued at work and may also reduce staff sickness absence. It does mean members of staff are treated differently, this new guidance was developed from the staff disability forum to ensure there's a 'yes' approach to what we can do to ensure staff are supported. Included with

the amendments were updates to the appeal process where you can request a 2nd look, there were also explanation about workplace passport and a link to the NHS website.

David questioned there being no deliberate attempt to slow recruitment but we did speak about how employers can achieve savings would be to increase overall turnover target. Beth explained using MSK as an example, they monitored vacancies and the budget they had available, due to recruitment taking up to 12 weeks, the steps to recruit naturally create a saving due to the period of time when a post was not filled.

David queried if we are increasing the turnover target, how can you make a saving without putting a delay in, Beth clarified staff are only required to give 4 weeks' notice, it takes more than 4 weeks to recruit, however, we might not get the same level of turnover therefore it's a safer way to achieve target and this is closely monitored.

Diana felt each time there is an underspend, it is due to staff vacancies, are we deliberately keeping posts vacant to save money. Beth gave the example of children's services being unable to cover staff, Lesley has 5 agency staff in place to reduce the pressure, and this situation is similar across Scotland at the moment.

5. National Care Service MJC

David highlighted that the Bill went through parliament with several unanswered questions. Margaret Jane advised this was expected to go live in 2025/26 however following re-negotiation and discussion with Cosla regarding the reshaping of the proposal, a new target date of 2028/29 has now been set, one key change is no staff transfers are being proposed. A new NCS Board will oversee reformed local integration and co-design all aspects of the structure and service delivery, this is at stage one of the Parliamentary process.

Dates for moving to stage two are unclear and there are a number of unanswered questions including the scope of the original Bill and accountability to Ministers.

Lesley added for awareness that discussions via the CSWO national group were that the National SW Agency would sit alongside NCS and would include children's services and adult services. They would consider a standardisation of resources to limit variation across local authorities. Version two has gone out to consultation with CSWO's, but noted that each HSCP may have different perspectives.

6. Any Other Business

a) Finance Presentation — GG
Paper was shared via APF

b) Three key elements for Area Partnership Forum

NCS Bill – potential to impact locally; ongoing development of NCS
Absence continues to be an area of concern
Industrial action – worked in partnership, medication policy FAQs agreed

7. Papers for Information — All

- NHS Workforce Analytics Storyboard – February
- APF (Strategy) - Info Exchange document – 20.03.24
- APF (Strategy) - Minutes – 20.12.23
- APF Agenda – 20.03.24
- CMT Report – Partnership Working – March 2024
- HR Slides – Reasonable Adjustment Guidance and the Workplace Passport

8. Date of Next Meeting

Thursday 23rd May 2024, 2.00pm, Clydebank Health Centre