East Dunbartonshire
Health & Social Care
Partnership




# Health and Social Care Partnership Strategic Plan 2018 – 2021 Draft Consultative Document

# CONTENTS

# FOREWORD

This is the second Strategic Plan for East Dunbartonshire Health & Social Care Partnership (HSCP). This outlines our ambition to further improve the opportunities for people to live a long and healthy life. We aim to provide early support to families and young children. We also want to focus on those most vulnerable in our communities.

There have been significant improvements in many of our services in the last three years but there is still much to do. In this draft plan for 2018/21 we will outline the next steps.

The previous plan related only to adult services. This draft outlines our plans for child health and social care services as well as criminal justice. These services are now part of the Health and Social Care Partnership. This enables us to consider the needs of, and plan for, services through a life span. It allows us to plan for the needs of children in the context of their families and, particularly for more vulnerable children, helping the transition to adulthood. It is even more crucial we work together in East Dunbartonshire in the increasingly challenging and uncertain financial environment.

In the preparation of our draft Plan we have engaged with our staff, service users, local communities and our partners in the Council, NHS and third sector. We want to hear your views at the next stage of formal consultation so we can truly reflect the views of our staff, stakeholder organisations and local communities.

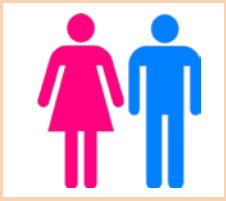
# EAST DUNBARTONSHIRE PROFILE

An understanding of communities and people across the HSCP population is vital in the planning and provision of health and social care services. This section provides a summary of the population structure, age profile, characteristics and potential impact on health and social care services and highlights the challenges to be addressed. Detailed and more extensive information is provided in the East Dunbartonshire HSCP Joint Strategic Needs Assessment (2016).

The estimated population of East Dunbartonshire in 2018 predicts a higher proportion of older people than the Scottish average.

**Figure 1 - Estimated Population in 2018**

**All People**
107,431

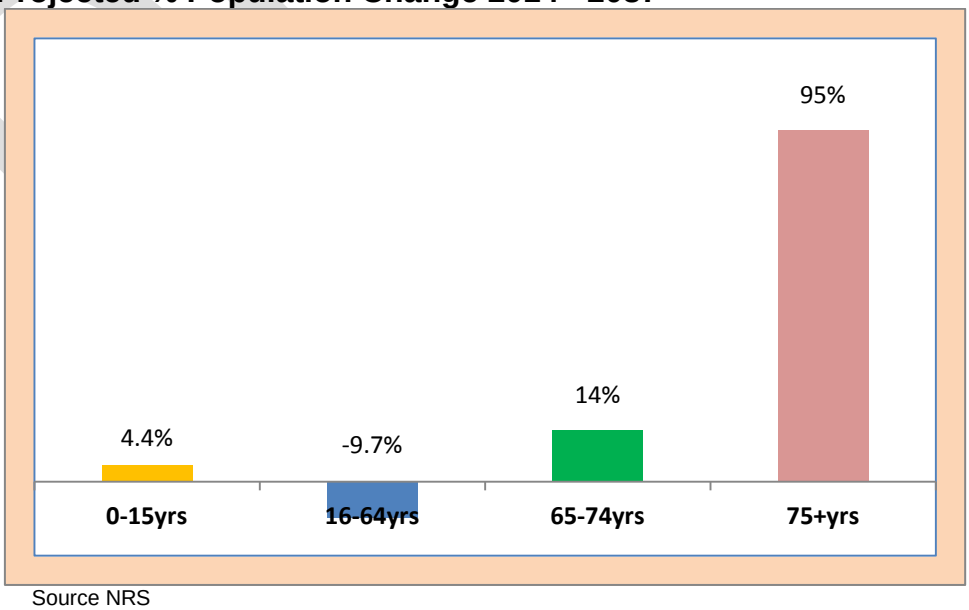


| Age | No. | Percent | *Scotland* |
|---|---|---|---|
| 0-15 | 18,361 | 17.1% | *16.9%* |
| 16-44 | 32,748 | 30.5% | *36.3%* |
| 45-64 | 31,871 | 29.6% | *27.7%* |
| 65-74 | 12,646 | 11.8% | *10.6%* |
| 75-84 | 8,360 | 7.8% | *6.2%* |
| 85+ | 3,445 | 3.2% | *2.3%* |

Source NRS

Over the 25 years 2014-2037, there is a projected increase of 95% in the number of people aged 75+yrs. During the same period, the number of children aged 0-15yrs is projected to increase by 4.4%.

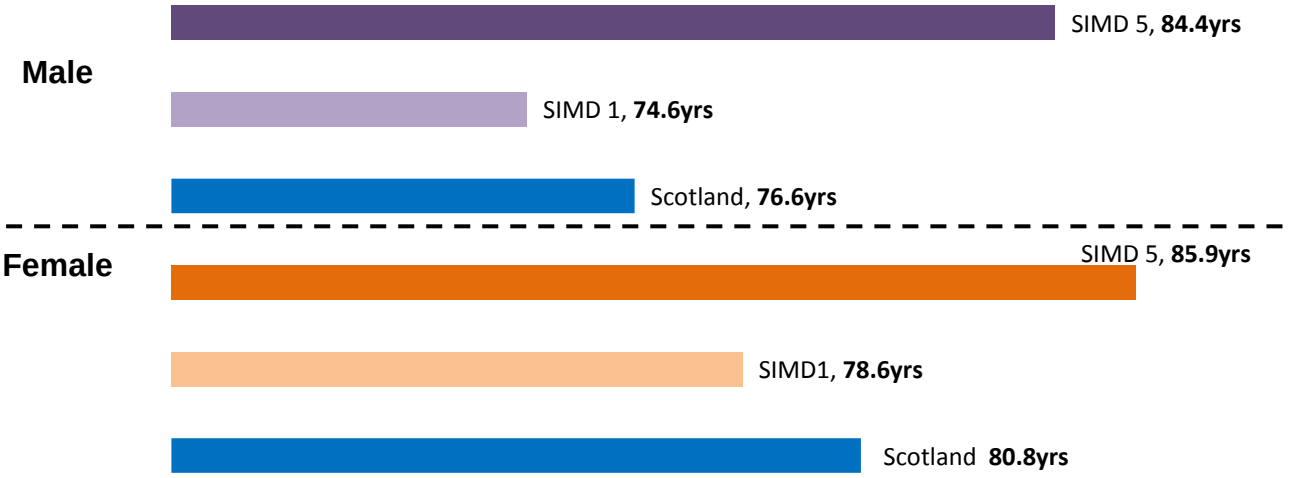
**Figure 2 - Projected % Population Change 2014 - 2037**




Source NRS

Whilst East Dunbartonshire has the highest life expectancy in Scotland at 83.5yrs for females and 80.5yrs for males (Scotland: 81.1yrs and 77.1yrs respectively), there is a demonstrable variance in life expectancy between the most deprived communities (SIMD 1) and the least deprived communities (SIMD 5)

**Figure 3 - Life Expectancy for our most deprived (SIMD 1) and least deprived (SIMD 5) populations in comparison to Scotland**

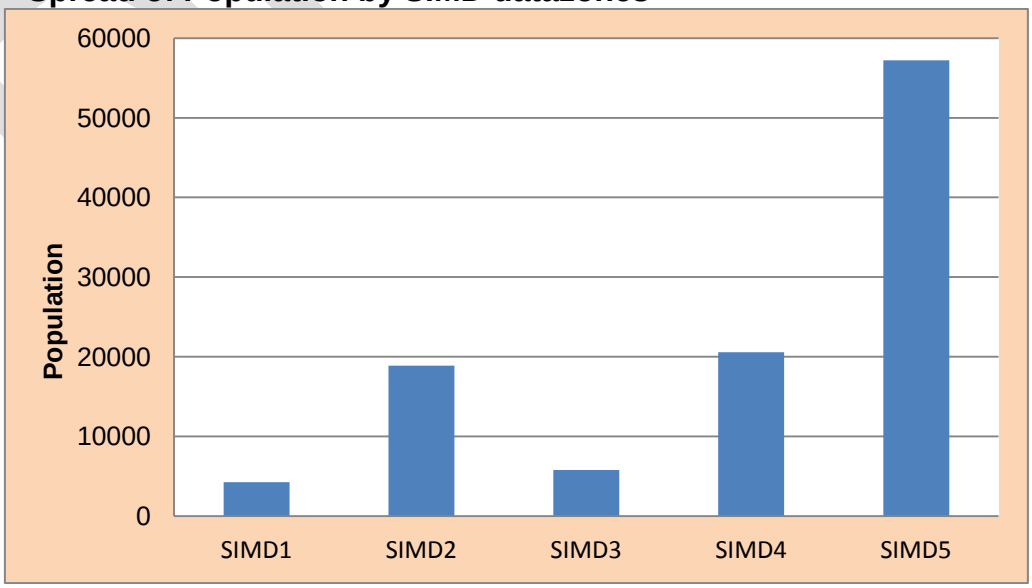



Source ScotPho

## Deprivation

There are five datazones within the 20% *most* deprived in Scotland: Two are in Hillhead, while Auchinairn, Kirkintilloch West, and Lennoxtown each have one most deprived datazone. The majority of East Dunbartonshire's residents live within the 20% *least* deprived datazones.

**Figure 4 - Spread of Population by SIMD datazones**



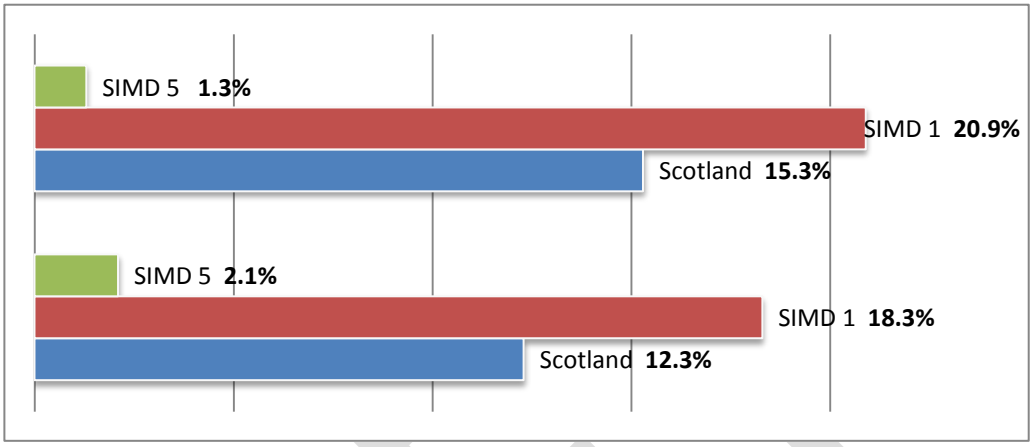

Source ScotPho

Almost 18% of children in East Dunbartonshire are living in the three most deprived datazones which are areas of multiple deprivation with poor health outcomes and reduced life expectancy.

**Figure 5 - Comparison of Poverty in East Dunbartonshire SIMD 5 and SIMD 1 datazones compared to national average**


Population Income Deprived *(2015)*

Children Living in Poverty *(2012)*




Source ScotPho

**WHAT THIS MEANS** Focussing on closing the gap between the most deprived and least deprived populations, reducing income deprivation and enabling people to keep well as long as possible.

### Healthy Lifestyles

The 2014 Health & Wellbeing Survey showed that in general, the population is healthy with 84.9% of residents describing their health as good or very good. Between 2011-2014, there has been a significant shift towards adopting more of the five positive health behaviours (physical activity, not smoking, not binge drinking, meeting fruit and vegetable target and BMI less than 25).

The Secondary Schools Health and Wellbeing Survey (2014/15) found that, overall, young people are adopting positive behaviours: 87% clean their teeth at least twice a day; 52% walk or cycle to school; 48% eat five portions of fruit or vegetables a day; 92% don't currently smoke.

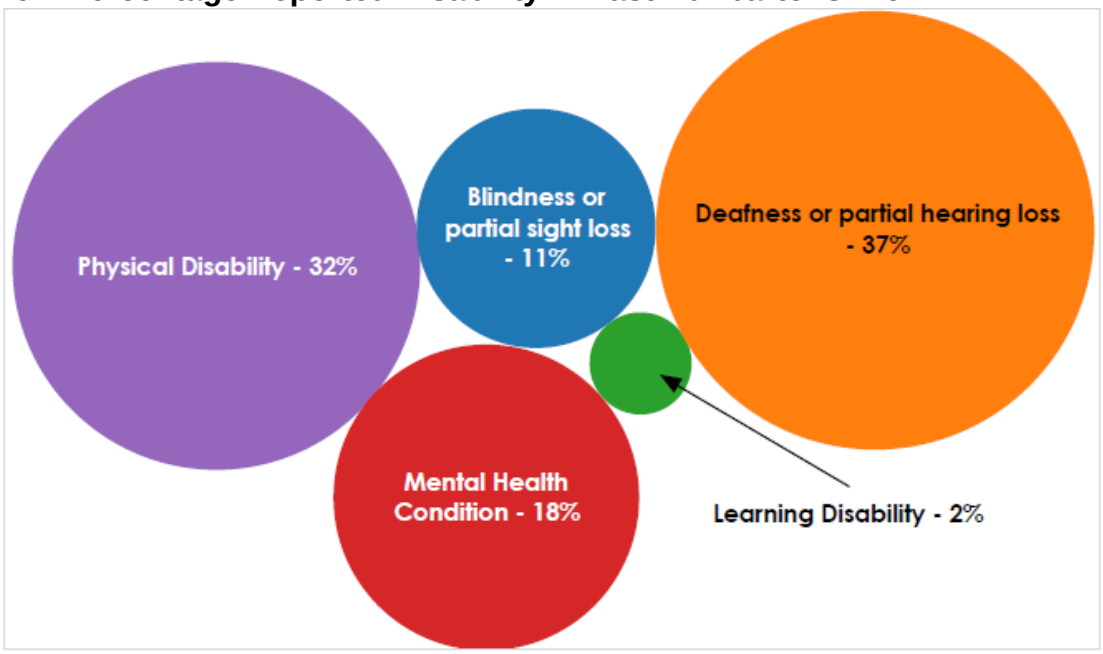
**WHAT THIS MEANS**

Services need to encourage and support more of the population, particularly children and young people, to adopt healthy lifestyles.

## Disability

In the 2011 Census, 5.6% of the adult population in East Dunbartonshire reported a disability, with hearing impairments and/or physical disability being the main disabilities reported.

**Figure 6 – Percentage Reported Disability in East Dunbartonshire**

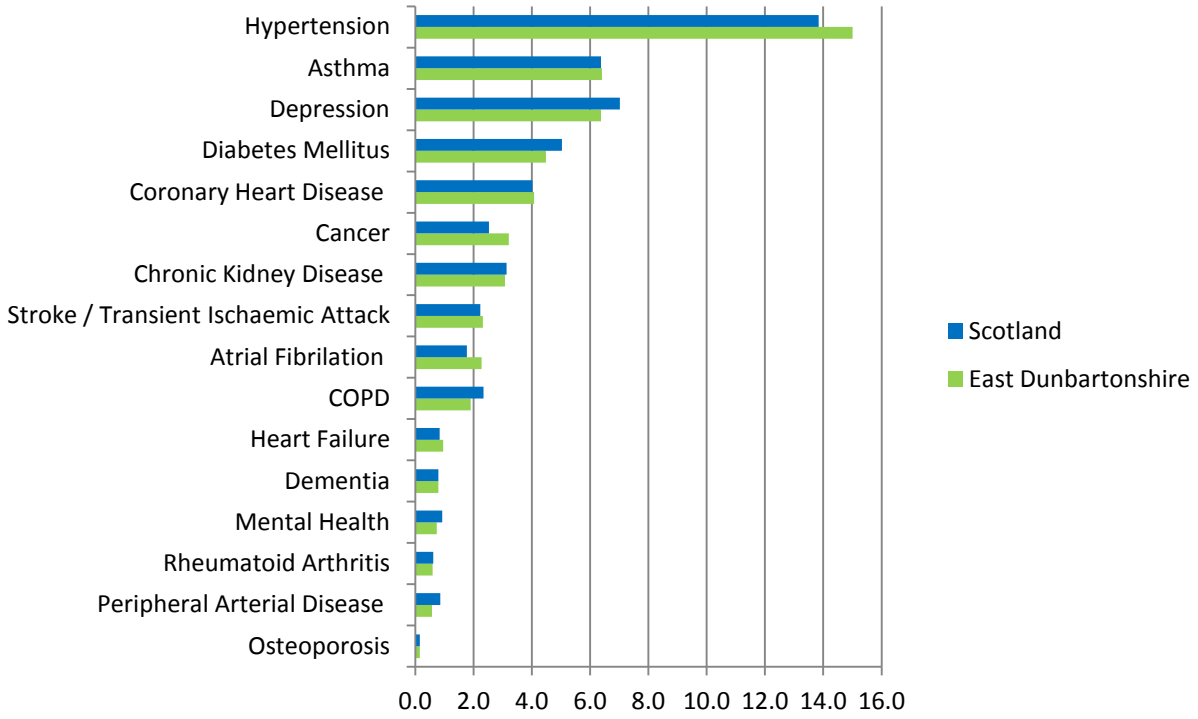



Source: Scotland Census 2011 *(N.B. data does not indicate if people reported more than one disability).*

## Long Term Conditions

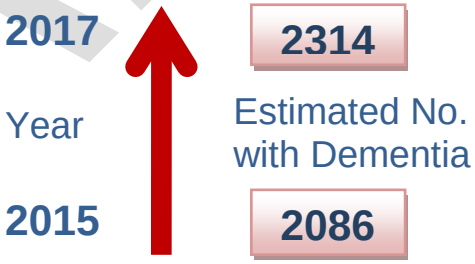
Many people live with one or more long term condition. The number of long term conditions rises with age and we need to support those with complex needs so that they may manage their conditions and lead an active, healthy life. The most diagnosed long term condition in East Dunbartonshire is hypertension. The prevalence for this condition, cancer and atrial fibrillation, are all notably higher than the rate for Scotland.

**Figure 7 - Disease Prevalence**




Source ISD

Between 2015 -17 there was an estimated 11% rise on the number of people with dementia. This number will continue to rise with the growing older population.



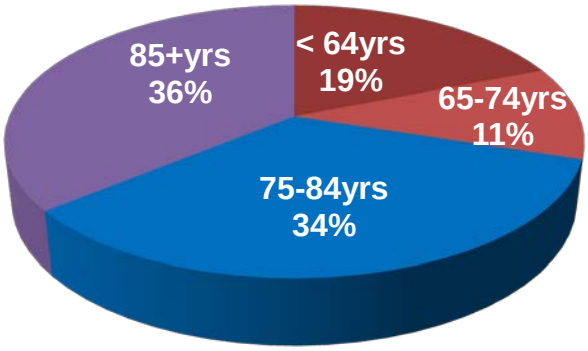

**WHAT THIS MEANS**

Prioritising the early detection of disease, supporting people to recover or manage their own conditions, and providing a range of supports, particularly for those with dementia and their carers.

## Home Care

In 2016, there were 1,325 people in receipt of home care in East Dunbartonshire, 70% of whom were aged 75yrs and over.

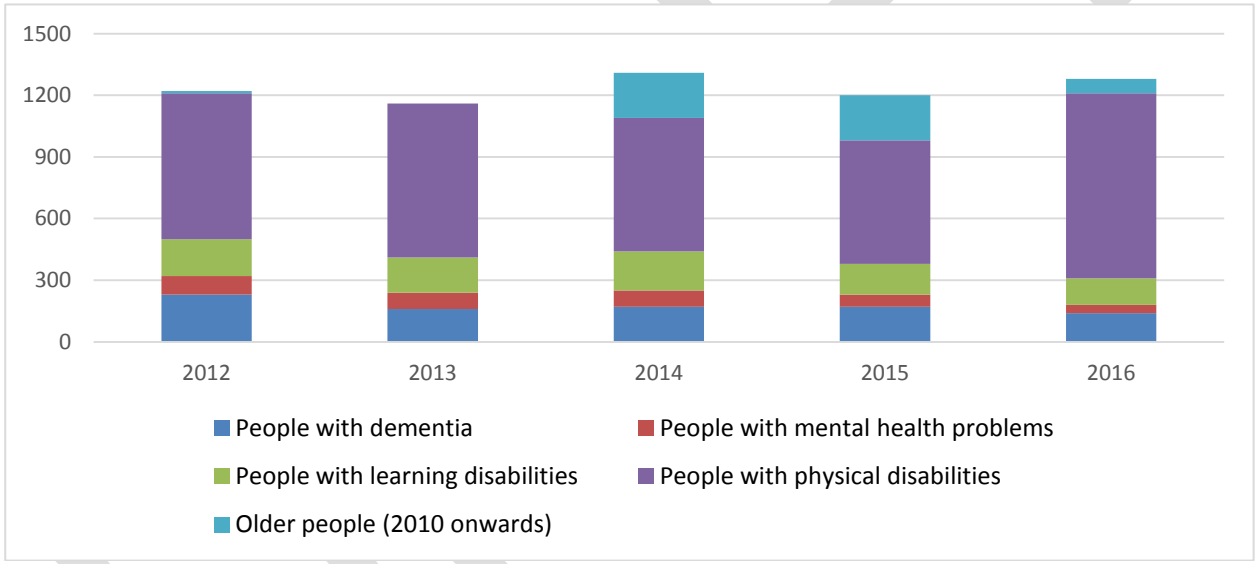
**Figure 8 - Age Breakdown of HSCP Home Care Clients**




Source Social Care Survey

Home care supports people to remain in their own homes across a range of client groups, particularly those with a physical disability.

**Figure 9 - Home Care Client Breakdown 2012-16**




Source Social Care Survey

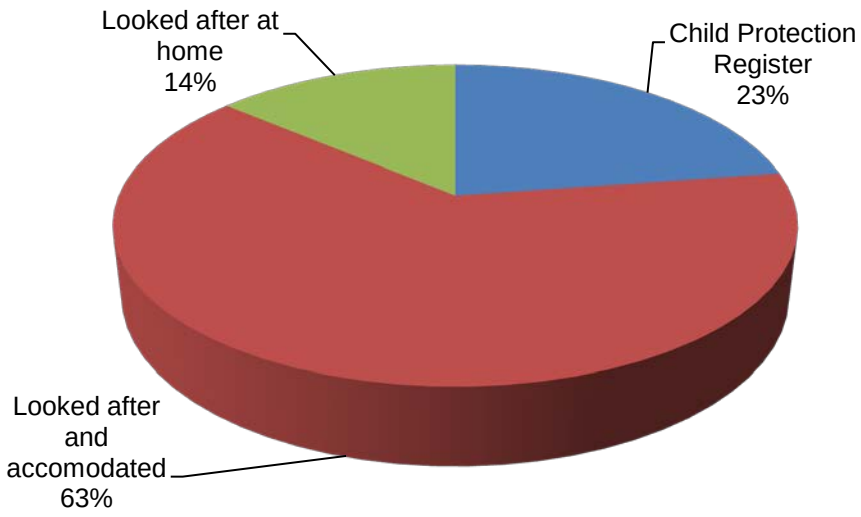
## Unpaid Carers

The 2011 Census identified 11,164 carers in East Dunbartonshire. There are 572 carers known to social work. Health and Social Care services work in partnership with carers, and are dependent on the care they provide. Easily accessible information and appropriate support help to ensure the wellbeing of carers and enable them to feel supported in continuing their caring role.

## Child Protection

East Dunbartonshire mirrors the national trend of identifying more vulnerable children who may be at risk of harm and therefore in need of statutory interventions in order to keep them safe. In November 2017 there were 203 children on the Child Protection Register or Looked After and accommodated in safe places.

**Figure 10 - Placement of Children Looked After and Accommodated (Nov 2017)**




## Unscheduled Hospital Care

People should only remain in hospital for as long as necessary and receive more appropriate care at home or in a homely setting. There has been significant progress in reducing delayed discharges and unscheduled bed days over the last three years but we need to ensure more people are getting the right care in the right place and at the right time. The aim is to reduce unplanned hospital care by 10% by the year 2021.

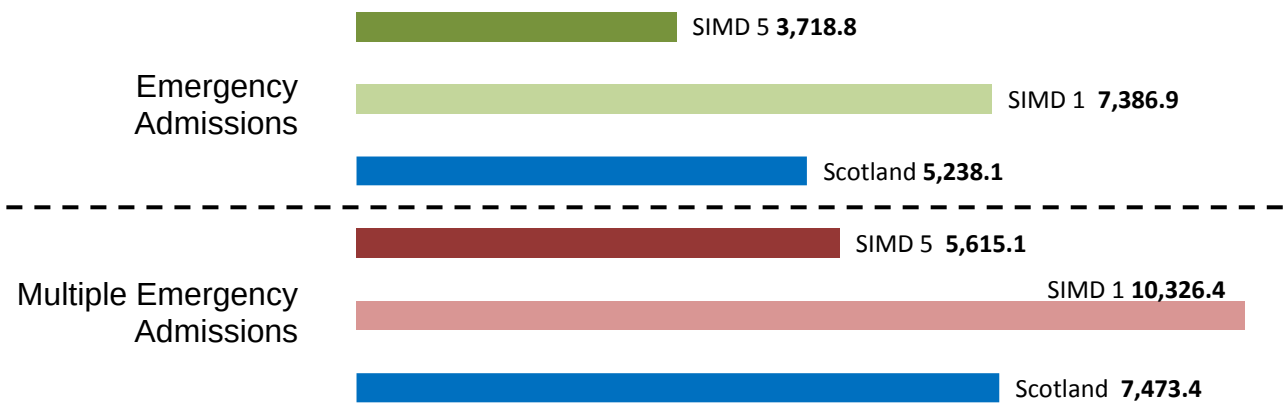
The HSCP has made significant progress in reducing delayed discharges and unscheduled bed days over the last three years, but further improvements are required to ensure people are getting the right care in the right place and at the right time. Therefore the HSCP aims to reduce unplanned hospital care by 10% from 2016/17 to 2021, and the current status demonstrates a downward trend towards achieving this goal.

**Figure 11 - Projected Unplanned Hospital Episodes 2016/17 to 2020/21**

| | 2016/17 | | 2020/21 | Current Status |
|---|---|---|---|---|
|   **A&E attendance** | 27289 | → | 24409 |  |
|  **Unscheduled Admissions** | 11308 | → | 10177 |  |
|   **Unscheduled Bed Days** | 78260 | → | 70434 |  |
|  **Delayed Discharges** | 3119 | → | 2807 |  |

There is a significant variance in unplanned hospital care between the most deprived population (SIMD 1) and the least deprived population (SIMD 5) in East Dunbartonshire. The rate of emergency admissions is greater amongst our more deprived populations.

**Figure 12 Emergency Admissions for our most deprived and least deprived populations**




*SR4 2014 standardised rate per 100,000*

**WHAT THIS MEANS**

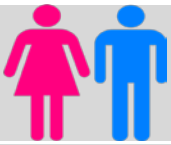
Prioritising the prevention of unplanned hospital admission through supporting people to remain in their own home, supporting timeous discharge, and providing specifically targeted, alternative, models of care.

# LOCALITY PLANNING

The HSCP established two Locality Planning groups during 2015/16 to support the understanding, planning and delivery of services around communities within these localities. These locality areas related to natural communities. They consisted of:-

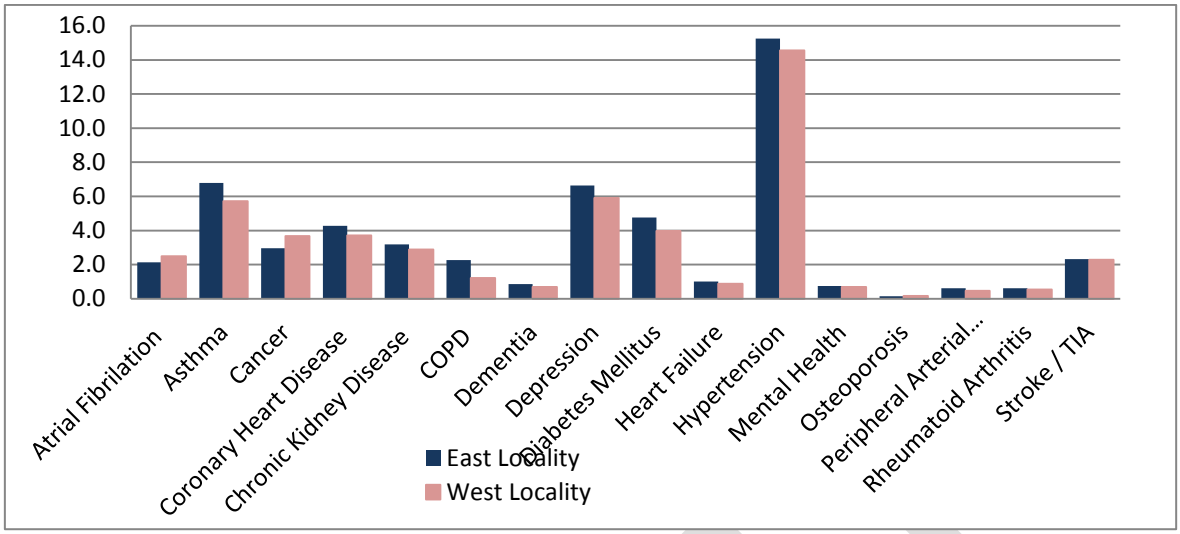
- The east of East Dunbartonshire (Bishopbriggs, Torrance, Lenzie, Lennoxtown, and Kirkintilloch).
- The west of East Dunbartonshire ( Bearsden and Milngavie)

**Figure 13 - Percentage Population by age group within each Locality.**

|  | East Locality | West Locality |
|---|---|---|
| 0-15 years | 17% | 18% |
| 16-49 years | 40% | 36% |
| 50-64 years | 22% | 22% |
| 65-74 years | 11% | 12% |
| 75-84 years | 7% | 8% |
| 85+ years | 2% | 4% |
| % of all East Dunbartonshire residents aged 75+yrs | 55.5% | 44.5% |

The Locality Groups have brought together a range of stakeholders including GPs, acute clinicians, social workers, carers and service users to facilitate an active role in, and to provide leadership for local planning of service provision. The groups commenced by undertaking an assessment of need which explored service and community strengths, potential gaps in service delivery and issues of inequality. Disease prevalence assisted in the identification of health conditions which affected people living in each locality.

**Figure 14 - Disease Prevalence by Locality**




This information formed the baseline for discussions within each locality group to help prioritise the areas they wanted to focus on and help make a difference within their community. Each group will develop a locality plan for their area involving key local groups and communities, linking to local services. These plans will align with priorities outlined in the Community Planning Partnership Local Outcomes Improvement Plan.

Each group has agreed the following priorities for 2018-19:

**East Locality Group**

- Cancer screening - Care after cancer treatment has been a theme with emphases on using social prescribing as a means of supporting wider rehabilitation. Establishing links with the local cancer prevention group are underway.
- Housebound – This has raised some inequalities and is an ongoing theme. Examples on how some voluntary services have dealt with isolation and loneliness have been circulated to the group.
- Acute/primary care interface - Developing positive dialogue with acute consultants has begun with our shared experiences of intermediate and continuing care.

**West Locality Group**

- Dementia - The emphases on linking in with current services, particularly those who have a strong self management approach has been highlighted as a useful model to help support clients and their carers.
- Day care services - Moving away from the traditional model towards day care services that focus on matching individuals to a wider range of HSCP and other third and independent sector services
- Housing - Tentative links with housing to have active dialogue with planners, particularly around local developments of care homes. Influencing their local development plan would be welcomed.

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# HEALTH & SOCIAL CARE SPENDING

## The Long Term Financial Landscape

In December 2016, the Scottish Government published the Health & Social Care Delivery Plan which sets out the programme for further enhancing health and social care services. Critical to this is shifting the balance of where care and support is delivered from hospital to community care settings, and to support individuals at home where appropriate. This furthers the Scottish Government's wider goal, to shift the balance of care from the acute hospital sector to community care by 2021.

It is anticipated that the public sector in Scotland will continue to face a challenging medium term financial outlook. Looking forward to 2018/19 and beyond, it is important that this context is understood and planned for in support of the delivery of the HSCP Strategic Plan, and adjusted on a year on year basis dependant on the allocation available.

In addition, subsequent Audit Scotland Reports on both NHS and Social Work in Scotland set out the real delivery challenges facing IJBs. These include:

- Social care faces growing demographic demand pressures which are unsustainable within existing service models and resources; and
- The NHS is facing a combination of increasing costs, staffing pressures which challenge how NHS boards balance demand for hospital care with investing in community-based services to meet future need.

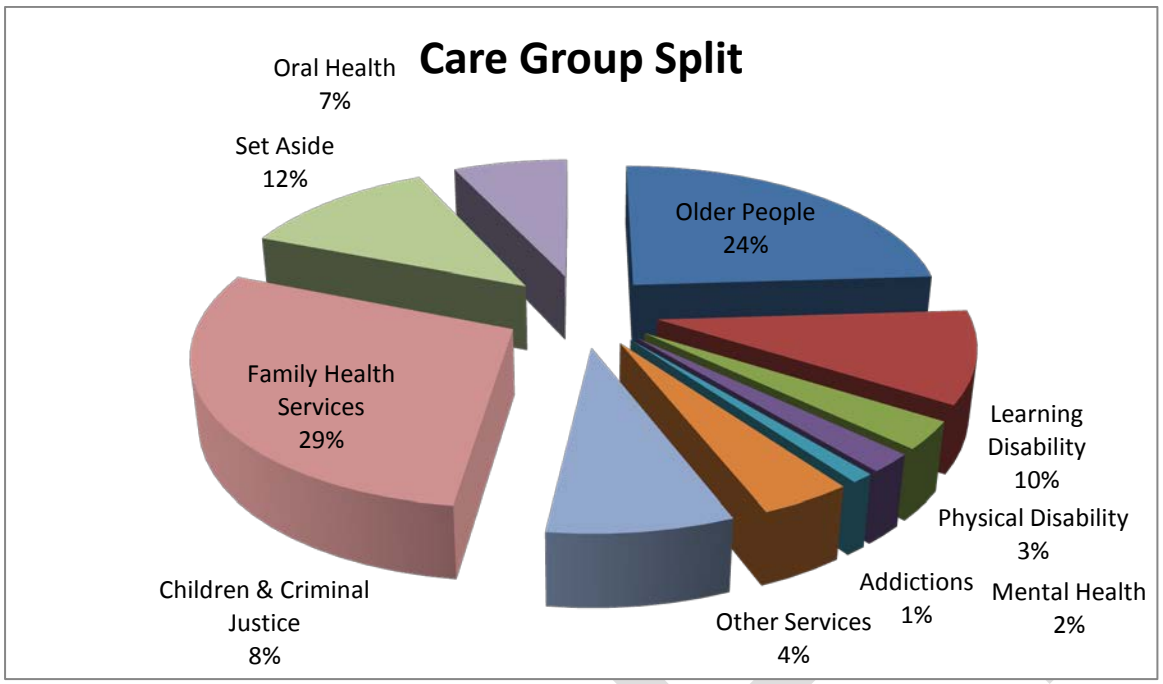
Currently the Scottish Government is carrying out a number of consultations which may have a direct impact on the 2018/19 budget allocations for IJB's. These include:

- Living wage and sleepover costs and implications;
- Impact of the carers legislation; and
- Impact of the proposal to extend free personal care to the under 65's.

## East Dunbartonshire Financial Landscape

The total budget for East Dunbartonshire HSCP for 2017/18 was £150.4m which includes £17.4m set aside (an allocation reflecting the usage of certain prescribed acute services including A&E Inpatient and Outpatient, general medicine, Rehab medicine, Respiratory medicine and geriatric medicine).

This is split across a range of services and care groups as follows:-




The current financial position (as at December2017) for East Dunbartonshire HSCP is indicating significant cost pressures in the areas of care at home services for older people, day care supports/supported living for young people transitioning through to learning disability and mental health services and residential placements for Children.

In terms of medium term financial planning, a detailed analysis of costs and demands has been undertaken for the partnership and assuming nothing else changes an additional £11.4m would be required to meet current and anticipated costs for the three years of the Strategic Plan, therefore significant change is required to ensure the sustainability of services and development required within this Strategic Plan.

The areas of key uncertainty for the HSCP include:-

- Impact of future Scottish Government funding levels on both the NHS and Local Authority;
- Pay Settlements and the impact of the decision to lift the pay cap on public sector pay;
- Demand led pressures particularly in the area of older people services but also for learning disability and children's Services;
- Prescribing costs as a consequence of rising costs and short supply of drugs.

The main areas of cost pressure relate to:

- Pay Inflation
  It is expected that pay increases will remain a recurring pressure for partnerships and current assumptions provide for 1.5% - 2% increase each year for both health and social work staff. This may be subject to a degree of variation given the decision to lift the pay cap for public sector pay. Assumptions also reflect the costs associated with the apprenticeship levy and increments for staff moving through the salary grades.
- Demographic and Volume
  This reflects increases anticipated across older people care at home services (assumed 6% increase year on year based on previous year trends), transitions from children's services to adult learning disability and mental health (assumed 10 – 15

cases transferring each year) and demands on residential school placements for children.

- Prescribing Costs
  Costs reflect current demand and cost pressures based on previous years' experience and analysis.
- Inflationary Pressures
  These reflect anticipated annual increases in payments to third parties and in the main reflect expected increases to the National Care Home Contract, fees for fostering, adoption and kinship care.
- Living Wage
  There were increases to the living wage in 2016/17 and then again in 2017/18 with an expectation that this will increase further to meet the Government's commitment to reach a national living wage of £9 by 2020. As in previous years it is expected that any increase will be funded by the Scottish Government through additional social care funding.

One of the Scottish Government's key policy commitments over the course of the parliament is to increase health spending by £500m above real term growth. Given the limited growth prospects for the Scottish Government budget, this commitment is likely to continue to have a challenging impact on respective partner agency budgets which are anticipated to be subject to sustained reductions over the coming years.

In addition to the delivery of key strategic priorities, it is expected that the HSCP will deliver significant year on year savings to address the financial challenges of reducing resources set against increasing cost and demand pressures. The partnership is therefore planning for the period 2018/19 to 2021/22 for a potential funding gap of £11.4m to £18.8m.

**Medium Term Financial Strategy**

In order to address the financial challenges over the medium term, the HSCP will need to develop plans to bridge the financial gap and focus spending on the areas which will deliver our strategic priorities. A medium term strategy will focus on a number of themes:-

- Maximise Efficiencies
  The HSCP will maximise opportunities to deliver services in the most efficient manner which seeks to protect frontline service delivery as much as possible.
- Strategic Planning and Commissioning
  The HSCP has strong links with the Third and Independent Sector and engage with them in a range of forums and we will work with them to ensure we are collectively agreeing plans for services and workforce. These arrangements inform service development and advise on direction of travel in progressing HSCP priorities. The Strategic Needs Assessment will inform the needs of the population and where resources should to be targeted, supplemented by a workforce strategy aligned to service redesign and commissioning intentions.
- Service Redesign and Transformation
  The underlying principle of integration is to shift the balance of care to enable individuals to live within their own home for as long as possible. To achieve this a shift in funding will also be required. This will require us to match service delivery with financial plans and consider responsibility in relation to acute / set budgets.

- Prevention and Early Intervention

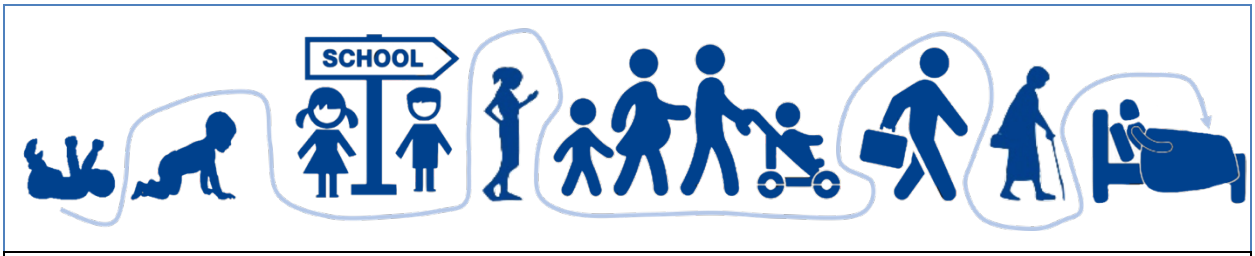
  This is an essential element of service changes and will have an impact on our financial position. We will need to consider the thresholds as part of our planning to ensure those on low incomes or minimum benefit levels are protected and there is equity of entitlement.

- Review of Eligibility and Charging
  The threshold for access to services is currently for those at critical or substantial risk and this is applied fairly and consistently across the HSCP. Equally there are opportunities for the HSCP to maximise income generation for the services it provides which ensures that those on low incomes or minimum benefit levels are protected from any charging as much as possible. This is set in the context of financial inclusion and ensuring that individuals are in receipt of all the benefits to which they are entitled through an income maximisation assessment.

- Service Reduction/Cessation
  As part of service redesign there will be a review of the range of services delivered across the HSCP which will inform not just areas which require expansion and investment but also areas where the HSCP will disinvest in line with the Strategic Plan.

# WHAT WE PLAN TO DO

The Strategic Plan emphasises the need to plan and deliver services that contribute to the health and wellbeing throughout people's lives. This approach focuses on a healthy start to life and targets the needs of people at critical periods throughout their lifetime. It promotes timely effective interventions that address the causes, not just the consequences, of ill health, deprivation and a range of other life circumstances.




Engaging and listening to communities, staff and partners about what matters to them was central to determining the HSCP's key priorities. Six engagement workshops were held across East Dunbartonshire involving members of the public, community organisations, partners organisations; and health and social care practitioners. These events focussed on the participants' perspective of what the priorities should be for the HSCP. Four themes emerged from the wide ranging discussions (a full report is available):

- Theme 1 : Keeping people healthy
- Theme 2 : Improving access to services.
- Theme 3 : Reducing unnecessary hospital admissions and supporting people to live at home or in a homely setting.
- Theme 4 : Supporting carers.


Service user and carer feedback and involvement will be a continuous process to ensure views from all sectors of the community are captured and shared to influence decisions made. Mechanisms for capturing this include:

- proactive feedback from service user and carers via face to face contact with practitioners; real-time independent patient surveys; national patient experience surveys
- reactive feedback in the form of complaints, comments and reported safety incidents;
- support the Service User & Carer Representative Group to ensure that service user experience is at the centre of everything the HSCP does; and
- regular stakeholder/community engagement events.

The Strategic Plan outlines eight key priorities to be delivered over the next three years.

Examples are given on what is already being delivered, what still needs to be delivered and what measures are in place to monitor performance. The eight priorities are:

| | | | |
|---|---|---|---|
| **PRIORITY 1.** Promote positive health and wellbeing, preventing ill-health, and building strong communities | **PRIORITY 2.** Enhance the quality of life and supporting independence for people, particularly those with long-term conditions | **PRIORITY 3.** Keep people out of hospital when care can be delivered closer to home | **PRIORITY 4.** Address inequalities and support people to have more choice and control |
| **PRIORITY 5.** People have a positive experience of health and social care services | **PRIORITY 6.** Promote independent living through the provision of suitable housing accommodation and support. | **PRIORITY 7.** Improve support for Carers enabling them to continue in their caring role | **PRIORITY 8.** Optimise efficiency, effectiveness and flexibility |

The development of commissioning priorities is an ongoing process and progress will be captured within HSCP Business Plans and reported through the Annual Performance Report.

**Equality Duties**

Health and Social Care Partnerships, as Public Sector Organisations, have specific legal duties applied to them under the Equality Act (2010) which are to:

| |
|---|
| Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Equality Act 2010. |
| Advance equality of opportunity between people who share a relevant protected characteristic that is protected under the Act, and those who do not. |
| Foster good relations between people who share a characteristic and those who do not. |

East Dunbartonshire HSCP's Equality Outcomes and Performance Measures were intimated in the Equality and Diversity Mainstream Report 2017–2021. Some of the identified activities that will take place during that period include:

- Engage with HSCP service users and particularly those with a disability to assess accessibility and work with East Dunbartonshire Council (EDC) and NHS Greater Glasgow & Clyde (NHSGG&C) to make all reasonable adjustments to Health and Social Care Services.
- Review services to ensure that they are based on biological rather than chronological access unless objectively justified.

- EDC and NHSGG&C employees are trained to use homelessness risk assessment tools and address need more effectively.
- Engage service users and carers to implement the engagement model as approved by East Dunbartonshire HSCP Board.
- Equality Impact Assessment is further developed as an online tool; training delivered to managers/lead reviewers and the process is embedded in practice.
- Set out mechanisms that enable service users and carers to have a voice in service planning and development.
- Develop and deliver health & wellbeing interventions through PLACE approach.
- Monitor participation levels for people with different characteristics through commissioned services.

The protected characteristics under the Equality Act 2010 are:

| | | |
|---|---|---|
| **AGE**<br>all ages | **DISABILITY**<br>all disabilities and health conditions | **GENDER**<br>male, female and transgender |
| **MARRIAGE and CIVIL PARTNERSHIP**<br>single, divorced, married, separated and civil partnership | **PREGNANCY and MATERNITY**<br>work, services, education, breastfeeding, premises etc | **RACE**<br>colour, nationality, ethnic, and national origins |
| **RELIGION or BELIEF**<br>All religions including no religious beliefs | **SEXUAL ORIENTATION**<br>bisexual, gay, heterosexual and lesbian | **CARERS**<br>All carers including formal and informal carers |

# STRATEGIC PRIORITIES

## STRATEGIC PRIORITY 1.

**Promote positive health and wellbeing, preventing ill-health, and building strong communities**

**What are we already doing?**

- Continuing to implement a successful 'WALK East Dunbartonshire' programme in partnership with the Leisure Trust that delivers appropriately graded supported walks for all ages.
- Supporting efforts to identify and increase employability opportunities, in particular, working with local employers and higher educational establishments to develop more opportunities for people with Autism/Aspergers.
- Developing the Community Assets map to help people to identify services and supports available to them
- Improving child health through the delivery of breastfeeding support; promoting good oral health and family registration with a dentist; delivering parenting programmes, and delivering childhood and school immunisation programmes.
- Implementing the Community Justice Local Outcome Plan and continuing to take forward the new Community Justice priorities.
- Criminal Justice Unpaid Work Service delivering community benefit activity for older and vulnerable people.
- Increasing access to leisure and culture services for children through the Corporate Parenting support.

**What matters to our residents, partners and staff?**

- The HSCP should help people to improve their health through activities such as walking, gardening and other social activities.
- Working with communities and partners to help people access the services they need whether or not it is a Council, Health or third sector service..
- Working with other organisations to promote and deliver a wide range of services that promote positive health, such as help to stop smoking; physical activity opportunities; healthy weight support; and promoting positive mental health.
- Social isolation has been highlighted as a significant issue for many in our communities. Loneliness can have an adverse impact on our health and well being should be addressed.

**What do we intend to do?**

- Address issues relating to loneliness including facilitating the development of befriending services; promoting social activities; developing intergenerational activities; and volunteering opportunities
- Further develop our successful model of Local area coordination in partnership with third sector organisations which improves access to services and decreases social isolation for vulnerable groups.
- Revise and improve our services to those suffering harm through alcohol and substance abuse
- Revise and update our Stop Smoking Services.
- Support people to better connect to their communities, for example development of the Community Asset Map, and utilising Self Directed Support to access a range of services provided by the community.
- Deliver a core programme of visits to all children from birth to 5yrs, to assess need, monitor development, promote positive health and support parenting (the Universal Pathway).
- Support free access to leisure facilities for looked after and accommodated children (LAAC) and care leavers.
- Improve access to welfare, health and wellbeing, housing and employability for people with convictions.
- Develop pathways within community payback orders to increase the use of specific alcohol, drug and mental health requirements and interventions to promote healthy living and risk reduction.
- Revise and update our Child Protection arrangement in line with national recommendation. Develop and implement the national child protection improvement programme.

**How we will measure our success?**

The HSCP aims to:

- Reduce smoking prevalence
- Increase the number of people meeting the national recommendation for physical activity, healthy eating and safer consumption of alcohol
- Increase levels of Breastfeeding rates
- Improve dental health and increase Child Smile registrations
- Maintain percentage of childhood immunisation uptake
- Increase community payback orders with alcohol, drug and mental health requirements to promote healthy living and risk reduction.

# STRATEGIC PRIORITY 2.

## Enhance the quality of life and supporting independence, particularly for those with long-term conditions

**What are we already doing?**

- Implementing the learning from the 'Wellbeing Workers' pilot programme, that supports people to access a range of social and community groups.
- Supporting people in recovery from alcohol and substance misuse by adopting a Peer Support approach.
- Ensuring full utilisation of the Intermediate Care facilities for service users being discharged from hospital.
- Providing demonstration visits to the Assisted Living Show Flat ensuring stakeholders are familiar with available technology.
- Delivering activities aimed at young people with learning disabilities via the Local Area Co-ordination Programme, for example, Music Group and Tennis Aces.
- Providing community payback orders with multi agency and third sector involvement.

**What matters to our residents, partners and staff?**

- Health and social care staff should be equipped to signpost people to services through routes into communities that have not been traditionally considered.
- Self management should be a partnership between people and the services that support them.
- Peer support approaches can play an important role in supporting people to self manage their health, providing information, support and sharing experiences.
- There needs to be care pathways to address relapse, ensuring people whose condition worsens find their way to the right service when they most need them.
- A range of effective early intervention services need to be in place to support more vulnerable people.

**What do we intend to do?**

- Re-orientate health services toward prevention of illness and promotion of health for our older and more vulnerable population so that they are supported by effective care and support services that enable them to maintain their independence and enjoy a high quality of life. This includes developing social prescribing approaches within all primary care settings.
- Develop and promote a range of sustainable approaches to self-management, early intervention and anticipatory care for people with long term conditions, including building on the learning from our 'House of Care' and 'Transforming Cancer After Treatment' (TCAT) pilot programmes.
- Identify and develop evidence based approaches to support people to better manage their long term health conditions including providing information to help

people connect people to a wide range of services in their community.

- Review and update our Older People Day Care services to deliver early a variety of services helping people live an active life
- Focus on improving our services for those people with dementia, and their carers, enhancing Dementia Post Diagnostic Support services, and further develop ‘Dementia Friendly Communities’.
- Roll out our Recovery Orientated System of Care (ROSC) service model which establishes closer links to communities for individuals with Alcohol & Drugs and/or Mental Health issues.
- Promote independent living through the uptake of telecare and telehealth solutions through the implementation of the Assisted Living Technology Strategy 2018-2023, and the development of E-frailty project and advancement of e-self solutions.
- Review and redesign service provision of both Learning Disability and Mental Health services to create modernised, sustainable and flexible service delivery models for service users, including developing community supports with the third sector.
- Review complex and non-complex care requirements and redesign Care at Home Services to ensure a balanced provision of in house/external services.
- Promote effective and efficient prescribing to minimise medicines waste, reduce prescribing costs and achieve a more consistent prescribing service across all GP practices.
- Review and improve services and interventions to support children who have long term conditions.
- Review and improve transition pathways for children and young people moving into adult services across all care groups.
- Improve access to health service interventions for the ageing population in custody.
- Implement an alcohol intervention and education programme, establishing closer links to partners and communities to raise awareness and reduce alcohol related harm.

**How we will measure our success?**

The HSCP aims to:

- Increase uptake of a variety of telecare/telehealth care solutions
- Improve drug and alcohol referral to treatment waiting times
- Improve psychological therapies referral to treatment waiting times
- Improve percentage of people newly diagnosed with dementia accessing post diagnostic support

# STRATEGIC PRIORITY 3.

## Keep people out of hospital when care can be delivered closer to home.

**What are we already doing?**

- Providing a seven day community nursing service including evening and overnight access to respond to unplanned care requirements in a timely manner through direct contact and single point of access at weekends.
- Reduced admissions through the Rapid Response service and established pathway between A&E and Community Rehabilitation Team to provide next day response.
- Working with care homes to introduce a falls pathway, reduce pressure ulcers and provide '*Stress and Distress'* training.
- Established pathways with Scottish Ambulance service to provide an alternative to hospital admission for non-injured people who fall.
- Reduced delayed discharges through the provision of intermediate care providing opportunity for full assessment and return home to the community.

**What matters to our residents, partners and staff?**

- Services should move beyond operating in a Monday to Friday, nine to five culture.
- Need to maximise the potential of telecare and access to services to support people in their own homes.
- Community rehabilitation is vital in returning people to independence.
- Services should incorporate different approaches to prevent people going into hospital and help them to be discharged quicker.
- Support needs to be in place before peoples' conditions reach crisis, meaning hospital admission becomes the last resort.
- Need to promote 'Advanced Statements' and 'power of attorney' to plan for future care needs.
- Care homes should integrate more with the local community for example encouraging intergenerational and befriending activities.
- Care home residents should be able to contribute to aspects of the care home life based on their skills and interests such as baking and organising activities.

**What do we intend to do?**

- Develop and commission recovery orientated care service provision for adults with complex mental health needs to provide alternative to long term hospital care. This will consider future models of care and support ensuring that the third sector is a key partner in our approach.
- Reshape and redesign community based rehabilitation services to avoid admission to hospital and facilitate discharge

- Contribute to NHS Greater Glasgow & Clyde Out of Hours (OOH) service review to support better access to services at different times and settings.
- Reduce unplanned hospital admission through the development of models to support people to receive the necessary care within their community, including the introduction of a Single Point of Access across health and social care services.
- Develop a joint approach with GP's and stakeholders to anticipate and respond to changes in those with life limiting conditions that require palliative care so that support can be provided at an early stage to enable people to remain at home.
- Develop the Care Home Liaison Nurse service to provide support and advice to care homes to enable them to care for residents with complex needs and prevent unplanned hospital admission.
- Support people who require end of life care in a homely setting to ensure their preferred place of death is met.
- Facilitate prompt discharge from hospital through working with hospital services to identify the needs of patients at an earlier stage.
- Utilise the opportunities which will come from the new GP Contract to improve local services and increase access to treatment and care in a local setting.

**How we will measure our success?**

The HSCP aims to:

- Reduce unplanned hospital admissions
- Reduce occupied bed days for unscheduled care
- Reduce A&E attendances
- Reduce bed days lost to discharges delayed
- Increase the percentage of last 6 months of life spent in the community

# STRATEGIC PRIORITY 4.

## Address inequalities and support people to have more choice and control.

**What are we already doing?**

- Increasing the number of early intervention/prevention and community assets available to all service user groups in partnership with the third sector.
- Delivering self directed support options to all service user groups and reviewing of local independent Self Directed Support information, advice and support.
- Increase accessibility; and support vulnerable and hard-to-reach individuals and groups access appropriate financial support services.
- Promoting and supporting the uptake of income maximisation services to increase financial benefit for children and their families and our older populations.
- Promoting and supporting the uptake of Healthy Start programme enabling families to access free vouchers every week to spend on milk, fruit, vegetables, infant formula milk and free vitamins.
- Work with families to enable them to appropriately access the Early Learning & Childcare entitlement.
- Deliver with Peer Volunteers, the Baby Café breastfeeding support within Hillhead PLACE community.
- Supporting people living in Hillhead & Harestanes, Lennoxtown and Auchinairn (PLACE communities) to establish or create new activities and strengthen community capacity through co-production and involving local residents and partners.

**What matters to our residents, partners and staff?**

- Remove barriers that prevent people taking action to maintain and improve their health and wellbeing, particularly for those people with mental health conditions; those fearing being a victim of crime; and children being bullied.
- The health and social care system is highly complex and is often difficult for people to understand and navigate easily.
- Waiting lists can create barriers to access and may prevent people getting the appropriate help when they most need it.
- Health and social care services should work with the voluntary sector to maximise financial advice and support advocacy for their service users in greatest need.
- Domestic violence has a negative impact on the physical and mental wellbeing of women and children.

**What do we intend to do?**

- Focus on Identifying where hidden health inequalities and poverty exist outwith areas of deprivation, particularly employability, fuel poverty and family income.
- Promote choice and control across all care groups through the implementation of the Self Directed Support Strategy 2018-21.
- Tackle child poverty, its cause and effects through working with our community planning partners and in line with the emerging Child Poverty Act
- Improve services for people with Autism by implementing a series of key community based actions
- Improving the health and well being of people subject to community orders and those leaving custody and returning to the community by improving access to local health services
- Deliver high quality health information, assessment and treatment to all prisoners.
- Provide health information, assessment and treatment for children who are looked after and accommodated.

**How we will measure our success?**

The HSCP aims to:

- Increase the number of service users utilising self directed support options.
- Increase the uptake of the income maximisation service.
- Monitor the uptake of Healthy Start programme.
- Increase the breastfeeding rates in deprived communities.
- Increase % of people released from a custodial sentence who are:
  - registered with a GP
  - have suitable accommodation
  - have had a benefits eligibility check

# STRATEGIC PRIORITY 5.

## People have a positive experience of health and social care services

**What are we already doing?**

- Service users and carers inform key HSCP decisions through their active representative on the HSCP Board, Strategic Planning Group and Locality Planning Groups.
- Service user feedback is being captured and acted upon through service user satisfaction surveys; service comments, complaints; and engagement events
- In partnership with Education, the HSCP has adopted an Alternative and Augmented Communication Protocol for young people with sensory impairment and provided AAC equipment
- Regularly reviewing the views of service users, family and partner agencies regarding the delivery of Justice Services.

**What matters to our residents, partners and staff?**

- People should experience their journey through the health and social care system as holistic and seamless.
- There needs to be more information about the transition from children's to adult services.
- Effective links between hospital services and community support will improve the experience of people, particularly those with dementia.
- The quality of the care provided could be improved through preventing duplication of assessments that just cover the same ground, as well as continuity of care delivered by those providing care.
- There should be better use of local pharmacies and promotion of the minor ailments service
- Joint working across health and social care teams and other organisations is more likely to enhance service provision.

**What do we intend to do?**

- Provide forums and opportunities for service users and carers to meet, discuss health and social care issues affecting local people and contribute to plans to reshape care locally.
- Establish more effective and consistent mechanisms to capture service user and carer feedback about the services they receive in order to inform service improvement.
- Improve transitional planning arrangements for young people, young carers and families who are approaching entry into adult health and social care services.
- Improve the effectiveness and efficiency of services by maximising opportunities for integrated service delivery including, reviewing referral pathways across care groups; implementing an Information Technology plan to promote information

sharing; and improving information systems.

- Develop a Community Justice Plan to improve supervision and services for people who have committed offences, from the point of arrest, through prosecution, community disposal or custody and alternatives to these, until they are reintegrated into the community.
- Increase the accessibility and availability of public information regarding Children's resources and eligibility criteria, including transitional arrangements between children and adult services.

**How we will measure our success?**

The HSCP aims to:

- Monitor the number of complaints and comments.
- Increase the percentage of service users satisfied with the quality of care provided
- Increase the percentage of service users satisfied with their involvement in the design of their care provided
- Increase the percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided

# STRATEGIC PRIORITY 6.

## Promote independent living through the provision of suitable housing accommodation and support.

**What are we already doing?**

- Building all new properties to meet the varying standards of need.
- Providing housing adaptations for residents in all tenures through the Care and Repair Scheme.
- Providing Telecare packages to existing residents.
- Utilise a 'Smart Flat' to demonstrate new technologies assisting older people to live in their home for longer.
- Providing a Care of Gardens scheme.

**What matters to our residents, partners and staff?**

- Suitable accommodation is available for vulnerable people within the communities in which they live at present.
- Many older people occupy homes unsuitable for their needs in terms of size or adaptation.
- People should have a range of housing options available to them to help match needs; there is no 'one size fits all' model.
- Support should be available for people to help assess available housing options.

**What do we intend to do?**

- Deliver the Affordable Housing Investment Programme, providing a percentage of amenity housing within larger development sites.
- Review our present older people's housing model and service provision to inform the development of a new generation of sheltered or extra care housing for rent that suits the needs of older tenants within their own communities.
- Actively pursue opportunities with the Registered Social Landlord sector to enable older people to continue as homeowners in accommodation more suitable to their needs.
- Establish the level and location of demand for housing for older people, particularly within the private sector, through a facilitated research study.
- Renew the commitment to the Care & Repair Scheme through new partnership working.
- Evaluate the Council's allocations policy to ensure that older people are being given an equitable opportunity to access the housing they need.

**How we will measure our success?**

The HSCP aims to:

- Increase the number of people receiving the ‘Care of Gardens’ Scheme.
- Increase the number of people accessing the Care and Repair Service.
- Increase the percentage of our housing for Specialist Needs with Community Alarm or Telecare systems to 65% by 2021.

# STRATEGIC PRIORITY 7.

## Improve support for Carers enabling them to continue in their caring role.

**What are we already doing?**

- Established a multi-disciplinary Carers Working group whose membership includes HSCP, Education, Carers Link, the third sector, and carers to inform the development of the new local Carers Strategy.
- Continue to involve carers in the planning of services at a strategic level through their representation on HSCP strategic groups.
- Eligibility criteria for carers published following consultation with carers.
- Identified Adult Support Plans and Young Carers Statements for identifying carers needs.
- Providing short breaks and respite for carers based on assessed need.
- Supporting raising the knowledge and awareness of carers about the Carers Act and the Adult Support Plans and Young Person Statement.

**What matters to our residents, partners and staff?**

- People should be supported to identify themselves as carers so that their needs can be assessed and supported.
- Carers' knowledge and understanding of the cared for person's situation needs to be better taken into account.
- More information about the services available and flexible respite is critical for carers to support them in their caring role.
- Young carers require support so that they can study and socialise.

**What do we intend to do?**

- Prepare and publish a local Carers Strategy with an accompanying action plan and performance framework which will embed the legislation into practice.
- Prepare and publish a Short Breaks Statement.
- Develop mechanisms to better identify adult carers and young carers in order to assess and monitor the impact of their caring role.
- Develop a system to harmonise the monitoring of carers identified and assessed carers across relevant disciplines and agencies.
- Work in partnership with carers organisations and other third sector organisations to raise awareness about the Act and carers rights, and develop services that support carers to continue in their caring role.
- Establish and maintain an accessible information and advice service for carers.

**How we will measure our success?**

The HSCP aims to:

- Increase number of adult carers identified and completing an Adult Support Plan
- Increase number of young carers identified and completing a Young Persons Statement
- Increase number of carers who feel supported to continue in their caring role

# STRATEGIC PRIORITY 8.

## Optimise efficiency, effectiveness and flexibility

**What are we already doing?**

- Developing HSCP and service area business plans outlining priorities and progress measures.
- Developing a Market Facilitation Plan to ensure there is diverse appropriate and affordable provision of available service providers across sectors to meet local needs and deliver effective outcomes both now and in the future.
- Co-located health and social care staff to achieve effective integrated communication and joint working.
- Involving staff in the development of a workforce plan to ensure organisational skills and capacity is fit for the future.
- Established a suite of governance arrangements to ensure the provision of safe, effective and efficient services
- Delivering Multi-Agency Protection Arrangements (MAPPA) bringing together the Police, Scottish Prison Service (SPS), Health and the Local Authorities, in partnership as the Responsible Authorities, to assess and manage the risk posed for certain categories of offender.

**What matters to our residents, partners and staff?**

- Local Hubs, libraries and community facilities should be better recognised and used as community resources.
- Build relationships with the third and voluntary sector who have critical knowledge, skills and capacity.
- Services should be redesigned to improve responseto meet need.

**What do we intend to do?**

- Enhancing contract management arrangements to ensure services are compliant, outcomes focussed and deliver best value.  Implement a Market Facilitation Plan to effect market change.
- Implement an Accommodation Plan to enable health and social care teams to work in an integrated way across both localities. This will mean completing our refurbishment of Kirkintilloch Health and Care Centre and review our accommodation arrangements in the Milngavie/Bearsden area
- Review and assess the impact of private sector care home developments across geographical areas.
- Engage and action feedback from the workforce through further embedding of iMatter staff survey across health and social care.
- Agree an Adult Learning Disability Strategy and Improvement Plan to improve the sustainability and consistency of resource allocation processes, redesign day services and streamline access to the continuum of accommodation-based

support services.

- Support the national priority for the implementation of the rollout of the Drugs & Alcohol Information System (DAISy) across alcohol and drugs services.

**How we will measure our success?**

The HSCP aims to:

- Monitor Adult and Child protection measures
- Reduction of re-offending
- Analyse and measure the impact and outcomes associated with the review and redesign learning disability and mental health services
- Monitor providers' compliance with contract monitoring framework

# APPENDIX A

The National Health and Wellbeing Outcomes are high-level statements of what the HSCP aims to achieve through improving quality across integrated health and social care services

| Outcome | | Priority 1 | Priority 2 | Priority 3 | Priority 4 | Priority 5 | Priority 6 | Priority 7 | Priority 8 |
|---|---|---|---|---|---|---|---|---|---|
| **1** | People are able to look after and improve their own health and wellbeing and live in good health for longer. | X | | | X | X | X | X | |
| **2** | 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. | | X | X | | | X | | |
| **3** | People who use health and social care services have positive experiences of those services, and have their dignity respected. | | X | X | X | X | | X | |
| **4** | Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. | | | X | X | | | X | |
| **5** | Health and social care services contribute to reducing health inequalities. | X | | | X | | | X | |
| **6** | People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being. | | | | | | | X | |
| **7** | People who use health and social care services are safe from harm. | | | | X | X | | | X |
| **8** | 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. | | | | | | | | X |
| **9** | Resources are used effectively and efficiently in the provision of health and social care services. | | | | | | | | X |