For meeting on

17 SEPTEMBER 2020

Agenda 2020

East Dunbartonshire Health & Social Care Partnership Board

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Health & Social Care Partnership

A meeting of the East Dunbartonshire Health and Social Care Partnership Integration Joint Board will be held within the **Committee Room, 12 Strathkelvin Place, Kirkintilloch, G66 1XT on Thursday 17th September 2020 at 9.00am** or via remote access during COVID Pandemic restriction arrangements to consider the undernoted business.

Chair: Susan Murray
East Dunbartonshire Health and Social Care Partnership Integration Joint Board

12 Strathkelvin Place
KIRKINTILLOCH
Glasgow
G66 1XT
Tel: 0141 232 8237

A G E N D A

Sederunt and apologies

Topic Specific Seminar – Autism Strategy, Richard Murphy, Resources and Registered Services Manager (Pages 1-12)

Any other business - Chair decides if urgent

Signature of minute of meeting for the HSCP Board held on; 25th June 2020

Item	Report by	Description	
STANDING ITEMS			
1.	Chair	Declaration of interests	
2.	Martin Cunningham	Minute of HSCP Board held on 25th June 2020	**13-18**
3.	Caroline Sinclair	Chief Officer's Report	**verbal**
STRATEGIC ITEMS			
4.	Caroline Sinclair	HSCP Strategic Plan	**19- 22**
5.	Caroline Sinclair	Covid-19: Recovery and Transition Plan	**23-40**
6.	Derrick Pearce	Draft Communications Strategy (2019 - 2022) and Action Plan	**41-178**
7.	David Aitken	Alcohol and Drug Recovery Service Funding	**179-184**
8.	Derrick Pearce	Older Peoples Housing Research	**185-288**
GOVERNANCE ITEMS			
9.	Caroline Sinclair	HSCP Annual Performance Report	**289-370**
10.	Caroline Sinclair	Quarter 1 / Annual Performance Report 2020-21	**371-408**
11.	Jean Campbell	Financial Performance Budget 2020/21 – Month3	**409-420**

12.	Paul Treon	Clinical and Care Governance Report	**421-438**
13.	Tom Quinn	Workforce Update	**439-454**
14.	Martin Brickley/Jenny Proctor	Public, Service User & Carer (PSUC) Representative Support Group	**455-458**
15.	Jean Campbell	Performance Audit and Risk Committee Minutes held on 18th June 2020	**459-464**
16.	Caroline Sinclair	East Dunbartonshire HSCP Board Agenda Planner	**465-466**
	Chair	Any other competent business – previously agreed with Chair	

FUTURE HSCP BOARD DATES

Date of next meeting – 9.30am to 1pm if Seminar schedule start time will be 9am.

Thursday 12th November 2020

All held in the Council Committee Room, 12 Strathkelvin Place, Kirkintilloch, G66 1XT or via remote access during COVID Pandemic restriction arrangements

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Agenda Item Number: Topic Specific Seminar

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17th September 2020
Subject Title	Information on Autism prevalence and provision in East Dunbartonshire Council, and areas of focus for 2020.
Report By	David Aitken, Interim Head of Adult Services
Contact Officer	Richard Murphy, Resources and Registered Services Manager richard.murphy@eastdunbarton.gov.uk

Purpose of Report	The purpose of this report is to advise the Board on supports to individuals with autism in East Dunbartonshire and our local prevalence with regard to national statistics. Also to advise of work undertaken to support individuals with autism across the lifespan and future areas of focus and development in line with Scottish Government policy.

Recommendations	It is recommended that the HSCP Board: 1. Note locally funded initiatives established through funding from the National Autism strategy. 2. Note the establishment of support to early years and education to help support more effective diagnosis and support 3. Note the autism prevalence in East Dunbartonshire in line with national statistics 4. Note the difficulty in establishing a definitive figure regarding individuals affected by autism and the reasons for this 5. Note current supports and resources for those affected by autism in East Dunbartonshire 6. Request further reports to the HSCP Board as required, to update on developments and progress with regard to the development and focus of the local ten year strategy

Relevance to HSCP Board Strategic Plan	This report supports the achievement of the HSCP Boards following priorities: **Priority 2** Enhance the quality of life and supporting independence for people, particularly those with long term conditions

	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

Implications for Health & Social Care Partnership

Human Resources	There are no Human Resources implications arising from this report at this stage. If any future Human Resources implications arise with regard to proposals or developments relating to the strategy, in its remaining five years, then these will be responded to in line with established policies and procedures

Equalities:	An Equality Impact Assessment (EQIA) has not been undertaken relating to the work of the Local Autism Strategy Steering Group. Any proposals or developments which would require an EQIA will be addressed as appropriate.

Financial:	There are no financial considerations attached to this update and it is expected that the progress of the Local Autism Strategy at this stage will remain within existing financial parameters

Legal:	None at this stage

Economic Impact:	It is hoped that the ongoing work of our local strategy will support individuals and families who are affected by autism into meaningful educational or employment opportunities, thus having a positive economic impact

Sustainability:	Existing developments from the strategy are sustainable; any future developments would be reviewed with regard to sustainability.

Risk Implications:	No risks identified with the report at this stage

Implications for East Dunbartonshire Council:	As a provider of supports and services to individuals and families affected by autism, and with knowledge that many families and individuals within EDC across the lifespan are affected by the condition, the Council will have significant interest in the development of appropriate ASD pathways and supports.

Implications for NHS Greater Glasgow & Clyde:	Implications could be with regard to scrutiny of diagnostic supports and services in relation to a support pathway for those affected by the condition.

Direction Required to Council, Health Board or Both	**Direction To:**	**Tick**
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	**x**

1.0 MAIN REPORT

Introduction

1.1 The ***Scottish Strategy for Autism*** was published jointly by Scottish Government and COSLA in 2011, the aim being to improve the lives of autistic people and their families and to build on improvement to autism services and access to them where appropriate. The original document set out 26 recommendations and set a vision that by 2021 *'individuals on the autism spectrum are respected, accepted and valued by their communities and have confidence in services to treat them fairly so that they are able to have meaningful and satisfying lives'*

1.2 Subsequently, in 2014 the Scottish Government published a report on the progress attached to the autism strategy. A mapping exercise was also conducted, which sought to 'map out' local autism services and to improve their coordination. This exercise coincided with the one-off investment of £35,000 for each local authority in Scotland to develop local autism strategies and action plans.

1.3 There has been a further commitment in spend from the Scottish Government towards an identified lack of educational psychologists in schools; the Scottish Government and COSLA agreed in 2018 to establishing £4m of funding, covering a three year period to 2021, to encourage training and recruitment, the money being targeted towards fees and living fees for educational psychologist trainees.

1.4 Funding was also made available for establishing 'autism toolboxes' for all schools. This is an online resource which is supported by the Scottish Government and has been developed by Scottish Autism with support from Autism Network Scotland. The resource aims to support the inclusion of autistic children and young people in mainstream education services in Scotland. As well as introducing and describing some of the more common challenges a pupil with autism might face, it provides life case studies from Scottish schools and practical examples of supports that can be used in school settings. It also signposts to other websites and resources.

1.5 In East Dunbartonshire there have also been 'Autism Advisers' introduced to all schools and there is representation from each of our 42 schools at two local conferences a year. The additional introduction of sector specific professional learning communities (4 for primary and 2 additional half day conferences for secondary colleagues) draws on and complements the core conferences

1.6 There has been no additional spend or investment attached to the strategy, however, which would support the development of activities or resources at a local level. There was the opportunity to make bids for the Scottish Autism innovation fund in 2015/16 – £4.5 million had been identified at that time for local authorities, independent sector and charities to submit funding proposals. East Dunbartonshire's Local Area Coordinators were successful with an EDC bid and received £32,764 to support the establishment of pop up information sessions in the council's hubs and leisure centres and to also support a travel training programme – specifically for young people affected by autism who required a support with travel to colleges and further education sites in Glasgow.

Autism Prevalence in East Dunbartonshire

1.7 According to 'The National Autistic Society' around 700,000 people in the UK may have autism or more than 1 in every 100 of the population. This is approximately 1.1% of the population (taken from the 2011 UK Census figures) An indicative figure for East Dunbartonshire, therefore, would be 1,200 individuals affected by the condition

1.8 The 2011 Scotland census as applied to East Dunbartonshire indicated a lower prevalence – 0.89% but the belief is that this may indicate under reporting, and better diagnostic provision in early years is hoped to improve detection of individuals who are on the spectrum. It can also be difficult to provide an accurate overall picture of ASD prevalence and reasons for under diagnosis may include:

Masked Symptoms. Higher intelligence and language skills can sometimes disguise certain symptoms. The ability of some individuals to do well in school and communicate effectively may remove autism as a possible diagnosis when looking for reasons for some perceived issues or behavior. Children's' strengths may possibly carry them through early school with only minor issues, which then become more pronounced when schoolwork becomes more abstract, demanding, and verbal—or when social interactions become more complex.

Early misdiagnoses. The individual may have received a number of other, related diagnoses while the underlying autism has went undetected. It is not unusual for individuals with autism to also have diagnoses of attention-deficit hyperactivity disorder, obsessive-compulsive disorder, social anxiety disorder, and other developmental or mental disorders. A child with another diagnosis may not be properly evaluated for autism until later in childhood or even into adulthood.

Age. The individual may have been born before the diagnosis of Asperger syndrome (now more commonly referred to as high functioning autism) was included in diagnostic literature. It was the 1990's before Asperger syndrome was added to the diagnostic manual along with other "milder" forms of autism and many individuals may never have thought of seeking a diagnosis as an adult.

Hidden symptoms. The individual may have developed the means to hide, manage, or overcome his or her symptoms. People with high functioning autism are, by definition, of average or above-average intelligence. If they are told often enough to comply with social presentation and, for example, to limit some behaviours associated with autism such as rocking, flapping, or talking exhaustively about the same subject matter—they are often able to either disguise, control, or actually overcome the need to present overt symptoms.

Diagnosis in females. Some research suggests that women and girls are under-diagnosed with autism. Four times as many boys and men are diagnosed with autism than women and girls, the reasons are not yet clear.

Review of current strategy and local developments and resources

1.9 In recognition that we were halfway through our local 10 year strategy we held a series of consultation events in East Dunbartonshire in November and December 2019, these involved drop in sessions during the day and at night in Kirkintilloch and Bearsden, with the possibility of also providing comment through information and materials published

on the council and board websites. This afforded the opportunity to gauge if the direction of our strategy met the main areas of importance for individuals and families affected by the condition and also resulted in dissemination of information on resources and supports, available for people in East Dunbartonshire, - which is now published on our council and HSCP board websites (see appendix 1)

1.10 Through the consultation exercise we highlighted the suggested focus for the local ASD strategy for the next year, and received positive feedback and support with regard to the two areas of development we had identified for 2020

1. **Establishing Clear Pathways** (from pre diagnosis, through to post diagnosis; covering significant transition periods for individuals and families and identifying and signposting to supportive resources)
2. **Developing Autism Friendly Communities** (Raising awareness of autism in EDC and exploring the development of autism friendly environments in HSCP, Council, Education and EDLC services - and in mainstream community settings and resources)

1.11 We also sought input and advice via our local ASD carers forum and have identified volunteers from this group to help us take forward work with regard to the establishment of autism friendly communities. Work will now proceed in this area with the aim to develop some practical information which can advise local organisations or businesses on how to make environments or services autism friendly.

Recent Scottish Government Policy and direction relevant to the development of the local strategy

1.12 The most recent Scottish Government review of its Autism strategy **'Outcomes and Priorities 2018-2021'** sets out priorities for action through to 2021 to improve outcomes for autistic people living in Scotland.

1.13 This report identifies 4 strategic Outcomes and Priorities which would inform future work and direction for our local strategy:

1. **Strategic Outcome One: A Healthy Life**
   Autistic people enjoy the highest attainable standard of living, health and family life and have timely access to diagnostic assessment and integrated support services.

2. **Strategic Outcome Two: Choice and Control**
   Autistic people are treated with dignity and respect and services are able to identify their needs and are responsive to meet those needs.

3. **Strategic Outcome Three: Independence**
   Autistic people are able to live independently in the community with equal access to all aspects of society. Services have the capacity and awareness to ensure that people are met with recognition and understanding

4. **Strategic Outcome Four: Active Citizenship**
   Autistic people are able to participate in all aspects of community and society by successfully transitioning from school into meaningful educational or employment opportunities.

1.14 These priority areas have been incorporated into the focus of the Autism Steering group and all four sit within the two main focus areas for the next year: Establishing Clear Pathways and Developing Autism Friendly Communities

Appendix 1 Local Additional Support Needs and ASD resources and activities

Below is a list of some activity and social groups within East Dunbartonshire for individuals with Autism or Additional Support Needs

Activity	Description	Website	Contact details
The Sporting Aces (formerly the Tennis Aces)	Sporting activities for people with a Learning disability and/or Autism in Kirkintilloch. Groups for ages 5+	www.thesportingaces.co.uk	Allwyn Crawford – 07869 033 345
Kirkintilloch 'Friday club'	Social club on Fridays 7-9pm at Hillhead community centre, Kirkintilloch. Different activities every week eg. karaoke, tea party, quizzes, Halloween party etc.	*(Facebook search)* 'The Friday Club Kirkintilloch'	Hannah Murray/George Burt (Local area co-ordinators) – 0141 578 2142 or Eilidh Swatton – 07847 225 284
Wednesday night ED club	Similar to the Friday club but on a Wednesday night at Kelvinbank resource centre from 6:30-9pm, run by Real Life Options	-	Isobel Aiton – 07726 695 803 or isobel.aiton@reallifeoptions.org
Gardening group	Gardening group for those with a Learning disability and/or Autism, starting again in Spring 2020.	-	Hannah Murray/George Burt (Local area co-ordinators) – 0141 578 2142
Sounds of the Gallery band	Band based in Kirkintilloch for those with a Learning Disability and/or Autism, meeting every Wednesday from 2-4pm.	-	Hannah Murray/George Burt (Local area co-ordinators) – 0141 578 2142
Womens group	Monthly group for females with an ASN, including autism, to meet and socialise, taking part in various activities across East Dunbartonshire & Glasgow	-	Hannah Murray/George Burt (Local area co-ordinators) – 0141 578 2142
Supper club	Cooking group for those with a Learning disability and/or Autism meeting on a Thursday afternoon at Hillhead Community centre. Must	-	Hannah Murray/George Burt (Local area co-ordinators) – 0141 578 2142

Appendix 1 Local Additional Support Needs and ASD resources and activities

	complete 'Good food, good health' course before attending group.		
Walking group	Local walks around Kirkintilloch from 11-12 every Friday starting from the Kirkintilloch leisure centre	-	Hannah Murray/George Burt (Local area co-ordinators) – 0141 578 2142
Teenscene	A supported youth group service for teenagers with an ASD ages 12-18 in East Dunbartonshire run by the National Autistic Society.	*(Google search)* 'National Autistic Society Scotland Teenscene'	Anna Williamson – 0141 221 8090 or anna.williamson@nas.org.uk
Aye can dae activities	Wellbeing workshops and activities for adults with an ASN including music/dance classes and social opportunities	www.ayecandae.co.uk	Eilidh Swatton – 07847 225 284 or ayecandae@outlook.com
EDICT Autism-specific groups	Creative art groups for people with an ASN in East Dunbartonshire	www.edictarts.co.uk/autism-spectrum	0141 578 0251 or main.office@edictarts.co.uk
Posi+	A part time personal and social awareness programme for learners (normally aged generally 18+) with mild to moderate learning disabilities/difficulties. The programme supports them to further develop their team working, communication and other soft skills by taking part in an exciting personal awareness, personal development and vocational programme. The primary purpose of the programme is to support targeted learners into a positive post-school destination in employment, education, training and/or volunteering.	-	Tam James – 0141 777 3099 or thomas.james@eastdunbarton.gov.uk

Appendix 1 Local Additional Support Needs and ASD resources and activities

Disability sport finder	Website to search for sporting activities within your local area for those with a disability	www.disabilitysportfinder.org.uk	-
Meetup.com	A range of social groups for specific interests in Glasgow and East Dunbartonshire (ie. anime fans, walking groups, dancing groups, music lovers etc.) Has some ASD-specific meetup groups.	www.meetup.com	-
Creatovators	Sessions for those with an ASD in East Dunbartonshire including Lego therapy, group activities and Playscheme. Targeted at younger children but open to all ages.	www.creatovators.com	June Grindley – 07981 656 184 or june@creatovators.com
Autism links befriending	Befriending scheme for people with a disability in East Dunbartonshire	*(Google search)* 'East Dunbartonshire befriending service Autism links'	Moira Hutchison – 0141 578 6680
Person to person	National Autistic Society's mentoring and befriending service for Autistic adults over 26 years old in East Dunbartonshire and Glasgow. (Also run coffee clubs in Glasgow city).	(Google search) National Autistic Society Person to Person	persontoperson@nas.org.uk
Creative Sparks theatre arts	All-inclusive arts school with classes in acting, singing and dancing in East Dunbartonshire. Ages 5-18	*(Google search)* 'Creative sparks theatre arts East Dunbartonshire'	Jennifer McDonald – 07828 731 407
Active schools ASN opportunities	Booklet containing details of sports opportunities for those with an ASN in East Dunbartonshire for ages 4+.	Contact active schools co-ordinators for a copy of the booklet or more information	karen.borland@eastdunbarton.gov.uk or Karen.oconnor@eastdunbarton.gov.uk or 0141 777 3023

Appendix 1 Local Additional Support Needs and ASD resources and activities

Twinkle tots	Play sessions for pre-school children with an ASN meeting every Thursday at Hillhead community centre Kirkintilloch.	-	Hillhead community centre – 0141 578 611
Campsie View Friday Fun	Play sessions for children under 2 years old with complex medical and learning needs. New attendees must be referred by a health professional	-	Moira Jones – 0141 955 2339
Contact point social groups	Social interaction groups twice a week in Kirkintilloch	www.contactp.co.uk	0141 776 4391 or contactp@yahoo.com
NAS social programmes	Social groups across Glasgow and East Dunbartonshire for people with Autism	*(Google search)* 'National Autistic Society social programmes'	-
Speech Language Communication Company youth group	Social groups for people between 11-18 years old who struggle with speech, language and communication, based in Bearsden	*(Facebook search)* 'SLCo'	Laura – 07525 852 853 or YouthClub@s-l-co.uk
Speech Language Communication Company 'Get a buddy'	Befriending service for people aged 17-24 with severe speech and language difficulties, based in Bearsden	*www.speech-language-communication-company.uk/services/*	admin@s-l-co.uk or 01382 202 644
ENABLE social groups	A range of groups across East Dunbartonshire and Glasgow	www.enable.org.uk/area	enabledirect@enable.org.uk or 01698 737 000
Some popular groups in Glasgow, not East Dunbartonshire -			
Riding for the disabled	Horse riding sessions for people with disabilities of all ages, based in Summerston	www.rdaglasgow.org	rda@rdaglasgow.org or 0141 945 1369
Dates n mates	A range of social groups for people with a Learning Disability over 18 years old eg. club nights, karaoke, speed dating, quiz nights, bowling etc.	www.dates-n-mates.co.uk	0141 427 2957 or dnm@c-change.org.uk

Appendix 1 Local Additional Support Needs and ASD resources and activities

Paragon music	Inclusive opportunities in music, dance and theatre classes	www.paragon-music.org	0141 354 0234 or admin@paragon-music.org

If you know of any changes to the groups or know of any other groups which should be included in this list then please contact Local Area Co-ordinators (LAC's) for East Dunbartonshire George Burt or Hannah Murray.

This list will be updated regularly. If you would like to be sent the most recent copy then either contact LAC's or google search **'East Dunbartonshire Council disability services'** 'where you can download a copy.

(There is also a parent and carers forum in Kirkintilloch every 2 months for parents or carers who have a responsibility for someone with Autism. Each session there is a guest speaker from a range of backgrounds, and a chance to network with peers and share information. If you would like to come along then please contact LAC's for details of the next meeting).

Local Area Co-ordinators for East Dunbartonshire –

George.Burt@eastdunbarton.gov.uk
Hannah.murray@eastdunbarton.gov.uk

Local Area Co-ordinator lead for Glasgow –

Raymond.traynor@sw.glasgow.gov.uk

Interim Chief Officer
Caroline Sinclair

East Dunbartonshire Health & Social Care Partnership

Agenda Item Number: 2.

Minute of meeting of the Health & Social Care Partnership Board held via Webex Remote Meeting, on **Thursday, 25th June 2020 at 9.00am.**

Voting Members Present: EDC Councillors **MECHAN, MOIR & MURRAY**

NHSGGC Non-Executive/Executive Director
FORBES, McGUIRE & RITCHIE

Non-Voting Members present:

C. Sinclair	Interim Chief Officer - East Dunbartonshire HSCP
J. Campbell	Chief Finance and Resource Officer - East Dunbartonshire HSCP
P. Treon	Interim Clinical Director
V. Tierney	Chief Nurse – East Dunbartonshire HSCP
M. Brickley	Service User Representative

Councillor Susan Murray (Chair) presiding

Also Present:

T. Quinn	Head of People and Change, NHS
D. Pearce	Head of Community Health and Care Services – East Dunbartonshire HSCP
G. Cornes	EDC Chief Executive
M. Cunningham	EDC Corporate Governance
A. Meikle	TSI
G. McConnachie	HSCP Chief Internal Auditor
K. Donnelly	EDC Chief Solicitor and Monitoring Officer
V. McLean	Corporate Business Manager – East Dunbartonshire HSCP
L. Tindall	Organisational Development Lead – East Dunbartonshire HSCP

APOLOGIES FOR ABSENCE

J. Proctor	Carers Representative
L. Johnston	Interim General Manager, Oral Health Directorate

ANY OTHER BUSINESS WHICH THE CHAIR DECIDES IS URGENT

The Chair advised that planning permission has been approved for Allander Sports Centre and Adult Resource Centre.

The Chair also wished to thank Caroline Sinclair Chief Officer, HSCP Senior Management Team, and HSCP staff for the significant work undertaken during Covid-19 and business continuity delivery.

1. DECLARATION OF INTERESTS

The Chair sought intimations of declarations of interest in the agenda business. There being none received the Board proceeded with the business as published.

2. MINUTE OF HSCP BOARD HELD ON 26TH MARCH 2020

There was submitted and approved a minute of the meeting of the Health & Social Care Partnership (HSCP) Board held on 26th March 2020.

3. CHIEF OFFICERS REPORT

The Chief Officer addressed the Board and summarised the national and local developments since the last meeting of the Partnership Board. Details included:-

- Resumption of HSCP Board arrangements and stand down of fortnightly update.
- Thanks to staff and providers on work delivered throughout the pandemic.
- Incredible support and work underway for Care Homes.
- As Recovery and Transition progresses, and resumption of services begin there will be continued use of technology to deliver services moving forward.
- Life Changes Trust bid was successful and will commence in the near future.
- Dr Paul Treon, appointed to Clinical Director post effective from 29th June 2020.
- Val Tierney will take up full time secondment as Chief Nurse in West Dunbartonshire HSCP until Christmas 2020. Process underway to backfill Chief Nurse post from 6th July 2020.

4. UNSCHEDULED CARE COMMISSIONING PLAN

A Report by the Head of Community Health and Care Services, copies of which had been circulated, was presented to the HSCP Board as an NHSGG&C wide plan noting unscheduled care performance and actions for East Dunbartonshire HSCP. Full details were contained within the Report and attached Appendices.

Following questions and further discussion, the Board noted the report and agreed:

a) to the interim implementation of the draft East Dunbartonshire Unscheduled Care Action Plan 2020-21, noting it will be further updated in line with wider consultative process and covid led changes;

b) to approve the East Dunbartonshire Ministerial Strategic Group unscheduled care performance targets for 2020-21 at **Appendix 4**, progress against which will be reported to the HSCP Board on a quarterly basis.

5. DRAFT ANNUAL ACCOUNTS 2019/20 AND FINANCIAL OUTTURN YEAR END

A Report by the Chief Finance and Resources Officer, copies of which had been circulated, was presented to update the HSCP Board on the financial out turn for 2019/20 and present the draft Annual Accounts.

It was noted that the annual accounts for the IJB are prepared in accordance with appropriate legislation and guidance. The Accounts have been forwarded to Audit Scotland with expected return end of September 2020.

The Chief Finance and Resources Officer provided an update highlighting;

- The partnership incurred a deficit during 2019/20 of £0.2m.
- The actual over spend on services is nearer £0.6m, after adjusting for the impact of funding received during the year for specific initiatives which would be taken to earmarked reserves to support future expenditure in these areas.
- This represents a positive movement from that reported in Month 10 of £1.3m (Month 10 projected a £1.9m deficit). This related in the main to a number of year end entries related to services managed outwith the HSCP, bad debts and the outcome of direct payment audits which all had a positive impact on the budget position. These are areas which will be monitored and reported on throughout the year to ensure the board has effective oversight of these as the year progresses.
- The HSCP reviewed the earmarked reserves available and applied a number of these to mitigate the over spend and also applied the limited general reserves available of (£41k) which provided a total of £0.6m applied from reserves to balance the year end position.
- There are no remaining general reserves going forward and the level of earmarked reserves is £0.8m and covers specific funding provided by the Scottish Government.

Following questions and further discussion, the Board noted the report and Unaudited Accounts for 2019/20.

6. QUARTER 4/ANNUAL PERFORMANCE REPORT 2019-20

A Report by the Chief Officer, copies of which had been circulated, was presented to the HSCP Board of an interim HSCP Performance Report for the period January to March 2020 (Quarter 4), as the full statutory report has been delayed due to the Covid-19 emergency response. Full details were contained within the Report and attached Appendices.

Following questions and further discussion, the Board agreed with the recommendations;

- Note the deferment of the full statutory HSCP Annual Performance Report for 2019-20 due to the impact of the Covid-19 emergency and agree to its later publication in the Autumn of 2020;
- Note the content of the Quarter 4 and Full Year Performance Report 2019-20 at **Appendix 1**.
- Provide a statement for the HSCP website to let the public know that the full report will be deferred until Autumn 2020.

7. CLINICAL AND CARE GOVERNANCE SUB GROUP – MINUTES OF MEETING HELD ON 13TH MAY 2020

The Chief Nurse provided a Report to the Board, copies of which had previously been circulated with an update of the work of the Clinical and Care Governance Subgroup. Full details are contained within the Report and draft note of Clinical and Care Governance Subgroup meeting – 13th May 2020. Summary points include;

- Meetings of Clinical and Care Governance Group were stood down at the beginning of HSCP Pandemic response. Alternative governance was established e.g. Local Response Management Team and Senior Management Team as well as a weekly Public Protection Leadership Group.
- Regular HSCP Clinical and Care governance meetings were reinstated as of 13.05.20 providing an opportunity to review governance of our Covid response and related service developments including opening of Covid Assessment Centre and, plans for Covid 19 Testing Streams in Care Homes.
- It was agreed that SCI /Datix Incidents and Complaints would be added to the SMT agenda to provide enhanced and more frequent oversight of these matters.
- Recognising the unprecedented demand on care homes during the pandemic period the mechanisms to provide additional assurance and support regarding quality of care within care homes were reviewed. An area of good practice is the significant clinical support that has been provided by

the HSCP – ANP, District Nurses and GP's and this is reported to have been greatly appreciated by local Care Homes.

Following questions and further discussion, the Board noted the report.

8. EAST DUNBARTONSHIRE HSCP STAFF PARTNERSHIP FORUM MINUTES OF MEETING HELD ON 13TH FEBRUARY 2020

A Report by the Head of People and Change, copies of which had previously been circulated, provided Members with the re-assurance that Staff Governance was monitored and reviewed within the HSCP. Full details were contained within the Report and attached Appendix.

Head of People and Change noted the HSCP has increased its engagement with staff side partners during the COVID-19 pandemic. The staff side Joint Chairs are invited to attend the weekly Local Response Management Team (LMRT). There has been an increase in the frequency of the staff forum from 8 weekly to 2 weekly by Microsoft Teams to ensure opportunity to engage in transition planning. Staff side colleagues have also been asked to provide nominations to work on a staff well-being strategy, which will focus on local solutions and process as well as connecting to the national frameworks.

Following consideration, the Board noted the contents of the Report.

9. EAST DUNBARTONSHIRE DRAFT PERFORMANCE, AUDIT & RISK COMMITTEE MINUTES O F MEETING HELD ON 17TH MARCH 2020

A Report by the Chief Finance & Resources Officer, copies of which had previously been circulated, provided the Board with an update on the business of the Performance, Audit and Risk Committee held on the 17th March 2020. Full details were contained within the Report and attached Appendix. A further meeting of the Performance, Audit and Risk Committee took place on 18th June 2020, however unable to bring next set of minutes to the Board Meeting as they were unavailable.

Audit Scotland presented plan and Chief Internal Auditor updated on the Transformation Plan.

Following questions and further discussion, the Board noted the contents of the minute of the Performance, Audit and Risk Committee held on the 17th March 2020.

The Board noted the contents of the Report and notes of meeting held on 17th March 2020.

10. EAST DUNBARTONSHIRE HSCP BOARD AGENDA PLANNER

The Chief Officer provided an updated schedule of topics for HSCP Board meetings 2020/21 which was duly noted by the Board. HSCP Organisational Development Lead will set dates for Board Development Sessions with first session to be arranged for August 2020.

ANY OTHER COMPETENT BUSINESS

DATE OF NEXT MEETING

Thursday 17th September 2020, 9.00am to 1pm

All held in the Council Committee Room, 12 Strathkelvin Place, Kirkintilloch, G66 1XT or via remote access during COVID Pandemic restriction arrangements.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17 September 2020
Subject Title	Strategic Plan 2018-21: Review
Report By	Caroline Sinclair, Interim Chief Officer and Chief Social Work Officer
Contact Officer	Alan Cairns, Planning, Performance & Quality Manager Alan.cairns2@ggc.scot.nhs.uk

Purpose of Report	To seek approval for a proposed arrangement for the statutory process of review of the Strategic Plan

Recommendations	It is recommended that the HSCP Board: • Approve the approach to reviewing the Strategic Plan 2018-21, as set out in this report.

Relevance to HSCP Board Strategic Plan	This report sets out the proposed arrangement for the statutory process of review of the Strategic Plan

Implications for Health & Social Care Partnership

Human Resources:	None
Legal:	None
Equalities:	None
Financial:	None
Economic Impact:	None
Sustainability:	None
Risk Implications:	None
Implications for East Dunbartonshire Council:	The Council has significant interest in the preparation of the Strategic Plan as a constituent authority of the HSCP. In addition, by statute a constituent authority must provide an integration authority with such information as the authority may reasonably require for the purpose of carrying out a review and preparing a

	strategic plan.

Implications for NHS Greater Glasgow & Clyde:	The NHS Board has significant interest in the preparation of the Strategic Plan as a constituent authority of the HSCP. In addition, by statute a constituent authority must provide an integration authority with such information as the authority may reasonably require for the purpose of carrying out a review and preparing a strategic plan.

Direction Required to Council, Health Board or Both	**Direction To:**	**Tick**
	1. No Direction Required	**X**
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

1.0 MAIN REPORT

1.1 The current East Dunbartonshire HSCP Strategic Plan is due for review by 31 March 2021. As part of this review it would be considered whether a replacement Strategic Plan should be prepared and the process to achieve that. These statutory provisions are set out in the Public Bodies (Joint Working) (Scotland) Act 2014, extracted at **Appendix 1** to this report.

1.2 Due to the impact of the Covid-19 pandemic, preparations for the review and replacement of the current Strategic Plan 2018-21 have been significantly curtailed. Officers who would have been involved in this work have been heavily engaged in supporting the Covid-19 pandemic response and continue to prioritise recovery and transition planning to ensure that services can be remobilised as safely and as quickly as possible.

1.3 The five HSCPs across Scotland that were due to review their Strategic Plan by 31 March 2021 have worked closely with the Scottish Government to propose a way forward that preserves the integrity of HSCP Strategic Planning whilst balancing the immediate and ongoing pressures of the Covid-19 crisis. A meeting to discuss the way forward was held on 3 August 2020, hosted by the Scottish Government.

1.4 Taking account of the advice of the Scottish Government and in pursuance of consistency across the country, the HSCP Chief Officer proposes to develop a one year bridging document for 2021-22 that would achieve the following:

- Meet the statutory requirement to review the HSCP Strategic Plan within the 3 year period. The document would set out a retrospective review of how well the Strategic Plan has delivered change in line with its priorities, in meeting the national Health and Wellbeing Outcomes and in line with the delivery principles. In addition, the review would take account of the impacts of Covid 19 and consider how well the existing strategic priorities stood up to this during the height of pandemic;
- Propose that the Strategic Plan is replaced, following a period of consultation and consideration that takes account of existing and new challenges (including Covid-19, finance, transformational change, the national review of social care and other national and local initiatives)
- Acknowledge the difficulty in replacing the Strategic Plan by March 21 due to the practical and resource impacts of Covid, the constraints on community and stakeholder consultation and the inevitable and overwhelming preoccupation with active Covid-19 response and recovery during 2021-22;
- Propose the continuation of the Strategic Priorities in the existing Strategic Plan for one year with the same success measures, with the addition of Covid recovery and transition and any other significant strategic priorities as may be agreed by the HSCP Board for this period;
- Propose that the intervening period would see the preparation of a Strategic Needs Assessment and programme of community consultation to support preparation of new Strategic Plan, to take effect from 1 April 2022.

APPENDIX 1

Public Bodies (Joint Working) (Act) 2014

(Extract)

37 Review of strategic plan

This section has no associated Explanatory Notes

(1) An integration authority—

(a) must before the expiry of the relevant period review the effectiveness of its strategic plan,

(b) may from time to time carry out such a review.

(2) In carrying out a review under subsection (1), the integration authority must—

(a) have regard to—

(i) the integration delivery principles, and

(ii) the national health and wellbeing outcomes, and

(b) seek and have regard to the views of its strategic planning group on—

(i) the effectiveness of the arrangements for the carrying out of the integration functions in the area of the local authority, and

(ii) whether the integration authority should prepare a replacement strategic plan.

(3) Following a review under subsection (1), an integration authority may prepare a replacement strategic plan.

(4) Subject to subsection (2), the process of such a review is to be such as the integration authority determines.

Agenda Item Number: 5

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17 September 2020
Subject Title	Covid-10: Recovery and Transition Plan
Report By	Caroline Sinclair, Interim Chief Officer and Chief Social Work Officer
Contact Officer	Alan Cairns, Planning, Performance & Quality Manager Alan.cairns2@ggc.scot.nhs.uk

Purpose of Report	The purpose of this report is to set out the approach East Dunbartonshire HSCP is taking to the transitional, post-emergency phase of the COVID-19 pandemic. The Covid-19 Recovery and Transition Plan at **Appendix 1** sets out key principles and priorities. It outlines our wide-reaching planning approach and the arrangements being put in place to oversee these processes.

Recommendations	It is recommended that the Health & Social Care Partnership Board: • Note the contents of this report; • Note the Recovery and Transition Plan at **Appendix 1**.

Relevance to HSCP Board Strategic Plan	The approaches outlined in the Recovery and Transition Plan ensure that any changes to services that have taken place or proposed are consistent with the strategic priorities laid out in the Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	The Recovery and Transition Plan acknowledges the need to ensure the recovery phase takes into account staff support, health and wellbeing. The operational recovery plans include reference to the implications of staffing levels, health and safety, and health and wellbeing.

Equalities:	The Recovery and Transition Plan includes reference to the importance of ensuring consideration is given to the impact of the pandemic and the response to it on those already facing health inequalities. The Plan also outlines the HSCP Board's responsibilities in terms of equalities and human rights and that change to services will be subject to engagement with stakeholders and where appropriate subject to equality impact assessment.

Financial:	Operational plans developed as part of the Recovery and Transition Plan will have financial impacts for the HSCP. Details of the

	financial impact are not included in the Recovery and Transition Plan but are set out in the HSCP's associated financial monitoring.

Legal:	None

Economic Impact:	None

Sustainability:	The issue of sustainability will be an ongoing consideration during the period of recovery and transition.

Risk Implications:	The risk of not having a clear and agreed approach to recovery and transition, and of not following it, could lead to a disorganised re-start of services that would have a detrimental impact on service users, patients and carers.

Implications for East Dunbartonshire Council:	This plan and our ongoing pandemic responses are being developed in alignment with the recovery and transition planning activity by East Dunbartonshire Council.

Implications for NHS Greater Glasgow & Clyde:	This plan and our ongoing pandemic responses are being developed in alignment with the recovery and transition planning activity by NHS Greater Glasgow and Clyde.

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	☒
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0	**MAIN REPORT**
1.1	The Covid-19 Recovery and Transition Plan sets out the approach East Dunbartonshire HSCP will take to the transitional, post-emergency phase of the COVID-19 pandemic. During this recovery period we will be working across service areas in collaboration with partner organisations, service users and the wider community to gradually re-establish service provision to meet the needs of our residents.
1.2	This plan sets out key principles and priorities for the recovery and transition period. It outlines our wide-reaching planning approach and the arrangements being put in place to oversee our recovery.
1.3	Our recovery and transition activity will follow a phased approach in line with the phased relaxation of lockdown outlined by the Scottish Government. As experience to date indicates, the ongoing crisis is changing week-to-week and needs to be closely monitored, particularly in relation to further waves of infection, potentially characterised by localised outbreaks. Given the developing situation it is essential that our approach to recovery recognises the need for flexibility and allows us to respond quickly to change.
1.4	This plan and our ongoing approaches are being developed in alignment with the recovery and transition planning activity by East Dunbartonshire Council, NHS Greater Glasgow and Clyde, other HSCPs across GG&C and at the national level.

Agenda Item: 5a.
Appendix 1

COVID-19 East Dunbartonshire HSCP Recovery and Transition Plan

1 PURPOSE OF PLAN

1.1 This high-level planning document sets out the approach East Dunbartonshire HSCP will take to the transitional, post-emergency phase of the COVID-19 pandemic. During this recovery period we will be working across service areas in collaboration with partner organisations, service users and the wider community to gradually re-establish service provision to meet the needs of our residents.

1.2 This plan sets out key principles and priorities for the recovery and transition period. It outlines our wide-reaching planning approach and the arrangements being put in place to oversee our recovery.

1.3 Our recovery and transition activity will follow a phased approach in line with the phased relaxation of lockdown outlined by the Scottish Government. As experience to date indicates, the ongoing crisis is changing week-to-week and needs to be closely monitored, particularly in relation to further waves of infection, potentially characterised by localised outbreaks. Given the developing situation it is essential that our approach to recovery recognises the need for flexibility and allows us to respond quickly to change.

1.4 This plan and our ongoing approaches are being developed in alignment with the recovery and transition planning activity by East Dunbartonshire Council, NHS Greater Glasgow and Clyde, other HSCPs across GG&C and at the national level.

2 CONTEXT

2.1 Novel coronavirus (COVID-19) is a strain of coronavirus first identified in Wuhan, China in 2019. Clinical presentation may range from mild-to-moderate illness to pneumonia or severe acute respiratory infection. COVID-19 was declared a pandemic by the World Health Organisation on 12 March 2020. We have experienced the spread of COVID-19 across the UK in the period since then.

2.2 Extensive measures have been implemented across many countries to slow the spread of COVID-19. In the UK the initial recommendations were for everyone to stay at home as much as possible and severely restrict their interactions with others outside the household. Over the period since mid-March, the process from full lockdown to the relaxation of aspects of these public health constraints has been measured and highly controlled.

2.3 Measures designed to prevent the spread of Covid 19 are dynamic and subject to change at short notice. The main business consequence and continuity risks for the HSCP since mid-March have been:

(i) Increased community-based demand due to:

- reduced acute hospital capacity, as a result of Covid 19 emergency admissions;
- reduced informal carer capacity, as a result of carers becoming ill with Covid and/or of being unable to provide support due to self-isolation or lock-down;
- reduced day and respite services due to service closures;

- reduced wellbeing of vulnerable people, post-infection;
- mental health impact of self-isolation and community lock-down;
- potential for increase in harm to children and vulnerable adults, and domestic violence due to self-isolation and lockdown;
- increased levels of end-of-life care at home;
- the deferred impact of reduced health and social care referral rates for non-Covid related concerns.

(ii) Reduced service capacity due to:

- HSCP staff illness due to Covid-19 infection;
- Potential increased sickness absence across the HSCP workforce;
- Equivalent staff pressures in the commissioned social care sector, with voluntary and independent sector provision under significant pressure;
- Primary care impact with GPs providing additional Health Board-wide support to assessment centres and NHS24;
- Diversion of community-based resources (especially nursing) to acute hospitals.

2.4 The projected infection trajectory across the country meant that the impact of these business continuity risks was highly significant and potentially critical from the outset. Over the period of lockdown, the curve of infections was successfully flattened, but with the relaxation of these constraints comes the potential for further infection activity and the possibility for further waves of the pandemic.

3 EAST DUNBARTONSHIRE HSCP BUSINESS CONTINUITY PLANNING

3.1 EDHSCP updated all of its departmental and service Business Continuity Plans (BCPs) to reflect the particular challenges of Covid-19 emergency planning requirements. The HSCP's overarching BCP has also been updated, with an additional Annex that provides significantly greater detail on Covid-19 specifics, including:

- Essential service continuity and prioritisation
- Team consolidation and merging
- Public protection
- Commissioned services
- Staffing
- Staff and public communications

3.2 A Local Response Management Team (LRMT) was established that initially met twice weekly, moving to weekly from 4 May 2020 and to fortnightly from 23 July. These meetings considered the detail of BCP implementation and impact, service prioritisation, service impact and staff availability. These meetings are supported by service "flash" meetings and ongoing Senior Management Team (SMT) meetings. On a wider level, EDHSCP is part of robust and routine Council, Health Board and national emergency planning activity.

3.3 Our response to the pandemic has necessarily been tailored within client groups to meet the specific needs of communities and respond to specific challenges posed within services. The key actions taken across the HSCP have included:

- Redeployment of staff to work at home;
- Social distancing of staff where use of buildings has been essential;

- Introduction of staff rotation and shift working for certain staff groups to ensure adequate support balanced with social distancing and staff protection;
- Roll out of technology such as Microsoft Teams to enable communication and meetings;
- Reduction and suspension of certain services (e.g. Day Care centres, group work);
- Redeployment of staff to cover essential services;
- Prioritisation of service provision based on the most urgent or complex needs (e.g. reduction of home visits to only critical need or the continuation of immunisations and first visits for children);
- The mobilisation of a wider community response (including volunteering);
- The increased partnership role of families and informal carers in providing support for vulnerable people;
- Extensive use of technology to support advice and triage processes (e.g. telephone and video-based conferencing, Attend Anywhere);
- Introduction of new services and service models (e.g. telemedicine model, postal medicine/collection from clinic options and temporary Assessment Centre)
- Introduction of tele-consultation and video-consultation with service users.

4 PREPARING FOR TRANSITION: THE NATIONAL APPROACH

4.1 It is clear that the process of transition through emergency planning and business continuity for Covid-19 will be neither linear nor guaranteed.

4.2 Scotland in common with all parts of the UK entered lockdown on 23rd March 2020. These constraints were implemented then strengthened through legislation (the Coronavirus (Scotland) Act 2020) and through the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020. Under law, the UK and Scottish Governments must review lockdown arrangements at least every three weeks. This ensures the impact of restrictions remains proportionate to the threat posed to wider societal and economic aspects.

4.3 In common with nations across the world, Scotland has been operating a managed **transition** away from current restrictions in a way that enables the suppression of transmission to continue. This will include ongoing physical distancing, the continued need for good hand hygiene and public hygiene, and enhanced public health surveillance - while seeking to very carefully open up parts of our economy and society.

4.4 As and when restrictions are lifted, the Scottish Government has indicated in its report *COVID-19 – A Framework for Decision Making (April 2020)* that it will need to put in place public health measures to stop cases becoming clusters, clusters becoming outbreaks, and outbreaks becoming an uncontrolled peak that would require a return to lockdown to avoid enormous loss of life and the overwhelming of our health and care system. This was a clear indication that the lifting of restrictions would be carefully phased and measured. The lifting of restrictions may also be reversed if the “reproduction number” or “R” rises above 1, i.e. the number of cases each infected person passes the virus on to.

4.5 A framework of assessments will be undertaken by the Scottish Government to inform its decision in how it manages its response to the epidemic:

Scottish Government Assessment Framework

1. Options for physical distancing measures – easing, maintaining, (re)introducing – are technically assessed using the best available evidence and analysis of their potential benefits and harms to health, the economy, and broader society so as to minimise overall harm and ensure that transmission of the virus is suppressed.

2. Potential options – individual and combinations of measures – are assessed for their viability, for example taking account of how easy they are to communicate and understand, likelihood of public compliance, the proportionality of any impact on human rights and other legal considerations.

3. Broader considerations also include equality impacts and consideration of tailoring measures, for example to specific geographies and sectors.

4. Assessments will inform the required reviews of the Coronavirus regulations and collective assessment and decision-making with the UK Government and other Devolved Administrations as appropriate.

4.6 "Scotland's Route Map Through and Out of the Crisis" is the Scottish Government's phased plan for the nation's exit from lockdown. The plan outlines a 4 phase process of incremental easing of restrictions and sets out the criteria that require to be met before progression to the next phase in the plan can be achieved. Phase 4 is reached if and when Covid-19 is no longer a threat to public health. The lockdown established during March 2020 is effectively Phase 0. A summary of this route map is attached at **Appendix 1**.

4.7 The Scottish Government's policy approach to transition provided a clear context within which the HSCP has prepared for its own transition, through its business contingency and continuity planning processes. It is essential that a plan is in place that allows the HSCP to take account of the path of the epidemic and the national response, while constantly re-orientating its continuity planning in line with presenting demand, shifting trends and trajectories and the impact of organisational capacity issues. In this respect, having clarity and perspective on our emergency arrangements is essential in order that we can act both reactively and proactively in response to the challenges we face.

5 RECOVERY AND TRANSITION PRINCIPLES

5.1 Since the COVID-19 outbreak our focus has been on implementing business continuity plans to ensure sustainable provision of health and social care services for East Dunbartonshire residents. This has seen innovation and collaborative working across the health and care system including with external stakeholders and our communities. Reflecting on the approaches we have been taking will illustrate the benefits and challenges experienced during the period and highlight opportunities for better processes, models and collaborative relationships going forward. The long term impact of COVID-19 will be significant so it is crucial that we learn from the pandemic and our response locally and nationally, and use this knowledge and insight to guide and improve how we work going forward. In this respect, we use the term "recovery and transition", to reflect the reality that not everything will be reinstated in precisely that way that was before.

5.2 The HSCP's overall vision is *Caring together to make a difference* and is supported by the values of *Honesty, Integrity, Professionalism, Empathy and Compassion*, and *Respect*.

5.3 The HSCP Strategic Plan establishes the strategic priorities of the HSCP as:

(i) Promote positive health and wellbeing, preventing ill-health, and building strong communities

(ii) Enhance the quality of life and supporting independence for people, particularly those with long-term conditions

(iii) Keep people out of hospital when care can be delivered closer to home

(iv) Address inequalities and support people to have more choice and control

(v) People have a positive experience of health and social care services

(vi) Promote independent living through the provision of suitable housing accommodation and support.

(vii) Improve support for Carers enabling them to continue in their caring role

(viii) Optimise efficiency, effectiveness and flexibility

5.4 The fundamental principle driving the HSCP's approach to recovery is that the Vision, Values and Strategic Priorities of the HSCP Strategic Plan continue to be as relevant to the planning and delivery of health and social care services during recovery as they were before the Covid-19 outbreak. Whilst the scale and pace of innovation and service transformation has been necessarily accelerated by the requirement to respond to the pandemic, any changes to services and service models reflect and complement the vision and priorities laid out in the Strategic Plan and do not constitute a shift in the strategic direction of the HSCP.

5.5 The key principles underpinning our approach to recovery can be summarised as follows:

(i) **Phased approach -** Restarting services should be managed via a phased approach using the Business Continuity plans and service-level Recovery Plans. Sequencing of restarting services may be different to the reduction/removal of services during the emergency and should focus on building the required infrastructure for consistent, high quality services to vulnerable citizens and be responsive to the easing of restrictions referred to in the Scottish Government's Route Map. Recovery activity should be considered early, and in tandem with incident response.

(ii) **Safeguarding -** The key principle which must guide recovery planning is the need to provide safe and effective services for people which maximise the health benefit for our residents, promotes independence and protects the most vulnerable. The safety of staff, service users, patients and carers will be paramount throughout recovery, including adherence to local and national testing and isolating guidelines and the continued provision of appropriate levels of PPE. The HSCP will ensure the safest environment and conditions possible for staff to best meet the needs of the population, recognising the safety and wellbeing of health and social care staff is on a par with the rest of our population.

(iii) **Intelligence-led -** Our recovery will be based on the lessons we have learned during the emergency phase; and also on lessons as they emerge during the transition for example around unequal impacts of the COVID-19 crisis on different groups and the changing nature of medium to longer term patterns of need and demand. We will collate learning from across service areas. We will keep any changes applied under review, collecting feedback from relevant stakeholders to inform ongoing recovery and planning for the future. Decisions made will be informed by evidence and learning about what has worked well during the response, what has not been successful and where might there be opportunities to make additional modifications to service provision to support long term, flexible recovery.

(iv) **Flexibility** - Restarting services must be done in a way that is considerate to the fact that COVID-19 still represents a very real public health challenge to the country and its population. The HSCP will be required to react quickly and decisively to additional outbreaks of the virus that may require further adaptations for services and staff, and to respond to external influences such as additional or changing guidance from the UK and Scottish Governments. Recovery of services will also have to be managed to cope with any predicted or unexpected increase in demand for services that may arise as lockdown restrictions are lifted.

(v) **Opportunities-focussed -** The HSCP will seek to identify, and wherever possible, take advantage of any opportunities that have emerged during the response to the pandemic. A wide range of changes have been made to services. Some of those changes have been successful and consideration must be given to retaining and developing them in order to progress the strategic priorities of the IJB. Where opportunities emerge to stop working in ways that no longer meet requirements they should be explored and considered. Maximising opportunities will include building on the adoption of technological opportunities in response to the pandemic.

(vi) **Collaboration -** The restarting of services will be done on the basis of maintaining ongoing and meaningful collaboration and cross-system working with our key stakeholders. This includes staff, service users, partner providers and Trade Unions/Staff Side. The HSCP will seek to utilise the collective knowledge and experience across the sector to ensure services continue to meet the needs of residents in a sustainable and equitable manner. Decisions about changes to services will be informed by appropriate levels of consultation and engagement with those most affected, and with consideration and assessment of the impact in terms of equalities and human rights to ensure equity of access.

(vii) **Compassionate leadership -** The HSCP will take a long term approach to safeguarding the mental health and wellbeing and resilience of its staff by addressing any psychological impacts that result from our ongoing response to the pandemic. Embedding a culture of compassionate leadership will support individual and team resilience and well-being, learning from and harnessing the support mechanisms, techniques and behaviours which have evolved during the crisis.

(viii) **Innovation and integration -** A key element in the response to the pandemic has been the ability of the HSCP and its partners to demonstrate agility and innovation in making the changes required to meet the needs of our residents. Through recovery activity the HSCP seeks to harness, identify and support innovation and embrace new approaches and ways of working (e.g. digital).

(ix) **Communication and transparency** - The HSCP's approach to recovery will include appropriate communication with all stakeholders. The success or failure of any re-starting of services or making/retaining changes to services

will rely on ensuring those affected understand the decisions being taken and how that affects how they access the services. We are developing a dedicated communications strategy to ensure a high level of communication to staff and residents.

6 LEARNING FROM AND BUILDING ON OUR CRISIS RESPONSE

6.1 In response to the emerging challenges resulting from COVID-19, the activity of the HSCP required to be significantly adapted, as outlined above. In many cases services were suspended and require in the recovery and transition phase to be re-instated to ensure continuity of care and support. In other cases more fundamental alterations were made to existing services and service models to enable services to continue within the constraints of the lockdown restrictions. The HSCP has begun reviewing the changes made during the crisis to identify areas where change has been positive. Examples of positive changes that have taken place during the crisis include:

- Use of digital technology to facilitate new and existing service user assessment, consultation and review (e.g. Attend Anywhere) where face to face methods are not essential;
- Evidence of improved partnership/joint working and information sharing;
- Expansion of Technology Enabled Care solutions
- Use of teleconferencing and videoconferencing amongst health and social care staff (where able to access the same platforms/software)
- Greater facilitation for working at home
- The growth of the wider network of community/voluntary supports and models of co-production
- An increased focus on mental well-being (including that of staff) and social connectedness
- The opportunity for services to undertake a review of the priorities and optimal methods of meeting need

6.2 Over the emergency period there has been a range of specific issues that we have had to face. The issues listed below represent the potential barriers that we may face as we move forward through the recovery and transition phase:

- Staffing levels (increased need for isolation anticipated through Test and Protect, in the event of potential local resurgence of infection levels);
- Confidence/willingness of service users to return to face to face service delivery;
- Ongoing lockdown and delay in returning staff to work in offices (ensuring social distancing guidance applied);
- Sufficient funding to support new ways of working and COVID-19 related costs;
- Capacity of staff able to work either from home/office;
- Reduction in current high levels of community support as people return to work;
- Potential gaps/delays in the recruitment process;
- Availability and capacity of IT to support staff to work at home where necessary;
- Access to the required resources and knowledge to maximise the effectiveness of new ways of working (e.g. digital inclusion);
- Closure / threat to sustainability of some partner organisations or specific services they provide

- Access to PPE
- Financial pressures as a result of increasing demand and decreasing capacity to respond
- Constraints to engagement and communication with relevant stakeholders, leading to potential opposition to transition arrangements or misconceptions.

6.3 Key enabling factors that will support our recovery include:

- Commitment and flexibility of staff
- Ability of staff to work in partnership to find innovative solutions
- Capturing the learning from staff across the system
- A readiness and enthusiasm to harness opportunities and consider new practices
- Capturing service user feedback as a regular part of service development and redesign
- Opportunities to deliver services using volunteers and/or different platforms
- Opportunity to build on the sense of resilience, partnership and community spirit.

6.4 As part of the recovery and transition planning processes, all HSCP services have been asked to assess changes that have be made as part of the HSCP's response to COVID-19 and to consider the impact on service users, staff, clinicians and partner organisations. They have been asked to consider whether as they move through and out of the crisis, they should:

(i) **Restart business as usual**: Initiate a return to service provision as it was delivered prior to the outbreak of Covid-19

(ii) **Adapt the current service models:** to improve processes or outcomes, to reflect ongoing constraints or opportunities, changing circumstances or changing needs of service users and clients. This might be where lessons learned during Covid may contribute to ongoing service development.

(iii) **Retain the current service models:** If assessment driven by data and feedback from stakeholders suggests it is working and is feasible, or if national guidance requires it, continue with the current approach.

(iv) **Stop the current service models:** At an appropriate and agreed point in time the current service models should stop. Of particular relevance to services that have been developed entirely in response to the pandemic and where adaptation is not being considered.

6.5 The outcomes from this process will form the basis of service-level recovery and transition planning.

6.6 Any proposed adaption or retention of revised processes or services will be subject to consideration, consultation, evaluation and impact assessment. These elements of due diligence will be essential as we work through the transition process, so that the HSCP emerges stronger by design.

7 PLANNING FOR RECOVERY AND TRANSITION

7.1 The overall pathway through the emergency planning arrangements in East Dunbartonshire will be one of Preparation→ Activation→ Recovery→ Stand-down. However, as can be seen from the Scottish Government's framework for decision-making, the process is going to be highly complex and uncertain in timescale, phasing and detail.

7.2 The process of business continuity planning usually involves a relatively linear process towards recovery to normal service. The unpredictable nature of pandemic planning means that the process in this situation involves a number of simultaneous elements, many of which will need regular revisiting as we move through the transition process:

(i) The continued process of business continuity planning for the foreseeable future. This may be ultimately determined by the successful development of a vaccine, improved treatments or a combination of both. The prevailing estimate on the timescale for this is 12-18 months. The purpose of this process is to ensure that essential services are delivered by well supported staff, to keep people safe and supported through ongoing public health and social distancing constraints;

(ii) The ongoing review and improvement of business continuity measures to ensure that they remain proportionate, effective, efficient, and economical;

(iii) The establishment of organised recovery and transition planning to support cross-cutting and service-specific processes and services;

(iv) A clear understanding of where services have been changed, reduced or stopped and the impact of that now and potential impacts in the future (for example: increased end of life care in the community);

(v) Evaluation of the changed profile of demand that may emerge as a result of Covid-19 (for example: the expected need for increased rehabilitation and reablement services to assist people recovering from Covid-19 infection, higher levels of mental ill-health, increased domestic violence and hidden public protection issues, increased alcohol and drugs use);

(vi) Consultation with trade unions, staff, service users, patients and carers on the process and impact of business continuity measures: what has worked and what could be improved, either during continued business continuity or in the longer term;

(vii) Evaluation of enforced business continuity changes that have resulted in unexpected success or indicate new potential ways of working that may be more effective, more efficient, more popular or better integrated;

(viii) Evaluation and establishment of resource-led changes that are needed to transition to greater efficiency, rather than a return to previous processes or services;

(ix) The identification and resolution of issues that are of a cross-cutting, common nature (for example: governance, staffing, accommodation, planning the future of and alternatives to congregate models of care, operational and strategic planning);

(x) The identification, planning and transition of services to pre-existing, interim and revised operating models on a phased and prioritised basis, in line with the Scottish Government's route map;

(xi) Linking the recovery and transition process to Transformation Planning, to acknowledge and quantify transformational service changes that emerge from the process in pursuit of longer term objectives;

(xii) Clarity on the mechanisms of Council, Health Board and HSCP Board governance to oversee the recovery and transition processes.

7.3 In order to move forward with these action areas, a number of workstreams has been established, which will be progressed by nominated SMT leads:

- Governance

- Business Continuity Planning
- Service recovery and transition
- Workforce
- Workplace
- Winter planning and influenza
- Workload tracking and service demand management
- Congregate care
- Care Homes
- PPE
- Oral Health recovery (hosted service)
- Children's Mental Health Services
- Transformation Plan and Financial Performance
- Public engagement and communication

7.4 These action areas will inevitably be influenced by ongoing public health constraints and may be subject to revision and prioritisation.

8 ALIGNMENT WITH COUNCIL AND HEALTH BOARD RECOVERY AND TRANSITION PROCESSES

8.1 It is important that the HSCP Recovery and Transition Plan aligns strategically with Council and NHS processes. East Dunbartonshire Council's "Strategic & Operational Planning Next Phase – Creating a New Normal" and NHS Greater Glasgow and Clyde's NHSGGC COVID-19 Recovery Plan both set out common objectives and broadly similar approaches.

8.2 The unique governance and accountability frameworks that establish the HSCP Board and its strategic planning responsibilities place it central to the process of linking operational recovery and transition to longer-term strategic priorities, including integrated effectiveness, efficiency and economy. The HSCP Board's directions to the Council and Health Board to deliver operational services in line with these strategic priorities ensure that the Council and Health Board will wish to have confidence that operational recovery and transition processes are well planned and executed. Furthermore, for reasons of consistency, the Council and Health Board separately may wish to align their approaches across whole systems and cross-cutting corporate issues that may include or affect aspects of delegated services. This may create a potential overlap of recovery and transition planning activity. The HSCP will therefore work in partnership to harmonise recovery and transition planning in pursuit of outcomes that are mutually supportive and meet the needs of all parties.

APPENDIX 1: "Scotland's Route Map Through and Out of the Crisis" - General Briefing

9 GENERAL

9.1 "Scotland's Route Map Through and Out of the Crisis" is the Scottish Government's phased plan for the nation's exit from lockdown. The plan outlines a 4 phase process of incremental easing of restrictions and sets out the criteria that require to be met before progression to the next phase in the plan can be achieved. Phase 4 is reached if and when Covid-19 is no longer a threat to public health. The lockdown established during March 2020 is effectively Phase 0.

9.2 Progression through the phases is predicated upon sustained success in reducing the R number (the average number of people that would be infected by one individual) and meeting World Health Organisation criteria[1].

9.3 Scotland is set to enter Phase 1 on 28 May, but other than that, there are no specific dates identified for transition through the phases.

9.4 The examples of changes set out by the Scottish Government for each phase provide broad descriptions or examples of the types of changes it will make. They will be refined and augmented over time, including through additional guidance for people and sectors. The steps will be careful, gradual and incremental. Businesses, public services and the third sector will need time to plan and to prepare workplaces, processes, supply chains and logistics in order to introduce any changes safely and effectively. In doing so, the Scottish Government stresses the importance of the role of trades unions and of undertaking risk assessments of workplaces conducted with staff and health and safety representatives. Communities, households and individuals will also need to adapt.

10 PHASE PROGRESSION REQUIREMENTS

Lockdown (Phase 0) - R is near or above 1 and there are a high number of infectious cases

Phase 1 - R is below 1 for at least 3 weeks and the number of infectious cases is starting to decline. Evidence of transmission being controlled also includes a sustained fall in supplementary measures including new infections, hospital admissions, ICU admissions, deaths of at least 3 weeks.

Phase 2 - R is consistently below 1 and the number of infectious cases is showing a sustained decline. WHO six criteria for easing restrictions must be met. Any signs of resurgence are closely monitored as part of enhanced community surveillance.

Phase 3 - R is consistently low and there is a further sustained decline in infectious cases. WHO six criteria for easing restrictions must continue to be met. Any signs of resurgence are closely monitored as part of enhanced community surveillance.

Phase 4 - Virus is no longer considered a significant threat to public health.

[1] **WHO Criteria:**

I. Evidence shows that COVID-19 transmission is controlled.
II. Sufficient public health and health system capacities are in place to identify, isolate, test and treat all cases, and to trace and quarantine contacts.
III. Outbreak risks are minimized in high vulnerability settings, such as long-term care facilities (i.e. nursing homes, rehabilitative and mental health centres) and congregate settings.
IV. Preventive measures are established in workplaces, with physical distancing, handwashing facilities and respiratory etiquette in place, and potentially thermal monitoring.
V. Manage the risk of exporting and importing cases from communities with high-risks of transmission.
VI. Communities have a voice, are informed, engaged and participatory in the transition.

11 RE-OPENING OF WORKPLACES AND SERVICES

11.1 An envisaged re-opening of different businesses and services through the phases is set out. However, in almost every instance, those prospective relaxations are made subject to Government guidance being issued.

11.2 As it stands no guidance accompanies the plan itself, but it is noted that following ongoing consultation with stakeholders, sector specific guidance will be provided "when the time is right to restart".

11.3 The plan does not amend the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020. Accordingly, the requirement upon businesses that do re-open to take all reasonable measures to maintain a distance of two metres between persons on premises remains a statutory requirement. Throughout phases 1, 2 and 3, remote working will remain the default position.

12 PHASE 1

12.1 From the current position of closure of all non-essential businesses, Phase 1 is likely to see some outdoor workplaces resume business, along with a gradual opening of drive through food outlets and garden centres. Unrestricted outdoors exercise for non-contact sports such as golf, hiking, canoeing, outdoor swimming, and angling is also permitted. Workplaces resuming in the later phases can undertake preparatory work on physical distancing and hygiene measures during Phase 1.

12.2 In terms of the construction industry, there is a little more detail. The Scottish Government appears prepared to use the staged return plan proposed by Construction Scotland. However, at present that is to the limited extent of advanced preparation of non-essential sites taking place, and the hope that a "soft start" to site works can commence with a return of a proportion of the workforce.

Extracts (Phase 1):

Community and public services: We are planning the gradual resumption of key support services in the community. We are expecting to restart face to-face Children's Hearings and for there to be greater direct contact for social work and support services with at-risk groups and families, and for there to be access to respite/day care *[not congregate settings[2]]* to support unpaid carers and for families with a disabled family member. All of these would involve appropriate physical distancing and hygiene measures.

Health and Social Care: In this phase we expect to begin the safe restart of NHS services, covering primary, and community services including mental health. We are also planning on retaining COVID-free GP services and planning a further scale up of digital consultations.

We expect to roll out the NHS Pharmacy First Scotland service in community pharmacies and increased care offered at emergency dental hubs as practices prepare to open. We will also restart, where possible, urgent electives previously paused. And there will be resumption of IVF treatment, as soon as it is safe to do so, and subject to the approval of Human Fertilisation and Embryology Authority. There will be an increase provision of emergency eye-care in the community. We will consider the introduction of designated visitors to care homes. The Test and Protect system will be available across the country.

[2] This caveat is not explicit in the document, but assumed. In Phase 3, the Scot Govt refers to restart of "communal living". More guidance needed on congregate settings, for example day centres, group therapies etc.

13 PHASE 2

13.1 Once Phase 2 has been reached, indoor non-office-based workplaces can resume, including factories and warehouses, and lab and research facilities. Small retail units should also be allowed to re-open, as well as outdoor markets, and the outdoor spaces of pubs and restaurants. In terms of leisure facilities, playgrounds and sports courts will become available. There is also an anticipated resumption of professional sport, although detail is not provided as to whether this will amount to training only, or include behind closed doors competitive events.

13.2 It is anticipated that the construction sector will be able to implement the remaining stages of their phased return plan.

Extracts (Phase 2):

Health and Social Care: In Phase 2, remobilisation plans will be implemented by Health Boards and Integrated Joint Boards to increase the provision for the backlog of demand, urgent referrals and the triage of routine services. This phase will see the reintroduction of some chronic disease management, which could include pain and diabetic services.

Prioritised referrals to secondary care will begin. We expect to expand the range of GP services, optometry and ophthalmology services and see an increase in availability of dental services. There will be an increased number of home visits to shielded patients.

We will continue to plan with COSLA and Scottish Care and other national and local partners to support and, where needed, review social care and care home services. Phased resumption of visiting to care homes by family members in a managed way where it is clinically safe to do so.

Community and public services: Scaling up of public services from Phase 1 where it is safe to do so.

14 PHASE 3

14.1 Phase 3 should see indoor office workplaces reopening, including contact centres, along with larger retail outlets, the indoor spaces of pubs and restaurants, hairdressers and gyms. Live events with limited numbers present may also be held.

Extracts (Phase 3)

Health and Social Care: We will see an expansion of screening services and adult flu vaccinations in care homes and at home. All dental practices will begin to see registered patients. All community optometry will reopen with social distancing safeguards. Some communal living experience can be restarted when it is clinically safe to do so.

Community and public services: Outside of health and social care, the main changes to public services will be a further resumption of justice system processes and services.

15 PHASE 4

15.1 Once coronavirus recedes as a significant threat to public health, Phase 4 commences with remote and flexible working no longer being the default position. All

types of workplaces, restaurants and bars should be able to open and larger live events, presumably some sporting events, may be held.

Extracts (Phase 4)

Health and Social Care: The full range of health and social care services would be provided with greater use of technology to provide improved services to citizens.

Community and public services: Public services would be operating fully, in line with public health advice, with modifications and changes to service design, including increasing use of digital services where appropriate.

16 PROTECTIONS

16.1 The Scottish Government have recommended that face coverings be worn on public transport and in enclosed public spaces throughout Phases 1 to 3, with that protection possibly still being advised in Phase 4.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17th September 2020
Subject Title	HSCP: Draft Communications Strategy (2019 - 2022) and Action Plan
Report By	Derrick Pearce, Head of Community Health and Care Services
Contact Officer	David Radford, Health Improvement & Inequalities Manager David.radford@ggc.scot.nhs.uk Telephone : 0141 355 2391

Purpose of Report	The purpose of this report is to advise the HSCP Board on the outcome of the consultation on the HSCP Communication Strategy and the Participation and Engagement Draft Strategy (Appendix 1), and to present for the approval the HSCP Communication Strategy and Action Plan (Appendix 2) and the East Dunbartonshire Health and Social Care Partnership Participation and Engagement Strategy final draft (2020-2023)

Recommendations	It is recommended that the HSCP Board 1. Notes the outcome of the aforementioned consultation 2. Approves the HSCP Communication Strategy and Action Plan. 3. Approves the East Dunbartonshire Health and Social Care Partnership Participation and Engagement Strategy.

Relevance to HSCP Board Strategic Plan	The report supports the ongoing commitment to engage with our Stakeholders in shaping the delivery of the HSCP priorities as detailed within the Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	An EqIA has been undertaken as part of the process, report is attached. (Appendix 4)

Financial:	None

Legal:	None

Economic Impact:	None

Sustainability:	None

Risk Implications:	None

Implications for East Dunbartonshire Council:	None

Implications for NHS Greater Glasgow & Clyde:	None

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	**x**
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0 Main Report

1.1 Effective and efficient communication is essential to the work of the East Dunbartonshire Health and Social Care Partnership (HSCP).

1.2 The HSCP has a wide range of stakeholders who contribute to the planning and delivery of services for the people of East Dunbartonshire and who, in turn, as service users support the HSCP and its Senior Management Team to continuously improve the approaches undertaken.

1.3 The HSCP must strive to endorse a variety of communication channels and approaches to maximise potential to reach everyone with whom we seek to communicate, directly and indirectly.

1.4 The Communications Strategy and Action Plan and the Participation and Engagement Strategy, will support the HSCP's approach to communication engagement and participation.

1.5 The proposed strategies and associated action plan;

a. sets out a framework for effective communication and participation
b. identifies Partnership stakeholders and who communication will be with – both internally and externally
c. identifies the ways in which communication and engagement will be undertaken
d. sets out how the effectiveness of communication and engagement activities will be further improved;
e. identifies an action plan to progress the development and roll-out of improved and effective communications and participation.
f. sets out our approach to align the HSCP activity to national strategies, including the Community Empowerment Act (2015) which supports enhanced public involvement in the delivery and distribution of health and social care services

1.6 The HSCP opened a consultation period (between December 2019 to February 2020) with stakeholders and partners (public, carers, service users, third and independent sector representatives and local communities), inviting their views and comments to the draft strategy and associated action plan.

1.7 A total number of 138 responses were received, with all responses and comments reflected within the full report. (Appendix 1)

1.8 The responses, overall, were positive and it is clear that many aspects of the communication and engagement processes undertaken by the HSCP are effective.

1.9 The attached Strategies and Action Plan have been amended following the results of the consultation and are presented here for approval on that basis.

East Dunbartonshire Health and Social Care Partnership (HSCP)

Communications Strategy (2020-23) and Participation and Engagement Strategy (2020-23)

Consultation Evaluation Report

March 2020

Contents

Acknowledgements

East Dunbartonshire Health and Social Care Partnership (HSCP) wish to thank all of the East Dunbartonshire public, carers, service users, third and independent sector representatives, our communities and our staff for their participation, assistance and feedback in the creation of this consultation evaluation report.

Equalities Information

Promoting equality and addressing health inequalities are at the heart of the HSCP's values. Throughout the development of this evaluation report, the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010[1]) and those who do not share it, and;
- given regard to the need to reduce inequalities between our stakeholders in access to, and outcomes from healthcare services and to ensure this might reduce health inequalities

[1] Equality Act 2010 (specific duties) Scotland

Executive Summary

East Dunbartonshire Health and Social Care Partnership (HSCP) conducted a 12 week consultation (December 2019 to February 2020) on its draft Communication Strategy (2020-23) and draft Participation and Engagement Strategy (2020-23).

The consultation undertaken utilised a quantitative and a qualitative approach, notably a questionnaire and face to face interviews. The evidence in this evaluation report highlights the depth of local interest and feedback in how the HSCP communicates and engages with its stakeholders. The resultant sample of the consultation questionnaire consisted of a total of 138 responses who identified themselves as follows:

- 34% of respondents described themselves as 'knowing a lot about' East Dunbartonshire HSCP
- 19% 'know about' the HSCP, with 7% stating they 'know nothing about' the HSCP
- 25% of respondents described their relationship with the HSCP as a patient / service user
- 38% described their relationship with the HSCP as an East Dunbartonshire resident
- 27% of respondents described themselves as having a caring role
- 71% described themselves as female, with 23% being male

The generated data and comments received demonstrates that a number of amendments and recommendations can be taken forward, such as:

- a single point of contact for residents, service users, carers etc. who wish to know more information about the HSCP, or are wishing to attend any engagement events or simply want to provide views on a one to one basis
- Information and articles about the HSCP placed in the HSCP and Council's staff newsletters and also various EDC housing newsletters
- the use of the info screens in Health Centres / EDC offices / Hubs and Libraries promoting the HSCP

The HSCP advise that the IJB should endorse the amendments to the draft Communication Strategy (2020-23) and draft Participation and Engagement Strategy (2020-23) and adopt both documents.

Introduction

The aim of this report is to evaluate the stakeholder feedback received on the recent consultation that was held to gather responses to the draft East Dunbartonshire Health and Social Care Partnership (HSCP) Communication Strategy (2020-23) and Participation and Engagement Strategy (2020-23) and implement a coherent approach to communications and engagement with our stakeholders.

The HSCP opened a consultation period (December 2019 to February 2020) with our stakeholders (public, carers, service users, third and independent sector representatives and local communities) asking them for their views and comments. The purpose was to allow for feedback to further inform the development of both strategies. The consultation sought views on:

- understanding stakeholders views of the role of the HSCP
- local knowledge of the HSCP
- how the HSCP communicates and engages with our communities, and;
- what the HSCP can do to further improve on how we communicate and engage with the communities of East Dunbartonshire, and;
- respondents equalities information.

Utilising an effective communication and engagement process creates an opportunity for stakeholders and the HSCP to co-produce strategies that are realistic, achievable and sustainable. It also makes practical sense to develop a coherent communications strategy and participation and engagement strategy/programme that will maximise support for and understanding of participation, engagement and involvement in the planning, review and evaluation of health and social care services, among staff, stakeholders, patients and the public.

Aims and Objectives

Over the course of 12 weeks, between December 2019 and February 2020, East Dunbartonshire HSCP has undertaken a consultation towards gaining feedback to our Communication Strategy (2020-23) and Participation and Engagement Strategy (2020-23). By increasing our local profile, increasing our knowledge base of our stakeholders and identifying the breadth and depth of the awareness of the HSCP and the services we offer.

1. Aims:

1.1 To understand the communities' views of the HSCP, and how we can improve our communication practises in East Dunbartonshire

1.2 To increase our profile and increase the knowledge base of our stakeholders on the health and social care services we provide

1.3 To understand the views of our stakeholders on how to access to participation and involvement activity in East Dunbartonshire

1.4 To identify clear recommendations to take forward to the HSCP's Senior Management Team (SMT)

2. Objectives:

2.1 To further inform the East Dunbartonshire HSCP Communication Strategy (2020-23) and Participation and Engagement Strategy (2020-23)

2.2 To carry out a desktop analysis of the HSCP's profile in East Dunbartonshire and the communities views on our communication, participation and engagement practises and how they can be improved

Methodology

To implement this investigation, a qualitative and quantitative-orientated approach was applied. This consisted of implementing survey-based interviews which were promoted through a range of platforms such as Facebook, Twitter and also face to face interviews carried out by East Dunbartonshire HSCP staff at a range of meetings and events occurring across our area.

We used the following methods to carry out this evaluation:

- a quantitative approach was applied, this consisted of a questionnaire
- a qualitative approach was applied, this consisted of purposive research
- a desk-top analysis review across the previous activity

The documents and questionnaire were shared widely in both paper and electronic format with our stakeholders:

- Residents associations
- Community councils
- Third sector orgs / community groups / independent sector organisations
- The local third sector interface (EDVA)
- NHS Greater Glasgow and Clyde (NHS GGC) staff
- East Dunbartonshire Council (EDC) staff
- East Dunbartonshire residents, and;
- East Dunbartonshire HSCP Public, Service User and Carer Representative group and networks

Paper copies were placed in and collected later from;

- Community Hubs
- East Dunbartonshire Citizen Advice Bureau office
- Older Peoples Groups

Publicity included:

- East Dunbartonshire HSCP Twitter page @EastDunHSCP
- East Dunbartonshire Council facebook / twitter pages
- East Dunbartonshire Council website
- Third sector orgs facebook / twitter accounts
- Publication on local resident's social media pages

The resultant sample of the survey consisted of a total of 138 responses, this is broken down by various participants

Conclusions

In conclusion, based on the completed questionnaires and comments received, it is clear that many aspects of the communications, engagement and involvement programmes carried out by the HSCP has been effective. For example, the development of the PSUC group and its involvement activities has been recognised as best practice. The PSUC group is seen to be robust and appropriate at garnering the views of the public, but by pursuing alternative avenues to communicate, engage and involve our stakeholders will be complimentary to the HSCP.

The HSCP is committed to further develop and improve the current communications, engagement and involvement functions to ensure that there is greater stakeholder participation in the development of our services from the different sections of East Dunbartonshire's communities.

Recommendations

This evaluation contains 3 recommendations. The recommendations are summarised below:

1. The Integrated Joint Board (IJB) should acknowledge the feedback and comments received
2. The IJB should agree to the recommendations as described in the strategies
3. The IJB should adopt both strategies as best practice going forward for the HSCP

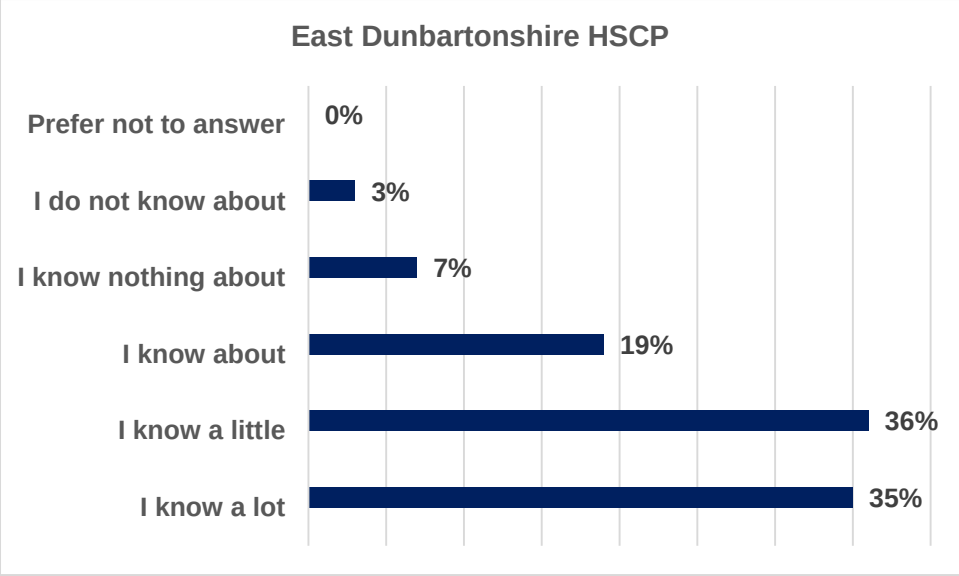
Appendices

Appendix 1; East Dunbartonshire Communications Strategy and Participation and Engagement Strategy consultation results.

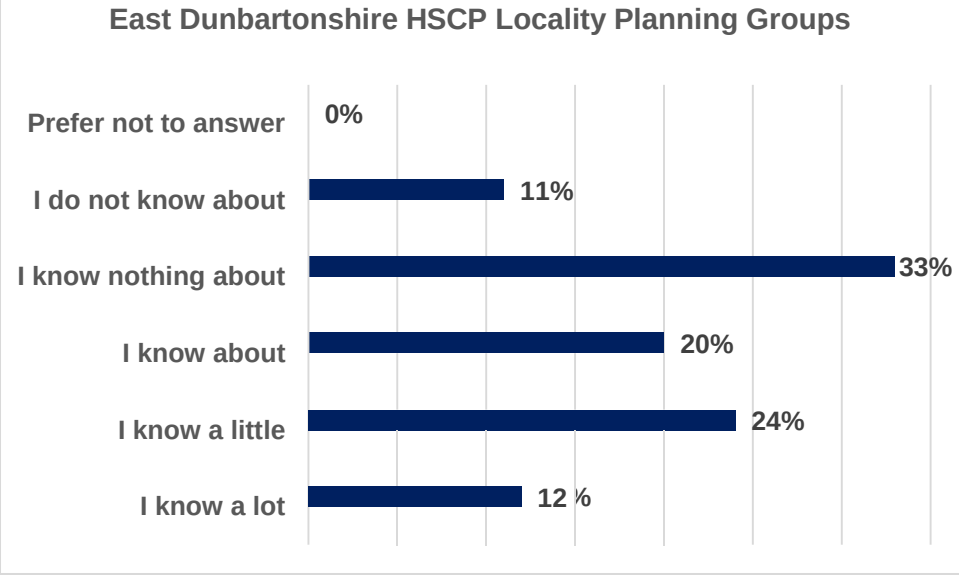
Question 1

We asked respondents about their current knowledge of East Dunbartonshire Health and Social Care Partnership (ED HSCP) and the services we provide.

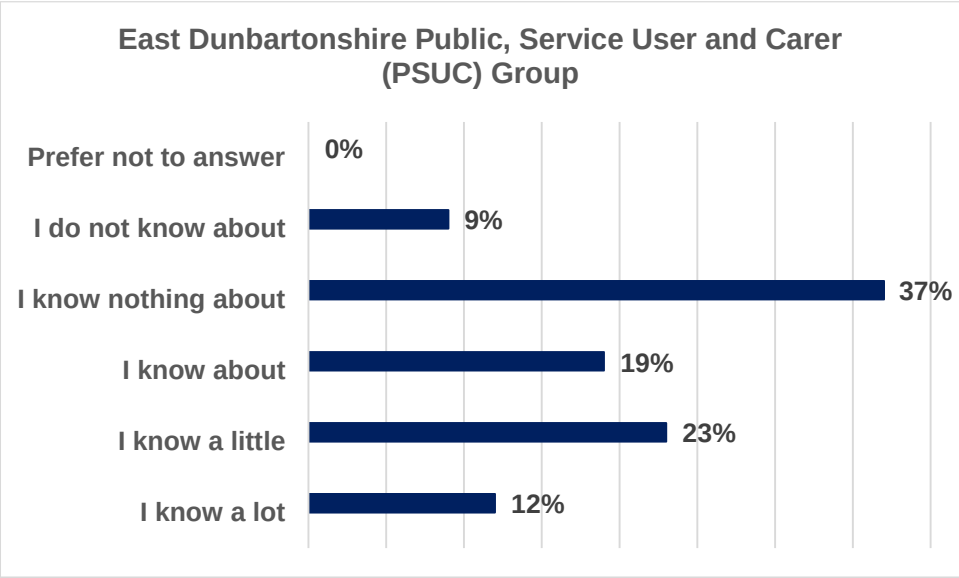
(a) How much do you know about the following?



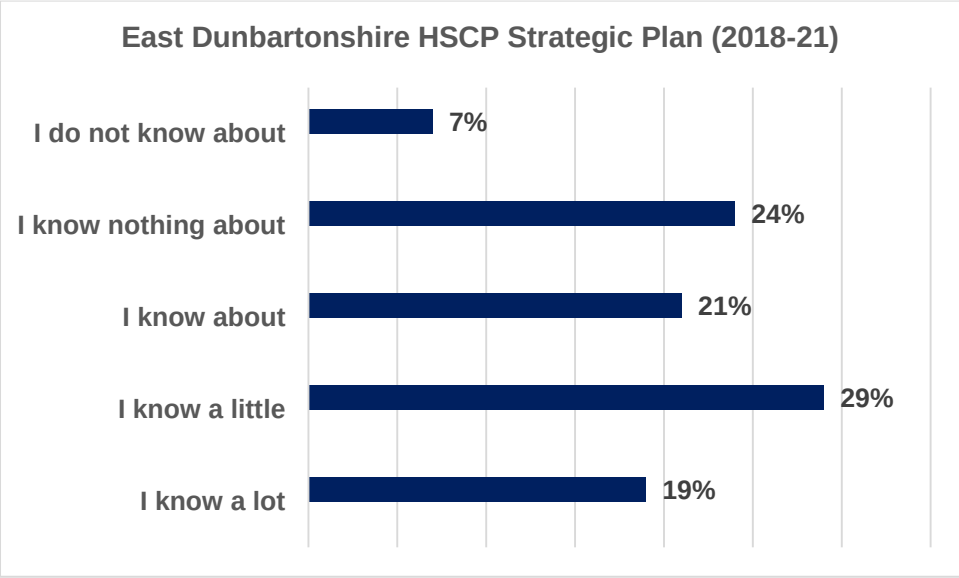
35% of the respondents **know a lot about** East Dunbartonshire HSCP, **36% know a little**, with **7% know nothing about** the HSCP



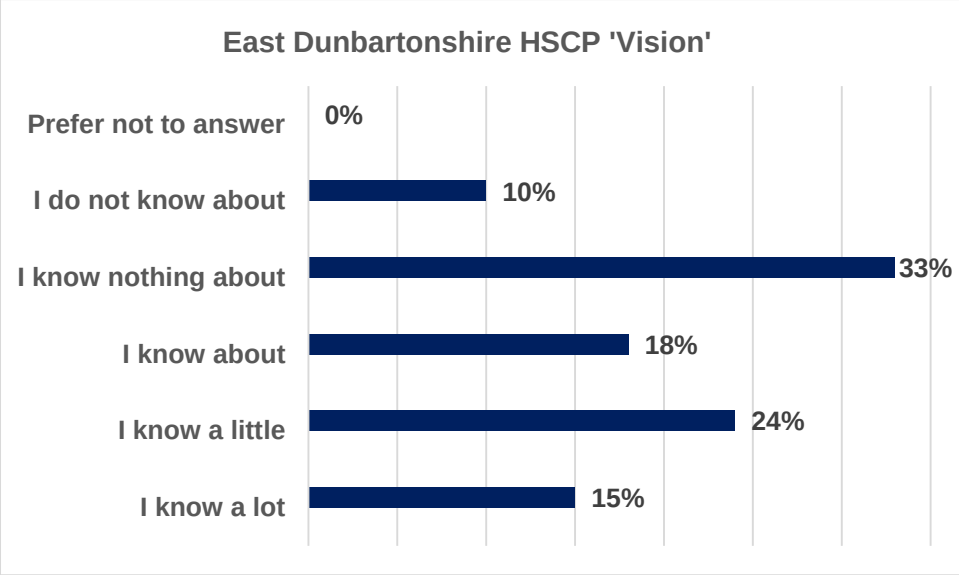
34% of respondents **know nothing about** East Dunbartonshire HSCP Locality Planning Groups, **20% know about**, **24% know a little** and **12% know a lot**



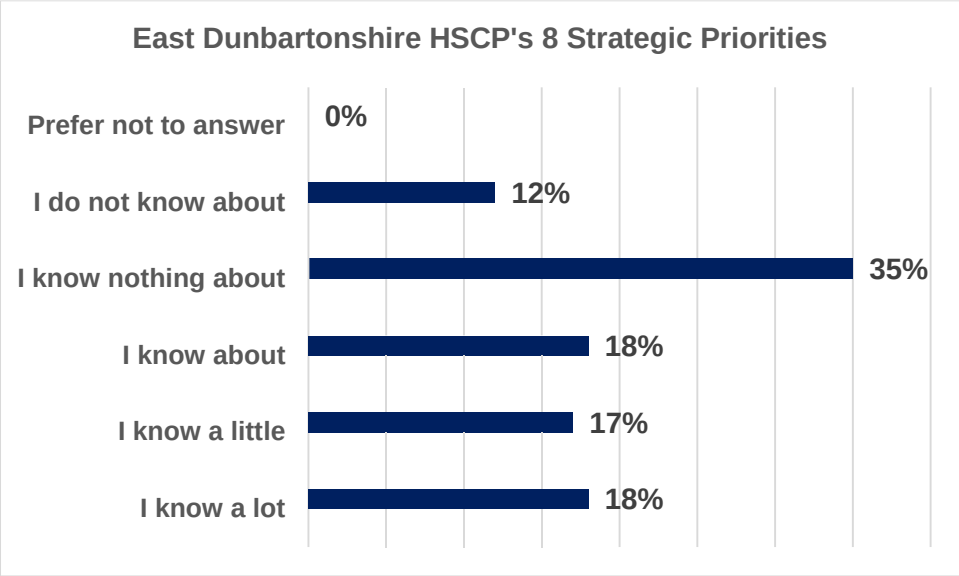
37% of respondents **know nothing about** East Dunbartonshire PSUC Group, **19% know about**, **23% know a little** and **12% know a lot**



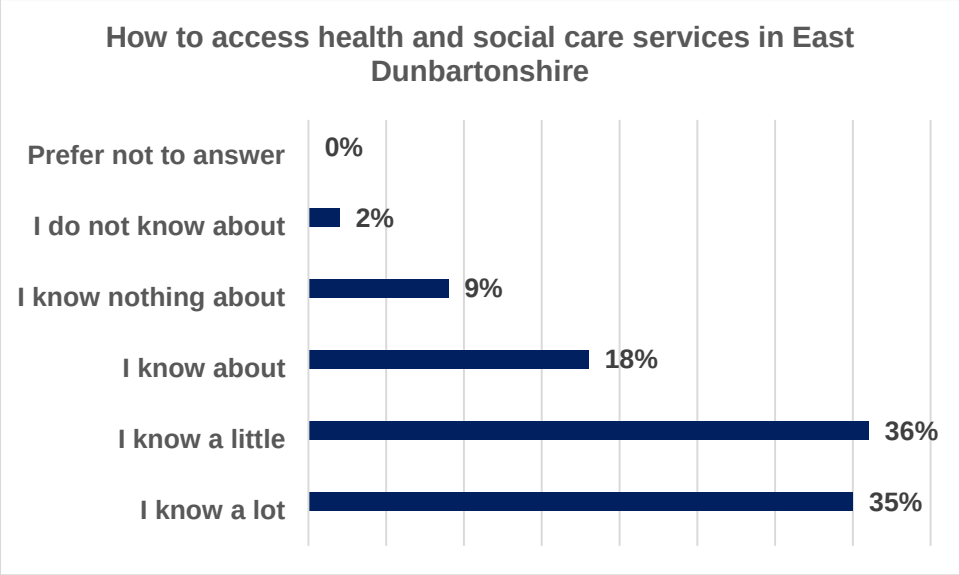
19% of respondents **know a lot** about the East Dunbartonshire HSCP Strategic Plan (2018-21), **21% know about** it, **29% know a little** and **24% know nothing about**



15% of respondents **know a lot** about East Dunbartonshire HSCP's **'Vision'**, **24% know a little,** with **33% know nothing about**



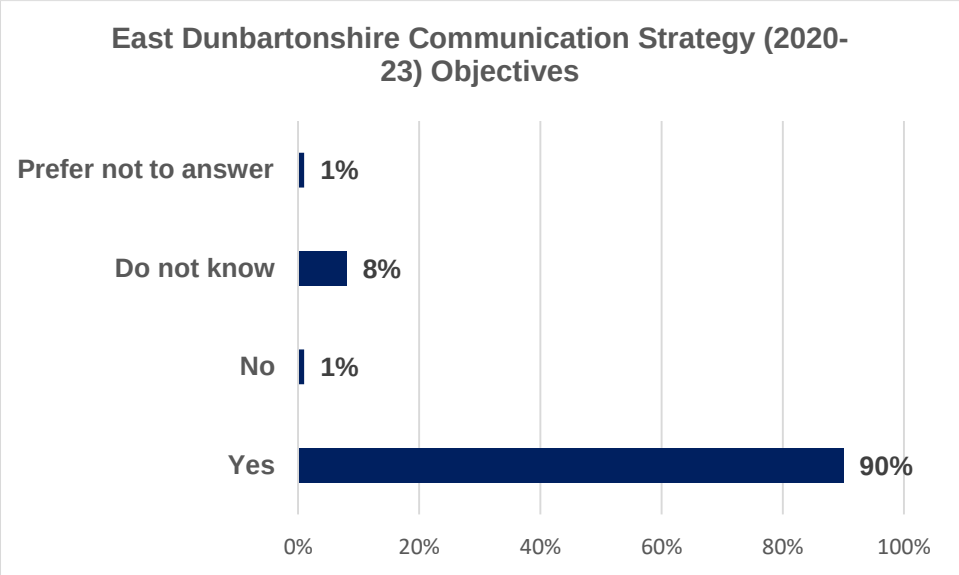
18% of respondents **know a lot** about East Dunbartonshire HSCP's **8 Strategic Priorities**, **17% know a little** and **35% know nothing about**



35% of respondents **know a lot** about how to access health and social care services in East Dunbartonshire, **18% know about** and **9% know nothing about** how to access services

Question 2

East Dunbartonshire HSCP outlined 14 objectives describing the HSCP's approach to communications and asked respondents if they agreed with the objectives?



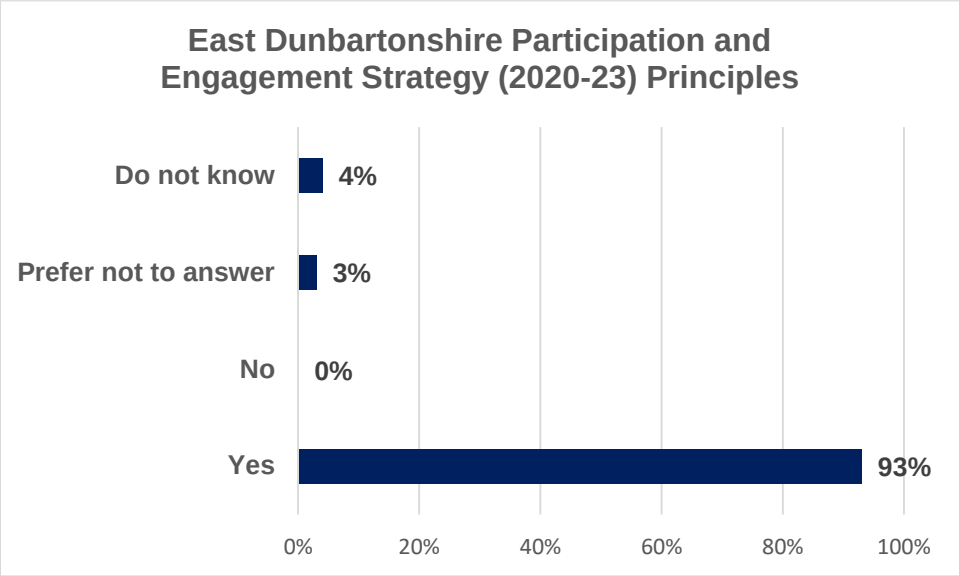
90% of respondents **agreed** with the objectives, **8% do not know** and **1% did not agree, with a further 1% preferring not to answer.**

We asked respondents at question 2 if they had and further comments:

1.	**You could also add "Commitment to develop community led and based services in collaboration with community groups and the third and independent sector'**
2.	**You should also consult with service users to seek out duplication and cost savings as these are the people who actually use the service.**
3.	**There are rather a lot of them - could they be distilled down?**
4.	**Possibly more idealistic than realistic**
5.	**I am not so sure about the idea of branding and corporate identity. I have seen a disconnect with the local development plan and the health and social care event I attended at Bearsden Hub – complete lack of communication between the two**
6.	**How do I find any information I'm a carer to a 32yr old severely disabled man and a 16 yr old with ASD**
7.	**There could be more focus on services to vulnerable people and the voices of children and young people.**
8.	**There is a lot of business jargon used in objectives. If people (not familiar with) business/strategic terminology, it is a flawed exercise asking the general public to comment on your Communication Strategy. Communication for all within a community is not about words like 'Branding' and 'Vision' etc.**
9.	**In the first line there is an interesting distinction made between 'people' and 'service users' (support people and service users to make better informed decisions about their health and social care needs) The objectives appear to be heavily weighted towards EDHSCP doing the communicating to others and has much less weight on enabling and encouraging communication in both directions.**
10.	**You should also put money into the organisations that help people like, EDAMH. I am not happy that they only get to work with people for 6 months.**
11.	**East Dunbartonshire Council need to prioritise their spending, so that services do not get shut down.**
12.	**"No mention of listening to service users, no mention of any person centred approaches"**
13.	**I think it will be good to know how the HSCP will manage its approach to communication its business.**
14.	**Would be good to be aware of these and also provided in BSL**
15.	**All looks good on paper but how do you plan to achieve the objectives. I have not been aware, as a stakeholder, of many opportunities to share views. Anything I have attended has been top heavy with East Dunbartonshire employees. I think events have to be communicated much wider. Not everyone gets the local paper. Perhaps leaflets through everyone's door.**
16.	**There are too many and should be more focussed, 5 maximum so that people can remember them and not forget the first one by the time the get to the end.**
17.	**To wordy, will the documents be more user friendly?**
18.	**Very comprehensive**

Question 3

East Dunbartonshire HSCP outlined 9 principles describing the HSCP's approach to our engagement with our communities, residents and stakeholders and asked respondents if they agreed with the objectives?



93% of respondents **agreed** with the objectives, **4% do not know** and **0% did not agree, with a further 3% preferring not to answer.**

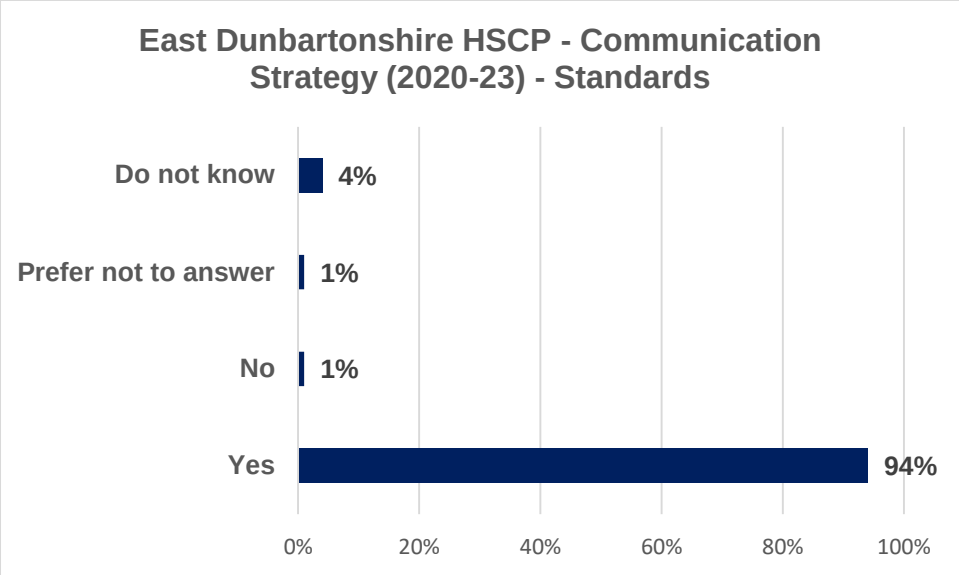
We asked respondents at question 3 if they had and further comments:

1.	**While I agree with these principles, I think the HSCP is a long way from making participation and engagement and inclusive feature. There are many groups of service users in existence and no attempts are made to engage with them. The process of engagement is not inclusive within the partnership. The process needs to meet the needs of service users and also needs to make every effort to engage with existing groups in order to gather as much feedback as possible from people who use services. The process also needs to improve feedback over service user input.**
2.	**This statement is a cop out: "We understand that a small number of people cannot fully reflect the views of an entire community, but are entitled to make representations on behalf of their wider community" You need to reach out to more people to make East Dunbartonshire Public, Service User and Carer representatives group more representative, where are the young people, mothers of young children, people accessing mental health and drug and alcohol services?**
3.	**How will we measure success?**
4.	**There has been a lack of communications/discussions with the local population of Milngavie/Bearsden about planning for a future health and**

	social care hub. This should have been aired in local newspapers and local libraries.
5.	**It is also good idea to feedback to individuals, communities and networks on how their responses will be taken forward.**
6.	**How are you going to communicate with us as a family?**
7.	**"Again, what are you trying to achieve when the communications and strategies are only written and presented in a business format that people would shudder at, if posted through their letterboxes. Many people in this authority are well aware that decisions are already made prior to these consultations taking place".**
8.	**Would like to see more encouragement of participation of minority groups such as disabled, LGBTQI+ and BAME for example as well as young people.**
9.	**These seem sensible and appropriate approaches.**
10.	**There needs to be a connection to staff participation**
11.	**Perhaps there should be a public event where local residents can call in and learn more about services, groups etc. What is available within the different areas? Communication is the key to all services.**
12.	**Watchwords are inclusive, coordinated, transparent and respectful**
13.	**Not fully aware and not in BSL.**
14.	**To provide formal training and opportunities for staff developments to deliver this.**
15.	**I do feel however that more could be done to reach out to residents associations and groups to obtain feedback and inform what is going on. At a local level these groups are better at passing information on, as community councils do not seem to be good a communicating with the actual residents. The residents associations are much better at this and I have found help from them which was not given to me from the community council. It is good for individuals to be informed because you never know when information can be passed on in the community. As the population in ED is forecast to contain a high elderly population, communication should not rely on electronic means and social media.**
16.	**As in Q1, there are too many**
17.	**Promote your volunteering roles better. Engage with mental health groups and drug service more.**

Question 4

East Dunbartonshire HSCP outlined 7 standards on our communication and engagement activity. We asked respondents if they agreed with the standards.



Question 5.

We asked respondents "In your view is there any audience groups and/or stakeholders that we have not listed".

1.	**There needs to be wider representation from service user groups**
2.	**The third sector organisations who work at the coal face.**
3.	**Young people and young people's groups should be a key audience - health education needs to start at an early age to be successful**
4.	**The recovery (addiction) community**
5.	**Education**
6.	**Looked after Children and Young People. Care experienced children.**
7.	**No mention of Disability Campaigning/Awareness Groups i.e. Inclusion Scotland, Centre for Inclusive Living. Also transport representation may be helpful.**
8.	**Representatives of specific minority groups (BAME, LGBTQI+ etc.) and deliberately and specifically seeking views form disadvantaged groups such as homeless, substance misusers, LAAC young people, school leavers.**
9.	**Seems very comprehensive to me**
10.	**Schools, Colleges, Universities, Educational Organisations**
11.	**This a comprehensive list, it is impossible to plan for every group**
12.	**Other local health contractors - Dentists, Pharmacists etc.**
13.	**Police and Fire Service**
14.	**Happy with the list.**

15.	**Large employers in the area**
16.	**Maybe here already, East Dunbartonshire Citizen Advice Bureau**
17.	**BSL people in East Dunbartonshire**
18.	**Police Scotland**
19.	**East Dunbartonshire residents associations. In our community they seem to be best at passing on information and helping in times of need**
20.	**Third sector organisations who are not necessarily representing people, but may be providing services to them**
21.	**Residents**
22.	**No, that has covered just about everyone... and I mean everyone... surely not all stakeholders are equal and some are more important than others...**
23.	**Charities, schools**
24.	**Seniors groups**
25.	**No, comprehensive**
26.	**The older population is growing and should have a bigger voice.**
27.	**Older people and older peoples groups**

Question 6.

We asked respondents "In your view are there any communication channels we should include".

1.	**Specific mention of E-Bulletin provided by EDVA and circulated to over 500 agencies and community groups across East Dunbartonshire**
2.	**A generic email address: Speak to your local HSCP where service users could direct questions/comments directly to you, a bit like care opinion**
3.	**Other services which are hosted by East Dun HSCP**
4.	**These communication methods are very staff oriented, how about an e-newsletter for the public, and use of Facebook and Instagram**
5.	**Roadshows held in local communities**
7.	**Local newspapers**
8.	**As before, include temporary staff in your briefings. We need to be contacted directly- moving from establishment to establishment means I miss all info about East Dunbartonshire policies, developments etc.**
9.	**No, the list seems inclusive.**
10.	**Mostly all digital. What about the people within the community who have no access to digital platforms.**
11.	**None known**
12.	**No, but not actually had feedback/information from most of these.**
13.	**A lot of this is written material and much of it online which excludes certain groups and individuals. It would be interesting to see how we could engage more people in a face to face way – church groups? Youth groups? Schools and colleges – there is a civic element in high schools – could we actually have a regular slot in schools – get them into the habit of thinking their views count from an early age**
14.	**Better links at promoting HSCP website and encourage staff to view it.**
15.	**Perhaps the media for big events or changes**
16.	**No, adequate**

17.	**Seems comprehensive**
18.	**LinkedIn, Facebook**
19.	**Regular face to face briefings for staff at the KHCC. Formal introductionary training / meeting for new staff. More promotion of the website and publishing of all community resources on it. More advertising in the local community**
20.	**This is a comprehensive list of comms channels**
21.	**Instagram and Facebook**
22.	**Better use of multi-media within Health, Social care, leisure and other community based resources.**
23.	**Communication into BSL**
24.	**Is there a newsletter for members of the pubic similar to the one for staff?**
25.	**Local newspapers is not an effective communication method. Local papers terrible.**
26.	**That is a very scatter gun and old fashioned approach to media and marketing. What are your main channels, do you have any idea what one or two channels reach the most people... who is actually crafting your message**
27.	**Facebook, Instagram**
28.	**No, again very comprehensive**
29.	**Other social media channels, such as facebook, youtube etc.**

Question 7.

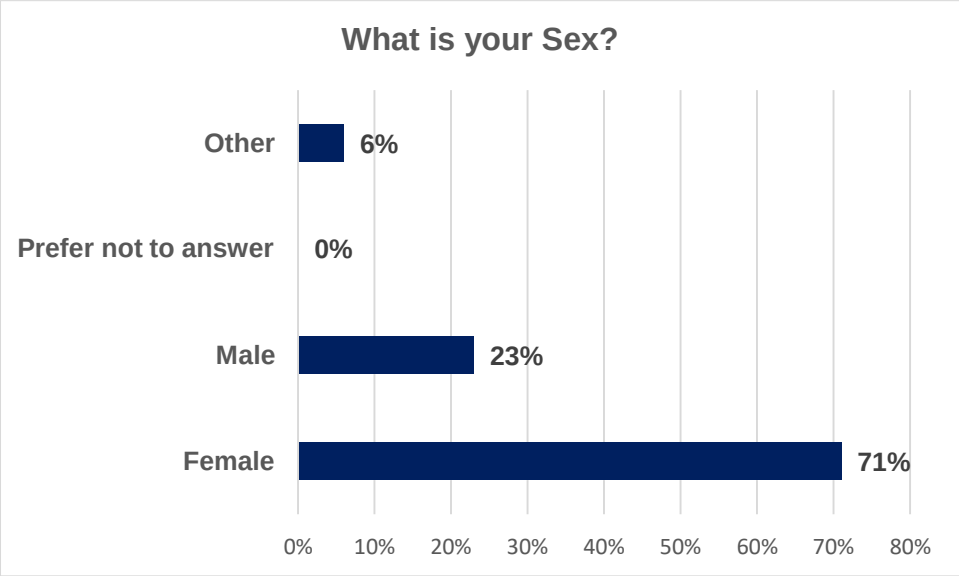
We asked respondents "Please take this opportunity to provide any further comments or suggestions on the draft Communication Strategy (2020-23) and the draft Participation and Engagement Strategy (2020-23)".

1.	**It needs to be meaningful and not tokenistic**
2.	**If all stakeholders are to be reached the online presence of EDC (HSCP) web will require a massive overhaul as it has glaring gaps and it's difficult to navigate.**
3.	**The general public in Bearsden and Milngavie are completely ignorant of what is proposed for their communities. There have been events staged locally that I have attended but there is still a failure to air the issues at the doorsteps – I know because I have been door to door in my neighbourhood**
4.	**Keep your communications simpler - even this survey is so 'wordy' it's hard to follow and off-putting.**
5.	**It would be ideal to add in a section of how personal data is stored under the new guidelines.**
6.	**Maybe if we had good contact with social work it would help to be pointed in the appropriate manner**
7.	**I work within an integrated HSCP and the workers are always the ones included in consultation events and development days but not always listened to. It's important to listen to folk on the ground making these changes happen as they are sometimes overlooked or mis-communicated to. Keep staff updated.**

8.	**None**
9.	**Less business jargon please.**
10.	**Any strategies need to be fed down to the staff on the ground; Those actually fulfilling most of the necessary roles. These staff also need to be heavily involved in any decision making, or at least asked their opinion.**
11.	**All sounds good on paper but a lot to commit to and provide all the amenities to do this. A lay man's version as well as the fancy words would also help.**
12.	**Very comprehensive piece of work.**
13.	**No further comments**
14.	**Nil. As a nurse I am happy with both the draft communications strategy and the draft participation and engagement strategy**
15.	**This Strategy is well planned. It is the overall Action that will bring the result.**
16.	**Complex issue to communicate with all staff and residents but this strategy attempts to engage with a wide group of people.**
17.	**A well written and clear strategy**
18.	**Well-presented strategy but we need to include some sort of link with reporting through our annual report**
19.	**Very thorough and seems like everything has been thought about**
20.	**A bit wordy**
21.	**It would be nice if DWP applied similar standards, especially, timeliness.**
22.	**Would be good if provision made into BSL**
23.	**Think I have covered in previous boxes. Would re-iterate that too much is relied on electronic and social media communication.**
24.	**It seems to be very clear, concise and well thought-out.**
25.	**Only advice if there are significant changes to the system.**
26.	**A lot of words, maybe more pictures, diagrams in the documents.**

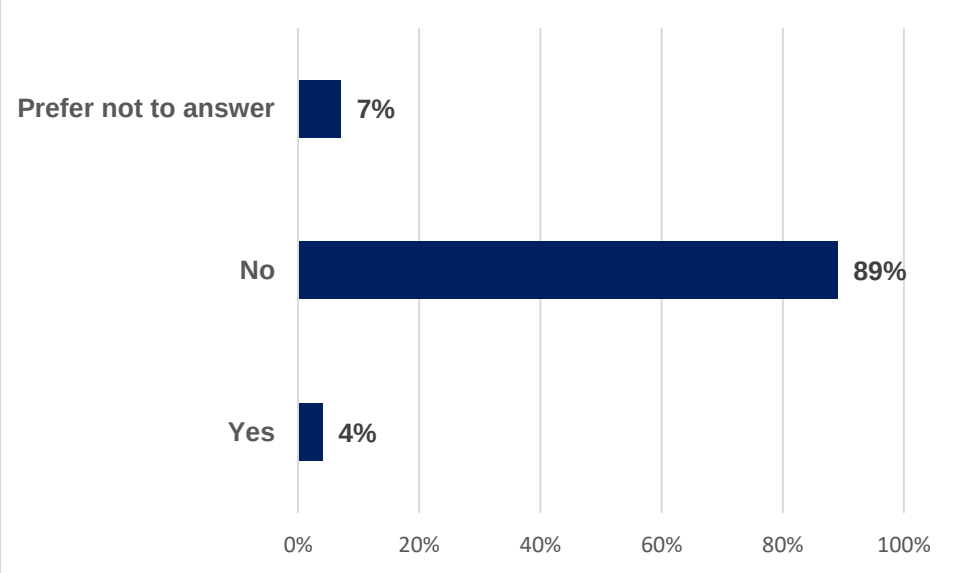
We asked the respondents some optional demographic question on their sex, age, health, ethnicity and if they are a carer.

Question 8 – What sex are you



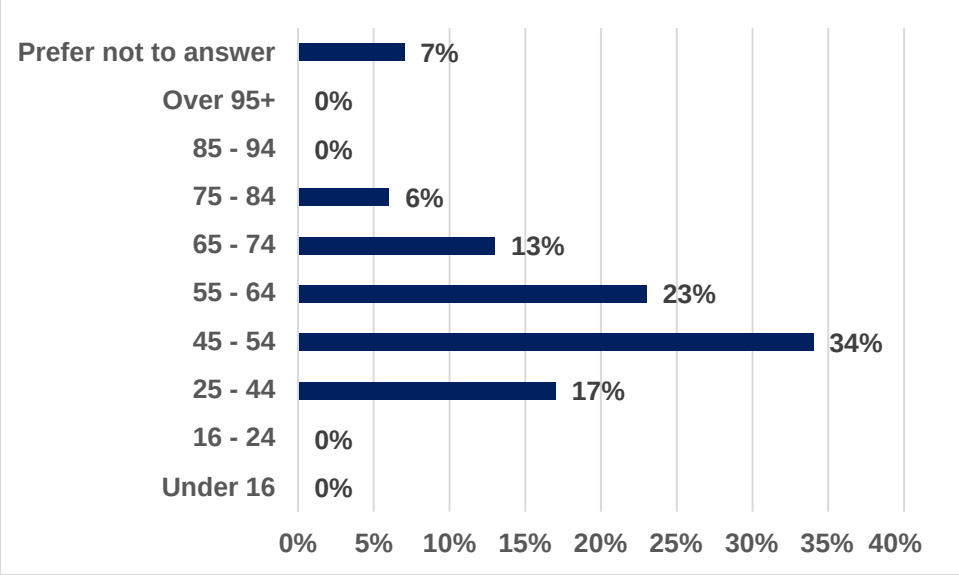
71% of respondents stated they are **female**, **23%** stated **male**, with **6%** stating **other**.

Question 9 - Is your current gender different from your gender at birth?



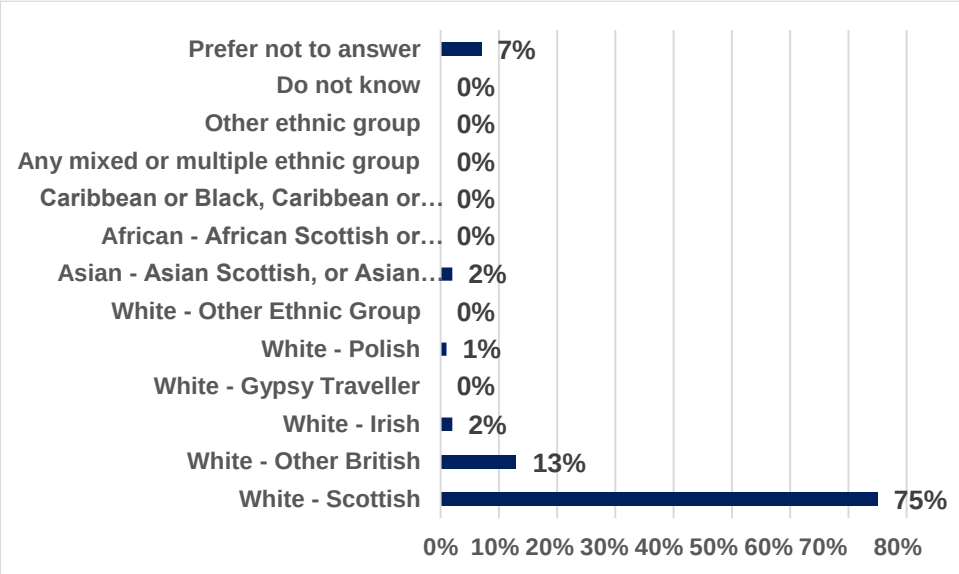
89% of respondents stated that their **gender is not different from their birth gender**, **4%** stated that **yes, their gender is different from their birth gender** and **7% preferred not to answer**.

Question 10 - What is your current age?



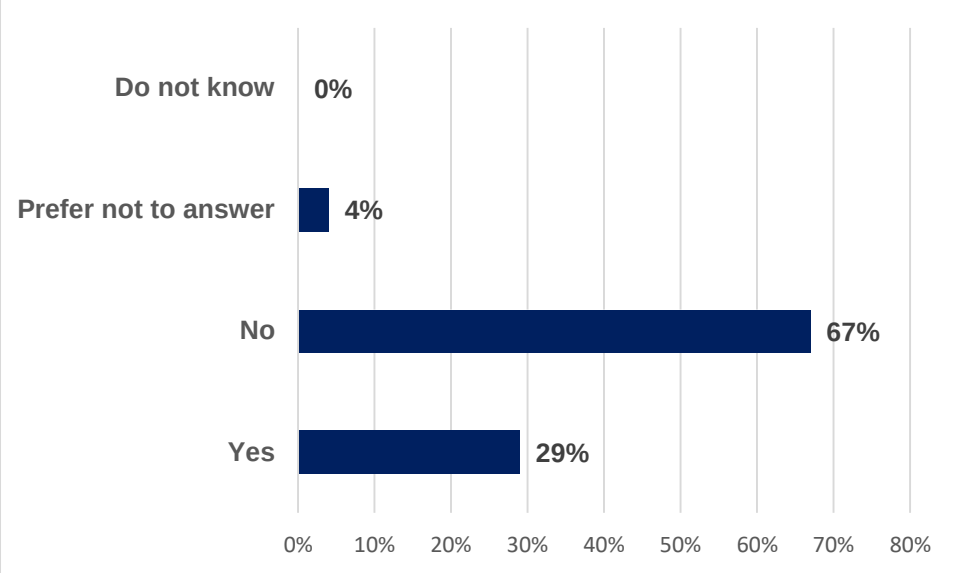
34% of respondents stated they were in the **45 and 54 years** age bracket. **23%** stated they were between **55 and 64 years**, with **13%** stating they are between **65 and 74 years.**

Question 11 – We then asked respondents "What is your ethnicity"?



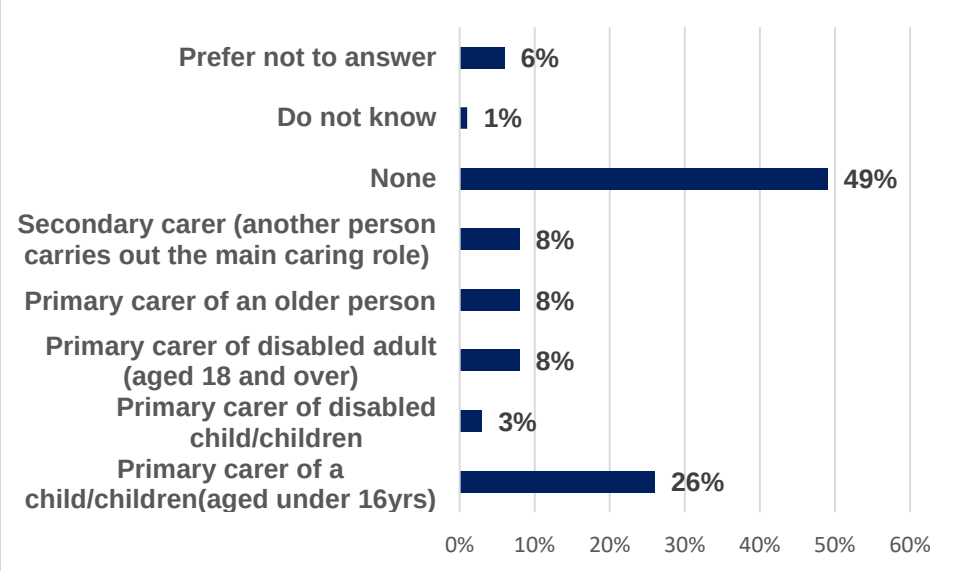
75% of respondents stated their ethnicity is **White – Scottish**, **13%** described themselves as **White – Other British**, **2%** are **White – Irish, 1% White – Polish** and **2%** described themselves as **Asian - Asian Scottish, or Asian British (Pakistani, Indian, Bangladeshi or Chinese)**.

Question 12 – The respondents were then asked "Do you consider yourself to have a long-term illness, health condition or disability lasting, or expected to last 12 months or more?



29% of respondents said **'yes'**, they do have long-term illness, health condition or disability lasting, or expected to last 12 months or more**. 67%** stated **'no'**, with **4%** preferring not to answer.

Question 13 – We then asked respondents "Do you have caring responsibilities"?



49% of respondents stated they had **'no'** caring responsibility, with **1%** stating they **'do not know'** and **6% 'preferring not to answer'**. **26%** of those surveyed are the **primary carers for a child/children under 16**. **3%** are the **primary carer of a disabled child/children**, **8%** are **primary carers of a disabled adult over 18** and

8% have a **primary caring responsibility for an older person**, with another **8%** having a **secondary carer** role.

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Health and Social Care Partnership (HSCP)

Communications Strategy (2020-23)

HSCP Chief Officer	Susan Manion
HSCP Head of Service:	Caroline Sinclair
Lead HSCP Officer:	David Radford
Contact HSCP Officer:	Anthony Craig
Approved by:	[e.g. Head of Service]
Date approved:	TBC
Date for Review:	TBC
Version:	Draft 5 (01042020)

CONTENTS

1. FOREWORD

We are pleased to present the East Dunbartonshire Health and Social Care Partnership (HSCP) Communication Strategy (2020-2023). The East Dunbartonshire HSCP has a long standing and well established approach to communication with carers, patients, service users, staff, partners and stakeholders.

Providing effective support for people is a priority for the East Dunbartonshire HSCP. Whenever possible, we will work to support people to live healthily and well within their local communities with their families and friends. To achieve this, we need to engage fully with all of our residents who are supported by our services. This requires effective channels of communication, which are designed to ensure that our information is clear, easily available to all and gets the right messages to the right people in the best possible way and for this reason, we have developed this Communications Strategy (CS).

The CS provides the framework for our overall approach to communication - who we communicate with and how we do it; and largely focuses on reaching wide audience groups. It also sets out a defined programme of communication activity with our HSCP colleagues and stakeholders.

This strategy will also compliment the accompanying HSCP Participation and Engagement Strategy (2020 - 2023), which is for individuals, groups and communities engaging in service planning and development. A significant amount of engagement activity already takes place in and across East Dunbartonshire. This strategy is designed to support our existing and future activity – ensuring we communicate effectively with all our stakeholders.

I hope you find it a valuable and useful framework that supports both individual and collective efforts across the HSCP.

Susan Murray (Chair)
East Dunbartonshire Health and Social Care Partnership (HSCP)
Integrated Joint Board (IJB)

2. INTRODUCTION

Effective communication is vital to the success of the East Dunbartonshire Health and Social Care Partnership (HSCP) ensuring that stakeholders are aware of, understand and are engaged in all relevant aspects of our work.

We know that the better informed and engaged people are about the services we provide the more satisfied they are likely to feel. Having good communications that are clear, honest and transparent and that seek to involve stakeholders early on in the process helps to build trust. We know that effective communications supports the planning, delivery and transformation of health and social care services, promoting effective professional practice and helping to increase stakeholder satisfaction.

It can therefore lead to better services, an improved reputation and stronger, more positive relationships with stakeholders, the people we serve and our partners in the public, voluntary and private sectors.

This Communications Strategy sets out how the HSCP will:

- provide the link between this document and our Strategic Plan (2018-21)[1] and the (eight) HSCP strategic priorities
- have a clear and effective approach to communication and engagement
- meet our vision and values
- identify our stakeholders and who we will communicate with (internally and externally) (see Appendix 1)
- describe how this document will support our commitment to meet the nine national health and wellbeing outcomes[2]
- identify the ways in which we will communicate, and;
- sets out how we will further improve the effectiveness of our communication activities

This Strategy also applies to all staff within the HSCP, regardless of whether they are employed by NHS Greater Glasgow and Clyde (GGC) or East Dunbartonshire Council (EDC).

[1] East Dunbartonshire HSCP Strategic Plan (2018 - 2021)
[2] Scottish Government National Health and Wellbeing Outcomes

3. KEY POLICY DRIVERS

The Public Bodies (Joint Working) (Scotland) Act 2014[3], is the legislative underpinning 'Integration' and sets out key planning and delivery principles of which communication and engagement are key components. Locally, the newly established East Dunbartonshire Integration Joint Board (IJB) will ensure that health and social care provision across East Dunbartonshire is joined-up and seamless, especially for people with long term conditions and disabilities, many of whom are older people.

There are several other drivers including local and national policies, guidance and legislation which place a duty on East Dunbartonshire HSCP to communicate and engage with the public. (See Appendix 2)

As a component part of the 'Integration' legislation, this Communication Strategy will strive to assist the HSCP in meeting our commitment to achieving the nine National Health and Wellbeing Outcomes as set out in **Table 1.** Only the outcomes which are directly relevant to this strategy are set out here for use. (See Appendix 3 for full list):

Table 1 - National Health and Wellbeing Outcomes

Number	National Health and Wellbeing Outcomes
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
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
9	Resources are used effectively and efficiently in the provision of health and social care services

[3] Public Bodies (Scotland) Act 2014

4. STRATEGIC APPROACH

The East Dunbartonshire HSCP is made up of EDC and NHS Greater Glasgow and Clyde (GGC) and is referred to as 'the Partnership' throughout this Communications Strategy (CS). As highlighted in section 3, the HSCP was set up in response to the Public Bodies (Joint Working) (Scotland) Act 2014. This created a requirement, in law, for Health Boards and Councils to work together in the planning, delivery and review of adult health and social care services, including services for children and older people. This is often referred to as 'Integration'.

Within East Dunbartonshire, all community and primary health and care services, including services for children, adults, older people, and criminal justice services, have been integrated. This means that those who use health and social care services should get the right care and support, at the right time and in the right setting, with a focus on community-based and preventative care and support.

East Dunbartonshire Health and Social Care Partnership Integration Joint Board (IJB) is the governance body that has the oversight for the strategic planning, funding and service delivery as outlined within the HSCP Strategic Plan (2018-2021). The HSCPs' aim is to work with partners, people and communities to deliver local health and social care services, improve health, deliver support, tackle health inequality, and improve community wellbeing.

The policy priorities of the HSCP as outlined in our Strategic Plan (2018 - 2021) are to:

Table 2 - East Dunbartonshire HSCP - Strategic Plan Priorities

Number	HSCP Strategic Plan (2018-21) Priorities
1	promote positive health and wellbeing, preventing ill health, and building strong communities
2	enhance the quality of life and supporting independence for people, particularly those with long-term conditions
3	keep people out of hospital when care can be delivered closer to home
4	address inequalities and support people to have more choice and control
5	people have a positive experience of health and social care services
6	promote independent living through the provision of suitable housing accommodation and support
7	improve support for carers enabling them to continue in their caring role
8	Optimise efficiency, effectiveness and flexibility

5. VISION AND VALUES

Effective communication will be fundamental to the attainment of the vision of the East Dunbartonshire HSCP, which is:

'Caring together to make a positive difference'.

East Dunbartonshire HSCP has agreed vision and values; these were developed in association with staff, patients, carers, service users and stakeholders. The values which are listed below in which everyone in a governance role, employed by, or contracted by, the HSCP is expected to adhere to are:

Table 3 - East Dunbartonshire HSCP- Values

East Dunbartonshire Health and Social Care Partnership (HSCP) Organisational Values	
Respect	Show kindness and courtesy and consider other people's feelings: • we will treat each other, our partners and people who access our services, fairly, as individuals and as equals with humanity and respect • we will be polite and courteous when dealing with each other • we will respect each other's diversity and differences • we will respect and maintain colleague's and the people who use our services need for privacy and confidentiality
Integrity	Live our values with our colleagues, partners and people who access our services: • we will take ownership of our actions and apologise when needed in a sincere way • we will be willing to learn from mistakes and make changes for improvement • we will take responsibility for and be accountable for our decisions and actions • we will support each other and demonstrate care and compassion in all our actions and communications • we will be open to feedback on our performance and acknowledge what is working well and what areas require further development
Professionalism	Behaving in a way that benefits the people who access our services: • we will never forget that everything we do is for our patients/service users • behave in a way consistent to the values of the HSCP in and out of our work • through integration learn about other professions and how this can support us in our service delivery • share best professional practice across the HSCP • make time as teams and individuals to reflect on what we have done and what needs to change when moving forward with integration
Empathy and Compassion	Understanding and caring for the wellbeing of others: • we will listen and hear what you have to say • we will acknowledge when we can't deal with a situation and sign post you in the right direction • we will take time to find out your personal preferences and needs • we will be sensitive and kind • we will never be too busy to care
Honesty	Be kind, honest, sincere, genuine, truthful and consistent: • in all our dealings with our colleagues and people who use our services we will promote an open and transparent environment

6. COMMUNICATIONS OBJECTIVES

The HSCP is committed to effective communication with all our stakeholders so that they are aware of, understand and are engaged with our services as appropriate. Taking a positive and proactive approach to communication ensures that information about what we do, why we do it and how we do it is provided in a clear and effective way.

This commitment supports the access to and the familiarisation of the services and activities available to people and communities and can help build trust and confidence in the HSCP, which in turn, helps build positive relationships and improves reputation.

Through this Communications Strategy and the Participation and Engagement Strategy, we will:

1. align our approach to national strategies, including the Community Empowerment Act (see Appendix 2), which supports enhanced public involvement in the delivery and distribution of health and social care services
2. further develop our own branding and corporate identity - for use on all digital and printed materials (ensure branding is distinctive and recognised as a separate legal entity from our parent organisations)
3. utilise our branding to promote our identity and priorities
4. deliver a co-ordinated, managed and consistent approach to communications
5. create awareness and understanding of, and engagement in, our vision for health and social care services
6. promote the HSCP and build a positive reputation and image
7. increase awareness of the services provided by the HSCP
8. support the development and promotion of our shared culture, vision, values and behaviours
9. provide information about our services and activities
10. provide stakeholders with opportunities to share their views and ideas and to contribute to the planning and delivery of health and social care services
11. support people and service users to make better informed decisions about their health and social care needs
12. assist in developing, sharing and promoting best practice
13. raise awareness of, acknowledge, promote and celebrate successes of the HSCP, and;

14. uphold, promote and embed approaches, standards and governance for effective communications by the HSCP as set out within the Communications Strategy

The Communications Strategy is underpinned by key standards, policies and guidelines from both East Dunbartonshire Council and NHS Greater Glasgow and Clyde on:

- accessible and equalities sensitive communications - tailored to the specific audience, as appropriate
- media relations protocols - setting out how we manage reactive enquiries and proactive communication with the media
- acceptable use of social media - applies to both corporate and personal use of social media
- data protection - compliance with the Data Protection Act 1998, and;
- General Data Protection Act (GDPR) (2018)

7. COMMUNICATION STANDARDS

Here we will describe how our Communications and Engagement activities will be delivered:

• **Open and honest**	• **In good time**
• **Clear**	• **Accessible**
• **Timely and accurate**	• **Relevant**
• **Three way**	

For full list and definitions, please see Appendix 4.

Evidence based research, statistics, proof of concepts, and case studies will also provide real-life examples of how we are making a difference and tell the HSCP's story in an effective and compelling way.

8. WHO IS OUR AUDIENCE?

Our key audience is anyone who has an interest or who has engaged with services or those who have a strategic and/or operational role in health and social care.
Our key audience groups and stakeholders may include: (See Appendix 5 for full list)

9. COMMUNICATION CHANNELS

The following key channels will be used by the HSCP to communicate with its audience. NHS GGC and East Dunbartonshire Council also have various channels to communicate with key stakeholders. (See Appendix 6 for full list)

10. ROLES AND RESPONSIBILITIES

HSCP Integrated Joint Board Members

It is the role of Board members to be the 'face' of the HSCP and to actively promote and drive forward the delivery of the strategic priorities. Board members may be required to provide quotes or to participate in media responses and can expect to receive advice and support from the EDC and NHSGGC communication teams when undertaking this role. Board members are responsible for being transparent about decisions taken and the strategic thinking behind them so that stakeholders can understand why decisions have been made.

Senior Management Team

The HSCP Senior Management Team (SMT) is responsible for driving the Communications Strategy, by clearly communicating their decisions (and the decisions of the HSCP Integrated Joint Board (IJB)). It is the role of SMT to identify potential communication opportunities for services and potential issues which the communications teams within EDC and NHS GGC can proactively promote and address.

Corporate Communication Teams

EDC and NHS GGC Communications Teams will support the HSCP in implementing and driving forward the Communications Strategy and its actions as well as supporting day-to-day functions. These teams are the first port of call for media, elected representatives and other queries and for staff in relation to advice on communications issues. The communications teams are responsible for ensuring the methods of communication adopted are appropriate and relevant. A Media Relations Protocol is in place to define the approach taken to media relations activity, roles and responsibilities within the HSCP and the respective communications teams.

Health & Social Care Staff

All staff have a responsibility to understand and promote the priorities of the HSCP through the work they undertake and to comply with the various internal communications channels and processes outlined in the staff Communication Strategy. All staff/employees are

ambassadors for the HSCP and have a role to play in upholding its reputation. They should be aware of this in both their personal and professional interactions.

11. GOVERNANCE

To ensure the consistency and accuracy of our information and communications, all HSCP branding and communications will be approved by the HSCP's Senior Management Team (SMT) or by the relevant delegated Service Manager for the service area it relates. Where a communication crosses service areas, a member of the SMT (or his/her nominee) will give final approval.

12. COMMUNICATION AMBITIONS

The following proposals for effective communications are detailed below;

- Further scoping to identify the feasibility of developing a corporate policy and a staff training plan that will further embed the HSCP vision, values and corporate identity on their working environment (HSCP internal)
- develop a HSCP-wide specific engagement and participation strategy (internal/external)
- scope and report on the potential for a bespoke HSCP website (internal/external)
- embed our branding and corporate identity throughout the HSCP - for use on all digital and printed materials (internal/external)
- engage and support comment and considerations from staff and from members of the East Dunbartonshire Public, Service User and Carer (PSUC) group to shape future communications both directly, involving both face to face and capitalising on the increase uptake and use of technology (internal/external)

13. COMMUNICATIONS ADVICE, GUIDANCE AND SUPPORT

Advice, guidance and support on the full range of communications channels and activities across the HSCP, EDC and NHS GGC have been made available. Both EDC and NHS GGC corporate communications teams also support external HSCP communications with the media and external organisations. (see policies below):

- East Dunbartonshire HSCP - Media Protocol (Oct 2017)
- East Dunbartonshire HSCP - Internal Communications Protocol (Oct 2017)

- East Dunbartonshire HSCP - Website/Webpages Protocol (Oct 2017)

14. MEASUREMENT AND EVALUATION

It is vital to assess how effective or not our communications activities are and whether they meet the objectives and outcomes we want to achieve. To do this, we will undertake to regular monitoring and evaluation to understand our baseline (starting point), and then to assess the levels of awareness and understanding of our messages and information, and the impact these are having on our people and communities (See Action Plan - action 3). Other measurement methods, which can help provide an indication of whether we're getting things right or not include:

- media coverage (local and national)
- webpage hits/visitors (EDC website)
- social media reach/engagement (HSCP Twitter and EDC Twitter / Facebook health and wellbeing specific messages), and;
- service user/client enquiries/compliments/complaints

There will be further discussion towards bi-annual reporting regarding communication activities to the Senior Management Team and Integrated Joint Board and/or its planning groups and committees. We will aim for all communications activities to be evaluated continually to ensure they meet the needs of the target audiences. The Strategy will be reviewed on an annual basis and any improvements identified will be incorporated into subsequent versions of both this Strategy and related action plans.

15. USEFUL CONTACTS

The communications teams within East Dunbartonshire Council and NHS Greater Glasgow & Clyde Health Board provide a communications function to support the HSCP in the delivery of the overall Communications Framework. This support includes taking care of media and stakeholder relations and can extend to creating content to make customers and stakeholders aware of the HSCP business and upholding the good reputation of the organisation.

Health and social care staff are required to follow the policies of their employing organisations and to refer to the relevant HSCP protocols that provide staff guidance.

Advice and support should be sought from the following contacts.

- **NHSGGC Communication Service:**

Tel: 0141 201 4429, press.office@ggc.scot.nhs.uk

- **EDC Communication Service:**

Tel: 0300 123 4510,corpcommunications@eastdunbarton.gov.uk

- **HSCP Contact:**

Vandrew McLean Vandrew.McLean@ggc.scot.nhs.uk

16. ACTION PLAN

In order to improve the effectiveness of our communication activities and evaluate the progress we make in the development and roll-out of improved and effective communications activity, the following high-level action plan is required:

Number	Action	Owner	Timescale
1.	a) Development of a corporate policy (staff code of conduct / staff charter) to ensure that HSCP publicity or information (both printed and digital) will not be released that does not fit our branding and/or HSCP corporate identity - This must be adhered to (internal) **b)** Create corporate templates that fit our values identity and will be the ONLY items used for all communications / publicity (posters, leaflets, surveys) by the HSCP and its teams **(see Appendix 7)** c) Corporate policy to also include and to further embed our corporate identity to enhance our communications both internal and external. (For defined values to be taken seriously, employees must adhere to these. Values and vision should be a prominent feature and SMT should offer guidance and support in meeting the requirements of this policy)	Named Senior Management Team Lead	Immediate to (March 2020)
2.	The HSCP and its teams will use established mechanisms to regularly communicate with the HSCPs internal and external audiences through the channels outlined (**see Appendix 6**) in this Communications Strategy	Senior Management Team and Senior Managers /	December / January 2020 on-going
3.	Develop and conduct a communications survey/questionnaire for both internal and external audiences who the HSCP communicates with and to understand: • the current awareness of the HSCP and its services • knowledge of our planning structures • the channels used for communications • the effectiveness of the HSCPs existing communications channels	Senior Management Team	By March 2020 (baseline) March 2021 (mid-point) March 2022

	• preferred communications channels and internal and external stakeholders' awareness and understanding of the HSCP and IJB and their work. To track changes and implement opportunities for improvement and conduct the survey three times over the course of the Communications Strategy, which will further inform its review in 2021		(end - point)
4.	A feasibility study will be undertaken to scope out the possibility of developing and implementing an external website for the HSCP and IJB to communicate with internal and external stakeholders including patients, service users, carers and their representatives and the public	Senior Management Team	by December 2021
5.	The HSCP will examine different and better ways of communicating with patients, service users, carers and their representatives, particularly hard-to-reach and vulnerable groups	Senior Management Team	by May / June 2020
6.	Establish, develop and implement a programme of external engagement opportunities (HSCP events x 2 per annum) for carers, patients, and public and service users to meet staff and managers, by using the PSUC group as a vehicle for participation	Senior Management Team	by May / June 2020
7.	Create and deliver a HSCP-wide specific engagement and participation strategy, (linking in with this Communications Strategy) including all HSCP teams covering all engagement, participation and involvement, including service change/redesign framework	Senior Management Team	by March 2020

APPENDIX 1. COMMUNICATIONS MATRIX

The following tables sets out the channels that will be used by the HSCP to communicate with its stakeholders at both corporate and partnership levels.

East Dunbartonshire Health and Social Care Partnership Communication Matrix
East Dunbartonshire Council / NHS Greater Glasgow and Clyde Corporate Level

Communications Channel	Corporate / ED HSCP	Internal / External	Frequency	Communications audience									
				Patients, service users, carers and their reps	The Public	ED HSCP staff	EDC and NHS staff	ED HSCP IJB, Elected members, NHS Non-Exec Directors	Trade Union / Staff side	Contractors/ Providers of health and social care	East Dun CPP members	Scot Gov and/or MPs / MSPs	The media
'Our News' HSCP staff newsletter	ED HSCP	Internal	Monthly			x	x	x	x				
Team Brief - Susan Manion (Chief officer)	ED HSCP	Internal	As and when required			x	x	x	x		x		
Managers briefings and Core Brief (NHS GGC)	Corporate	Internal	As and when required			x	x	x	x		x		
HSCP webpages on EDC website	Both	External	On-going	x	x	x	x	x	x	x	x	x	x
NHS GGC and EDC Intranet inc health and social care related web-pages (inc Staffnet and The Hub)	Both	Internal	On-going			x	x	x	x		x		
All HSCP staff emails (all NHS GGC and all EDC)	Both	Internal	On-going			x	x	x	x		x		
HSCP IJB and its committees approved agendas, minutes and reports	ED HSCP	External	On-going	x	x	x	x	x	x	x	x	x	x

Communications Channel	Corporate / ED HSCP	Internal / External	Frequency	Communications audience									
				Patients, service users, carers and their reps	The Public	ED HSCP staff	EDC and NHS staff	ED HSCP IJB, Elected members, NHS Non-Exec Directors	Trade Union / Staff side	Contractors/ Providers of health and social care	East Dun CPP members	Scot Gov and/or MPs / MSPs	The media
HSCP Twitter	ED HSCP	External	On-going	x	x	x	x	x	x	x	x	x	x
NHS GGC / EDC and its committees approved agendas, minutes and reports	Corporate	External	On-going	x	x	x	x	x	x	x	x	x	x
HSCP Service-specific channels: newsletters, websites, social media, leaflets, surveys, posters and projects/initiatives/ campaigns	ED HSCP	External	On-going	x	x	x	x	x	x	x	x	x	x
Public, Service User and Carer group participation / involvement	ED HSCP	External	On-going	x	x		x	x					
Public, Service User and Carer (PSUC) group - newsletter	ED HSCP	External	Quarterly	x	x		x	x	x	x	x	x	x
Public, Service User and Carer (PSUC) group - Posters and leaflets	ED HSCP	External	On-going	x	x		x	x	x	x	x	x	x

Communications Channel	Corporate / ED HSCP	Internal / External	Frequency	Communications audience									
				Patients, service users, carers and their reps	The Public	ED HSCP staff	EDC and NHS staff	ED HSCP IJB, Elected members, NHS Non-Exec Directors	Trade Union / Staff side	Contractors/ Providers of health and social care	East Dun CPP members	Scot Gov and/or MPs / MSPs	The media
Local third sector interface (TSI) / voluntary	ED HSCP	External	On-going	x	x								
Independent providers	ED HSCP	External	On-going							x			
Events	ED HSCP	External	As and when required	x	x		x	x	x	x	x	x	x
Solus screens in KHCC / health centres	ED HSCP	External	On-going	x	x								
'Health Working Lives' briefings, emails and posters	ED HSCP	Internal	On-going			x			x				
HSCP partnership briefings	ED HSCP	Internal	On-going			x			x				
Chief Officer and Heads of Service sessions, HSCP-wide Leadership sessions, Head of Service sessions with locality groups, iMatters and staff awards	ED HSCP	Internal	On-going			x			x				
All-staff emails (all HSCP, all health and all social work and all NHS GGC)	Corporate and ED HSCP	Internal	On-going		x			x					

APPENDIX 2. KEY POLICY DRIVERS

Community Empowerment (Scotland) Act 2015

Part 10 of the Act focuses on participation in public decision making. 'A new regulation-making power, enabling Ministers to require Scottish public authorities to promote and facilitate the participation of members of the public in the decisions and activities of the authority, including in the allocation of its resources. Involving people and communities in making decisions helps build community capacity and also helps the public sector identify local needs and priorities and target budgets more effectively'. www.gov.scot/publications/community-empowerment-scotland-act

The Scottish Government National Health and Wellbeing Outcomes (2014)

Outcome 8 concentrates on engagement: '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'. www2.gov.scot/National-Health-WellbeingOutcomes

Patient Focus Public Involvement (2006)

In 2006, Patient Focus Public Involvement was launched nationally. Patient focus, public involvement, often referred to as PFPI, emphasises two different ways in which people can participate in healthcare. Patient Focus: means the provision of treatments and services which put the needs of the person at the centre to improve their experiences and outcomes of care and treatment. Public Involvement: means involving people in decisions about how their health service is designed and provided. Public involvement should be part of the planning approach of an organisation. www.webarchive.org.uk/Resource/Doc/158744/0043087.pdf

Carers (Scotland) Act 2016

The Carers Act 2016 places a duty on local authorities and health boards to involve carers in planning the carer services they provide. must 'take such steps as they consider appropriate' to involve carers and carer representatives in the planning and evaluation of services that support carers. www.gov.scot/Unpaid-Carers/Implementation/Carers-scotland-act-2016

APPENDIX 3. NATIONAL HEALTH AND WELLBEING OUTCOMES

National Health and Wellbeing Outcomes	
1	People are able to look after and improve their own health and wellbeing and live in good health for longer
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
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
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
7	People using health and social care services are safe from harm
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
9	Resources are used effectively and efficiently in the provision of health and social care services

APPENDIX 4. COMMUNICATION STANDARDS

COMMUNICATION STANDARDS	
Open and honest	taking a person centred approach; sharing information which is truthful and accurate
In good time	providing up to date information as soon as possible, consistently and quickly
Clear	easy to understand; avoiding the use of jargon and in plain English
Accessible	meeting the standards of the Equality Act (2010). Use styles, formats, fonts and materials that are accessible and appropriate to the needs of the audience (Ariel 12 minimum)
Timely and accurate	support transparency, accountability and fairness
Relevant	informative with a focus on the needs of the intended audience
Three way	communication will be three way and work as a conversation - not a broadcast - with means for people to actively contribute at all levels and across the organisation

APPENDIX 5. KEY AUDIENCES AND STAKEHOLDERS

OUR KEY AUDIENCE GROUPS AND STAKEHOLDERS

- carers, patients, service users and their representatives
- the public and local residents
- staff working within East Dunbartonshire Health and Social Care Partnership
- East Dunbartonshire Council and NHS Greater Glasgow and Clyde employees
- East Dunbartonshire Integration Joint Board (IJB) Members
- East Dunbartonshire Council Elected Members
- HSCP Strategic planning group
- HSCP Locality planning groups (East and West)
- NHS Greater Glasgow and Clyde Executive & Non-Executive Director Board Members
- East Dunbartonshire Public, Service User and Carer (PSUC) group
- neighbouring HSCP Boards, NHS 24 and Scottish Ambulance Service (SAS)
- Trade Unions/staff representatives
- Contractors/providers of health and social care services and their representative groups (including third and independent sector and General Practitioners)
- Housing associations
- East Dunbartonshire Community Planning Partners (inc Scottish Fire & Rescue Service, Police Scotland, local colleges, Strathclyde Passenger Transport (SPT) Scottish Enterprise)
- MPs/MSPs within East Dunbartonshire and those who's constituency borders / overlaps and those with a health and social care remit
- Community councils / residents associations
- Relevant external organisations (e.g. Scottish Government & Scottish Health and Social Care Regulators), and;
- the media (local and national)

APPENDIX 6. COMMUNICATION CHANNELS

East Dunbartonshire Health and Social Care Partnership (HSCP)

- HSCP 'Our News' e-newsletter (staff newsletter with the Chief Officer's message)
- Team Brief (corporate briefing for staff from Susan Manion - Chief Officer)
- East Dunbartonshire HSCP webpages (EDC website)
- East Dunbartonshire Council and NHS Greater Glasgow and Clyde health and social care specific web pages (Internet web pages for the public)
- Twitter - @EastDunHSCP
- East Dunbartonshire HSCP Integration Joint Board and its committees approved agendas, minutes and reports
- health and social care service(s) specific newsletters
- service specific leaflets and posters displayed in GP offices, social work offices, health centres, hospitals, libraries, schools and community centres
- service specific projects/initiatives/campaigns
- local engagement groups (for example, PSUC group, Carers Group)
- third sector/voluntary and independent providers
- engagement events
- other channels (for example, service directories, EDC corporate comms/media stories and marketing campaigns)
- Healthy Working Lives briefings (internal letter / briefings to inform staff within the HSCP about health and wellbeing issues and promotions/campaigns)
- HSCP Briefing (briefing for staff within the Partnership on specific topics affecting them - as and when required)
- Team Meeting Communications Briefing (communications as part of staff team meetings)
- staff engagement opportunities including Chief Officers and Heads of Service sessions, annual staff awards, Head of Service sessions with locality planning groups, service-led sessions with Core Leadership Leads and iMatters
- all-staff emails (internal / external)
- word of mouth, one to one discussion with stakeholders

NHS GGC and East Dunbartonshire Council also have various channels to communicate with key stakeholders.

NHS Greater Glasgow and Clyde (GGC) (corporate communications):

- Health News (public newspaper)
- Staff News (staff magazine)
- NHS Greater Glasgow and Clyde Internet website
- Staffnet (Intranet website for staff and authorised users)
- Twitter - @NHSGGC
- Facebook - NHS Greater Glasgow and Clyde
- Team Brief (corporate briefing for staff from NHS GGC Chief Executive)
- Core Brief (corporate briefing for staff on specific topics affecting them)
- all-staff emails
- Health Board approved Board/Committee agendas, minutes and reports

East Dunbartonshire Council (EDC) (corporate communications):

- Edit (staff magazine)
- East Dunbartonshire Council website
- The Hub (Intranet website for staff and authorised users)
- Twitter - @EDCouncil
- Facebook - East Dunbartonshire Council
- Executive Message and Corporate Briefing (corporate briefing for staff from the Chief Executive)
- Managers' Briefing (corporate briefing for staff on specific topics affecting them)
- Corporate Announcements (all-staff emails)
- East Dunbartonshire Council approved Committee agendas, minutes and reports

APPENDIX 7. CORPORATE IDENTITY

(TEMPLATE CREATION)

Stationery and written communications

- Letterheads
- Compliment slips
- Fax header sheets
- Emails
- Business cards

Digital and online communications

- Webpages (EDC website)
- Intranet (NHS GGC / EDC)
- Social media channels (Twitter)
- E-bulletins and newsletters (Our news / patient/public newsletters)

Patient information

- Leaflets
- Posters
- Surveys

Presentations

- PowerPoint presentations

Marketing and promotional and organisational development materials

- Displays
- Exhibition/event stands
- Pull-up banners

Uniform and identification

- Lanyards (reminder to all staff this must be adhered to)

Media Relations

- All templates form part of the HSCP Identity

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Health and Social Care Partnership (HSCP)

Participation and Engagement Strategy (2020-23)

HSCP Chief Officer	Susan Manion
HSCP Head of Service:	Caroline Sinclair
Lead HSCP Officer:	David Radford
Contact HSCP Officer:	Anthony Craig
Approved by:	[e.g. Head of Service]
Date approved:	TBC
Date for Review:	TBC
Version:	Draft 5 (01042020)

CONTENTS

1. FOREWORD

We are pleased to present the East Dunbartonshire Health and Social Care Partnership (HSCP) Participation and Engagement Strategy (2020 - 2023). This Strategy is supported by the East Dunbartonshire HSCP Communications Strategy (2020 - 23).

East Dunbartonshire HSCP has a long standing and well established approach to communication with our communities, the public, carers, patients, service users, staff, partners and stakeholders.

East Dunbartonshire HSCP is continually looking for ways to make our services the best they can be for all of our communities, public, carers, patients, service users, staff, partners and stakeholders; and your feedback on how we are doing will help us to achieve this. By listening carefully to you, the HSCP can better understand what our communities want and need and how we can best support them. By working together, we can bring about real and lasting improvements.

We know from experience that the people who use our services have the lived experiences and are the true experts on how those services should be planned, developed and delivered and your views and experiences will help us to improve services for everyone who uses them.

Throughout the life of this Participation and Engagement Strategy (2020-2023) our stakeholders will have the opportunity to provide feedback on all aspects of our services via the Public, Service User and Carer group, local stakeholder groups, consultations, events and local and national surveys. We will use this feedback to make continuous improvements to the way we deliver local health and social care services.

Susan Murray (Chair)
East Dunbartonshire Health and Social Care Partnership (HSCP)
Integrated Joint Board (IJB)

2. INTRODUCTION

This document sets out the East Dunbartonshire Health and Social Care Partnership (HSCP) Participation and Engagement Strategy (2020-2023). Effective participation and engagement is vital to the success of the HSCP, ensuring that all stakeholders are aware of, understand, participate and are engaged in all relevant aspects of our work.

Scottish Government guidance on strategic planning states services should be 'planned and led locally in a way which is engaged with the community' (including those who look after service users and those who are involved in the provision of health and social care)[1]. Locally, this means that patients, service users, carers and their families, the Third and Independent sectors and HSCP staff will be embedded in the process as key stakeholders in the shaping and the redesign of health and social care services.

The HSCP conducts its business in an open and transparent way and will encourage all staff working with the HSCP to do likewise. Effectively this means putting the needs and aspirations of patients, service users, carers, and their families at the heart of their work. The HSCP will also encourage Third and Independent sector organisations who are commissioned by the HSCP to operate in a similar way.

This Participation and Engagement Strategy sets out how the HSCP will:

- describe how this document will support our commitment to meet the seven community engagement standards (Appendix 1)
- align our approach to national strategies, including the Community Empowerment Act (2015) (Appendix 2), which supports enhanced public involvement in the delivery and distribution of health and social care services
- provide the link between this document and our Communications Strategy (2020-2023), Strategic Plan (2018-21) and the eight HSCP strategic priorities
- deliver a clear and effective approach to participation and engagement
- meet our vision and values
- identify the ways in which we will involve communities and stakeholders, and;

[1] Public Bodies (Scotland) Act 2014

- establish the procedure to further enhance participation and engagement activities, through our planning, designing and reviewing of health and social care services

The consultation process, began in May 2019 and ran until February 2020, this has been achieved (thus far), through a range of engagement events; (Moving Forward Together events), stakeholder groups (PSUC group/Carers forum) and both the Strategic Planning Group (SPG) and the two Locality Planning Groups and their respective networks. The next stage will be to further engage with the public, carers, service users and with Third sector and Independent sector colleagues to widely share the document.

The HSCP will ensure that community participation and engagement is a cornerstone of the Partnership.

3. KEY POLICY DRIVERS

The Public Bodies (Joint Working) (Scotland) Act 2014[2], is the legislative underpinning to 'Integration' and sets out key planning and delivery principles of which communication and engagement are key components. Locally, East Dunbartonshire Health and Social Care Partnership Integration Joint Board (IJB) will ensure that health and social care provision across East Dunbartonshire is joined-up and seamless, especially for people with long term conditions and disabilities, many of whom are older people.

Other legislation passed by the Scottish Parliament including the Self Directed Support Act, 2013 and the Children and Young People Act, 2014, which empowers and supports individuals, families and carers to have greater choice and control over how they receive social care services.

The Community Empowerment (Scotland) Act, 2015[3] empowers local communities and individuals in a number of different ways, but particularly by strengthening their voices in the decision making process. New participation requests will allow local communities with an identified need to request that action is taken or to request

[2] Public Bodies (Scotland) Act 2014
[3] Community Empowerment (Scotland) Act 2015

involvement in improving a service. In addition, through the Community Planning Partnership (CPP), partners are required to engage with local communities, identified as living with deprivation to produce an action plan to address inequalities in the area.

In 2006, Patient Focus Public Involvement was launched nationally. Patient focus, public involvement, often referred to as PFPI, emphasises two different ways in which people can participate in healthcare. Patient Focus means the provision of treatments and services which put the needs of the person at the centre to improve their experiences and outcomes of care and treatment. Public Involvement means involving people in decisions about how their health service is designed and provided. (See Appendix 2)

4. VISION AND VALUES

Effective participation and engagement will be fundamental to the attainment of the vision of the HSCP, which is:

‘Caring together to make a positive difference’.

The HSCP has agreed vision (above) and values (see page 7); these were developed in association with staff, patients, carers, service users and stakeholders. The values which are listed below in which everyone in a governance role, employed by, or contracted by, the HSCP is expected to adhere to are:

Table 1 - East Dunbartonshire HSCP- Values

East Dunbartonshire Health and Social Care Partnership (HSCP) Organisational Values	
Respect	Show kindness and courtesy and consider other people's feelings: • we will treat each other, our partners and people who access our services, fairly, as individuals and as equals with humanity and respect • we will be polite and courteous when dealing with each other • we will respect each other's diversity and differences • we will respect and maintain colleague's and the people who use our services need for privacy and confidentiality
Integrity	Live our values with our colleagues, partners and people who access our services: • we will take ownership of our actions and apologise when needed in a sincere way • we will be willing to learn from mistakes and make changes for improvement • we will take responsibility for and be accountable for our decisions and actions • we will support each other and demonstrate care and compassion in all our actions and communications • we will be open to feedback on our performance and acknowledge what is working well and what areas require further development
Professionalism	Behaving in a way that benefits the people who access our services: • we will never forget that everything we do is for our patients/service users • behave in a way consistent to the values of the HSCP in and out of our work • through integration learn about other professions and how this can support us in our service delivery • share best professional practice across the HSCP • make time as teams and individuals to reflect on what we have done and what needs to change when moving forward with integration
Empathy and Compassion	Understanding and caring for the wellbeing of others: • we will listen and hear what you have to say • we will acknowledge when we can't deal with a situation and sign post you in the right direction • we will take time to find out your personal preferences and needs • we will be sensitive and kind • we will never be too busy to care
Honesty	Be kind, honest, sincere, genuine, truthful and consistent: • in all our dealings with our colleagues and people who use our services we will promote an open and transparent environment

5. GOOD PRACTICE

The HSCP will adopt the National Standard for Community Engagement as part of its Participation and Engagement Strategy (2020-23). These were first launched in May, 2005 and further updated in 2015/16 and have been widely adopted. The 7 standards detailed (see Appendix 1) set out best practice principles for the way in which public bodies engage with communities.

6. MEASUREMENT AND EVALUATION

The implementation and efficacy of the Participation and Engagement Strategy (2020-23) and the Communications Strategy (2020-23), will be reported on each year in the HSCP Business Development Plan. The annual evaluation of the East Dunbartonshire HSCP Public, Service User and Carer (PSUC) representative group and their associated networks and will include examples of participation and engagement that has taken place throughout the preceding year (public events, consultations etc).

The strategy will be reviewed after it has been in operation for 12 months and if it requires amendment an updated document will be prepared and submitted to the Integration Joint Board for approval. Following this initial 12 month period, the strategy will be routinely reviewed every three years, in line with the full rewriting of the Communications Strategy (2020-23).

7. NATIONAL OUTCOMES

The work of the HSCP, as directed by the IJB, will primarily be to plan, deliver, commission and co-produce health and social care services locally in a way that demonstrates effective progress against the National Outcomes for Adults and Older Peoples, Children and Families and Criminal Justice. Participation and engagement activity undertaken by the HSCP will be in pursuit of work connected with the achievement of these National Outcomes. (See here and Appendix 3)

8. PRINCIPLES AND POLICY PRIORITIES

The following principles will form the basis of our Participation and Engagement Strategy (2020-23), and are informed by findings of the review of existing engagement networks, comments from key stakeholders and the legislative context:

1. we will take an inclusive approach to participation and engagement, and promote opportunities for individuals and groups from all walks of life to engage with the East Dunbartonshire HSCP

2. we are responsible for the delivery of health and social care services in East Dunbartonshire to people of all ages and from all backgrounds, and we want to give all of our service users and patients the opportunity to influence those services through participation with the PSUC group and with various service reviews

3. we will further develop our participation and engagement activity with young people, recognising our existing engagement networks with young people are evolving, but less developed than with other groups and further promote digital and social media platforms to support communication with this group of stakeholders

4. we will be approachable, with information made available through a variety of accessible means on how to engage with East Dunbartonshire HSCP

5. we will be transparent in all of our engagement activity. We will share information, and will answer questions fully and frankly. The HSCP will regularly review and consider feedback from our participation and engagement networks

6. we are committed to two-way communication (see Communications Strategy 2020-23), and we will listen to what individuals, groups and networks have to say through communications with the PSUC group members and also through their contact email address (ED.PSUC@ggc.scot.nhs.uk). We will value and respect people's opinions. We understand that a small number of people cannot fully reflect the views of an entire community, but are entitled to make representations on behalf of their wider community

7. our communication and engagement across the East Dunbartonshire Public, Service User and Carers representatives group, the East Dunbartonshire Strategic Planning Group and both of the East Dunbartonshire Locality Planning Groups will be co-ordinated. We recognise the significant links, dependencies and overlaps between every group and how they relate to each other

8. we will have a strong local focus to our participation and engagement activity, recognising that the needs of localities are best represented by the people who live and work in those areas, and;

9. we will be flexible to the needs of our localities, recognising that one approach does not fit all.

The policy priorities of the HSCP as outlined in our Strategic Plan (2018 - 2021) are to:

Table 2 - East Dunbartonshire HSCP - Strategic Plan Priorities

Number	HSCP Strategic Plan (2018-21) Priorities
1	promote positive health and wellbeing, preventing ill health, and building strong communities
2	enhance the quality of life and supporting independence for people, particularly those with long-term conditions
3	keep people out of hospital when care can be delivered closer to home
4	address inequalities and support people to have more choice and control
5	people have a positive experience of health and social care services
6	promote independent living through the provision of suitable housing accommodation and support
7	improve support for carers enabling them to continue in their caring role
8	Optimise efficiency, effectiveness and flexibility

9. A CONSISTENT APPROACH

By offering a common understanding and consistent approach to the participation and engagement process, the participation and engagement framework enables the HSCP to be better able to undertake participation and engagement as part of an integrated service delivery. The Framework (Page 12) provides a clear definition of participation and engagement and sets specific standards to assist in planning, and conducting effective community participation processes. It assists to develop and maintain an

organisational culture that respects and values participation and engagement with our service users and communities.

The HSCP acknowledges the importance of building relationships with the community and embraces ongoing dialogue to improve decision making processes through timely, transparent, honest, inclusive, accessible and responsive community participation and engagement. By receiving diverse perspectives and potential solutions enables the HSCP to make more informed decisions. It does not replace the decision making functions of the HSCP but informs it. Furthermore it is not always practical or appropriate to engage the community in all HSCP decisions.

It is crucial that the community members of East Dunbartonshire are sufficiently informed of major issues, plans, projects and all matters that are likely to affect them and have opportunities to participate meaningfully in community engagement to enhance the HSCPs decision making process. This will thereby reduce potential misinformation and miscommunication.

10. PARTICIPATION AND ENGAGEMENT FRAMEWORK

The framework (Table 3) does not prescribe exactly how the communities of East Dunbartonshire should be engaged with for every project or issue. Rather, HSCP staff should determine the most appropriate participation and engagement approach, deciding on the level of participation and engagement based on the nature of the issue, project, plan or decision to be made. Moving to the right of the framework responds to an increase in expectation for public and community participation and impact. The framework has five levels describing the goal and promise for each.

In many cases, more than one level of participation will be required to achieve the HSCPs engagement objectives (e.g. inform and consult). Movement between engagement activities may occur as the engagement proposal is implemented and/or before the HSCP makes a final decision. Please refer to the service user engagement framework (page 14) for the table of service user engagement tools and techniques.

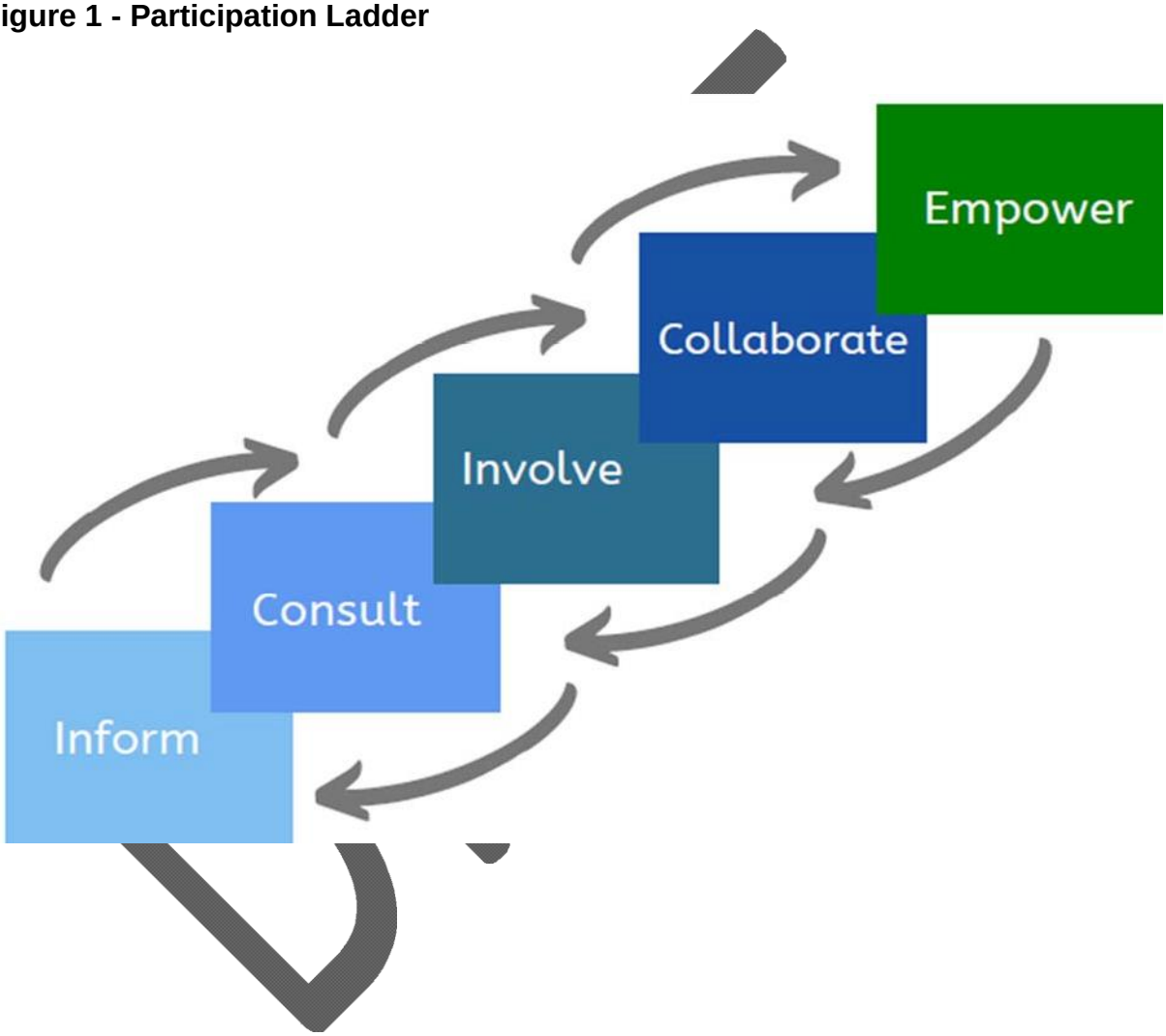
Table 3 - Participation and Engagement Framework

	INCREASING IMPACT ON THE DECISION MAKING PROCESS >>>>>				
	Inform	**Consult**	**Involve**	**Collaborate**	**Empower**
PUBLIC PARTICIPATION GOAL	To provide local service users with relevant health and social care information to assist them in understanding the challenges, alternatives, opportunities and/or the solutions	To obtain local service users feedback on analysis, alternatives and/or health and social care decisions	To work directly with local service users throughout any processes to ensure that residents health and social care concerns and aspirations are consistently understood and considered	To partner with local service users in each aspect of health and social care service re-design and/or service change including the development of alternatives and the identification of the preferred solution	To place the final decision making in the hands of service users and communities
PROMISE TO LOCAL COMMUNITIES	We will keep you informed of any development within local health and social care services	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how your input influenced the decision and we will seek your feedback on proposals	We will work with communities to ensure that their concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how their feedback influenced the decision	We will work with communities to formulate solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible	We will implement what you decide

11. PARTICIPATION AND ENGAGEMENT LADDER

In pursuit of our Vision, Values, Principles and Policy Priorities, the HSCP will actively seek the involvement of the community and all of its stakeholders in its decision making. It will do this in line with the community engagement standards outlined in Appendix 1 and by the deployment of the following participation and engagement ladder which is used in conjunction with the participation and engagement frameworks.

Figure 1 - Participation Ladder



12. ENGAGEMENT APPROACHES, TOOLS AND TECHNIQUES

We engage with our communities, service users and carers for a variety of reasons. Sometimes we may want to provide people with information or consult on something and get feedback, whilst at other times we may want people to participate more actively, so they can directly influence and get involved in our work.

Table 4 - Service User Engagement Framework

	Community Engagement and Participation Framework		
	Meaning	**Impact**	**Examples**
Inform	To provide good quality information to assist local people in understanding key issues	Local people are well informed about our work, services, visions and goals	Newsletters Leaflets, Posters Social media Website
Consult	To inform local people about what we would like to do to improve services and receive their feedback	Local people are listened to and their feedback is used to help us with our decisions	Patient and carer forums Surveys Feedback forms
Involve	To work directly with service users, carers and others to ensure their views are used to design or redesign a service or process	Local people's advice and ideas are used to improve services and outcomes for themselves and others	Workshops, Focus groups, Locality groups and Strategic planning groups
Collaborate	To work together in partnership with service user, carers, and/or other agencies to design, create or run services	People will work with us as equal partners to improve services and outcomes	Co-deliver or are involved in a pilot or new programme participatory decision making user panels / reference groups
Empower	The decision making in the hands of local communities	Local people lead on the planning and development of local services	Participatory budgeting Co-production

The remainder of this strategy document will set out the ways in which the HSCP will encourage participation and engagement, and the mechanisms that it will establish to ensure that this is effective, efficient, and equal and is done in a way that will assist it to deliver best value for the people of East Dunbartonshire.

13. THE INTEGRATION JOINT BOARD (IJB)

The Integration Joint Board (IJB) encourages participation in its decision making by having a number of representative members and others in addition to the voting members appointed by the NHS Greater Glasgow and Clyde (GGC) and East Dunbartonshire Council (EDC) to be an integral part of it and to contribute to debate and discussion. There will be a representative member appointed from each of the following: trade union representative, service users, carers, the third sector, council staff, NHS Board staff and General Medical Practitioners (GP's). These members will be entitled to attend and to participate in all formal decision making meetings of the board. More information can be found here.

14. STRATEGIC PLANNING GROUP

The Integration Joint Board established a Strategic Planning Group (SPG) for the HSCP as required through regulation. This is the principal stakeholder group of the HSCP. Its membership, which is wide ranging and representative, is set out in Appendix 5. The remit of the SPG is to:

- express its views on drafts of the Partnership's Strategic Plan (2018-22)
- comment on the implementation of actions outlined in the Plan
- work with the Senior Management Team (SMT) to update the Plan each year to reflect new needs and priorities and the changing environment, and;
- contribute to the development of HSCPs policies and strategies and to be consulted on these

More information can be found here.

15. LOCALITY PLANNING GROUPS

The HSCP has established two Locality Planning Groups (East and West) to provide a voice for local people, organisations and professionals working together to

communicate local needs and how these should be prioritised in future versions of the HSCPs Strategic Plan (2018-21). Performance information will in future be provided to both Locality Planning Groups and will be reported on in the HSCPs annual reports. This will enable groups to hold the HSCP to account for the delivery of services and the support provided in their areas. Delegation to Locality Planning Groups is an empowerment issue that will be further considered by the IJB.

16. ENGAGEMENT WITH STAFF

Staff working directly within the HSCP and who are employed by EDC and NHS GGC are recognised by the IJB as one of the most important resources that it has, in its drive to deliver on its Strategic Plan objectives and policy priorities. Representatives of the integrated workforce sit on the IJB and SPG. The HSCP has also established the East Dunbartonshire Staff Partnership Forum (SPF) which is the principal consultation body for engagement with staff and through which participation will be sought. This body meets regularly throughout the year.

17. PUBLIC, SERVICE USER AND CARER GROUP

The Public, Service User and Carer (PSUC) representatives group in East Dunbartonshire was formed in 2016 and is a network of local people with an interest in improving the services provided by the HSCP. Involving carers, service users, the public and local communities is an important part of improving the quality of services provided by the HSCP. The PSUC group help the HSCP to improve services and ensure they are person centred; they also assist the HSCP to change or redesign local health and social care services and to strengthen local knowledge and confidence in the HSCP. The PSUC group also:

- assist the HSCP in developing new services which meet the needs of the local population
- assist in creating an improved service and the overall experience people receive; and,
- assist the HSCP in developing and promoting better communication techniques to inform and engage local residents

Representatives from the PSUC group sit on the Integration Joint Board, Strategic Planning Group and both Locality Planning Groups. For more information please email ED.PSUC@ggc.scot.nhs.uk

18. THE THIRD SECTOR

The Integration Joint Board recognises the key role that the Third Sector plays locally and how central it is to the development of a co-produced model of service delivery and to the development of capacity in local communities. This essentially describes the relationship between service providers, service users and wider community that utilises their knowledge, ability and resources to develop services, so that they become more efficient, effective and productive.

In addition to being members of the IJB and the Strategic Planning Group, East Dunbartonshire Voluntary Action (EDVA), the local Third Sector Interface (TSI), is represented on the Commissioning Group that is overseeing the development of the HSCP Commissioning Strategy and both Locality Planning Groups. EDVA jointly participates in community engagement activities with the HSCP and has facilitated a number of consultation events with third sector and independent sector organisations, for example, on the development of the HSCPs Strategic Plan and Commissioning Strategy. More information can be found here.

19. THE INDEPENDENT SECTOR

The Independent Sector is represented on the Strategic Planning Group through a chosen representative, who has a seat on the group. In addition, the HSCP has established a number of provider's forums, with representatives from both independent sector and voluntary sector organisations. These groups participate in the development of new strategies and commissioning arrangements for a range of activity areas and will be instrumental in the modernisation of services and in the development of new and innovative approaches. These forums will also provide effective mechanisms for the discussion of issues, both opportunities and difficulties between providers and the HSCP's management and staff. To date such groups have been established in the following areas:

- Care Homes

- Learning Disability
- Physical Disability
- Mental Health and
- Older People

20. PROFESSIONAL GROUPS AND NETWORKS

The HSCP is the lead partnership in East Dunbartonshire for Allied Health Professionals (AHP's). Staff from a range of health, social care, and other professions, comprise a significant element of the workforce within the HSCP. Engagement with professional groups is another key element of the HSCPs Participation and Engagement Strategy. In addition, engagement with these groups that takes place through established mechanisms in NHS GGC and East Dunbartonshire Council. The HSCP, in accordance with the provisions of the Integration Scheme (Partnership Agreement), has established a Health and Care Governance Group, to engage with professionals and to seek their participation. The Health and Care Governance Group will consider matters relating to Strategic Plan development, governance, risk management, service user feedback and complaints, standards, education, learning, continuous improvement and inspection activity. The Health and Care Governance Group will provide advice to the Integration Joint Board, Strategic Planning Group, and locality groups.

21. GENERAL PRACTIONERS AND CLUSTERS

General Medical Practitioners (GP's), or family doctors, have a significant role to play in the delivery of Integration Principles as set out in the Public Bodies (Joint Working) (Scotland) Act, 2014, by working in partnership to improve the wellbeing of service users. In addition, fundamental to the HSCP's Strategic Plan is the desire to achieve a shift in the balance of care from hospitals and other institutions to local communities and people's homes. GP's will be at the heart of the HSCP's efforts locally to achieve this objective and the 2018 Scottish General Medical Services Contract sets out the distinctive new direction for General Practice in Scotland which will improve access for patients, address health inequalities and improve population health. East Dunbartonshire HSCP, through the new Primary Care Improvement Plan, has three distinctive locality based General Practice (GP) Clusters:

- Bearsden and Milngavie
- Bishopbriggs, and;
- Kirkintilloch, Lennoxtown, Lenzie, Torrance and Twechar

The purpose of these Clusters is to share resources, use data and health intelligence at a local level, be cognisant of local priorities, to facilitate assurance and to drive improvement in the quality of care provided by different parts of the health and social care system, while knowing local priorities. This aims to drive improvement in the quality of care provided by different parts of the health and social care system[4].

22. COMMUNITY PHARMACY / OPTOMETRY / DENTISTRY

The role of Community Pharmacists, Optometrists and Dentists is changing, with a much greater range of healthcare services and advice now available from pharmacies located in communities throughout East Dunbartonshire. Pharmacists have a key role to play in assisting the HSCP to achieve many of its priorities. The HSCP is committed to a process of regular consultation and engagement with pharmacists via their Stakeholder Group and a representative from this sits on the HSCP Strategic Planning Group. Information sharing with Optometry Services is shared via our Optometry Lead.

23. PUBLIC ENGAGEMENT AND PARTICIPATION

There will be occasions on which it will be appropriate for the HSCP to engage generally with the people of East Dunbartonshire and seek their participation. The HSCP will do this through a variety of means including events, public meetings, questionnaires, and written and on-line surveys. Some of the survey information used will be obtained through national exercises such as the Health and Wellbeing Survey.

Specific examples of exercises that will be conducted in this way will include the development and updating of the HSCP's Strategic Plan, the development of policy priorities and proposals to address health inequalities, particularly within the two localities. The HSCP will also actively participate in appropriate consultation and engagement activity being undertaken by others in fulfilment of its wider Community Planning Partnership (CPP) responsibilities.

[4] Improving Together - National framework Quality - GP Clusters (Scotland) 2017

24. CARERS

From 1 April 2018, the Carers (Scotland) Act 2016 extends and enhances the rights of Carers in Scotland to help improve their health and wellbeing, so that they can continue to care, if they so wish, and have a life alongside caring. The Scottish Government have also prepared a Carers Charter setting out the rights of carers in Scotland. The HSCP has just published our local Carers Strategy. In East Dunbartonshire 11,347[5] individuals identified themselves as unpaid carers. The HSCP also facilitates a Carers Working Group for carers and young carers in East Dunbartonshire. The local Carers organisation is called Carers Link and coordinates and supports the Carers Working Group.

The PSUC group also has Carer representatives who sit on the Integration Joint Board, the Strategic Planning Group and both Locality Planning Groups. Issues arising from these groups are considered at the Carers Working Group (Forum). With the enactment of this new legislation, engagement with Carers of all ages and the support provided to Carers will be subject to change. All of this has been addressed in the new Carers Strategy referred to above, and this was developed with Carer Representatives. There was full engagement with Carers before its subsequent approval by the Integration Joint Board. The Board recognises the significant role played by Carers in the support of many people living in East Dunbartonshire and is committed to a process of on-going participation and engagement.

25. COMMUNITIES OF EAST DUNBARTONSHIRE

The HSCP is committed to engaging with groups and individuals who face a range of social care and health inequalities and when encouraging participation will actively consider how to seek involvement from the following:

- those with/recovering from addictions
- homeless people
- ethnic minorities
- LGBT community, and;
- travellers / travelling community, and;

[5] 2011 Census, East Dunbartonshire

- those with additional or different communication needs, (those who may require different routes to communicate) BSL, Braille, community language etc.

26. ADVOCACY SERVICES

The HSCP recognises that a number of people in East Dunbartonshire across all age ranges will not necessarily be able on their own to make their views known or to actively take part in decision making. To facilitate this and to ensure that all voices are heard, the HSCP will signpost residents to independent advocacy services that operate and provide support and assistance across East Dunbartonshire to ensure, in so far as is practicably possible, that participation and engagement by the HSCP is inclusive and equal. More information can be found here.

27. CARE OPINION / PATIENT OPINION

Care Opinion is an external website which allows patients to give their opinion of their care. Through the website patients, service users, or people acting on their behalf are encouraged to write stories of their experience of health and care across all sectors. Stories are responded to by the relevant organisation concerned. Stories can be both positive and negative and are regarded by East Dunbartonshire HSCP as a useful way of assisting us to improve the services we are responsible for.

28. FREEDOM OF INFORMATION

The HSCP is subject to the provisions of Freedom of Information legislation and participates in the provision of information requested under the provisions of the Act. More information can be found here under documents.

29. COMMENTS, COMPLAINTS AND COMPLIMENTS

East Dunbartonshire IJB welcomes both positive and constructive feedback on the full range of its activities to inform future organisational learning and development. When a complaint is received, the Chief Officer, NHS GGC and Chief Executive, East Dunbartonshire Council will work together to achieve where possible a joint response identifying the lead party in the process.

For complaints regarding the business of the Health and Social Care Partnership information can be found here.

For complaints regarding services delivered by NHS Greater Glasgow and Clyde please visit www.nhsggc.org.uk/get-in-touch

With effect from 1 April, 2017 legislation and guidance in relation to Social Work complaints changed. Social Work complaints will now be handled through a two stage process. The full Social Work Complaints Handling Procedure can be viewed here.

30. SERVICE CHANGE AND / OR SERVICE RE-DESIGN

Patients, service users, carers, their families, staff and members of our wider communities must increasingly feel they are being treated as vital and equal partners in the design, assessment and delivery of their local health and care services. They should be confident that their feedback is being listened to and see how this is impacting on their own experience of care and the care of others and how it is used to shape local services in the future.

Health and Social Care Partnership's are required to work with people when they are considering changes to health and care services. The Statutory Guidance (CEL 4) (2010) outlines the process that HSCP's should follow to involve people in decisions about local services. East Dunbartonshire HSCP endorses the need for the whole partnership approach to engagement activities in line with Statutory Guidance (CEL 4) (2010). The flowchart (Appendix 4) describes the service change process and summaries the key elements and steps of the guidance. This should be viewed as supplementary to the full guidance.

The full guidance for NHS services can be found here. For social care services the HSCP will follow the guide as set out by East Dunbartonshire Council (Appendix 5).

APPENDIX 1. COMMUNICATION STANDARDS

Each of the seven National Standards for Community Engagement includes a short headline statement alongside a set of indicators to show progress towards meeting each standard. The following terms are used throughout the National Standards for Community Engagement:

('We' refers to the leaders or organisers of the community engagement process.)

• 'Partners' are any organisation or group who is involved in planning or delivering the community engagement process
• 'Participants' are all of the people or groups who are actively involved at any level throughout the community engagement process
• 'Community' is a group of people united by at least one common characteristic, including geography, identity or shared interests

For more detailed information about the community engagement standards click here

APPENDIX 2. KEY POLICY DRIVERS

Community Empowerment (Scotland) Act 2015

Part 10 of the Act focuses on participation in public decision making. 'A new regulation-making power, enabling Ministers to require Scottish public authorities to promote and facilitate the participation of members of the public in the decisions and activities of the authority, including in the allocation of its resources. Involving people and communities in making decisions helps build community capacity and also helps the public sector identify local needs and priorities and target budgets more effectively'. For more detailed information click here.

The Scottish Government National Health and Wellbeing Outcomes (2014)

Outcome 8 concentrates on engagement: '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'. For more detailed information click here. (See Appendix 3)

Patient Focus Public Involvement (2006)

In 2006, Patient Focus Public Involvement was launched nationally. Patient Focus, Public Involvement, often referred to as PFPI, emphasises two different ways in which people can participate in healthcare. Patient Focus means the provision of treatments and services which put the needs of the person at the centre to improve their experiences and outcomes of care and treatment. Public Involvement means involving people in decisions about how their health service is designed and provided. Public involvement should be part of the planning approach of an organisation. For more detailed information click here.

Carers (Scotland) Act 2016

The Carers Act 2016 places a duty on local authorities and health boards to involve carers in planning the carer services they provide. The HSCP, Local Authorities and Health Boards must 'take such steps as they consider appropriate' to involve carers and carer representatives in the planning and evaluation of services that support carers. For more detailed information click here.

APPENDIX 3. NATIONAL HEALTH AND WELLBEING OUTCOMES

National Health and Wellbeing Outcomes	
1	People are able to look after and improve their own health and wellbeing and live in good health for longer
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
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
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
7	People using health and social care services are safe from harm
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
9	Resources are used effectively and efficiently in the provision of health and social care services

APPENDIX 4. SERVICE CHANGE / RE-DESIGN FLOWCHART

East Dunbartonshire Health and Social Care Partnership (HSCP) Informing, Engaging and Consulting with People in Developing and/or re-provisioning HSCP Health and Social Care Services	
Planning	Identifying need for change • Develop a background paper detailing the rationale for change • Identify stakeholders and establish a project group to oversee process • Equality Impact Assessment (EQIA)/ Health Inequality Impact Assessment (HIIA) of process (if applicable) • Develop an Involvement and Communication Plan including evaluation of activity / Involve PSUC at this stage to consider wider participation • Consider work with NHS GGC / EDC and other NHS Boards / Councils who may be affected by change • Consider initial discussion with Scottish Government (if appropriate)
Informing	Inform potentially affected people of the planned timetable for engagement, reasons for change and share any other background information • Carry out communication and engagement activities that can be used to inform the engagement work and development of options and benefits that are expected to flow from proposed change • Consider evaluation of engagement
Engaging	Development of model(s) with key stakeholders and Option Appraisal process • Develop options with key stakeholders including PSUC group / carers working group / service specific service users / their families • An option development process should be used to seek consensus, even when there are limited number of options in line with requirements of paragraph 29 of Scot Gov - CEL 4 (2010) guidance • Agree criteria and weightings, option appraisal and scoring process, sensitivity analysis (if required) • Agree preferred option(s) for consultation and feedback to those involved • EQIA assessment on preferred option(s) (if applicable) • Seek Scottish Government view (if applicable) If considered Major Service Change: IJB / HSCP should not move to consultation until public involvement has been in accordance with guidance Follow guidance for independent scrutiny if relevant
Consulting	A proportionate approach may include a form of consultation for proposals not considered to be major. Seek advice from planning / participation team on methods and process.

	If considered Major Service Change • Plan for minimum 3 month consultation period, timescales for analysis of results and reporting to relevant Board meetings • A consultation paper needs to be produced which incorporates requirements of paragraph 33 of CEL 4 (2010) guidance • Agree how information will be shared (methodology)
Feedback and decision making	Provide feedback to stakeholders and interested parties on outcome • Explain results of the consultation process, final proposals and next steps • Evidence how views were taken into account in developing final proposals • Provide reasons for not accepting any widely expressed views • Outline plans for implementation and further opportunities for engagement • Evaluation of engagement, and consider undertaking an after action review.

APPENDIX 5. SERVICE CHANGE / RE-DESIGN / RE-PROVISION CHECKLIST (DRAFT)

1. Title of HSCP service proposal / re-design / re-provision[6]
2. Accountable Senior Management Team (SMT) Officer
3. Designated Staff Officer(s) (Names and Job Titles) for developing proposal
4. What is the nature of the proposal?
☐ Update or introduction of a new HSCP policy, plan, strategy etc. ☐ Review existing or introduction of new HSCP service or function ☐ Re-design or re-provision of an existing HSCP service or function ☐ Financial / budget proposal ☐ Other (e.g. technical note, decision). Please provide details: Click or tap here to enter text.
5. What are the main implications from this proposal? Select all that apply
☐ Re-design of a health and / or social care service ☐ Increase or addition of a health and / or social care service ☐ Re-provision of a health and / or social care service ☐ New ways of working or updates to procedures of a health and / or social care service ☐ Different location, format or time of a health and / or social care service ☐ New/changed priorities or criteria of a health and / or social care service ☐ Other. Please provide details: Click or tap here to enter text.
6. What is the purpose of the proposal?
7. What are the proposed vision, aims and objectives, if applicable?
8. What prompted the development of the proposal? (e.g. new legislation, administrative)
9. What is the subject of the proposal (e.g. health, social care)?
10. What are the intended outcomes and functions of the proposal?
11. Will the proposal be driven by, influence or be influenced by any other existing or emerging proposals? (strategic plan etc)
12. Has a previous version, or parts (e.g. objectives, actions) of this proposal been considered by any assessment before this?

☐Equality Impact Assessment (EqIA) ☐Risk Assessment	**If yes for 1 or more assessment, please provide details:** Click or tap here to enter text.

[6] This includes policies, business plans, procedures, programmes, frameworks, strategies, strategic decisions, service changes, masterplans etc.

13. What is the period covered by the proposal and/or implementation date	
14. What is the frequency of updates/reviews (e.g. annual)? Please include dates if possible	
15. Identify how the proposal supports the National Health and Wellbeing Outcomes[7] (select all that apply)	☐ **Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer ☐ **Outcome 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 ☐ **Outcome 3:** People who use health and social care services have positive experiences of those services, and have their dignity respected ☐ **Outcome 4:** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services ☐ **Outcome 5:** Health and social care services contribute to reducing health inequalities ☐ **Outcome 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 ☐ **Outcome 7:** People using health and social care services are safe from harm ☐ **Outcome 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 ☐ **Outcome 9:** Resources are used effectively and efficiently in the provision of health and social care services
16. Identify how the proposal supports the policy priorities of the HSCP as outlined in our Strategic Plan (2018 - 2021)	☐ **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

[7] The HSCP > Strategic Plan 2018 - 2021 > Health and Wellbeing Outcomes / Local Outcomes Improvement Plan 2017-2027

	☐ **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
17. Identify how the proposal supports the Local Outcomes Improvement Plan (LOIP)[8] select all that apply (if applicable)	☐ **Outcome 1:** East Dunbartonshire has a sustainable and resilient economy with busy town and village centres, a growing business base, and is an attractive place in which to visit and invest ☐ **Outcome 2:** Our people are equipped with knowledge and skills for learning, life and work ☐ **Outcome 3:** Our children and young people are safe, healthy and ready to learn ☐ **Outcome 4:** East Dunbartonshire is a safe place in which to live, work and visit ☐ **Outcome 5:** Our people experience good physical and mental health and wellbeing with access to a quality built and natural environment in which to lead healthier and more active lifestyles ☐ **Outcome 6:** Our older population and more vulnerable citizens are supported to maintain their independence and enjoy a high quality of life, and they, their families and carers benefit from effect care and support services ☐ **Guiding Principle 1:** Coproduction and engagement ☐ **Guiding Principle 2:** Best Value ☐ **Guiding Principle 3:** Evidence based planning ☐ **Guiding Principle 4:** Fair and equitable services ☐ **Guiding Principle 5:** Planning for place ☐ **Guiding Principle 6:** Prevention and early intervention ☐ **Guiding Principle 7:** Sustainability
18. Who is this proposals main audience? Select all that apply	☐ East Dunbartonshire HSCP employees ☐ East Dunbartonshire HSCP patients / service users ☐ Independent sector contractors or organisations / individuals carrying out a service on behalf of the HSCP ☐ Voluntary sector groups/organisations ☐ People living in a specific locality area of East Dunbartonshire. (SIMD area) Please detail: Click or tap here to enter text. ☐ Everyone living in East Dunbartonshire ☐ Specific users of a HSCP service Click or tap here to enter text.

[8] The HSCP > Strategic Plan 2018 - 2021 > Health and Wellbeing Outcomes / Local Outcomes Improvement Plan 2017-2027

	☐ People with a long term limiting health condition or disability / their carers / families ☐ Older people ☐ People with Dementia / their carers / families ☐ Carers ☐ Specific group(s) of people with a shared interest. ☐ Experiencing socioeconomic disadvantage (this includes low/no wealth, low income, area deprivation, material deprivation) ☐ Being in a particular age category ☐ Being from a black or ethnic minority group e.g. Gypsy/Travellers ☐ Speaking a language other than English ☐ Identifying as Lesbian, Gay Bisexual or Transgender ☐ Belonging to a particular religion or faith ☐ Pregnant women or those on maternity / paternity leave ☐ Another marginalised and / or hard to reach group e.g. those experiencing homelessness, offenders/ex-offenders. Please detail: Click or tap here to enter text. ☐ None of the above
19. Risk Management	Please tick boxes to confirm completion of each stage. ☐ Equality Impact Assessment ☐ Risks Assessment document reviewed by SMT ☐Risks Assessment document attached to SMT papers along with Impact Assessment Checklist
Signed:	**Date:** Click or tap to enter a date.

Appendix 6

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire Health and Social Care Partnership (HSCP)

Patient and Public Involvement - Project Planning and Involvement Checklist

ISSUE	ACTION	CHECKLIST
PRE – PLANNING		
Do I need to carry out this exercise?		**Stage 1** – *Why are you Involving?* (See Appendix 7 - Consultation and Engagement Checklist)
Can I link up with another colleague / someone else?		
Do we already know the answer?		
How specifically will I use the results of this consultation?		***Stage 2*** *– What are you consulting about? – What is the purpose of this consultation exercise?*
What is the decision that I am seeking views on?		
When does this exercise need to be completed?		**Stage 4 –** *When to Involve? Preparing Your Timetable*

When will a decision be made?		
What approval process do I need to go through in order to make a decision?		
What is the timeframe for this?		
How long will this consultation exercise take?		
At the end you want to be able to measure whether: • The timetable was clear and kept to and if not, why not • Enough time was allowed for responses.		
Who needs to give approval for this exercise to take place? • What do I need to do to obtain approval? • By when.		

What have I learnt previously about what does and does not work in public, service user, carer and involvement? What methods have I used previously that worked well? How can I use this knowledge to help this time?		**Stage 8 –** *Evaluating your involvement exercise*
What resources do I need to complete this exercise? • Human • Financial • Technical		
My estimate of how much this exercise will cost is? (if applicable) Is the cost of this exercise proportionate to the issue under consideration? At the end you need to be able to measure whether: • You budgeted adequately • You made savings in particular areas or overspent in others - and why • There were unforeseen costs - and what they were.		

My analysis of how I will know this exercise has succeeded is		*Identify critical success factors*
PLANNING YOUR EXERCISE		
What specifically will I consult about?		***Stage 2*** *– What are you consulting about? What is the purpose of your consultation exercise?* *.*
What are my key objectives?		
What is open to change and what is not?		
Make this clear in your consultation material		
At the end, you want to be able to measure whether: • objectives were clear • they were relevant to the consultation itself and linked to your wider planning process		

• they were explained to, and understood by, all relevant staff and those consulted		
Who will I consult?		***Stage 3*** *– Deciding Who To Involve – Identifying Your Stakeholders.* *What sort of views can you expect from different stakeholders?*
Who are my key stakeholders?		
How will I ensure that I reach groups that we have traditionally found hard to engage in consultation?		
Whose views and responses do I consider to be most important?		
Set specific targets for the level of response you want from your different stakeholders		

At the end, you want to be able to measure whether: • You have views from those you wanted • You were successful in consulting minority, disadvantaged or under-represented groups • Different groups responded to different methods • You gave feedback to those involved • The people consulted felt that the consultation was worthwhile		
What methods of involvement will I use? Ideally use a mix of quantitative and qualitative methods		***Stage 5*** *– How should I carry out the involvement?* *The Data Protection Act and other legal frameworks.*
Do I need to reserve premises, book interpreters, etc?		

At the end, you want to be able to measure whether:
• the methods used were right for your objectives
• if you used more than one method, which worked better than others - and why
• you gathered the required
  ○ quantitative and/or qualitative information
  ○ response rate		

How will I analyse the results?		**Stage 6 –** *Analysing the results. Identifying Key Messages Identifying Priorities and Actions*
How will I use the findings?		**Stage 7 – Providing Feedback** *– Who needs to know your results?*
Who needs to know what I have found out: • The HSCP? • Other partners/stakeholders?		
How will I provide feedback to participants?		***Stage 7*** *– Providing Feedback*
Make this clear in any consultation material.		

Build in time to evaluate this involvement exercise		***Stage 8*** *– Evaluating Your Involvement Exercise.*
Ensure that you give your participants an opportunity to evaluate your exercise		
Consider lessons that you have learnt from previous involvement		

East Dunbartonshire Health & Social Care Partnership

Appendix 7

East Dunbartonshire Health and Social Care Partnership

Consultation and Engagement Checklist

Stage 1	Why are you Initiating an Involvement Exercise?	
a	Be clear about what you are doing – where are you on the ladder of participation?	
b	Do we already know the answer to your question? Do you really need to carry out this involvement exercise?	
c	Carry out desk research and gather intelligence before you start	
d	Identify opportunities to link up with other involvement exercises	
e	Complete or at least consider the Involvement Project Plan	
f	Obtain any necessary approval and identify a project sponsor if appropriate	
g	Make sure that you publicise your consultation	

Stage 2	What are you Consulting About?	
a	Think through the purpose of your exercise - what do you want to achieve? Think about what you are really trying to achieve. A clear sense of the purpose will help you decide on the appropriate methods, who to consult, and enable you to decide at the end whether the process was successful.	
b	Clarify your objectives	
c	Think through how you will use the results	
d	Make sure that this exercise can influence a decision, policy or strategy	

e	Be clear about the opportunities for influence and any constraints	
f	Manage expectations clearly tell those you are involving what you are trying to achieve, the limitations and discuss the possible outcomes	
g	Think – what do you need to know, what might people want to tell you?	
h	At the end you will be able to measure whether objectives were: clear; relevant to the involvement activity itself and linked to your wider planning process; explained to, and understood by, all relevant staff and those consulted	

Stage 3	Deciding who to Involve	
a	Identify your stakeholders – who do you want to reach? Consider whether you can use existing groups and networks creatively – this will be time and cost effective	
b	Think - how can you reach groups who traditionally we have not engaged with?	
c	What sort of views are you looking for? Do you need responses that are representative, in–depth, individual's experience?	
d	Set targets for the involvement of different groups of stakeholders	
e	Think about how you will balance stakeholders' views – whose views will be given most weight and why?	
f	Use a variety of methods that suit your target audience	
g	At the end you want to be able to measure that you have the views that you wanted, and that you were successful in reaching groups who are traditionally hard to engage	

Stage 4	When to Involve	
a	Be clear about when the decision on this issue will be taken	

b	Think about at what stage you want to canvas opinion – before you develop your proposals, or when options and proposals have been worked up	
c	Build and agree a realistic timetable	
d	Complete your consultation plan	
e	Make sure you build in sufficient time for reporting your findings and the decision making timetable	
f	Allow time for feedback and evaluation	

Stage 5	How should I Carry out the Involvement?	
a	Make sure your method is appropriate to meet your objectives	
b	Consider using existing networks and groups to consult – even for issues outside their usual remit. Remember to check that this does not contravene the Data Protection Act	
c	Consider using a variety of quantitative and qualitative methods	
d	Think about methods that work with groups who we find difficult to engage	
e	Use the checklist when planning a consultation event to make sure that you have thought through the arrangements	
f	Write in plain English and consider the communication needs of your Consultees	
g	Make sure that you provide sufficient information for people to consider and respond	
h	Think through the impact of the Data Protection Act and other legal frameworks on your exercise	
i	If this is a statutory exercise ensure that you follow the appropriate guidance	
j	Consider whether you need external expertise to carry out your exercise	

k	Make sure you allow adequate time for people to respond to your consultation or involvement activity	

Stage 6	Analysing the Results	
a	Allow sufficient time to analyse your results	
b	For qualitative methods identify themes and variations in perspective	
c	Ensure that you comply with the Data Protection Act and respect confidentiality where this has been requested	
d	Identify your key messages – and areas where views diverge. You must give a balanced account of the responses you have received	
e	Decide what action can follow from your results	
f	It is important to consider how you will balance conflicting results – identifying which stakeholders' views will be given priority will help with this. Include findings that you cannot act upon in the short term – provide clear	
g	Include findings that you cannot act upon in the short term – provide clear feedback about these areas	

Stage 7	Providing Feedback	
a	Identify the different audiences who will need feedback about your exercise	
b	Identify what level of information these audiences will need	
c	Identify how you will make sure they receive the information – how will you tell them?	
d	Link your results to decision making	
e	Consider using the media and the HSCP Communications Team to get your message across and make the link between what we learnt and what we did	

Stage 8	Evaluating the Involvement	
a	Evaluation is important and should be built in from the beginning of the process	
b	Give those you involved an opportunity to evaluate the exercise	
c	Work through a basic evaluation every time and remember to keep this on file as it may be needed for audit purposes	
d	The key question - what effect has the involvement activity had? Check you can measure what happened as a result	
e	Managers should consider undertaking a more strategic look at evaluating consultation	
f	Sometimes an independent evaluation of your exercise may be valuable	

APPENDIX 8. STRATEGIC PLANNING GROUP

GROUP MEMBERSHIP / THE GROUP IS CHAIRED BY THE CHIEF OFFICER OF THE HSCP.

Stakeholder group	Number of representatives
Chief Officer of the HSCP (Chair)	1
HSCP Head of Service and Interim Chief Social Worker (Vice Chair)	1
HSCP Head of Service and Locality Lead	1
HSCP Health Improvement and Inequalities Lead	1
HSCP Planning Manager	1
GP Reps (Localities)	2
Voluntary Sector Rep	1
Independent Sector Rep	1
Health Professional Rep - Nursing	1
Health Professional Rep - AHPs	1
Health Professional Rep - Dentistry	1
Health Professional Rep - Community Pharmacy	1
Social Work Professional Rep (Justice) – social work	1
Social Care Professional Rep (adults) – social work	1
Social Work Professional Rep (adults) – social care	1
Social Work Professional Rep (Children and Families)	1
Acute Services Rep	1
Service User Rep	2
Carer Rep	2
Social Housing Rep	1
Strategic Housing Rep	1
Total	**25**

To see the East Dunbartonshire HSCP Strategic Plan (2018 - 2021) please click here. (Under documents)

APPENDIX 8. GLOSSARY OF TERMS

Advocacy Services
Organisations or groups that ensure that people are able to have their voice heard on issues that are important to them.

Allied Health Professionals
Staff who include podiatrists, dieticians, physiotherapists, speech and language therapists and radiographers.

Best Value
The most valuable combination of cost, quality and sustainability to meet customer requirements.

Carers
People who look after, unpaid, a friend or family member who due to illness or disability cannot cope without their support.

Children and Young People Act, 2014
A law that strengthens children's rights and helps improve the services that support children and families.

Community Based Support Networks
A range of organisations and people in a community that can provide support.

Community Capacity Building
Activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and

Community Engagement
A working relationship between one or more public body and one or more community group, to help them both to understand and act on the needs or issues that the community experiences.

Community Empowerment (Scotland) Act, 2015
A law which helps communities having greater influence or control over things that matter to them. Including the extension of the community right to buy or otherwise have greater control over assets.

Community Pharmacy
Businesses that used to be known as chemists.

Community Planning Partnership
Is a group of organisations that work together with local communities to design and deliver better public services, making sure that they meet the needs of local people.

Hard To Reach Groups
Groups of people who use public services and who are less likely to be involved by professionals and decision-makers.

Health and Care Governance Group
A group of people who are Responsible for making sure of the accountability of an organisation and its responsibilities to support staff and provide a good service to the public.

Health Board
A group of people that is responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services.

leading roles in the development of communities.

Health and Social Care Partnership
NHS and the local council care working together to provide health and care services.

Health and Social Care Integration

Is the steps taken to join up the services from NHS and the local council.

Health Inequalities
Means the differences in health status or in the distribution of health determinants between different population groups.

Independent Sector
Organisations which are private companies or social enterprises that are not NHS or local council.

Integrated Budget

A budget which is made up from budgets from NHS GGC and East Dunbartonshire Council.

Integration Joint Board

A committee of people from who have overall responsibility for the planning and delivery of community health and social work / social care services, including those for older people, adults, children and families and people in the Criminal Justice System.

Integration Scheme
A plan of how the services will be joined up.

Legislation
A law or set of laws, such as an Act, suggested by a government and made official by a parliament, e.g. Scottish
Parliament, UK Parliament.

Locality and Neighbourhood Planning
Is a way of planning health and social care services with smaller areas within East Dunbartonshire.

Locality Planning Group
A committee of people including local residents, which represents the interests of the local community and staff within an area.

National Outcomes
Are priorities that the Government wants to achieve over the next ten years.

National Standard for Community Engagement
Are good practice principles designed to support and inform community engagement and improve what happens as a result.

Participation and Engagement Strategy
A document that outlines the different ways that an organisation will engage with individuals, groups and communities to help in the planning of services.

Public Bodies (Joint Working) (Scotland) Act, 2014
A law which helps to bring together NHS and local council care services under one partnership.

Scottish Care
An organisation that represents independent sector health and social care providers.

Self Directed Support Act, 2013
A law which helps to give people more control over the range of options on how their social care is delivered, which best meets their needs.

Social Care
Care or support that helps to meet people's social needs and supports people to lead an active life, as independently as possible.

Social Isolation
Is a term used to describe the state of people having minimal contact with other people, such as family, friends or the wider community.

Social Media
Different types of electronic communication, websites for social networking, to share information, ideas and personal messages.

Stakeholder
A person, group or organisation that has interest or concern in something.

Strategic Plan
A planning document that sets out an organisation's needs and priorities. It also contains proposals on how the organisation will use all of its resources, including its budget, staff and other resources.

Strategic Planning Group
A committee that will provide stakeholder advice to the Integration Joint board (IJB) for any plans and programmes related to the delivery of community health and social work/social care services.

Third Sector
The voluntary sector, organisations which are not run for private profit, or by government.

Third Sector Interface
An organisation that represent voluntary sector, organisations which are not run for private profit or by government.

Local Third Sector Partners Mentioned

Ceartas
An independent Advocacy organisation who provide support and assistance across East Dunbartonshire.

Carers Link
An organisation that provides support to carers in East Dunbartonshire.

East Dunbartonshire Voluntary Action
The organisation that represents the voluntary sector in East Dunbartonshire.

APPENDIX 9. USEFUL CONTACTS

The communications teams within East Dunbartonshire Council and NHS Greater Glasgow & Clyde Health Board provide a communications function to support the HSCP in the delivery of the overall Communications Framework. This support includes looking after media and stakeholder relations and can extend to creating content to make customers and stakeholders aware of the HSCP business and upholding the good reputation of the organisation.

Health and social care staff are required to follow the policies of their employing organisations and to refer to the relevant HSCP protocols that provide staff guidance.

Advice and support should be sought from the following contacts.

- **NHSGGC Communication Service:**

Tel: 0141 201 4429, press.office@ggc.scot.nhs.uk

- **EDC Communication Service:**

Tel: 0300 123 4510,corpcommunications@eastdunbarton.gov.uk

- **HSCP Contact:**

Vandrew McLean Vandrew.McLean@ggc.scot.nhs.uk

NHS Greater Glasgow and Clyde
Equality Impact Assessment Tool

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. Please refer to the EQIA Guidance Document while completing this form. 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 alastair.low@ggc.scot.nhs.uk for further details or call 0141 2014560.

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

East Dunbartonshire Health and Social Care Partnership (HSCP) – Communications Strategy (2020-23) and Participation and Engagement Strategy (2020-2023)

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.

This Equality Impact Assessment (EqIA) was undertaken to collect information relevant to different groups and communities in East Dunbartonshire with protected characteristics and will be used to inform specifically the East Dunbartonshire Health and Social Care Partnership's (HSCP) Communications Strategy (CS) (2020-23) and Participation and Engagement Strategy (PES) (2020-2023) and will cover a 3 year period (2020-23). Specific service proposals and EqIA's relating to the work of the HSCP has been undertaken to ensure that any new policy, service change or re-design is compliant with the HSCP Integrated Joint Board's (IJB) legal duties in respect of their Public Sector duty, which is to eliminate unlawful discrimination, harassment and victimisation and other prohibited conduct, advance equality of opportunity between people who share a protected characteristic and those who do not.

East Dunbartonshire HSCP – Communications Strategy (CS) (2020-23) and Participation and Engagement Strategy (PES) (2020-2023) outlines 6 key themes that will apply to the way the HSCP communicates, engages and involves our local communities and aims to:

- set out our framework for communications and engagement – communications vision, objectives, approach, standards and governance and to support the development of a culture of public participation, engagement and involvement that is embedded into organisational practice
- define our key audiences who we will communicate and engage with, that is, our main stakeholders – both internal and external
- define our communication and engagement channels, that is, the tools and methods that we will use to communicate and engage with our audiences
- includes a communications action plan that we will progress to improve and implement our communication channels and practices
- define accountability structures so that relevant service user, carer and public participation can be assured in shaping the development and delivery of local services, and;

- ensure participation and engagement activities adhere to a high standard of consistency and quality.

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.)

East Dunbartonshire HSCP has written and consulted on their new Communications Strategy (CS) (2020-23) and Participation and Engagement Strategy (PES) (2020-2023) along with a Communications Strategy action plan, aiming to improve the way it communicates with a range of internal and external stakeholders. These Strategies sets out a consistent approach and a set of arrangements to communicate with patients, services users, carers, local communities and stakeholders to support them to be more aware of, understand and engaged in the work and services of the HSCP.

This includes communicating the vision, values and priorities for health and social care in East Dunbartonshire as set out East Dunbartonshire HSCP's Strategic Plan (2019-22). Both Strategies has involved and been informed by a significant amount of consultation and engagement activity with internal and external stakeholders, including stakeholders who have one or more protected characteristic. The EQIA has been undertaken to ensure any adverse impact on protected characteristic groups is minimised as a result of these Strategies and that the equalities duties placed upon us by the Equalities Act 2010 are upheld.

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:	Date of Lead Reviewer Training:
Anthony Craig (Development Officer)	01/05/2018

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):

Caroline Sinclair (Interim HSCP Chief Officer)
Tom Quinn (Head of People and Change)
Derrick Pearce (Head of Community Health & Care Services)
David Aitken (Interim Head of Adult Health and Social Care)
David Radford (Health Improvement and Inequalities Manager)
Gordon Cox (Chair – Public, Service User and Carer Group)
Alex Meikle (EDVA – Chief Officer)
Margaret Hopkirk (People and Change Manager and Joint Chair of Healthy Working Lives Group)

		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.*	Promoting equality and addressing health inequalities are at the heart of East Dunbartonshire Health and Social Care Partnership's (HSCP) vision and values. **Vision:** 'Caring together to make a positive difference' Throughout the development of the Strategies cited in this document, we have: • given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it, and; • given regard to the need to reduce inequalities between our stakeholders in access to, and outcomes from healthcare services and to ensure this might reduce health inequalities. East Dunbartonshire Health and Social Care Partnership (HSCP) conducted a 12 week consultation (December 2019 to February 2020) on its draft Communication Strategy (2020-23) and draft Participation and Engagement Strategy (2020-23). Utilising an effective communication and engagement process creates an opportunity for stakeholders and the HSCP to co-produce strategies that are realistic, achievable and sustainable. It also makes practical sense to develop a coherent communications strategy and participation and engagement strategy/programme that will maximise support for and understanding of participation,	The CS and PES was widely shared and promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.

			engagement and involvement in the planning, review and evaluation of health and social care services, among staff, stakeholders, patients, service users, carers and the public. The consultation undertaken utilised a quantitative and a qualitative approach, notably a questionnaire and face to face interviews. Participants were asked to share their views on: • understanding stakeholders views of the role of the HSCP • local knowledge of the HSCP • how the HSCP communicates and engages with our communities • what the HSCP can do to further improve on how we communicate and engage with the communities of East Dunbartonshire • respondents equalities information • how they find out about our work and services • their preferred communication channels • the usefulness of our communications • how our communications can be improved • how we can improve participation and engagement with service users, carers, patients and staff in relation to service change and re-design, and; • support the development of a culture of engagement, participation and involvement that is embedded into HSCP organisational practice. Both the electronic survey and printed versions of the survey were available to complete, and it was made available in a range of community facilities and offices including the Kirkintilloch Health and Care Centre (KHCC), GP practices, hubs, libraries and community centres. The survey was also promoted through the East Dunbartonshire HSCP Strategic Planning Group (SPG), both HSCP Locality Planning Groups (East and West) and	

			the Public, Service User and Carer (PSUC) group and their networks, in both print and electronic formats. The survey was also shared through digital communication channels, via newsletters, email and through East Dunbartonshire Council's website and social media channels and also through local Third Sector Organisations. The survey was completed anonymously by the participants and also captured equalities monitoring information. This included information on age, disability, sex and gender and participants had the opportunity to identify their primary relationship to East Dunbartonshire HSCP (e.g., patient, service user, carer, staff member etc.). The resultant sample of the survey consisted of a total of 138 responses, this is broken down by various participants. Both Strategies were also informed by engagement sessions with members of East Dunbartonshire HSCP's PSUC group (15 members), with another 56 people participated in face-to-face engagement sessions, which mainly consisted of carers, older peoples groups and third sector orgs. Utilising an effective communication and engagement process creates an opportunity for stakeholders and the HSCP to co-produce strategies that are realistic, achievable and sustainable. It also makes practical sense to develop a coherent communications strategy and participation and engagement strategy/programme that will maximise support for and understanding of participation, engagement and involvement in the planning, review and evaluation of health and social care services, among staff, stakeholders, patients and the public.	
		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)*	The data captured during the consultation period (Dec 2019 - February 2020) to inform both the Communications Strategy (2020-23) and Participation and Engagement Strategy (2020-23), will enable the HSCP to further improve our communication and engagement activity with our stakeholders and the channels and techniques we utilise. The survey findings in particular informed the development of our approach to communications, participation and engagement, in that we will strive for our communications to be clear and concise ('Plain English'); inclusive; consistent; accessible (with arrangements in place to adapt styles, formats, layouts, languages and material); timely, accurate and approved; transparent; targeted; multi-channel; three-way; evidence-based and endorsed. Our participation and engagement approaches will: • deliver a clear and effective approach to participation and engagement • meet our vision and values • identify the ways in which we will involve communities and stakeholders, and; • establish the procedure to further enhance participation and engagement activities, through our planning, designing and reviewing of health and social care services The data captured was used to emphasise in our Strategies that our approaches to communications, participation and engagement should strive to be clear and concise ('Plain English'); accessible (with arrangements in place to adapt styles, formats, layouts, languages (BSL) and material) and inclusive, and that communications are adapted to meet the communication needs and preferences of different audiences including those with protected characteristics (e.g., older service users for	Although the questionnaire that was distributed to inform the Strategies was promoted with all colleagues through HSCP services and also with the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks), it may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our Communications Strategy, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups. When developing our communications, we will actively consider identifying and removing any barriers to accessibility or inclusivity. A communications 'Jargon Buster' (Glossary of Terms) has been developed and in the Communications Strategy Action Plan we will also look to develop

			example generally prefer print and face-to-face communications over social media). By adopting this approach towards our communications, we aim to ensure that they remove discrimination, promote equality of opportunity and foster good relations.	a 'Communications Toolkit' with 'hints and tips' to encourage more consistent communications that support the communication, engagement, participation and involvement needs of different audiences, particularly those who have a protected characteristic.
		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 ☒	*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).*	The HSCP questionnaire for our Communications Strategy and Participation and Engagement Strategy, also included a range of engagements with our PSUC group (meetings and one to one chats), face-to-face engagement sessions with community groups with a protected characteristic (older people, BAME, young mothers) and also with third sector orgs (Recovery groups, church groups, young people etc). This allowed us to gather a closer understanding of the communication, participation and engagement needs and preferences of various stakeholder groups, including those who have one or more protective characteristics. The feedback also informed our approach to the amendments we made to these Strategies. The communication action plan that we will be progressing with, will allow the HSCP to continually improve how we communicate with our staff, patients, service users, carers and stakeholders. This understanding also allows for the communications and participation strategies to be adapted towards and respond to a variety of communication, participation and engagement needs of our communities, removing discrimination, promoting equality of opportunity and foster good relations.	Although the questionnaire that was distributed to inform the Strategies was promoted with all colleagues through HSCP services and also with the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks), it may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our Communications Strategy, we will continue to be committed to consider for any future communication activity the

	4) Not applicable ☐			specific needs and preferences of the communications audience including protected characteristic groups. When developing our communications, we will actively consider identifying and removing any barriers to accessibility or inclusivity.
		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? 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 ☒	*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)* ** The Child Poverty (Scotland) Act 2017 requires organisations to take actions to reduce poverty for children in*	Throughout our communications, participation and engagement consultation period, we also worked closely with our local PSUC group whose members represent a variety of third sector and/or local community groups. These groups are such as, older people's groups, carers, disability groups, alcohol and drugs recovery and groups. We also have members who come from a protected characteristic background. We also included equalities questions in the consultation questionnaire, capturing views from various East Dunbartonshire communities, such as those from BAME communities. We also received feedback from members of the deaf community who are users of BSL and we have taken their comments on board and initiated contact with a colleague from GGC public health improvement team to who advocates on behalf of the BSL community. Our research has shown to us that it is essential that our communications are clear and concise ('Plain English'); accessible (with arrangements in place to adapt styles, formats, layouts, languages and material styles) and inclusive, and that they are tailored to the communication needs of the intended audience. This includes the way in which we communicate with those who have a protected characteristic. This is	Although the questionnaire that was distributed to inform the Strategies was promoted with all colleagues through HSCP services and also with the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks), it may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our Communications Strategy, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience

	3) Foster good relations between protected characteristics ☒ 4) Not applicable ☐	*households at risk of low incomes.*	reflected in the communications approach taken within our Communications Strategy, and in its aims and objectives. Through collecting and using the responses from the range of stakeholders including patients, service users, carers and staff from a range of backgrounds as a basis for our Communications Strategy and Participation and Engagement Strategy, we are demonstrating due regard to removing discrimination, promoting equality of opportunity and fostering good relations.	including protected characteristic groups. When developing our communications, we will actively consider identifying and removing any barriers to accessibility or inclusivity.
		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 (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☒ 2) Promote equality of opportunity ☒	*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).*	Not Applicable	Not Applicable

	3) Foster good relations between protected characteristics. ☒ 4) Not applicable ☐			
		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 considered (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☒ 2) Promote equality of opportunity ☒ 3) Foster good relations between protected characteristics ☒	*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.* *Written materials were offered in other languages and formats.* *(Due regard to remove discrimination, harassment and victimisation and promote equality of opportunity).*	The East Dunbartonshire HSCP Communications Strategy (CS) (2020-23) and Participation and Engagement Strategy (PES) (2020-23) has been influenced by and reflects patient, service user, carer and staff experience among other stakeholders, including those from a protected characteristic group. Our comprehensive communications matrix of how we will communicate with different stakeholders has given those with one or more protected characteristics an opportunity to share their views. The supporting action plan for how we will improve our communications also takes into account the suggestions of patients, service users and staff among other stakeholders, including those from a protected characteristic group. Stakeholders are therefore playing an active role when it comes to improving how we communicate, especially the role of our PSUC group. As above, the CS is committed to communications that strive to be clear and concise ('Plain English'); accessible (with arrangements in place to adapt styles, formats, layouts, languages and material) and inclusive, and that communications are adapted to meet the communication needs and preferences of different audiences including those with protected characteristics.	The CS and PES was widely shared and promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.

	4) Not applicable ☐ The British Sign Language (Scotland) Act 2017 aims to raise awareness of British Sign Language and improve access to services for those using the language. Specific attention should be paid in your evidence to show how the service review or policy has taken note of this.		This includes the use of British Sign Language (BSL). Through the provision of an accessible and inclusive CS we are demonstrating due regard to removing discrimination, promoting equality of opportunity and fostering good relations.	
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 (tick relevant boxes).		This section must be read in context with the intersectionality for all protected characteristics. The East Dunbartonshire HSCP Communications Strategy (2020-23) and Participation and Engagement Strategy (2020-23) both recognise that the demographic breakdown of East Dunbartonshire continues to change. According to most recent projections, Over the 25 years 2014-2039, there is a projected increase of 95% in the number of people aged 75+yrs, also, during the same period; the number of children aged 0-15yrs is projected to increase by 4.4%. https://www.nrscotland.gov.uk/statistics-population-and-household-sub-council-area	The CS and PES was widely shared and promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities

1) Remove discrimination. harassment and victimisation ☒

2) Promote equality of opportunity ☒

3) Foster good relations between protected characteristics. ☒

4) Not applicable ☐

Table 1 – East Dunbartonshire population by Locality (2015 GP Pop - QOF, ISD)

Age Group	East Locality	West Locality	East Dunbartonshire
0 - 14yrs	10380	5903	16283
15 - 24yrs	7887	4094	11981
25 - 44yrs	16663	8153	24786
45 - 64yrs	19485	10615	30100
65 - 84yrs	11204	7412	18616
85yrs +	1350	1206	2556
All	66939	37383	104322

Between 2015 -17 there was an estimated 11% rise on the number of people with dementia in East Dunbartonshire (2086 to 2314 people). This number will continue to rise with the growing older population and is one of the key development areas for services (Alzheimer Scotland). Scotland wide rates of dementia increase with age from 1.8% of males and 1.4% at age 65-69 rising to 32.4% of males and 48.8% of males in the 95-99 and 100+ age ranges – we will ensure that this group of service users does not receive a lesser service due to their protected characteristics.

Generally population statistics show people in East Dunbartonshire die younger in more disadvantaged areas (SIMD 1), with data showing that older populations tend to be more concentrated in local authority areas of greater wealth (SIMD 5) and less so in those most deprived (www.sehd.scot.nhs.uk).

The life expectancy of people with profound, complex and multiple disabilities has increased over the course of the last 70 years. This is despite the fact that people with learning disabilities are 58 times more likely to die before the age of 50 than the rest of the population (Emerson and Baines 2010).

East Dunbartonshire. particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.

		The ability to access quality services is a fundamental aspect in ensuring that older people enjoy a high quality of life once leaving the labour market. Research has demonstrated the need to involve older people in the decision making process underpinning service planning, service design and service delivery, whilst also ensuring individuals from across the protected characteristics are represented. Furthermore, it is important to be aware of potential impacts associated with age discrimination that leads to inequality in terms of access to services and user experience amongst different age groups, and the need to develop multi-dimensional approach to tackling inequality as a consequence of age discrimination. Glasgow City HSCP Resource Allocation for Adults	
(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 ☐	This section must be read in context with the intersectionality for all protected characteristics. As stated by ScotPHO (2014), 16.4% of the East Dunbartonshire population are currently prescribed drugs for anxiety/depression/psychosis, with 3,545 adults claiming incapacity benefit/severe disability allowance/employment and support allowance. 49% of adults living in the 20% most deprived datazones in East Dunbartonshire reported having at least one long term condition in, compared to 35% in the remaining datazones. (World Health Organization [WHO], 2003). The relationship between disability and poverty cannot be over-emphasized. Poverty can lead to malnutrition, poor health services and sanitation, unsafe living and working conditions etc. that are associated with disability; disability can also trap people in a life of poverty (Mont 2007). Taking cognisance of guidance stated within 'A Fairer NHS Greater Glasgow & Clyde', The CS and PES (2020-23) recognises that identified priority topics are required	The CS and PES was widely shared and promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks. Certain barriers that have been identified are commonly given as; Difficulty in reading and understanding letters; Difficulty using telephones to arrange appointments; Transport difficulties including costs, and; Engagement in health services arising from mental health problems. In cases where the preferred communication method/channel for any protected characteristic group is not the primary method employed (e.g., due to time or resource constraints), all feasible

		to identify positive action / initiatives, to meet specific needs of the vulnerable and disadvantaged members of our community. Evidence suggests that disabled people have more difficulties in accessing health services than nondisabled people. The barriers that have been identified are commonly given as; Difficulty in reading and understanding letters; Difficulty using telephones to arrange appointments; Transport difficulties including costs, and; Engagement in health services arising from mental health problems.	efforts will be made to ensure that group is reached. This could be through a 'larger reach' communication channel or engagement with partners (e.g., The third and independent sectors) with knowledge and experience of or access to such groups. East Dunbartonshire HSCP's Participation and Engagement Strategy (2020-23) will be referring to the need to utilise our colleagues across the city to offset difficulties we may have reaching certain groups.
	Protected Characteristic	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
(c)	Gender Identity Could the service change or policy have a disproportionate impact on people with the protected characteristic of gender identity? 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 ☐	This section must be read in context with the intersectionality for all protected characteristics. The term Transgender refers to a number of characteristics. These include transsexual women and men, intersex people, androgyne people and cross-dressing (transvestite) men and women. Transgender People are one of the most marginalised protected characteristic groups in Great Britain. Tran's people are likely to experience abuse at various points throughout their lives (Scottish Transgender Alliance - Transgender experiences in Scotland 2008). NHS GGC offer guidance on health needs for Tran's people and how to address discrimination against Tran's people in their briefing paper on Transgender reassignment and Transgender people as well as offering training for NHS staff on the subject of transgender people (NHS GGC Transgender Briefing).	The CS and PES was widely promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS

		The CS and PES (2020-23) will be fully inclusive to all. Partnership working, inclusive of the Third Sector is highlighted in various themes within both Strategies and should also impact positively on Transgender people as major research and policy direction around Tran's people is largely shaped by the Third Sector.	and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.
	Protected Characteristic	Service Evidence Provided	Possible negative impact and Additional Mitigating Action Required
(d)	Marriage and Civil Partnership 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 (tick relevant boxes). 1) Remove discrimination, harassment and victimisation ☒ 2) Promote equality of opportunity ☒ 3) Foster good relations between protected characteristics ☒ 4) Not applicable ☐	This section must be read in context with the intersectionality for all protected characteristics. The CS and PES 2020-23 does not make any specific reference to marriage and civil partnership. All residents of East Dunbartonshire have the same rights in law as anyone else to marry, enter into a civil partnership or live together. Providing the person is over 16 years and has a general understanding of what it means to get married, he or she has the legal capacity to consent to marriage. No one else's consent is ever required. The District Registrar can refuse to authorise a marriage taking place if he or she believes one of the parties does not have the mental capacity to consent, but the level of learning disability has to be very high before the District Registrar will do so.	The CS and PES was widely promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.

(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 ☒ 2) Promote equality of opportunity ☒ 3) Foster good relations between protected characteristics. ☒ 4) Not applicable ☐	This section must be read in context with the intersectionality for all protected characteristics. The CS and PES (2020-23) are fully inclusive to all. East Dunbartonshire HSCP has in place policies that advise on **Pregnancy and Maternity,** pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding. It is known that there were 1036 births in East Dunbartonshire during 2017. This is an increase of 9.0% from the 951 births in 2016. Of these 1036 births in 2017, 474 (45.8%) were female and 562 (54.2%) were male. www.nrscotland.gov.uk/east-dunbartonshire- births	The CS and PES was widely promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.
	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?	This section must be read in context with the intersectionality for all protected characteristics. A community, where there is a lack of data is the Gypsy and Travellers. According to a desktop survey carried out in 2015 to assist with informing the development of Local Housing Strategies estimated that there is one site in East Dunbartonshire, with five Gypsy and Traveller households	The CS and PES was widely promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314

	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 ☐	(Desktop Survey - East Dun 2015). Scotland's Census 2011 indicated there are 27 persons living in East Dunbartonshire from the Gypsy / Traveller community (There are no figures for 2017/2018, so we are unaware of recent population figures). The Gypsy / Traveller community experiences of stigma, poverty and illiteracy have placed them in a disadvantaged position in seeking for support from services. They also felt that services, as a whole, are not sensitive to their culture. Through in-depth focus groups, many BME disabled people report that access to services can be compromised by poor translation, inconsistent quality of care and weak links between services and communities. Disabled people are more likely to live in poverty but BME disabled people are disproportionately affected with nearly half living in household poverty. Like all disabled people, many of those from black and minority ethnic backgrounds find themselves socially excluded and pushed to the fringes of society (Trotter R, (2012))	members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.
(g)	Religion and Belief 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. ☒	This section must be read in context with the intersectionality for all protected characteristics. There is little evidence to indicate specific faith groups fare more poorly than others in terms of access to HSCP services. In East Dunbartonshire In East Dunbartonshire 62.5% of the population stated they belonged to a Christian denomination. In terms of the Christian denominations 35.6% of the population in East Dunbartonshire belonged to the Church of Scotland and 22.3% stated they were Roman Catholic. The 'Other Christian' group accounted for 4.6% of the population. A large percentage of residents reported they had no religion (28.2%) lower than the Scottish average of 36.7%. This can be seen across all Wards with Milngavie showing the highest percentage of residents stating they had no religion (31.5%). 2.43% of the population in Bearsden South	The CS and PES was widely promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To

	4) Not applicable ☐	reported that they were Muslim, 2.18% reported they were Sikh and 1% reported that they were Hindu. (Scotland Census shows specific proportions of people's religion by local authority are as stated in the **2011** census)	mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.
	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). 1) Remove discrimination, harassment and victimisation ☐ 2) Promote equality of opportunity ☐ 3) Foster good relations between protected characteristics. ☐ 4) Not applicable ☐	This section must be read in context with the intersectionality for all protected characteristics. Equality Duty forms an integral part of the CS and PES. In this way, we can ensure that our equalities requirements are being met and that the quality of services to specific target groups remains high. In East Dunbartonshire there are inequalities of life expectancy between men and women across East Dunbartonshire. Generally women live longer than men. The average life expectancy for women in East Dunbartonshire is 83.5 years and for men is 80.5 years. In East Dunbartonshire, the average life expectance at 65years was 19.4yrs for men and 21.4yrs for women. The links between gender and health are becoming more widely recognised and an example of this can be illustrated by looking at mental illness. Although there do not appear to be sex differences in the overall prevalence of mental and behavioural disorders there are significant differences in the pattern and symptoms of the disorders. These differences vary across age groups. In childhood a higher prevalence of conduct disorders is noted for boys than in girls.	The CS and PES was widely promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.

		During adolescence girls have a much higher prevalence of depression and eating disorders and engage more in suicidal thoughts and suicide attempts than boys. (A Report on the Health of the Population of NHS GGC 2017-19). Of the 2314 people with dementia that Alzheimer Scotland estimates (825 males and 1,488 females) in East Dunbartonshire in 2017. The majority of dementia sufferers are aged 65 or over and female. Scotland wide rates of dementia increase with age from 1.8% of males and 1.4% at age 65-69 rising to 32.4% of males and 48.8% of males in the 95-99 and 100+ age ranges – we will ensure that this group of service users does not receive a lesser service due to their protected characteristics. https://www.alzscot.org/campaigning/statistics	
(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 ☐	This section must be read in context with the intersectionality for all protected characteristics. Evidence shows that especially the older LGBT population have an increased likelihood of living alone and an increased need to be supported through older adult services, but it also identifies many reasons why people are less likely to access the services they could benefit from. The HSCP, along with the Community Planning Partners (CPP) previously commissioned LGBT Youth Scotland to carry out a programme of work to find out more about the views and needs of our older LGBT residents. Among the approaches was a survey open to anyone over 50 living in the area and researchers also spoke with carers to try and gain an understanding of what individuals identify as their needs. Many LGBT people fear potentially experiencing homophobia, biphobia and transphobia from services or have previous experience of discrimination from a service. There is often a lack of visibility of LGBT	The CS and PES was widely promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any

		identities within services (such as staff knowledge of the issues affecting LGBT people, promotion of inclusive posters or websites, and explicitly stating that the service is LGBT-inclusive), which are necessary to counter LGBT people's expectations of discrimination or a lack of confidence that service services are able to meet their needs.	future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.
	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 the 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 in strategic planning. You should evidence here steps taken to assess and mitigate risk of exacerbating inequality on the ground of socio-economic status.	This section must be read in context with the intersectionality for all protected characteristics. Only 9% of the East Dunbartonshire population were income deprived (Scotland 16%), but there were wide variations across different areas, for instance in the Hillhead area of Kirkintilloch the population was 30% income deprived, yet just over a mile away in Lenzie south it is 3%. East Dun JSNA 2016 The East Dunbartonshire Local Housing Strategy (2017/22) shows there has been an overall reduction, demand for homelessness services since 2011/12 in East Dunbartonshire. From a peak of just under 700 applications in 2010/11, homeless applications have fallen to just over 500 in 2015/16. Unfortunately there is no available breakdown of demographic information to identify the age ranges of homelessness applications. (see JSNA above) SCVO - SDS Regulations and Statutory Guidance expressed their concern relating to the current substantial and poverty inducing changes to benefits drive through the intentions behind the SDS legislation. SCVO felt that already, people may have lost amounts of significant income, without even considering the potential loss of mobility components/support in the transfer to Personal Independence Payment (PIP).	The CS and PES was widely promoted and shared with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks. It was also shared with the local Citizens Advice Centre (CAB) through their local main and satellite office amongst staff and volunteers. It was also shared through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any

			future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.
(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?	As described above, the CS and PES has been written with input from a wide range of communities within East Dunbartonshire. The aim of the CS and PES is to ensure that we communicate, engage with and involve all other groups and communities of interest and to identify and focus activity and resources proactively to where they are needed most to improve the health and social care outcomes of our population. The Public Sector Equality Duty requires public authorities, in the exercise of their functions, to have due regard to the need 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 and those who do not, and; • foster good relations between people who share a relevant characteristic and those who do not The Equality Duty is non-delegable. In practice this means that public authorities like EDHSCP need to ask their suppliers and those they commission services from to take certain steps in order to enable the public authority to meet their continuing legal obligation to comply with the Equality Duty. Cross referral to sex, age, gender reassignment, race, disability, sexual orientation, marriage and civil	The CS and PES was widely promoted with colleagues and stakeholders through HSCP service teams and also with the local PSUC group, its various networks and also through the local Third Sector interface who forwarded it to their 314 members (charities, community groups, networks). It may not have reached all groups / people who have a protected characteristic. Therefore, the Strategies may not have been viewed and responded to by all representatives of communities of East Dunbartonshire, particularly protected characteristics groups. To mitigate this, as stated in our CS and PES, we will continue to be committed to consider for any future communication activity the specific needs and preferences of the communications audience including protected characteristic groups.

		partnership, social and economic status. Any changes to services or to service provision we must ensure that we communicate and involve all communities who may be affected, any East Dunbartonshire resident, service user, patient, carer or family member do not receive a lesser service due to their protected characteristics. The East Dunbartonshire breakdown is; In 2014, 62% (65,720/106,730) of the population of East Dunbartonshire was of working age (16–64 years), lower than the national percentage of 65%. Children and young people (aged 0–15 years) made up 17% (18,386/106,730) of the population, similar to the national 17%. Adults aged over 75 years comprised 10% (10,695/106,730) of the population, higher than the national average of 8%. The population structure of East Dunbartonshire has similar younger people; there is more older people and fewer people of working age than the national average. (https://www.scotpho.eastdunbartonshire). In 2014, 3.3% of adults claimed incapacity benefit, severe disability allowance or employment and support allowance; this was lower than the Scottish figure of 5.1%. The percentage of those aged 65 years and over with high care needs cared for at home, at 38%, was higher than in Scotland overall (35%). The crude rate for children, who were looked after by the local authority, at 7/1000, was similar to Scotland's rate of 14/1000. (https://www.scotpho.eastdunbartonshire). The Learning Disability rate per 1,000 in 2011 is 4.4, the Scotland rate, per 1000 is 5 (Scotland's Census 2011 - National Records of Scotland (Table QS304SC - Long-term health conditions). The number of people with learning difficulties 0-15 is 101, 16-64 is 305, 65+ is 52 (https://www.sldo.ac.uk/census-2011-information/learning-disabilities/local-authorities/east-dunbartonshire/)	

		There is no local population data with regards to Gender Reassignment available within East Dunbartonshire, there is no reliable information on the number of transgender people in Scotland. GIRES estimates that in the UK, the number of people aged over 15 presenting for treatment for gender dysphoria is thought to be 3 in 100,000. (http://www.gires.org.uk/) It is known that there were 951 births in East Dunbartonshire during 2016. This is a decrease of 2.1% from 971 births in 2015. Of these 951 births in 2016, 461 (48.5%) were female and 490 (51.5%) were male. (www.nrscotland.gov.uk/east-dunbartonshire- births) In the 2011 census, just under 96% of the East Dunbartonshire pop stated they are white Scottish, white British, and white Irish or white other. The demographic / area profiles recognise that 4.2% of the population of East Dunbartonshire is from a minority ethnic (BME) background (compared to Glasgow City with 11.6% of the pop). This is made up of mixed or multiple ethnic groups which stated they are from a, Asian, Asian Scottish or Asian British, African, Caribbean or Black and other ethnic groups (http://www.scotlandscensus.gov.uk/scottish-council-areas-2001-and-2011). 62.5% of the population stated they belonged to a Christian denomination. In terms of the Christian denominations 35.6% of the population in East Dunbartonshire belonged to the Church of Scotland and 22.3% stated they were Roman Catholic. The 'Other Christian' group accounted for 4.6% of the population. A large percentage of residents reported they had no religion (28.2%) lower than the Scottish average of 36.7%. This can be seen across all Wards with Milngavie showing the highest percentage of residents stating they had no religion (31.5%). 2.43% of the population in Bearsden South reported that they were Muslim, 2.18%	

		reported they were Sikh and 1% reported that they were Hindu, compared to Kirkintilloch East & Twechar which has 0.20%, 0.06% and 0.03% respectively (www.www.eastdunbarton.gov.ukareaprofile). In East Dunbartonshire the population is 106,730, The split between those who are female to male of 48/52, compared to Scotland which is 49/51. (www.www.eastdunbarton.gov.ukareaprofile). It is estimated between five and seven per cent of the East Dunbartonshire population is lesbian, gay or bisexual. This equates to one in every fifteen people, or over 7,000 East Dunbartonshire residents. https://www.eastdunbarton.gov./lgbt-health The United Nations Convention on the Rights of Persons and Optional Protocol requires all service provision to be concerned about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status. https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx	
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 ☒	Not applicable to these Strategies	Not applicable

	2) Promote equality of opportunity ☒ 3) Foster good relations between protected characteristics. ☒ 4) Not applicable ☐		
		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 groups? As a minimum include recorded completion rates of statutory and mandatory learning programmes (or local equivalent) covering equality, diversity and human rights.	East Dunbartonshire HSCP is committed to regularly training and empowering staff on equalities issues in order to prevent discrimination, promote equality of opportunity and foster good relations between protected characteristic groups.	Non applicable

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.

There are no reported risks in relation to human rights.

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* .

East Dunbartonshire HSCP No specific or definable approach was applied in the development of the Communication Strategy but the PANEL principles underpin the general approach to communication activity pursued by the HSCP, particularly in respect of maximising participation, preventing discrimination and promoting equality and empowerment of communities.

*

- **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)
X	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.

East Dunbartonshire HSCP, as part of the Communications Strategy (CS) Action Plan has developed and conducted a communications survey/questionnaire. This is for both internal and external audiences and it will be carried out over the life of the CS. who the HSCP communicates with, this is to understand:

- the current awareness of the HSCP and its services
- knowledge of our planning structures
- the channels used for communications
- the effectiveness of the HSCPs existing communications channels, and;
- preferred communications channels and internal and external stakeholders' awareness and understanding of the HSCP and IJB and their work.

To track changes and implement opportunities for improvement, the HSCP will conduct the survey three times over the course of the Communications Strategy, which will further inform its review in 2022 (March 2020 - baseline) (March 2021 - mid-point) (March 2022 (end - point))

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)
In reviewing the Communications Strategy (CS) (2020-2023) and Participation and Engagement Strategy (PES) (2020-2023) we will explore the opportunities to collect more robust data pertaining to communities and groups who have identifiable protected characteristics (see survey/consultation info above). East Dunbartonshire HSCP also facilitate the East Dunbartonshire PSUC group who are made up of 16 members of the public who work with the HSCP to: • assist the HSCP in developing new services which meet the needs of the local population • assist in creating an improved service and the overall experience people receive; and, • assist the HSCP in developing and promoting better communication techniques to inform and engage local residents.	3 x surveys/consultations (Baseline March 2020 / midpoint March 2021 / endpoint March 2022) AC	

We have also in conjunction with the PSUC group created a 'Glossary of Terms' jargon buster to make it easier for members of the public and communities to better understand the terminology used by health and social care staff and the meanings of certain names etc. This was shared widely around East Dunbartonshire.	

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

Anthony Craig (Development officer) December 2020

Lead Reviewer: Name Anthony Craig
EQIA Sign Off: Job Title Development Officer
Signature Anthony Craig
Date

Once complete please e-mail a copy of the assessment to alastair.low@ggc.scot.nhs.uk for quality assurance (QA). Please note QA offers advice on content and is an optional process for HSCPs who can proceed directly to publication if required.

Quality Assurance: Name:
Job Title:
Signature:
Date:

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:

Please email a copy of this EQIA to alastair.low@ggc.scot.nhs.uk or send to Equality and Human Rights Team, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospitals Site, 1055 Great Western Road, G12 0XH. Tel: 0141-201-4817.

Agenda Item Number: 7

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Date of Meeting	17th September 2020
Subject Title	Drug Deaths Taskforce funding update
Report By	David Aitken, Interim Head of Adult Services Tel: 0300 123 4510
Contact Officer	Lynsay Haglington, Alcohol and Drug Partnership Coordinator Telephone: 0141 777 3311 Ext 3082
Purpose of Report	The purpose of this report is to provide the Board with an update on the Drug Deaths Taskforce additional funding bid submitted to Scottish Government on Friday 26th June and the subsequent decision.
Recommendations	The Integration Joint Board is asked to: 1. Note the contents of the report
Relevance to HSCP Board Strategic Plan	The HSCP Strategic Plan 2018 – 2021 includes strategic priorities for Drugs and Alcohol under priorities 1, 2 and 8: **Priority 1** • Revise and improve our services to those suffering harm through alcohol and substance abuse **Priority 2** • 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. **Priority 8** • Support the national priority for the implementation of the rollout of the Drugs & Alcohol Information System (DAISy) across alcohol and drugs services.

Implications for Health & Social Care Partnership

Human Resources	Current vacant posts will need to be reviewed and amended where required, new posts may need to be developed as part of the work required from the DRD Taskforce bid.
Equalities:	Areas of deprivation may be tackled specifically as part of the work done based on the DRD Taskforce bid.
Financial:	An additional £34,753 has been awarded initially with a possible additional £2,400 – total additional budget would be £37,153,

	which is committed against the DRD Taskforce priorities as in Appendix 1 and will be monitored and reported back to Scottish Government.	
Legal:	None	
Economic Impact:	None	
Sustainability:	The funding is over two years so service and support sustainability will need to be built in wherever possible.	
Risk Implications:	The possible risks are around posts not being filled internally, if this is the case then external supports via the procurement process will be tendered for.	
Implications for East Dunbartonshire Council:	There are risks to East Dunbartonshire Council if these priorities are not supported, as there could be an increase in drug related deaths.	
Implications for NHS Greater Glasgow & Clyde:	There are risks to NHS Greater Glasgow & Clyde if these priorities are not supported, as there could be an increase in drug related deaths.	
Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	☒
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

MAIN REPORT

1. Scotland continues to face significant challenges relating to the use of illicit drugs including rising numbers of drugs deaths. Tackling this issue, including reducing the number of deaths is an important public health priority. The Scottish Government's policy is set out in the national strategy "Rights, Respect, and Recovery". It sets out a clear public health approach including a number of measures designed to reduce harm, and death.

2. The Drugs Deaths Taskforce was established in July 2019 by the Minister for Public Health and Sport, supported by the Cabinet Secretary for Justice, to tackle the rising number of drug deaths in Scotland.

3. The primary role of the taskforce is to co-ordinate and drive action to improve the health outcomes for people who use drugs, reducing the risk of harm and death.

4. The taskforce will specifically:

    1. examine and publish evidence of the triggers of drug deaths and what we have learned in Scotland about how they can be prevented

    2. collate and publish good practice about what has worked in other parts of the UK and internationally to prevent death and harm arising from drug use

    3. work with partners to identify, spread and sustain good practice in Scotland

    4. identify specific barriers in the planning, commissioning and delivery of addiction services in Scotland

    5. review whether the Misuse of Drugs Act 1971 affects the provision of a strengthened and consistent public health approach to drug use, recognising that this is reserved to the UK Parliament and any changes will require the agreement of the UK Parliament

    6. identify the extent to which the availability of appropriate programmes and treatment options limit the use of diversion from the criminal justice system or the use of constructive sentencing options within the criminal justice system

    7. identify the full range of support services which help to reduce harm and identify deficiencies in the delivery framework, availability and provision of such services

    8. make recommendations for changes in current health and social care practice and on how a public health approach to drugs might be more fully realised across all relevant services and in the justice system

5. Each ADP is required to drive forward the recommendations from the Drug Deaths Taskforce to help reduce drug deaths and drug related harm.

6. The Drug Deaths Taskforce established six evidence based Priorities to reduce drug deaths and drug harms:

    1. Targeted Distribution of Naloxone
    2. Implement Immediate Response Pathway for Non-fatal Overdose
    3. Optimise the use of Medication-Assisted Treatment
    4. Target the People at Most Risk
    5. Optimise Public Health Surveillance
    6. Ensure Equivalence of Support for People in the Criminal Justice System

7. Potential funding of £37,153 was made available to East Dunbartonshire, which was obtained via a funding bid to Scottish Government, to support Integration Authorities to provide these services where they are not already in place for all those at risk in the local area. Bids were developed in partnership through local ADPs to ensure they aligned to existing approaches across the local alcohol and drug strategy.

8. Applications were reviewed by a panel made up from representatives from the Drug Death Taskforce, including people with lived experience. The criteria used to assess the bids was as follows:

    - Clear understanding of the gaps in service delivery
    - Relevance of the proposal to the evidence based Strategy
    - Relevance of the proposal to meet the gaps identified in service delivery
    - Innovative and person centred approach

9. At the time of submission, funding was sought against priorities 1, 3, 4, 5 and 6, but not priority 2 due to work that was still on-going in GGC around information sharing protocols.

10. Funding was awarded across the six Priorities, and agreed initially for Priorities 1,3,4 and 6. With additional funding for Priority 5 'Optimise Public Health Surveillance' agreed as part of Priority 2 funding 'Implement Immediate Response Pathway for Non-fatal Overdose' as work had progressed within this work stream which was not in place at the time of the original bid.

Priority	**Total £ required**	**Status**
Priority 1	£500	Agreed
Priority 2	£2,400	Included in revised submission
Priority 3	£13,080	Agreed
Priority 4	£11,619	Agreed
Priority 5	£0	Resubmit under priority 2
Priority 6	£9,554	Agreed
Overall total	**£37,153 (per year)**	**Funding is over two years**

11. Scottish Government will ensure this funding is made available over the course of two years, at a total of £74,306, and have requested that Alcohol and Drug Partnerships provide performance and monitoring information where appropriate.

12. Summary of spend:

    1. **Targeted Distribution of Naloxone** – provision of postal Naloxone and promotional materials
    2. **Implement Immediate Response Pathway for Non-fatal Overdose** – development of assertive outreach programme, provision of Naloxone and access to MAT
    3. **Optimise the use of Medication-Assisted Treatment (MAT)** – increase medical sessions to support provision of same day prescribing and support the implementation of MAT Standards
    4. **Target the People at Most Risk** – develop Peer Recovery Worker post with lived experience
    5. **Optimise Public Health Surveillance** – No funding has been obtained at present, however links have been made with national support team
    6. **Ensure Equivalence of Support for People in the Criminal Justice System** – Enhance current nursing post to support Criminal Justice, including DTTO's (Drug Testing and Treatment Order)

13. The Drug Deaths Taskforce priorities will also be included in the Alcohol and Drug Partnership Strategy and Delivery Plan and reported on annually. The work under these priorities will be undertaken in partnership with Alcohol and Drug Recovery Service, Criminal Justice, GGC and other ADP partners including the third sector.

Agenda Item Number: 8.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17th September 2020
Subject Title	Older Persons Housing Research
Report By	Derrick Pearce, Head of Community Health and Care Services
Contact Officer	Thomas Gahagan, Rehabilitation Team Manager thomas.gahagan@eastdunbarton.gov.uk; Telephone: 0141 355 2264
Purpose of Report	To report progress on East Dunbartonshire HSCP's (and the Council's Land Planning & Development Service and Housing Service) jointly commissioned research on Older People and Specialist Housing Research
Recommendations	The Integration Joint Board is asked to: 1. Note the contents of the Older People and Specialist Housing Research 2. Approve ongoing commitment to work with the Council's Land Planning & Development Service and Housing Service 3. Seek an update report at a future date in one year's time to review the impact and changes made
Relevance to HSCP Board Strategic Plan	Fulfils the HSCP Boards responsibilities in respect of the strategic planning of future care and support services, and in particular to the following key priorities: 1. Priority 3 – Keep people out of hospital when care can be delivered closer to home 2. Priority 5 – People have a positive experience of Health and Social Care services. 3. Priority 6 – Promote independent living through provision of suitable housing, accommodation and support 4. Priority 8 – Optimise efficiency, effectiveness and flexibility

Implications for Health & Social Care Partnership

Human Resources	None at this stage
Equalities:	None at this stage
Financial:	None at this stage
Legal:	None
Economic Impact:	None
Sustainability:	None
Risk Implications:	

Implications for East Dunbartonshire Council:	None	
Implications for NHS Greater Glasgow & Clyde:		
Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	☐
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☒
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

MAIN REPORT

1. East Dunbartonshire HSCP and the Council's Land Planning & Development Service and Housing Service jointly commissioned research on Older Peoples and Specialist Housing in 2019.

1.1 Research was undertaken by consultants Arneil Johnson to understand the need and demand, functioning, issues and solutions relating to older peoples and specialist housing in East Dunbartonshire in order to set out recommendations for solutions to the challenges relating to our ageing population. The Study is contained in Appendix 1.

1.2 This Report sets out
a. The Background to the Study
b. Content of the research
c. Key recommendations
d. Use of the study's findings

2. Background to the Study

2.1 The proportion of people in East Dunbartonshire of **pensionable age** and over is predicted to grow by 21.7% by 2036, and the proportion aged **75 and over** by 63.7% (NRS projections 2016).

2.2 The provision, quality and experience of housing for older people and those with specialist needs impacts upon the work of various teams within East Dunbartonshire Health and Social Care Partnership and East Dunbartonshire Council.

2.3 Local outcome 6 of the East Dunbartonshire Local Outcome Improvement Plan (LOIP) 2017 – 2027 is that '***Our older population and more vulnerable citizens are supported to maintain their independence and enjoy a high quality of life, and they, their families and carers benefit from effective care and support services.***' The LOIP identifies a number of issues for older people that relate to the supply and provision of appropriate housing and require to be addressed in order to achieve local outcome 6.

2.4 The ageing population has already resulted in increased demand for health and social services. This is set against a backdrop of many years of reductions in public service budgets and challenges in retaining the workforce, has led to significant pressures on delivery.

2.5 The continuing increase in the number of older people, together with uncertainty following the UK's exit from the European Union (and now the Covid-19 pandemic) may exacerbate these pressures on services and the ability to deliver them.

2.6 The quality and suitability of housing plays a major role, not only in how services for older people are delivered, but also in the prevention of health conditions and improving quality

of life. Improving the housing supply to better fit the needs of older people will play a significant part in enabling services to keep pace with demand.

2.7 The impact of health upon housing and vice versa however is not exclusive to older people and thus the quality and suitability of housing has a significant impact upon the health and care of persons with non-age related conditions, both physically and mentally.

2.8 A coordinated response by the HSCP and the Council's Housing and Land Use Planning teams is needed to ensure that housing in East Dunbartonshire meets people's needs, now and in the future, and contributes positively to the ageing population.

2.9 A holistic approach will ensure best use of resources and that change is implemented consistently across the services through their respective areas of work. This led to the joint commissioning of a study into older peoples housing to understand the particular issues faced in East Dunbartonshire and how these could be addressed. The study is based on several aims which were set and agreed by the services involved and is intended to examine current and potential future issues.

2.10 Arneil Johnston were appointed in February 2019 to conduct the study. Arneil Johnston have previously undertaken work on older peoples housing for Registered Housing Landlords and other local authorities, and have previously been contracted by the Council's Housing Service to conduct various pieces of work.

3. Content

3.1 A summary of each chapter in the study is as follows:

3.2 Local and National Policy Context

This section summarises the relevant local and national policy and brings together to set out key areas and messages for the study to consider.

3.3 Relationship between Health, Frailty and Housing Need

This chapter explores emerging thinking that challenges the concept that 'old age' is defined by numerical age and explores 'frailty', 'place' and 'ageing and living well' as key themes which should define policy perspectives. In exploring the interactions between health, frailty and housing, the report considers:

a. what we mean by older age;
b. how frailty might define our perspective on specialist housing provision; and
c. whether 'ageing in the right place' is a key concept in encouraging older people to live independently and well.

3.4 Literature Review: Best Practice in Delivering Housing, Care & Support Services to Older People

This section assesses current literature on older people's housing, care and support services to assemble a policy and practice evidence bank detailing 'what works' in terms of:

a. customer access, empowerment and choice;

b. product design;
c. service delivery and flexibility of provision;
d. technological innovation;
e. partnership and funding models; and
f. procurement and commissioning arrangements.

3.5 What are the Age Exclusive Housing Options that could be considered?

This chapter explores the various types of housing options available and the potential advantages for older people in moving to a more appropriate home compared with ageing in so called mainstream housing. The report states that 2.4% of the current housing stock in East Dunbartonshire is classed as specialist housing for older, however demand is estimated at 7%. The types of housing considered are:

a. Sheltered housing
b. Extra care housing
c. Private retirement housing
d. Rightsizer/ Downsizer homes
e. Independent living units
f. Co-housing

3.6 Estimating Need and Demand for Provision

This section seeks to estimate the need and demand for various types of housing and housing related services, acknowledging that the vast majority of older people will continue to wish to age in their current home (though the report recommends that this perception should be challenged). Need and demand is explored taking the following factors into account:

a. Area and Demographic Profile – demographic profile, deprivation, general population health and dementia.
b. Social Care Profile – telecare and telehealth technology, provision of care and equipment and adaptations.
c. Housing Stock Profile – profile of current housing stock, housing list and pressure analysis and areas of stock pressures.

3.7 Engaging Older People in East Dunbartonshire: Household Survey Results

This chapter presents the results of the face to face survey that was conducted with 500 East Dunbartonshire residents over the age of 55. The results provide a comprehensive account of the attitudes of local residents on a number of issues regarding housing for older people. The survey sought to gain detailed insight on:
Current household circumstances including amenity and suitability of current home;

a. What are the main motivating factors that result in people choosing to leave their current home and move into age exclusive / specialist housing?
b. Health, independence and disability profile;
c. Extent and nature of housing support needs (if any);
d. What proportion of older people and those planning for their later years wish to remain in their current home?
e. What proportion of older people and those planning for their later years wish to move into age exclusive housing and/ or care settings?
f. Household income levels and percentage of income devoted to housing costs;
g. Preferred housing products and tenures;

h. Interest in downsizing/rightsizing;
i. Attitudes to housing support, care and services to promote independent living;
j. Access to community and/or social networks; and
k. Suggested improvements and developments to current housing and support provision.

3.8 Engaging the next Generation of Older People in East Dunbartonshire: Interactive Workshops

In addition to understanding the current issues and challenges for older peoples housing in East Dunbartonshire, it was important that the research looked into the future expectations and aspirations of the next generation of older people. This section presents the results of two workshops that were conducted with people aged 45 to 60 who were asked to examine and reflect on:

a. How supporting others has shaped their personal expectations of future housing and care wants and needs;
b. Their level of realism regarding their personal vision for future housing and care provision;
c. Future financial planning and how participants are arranging to fund older age; considering affordability, and views about wealth, housing equity and equity release;
d. What services may be required to support independent living and meet their lifestyle aspirations and expectations;
e. Preferences in relation to housing types, design, amenity and size and the extent to which moving from their current home is essential, desirable or a potential;
f. Considering the balance between remaining at home with support and moving for a more specialist service; and
g. Tenure aspirations and whether this shifts with increasing age.

3.9 Interviewing the Experts: Planners, Commissioners and Developers

This chapter details the results of semi-structured interviews with professionals to understand the challenges, opportunities and market issues that need to be considered in meeting the housing, care and support needs of older people in East Dunbartonshire. Various discussions were held with participants from the following:
Housing association developers and providers;

a. East Dunbartonshire Council and Health and Social Care Partnership and
b. Private housing developers.

4. Key Recommendations

4.1 Best Practice recommendations

a. The HSCP should review its definition of ‘older people’ when considering how it applies policy interventions in delivering future services (improvements in life expectancy and health mean that categorising someone as old because they've turned 65 no longer makes sense).
b. The HSCP should reflect on the impact of age exclusive housing on improving the wellbeing and outcomes of older people who are frail.
c. The HSCP should consider how ‘Third Agers’ can be encouraged to engage in future planning (including personal housing planning) on a proactive basis.

d. The HSCP should consider the potential cost savings that can result from employing preventative support services (PSS) - centred on enabling independence among older people with low support needs. .
e. The HSCP and should prioritise technology-based solutions to help older people self-manage with the help of greater Technology Enabled Care.
f. The HSCP should consider more ways for RSLs and other housing providers to engage at a strategic level to champion new models of delivery and secure appropriate investment.
g. The HSCP should build planning, funding and commissioning partnerships to develop age-exclusive housing which is 'care ready'.
h. The HSCP should promote the role that housing partners can play in meeting the needs of older people and enabling preventative activity.

4.2 Recommendations regarding HSCP delivered services:

Technology Enabled Care

a. Assess the barriers to take up;
b. Monitor targets for TEC take up levels at a strategic partnership level
c. Review the impact of charging policies;
d. Market the eligibility and benefits to EDC residents;
e. Work with national partners to integrate this service into existing smart devices
f. Consider how predictive technology and Internet of Things capabilities can be incorporated into new build design briefs and in adaptations solutions; and
g. Consider how carers can be supported through technology.

Adaptations

a. Assess the adequacy of all adaptation budgets
b. Review adaptations waiting list time for EDC and partner RSLs;
c. Consider adaptations policy and assess the feasibility and benefits of a preventative offering in addition to current arrangements;
d. Review how a housing options model of information and advice could operate for older people in the East Dunbartonshire area;
e. Consider how housing health check advice is made available to tenants of social landlords and private owners/renters;
f. Consider how the HSCP can harness the recommendations and practice examples of the Adapting for Change project undertaken by the iHub (https://ihub.scot/improvement-programmes/place-home-and-housing/adapting-for-change

Carer Support

a. Review take up levels of SDS
b. Review respite provision to support carers
c. Review housing allocation policies to maximise opportunities for households to move nearer to their support/family network
d. Ensure age friendly neighbourhood principles are incorporated into planning policies, integrating age friendly housing as part of healthy, inclusive mixed tenure housing developments.

Home Care

a. Review take up levels for SDS and explore barriers to take up;
b. Consider if support delivery policies can be changed to assess frailty rather than age
c. Consider maximum and minimum thresholds for home care;
d. Consider the promotion of privately funded home care options which can step up and down as required
e. Review how housing, care and support services can collectively contribute to positive delayed discharge performance.

5. Use of the Study going forward

5.1 The study is an evidence report and it is not a policy document. Following sign off of the study, it is for the HSCP to determine how to utilise the detailed evidence base and recommendations provided in the study.

5.2 Prior to the onset of the Covid-19 pandemic, the intention had been to hold internal seminars and discussions to disseminate the findings in the study beyond the project team managing the production of the study and to discuss the options for taking the study forward. Such sessions are still needed but will not be possible until capacity returns to the HSCP and Council services.

Arneil Johnston

East Dunbartonshire Council & HSCP

Older People and Specialist Housing Research

June 2020

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Preface:

The Impact of Covid-19 on the Older People & Specialist Housing Research Study

East Dunbartonshire Council (Housing and Land Use Planning Services) and East Dunbartonshire Health and Social Care Partnership (HSCP) commissioned the Older People & Specialist Housing Research Study in January 2019.

All research elements including desk based analysis, primary research and stakeholder consultation were completed prior to the Covid-19 global pandemic and the subsequent UK lockdown to contain the virus. As a result, the research outcomes do not reflect the societal, economic, housing market, public health or social care impact of Covid-19, which may have a significant influence on the future planning, commissioning and delivery of housing for older people.

1 Introduction

In January 2019, East Dunbartonshire Council (Housing and Land Use Planning Services) and East Dunbartonshire Health and Social Care Partnership (HSCP); commissioned Arneil Johnston to undertake an independent study of the housing issues facing the growing population of older people in East Dunbartonshire and to identify the potential policy and delivery solutions needed to meet housing need.

This unique partnership study brings together the public services responsible for the planning and delivery of housing and associated care and support services; to identify how a sustainable housing, care and support model can be planned, funded, delivered and made accessible to older people in East Dunbartonshire. It explores how older people can be encouraged to meet their needs in a proactive and planned way and examines the role of both mainstream and age exclusive housing in meeting future need.

1.1 Background to the Research Study

There is widespread agreement among policy makers, advisors and providers, that Scotland's population is ageing rapidly, and in doing so, creating substantial challenges in terms of housing and care provision. By 2050, it is projected that the proportion of Scotland's population over age 75 will rise to 16% with 913,000 people in this age group. The 60-74 age group will peak in 2030 at 19% of the population (1,065,000 people). In 2020 there will be an additional 124,000 people over age 60 in Scotland than there was in 2015. In short, the future demographic environment is one where more than 1 in 3 of Scotland's population will be aged 60 or over[1].

In East Dunbartonshire, the projected growth of older people is more rapid than the national profile. The proportion of people of pensionable age and over in East Dunbartonshire is predicted to grow by 21.7% by 2036, with the proportion aged 75 and over by 63.7%[2]. The ageing population has already resulted in increased demand for health and social services locally which, set against a backdrop of continued public sector resource constraints, has led to significant pressures on delivery. The quality and suitability of housing plays a major role, not only in how services to older people are delivered, but also in the prevention of health conditions and the quality of life experienced. Improving housing supply to better meet the needs of older people will play a significant part in enabling services to keep pace with demand. As a result, a key building block for the project is to explore the interaction between health, housing and frailty by drawing on the East Dunbartonshire Strategic Needs Assessment and integrating it with analysis of existing housing and support provision in the area.

Whilst many older people will be able to live healthy, fulfilled, independent lives it can also be expected that the numbers of people dealing with long-term ill health, disability and age-related conditions will also increase substantially as the population ages. Clearly, there is an important public policy need to identify and deliver new models of housing and care which are more financially sustainable given Scotland's demographic future. However, the agenda is not simply financially driven, it is also driven by what older people want. This research project therefore seeks to understand the need and demand for older people's housing, care and support services in East Dunbartonshire both now and in the future.

1.2 Research Aims and Objectives

The aim of the research project was twofold:

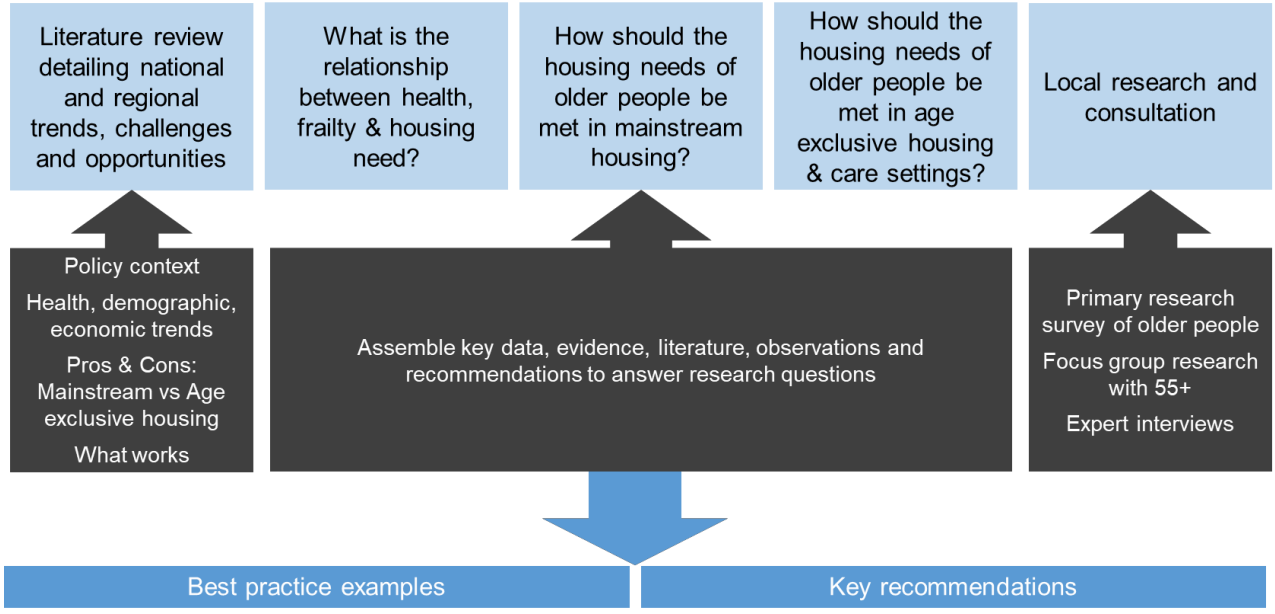
1. To present data and findings on the nature of need and demand for older people housing and related health provision in East Dunbartonshire, both now and over the next 15 years; and
2. To provide recommendations to the Council and HSCP on how this need and demand can be most effectively met at a local level.

[1] NRS 2016-based Sub-National Population Projections Scotland, Tables
2 NRS 2016-based Sub-National Population Projections Scotland, Tables

To achieve this, final research outcomes should synthesize current research, analysis and best practice on housing for older people with local evidence of housing need and demand. A strong aspect of the research brief therefore focused on engaging and consulting with older people in East Dunbartonshire; and with local stakeholders and delivery partners involved in the provision of housing, health, care and support services.

Research outcomes should enable an effective and coordinated response by the HSCP and the Council's Housing and Land Use Planning teams, to overcome the challenges and barriers associated with meeting the housing, care and support needs of the ageing population in East Dunbartonshire.

The project aim was broken down into specific research questions and activities summarised in the following diagram:



The research programme should therefore:

1. Deliver a comprehensive literature review detailing the national policy context; health, demographic and economic trends, and defining 'what works' in the provision of services to older people;
2. Explore the relationship between health, frailty and housing need;
3. Examine how the housing needs of older people could be met in mainstream housing;
4. Examine how the housing needs of older people could be met in age exclusive housing;
5. Execute a comprehensive programme of consultation and engagement with older people, delivery partners and stakeholders;
6. Produce key recommendations building on the various research outcomes; and
7. Based on these recommendations, identify best practice examples that could be explored in more detail in an East Dunbartonshire context.

Arneil Johnston designed the following eight stage methodology to meet the requirements of the research brief:

This research report brings together the outcomes and findings from all of these strands of activity, providing:

- A credible evidence base on current thinking and best practice in relation to the planning, design, commissioning and delivery of housing and care services for older people;
- Intelligence on the extent and nature of projected change in the population of older people from a demographic, health and socio-economic perspective;
- An assessment of the extent to which mainstream and/or age exclusive housing is successful in meeting the needs of older people in East Dunbartonshire;
- Analysis of expectations, aspirations and ability of the next generation of older people to meet their housing and care needs;
- Expert opinion and predications on how public sector policy and emerging innovation will influence the future delivery of housing, care and support services; and
- Recommendations detailing the range of interventions, innovation, models and approaches that should inform the work of the Council's Housing and Land Use Planning teams and the HSCP to meet the housing, care and support needs of older people.

1.3 Final report structure and content

This final report presents the main findings, learning recommendations and outcomes from each stage of the Housing and Older People research programme. It is an interactive document which offers a range of briefings which outline the extensive analysis performed in:

- the local and national policy context for housing and older people (Chapter 2);
- the relationship between housing, health and frailty (Chapter 3);
- a literature review setting out the latest thinking and innovation in meeting the housing, care and support needs of older people (Chapter 4);
- an overview of the range of age-exclusive housing options from Scotland, the UK and wider afield (Chapter 5);
- analysis of local need and demand for housing, care and health provision; reviewing social, demographic, health and economic trends (Chapter 6);
- primary research outcomes on the circumstances, needs, aspirations and expectations of older people who live in East Dunbartonshire (Chapter 7);

- focus group outcomes of the anticipated needs, aspirations and expectations of the next generation of older people in East Dunbartonshire (Chapter 8);
- partner and stakeholder feedback examining the policy, resource and market challenges and opportunities in delivering housing and support provision in East Dunbartonshire; (Chapter 9); and
- recommendations on the policy, practice, planning and delivery interventions the partnership could program to meet the housing, health and support needs of older people in East Dunbartonshire (Chapter 10).

Detailed analysis and research outcomes can be accessed by clicking on the hyperlinks at the beginning of each chapter, which are set out in a range of available appendices.

2 The Local & National Policy Context for Housing & Older People

Recognising the substantial challenges associated with meeting the rapid growth in the older population in Scotland, over the last decade, three major policy developments have combined to set the agenda for housing and older people, namely:

1. **The Christie Commission, Renewing Scotland's Public Services (2011)**, a strategic review of how future public services should be designed and delivered, outlining four pillars for public service reform:
   i. Shift towards prevention;
   ii. Greater integration at the local level;
   iii. Greater investment in people who deliver the services; and
   iv. A sharp focus on improving performance.
2. **Reshaping Care for Older People: A Programme for Change 2011-2021,** which provided a long term and strategic approach to delivering change in future care for older people in Scotland, creating a foundation for the integration of Health and Social Care Services in the Public Bodies (Joint Working) (Scotland) Act 2014; and
3. **Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012-2021,** which extended the focus from health and social care agendas, recognising that housing is a critical dimension to getting it right.

Considering the three major policy developments together results in a number of key policy themes which should guide the future delivery of housing, care and support for older people in Scotland:

- Housing, care and support strategies should deliver person-centred solutions for older people which offer choice and recognise the unique needs of people and communities;
- The availability of resources will be reduced, whilst demographic change is increasing service requirements;
- Services should focus on prevention and maintenance of independence;
- The integration of services and budgets is a priority;
- There should be clear and agreed care pathways to enable smooth movement through housing, care and health systems;
- A focus on improving performance and delivering outcomes should be maintained;
- Technological innovation should be prioritised; and
- Co-production and delivering information and advice should be ongoing priorities.

This policy framework is now very mature and has created a planning system with which health and social care integration have joint responsibilities for the planning, delivery and commissioning of housing services as follows:

- National Health & Wellbeing Outcomes provide a blueprint for the integration of Health & Social Care through the creation of Integrated Joint Boards (IJBs) at a local level;
- IJB require to produce a Strategic Commissioning Plan which sets out housing activity/contribution to Health & Social Care integration;
- Housing Contribution Statements link to each local Strategic Commissioning Plan setting out:
  - Key housing issues related to health and social care provision including future challenges and required improvements;
  - Shared local outcomes and service priorities for housing, health and social care services; and
  - The current and future housing resource and investment contributing to meeting outcomes and priorities.

In 2020, the following progress has been made in Scotland in delivering housing, care and support services for older people:

- The introduction of health and social care integration which has resulted in the creation of 31 new Health and Social Care Partnerships;
- Integrated Joint Boards, bringing health and social care services together to plan services and pool budgets;
- The Scotland Act 2016 which devolved a range of social security powers to the Scottish Parliament;
- Self-Directed Support (SDS) which enables people to have more choice and control over how their care and support is delivered;
- Welfare reform measures including changes to local housing allowance which impact on people living in supported accommodation; and
- Age Home and Community: A Strategy for Housing for Scotland's Older People: 2012 – 21 launched the next phase of activity in 2018.

Whilst significant progress has been made a number of challenges remain including:

- Although improving, the role of housing and home is not always widely understood and valued by planners and commissioners;
- A lack of meaningful housing advice, options and solutions for older people remains a challenge across the country; and
- The Scottish Government is seeking to develop more affordable retirement housing to offer different housing choices for the mid-market.

2.1 National Strategies

Age, Home and Community: A Strategy for Housing for Scotland's Older People 2012-2021 aims to support older people to live independently in their homes and recognises the importance of housing and housing-related support in delivering this aim. This strategy has undergone different iterations since 2011. Initially, in 2011 the following five goals for the strategy were set:

- Clear strategic leadership;
- Information and advice;
- Better use of existing housing;
- Preventative support services; and
- New build housing.

Under these goals, 34 commitments were made. The main ways that the housing sector was stated to support the aims of the strategy and thus the reimaging of health and social care services, the promotion of independent living and the shifting of the "balance of care" was through:

- Ensuring that there was a range of housing across all tenures, sizes and types;
- Providing suitable specialist housing along with care and support and accommodation to facilitate early hospital discharge;
- Providing adaptations to housing and preventative property-related services such as housing support and small repairs to reduce the risk of accidents;
- Providing information and advice on housing and other support services;
- Building new housing that is adaptable and meets the needs of older people; and
- Supporting local communities e.g. through providing activities to strengthen community cohesion.

In 2017, a progress report was published documenting to what extent these commitments had been met. The results were positive, yet the progress report also announced a refresh of the strategy in light of changes within Scotland including the formation of 31 new Health and Social Care Partnerships. Subsequently, the next phase for the Age, Home and Community strategy was produced in 2018. To address the initial vision, the following three principles (and related commitments) were identified:

Right Advice

- Provide guidance on Housing Options for Older People
- Fund advice projects that benefit older people
- Support digital participation initiatives for older people
- Continue to provide guidance on accessing reliable contractors and local services

Right Home

- Provide guidance on the funding and delivery of housing adaptations
- Publish new dementia strategy
- Encourage social landlords to provide housing health check advice
- Continue to support the development of telecare/telehealth including shift to digital telecare
- Deliver housing for older and disabled people in affordable housing supply programme
- Introduce 'Help to Buy' for older people to buy more energy efficient new homes

Right Support

- Recognise the role of housing in integration of health and social care
- Raise awareness of self directed support and what it can offer
- Develop a social inclusion & loneliness strategy recognising the role of housing
- Support fuel poverty programmes which help older people to maintain a comfortable/warm home

Furthermore, Scotland's National Dementia Strategy (2017-2020) has a vision to make "timely, skilled and well-coordinated support from diagnosis to end of life" available to those who have dementia and those who care for them. Scotland's Dementia Strategy has 21 commitments and provides a framework within which to realise the vision of the strategy. With regards to housing, a key outcome of this strategy is for people with dementia to be able to "live well and safely at home or in a homely setting for as long as they and their family live". Commitment 12 of the strategy is:

"We will work with national and local stakeholders to implement actions in the refreshed Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012-21 to support people to live safely and independently at home for as long as possible."

The Scottish Government released its consultation on its Housing to 2040 draft vision earlier this year, detailing ambitious plans for housing over the next 20 years. Part of this vision focused on Scotland's ageing

population, as this has been noted as a key challenge to the sector in this time period. Specifically, in relation to older people, the vision states that an older person who would like to move should be able to receive help to move to a home more suitable for their needs.

Principle 1 of the vision also states that there should be an increase in the availability of affordable and accessible housing to support older people to live independently.

2.2 Local Policy Background

At a local level, given the unique scale of the challenge in East Dunbartonshire, meeting the needs of older people is a priority on all strategic planning agendas including the Community Planning Partnership, the Health & Social Care Partnership and East Dunbartonshire Council:

Outcome 6 of the East Dunbartonshire Local Outcome Improvement Plan 2017 – 2027 identifies addressing the needs of older people and those with additional needs as a key priority for the area.

Priority 3 of the Local Housing Strategy sets out a range of actions for supporting and encouraging older people and those with particular housing needs to live independently.

Strategic Priority 6 of the Health and Social Care Partnership Strategic Plan sets out to promote independent living through the provision of suitable housing accommodation and support.

The next Local Development Plan provides an opportunity to allocate land and set out policies to address evidence of need and demand for older people's housing and related health provision.

The EDHSCP Strategic Plan has identified eight priorities as follows:

Promote positive health and wellbeing, preventing ill-health and building strong communities	Enhance the quality of life and supporting independence for people	Keep people out of hospital when care can be provided at home	Address inequalities and support people to have more choice and control
People have a positive experience of health and social care services	Promote independent living through the provision of suitable housing accommodation and support	Improve support for carers enabling them to continue in their caring role	Optimise efficiency, effectiveness and flexibility

Alongside these eight priorities, the Local Housing Strategy has identified five strategic outcomes it is working towards. These are:

Outcome 1 – Enable a suitable, efficient and affordable supply of housing;

Outcome 2 – Enhance the role of housing options in preventing homelessness;

Outcome 3 – Encourage independent living;

Outcome 4 – Address housing condition, fuel poverty and regeneration; and

Outcome 5 – Improve service delivery, quality and value for money.

Under LHS outcome 3, the key contributions that the housing sector in East Dunbartonshire will make towards the delivering the HSCP Strategic Plan (as set out in the Housing Contribution Statement) are:

- Promote the benefits and make better use of technology within a housing setting to enable people to live comfortably and independently in their own home;
- Maximise investment in adaptations to enable older people to enjoy independence in their own home including promoting access to the Help to Adapt scheme;
- Work with partners in health & social care to ensure that housing makes a contribution to alleviating hospital admissions and speeding up the discharge of patients from hospitals;
- Ensure that housing options services have a strong focus on the health and well-being of customers; and
- Design and build new homes suitable for people with particular needs across all tenures.

2.3 Key Messages: Local & National Policy Context & Delivery Planning

Exploring the national and local policy context for meeting the housing, care and support needs of older people in Scotland outlines a range of policy principles that should guide future planning, commissioning and delivery. Key messages include:

- Ensuring that there is a range of housing across all tenures, sizes and types;
- Providing suitable specialist housing along with care and support and accommodation to facilitate early hospital discharge;
- Providing adaptations to housing and preventative property-related services such as housing support and small repairs to reduce the risk of accidents;
- Providing information and advice on housing and other support services;
- Building new housing that is adaptable and meets the needs of older people; and
- Supporting local communities e.g. through providing activities to strengthen community cohesion.

Furthermore, the national strategy for housing and older people recognises that the following principles should be prioritised at a local level:

- **Older People are an Asset:** Older people's experiences are vital to ensuring that the services they use are fit for purpose. They are also big providers of care;
- **Choice:** There is no single model of housing and support services that meet the needs of all. There is a need for a range of different types of services that are flexible and enable older people to choose;
- **Planning Ahead:** Planning for older age should be seen as a positive part of life, enabling people to prepare at an early stage for their future needs;
- **Preventative Support:** Housing and housing-related services provide a relatively inexpensive and cost effective way of enabling older people to live independently at home when compared with care homes and hospital admissions.

3 The Relationship between Health, Frailty and Housing Need

Emerging thinking on housing and older people increasingly challenges the concept that old age is defined by age and explores 'frailty', 'place' and 'ageing and living well' as key themes which should define our policy perspective. In exploring the interactions between health, frailty and housing, we need to consider:

- What we mean by older age;
- How frailty might define our perspective on specialist housing provision; and
- Whether 'ageing in the right place' is a key concept in encouraging older people to live independently and well.

3.1 Defining what we mean by older people

Housing for older people is a complex topic covering the situation for people who 'stay put' as much as those who move and what they move to. There are a range of issues for older people to consider in making choices about housing from considering the need for home maintenance and adaptations, to the role of housing in accessing care, support and community. Older people are not a homogenous group, so it is important that we recognise they will all have their own individual preferences when it comes to choosing how, and where they live.

Just like any other age group, 'older people' are highly diverse. They may be rich, poor or somewhere in between. They may be healthy or have health problems, physical and/or mental. Their housing situations and the options open to them vary greatly dependent upon their tenure, geographical location, income and equity. Their personal situations — links with family, friends, neighbours, their interests, lifestyles and aspirations — are also diverse.

"Most developed world countries have accepted the chronological age of 65 years as a definition of older person"[3]

Older, elderly, retired and pensioner are all terms used to describe older people. But being an older person, and the reality of managing the challenges that being older may present (either in chronologically or in health terms) can be quite different for each individual. We know most people do not willingly describe themselves as an older person. We do not want to put older people into boxes and categorise them purely by age.

The term "Third Age", refers to those who are older or retired and coming into a new phase in their life – many creating new roles, travelling, attending further education etc. Many older people may also be supporting their children (financially or by providing free childcare), they may be caring for elderly parents and many may still be working.

The Scottish Government in its 2018 'Age, Home and Community Next Phase' document suggests it is important for older people to be thinking about their housing needs. It is often a health crisis that forces people to consider their circumstances and look at their housing needs more closely. Illness, a fall or an unscheduled visit to the hospital is the first-time many people will stop to consider if their house is suitable, both now and in the longer term. Even then the prospect of taking a major decision to move to a new home is often daunting, and many choose to stay in homes that may have become too large or do not suit their changing needs.

In 2015, a population modelling study estimates that due to increased lifespan, what was once regarded as elderly should be seen as middle-aged, and this trend will continue into the future[4]. Traditionally, medical professionals, particularly epidemiologists, regarded 65 as the age at which somebody becomes elderly. This

[3] World Health Organisation

[4] Lifespan and Healthspan: Past, Present, and Promise, The Gerontologist, Volume 55, Issue 6, December 2015, Pages 901–911, https://doi.org/10.1093/geront/gnv130

was based on the expectation that they probably only had a few years left to live. As this study argues, however, this expectation is no longer valid.

What do we mean by Older People?

"Most developed world countries have accepted the chronological age of 65 years as a definition of older person" (WHO)

- Improvements in life expectancy and health mean that categorising someone as old because they've turned 65 no longer makes sense
- We should look at how long a person may have left to live based on average life expectancy, which in the UK is 79 years for men/82 for women (expected to rise)
- People in their late 60s with a life expectancy of 10-15 years would not count as old, and the proportion of the population considered old would be smaller
- While healthy living may contribute to longer lifespans, the study doesn't suggest that we hit middle age later. Using the new definitions, middle age lasts longer, with old age postponed to our last decade-and-a-half of life

The Scottish Government did not use any fixed definition of 'older person' in their strategy for older people. It highlighted that life expectancy varies quite considerably across Scotland, from 71.6 years for men in Glasgow to 82.7 years for women in East Dunbartonshire[5], and older age means different things in different communities. At the moment, many people undergo a major transition in their lives between the ages of 60 and 65, when they retire from full-time work. The age at which this transition occurs will increase in the coming years, as the State Pension age rises to reach 66 for both men and women in 2020.

Many older people will live their lives, without a need for specialised housing or support services. This may be because they don't need such support, or because it is provided by family or friends. However, they should be aware of the support that is available. Others will need low levels of support for minor health conditions, while some will need high level intensive support to combat the effects of serious health problems.

East Dunbartonshire Council and HSCP may wish to reflect on its own definition of 'older people' when considering how it applies policy interventions in delivering future housing, care and support services.

3.2 The Concept of Frailty

The term frailty or 'being frail' is used to describe a particular state of health often experienced by older people. But sometimes it's used inaccurately. If someone is living with frailty, it doesn't mean they lack capacity or are incapable of living a full and independent life. When used properly, it actually describes someone's overall resilience and how this relates to their chance to recover quickly following health problems.

Frailty is the manifestation of ageing that is associated with poor outcomes, including increased risk of disability, hospital admission, institutional care or death. The impact on a person's quality of life can be considerable, as well as an increased use of primary care and unplanned secondary care services. Frailty is also recognised as a risk factor for falls.

Main features of frailty include weakness, as well as balance and gait problems, all of which predispose older people to falling. Falls in older people often occur as a result of diminished functional reserve capacity involved in maintaining the upright position and vulnerability to internal and external stressors, such as environmental hazards, impairments, disease processes, or adverse pharmacological effects. Approximately

[5] Housing and Ageing: Linking Strategy to future delivery for Scotland, Wales and England 2030

30% of older people aged 65 years or more and 50% of those over 80 years fall every year[6]. Not only are falls related to injuries or fractures and are a leading cause of morbidity and mortality in older people, but falls are also shown to have a negative psychological impact. Because of these detrimental physical and psychological impacts on older people, falling is a major public health problem.

There are many screening tools available to identify frailty and falls: some are individual based and others population based. The frailty screening and assessment tools comparator provides more information on the other tools that are available (see http://ihub.scot/a-z-programmes/lwic-frailty-and-falls). For the purpose of individual screening, the Dalhousie University Clinical Frailty Scale (also known as Rockwood) is used[7]. This framework defines frailty in 9 degrees from Very Fit to Terminally ill as illustrated below:

Clinical Frailty Scale

1. Very fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, *eg* seasonally.

3. Managing well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being 'slowed up', and/or being tired during the day.

5. Mildly frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cueing, standby) with dressing.

7. Severely frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

8. Very severely frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

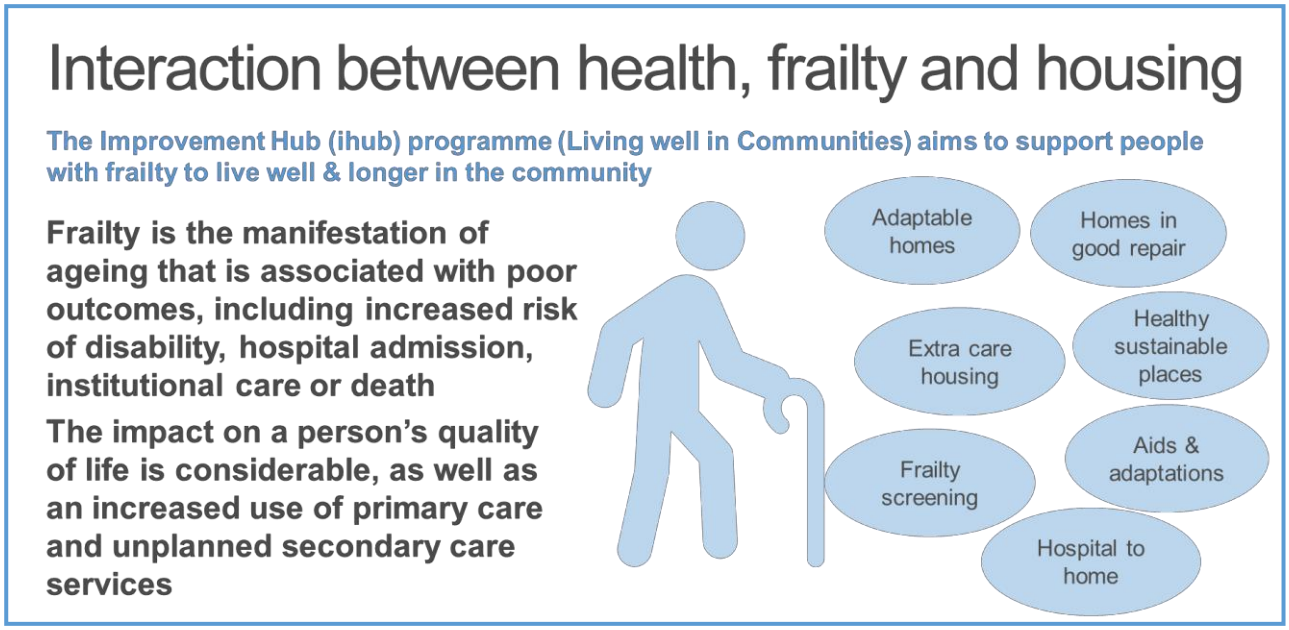
9. Terminally ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

IADLs = instrumental activities of daily living

Five important facts about using a measure of frailty are indicated below:

1. Although diagnosed illness has an impact on need for health and social care, people can be frail without having a diagnosed disease;
2. Once a frailty level is considered, chronological age has little further predictive power in terms of health and independence outcomes;
3. On average, frailty increases at a stable rate in the general population. Rockwood and Mitnitski (2007) analysed data using a range of measures, over 4 developed countries, and at different time points over a range of 20 years, and found a stable increase in frailty of 0.03 per year on average;
4. Women become frailer over time than men, but live longer with frailty (for any given frailty level, men have a higher mortality rate); and
5. Frailty is highly related to age in community-based samples, but less so in institutional or specialist housing settings.

6 Falls in older people: assessing risk and prevention, Clinical guideline [CG161], NICE, June 2013
7 A global measure of fitness and frailty in older people, K Rockwood et al (2005)



The Extra Care Charitable Trust report (Integrated Homes, Care & Support: A proven model to achieve better lives for older people, 2018) explores the impact that specialist housing has on frailty, building on the findings from a 2015 report. The focus in both studies is on the benefits to residents provided by Extra Care villages and schemes including sustained improvements in markers of health and well-being for residents and subsequent cost implications for the NHS. The 2015 report[8] showed that there were significant continuous improvements over the three years in depression, perceived health, memory and autobiographical memory that were unique to Extra Care participants. A number of these analyses were repeated over a three-year period to assess for any continued change and over the full 60 months for Extra Care residents only. Key results from 2012-15 and 2015-18 research studies were:

- Since moving in, significant improvements can be found in Extra Care residents' health and well-being. Residents get more physical exercise and have improved their memory and cognitive abilities;
- In some critical health factors where a downward trend might normally be expected with age, for example functional ability or independence, no such trends are emerging;
- Levels of depression are low among residents while social well-being is high, with lower levels of loneliness than national averages; and
- Extra Care residents have changed the way they use health care resources. Usual age-related changes in frailty status are delayed in Extra Care residents.

Over the 5-year research period, the Extra Care Charitable Trust analysis suggests there is no clear increase in frailty in residents of Extra care (i.e. specialist) housing. This is important and suggests that frailty increase with age still occurs but is being **delayed** in Extra Care residents, and that specialist housing can have a positive impact, delaying an acceleration in frailty.

It is important that people living with frailty have access to proactive, joined-up care to maximise health and wellbeing and prevent problems arising in the first place. Equally East Dunbartonshire Council and HSCP may wish to reflect on the impact of specialist housing on improving the wellbeing and outcomes of older people who are frail. This might include considering whether access to specialist provision should focus on frailty scoring and less so on age criteria.

[8] Integrated Homes, Care & Support: A proven model to achieve better lives for older people, The Extra Care Charitable Trust (2018)

3.3 Ageing in the Right Place

A recently published report, **"Housing and Ageing: Linking Strategy to future delivery for Scotland, Wales and England 2030"**[9], recommends that housing should play a central role in the provision of services for older people. It also calls for new adaptable and affordable housing to be built; investment in early intervention; and meaningful consultation with older people. It makes the point that by 2030 there will be over 600,000 people aged 75 or over in Scotland. We will need to ensure there is suitable housing and services for individuals to continue living independently at home, maintaining their connections with people and place. Key themes arising from the study offer important concepts for the future planning, commissioning and delivery of housing, care and support services for older people:

Ageing in place – looking at housing from a more holistic perspective

When building housing for older people, we need to think about more than the bricks and mortar. **Firstly**, a home is more than four walls – the physical, psychological and social aspects of 'home' all come together, and if you change one, you impact the others. **Secondly**, housing and community are integrally interconnected. We need to think about changing communities to be more age-friendly and intergenerational. We need to view older people not as a burden to be segregated, but as people who can actively contribute to the life of the community. Not dependent, not independent, but interdependent. **Thirdly**, we need to think about housing in terms of the changing dynamics of the person and the environment.

People grow older and their requirements for living at home change. Getting the appropriate housing adaptations in place when required can mean the difference between 'staying put' or enforced relocation. Similarly, the physical and social environments of home and community are constantly changing, creating environments which may no longer 'fit' the person's social, health and wellbeing requirements for a good quality of life. Taken together, this means we also need to consider that ageing in place **may not always be the right decision** for people. Sometimes it is better that older people move on to new accommodations as their health and social circumstances change.

We must challenge this notion of ageing in place as a uniquely positive force in an older person's life and focus instead on ageing in the right place.

Age Friendly Communities

Housing an ageing population needs to incorporate a holistic, age-friendly neighbourhood approach. Age-friendly neighbourhoods are communities where policies, services and structures related to the physical and social environment are designed to enable older people to 'age actively' – to live in security, enjoy good health and continue to participate fully in society. Homes and housing are central to this.

Housing supports located in a neighbourhood of choice, with accessible outdoor spaces, opportunities for social participation and civic engagement, and next to transport networks and other assets are a desirable environment in which to age.

Homes located in communities without these supports will fail to support older adults in sustaining a high quality of life in old age. The regeneration of town centres and urban areas should put older adults' housing front and centre in redevelopment attempts.

Rethink attitudes and values in older people's housing development

Findings from a co-designed project with older people in Sheffield highlighted the importance of working with developers to explore options for older people's housing. Speaking to the local older population, many people wanted to downsize into the city centre, but this often contrasted with some developer assumptions around it being 'the right time', who tended to base their building decisions on housing needs assessments.

9 Housing and Ageing: Linking Strategy to future delivery for Scotland, Wales and England 2030, University of Stirling, 2018

Other developers, however, took a more proactive, innovative approach, and focused on understanding not just what older people needed – but what they wanted.

They understood that diverse housing is needed – there's no one-size-fits-all. Because older people are not an abstract, stereotypical group – they are us, in the future. A good starting point for development is: Would I want to live there?

3.4 Exploring the Interaction between Housing, Health & Well-being

Where we live and call home matters hugely to our health and wellbeing. A settled home is critical to our sense of self and wellbeing and provides a foundation from which people can flourish. Where that home is in an attractive, safe and connected community with accessible and welcoming services, the impact can be enormous. The activities of housing organisations influence people's everyday lives and the places they live.

There are well-documented shortfalls in housing across all tenures, including a lack of affordable homes and homes suitable for people with care and support needs. **Delivering sufficient housing to meet the varied needs and demands of people at different stages of their life is a key role for the housing sector.** This can only be achieved by building accessible dwellings or by adapting the existing housing stock to meet people's needs. Technological innovation has stagnated in the housing sector as a result of a lack of customer choice and competition. However, some literature has explored the benefits of the use of modern construction processes and materials (Agile Ageing Alliance, 2019).

There is recognition that planning for housing in later life is about **ageing in place** and staying in your home of choice for as long as possible. Increasing stock of accessible housing is a fundamental part of promoting independence, flexibility and social inclusion. This can only be achieved by building accessible dwellings or by adapting the existing housing stock to meet people's needs.

Housing policies and activities to enable older people and their families to secure, maintain and pay for a suitable home or to modify their current home are as relevant to sustaining and promoting health and wellbeing as those centred on improving housing supply.

Estimates suggest that the numbers of older people requiring an adaptation to make their home more accessible may increase by 60% between 2008 and 2033[10]. Home safety assessments, adaptations, care and repair and handyperson services area central contribution by housing organisations to people's health and wellbeing. Recent material from the *Cochrane Database of Systematic Reviews* provides compelling evidence that home safety assessments, housing adaptations and minor modifications and repairs (such as those carried out by handyperson services) reduce the risk and rate of falls and deliver savings to health and social care, especially if the intervention is timely and tailored to the needs of the individual.

3.5 Key Messages: The Relationship between Health, Frailty and Housing Need

Exploring the interaction between health, frailty and housing need should encourage East Dunbartonshire Council and EDHSCP to consider the following concepts when planning, commission and delivering future housing, care and support services:

- Redefining what we mean by old age;
- Ageing in place – looking at housing from a more holistic perspective;
- The importance of age friendly communities;
- Rethinking attitudes and values towards older people's housing development;
- Whether frailty should define perspectives on specialist housing, care and support provision;
- Living and ageing well; and

[10] The role of home adaptations in improving later life, Centre for Ageing Better/BRE/University of the West of England (November 2017)

- The importance of planning healthy, sustainable places and homes.

Key messages include:

- Most developed world countries have accepted the chronological age of 65 years as a definition of older person. Improvements in life expectancy and health mean that categorising someone as old because they've turned 65 no longer makes sense;
- The term “Third Age”, refers to those who are older or retired and coming into a new phase in their life – many creating new roles, travelling, attending further education etc. It is important for people in ‘Third Age’ to be thinking about their future housing needs. It is often a health crisis that forces people to consider their circumstances and look at their housing needs more closely;
- East Dunbartonshire Council and HSCP may wish to reflect on its own definition of ‘older people’ when considering how it applies policy interventions in delivering future housing, care and support services;
- It is important that people living with frailty have access to proactive, joined-up care to maximise health and wellbeing and prevent problems arising in the first place;
- East Dunbartonshire Council and HSCP may wish to reflect on the impact of specialist housing on improving the wellbeing and outcomes of older people who are frail. This might include considering whether access to specialist provision should focus on frailty scoring and less so on age criteria;
- We must challenge this notion of ageing in place as a uniquely positive force in an older person’s life and focus instead on ageing in the right place;
- Housing supports located in a neighbourhood of choice, with accessible outdoor spaces, opportunities for social participation and civic engagement, and next to transport networks and other assets are a desirable environment in which to age; and
- Housing policies and activities to enable older people and their families to secure, maintain and pay for a suitable home or to modify their current home are as relevant to sustaining and promoting health and wellbeing as those centred on improving housing supply.

4 Literature Review: Best Practice in Delivering Housing, Care & Support Services to Older People

A key element of the project research brief is to assess the current literature on older people's housing, care and support services to identify best practice themes and sources of research, policy and good practice in this area. To achieve this, the research assembles a policy and practice evidence bank detailing 'what works', detailing best practice in the provision of housing, support and care services for older people in terms of:

- customer access, empowerment and choice;
- product design;
- service delivery and flexibility of provision;
- technological innovation;
- partnership and funding models; and
- procurement and commissioning arrangements.

The following literature review summarises research, policy and good practice in meeting the housing, care and support needs of older people in Scotland and the UK.

Appendix 1 details the full: Housing and Older People Literature Review.

4.1 Access, Empowerment and Choice

Person-centred solutions that promote empowerment and choice are key to the current and future agenda for housing, care and support. However, research has shown that there are real challenges with choice (Pannell, 2012).

"There is very limited choice for older person households moving home to accommodate their support needs (in terms of tenure, location, size, affordability and type of care/support). There is a limited range of models of specialist housing; most of the focus has been on specialist provision, including an increase in retirement villages and housing with care. Compared with older people's existing housing tenure (around 70% owner-occupation), there is much less specialist housing available for purchase (around 30%) than for social rent. Retirement housing models carry extra costs, such as service charges, and re-sales are not always easy."[11]

Whilst there has been much discussion about choice and widening housing options in practice, a broader range of housing choices is yet to materialize in Scotland. The current market conditions make delivery of this choice increasingly difficult for developers of housing for sale and there are restrictions on the level of public money available for new social rented housing.

Whilst on a structural, bricks and mortar level, the prospect of growing and extending choice is limited; on a personal, individual level there are some interesting developments. From the Christie Commission to the Reshaping Care for Older People agenda, there is a clear understanding that older people have 'assets', such as knowledge, skills, characteristics, experience, friends, family, colleagues, and communities, and that these assets need to be factored in and indeed put at the centre of the development of housing, care and support solutions. A key policy innovation aimed at improving customer access, empowerment and choice is the use of 'assets-based approaches' such as **co-production** in order to shift the balance of health and social care and develop public services that are focused on prevention and independence.

It is important to consider how this type of personal outcomes approach can be built into future models of housing, care and support. It is also important to consider what models of housing, care and support best facilitates consideration of the role that the person themselves can play in contributing towards their outcomes. **It should be noted that there are substantial similarities between this type of personal**

[11] Pannell, J, "Market Assessment of Housing options for Older People" New Policy Institute 2012, p 7

outcomes approach in social care and the *'Housing Options'* approach which is the national model for meeting the housing need of homeless households in Scotland.

4.2 Product Design

In the UK, the vast majority of over 65s currently live in the mainstream housing market. Over £1tn of equity is locked in residential property occupied by older households, many of whom are under occupying those homes and sometimes struggling to manage their housing circumstances. Only 0.6% of over 65s live in 'housing with care' which is 10 times less than in more mature retirement housing markets such as the USA and Australia where over 5% of over 65's live in housing with care.[12] There is potential to develop the market, product and service design to enhance the housing options that older people have.

When looking at product or service innovation and considering what new models may emerge it is important to start from a solid base. The HAPPI 'Housing our Ageing Population: Panel for Innovation'[13] sought to answer the question, "What kind of housing will meet our needs as we grow older?" The conclusions were as follows:

Most of us want our housing to maintain our chosen lifestyle as we grow older	Because we are likely to spend more time in our homes, we will need more space and light, comfort and convenience	We will look for safe and secure, healthy, attractive environments, close to the shops and amenities we need, and to our social networks
We will want homes that are easy to maintain, can be adapted to our changing needs, and that do not force us into an institutional setting if we require more care & support	We will wish to feel in control of our own destiny, able to take our own decisions about our homes	While we believe strongly in greater accessibility, solutions to our housing needs will very often be found in purpose built new homes that are specially designed and planned with older people in mind

That initial HAPPI report also provides a wide range of case study examples from around the world of housing which meets these needs.

Design can contribute to autonomous ageing and compensate for functional changes associated with ageing. Design appears to be particularly important for sustaining health and well-being of people with physical and sensory disabilities, dementia and severe mental illness (Atkin, 2010; Goodman, 2011; Keating, Eales, & Phillips, 2013). Much of the literature considers the importance of accessible and flexible design that meets the widest range of people and promotes independence and equal access (Agile Ageing Alliance, 2019; Goodman, 2011). However, life-time homes have progressed little beyond the national access standards to date and are heavily biased towards the physical access needs of older, adult wheelchair users. Housing needs to be adaptable, morphing to support a growing family and accommodating an ageing one.

Policies aimed at age-friendly communities need to be much more attentive to the nuances of both community and individual needs. A range of interventions that can respond to the diversity and inequalities of place and people are required if age-friendly communities are to develop and be sustainable. There is no one ideal model to suit all community contexts.

[12] Housing our Ageing Population: Learning from Councils meeting the housing need of our Ageing population: LGA p6
[13] HAPPI: Housing our Ageing Population: Panel for Innovation 2009, p 31

There is a global drive to ensure the design of our homes and environment is integral to actions to keep us all healthy as we grow up and age. It is important to remember that no single design suggestion will work in all situations.

Good design should acknowledge diversity and difference and meet as many needs as possible by identifying barriers and providing solutions to overcome them.

Sustainable Urban Development, far from being an abstract concept, requires a high level of integration in public policies. Much research was focused on the importance of well-designed spaces that are accessible and encourage a feeling of community (Department for Aging, 2016; Kennedy, 2010). The literature highlights the importance of good design for shared spaces and creating spaces that are easy to navigate, usable by all and encourage people to gather together (Bookman, 2008; CABE, 2010; Craig, Dentato, & Iacovino, 2015; Maisel, 2006). It reinforces the importance of accessible design in creating a sense of community to bring people together to avoid isolation. Local authority planners have the lead responsibility for planning the wider neighbourhood structure and infrastructure. However, housing organisations, as managers of social and mixed tenure housing estates, developers of new estates and agents of area renewal, have an important role to play too.

4.3 Service Delivery and Flexibility

The previous section has outlined key elements and innovations in product design for older people both in delivering mainstream and specialist housing products. Given the dynamics of the current public policy agenda which puts a focus on reducing availability of public funding, person centred approach and prevention and independent living, it is likely that providers will keep their portfolio of services under review.

The ageing in place agenda creates a public policy agenda to “delay” older age until the 75 plus age group and to support people in their own homes for as long as possible. The COSLA and Scottish Government Task Force for the Future of Residential Care in Scotland report, “Recommendations for the Future of Residential Care for Older People in Scotland” gives an indication of where such detailed exploration should focus. The report recommends:

“The development of the residential sector over the next period should see expansion in three directions: an evolution and expansion of the extra care housing sector; a growth in the residential sector focused on rehabilitation and prevention (step-up/step-down care); and a smaller, more specialised residential sector focused on delivering high quality 24-hour care for people with substantial care needs. We anticipate that in some areas, single facilities or hubs might provide all of these service types.”

The Centre for Housing Policy at the University of York produced an interesting report, “The Costs and Benefits of Preventative Support Services (PSS) for Older People”[14] which illustrates why some of the benefits of the preventative approach are so attractive to policy makers. They examine four areas of ‘Preventative Support Services’ (PSS) namely:

- handyperson services;
- telecare and alarm services;
- adaptations; and
- floating housing support services.

PSS have a role within wider developments in health and social care within Scotland and are being employed to shift the balance of care as part of the national agenda to increase preventative care while also providing more care and more support in people’s own homes. In addition, the Integrated Resource Framework (IRF) for health and community care[15] has clearly shown that unplanned admissions to hospital

[14] *Please, N “The Costs and Benefits of Preventative Support Services for Older People”, Centre for Housing Policy, University of York 2011*
[15] *Scottish Government, Health and Community Care – Evaluation of Integrated Resource Framework Test Sites”*

are a major cost to NHS Scotland. If PSS can result in levels of unplanned admissions being reduced, the potential for savings to health and social work budgets is considerable. PSS can generate savings across the health and welfare system by helping reduce the need for more expensive services by offering preventative and low-level support. After evaluating the costs and benefits of these four types of PSS the Centre for Housing Policy report concludes that:

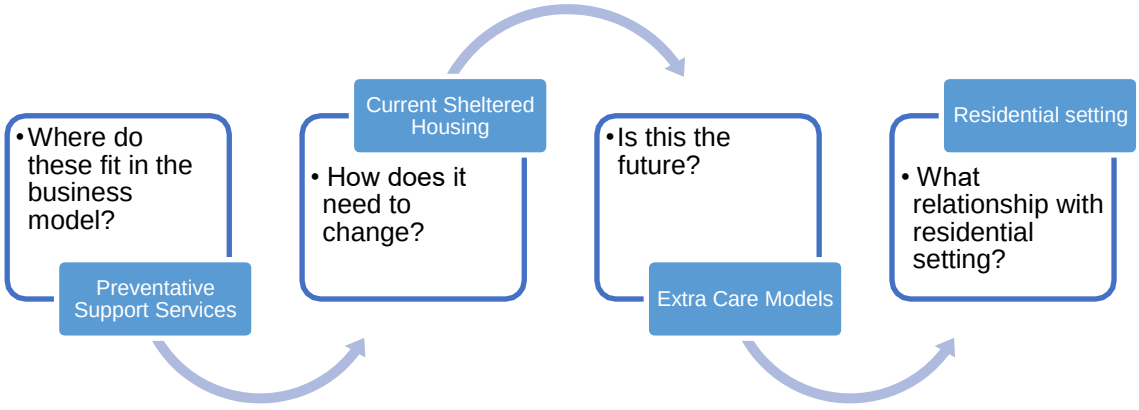
"While data is limited, it appears to be the case that the potential cost savings that can result from employing PSS are centred on enabling independence among older people with low support needs. PSS can also prolong independent living among those with support needs who might otherwise require a move to specifically designed housing settings, such as sheltered housing… When health and support needs become very pronounced, the cost of supporting an older person in their own home may in some instances exceed the costs of residential care or extra-care housing."

It was further noted that evidence on cost effectiveness is stronger in some areas of activity, namely telecare, adaptations and handyperson services than it is for floating housing support services.

In some areas in England where support services for older people are still commissioned by Adult Social Care authorities (a declining number) preferred service models have tended to focus more on floating support. In these instances, providers are typically appointed to serve an entire local authority area and interventions are usually expected to be short term, between 8 and 12 weeks. Services are often associated with periods of intensive health care and especially the run up to or aftermath of periods of hospitalisation. The trend in England is to move away from defining these services as support or PSS and to designate the activity as a 'well-being' service.

In Wales, well-being is now defined and codified in a combination of the Social Services and Well-Being (Wales) Act 2014 and the National Outcomes Framework for People Who Need Care and Support 2016. Eight aspects of a person's well-being are included for the purposes of the regulation and measurement of success in meeting policy expectations. Target outcomes for each of the eight aspects are set out in the framework. The Welsh Government has a clear commitment to improving the well-being of people in Wales and recognises the continuing value of PSS and therefore the importance in allocating funding to these services.

As EDC and EDHSCP look at its product and service offering there will be a need for great flexibility in order to maximise the efficiencies that the Strategic Plan aims to deliver.



4.4 Technological Innovation

The public policy agenda in improving the housing, care and support services for older people in Scotland touches upon the importance of technological innovation for the future provision of these services. It has been argued that embracing technological development could enable planners, commissioners and providers to deliver positive outcomes to older people which improve their health and wellbeing.

It is important to look into the future and consider what might work in the future and give due consideration to technological development in the future. Looking at the pace of technological development over the past 30 years it is likely that this will be mirrored in the next 30 years. Therefore, while concepts like 'robotic care' might seem fanciful at the moment, any meaningful consideration of the future will have to give some consideration to the likely patterns in technological development. Before looking at the more futuristic options, it will be worth considering progress made in relation to telehealth and telecare.

Health systems globally are exploring ways to increase quality of care while achieving value for money, with a particular focus on people with long-term health conditions. One approach involves installing technology (termed 'telehealth' devices) in patients' homes, to allow patients to measure items such as blood glucose and hemoglobin oxygenation levels on a daily basis, and to transmit this information to health care professionals working remotely. In addition, often sensors are applied to chairs and beds to allow remote monitoring of functionality. The professionals are then alerted to early warning signs of deteriorations in patient health and can provide appropriate responses. The idea is that this enhances independence, reduces hospital admissions and has the potential to improve and prolong quality of life.

It seems reasonable to conclude that any strategic review of future services which aims to embrace the current public policy agenda will need to include detailed consideration of telehealth and telecare.

Many governments around Europe are investing in new technologies to support independent living. Harnessing digital technology to support existing carers and over time, provide care directly to people, provides an opportunity to help address these challenges. It is anticipated that the successful deployment of technology in the delivery of health and social care can deliver a range of benefits (Carnegie UK Trust, 2018). Technology has the potential to help realise these desires, but only if sufficient attention is paid to how it is implemented and integrated into individual lives. Digital solutions cannot and should not replace face to face care for those who require it, but they can empower individuals and communities to become more self-reliant (Agile Ageing Alliance, 2019).

The social housing sector in Scotland has recognised the important role of technology in the housing sector. The TEC in Housing Charter hosted by the SFHA outlines a series of pledges for housing organisations to engage with different elements of technology that supports health, social care and living independently at home for as long as possible. Albyn Housing Associationis showcased in the TEC in Housing programme with their 'Fit Homes' project which aims to utilise data capture and Internet of Things capabilities to predict and prevent episodes that can lead to ill health. The idea being this should enable people to live independently at home for as long as they want, while potentially allowing for early hospital discharge, with potential savings for health and care services. The proof of concept project will see accommodation built that will include ambient, physiological and building sensors. The sensors will collect data that can be monitored and responded to by a variety of agencies. The first cluster is specifically targeted at people with long-term health conditions or who are at increased risk as a result of ageing. They may or may not already be receiving health and social care services.

4.5 Partnership and Funding

The Public Policy agenda in Scotland has increasingly become more partnership focused and collaborative. The Christie Commission has made it clear that public service organisations must work together effectively to achieve outcomes – specifically by delivering integrated services that secure improvement in quality of life and social and economic wellbeing. In addition, both "Reshaping Care for Older People" and "Age, Home and Community: A strategy for housing Scotland's Older People" put a strong emphasis on partnership including the fact that public sector resources from all sources should be available to jointly fund any agreed aspect of care.

To some extent progress in this agenda has been made through the implementation of the integration agenda, however as noted earlier, the Audit Commission has some concerns about the pace and depth of change being delivered by RCOP.

The SFHA commissioned research, "Supporting Older People to live at Home: the contribution of housing associations and cooperatives in Scotland" (2012) which sought to articulate the central role of Registered Social Landlords in this area. In relation to funding, this research indicated that:

- 58% of RSLs responding said they received funding from local authorities for supporting older people in the own homes;
- 51% received funding from charging;
- 67% received funding from rental income and deficit funding; and
- 3% received funding from Health Boards.[16]

It is of note that very little funding seems to come from Health (3%). Given the drive towards integrated service delivery and funding and the fact that public sector resources from all sources should be available to jointly fund any agreed aspect of care, it is expected that this should increase. Indeed, if RSLs are to embrace developments like telecare and telehealth in their future product offering there would need to be a significant role for health funding.

4.6 Procurement and Commissioning Arrangements

Securing future investment to develop new models of housing provision is a potential challenge due to the public resource pressures and medium-term uncertainty. However, new models are currently being developed in order to support development of new properties and remodelling of existing stock. An example of this is a service provided under Aviva Investors who offer a lease and leaseback scheme which would allow RSLs to substitute properties in and out of the funding portfolio which ensures that the RSL is in a constant cash generating position (CIH, 2014). Leaseback schemes usually present significant risk to RSLs especially in connection to managing revenue costs effectively. Typically, leaseback deals will require the operator (RSL) to underwrite lease payment increases indexed to at least RPI.

Commissioning is much more than local authorities organising and buying services, it is also reflects how Councils and IJB's work together to plan services that will meet future demands and make effective use of their combined resources. This joint strategic approach to commissioning is essential to provide joined-up services to people and prevent, delay or shorten a stay in hospital. The strengthening of the integration of adult health and social care services through Health and Social Care Partnerships is transformative and presents opportunities for the RSL sector as a whole to influence commissioning and demonstrate the role that RSLs can play in securing both health and social care outcomes for older people. However, Audit Scotland Report on 'Commissioning Social Care' March 2012 suggests that:

"There are indications that Councils are continuing to focus resources on people who need more intensive support, tightening eligibility criteria and increasing charges. There is a risk that people who need a small amount of support are not being offered the preventative services that might help delay or avoid their needing more costly intensive support, such as being admitted to hospital or into residential care."[17]

The introduction of Self-Directed Support which came into force in 2014 is an important step in offering great opportunities for people with social care needs, and their carers, to have more control and choice over their care outcomes. It is a key part of the personalisation agenda of meeting the needs of older people. EDC and EDHSCP could encourage the RSL sector to develop models that people want and are prepared to self-direct their resources towards.

In 2016, the King's Fund, in partnership with the Nuffield Trust, published a report on the social care system in England for older people. Most of the findings of the report resonate strongly with experience in other parts of the UK. At the time of publication, there had been six consecutive years of cuts to local authority budgets and this had resulted in 26% fewer older people receiving help. The report recognised that no one had a full

[16] *SFHA, "Supporting Older People to Live at Home: The Contribution of Housing Associations and Co-operatives in Scotland" July 2012, p 14*
[17] *Audit Scotland, "Commissioning Social Care" March 2012 Pg 4*

picture of the consequences of the loss of service for those older people no longer entitled to publicly funded care. The report emphasised that the situation for older people had been compounded by pressures elsewhere in the NHS. Cuts in social care should not be viewed in isolation from overstretched general practice and other community health services. A visible manifestation of pressures on health and social care budgets is the rapid growth in delayed discharges from hospital.

The report recognised three major strategic challenges going forward:

- Achieving more with less- this linked to a recommendation to bring forward further investment in the Better Care Fund (England), funding which diverts planned NHS investment into preventative social care and support initiatives.
- A different offer- being more explicit with people about funding constraints and encouraging better planning for future care needs by individuals themselves.
- Long term reform- more clarity and joined-up thinking on funding health and social care in the longer term, especially at a policy level.

4.7 Key Messages: Best Practice in Delivering Housing, Care & Support Services to Older People

A literature review of the latest thinking, innovation and best practice in older people's housing, care and support services, has been instrumental in delivering a bank of planning, commissioning and delivery principles which reflects 'what works'. This best practice bank should encourage East Dunbartonshire Council and EDHSCP to consider the extent and nature of interventions required to deliver VFM and improve outcomes for older people in East Dunbartonshire. Key messages include:

Customer Access, Empowerment and Choice

- The concepts of access, empowerment and choice need to be at the heart of future solutions in the planning, commissioning and delivery of future housing, care and support services;
- Consideration needs to be given to how a personal outcomes approach can be embedded in future product design and service delivery thereby maximising choice. This has equal importance for the approach of housing planners and developers as well as service commissioners;
- It should be noted that the personal outcomes approach so central in health and social care has major similarities with the 'Housing Options' agenda in housing;
- EDC and EDHSCP should consider how the personal outcomes agenda, combined with the housing options agenda might shape their future product and service development to maximise customer access, empowerment and choice; and
- EDC and EDHSCP should consider how it can promote choice in tenure options in older people's housing. In particular, specialist housing options for sale should be tested for feasibility as well as RSL subsidiary development that could provide retirement housing for sale or market rent.

Product Design

- In the UK, the vast majority of over 65s currently live in the mainstream housing market. There is potential to develop product and service design to enhance the market housing options that older people have in East Dunbartonshire;
- The LDP should consider adopting the HAPPI design principles in local planning guidance on meeting the needs of older people;
- Product design can contribute to autonomous ageing and compensate for functional changes associated with ageing. The importance of accessible and flexible design that meets the needs

of the widest range of people and promotes independence and equal access in ageing should form core development principles within the LDP framework;

- Policies aimed at age-friendly communities need to be much more attentive to the nuances of both community and individual needs. There is no one ideal model to suit all community contexts; and
- The research on Sustainable Urban Development reinforces the importance of accessible design in creating a sense of community to bring people together to avoid isolation. This is particularly important in designing new housing for older people.

Service Delivery & Flexibility

- The potential cost savings that can result from employing preventative support services (PSS) centred on enabling independence among older people with low support needs are substantial. PSS can also prolong independent living among those with support needs who might otherwise require a move to age-exclusive housing settings;
- The evidence on cost effectiveness is particularly strong in some areas of activity, namely telecare, adaptations and handyperson services;
- In England and Wales, there is movement from defining housing related floating support and reablement services as support or PSS and to designate these activities as a 'well-being' service; and
- It is important to take a long-term strategic view as to the extent that EDHSCP wishes to engage with the Preventative Support Service agenda and how that relates to the wider product and service offering in the long term.

Technological Innovation

- Technology will undoubtedly play a significant part in future social and health care systems;
- There seems to be clear evidence from England that demonstrates benefits from Telehealth and Telecare, particularly in relation to reducing hospital admission and mortality;
- Effective use of technology has the potential to reduce the levels of loneliness and social isolation experienced by older people;
- As we move into the medium term there is potential for technology to provide real gains which put people in control and make a significant contribution to independent living, allowing older people real access to participation in the wider society;
- New technology will be a key tool in driving the prevention agenda, particularly as the tele-health agenda gains traction across the country; and
- Predictive technologies using Internet of Things capabilities have the potential to enable people to live independently at home for as long as they want with potential savings for health and care services.

Partnership and Funding

- Partnership and Integration are embedded in the public policy arena. This is most clearly seen in integration of social care and health. The RCOP and Age, Home and Communities agendas place a strong emphasis on partnership including the fact that public sector resources from all sources should be available to jointly fund any agreed aspect of care;

- The health service funds a comparatively low level of RSL engagement with older people (just 3% of RSL funding). Potential new models of delivery mean that this needs to change; and
- Supported by EDC and EDHSCP, specialist RSLs need to develop clear points of access to integration partnerships as new strategic models of housing, support and care for older people are developed.

Procurement and Commissioning

- The procurement and commissioning framework for older people remains complex and is yet to fully engage housing providers planning processes;
- EDC and EDHSCP should consider more ways for RSLs and other housing providers to engage at a strategic level with the IJB to champion new models of delivery and secure appropriate investment;
- Self-directed funding presents a clear opportunity for the specialist RSL movement to develop new services and products which meet customer demands; and
- Pressure on health and social care budgets is a growing phenomenon. Health care for older people 65 and over accounts for 44% of NHS spend in the UK, according to The Nuffield Trust. RSLs need to concentrate on evidencing the savings to the NHS of good quality preventative services and well-designed housing.

5 What are the Age Exclusive Housing Options that Could be Considered?

The vast majority of older people in Scotland today live in mainstream housing. 'Age, Home and Community: A Strategy for Housing for Scotland's Older People: 2012 – 2021'; estimates that just 10% of Scotland's current older population live in age-exclusive or residential housing.

In the UK, around 3% of new homes constructed would be categorised as age exclusive housing, with associated specialised design or features. With the older population growing by 155,000 every year and accounting for 74% of total expected household growth up to 2037, it would be unrealistic to place too high a reliance on new specialist or age exclusive provision to satisfy older people's housing needs in the future.

However, public policy in Scotland recognises an important place for age exclusive housing, particularly in meeting the needs of those who with acute care needs including '*an evolution and expansion of the extra care housing sector; and a smaller, more specialised residential sector focused on delivering high quality 24-hour care for people with substantial care needs'.*[18] Furthermore, research into age-exclusive options such as Extra Care housing reveals an important positive impact on decelerating the pace of frailty in its residents.

It is also likely to be the case, that older people in East Dunbartonshire are interested in age-exclusive housing options for life-style reasons including becoming part of a secure, deliberate community and accessing housing of the right size and in the right place. It's therefore important that the research explores the potential options for delivering age-exclusive housing in East Dunbartonshire including the realities of planning, funding and delivering such provision. The following chapter assesses the main forms of age-exclusive housing in Scotland, the UK and where relevant further afield.

5.1 Sheltered Housing

The standard model of housing for older people in Scotland has been the provision of sheltered housing mainly by local authorities and by Registered Social Landlords. In 2008, there were 1,200 sheltered housing schemes with approximately 36,000 dwellings, and 145 'extra care' housing schemes with just over 3,700 dwellings. In 2008, the Scottish Government undertook a major review of sheltered housing[19]. It is clear from this research that sheltered housing has played an important part in providing housing and care for many older people in Scottish society.

However, it is also clear that many in the sector are questioning the long-term future and viability of sheltered housing as a model of provision. Whilst the above research dates back to 2008, that same questioning and consideration has continued throughout recent years and is influenced by the 'Reshaping Care for Older People' agenda.

It is clear that levels of sheltered housing stock have been in decline for some time. In 2010, a report commissioned by the Scottish Government and Communities Scotland from the University of York concluded that "it is very clear that sheltered housing remains very popular with those who live in it". The report noted however, that although the support element was what made sheltered housing attractive, "it is the support element that is being eroded". The authors identified "clear requirements for additional funding" if sheltered housing was to continue in its current form, and if the current stock of sheltered housing "is to be maintained and improved to provide suitable accommodation for elderly people into the future". In considering the potential role of extra care housing, the authors concluded that this is widely perceived by providers to be an expensive option,

[18] Recommendations for the Future of Residential Care for Older People in Scotland, COSLA/SG (2014)
[19] Review of Sheltered Housing in Scotland, Scottish Government/Communities Scotland (2008)

particularly for "self-funders" i.e. those electing to choose their own care provider, potentially out with local authority provision, albeit with state provided resources.

There appears to be a public policy vacillation between recognising the popularity and usefulness of sheltered housing as a model on the one hand and the desire for change, development and innovation in the model on the other. A report for the National Housing Federation from James Berrington[20] in January 2017 assessed the costs and benefits provided by sheltered and extra care housing. The study concluded that the value derived from sheltered and extra care housing "can be found in benefits to the individual, to the community and to the taxpayer, mostly as a preventative service". Bennington cites an Evaluation of Supporting People Programme carried out in 2009 for DCLG, by Cap Gemini which found that, for older people in sheltered housing, an investment of £198.2m generated a net financial benefit £646.9m. (For very sheltered housing, the comparable figures were £32.4m and £123.4m). It has been calculated by Amicus Horizon HA that around 10% of sheltered housing residents might need residential care if sheltered housing was not available. This study calculated that the extra cost to the taxpayer of residential care versus sheltered housing is estimated at £5,000.00 per person a year.

Recent research by Arneil Johnston in partnership with ALACHO[21] has shown that despite its continued popularity, and evidence of the significant cost and health and well-being benefits arising from sheltered housing, many Scottish local authority (and housing association) landlords have reviewed (or are reviewing) their provision on sheltered housing and related warden support services.

Fife Council – Case Study

In 2016 Fife Council, de-registered their sheltered housing service from the Care Inspectorate and SSSC regulation (although retaining for extra care/very sheltered provision where increased tenant support is required) and moved to a "retirement housing" model. The new model, which replaces sheltered housing, is described as "an area of bungalows or flats for older people who wish to keep their independence". All are fully accessible with lifts and level access from outside. A criterion for application and allocation is that "prospective tenants should be able to live independently with minimal assistance".

Based on a Scottish Secure Tenancy, retirement housing typically has one bedroom, access to a community alarm system, secure entry/fire and smoke safety systems in communal areas, laundry facilities, and a communal lounge and garden for socialising. Staff are available between 9am and 3pm Monday-Friday to offer advice and assistance "with tenancy related matters" and a mobile team available between 3pm and 9am seven days a week for care related emergencies.

To support transition to the new service model, Fife Council have developed a Service Standards Agreement which set out what tenants in Retirement Housing can expect in terms of service delivery. With 47 retirement housing developments across Fife, the Council believes that the remodelling exercise has been very successful. In choosing this route the Council are also following in the footsteps of some large national housing associations which specialise in housing for older people.

[20] NHF/Berrington, J – The Value of Sheltered Housing January 2017
[21] Arneil Johnston/ALACHO: Sheltered housing in Scotland – A short survey into local authority costs (August 2017)

Angus Council – Case Study

Angus Council undertook a wide-ranging review of its sheltered housing provision in 2015. Noting that Angus has a higher proportion of sheltered housing relative to the Scottish average, and aware of both reduced demand for sheltered housing and the imperatives of self-directed support (SDS), the Council facilitated a review involving tenant representatives, elected members and other stakeholders. This was followed by "extensive consultation" with tenants, during which 397 survey returns were received and over 400 tenants, family members and support workers attended consultation events. The review resulted in the following proposals:

- The adoption of a revised model of housing for older people in Angus - a combination of sheltered and retirement housing (with 210 of the existing 626 sheltered stock being re-designated as retirement housing);
- A modernised preventative care service in collaboration with a social enterprise organization "Care about Angus";
- Retention and improvement of communal facilities, including lounges, guest rooms and laundries;
- An expansion of housing management and maintenance services; and
- A programme of tailored capital investment based on discussions with tenants at individual schemes - including telecare and enablement investment - to be built into the fabric of the complexes and funded from the Angus HRA.

A final substantial development in the review of sheltered housing as a model of delivery is worth considering. In 2014 Glasgow City Council undertook a review of support for older people. Following the review, the Council reduced the Housing Support budget (given to HAs to support the provision of wardens) from £5M to £3M in April 2016, with a further £1M reduction from April 2017. The Council is retaining £2M of funding and re-directing this towards those with greater and more complex needs to remain living at home. This sees the potential for existing sheltered housing accommodation to be used for a different population in future, linked to the desired expansion of supported living and telecare.

As a consequence of the review's implementation, many housing associations are de-commissioning, or planning to disengage from, their warden service, preferring this to the significant rent increases which otherwise might be required to maintain warden provision. A key conclusion of the GCC review was that sheltered housing "is not targeted exclusively to those with a social care need". Moreover, as housing support providers are solely responsible for determining who accesses their services, many service users are consequently not known to Social Work. The review noted that "This is clearly at odds with a Social Work service that purposefully targets its resources at those whose needs are consistent with specified eligibility criteria".

5.2 Extra Care

While there are a number of extra care housing developments in Scotland, activity in England has been much more substantial. This activity in England has in part been stimulated through the Department of Health's Extra Care Housing Fund which, between 2004 and 2010, provided £227m capital funding to local authorities and housing associations to encourage innovative schemes and partnerships. Another key stimulus has been the formulation of Older People's Strategies by Adult Social Care authorities which actively seek to rebalance provision away from residential care and in favour of extra care housing capable of meeting the needs of residents with high dependencies, including dementia. A recent longitudinal study by Aston University[22] for, "The Extra Care Charitable Trust" identified that Extra Care housing has the potential to generate savings to Councils in relation to social care of £4,500 per annum for high care customers and £1,700 for low care needs customers. In addition, the study suggests a reduction of GP visits of almost

[22] http://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Aston_ECCT_research.pdf

50%". Clearly extra care housing appears to be delivering substantial economies to health and care services in the English context.

For some years in Scotland there has been an interest in a range of forms of housing with care. The report 'Housing with Care for Older People' [23] outlines a range of case studies of different types of housing with care across Scotland. However, extra care housing (as conceived of in England) has never been developed or tested at a similar scale, although recent delivery of extra care villages by Fife Council (2019) and Scottish Borders Council (2019) shows new interest and support for this model of provision.

The COSLA and Scottish Government Task Force for the Future of Residential Care in Scotland report, "Recommendations for the Future of Residential Care for Older People in Scotland" gives an added impetus for such detailed exploration [24]. The time seems appropriate for a detailed discussion and consideration about the potential for extra care housing to be part of the future model for housing and care in Scotland. Baumker et al suggest:

"It could be argued that extra care housing is the embodiment of many of the core principles of current social care policy … prevention, personalisation, partnership, plurality and protection." *[25]*

There are many definitions offered for what extra care actually is. However, it might best be conceived as a housing development which offers self-contained accommodation units, where support is accessible over 24 hours, where a dedicated care service is linked to the scheme and where some collective meal provision exists together with a range of leisure and other facilities on site.

City of Lincoln Council – Case Study

City of Lincoln Council (CoLC) is pursuing the redevelopment of the site of a redundant sheltered housing scheme to create the city's first true extra care housing scheme.

The scheme will offer 70 one and two bedroom flats for rent as well as a range of communal facilities including a café, a restaurant, activity spaces, a shop, a therapy suite and extensive gardens. Residents will benefit from an on-site staff resource employed by CoLC and a care and well-being service commissioned by Lincolnshire County Council (LCC).

The partnership between CoLC and LCC is a particular feature of this scheme's development. The two authorities are entering into a Co-operation Agreement to establish their respective roles and responsibilities. LCC is contributing a significant amount of capital to the overall funding of the scheme. COLC will be responsible for the design, development and operation of the scheme and LCC will commission care and support in accordance with a Care Vision agreed between the parties. Both councils will collaborate on allocations to ensure an agreed and balanced mix of dependencies among residents accommodated at the scheme.

[23] Newhaven Research, Housing with Care for Older People, CIH and JIT, 2013
[24] COSLA/SG, "Recommendations for the Future of Residential Care for Older People in Scotland" (2014), p 20
[25] Baumker T (2011) Evaluating extra care housing for older people in England: a comparative cost and outcome analysis with residential care, Journal of Service Science and Management, 4, p 524

In theory, extra care housing can offer a range of tenure options including renting, ownership and shared ownership; however, most developments tend to be single tenure, though there has been some recent mixed tenure development. Petch[26] suggests that Scotland has seen fewer developments of extra care options than England and these have been on a smaller scale with only Auchlochan and Inchmarlo being examples of the retirement village approach. Petch's research suggests that extra care housing offers additional housing options for older people, which is particularly relevant to the Scottish policy agenda outlined earlier in this report and particularly in terms of 'Reshaping Care for Older People'. It also seems to be viewed as an important aspect of future provision in the 'Recommendations for the Future of Residential Care for Older People in Scotland' Task Force reports.

As EDC and EDHSCP seek to understand the needs and demands of older people now and across the next 15 years, it will be important to make some key strategic decisions about extra care housing including:

- Does extra care housing provide a workable, sustainable long-term model in an East Dunbartonshire context?
- Can the commissioning agencies across health, social care and housing come up with a funding model that allows extra care housing to work on a long-term basis?
- Can extra care be made 'affordable' for self-funders or part self-funders?
- Is there any mileage in multi-tenure extra care housing in Scotland?

In developing a strategy for the future, it will be important to take a view on these key questions.

5.3 Private Retirement Housing

Following the financial crash in 2008, the private retirement housing sector experienced a pronounced slump. Prospective purchasers were reluctant to commit to move and the sometimes vulnerable financial circumstance of retirement developers (cash flows are typically more stretched than for ordinary volume house builders) brought about a rapid contraction of this sector. Activity levels have only slowly recovered but, in more prosperous locations, recent years have seen evidence of significant increases in activity.

McCarthy and Stone continues to dominate development and sales levels across the UK. However, despite recent developments in Glasgow, Fife, East Dunbartonshire and East Renfrewshire, McCarthy and Stone has recently withdrawn from the Scottish market following a strategy review and cost reduction plan aimed at saving £40M by 2021.

Research by the Elderly Accommodation Counsel in 2017, reveals declining property values and challenging re-sale opportunities is raising questions about the sustainability of private retirement housing model in the UK.

[26] Petch, Alison 2012/04/01 The Scottish route to health and social care integration, Journal of Care Services Management

Although the private retirement product remains relatively expensive for what is on offer, it represents the more basic end of product offer when viewed against much other retirement housing output. The trend overall is towards premium level product at the upper end of the market and there is now considerable concentration of activity on locations perceived to offer ideal 'lifestyle' choice for wealthier buyers.

For example, in Cheltenham, an attractive Gloucestershire town with a wealth of festivals and other attractions and with the Cotswolds on its doorstep, almost every single major town-centre residential scheme promoted in the past five years has been a retirement housing scheme. The HAPPI 3 report showcased Pegasus Life's One Bayshill Terrace scheme in Cheltenham. Design quality is exceptional in this remodelling/partial redevelopment of an ex-corporate headquarters building but prices for apartments start at £450,000.

5.4 The 'Rightsizer' / 'Downsizer'

According to University of Sheffield Report, "Dealing with Downsizers" (2016), "there are a growing number of 'third-agers' whose future housing aspirations are not being met by either specialist retirement developments or mass market housing products. Much of the existing and new housing stock in the UK is designed with younger families and first time buyers in mind, which has resulted in a chronic shortage of accessible and age-friendly housing options." The report outlines evidence that many households would be keen to downsize IF there were attractive options available in the right locations. The research found strong demand for better quality and more accessible homes – located in 'normal' streets and neighbourhoods.

The DWELL research project worked with stakeholders to co-design a series of typologies that meet aspirations these included:

- Demand for accessible single storey or two storey typologies with a continuing appetite for bungalow types
- A willingness to consider apartment living, as long as the offer feels secure, spacious and is in a good location
- Demand for fewer bedrooms but more space and adaptability to accomodate seperate living, visiting friends and family and grandchildren
- Provision of a manageable outdoor space for gardening and relaxation
- Need for dedicated resident and visitor car parking provision
- Above all, a home that continues to allow people to pursue the pleasures of life today, while feeling secure that their home can adapt to their future needs

The design is intended to make it possible for people to use the property like a traditional smaller house, but if their mobility becomes restricted, they can simply live downstairs, leaving the upstairs accommodation for visitors or a live-in carer. The properties are aimed at people aged 55 plus. This is an attractive offer that encourages people to downsize from their current homes. As at 2016 they had built 16 of these properties with more planned and feedback being overwhelmingly positive.

Birmingham City Council – Rightsizer Case Study

[27]Through Birmingham Municipal Housing Trust, the Council is working with private developers to produce 'rightsizer' properties. Research among older people identified that what they wanted was:

- Two bedrooms: either through household need or quality of life requirements;
- Decent space standards and storage;
- Economic to run and easy to maintain;
- Flexible to cater for changing needs;
- Manageable outside space; and
- Rightsizing needs to be an aspirational move so needs to be genuinely appealing.

The housing solution that Birmingham City developed in response to this was a 'two bedroomed dormer style bungalow'. Each has a ground floor bedroom and shower room, a lounge and kitchen and also a second bedroom and bathroom upstairs. The design is in summary:

- Based on HAPPI principles;
- Dormer style bungalow – with second bedroom and bathroom upstairs;
- Bespoke design with good space standards including the ability to dry clothes in vented spaces or outside;
- Lifetimes homes standard enabling adaptation as needs change;
- Smaller gardens or balconies providing manageable outside space; and
- The Council has used some of its own sites to develop this model.

Early prototypes have been hugely popular and perceived as an attractive market offer that encourages people to downsize from their current homes. Consideration should be given to the 'downsizer/ rightsizer' approach and whether this might form part of the EDC and EDHSCP housing strategy for older people.

5.5 Independent Living Units

[28]Essex County Council is currently working to transform the provision of accommodation for its older people. The Council has worked in partnership with the Local Economic Partnership and the NHS to assemble land for potential 'Independent Living' sites. In July 2015 the Council approved capital investment of £27M with enabling revenue investment to deliver 1,800 units between 2015 and 2020. The programme is designed to provide housing for people over the age of 55 whose current home no longer meets their needs.

The model has the following features:

- Attractive, self-contained housing - a mixture of one and two bed apartments;
- 24/7 care and support based on site;
- Scheme size typically from 60 to 300 units;
- Units designed to Lifetime Homes design criteria;

[27] LGA – Housing our Ageing Population p 24
[28] LGA – Housing Our Ageing Population p 32-33

- Located in large town or large village close to public transport links and near urban centre;
- Even balance of low or no care need (0-9 hours per week), medium care needs (10-15 hours/week) and high care needs (15 hours/ week plus); and
- Care delivered through direct payments with choice.

The Council has developed a robust financial model and business case to justify capital and revenue investment in the Independent Living Programme. The financial case projects a net saving to the council of approximately £3,900 per person per annum compared with alternative options. Aggregating the projected savings in care costs across the programme has enabled the Council to justify the investment of capital funding and land assets owned by the Council to support delivery of the programme.

5.6 Cohousing

Another potential future development worthy of strategic consideration is the idea of cohousing for older people. Cohousing communities are intentional communities, created and run by their residents. Each household has a self-contained, private home as well as shared community space. Residents come together to manage their community, share activities, and regularly eat together. Cohousing is a way of resolving the isolation many older people experience today, recreating the neighbourly support of the past.

This is another initiative where the 'Older People's Housing Strategy, Age, Home and Community' (2011) would like to see research and development. Recently, [29]"Older women's Cohousing Cooperative" became the first cohousing project in the UK.

OWCH, are the UK's first senior cohousing community. Organised by women over fifty (current age range from 51 to 87), they started moving in to their newly built home in 'New Ground' Cohousing at the end of November 2016.

The governance structure for OWCH is a fully mutual company, managed through regular group meetings, along with a small elected management committee. In addition, a number of small service teams have been set up to take care of the building, garden, communal life and outward-facing activities like membership and communications.

There are 25 flats in 'New Ground', 11 x one bedroom, 11 x two and 3 x three. Two thirds of are leasehold and the remainder are for social rental. Housing for Women, a small housing association, is the landlord for these 8 units. A local property management company acts as managing agent for insurance, repairs, emergencies and servicing the lift and other equipment.

As yet, this is the only cohousing community which has managed to establish itself in the UK. Maria Brenton in her JRF paper, "Senior Cohousing Communities: An alternative Approach for the UK?" (2013) suggests that:

"In recent years, a surge of interest in the potential of the senior cohousing model has resulted in several groups forming around the country and the UK Cohousing Network has been active in promoting to housing associations the possibility of forming cohousing partnerships with groups of older people." [30]

She suggests that there are a number of barriers to cohousing, namely:

- Unfamiliarity of the cohousing model both to older people and the housing sector;

[29] https://cohousing.org.uk/case-study/new-ground-older-womens-cohousing-community-owch-high-barnet/
[30] Brenton, M, "Senior Cohousing Communities: An alternative approach for the UK?" JRF, Jan 2013, p 7-9

- The cost of land, the difficulty of locating sites and the dominance of volume developers;
- Unwillingness of policy makers to learn from successful experience abroad;
- Lack of leadership at the national policy-making level and unwillingness to innovate;
- Local authority planning and other blockages such as departmental silos;
- The dominance of a narrow range of options for older people such as sheltered housing;
- A tradition of institutional paternalism in relation to older people and ageism; and
- The absence of a support infrastructure supplying the specialist financial and other skills that groups of older people lack to organise a cohousing project.

On the latter point, Southside Housing Association in Glasgow is currently working with a group of local residents to test the feasibility of the co-housing model. The key decision for policy makers and for provider organisations such as the RSLs commissioning this project is whether cohousing can be seen as a mainstream contribution to address the needs of older people across the country or whether cohousing will remain a niche interest.

Interest in the co-housing model has been expressed locally from an interest group in Lenzie. In 2016, East Dunbartonshire Council received a petition from Lenzie Housing for the Elderly Interest Group regarding the provision of specific housing for the elderly. The key points raised in the petition were that the Council should:

- Identify housing and support options in Lenzie to enable older people to maintain independence;
- Recognise that there is a strong demand for specifically designed housing for older people;
- Acknowleddge that older people are being forced to either move away, or, live in unsuitable housing in the area, where they are supported by family or friends; and
- Be aware that the lack of older peoples housing is also restricting the turnover of larger family-sized homes.

Specifically, the motion expressed support for the local development of a co-housing model. The Group also asked the Council to look at the funding opportunities associated with the integration of Health and Social Care which could be used to support the delivery of specialist housing for older people in the Lenzie area, as well as appropriate development sites. At the close of the petition, 405 local people supported the proposal set out by the Group. More recently, the Lenzie Community Development Trust, as stakeholders in the Lenzie Housing for the Elderly Interest Group, have continued to promote the aims of the petition, specifically highlighting cohousing as a model to opmitise social engagement and reduce loneliness.

In reviewing whether a co-housing model can be viable age exclusive housing option in East Dunbartonshire and become a mainstream solution in a wider strategy to meet the housing, care and support needs of older people; partners should be encouraged to record local expressions of interest in co-housing and engage interested parties in testing feasibility.

5.6.1 Other Considerations

Consideration of product and service quality should not be limited to the consideration of new forms of housing. As noted earlier in this paper the COSLA and Scottish Government Task Force for the Future of Residential Care in Scotland report, “Recommendations for the Future of Residential Care for Older People in Scotland” recommends:

“The development of the residential sector over the next period should see expansion in three directions: an evolution and expansion of the extra-care housing sector; a growth in the residential sector focused on rehabilitation and prevention (step-up/step-down care); and a smaller, more specialised residential sector focused on delivering high quality 24-hour care for people with

substantial care needs. We anticipate that in some areas, single facilities or hubs might provide all of these service types." [31]

The evolution and expansion of extra care housing and perhaps cohousing and other bricks and mortar initiatives is only one part of the three directional expansion it sees taking place in the future. EDC and EDHSCP will require to give consideration to the extent to which they see their products and services expanding in the other directions and to what extent. More importantly perhaps, a shift toward extra care housing presupposes investment in prevention activity that aims to maintain and support people in their own homes. EDC and EDHSCP will require to give consideration to the extent to which provision of the sort of care and support required to maintain people in their own homes is part of their future strategy.

5.7 Key messages: Age Exclusive Housing Options

Whilst it would be unrealistic to place too high a reliance on new specialist or age exclusive provision to satisfy older people's housing needs in the future, it continues to be recognised in national strategies for older people and continues to generate consumer interest.

Whilst, this research explores a range of potential options for delivering age-exclusive housing in East Dunbartonshire, it will be essential that EDC and the EDHSCP consider carefully which models will have most impact in an East Dunbartonshire context and in co-production with older people themselves. It is clear that several models have the potential to generate significant public sector health and care savings as well the capability to appeal to older consumers. Key messages include:

Sheltered Housing

- Sheltered housing remains an important element of provision however the current public policy agenda, together with changing customer needs and aspirations will necessitate a re-thinking and updating of this model of provision;
- The financial benefit associated with investment in sheltered housing (a 4x's multiplier to the public sector in reduced health and care costs) should be given careful consideration by EDC and EDHSCP in the planning, commissioning and delivery of provision for older people;
- The decommissioning of sheltered housing provision in pursuit of a retirement model is worth consideration particularly as part of a wider strategy to divert resources towards high care needs in a community setting; and
- There is lots of evidence to demonstrate the value of the support/enhanced housing management service associated with sheltered housing. It promotes independence and good health and yet commissioning/funding policy is working against the retention of this service.

Extra Care Housing

- A judgement needs to be made as to whether extra care housing can deliver the gains in prevention, personalisation, partnership, plurality and protection that is claimed for it particularly given the challenges associated with the capital funding model for such provision;
- Consideration needs to be given to whether the right kind of integrated funding and planning can be achieved to deliver extra care housing options in East Dunbartonshire; and
- The English experience seems to indicate that with the right funding and right planning, extra care housing can provide a valuable resource, however questions remain about the affordability of the model, particularly for self-funders.

[31] *COSLA/SG, "Recommendations for the Future of Residential Care for Older People in Scotland", p 20*

Private Retirement Housing

- Although the private retirement product remains relatively expensive for what the service offers, it represents the more basic end of product offer when viewed against much other retirement housing output;
- Whilst recent research revealing declining property values and challenging re-sale opportunities, raises questions about the sustainability of private retirement housing model in the UK, it continues to offer valuable options at the upper end of the market and ideal 'lifestyle' choices for wealthier buyers; and
- Undoubtedly, private retirement housing offers often much needed tenure choice for older people and a product range that is accessible to ageing. It is likely to remain popular in an East Dunbartonshire context where older households have substantial property capital to enable such lifestyle choices.

The 'Rightsizer' / 'Downsizer'

- According to University of Sheffield Report, "Dealing with Downsizers" (2016), "there are a growing number of 'third-agers' whose future housing aspirations are not being met by either specialist retirement developments or mass market housing products;
- Evidence that many households would be keen to downsize IF there were attractive options available in the right locations;
- DWELL have developed a series of 'right-sizer' typologies co-designed with "third agers", which make it possible for people to use the property like a traditional smaller house, but if their mobility becomes restricted, they can simply live downstairs, leaving the upstairs accommodation for a live-in carer; and
- Early prototypes have been hugely popular and perceived as an attractive market offer that encourages people to downsize from their current homes. Consideration should be given to the 'downsizer/ rightsizer' approach and whether this might form part of the EDC and EDHSCP housing strategy for older people.

Independent Living Units

- Providers need to be brave and bold in developing good quality and appropriate retirement housing solutions for the future. Demand is substantial and growing provided the offer is right;
- Local authority, NHS Boards and Local Economic Partnerships in England are assembling land for potential 'Independent Living' housing development. The programme is designed to provide housing for people over the age of 55 whose current home no longer meets their needs; and
- Aggregating the projected savings in care costs across the programme has enabled the Council to justify the investment of capital funding and land assets owned by the Council to support delivery of the programme.

Cohousing

- Cohousing communities are intentional communities, created and run by their residents. Each household has a self-contained, private home as well as shared community space. Residents come together to manage their community, share activities, and regularly eat together;
- Whilst co-housing projects are now successfully coming to fruition in the UK, there are a number of barriers to cohousing including: the cost of land, local authority planning blockages, and the absence of a support infrastructure supplying the specialist financial and other skills that groups of older people lack to organise a cohousing project; and

- Consideration needs to be given to the extent to which cohousing can be a mainstream solution rather than a niche interest.

6 Estimating Need and Demand for Provision

As the vast majority of older people in East Dunbartonshire live in mainstream housing and will continue to in the future, it is important that the research actively considers whether there is the suitable and sufficient provision of housing, care and support to meet the needs of this growing population.

As a result, estimates of local need and demand for housing, care and support provision have been assembled through statistical analysis of demographic, social, health and economic data to better understand the extent and nature of need present in the population of older people in East Dunbartonshire; and to assess projected change over the next 15 years.

6.1 East Dunbartonshire Area Profile

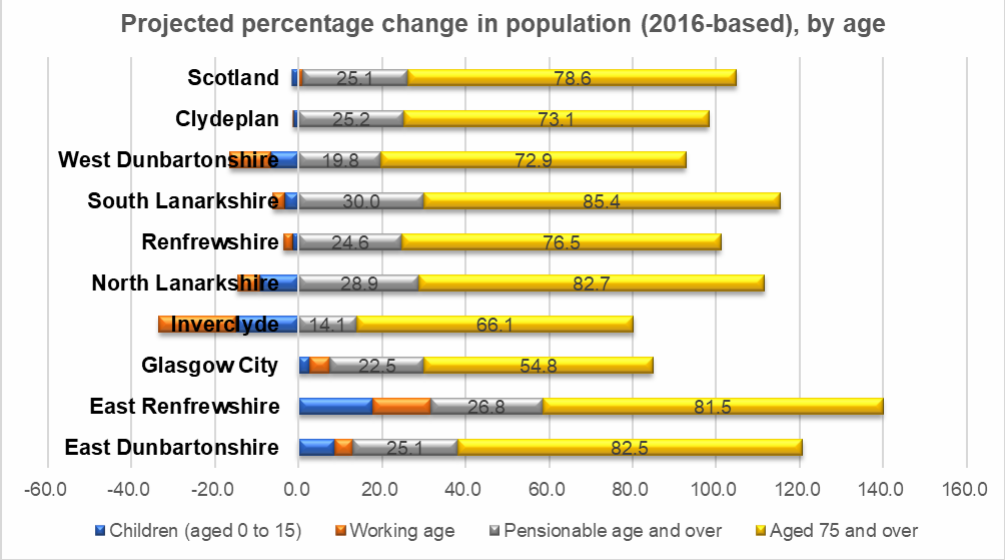
East Dunbartonshire has a population of 108,330 placing it in the mid-range of Scottish local authorities and covers 77 square miles. It comprises a mixture of urban and rural area that includes the settlements of Bearsden, Bishopbriggs, Kirkintilloch, Lennoxtown, Lenzie, Milngavie, Milton of Campsie, Torrance and Twechar. It has been recognised as one of the best areas to live in Scotland based on residents' health, life expectancy, employment, school performance and climate. Nonetheless, inequalities do exist across the authority and there are pockets of deprivation where the quality of life falls below the national average. There were 6.02 individuals per hectare in 2011 (compared to 0.68 persons per hectare for Scotland), which made East Dunbartonshire the 7th most densely population region in Scotland.

6.1.1 Demographic Profile

Ageing Population

The population is ageing at a faster rate in Scotland than the rest of the UK. Median age (the age at which half the population is older and half younger) in Scotland is 42.0 years from the mid-2017 population estimates, around two years higher than in the UK as a whole and is projected to rise to 45.4 year by 2041, compared to 43.5 years for the UK. There is also considerable geographical variation in the ageing of the population within Scotland. In general, it is lowest in the cities and higher in more rural areas.

In 2017, the National Records of Scotland estimated that 22% (23,697) of East Dunbartonshire's population is over 65. This is higher than across Scotland and Greater Glasgow and Clyde Valley where 19% of the population is over 65. It is predicted that the older population in East Dunbartonshire will continue to increase at a rate faster than the Scottish average as illustrated in Graph 6.1.



Graph 6.1: (Source: NRS 2016-based Sub-National Population Projections Scotland, Tables)

This means that 17.0% of the East Dunbartonshire population will be over 75 by 2040 compared to 13.9% of the population across Scotland. This is predominantly as a result of high life expectancy[32].

Life Expectancy

East Dunbartonshire has the highest life expectancy in Greater Glasgow and Clyde Valley for males (80.0) and for females (83.3) and this is notably higher than the Scottish average (males 77 and females 81). This is a great reflection on the health and longevity of its residents however, this suggests that demand for housing, care and support services will rise exponentially.

Life expectancy and healthy life expectancy provide useful measures for planning future service provision. Healthy life expectancy estimates the number of years an individual will live in a healthy state. Therefore, the number of years people are expected to live in 'not healthy' health is the difference between life expectancy and healthy life expectancy. Table 6.1 shows the number of years people were estimated to live in 'not healthy' health, with East Dunbartonshire having a lower estimate than for Scotland.

Local Authority	Expected period in 'not healthy' health	
	Males	Females
East Dunbartonshire	4.39	5.55
Scotland	4.8	5.8

Table 6.1: (Source: NRS Tables Healthy life expectancy in Scottish areas, 2015-2017 Table 2: Life expectancy and healthy life expectancy in Scottish council areas, 2015-2017)

Advances in diagnosis and treatment have meant that as a society we are all living longer. Yet despite average life expectancy increasing for both men and women, the number of years we spend living in ill-health is also rising. For example, the life expectancy for someone born in East Dunbartonshire during 2015-2017 is 80 for males and 83 for females, however the healthy life expectancy for males was 68.9 years and for females 68.2. These differences are strongly influenced by social conditions in Scotland, the circumstances into which people are born, the places where they live, their education, the work they undertake, and the extent to which good social networks exist. For example, there is a considerable difference in life expectancy between the least deprived communities and the most deprived communities, with a 10-year difference between men in the least deprived communities (84.4) and the most deprived communities (74.6).

Tackling the problems most commonly associated with health inequalities would also help to reduce the direct costs to the NHS and wider societal costs. For example, the Scottish Public Health Observatory has estimated that a one per cent reduction in smoking prevalence would save around 540 lives a year; reduce smoking-attributable hospital admissions by around 2,300; and reduce estimated NHS spending on smoking-related illness by between £13M and £21M [33].

It is estimated that Alcohol-related issues cost Scotland around £3.6 billion each year, including £267M to the NHS, £209M to social care services, and £727M to the justice system. The annual cost to NHS Scotland of overweight and obesity combined may be as much as £600M. Average health care costs for people with a body mass index (BMI) of 40 (severe obesity) are estimated to be at least twice those for people with a BMI of 20 (within normal weight range). Estimates of the total economic cost of obesity to Scotland range from £0.9 billion to £4.6 billion per year[34].

[32] NRS 2016-based Sub-National Population Projections Scotland
[33] ScotPHO Smoking Ready Reckoner – 2011 Edition, Scottish Public Health Observatory, June 2012
[34] A Castle (2015) Obesity in Scotland. SPICe Briefing, 15/01. 7 Jan 2015. http://www.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_15-01_Obesity_in_Scotland.pdf

Population Dependency Ratio

The population dependency ratio refers to the proportion of the dependent population (0-16 years and over 65 years or non-working age) in relation to the independent population (16-64 years or "working age"). The higher the dependency ratio, the lower the working age population compared to the proportion of "dependents". This can have resource implications for housing, care and support related support services. The population dependency ratio is calculated using recent NRS population estimates projected to 2037, taking into account changes in the State pension age.

As the total number of the dependent population in East Dunbartonshire is increasing faster than the working age population, the population dependency ratio is projected to increase to 84% in 2037, substantially higher than that for Scotland at 62.9%.

Households

In 2016, there were 45,350 households in East Dunbartonshire. This was an increase of 5.9% since 2006 (Scotland 6.8%). The table below shows the number of households in East Dunbartonshire and Scotland and changes over the years.

Area	Number of households 2016	Change 2006 to 2016	
East Dunbartonshire	*43,350*	*2,541*	*5.9*
Scotland	*2,451,869*	*156,683*	*6.8*

Table 6.2: (Source: NRS Estimates of Household and Dwellings in Scotland, 2016)

The total number of households in East Dunbartonshire is projected to increase by 15% by 2041, compared to a projected increase of 13% across Scotland. Most residents living in East Dunbartonshire households were either pensioners or adults and a quarter of residents comprised of families.

Household Structure	% East Dunbartonshire	% Scotland
One person household: aged under 65	*14*	*22*
One person household: aged 65+	*14*	*13*
One family: aged 65+	*11*	*8*
One family, no children	*16*	*18*
One family, dependent children	*22*	*17*
One family, all children non-dependent	*10*	*6*
One family, lone parent, with dependent children	*4*	*4*
Other household types	*3*	*6*

Table 6.3: (Source: Census, 2011)

Migration

In the period 2017-18, the level of in-migration in East Dunbartonshire was 3,980, a 1.7% decrease from 4,050 in the period 2016-17. The level of out-migration in East Dunbartonshire was 3,610, which is a 7.4% increase from 3,360 in 2016-17.

In 2017-18, East Dunbartonshire had the 18th highest level of net migration out of the 32 Council areas in Scotland, with a net total of 370 people. This is a decrease of 320 from 690 people in 2016-17.

Ethnicity

The 2011 Census showed 5.4% of East Dunbartonshire's population were from a minority ethnic group, an increase of around 2% since the last census in 2001, with the Asian population constituting the largest minority ethnic group.

Ethnicity	East Dunbartonshire (2011)	Scotland (2011)
	%	%
White Scottish	*88.6%*	*84.0%*
White Other British	*4.8%*	*7.9%*
White Irish	*1.2%*	*1.0%*
White Polish	*0.1%*	*1.2%*
White Other	*1.1%*	*2.0%*
Asian, Asian Scottish or Asian British	*3.3%*	*2.7%*
Other	*0.9%*	*1.3%*

Table 6.4: (Source: Census, 2001, 2011)

6.1.2 Deprivation

The Scottish Index of Multiple Deprivation (SIMD) ranks datazones, small areas with an average population of 800 people, from the most deprived to the least deprived. The table below lists the ten most deprived datazones in East Dunbartonshire and where they rank compared to the rest of Scotland.

Data zone	Data zone name	Rank	Vigintile
S01008137	*Hillhead – 02*	*458*	*5-10%*
S01008138	*Hillhead – 03*	*740*	*10-15%*
S01008131	*Kirkintilloch West – 01*	*1149*	*15-20%*
S01008106	*Auchinairn – 05*	*1157*	*15-20%*
S01008159	*Lennoxtown – 02*	*1202*	*15-20%*
S01008139	*Hillhead – 04*	*1373*	*15-20%*
S01008105	*Auchinairn – 04*	*1667*	*20-25%*
S01008143	*Rosebank and Waterside – 03*	*1795*	*25-30%*
S01008145	*Twechar and Harestanes East – 01*	*1887*	*25-30%*
S01008140	*Hillhead – 05*	*1891*	*25-30%*

Table 6.5: (Source: SIMD, 2016)

Although the majority of the population live in the least deprived deciles, there are two datazone areas in East Dunbartonshire categorised amongst the 15% most deprived in Scotland, located in the Hillhead area of Kirkintilloch. There are also four datazones categorised amongst the 20% most deprived in Scotland, two are located in Kirkintilloch, one in Lennoxtown and another in the Auchinairn area of Bishopbriggs. Only 7% of the population were income deprived (Scotland 12%), but there are wide variations across the different areas.

The Scottish Household Survey illustrates that in 2017, 82% of households in East Dunbartonshire aged over 65 years "manages well" financially, compared to 67% of households in Scotland. This is also higher than the average across all households in East Dunbartonshire (65%). Furthermore, only 1% of households in East Dunbartonshire aged over 65 years do not manage well, compared to 11% of households in Scotland.

	% East Dunbartonshire				% Scotland			
	16-39	*40-64*	*65+*	*All*	*16-39*	*40-64*	*65+*	*All*
Manages Well	-	*53*	*82*	*65*	*49*	*53*	*67*	*56*
Gets by	-	*37*	*17*	*29*	*40*	*36*	*30*	*35*
Does not manage well	-	*10*	*1*	*6*	*9*	*11*	*11*	*9*

Table 6.6: How are you and your household managing financially? (Source: SHHS, 2017)

6.1.3 Population Health

In terms of general health, some 84.9% of people in East Dunbartonshire report as being in very good or good health which is comparable to 82.2% of Scotland. The proportion of people in East Dunbartonshire who consider themselves to be in bad or very bad health is 4.3%, slightly lower than Scotland where 5.6% report to be within this category[35].

Limiting Long-Term Illness

According to the 2011 Census data, 17.4% of East Dunbartonshire's population experience a limiting long-term illness in comparison to 19.6% of Scotland's population overall. This is a slight increase in comparison to the 2001 Census (16.0%). Of the population in East Dunbartonshire who experience a limiting long-term illness, 7.8% report that they are 'limited a lot' in terms of their daily activities and life. This is in comparison to 9.6% of Scotland's overall population. In the 2011 Census, 5.6% of all reported long-term health conditions related to a physical disability. As the older population of East Dunbartonshire increases, the number of people living with a physical disability is expected to increase.

Long-term health condition	East Dunbartonshire (%)	Scotland (%)
No condition	*72.0*	*70.1*
One or more long-term health conditions	*28.0*	*29.9*
Deafness or partial hearing loss	*6.5*	*6.6*
Blindness of partial sight loss	*2.0*	*2.4*
Learning disability (for example, Down's Syndrome)	*0.4*	*0.5*
Learning difficulty (for example, dyslexia)	*1.3*	*2.0*
Development disorder (for example, Autism Spectrum Disorder, Asperger's Syndrome)	*0.5*	*0.6*
Physical disability	*5.6*	*6.7*
Mental health condition	*3.2*	*4.4*
Other condition	*18.4*	*17.7*

Table 6.7: (Source: Census, 2011)

There is a higher proportion of patients, at a rate per 100,000 registered with mental health (7.1), depression (54), addiction (9.8), learning disability (3.7), Coronary Heart Disease (54.1), Asthma (64.3), Chronic Obstructive Pulmonary Disease (20.7) and Diabetes (45.2) in the East locality than the West locality, however there is a higher proportion of patients in the West, at a rate per 100,000 population, diagnosed with cancer (27.8%)[36].

[35] Scottish Household Survey, 2017
[36] East Dunbartonshire Joint Strategic Needs Assessment, 2016

East Dunbartonshire have a lower percentage of the adult population who are living with a disability (5.6%) in comparison to Scotland (7%).

Emergency Admissions for those over 65 has increased by 11% in East Dunbartonshire from 2012 to 2017 compared to 8.4% across Greater Glasgow and Clyde Valley (GGCV).

However, when comparing the number of emergency admissions to the over 65 population in 2016/17, East Dunbartonshire has the lowest percentage (24%) of Emergency Admissions for the over 65's in Greater Glasgow and Clyde Valley, with the average across GGCV being 30%.

Mental Health

Mental health problems are extremely common, affecting around one in four people. A total of 3.2% (3,341) of East Dunbartonshire's population identified themselves as having a mental health condition that had lasted, or would last for more than 12 months, in the 2011 Census. Self-reported identification varied by gender and age. A higher proportion of females (59%) reported having a mental health condition compared to males (41%). As you get older, changes in your life, such as bereavement, illness or retirement, can make you more vulnerable to them, but mental health problems are not a normal part of ageing.

Across all age groups, there was a gradual increase in the proportions of mental health identified, with the highest proportions seen in individuals aged 35-49 (31%) and 50-64 (30%) years old, thereafter decreasing in older adults.

Depression

Depression is the most common mental health condition in older people[37]. It describes a range of moods, from feeling a bit low in mood to feeling unable to cope with everyday life. It can affect anyone, of any culture or background but more older people are affected than any other age group.

Mental health problems in older people are common and are often more apparent in settings such as hospitals and care homes. Depression affects 4 in 10 people living in care homes and in nursing homes[38]. Depression is the most common mental health condition in older people[39]. However, estimating the true prevalence of depression remains a challenge.

6.1.4 Dementia

In East Dunbartonshire, the leading cause of death for females in 2018 was dementia and Alzheimer's disease (16.7% of all female deaths, compared to 14.4% in Scotland)[40].

Dementia is one of the foremost public health challenges worldwide. As a consequence of the improved healthcare and better standards of living more people are living for longer. While this is very positive, it does introduce an increased prevalence of age-associated dementia and cognitive impairment.

Identifying the true prevalence of dementia remains a challenge however Alzheimer Scotland estimates that 2,314 people are living with dementia in East Dunbartonshire in 2017, of which 64.3% (1,488) were likely to be female[41], most likely because women live longer than men. This is in keeping with the national data on the prevalence of dementia which shows that 67% of people with dementia are women.

37 NHS England/NHS Improvement. Mental Health in Older People: A practice primer (2017)

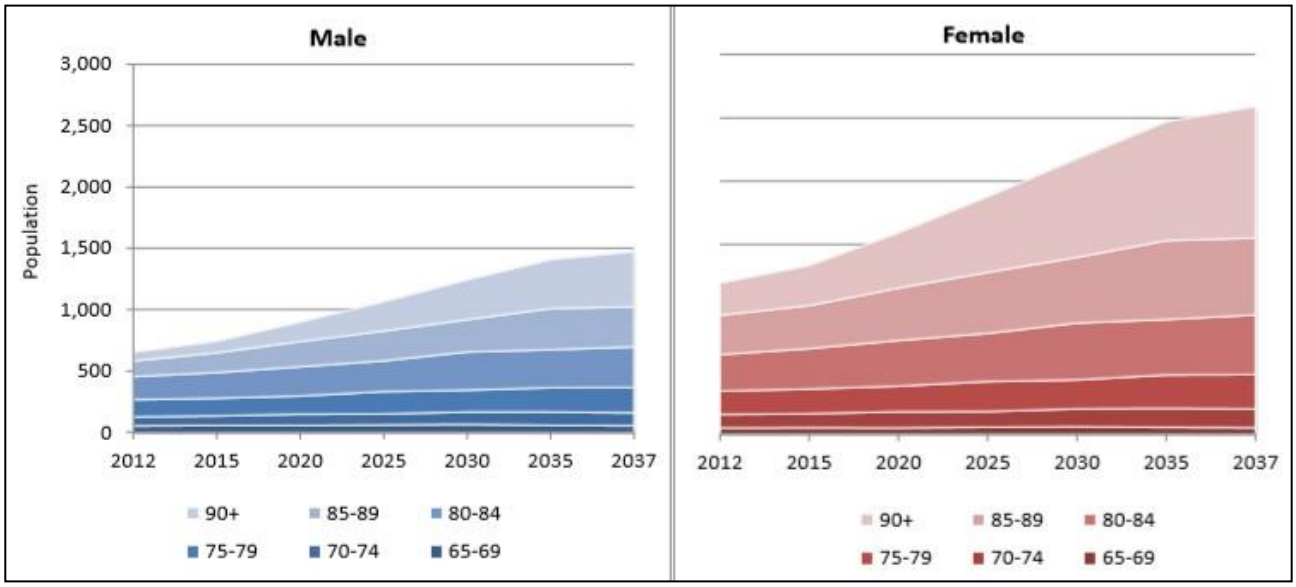
38 Faculty of Public Health, Mental Health Foundation. Better Mental Health for All: A Public Health Approach to Mental Health Improvement (2016)

39 NHS England/NHS Improvement. Mental Health in Older People: A practice primer (2017)

40 NRS, 2018 Deaths by Sex, East Dunbartonshire, 1998-2018

41 East Dunbartonshire Dementia Network

The risk of developing dementia increases exponentially with age. Projections have been estimated using dementia prevalence rates from Alzheimer Scotland and NRS population projections. These show a higher prediction of dementia in females which increases significantly with older age (see Graph 6.2). Therefore, it is anticipated that the numbers of older people with dementia in East Dunbartonshire will increase significantly over the years as the older population increases.



Graph 6.2: (Source: Alzheimer Europe (2009) *EuroCoDe*)

Most people with dementia live in the community, and it is recognised that this is generally where they do best, initially with the help of relatives and friends, and latterly with support from health and social work. An Alzheimer Scotland report in 2013 estimated that around 60% of people with dementia in Scotland live in the community (approximately 35,000-39,000), with the remaining 40% living in care homes or hospitals (approximately 23,000-26,000)[42].

Scotland's National Dementia Strategy 2013-2016 notes a series of housing support and interventions that extend beyond the development of specialist housing for people with dementia. It identifies appropriate services to support them maintain the fabric of their property, provide adaptations to enable independent living, and ensure housing management services are responsive to the needs of people with dementia.

6.2 Social Care Profile

6.2.1 Telecare and Telehealth Technology

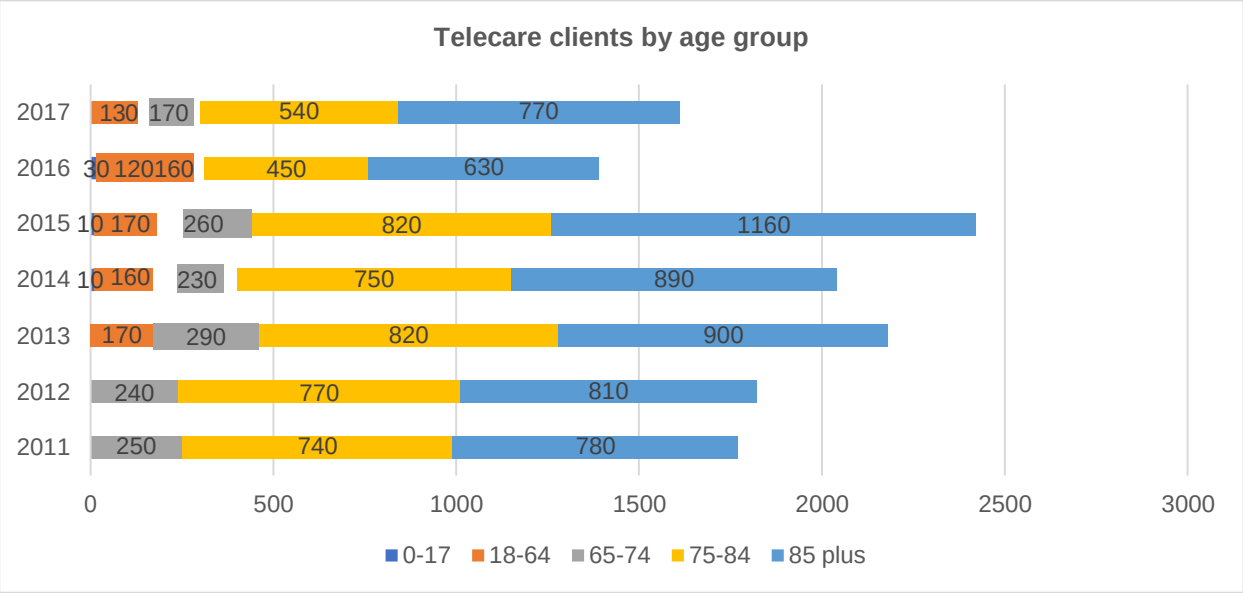
There has been a shift away from traditional forms of support such as care homes and care at home towards assisted living technologies, such as telehealth and telecare, which increase independence. Scotland has made progress in the deployment of telehealth and telecare over the past few years and is recognised by the European Commission as a leader in this field. The national Telehealth and Telecare Delivery Plan aims to increase provision and improve access to Telecare solutions to help address the challenges presented by the ageing population.

Over the period 2011-2017 Telecare packages provided within East Dunbartonshire decreased by 16.6% (from 1,930 in 2011 to 1,610 in 2017).

Most people received community alarms only (85.0%), while 3.7% received telecare only and 11.2% received both an alarm and telecare package. Approximately 92.2% of those receiving telecare in East

[42] The Dementia Epidemic - Where Scotland is now and the challenge ahead, Alzheimer Scotland (2013)

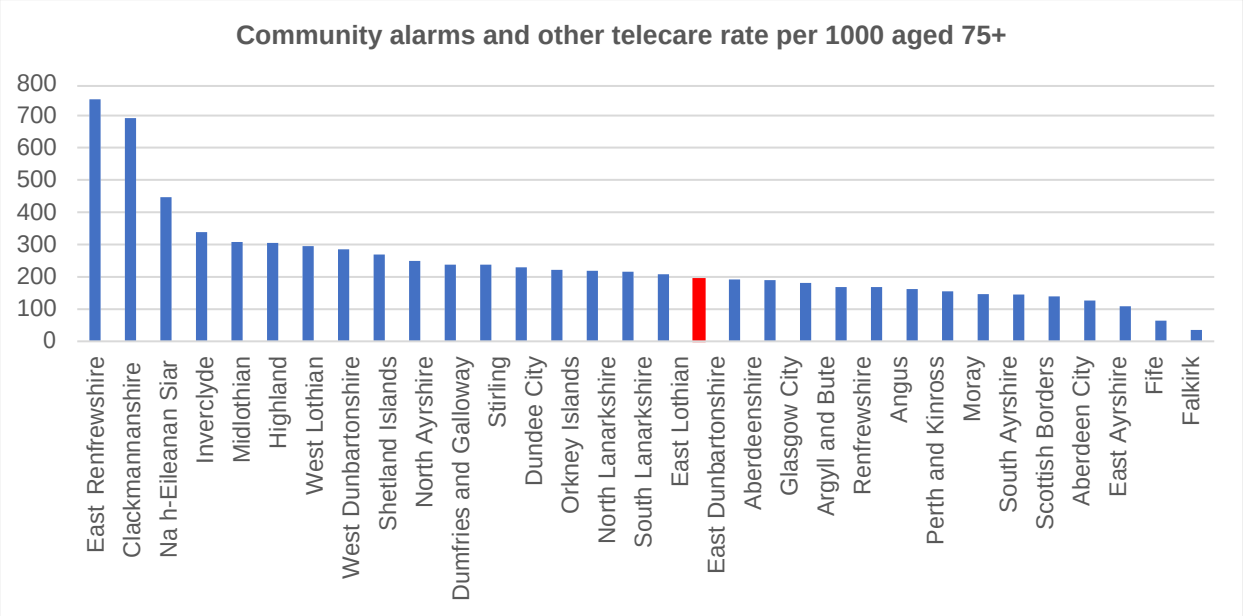
Dunbartonshire were aged over 75 years, a rate of 0.14 per 1,000 population (Scotland 0.20). The following graph summarises Telecare client numbers in East Dunbartonshire by age group over the last seven years.



Graph 6.3: (Source: Social Care Statistics, December 2017 update)

East Dunbartonshire Council has continued to promote the benefits of these services in order to support independent living however East Dunbartonshire has a lower percentage (6.2%) of over 65s with a telecare package than in Scotland (11%) and Greater Glasgow and Clyde Valley (11.7%).

The graph below illustrates the position of East Dunbartonshire relative to the national provision of Telecare services.

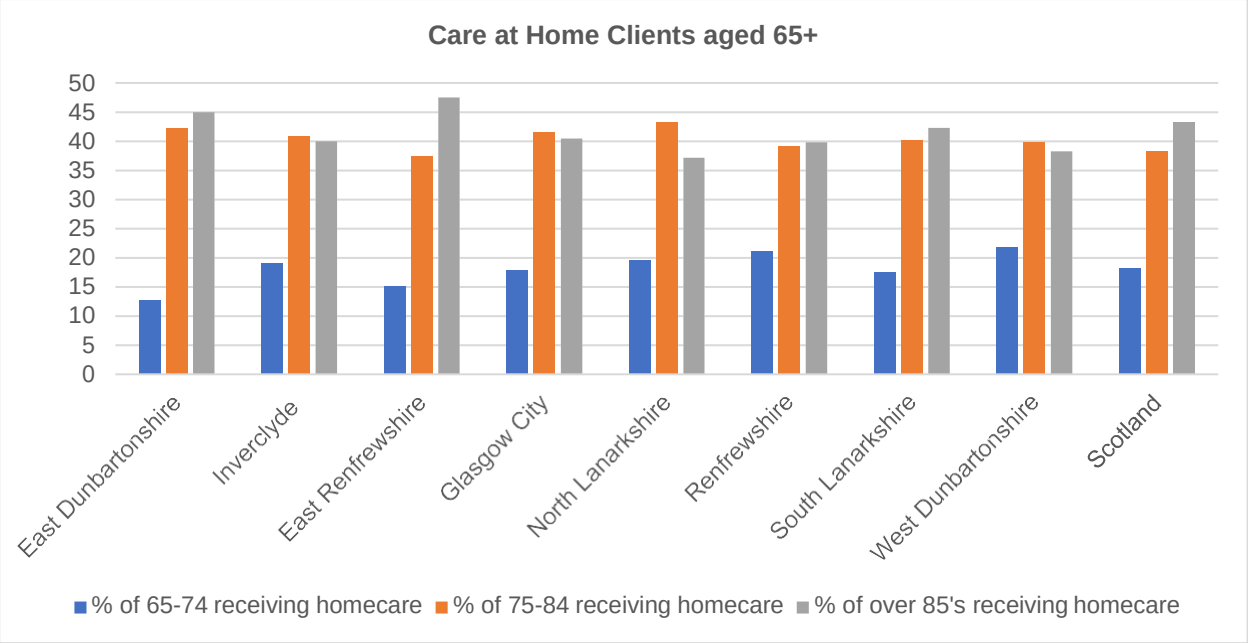


Graph 6.4: (Source: Social Care Statistics, December 2017 update)

6.2.2 Provision of Care

Care at Home

East Dunbartonshire has a low proportion of the older aged population receiving care at home. As at December 2017, there were 1,340 people receiving care at home in East Dunbartonshire, a decrease of 10.0% since 2010. Those aged over 65 account for 81.3% of all care at home clients, of which 45.0% are aged over 85 suggesting a rise in complexity of need (Graph 6.5).



Graph 6.5: (Source: Scottish Gov. Social Care Data Sets 2017)

East Dunbartonshire has one of the lowest proportions of over 65's receiving free personal care at home across the Clydeplan SDPA (4.4%).

The figures for those receiving free personal care show a 2.7% decrease, in line with national trends that suggest an overall decrease in the number of care at home clients since 2006. This may be as a result of the enablement agenda which promotes independence and reduces the demand for care and support services.

	2010*	2011	2012	2013	2014	2015	2016	2017
Number of clients	1,490	1,400	1,240	1,210	1,330	1,350	1,330	1,340
Total Hours	16,570	16,960	16,730	17,560	21,130	19,730	17,910	18,220
Hours per client	11.1	12.1	13.5	14.5	15.9	14.6	13.5	13.6
Number of clients aged 65 plus receiving 10+ hours	160	170	200	290	420	440	430	440

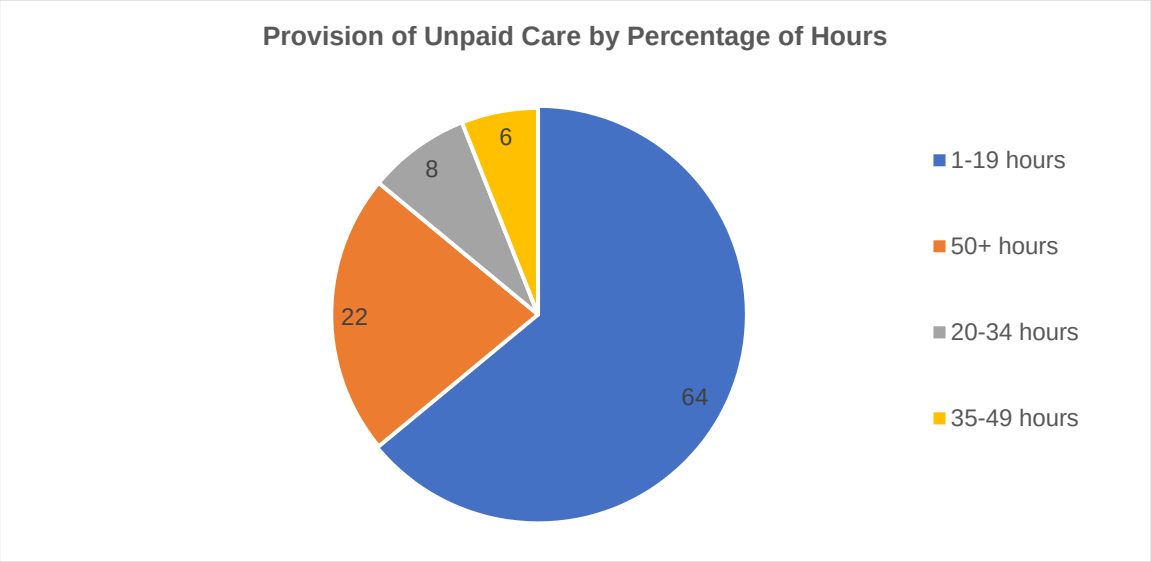
Table 6.8: (Source: Home Care Census up to 2012, Social Care Survey from 2013)

Around 40.7% of the 65+ age group household currently receive greater than 10 hours of care at home, suggesting a rise in complexity of need. In 2017, a total of 18,220 hours of home care was received by East Dunbartonshire residents.

Unpaid Care

Carers provide an important role in the provision of care and support in the community. As equal partners in the delivery of care, they enable people to remain in their own home and community through contributing to the overall health and wellbeing of the person they look after, preventing avoidable hospital admission.

There were 11,164 individuals aged 16 years and over in East Dunbartonshire who identified themselves as an unpaid carer in the 2011 Census. The majority of carers (64%) provided between 1-19 hours of unpaid care per week (Scotland 55%), while 22% provided over 50 hours of unpaid care per week (Scotland 27%).



Graph 6.6: (Source: Census, 2011)

The highest proportions of carers (19%) were aged 50-64 years, the majority of whom provided 1-19 hours of care per week. Although there were a smaller number of carers aged over 65 years, the carers (42%) in this age group provided over 50 hours of care per week (Scotland 47%).

Providing unpaid care can have a negative effect on the carer's health. The 2011 census data showed that those adults who identified themselves as carers were less likely to report their health as 'good' or 'very good' (79%) than those who provided no care (84.9%). This figure decreased in relation to the number of hours of care provided.

Care Homes

There are currently 15 Care Homes across East Dunbartonshire providing 991 units. One care home provides care for learning disabilities, and the remainder are designed for older people.

Locality	Care Homes	Units	%	Provision as a % of older population aged 65+
Bearsden	7	478	47%	7%
Bishopbriggs	1	60	7%	1%
Kirkintilloch	2	134	13%	3%
Lennoxtown	2	155	13%	22%
Lenzie	1	45	7%	2%
Milngavie	2	119	13%	4%

Table 6.9: (Source: East Dunbartonshire Council, 2019)

East Dunbartonshire has a lower percentage (2.7%) of over 65's in long term stay care homes in comparison to Scotland (3.0%), with 667 residents in 2016. This is the second lowest in Greater Glasgow and Clyde Valley.

However, it is also significant to note that across Scotland there has not been an increase in care home residents between 2006 and 2016, but in East Dunbartonshire there has been a 42% increase in care home residents, this is the most significant increase in Greater Glasgow and Clyde Valley.

There has also been an increase in over 65 long stay residents with a physical disability or chronic illness (29%) and medically diagnosed dementia (22%), this increase is not significantly different to Scotland.

Of those in care homes in East Dunbartonshire 22% are male and 78% are females. Of all the males in care homes 63% are over 85 and of all the women in care homes, 72% are over 75, with the mean admission age for a male being 85 and 86 for a female. For those who are in care homes in East Dunbartonshire only 12% are there for longer than 3 years. This is significantly lower than across Scotland with 26% staying longer than 3 years.

6.3 Equipment and Adaptations

East Dunbartonshire's Care and Repair service, previously managed by Caledonia Housing Association, is now operated by East Dunbartonshire Council. The service provides free and practical advice and assistance for East Dunbartonshire residents aged 65 and over, or 60 and over with a disability or long-term illness. This support extends all the way from completing minor repairs, through to assistance for adaptations. The service works closely with the Council's Occupational Therapy service and contributes to the alleviation of delayed hospital discharge.

Within the social rented sector RSLs carry out adaptations to properties which they own where the tenant has an identified need. The adaptations service enables tenants to live safely and comfortably in their homes. Local data from the Council tracks the referrals for adaptations in the LA and private sectors and these are illustrated below. The greatest demand is evident in the private sector both in terms of referrals and spend. This most likely reflects the profile of tenure and older people in East Dunbartonshire with higher proportions living in home ownership. Indications are that as the population ages, demand for adaptations will increase with pressure on budgets for adaptations. This will lead to a sharper focus on prioritisation of needs along with the issue of resourcing and the balance between state and individual responsibility.

	2014/15	2015/16	2016/17	2017/18	2017/18	Totals
Private Sector: Number	129	116	154			
Private Sector: Spend	£416,000	£425,000	£450,000			
Council Sector: Number	116	114	110	104	102	446
Council Sector: Spend	£418,500	£480,391	£180,850	£167,000	£315,000	£1,561,741

Table 6.10: (Source: Housing Statistics for Scotland – Scheme of Assistance – Web Table)

Measuring and projecting demand for adaptations can be difficult given the nature of the planning and operation of services as well as data sources relating to specific demographic impacts on demand.

HNDA2 provides some estimates of the number of adapted homes across East Dunbartonshire: 11,000 in total, representing 26% of all homes. The public sector, while smaller in overall numbers, does have a higher proportion of adapted properties, at 31% compared to 25% of private sector homes. HNDA2 also quotes a figure of 3,000 dwellings requiring adaptations in East Dunbarontshire[43].

As older households are more likely to live in either owner occupied sector or social renting there is likely to be a continuing demand for adaptations services to enable older people to remain independent at home.

The SHCS (The Scottish House Condition Survey) estimates that around 2% of households in East Dunbartonshire have a requirement for adaptation, suggesting that the main need is within the owner-

[43] Scottish House Condition Survey 2010-12

occupied sector[44]. However, it should be noted that the national survey is based on a very small sample of dwellings and households, and therefore the result must be treated with some caution.

It is difficult to match the current supply of adaptations with those who are seeking housing and require them. In the private sector there is little way to control the purchase of properties where adaptations have been made but will not be required; the purchaser will bear the costs of removal of these items or will leave them in situ. In the social rented sector, there is more scope to allocate properties which currently have adaptations to those who need them however this is a difficult task as the likelihood of matching an applicant with a home which contains the exact adaptations which they require will be limited.

6.4 Housing Stock Profile and Pressures

6.4.1 Stock profile

There are currently some 46,719 dwellings in East Dunbartonshire, an increase of 7.6% on 12 years ago. While this rate of growth is below the Scottish rate (9.1%), very recent levels are higher, responding to pressures in the housing markets.

Area	2005	2018	Change 2017-2018		Change 2005 to 2018	
East Dunbartonshire	*43,405*	*46,719*	*282*	*0.6*	*3,314*	*7.6*
Scotland	*2,396,782*	*2,614,982*	*20,099*	*0.8*	*218,200*	*9.1*

Table 6.11: (Source: NRS, 2019)

Home ownership is the largest sector in East Dunbartonshire overall (81.4%, 35,364), almost 20 percentage points higher than the Scottish average of 62.0%.

In comparison, the social rented sector accounts for only 12.0% of all stock (5,219), below the Scottish average of 24%, with 64.1% of stock held by local authorities and 35.9% by RSLs. There are some variations across East Dunbartonshire, with the highest rate of homeownership in Bearsden South and the lowest level of homeownership in Kirkintilloch East & Twechar. There are relatively high levels of social renting in Kirkintilloch East & Twechar, 16.6% of households renting from the Council and 17.7% from other social landlords. Levels of social renting are low in Bearsden South (2%) and in Bishopbriggs North (3%).

The private rented sector accounts for only 6.6% of the stock (1,890) but has increased from 3.87% in 2001. Due to the high pressures in both social rented and owner occupation housing tenures, there has been an increase in the use of the private rented sector to meet housing need. However, the Local Housing Allowance for East Dunbartonshire is one of the highest in Scotland, meaning that this tenure may be unaffordable for some households who then move out of the area to rent or buy[45].

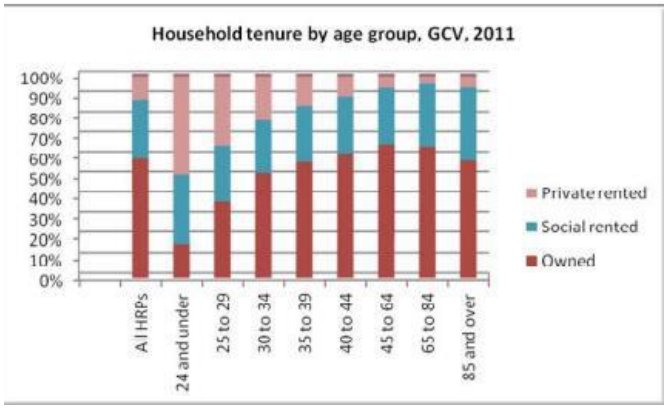
Age by tenure		Owner Occupier	Social Rented	Private Rented (or living rent free)	Total
24 and under	*No*	165	254	286	705
	%	23	36	41	100
25 to 44	*No*	7,607	1,528	1,350	10,485
	%	73	15	13	100
45 to 64	*No*	15,992	1,910	830	18,732
	%	85	10	4	100
65 and over	*No*	11,600	1,527	424	13,551
	%	86	11	3	100

Table 6.12: (Source: NRS, 2019)

[44] SHCS Local Authority Analysis 2015-2017
[45] Glasgow and the Clyde Valley Housing Need and Demand Assessment, 2015

Older households are generally less likely to live in the private rented sector than younger households, and conversely more likely to live in either the owner-occupied sector or social renting. Social landlords provide accommodation for at least 1,527 older households, which is equivalent to 11% of all older households in East Dunbartonshire. In comparison, 86% of the 13,551 households aged over 65 in East Dunbartonshire live in the owner-occupied sector.

The chart below shows how the tenure profile by householders' age: there is a marked increased propensity to be owners throughout the working years. This is reversed for older age-groups, particularly for those aged over 85. In part this will simply result from the natural ageing of existing tenants, but it may reflect a shift from owner occupation to social renting to enable householders meet their housing/care needs. The same profile holds across the GCV conurbation, although, as might be expected, the levels of owner occupation and social renting vary significantly[46].



Graph 6.7: (Source: Clydeplan HNDA2)

Older people, in particular older owner occupiers, tend to live in larger homes than other households. Sixty-eight per cent of older homeowners live in a home that has a least two spare bedrooms, technically known as 'under-occupation'.

The vast majority of households in East Dunbartonshire live in houses (79%, compared with 62% for Scotland), with only 27% of all houses having 1-3 rooms compared to 42% nationally (Table 6.13). Therefore, it can be assumed that within East Dunbartonshire that a significant number of owner occupiers are generally living in larger homes.

Area	Dwelling type (% of total dwellings)						Number of rooms per dwelling (% of total dwellings)				
	Flats	Terraced	Semi-detached	Detached	Unknown	Total	1-3 rooms	4-6 rooms	7 or more rooms	Unknown	Total
East Dunbartonshire	21	15	33	31	0	100	27	62	9	2	100
Scotland	38	20	20	21	1	100	42	50	6	2	100

Table 6.13: (Source: NRS, 2019)

[46] See Census DC4111SC, Tenure by age of HRP for further detail

There are problems of poor condition associated with some private sector properties, especially those built pre-1945. It is estimated that 6,000 older households are living in dwellings that show evidence of disrepair to critical elements[47].

Research suggest that older homeowners feel that the cost of home maintenance was their major concern for later life[48]. Being able to stay comfortable, warm, safe and mobile in the home becomes increasingly important to older people. The majority of older owner-occupiers may be asset rich but income poor. Their home is valuable with little or no debt secured on it; but their income so small that they are entitled to Pension Credit. In such circumstances, older homeowners may not be able to afford to pay for necessary maintenance and improvements to their home even though this could improve their quality of life considerably.

Specialist Housing Provision for Older People

2.4% of housing stock in East Dunbartonshire is classed as specialist housing provision for older people, the majority of which are sheltered housing 88.6% (824). When all housing designed specifically for older people is considered, there are 929 homes in total in East Dunbartonshire.

Almost one quarter (21%) of sheltered housing in East Dunbartonshire is provided by East Dunbartonshire Council and is located across Bearsdon (50%), Milngavie (37%) and Bishopbriggs (13%). The second largest provider of sheltered housing is Bield Housing and Care who have provision across Bearsden (13%), Kirkintilloch (54%), Lenzie (16%) and Milngavie (17%).

Locality	Abbeyfield Bearsden	Abbeyfield	Bield Housing & Care	Blackwood Homes and Care	EDC	First Port	Hanover (Scotland)	McCarthy & Stone	Sanctuary Housing	Trust Housing Association
Bearsden	11		20		76			23		32
Bishopbriggs				9	20	112	105	33		36
Kirkintilloch			8				35			11
Lennoxtown							36			
Lenzie		10	24							
Milngavie			26		56	73	39	49	12	

Table 6.14: (Source: East Dunbartonshire Council, 2019)

One third (290 units) of specialist housing for older people is private retirement housing provided by McCarthy & Stone and FirstPort. Half of all private retirement housing is located in Bishopbrigs (50%), with the remaing provision located in Milngavie (42%) and Bearsden (8%).

With a variety of terminology and language used to describe older people's housing across housing organisations it is important to exercise a degree of caution in all categories with the exception of sheltered housing it is likely that there is some double counting in this figure due to different interpretations of categories.

Slight variations are evident in the geographic distribution of specialist housing stock, with Bishopbriggs and Milngavie having the greatest proportion of specialist stock in East Dunbartonshire (34% and 27% respectively). Lennoxtown and Lenzie having the lowest provision (4% and 4%). However, when specialist stock is considered as a percentage of older population aged 65+ Bearsden, Bishopbriggs and Lenzie have the lowest proportion of specialist stock in East Dunbartonshire (2%) in comparison to Lennoxtown which has the highest (32%).

[47] Scottish Household Condition Survey, 2012-2014
[48] Age UK, Cost of home maintenance key concern for over 60s putting their home insurance at risk

Locality	Specialist stock (sheltered, amenity)	% of all EDC specialist stock	All locality stock (mainstream and specialist)	Specialist as % of all locality stock	Specialist as % of older population aged 65+
Bearsden	162	17%	10,601	2%	3%
Bishopbriggs	315	34%	8,962	4%	3%
Kirkintilloch	127	14%	8,805	1%	4%
Lennoxtown	36	4%	1,555	2%	32%
Lenzie	34	4%	3,325	1%	3%
Milngavie	255	27%	5,341	5%	7%

Table 6.15: (Source: East Dunbartonshire Council, 2019)

There is a shortage of specialist provision which invariably boosts demand for amenity housing and supported housing. The profile of supported accommodation may not be fit for purpose with increasing need for housing that includes higher levels of support as well as increasing demand for housing that enables low level support. As well as re-provisioning some social rented sheltered housing, there is a need to consider the development profile of specialist accommodation across all tenures.

6.4.2 Housing List and pressure analysis

East Dunbartonshire Council operates a common housing application form with one other locally operating Housing Association. The remaining 13 social landlords each operate with their own housing application form and housing waiting list. Applicants can be nominated from EDC's waiting list when a Housing Association property becomes vacant.

As at February 2020, there were 1,822 households registered on East Dunbartonshire Council's housing waiting list as seeking a new home across East Dunbartonshire, and of these 1,011 (55.5%) are aged over 45. The proportion of applicants aged over 45 with health needs on the housing register is higher than the population of people with health needs (4.3%) and higher than the estimate of households with a requirement for an adaptation (2%).

Need Group	Description	Applicants	
		No.	%
Priority Category: Groups	• People who are homeless or threatened with homelessness, who have unmet housing needs; • People living in unsatisfactory housing conditions who have unmet housing needs; and • Tenants of houses held by a social landlord which are being underoccupied.	476	47%
Local Needs Category: Groups	• Insecurity of tenure; • Overcrowding (non-statutory); • Other underoccupation; • Sharing amenities; • Access and support needs – medium priority; and • Family and social preference.	377	37%
Other Needs Category: Groups	• Caravan dwellers; • Outwith East Dunbartonshire needs; and • Outwith East Dunbartonshire aspirational.	153	15%

Table 6.16: (Source: East Dunbartonshire Council)

Further analysis of the housing register highlights the following:

- **Some 20% of the demand for East Dunbartonshire was from the 65+ age band and more than 8% was from those aged 75+;**
- **There are 238 applicants on the housing register who wish to be considered for Sheltered housing; and**
- **24 applicants on the register indicated that they requested wheelchair access.**

6.4.3 Stock Pressures

A review of pressures at local level was carried out for the Clydeplan HNDA2. The review covered key issues identified by the local authorities: tenure change; property profile mismatches; property condition; occupancy issues; and high/low demand stock. The review highlighted the following key concerns for East Dunbartonshire:

- **The bulk of the total housing stock (69%) has 3 or more rooms:** RSLs report increasing demand for smaller properties linked to demand from households on the waiting list and the impact of welfare reforms. However, uncertainty around the changes being introduced through the welfare reform agenda means the required scale and pace of change is also uncertain.
- **Stock Mismatch:** There is a particular mismatch between social rented and private sector stock in parts of East Dunbartonshire. There is a need to widen tenure options and expand housing choices in the areas concerned to create more balanced communities.
- **Supply of affordable homes for sale:** House builders generally opting for "tried and tested" markets. Concentration on high end housing is distorting market and reducing options and choices for those moving both up the property ladder and those wishing to downsize to more manageable accommodation. East Dunbartonshire Council has been developing and implementing its Affordable Housing Policy: 25% of all new housing developments will be made available for affordable housing. In light of the lack of affordable housing choices, the Council has investigated varying housing options to help meet housing need and demand including Mid-Market Rent, Housing Association Shared Equity and Rent off the Shelf which have proven to be successful.
- **Demand for equipment and adaptations:** Most people live, and are likely to continue to live, in mainstream housing that is not specifically designed or set up to meet particular needs. The Scottish House Condition Survey estimates that around 2% of households in East Dunbartonshire have a requirement for adaptation[49]. As older households are more likely to live in either owner occupied sector or social renting there is likely to be a continuing demand for adaptations services to enable older people to remain independent at home.

6.5 Key Messages: Estimating Need and Demand for Provision

Estimates of local need and demand for housing, care and support provision have been assembled through statistical analysis of demographic, social, health and economic data to better understand the extent and nature of need present in the population of older people in East Dunbartonshire; and to assess projected change over the next 15 years.

The East Dunbartonshire profile is unique in many respects from the scale and pace of growth in the older population; to a comparatively positive health and wealth profile; to a lower dependency on community based care services than may be expected; to the scale of potential housing unsuitability faced by older in private dwellings which may no longer be fit for purpose. The extent and of the challenge to meet the housing, care and support needs of the older population is therefore complex and increasingly so.

Key messages include:

Analysis of East Dunbartonshire's demographic profile reveals that the older population (22%) is greater in scale than is the case nationally and regionally and is projected to increase at a faster

[49] SHCS Local Authority Analysis 2015-2017

pace. This trend is underpinned by a higher life expectancy in East Dunbartonshire indicating that more older people live healthily and well locally than in other areas of Scotland. However, the scale of increase in the older population is driving a substantially higher population dependency ratio (84%) than is the case for Scotland (63%). Support at a community level to enable older people to remain independent is therefore more limited in East Dunbartonshire than elsewhere. This statistic creates further pressures given the proportion of the overall population of single older people (13%) in the area.

Most older people in East Dunbartonshire (82%) describe themselves as financially managing well, a substantially higher level than is the case for Scotland (67%). As well as financially secure, older people in East Dunbartonshire also appear to be more healthy than elsewhere with a lower proportion of older households (24%) experiencing an emergency hospital admission than across Glasgow and Clyde Valley.

So, whilst a positive profile of the older population in East Dunbartonshire can be traced in terms of income security and health, the scale and pace of growth in the population creates a disproportionately greater challenge for housing, care and support partners.

Telecare packages provided within East Dunbartonshire declined by 44.1% between 2011 and 2017. Whilst East Dunbartonshire Council continues to promote the benefits of telecare services, a substantially lower percentage (6.2%) of over 65's receives a telecare package locally than in Scotland (11%) and Greater Glasgow and Clyde Valley (11.7%). These figures run contrary to the projected increase in the older population, which would suggest the need for more innovative and flexible forms of technology-based care to enable independence.

Whilst East Dunbartonshire has one of the lowest proportions of over 65's receiving free personal care at home (4.4%) regionally, higher proportions (40.7%) currently receive more than 10 hours of care at home, suggesting a rise in complexity of care and support needs.

It is estimated that roughly 11,000 homes in East Dunbartonshire have adaptations, which is about a quarter of all dwellings. Over and above this, it is estimated that up to 3,000 dwellings currently require adaptations in East Dunbartonshire. Investment in preventative support services such as technology enabled care, adaptions and home care services will become increasing important in the strategy to meet the housing care and support needs of older people as rate and pace of growth accelerates in the next 15 years.

In line with its socio-economic profile, home ownership dominates the housing sector in East Dunbartonshire comprising 81% of the total housing stock, almost 20% higher than the Scottish average of 62.0%. In line with the tenure profile, most older people (86%) live in the owner-occupied housing.

Older people tend to live in larger homes than other households and under occupy their home. Sixty-eight per cent of older homeowners live in a home that has a least two spare bedrooms. As well as unsuitability by size, there are problems of poor condition associated with some private sector properties, especially those built pre-1945. It is estimated that 6,000 older households are living in dwellings that show evidence of disrepair to critical elements.

Just 2.4% of housing stock in East Dunbartonshire is classed as specialist housing stock for older people for an overall population in area of 22%. The majority of these units are sheltered housing provided by social landlords 89.8% (929). Future demand for supported housing for older people may be up to 7% of the population aged 60 and over; suggesting a need to look at age-exclusive housing options which provide a more diverse range of tenure choices. This is particularly

important given research evidence of the impact of age-exclusive provision on arresting frailty amid the substantial projected increase in the number of older households 75+ in East Dunbartonshire.

Furthermore, house builders in East Dunbartonshire generally opt for “tried and tested” markets delivering high end housing which reducing options and choices for those moving both up the property ladder and those wishing to downsize to more manageable accommodation. There is a need to widen tenure options and expand housing choices in the areas concerned to create more balanced communities.

7 Engaging Older People in East Dunbartonshire: Household Survey Results

An essential aspect of this research study focuses on engagement with older people living in East Dunbartonshire to seek their views and opinions on current and future housing, care and support needs. If future interventions are to have a meaningful impact, it is vitally important that public services codesign and coproduce solutions with older people. Both EDC and EDHSCP recognise this, hence the significant focus on primary research within the research methodology.

To ensure that future planning, policy and delivery interventions are informed by credible evidence of the circumstances, needs, expectations and aspirations of older people in East Dunbartonshire, an extensive primary research exercise was delivered in the form of a statistically representative household survey of older people in East Dunbartonshire in 2019.

7.1 Survey Methodology

The East Dunbartonshire Older People Survey was undertaken utilising a face to face methodology with tenants. It was administered by Research Resource, a professional market research firm, with interviews taking place between the 1st May and 26th June 2019.

The survey comprised two elements

- 400 face to face interviews with households aged over 55 targeted using a quota-based sampling methodology to ensure a representative sample of the general population aged 55+ was achieved across multi member wards in East Dunbartonshire; and
- 100 face to face interviews with a sample of older people living in sheltered and retirement housing in East Dunbartonshire.

This total sample delivered a statistical accuracy level of +/-4.35% across the older population in East Dunbartonshire therefore providing a 95% confidence level in the accuracy and representativeness of the results. A face to face survey methodology was determined the most effective approach for undertaking this type of research given the administration of a fairly lengthy questionnaire which asks some data of a personal nature. An interview led methodology, such as door to door, allows the interviewer to build up a rapport with the respondent, ensuring that the questionnaire is answered in full and allowing explanation of the necessity to ask for personal data, providing high quality output and a positive interviewing experience for those who participated.

The aim of the survey was to develop a clear understanding of the needs, aspirations and expectations of older people (55+) living in East Dunbartonshire.

Specifically, the survey sought to gain detailed insight on:

- Current household circumstances including amenity and suitability of current home;
- What are the main motivating factors that result in people choosing to leave their current home and move into age exclusive / specialist housing?
- Health, independence and disability profile;
- Extent and nature of housing support needs (if any);
- What proportion of older people and those planning for their later years wish to remain in their current home?
- What proportion of older people and those planning for their later years wish to move into age exclusive housing and / or care settings?
- Household income levels and percentage of income devoted to housing costs;
- Preferred housing products and tenures;
- Interest in downsizing/rightsizing;

- Attitudes to housing support, care and services to promote independent living;
- Access to community and/or social networks;
- Suggested improvements and development to current housing and support living;
- Access to community and/or social networks; and
- Suggested improvements and developments to current housing and support provision.

After consultation with EDC and EDHSCP a questionnaire was agreed which fully met the information research requirements of all partners.

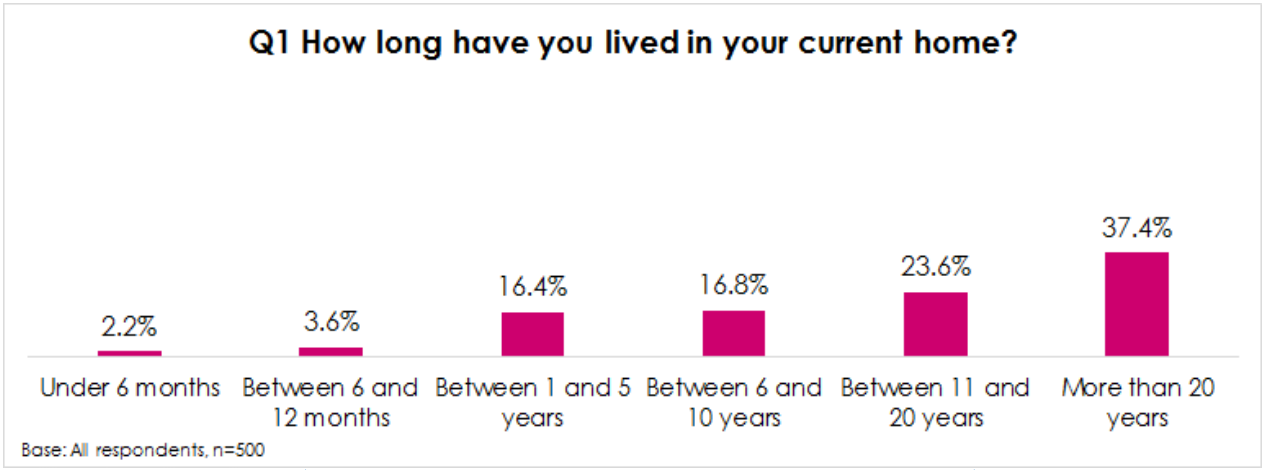
Appendix 2 provides: Research Resource Older People's Survey Report & Questionnaire.

The research outcomes arising from the survey are detailed fully in the following Chapter.

7.2 Current housing circumstances

7.2.1 Length of stay in home

The survey opened by asking respondents how long they had lived in their current home. Only 6% had lived in their home for less than 1 year. 16% had lived in their home between 1 and 5 years, 16% between 6 and 10 years, 24% between 11 and 20 years and 37% had lived in their home for more than 20 years.



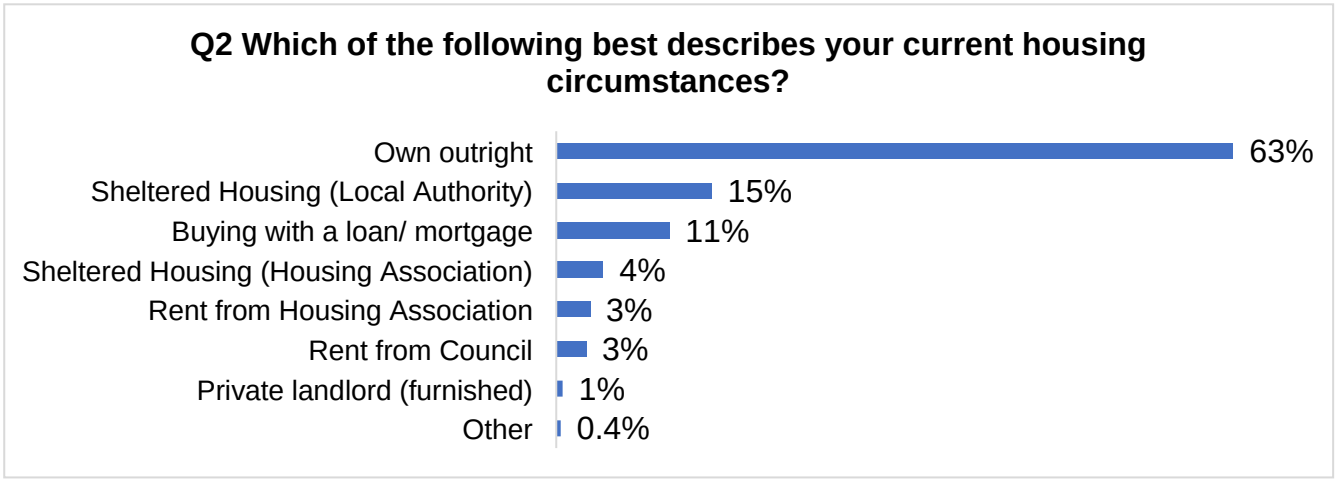
50% of those in sheltered had moved in in last 5 years (15% of general population)

71% of those not living in sheltered had lived in their property for 11+ years

Analysis by age indicates that respondents in the middle age category (65-74) were most likely to have stayed in the area for more than 20 years (41%).

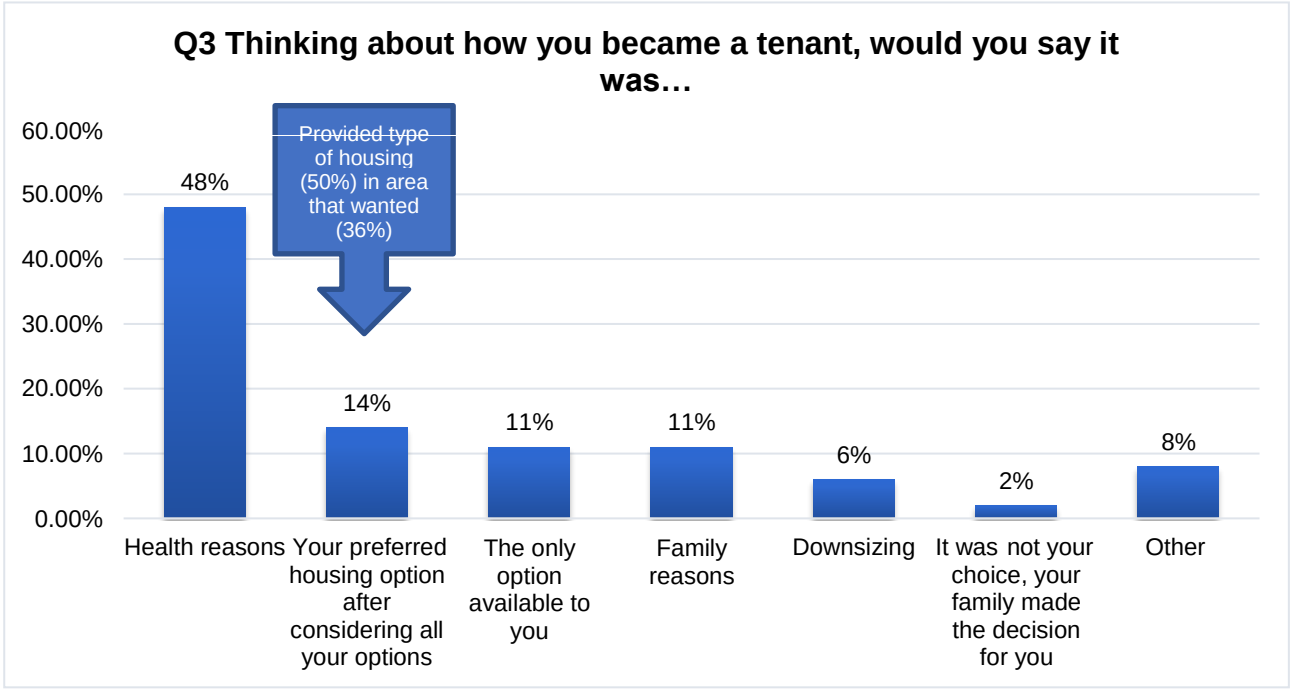
7.2.2 Tenure

With regards to tenure, the majority of respondents owned their home (74%) either outright (63%) or were buying their home with a loan or mortgage (11%). Just over 1 in 10 respondents were East Dunbartonshire Council tenants. As may be expected, as age increases, the proportion of respondents living in sheltered housing (both Local Authority and Housing Association properties) also increases.



7.2.3 Route into older persons housing

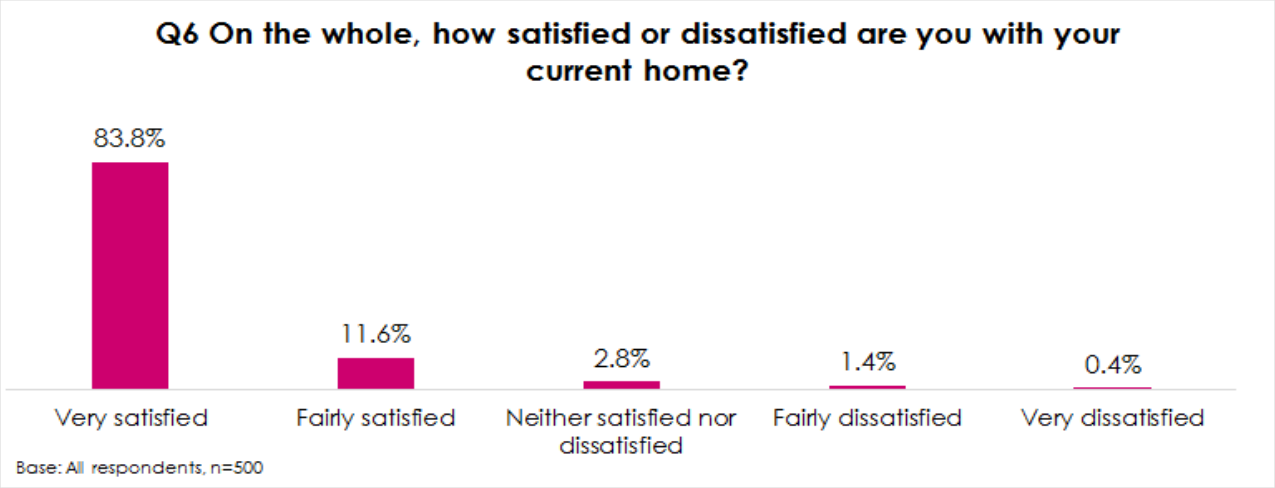
All sheltered tenants were asked about how they became tenants, just under half (48%) said this was due to health reasons, 14% said it was their preferred housing option after considering all their options, 11% said it was their only available option and 11% said it was due to family reasons.



Those who said that becoming a tenant was their preferred housing option (14 tenants) were asked why this was their preferred option. Half of these tenants said their landlord provided the type of housing they wanted, and a further 5 tenants said their landlord had housing in the area they wanted.

7.2.4 Satisfaction with current home

The vast majority of respondents said they were very or fairly satisfied with their home (95%) compared to 2% who were very or fairly dissatisfied and 3% who were neither satisfied nor dissatisfied.



Analysis by age reveals that as age increases, the proportion of respondents very satisfied with their current home decreases. For example, from 92% for respondents aged 55-64 to 82% for those aged 65-74 and 75% of respondents aged 75 and over.

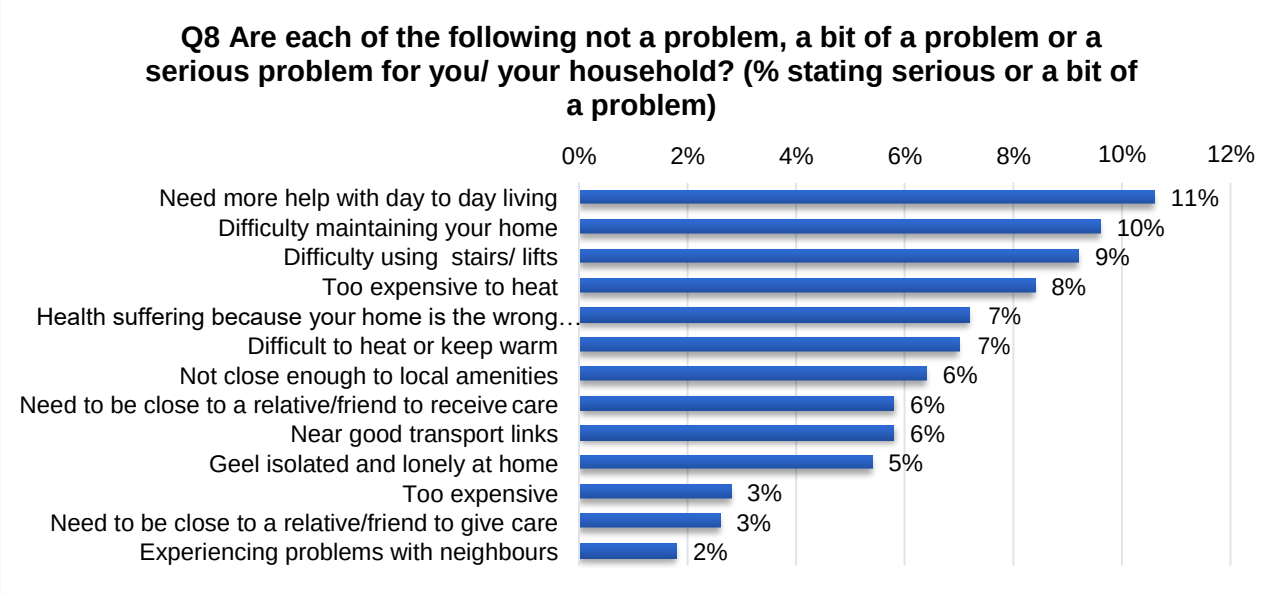
Analysis by housing type reveals that tenants who did not live in sheltered housing were significantly more likely to be very satisfied with their current home (88%) than tenants who lived in sheltered housing (68%).

7.2.5 Potential problems in current home

All respondents were asked to rate the extent to which various housing related issues were a problem or not a problem for either themselves or their household. These issues focused on potential barriers to independent living or wellbeing.

The vast majority of respondents (90% for all but one issue) considered housing related issues not to be a problem or barrier to independent living.

However, the biggest concerns related to a need for more help with day to day living at home and basic tasks (11% stating this was a bit of a problem or a serious problem) and where respondents were experiencing difficulty maintaining their home (10%).

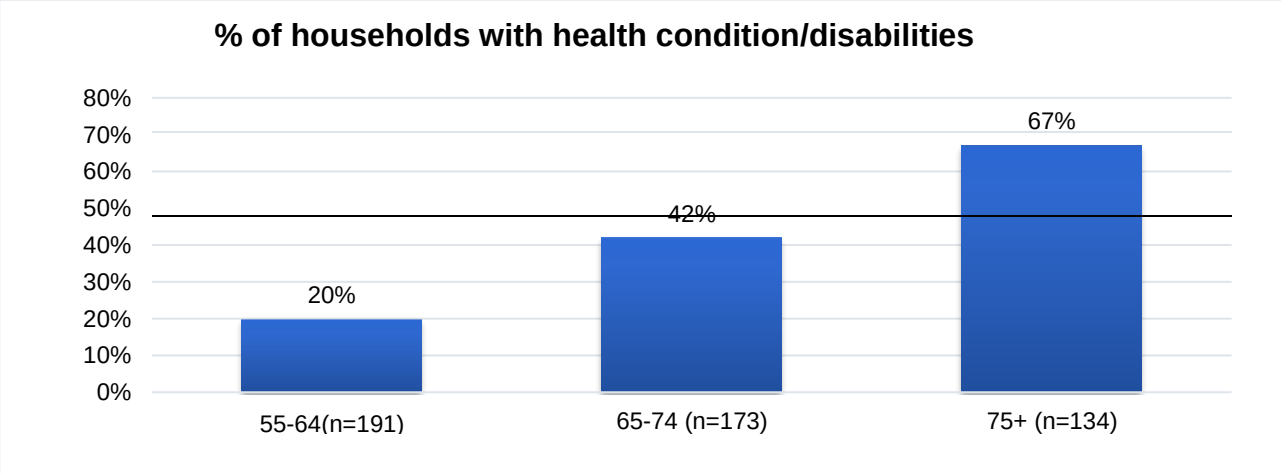


7.3 Health and support needs

7.3.1 Long term health conditions or disabilities

Almost half of survey respondents (41%) reported that either themselves or someone else in their household had a long-term illness, health problem or disability. This tended to be either a mobility or physical disability (27%) or a chronic disease (16%).

Analysis by age reveals that as age increases, the proportion of households with a health condition or disability also increases, e.g. from 20% for those aged 55-64 to 67% for tenants aged 75 and over.



7.3.2 Suitability of housing

Households with at least one person with a health condition or disability were asked about any aids or equipment they had which helped them in their home. Over half (51%) said they had walk in showers, 50% had handrails and 44% had walking sticks or walking frames. On the other hand, 30% of respondents had no equipment or aids.

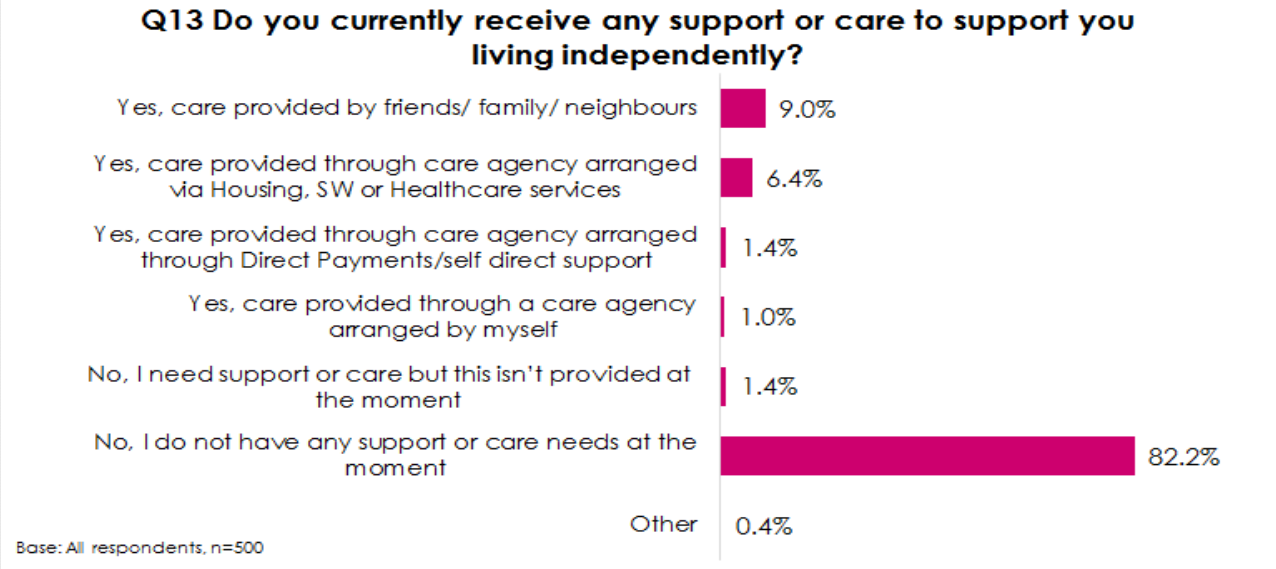
Those living in households with at least one person with a health condition or disability were asked if there was anything that limits the activities, they (or anyone in their household) can do. The vast majority said there was nothing about their home that limited either them or anyone else in their household. On the other hand, 10% said they were unable to get up and down stairs, 7% said it was difficult to access or use the bath or shower, 5% could not leave the house because of steps to the house and 5% said cupboards or shelves were difficult to reach or use.

The majority of households with at least one person with a health condition did not have an unmet need for any adaptations or help in their property. Where respondents did mention an unmet need this tended to be for internal grab rails (5%) or stairlifts (5%).

7.3.3 Support/care received

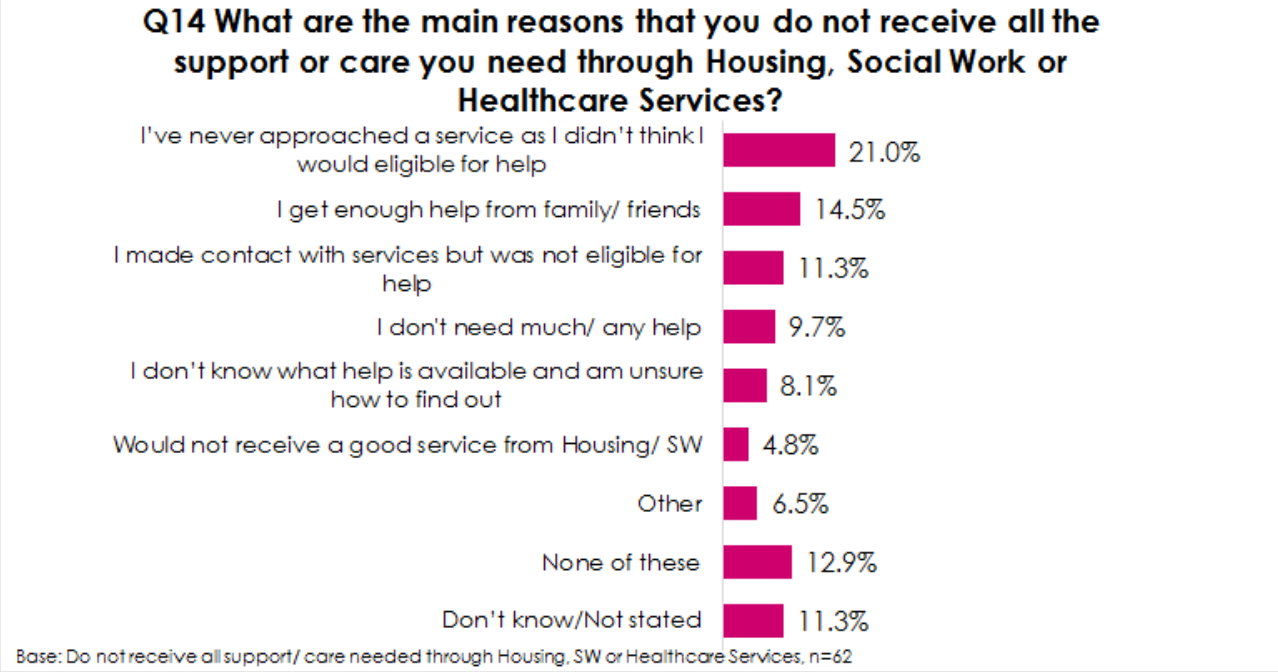
All respondents were asked if they were currently receiving any support or care to support them living independently. The vast majority (82%) did not have any support or care needs.

On the other hand, 9% said they received support or care provided by friends, family or neighbours and 6% said they received support or care provided through a care agency arranged via housing, social work or healthcare services.



7.3.4 Reasons for not receiving care

Respondents who were not currently receiving support were asked for their reasons for not receiving support. The top response was where respondents said they have never approached a service as they didn't think they would be eligible for help (21%) and this was followed by receiving enough help from family and/ or friends (15%).



7.3.5 Services to aid residents to live independently

Respondents were then asked to choose from a list of services that could help to support them to live independently. The top three services respondents would use at the moment were general cleaning (16%), grass cutting and garden care (11%) and shopping services (10%). The top three services respondents would consider using in the future were the same, with 37% considering general cleaning, 23% considering grass cutting and garden care and 24% considering shopping services.

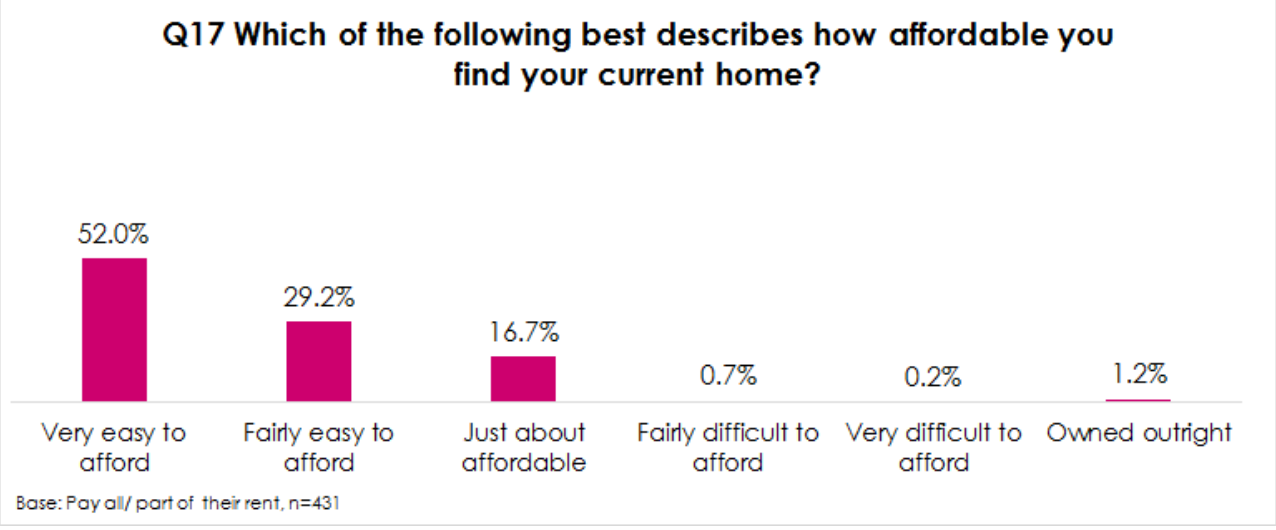
Q15 Services which could help to support individuals to live independently				
	(a) Top 3 services would use at the moment		(b) Top 3 services would consider using in the future	
	No.	%	No.	%
General Cleaning	82	16.4%	185	37.0%
Grass Cutting/Garden Care	54	10.8%	117	23.4%
Shopping Services	51	10.2%	120	24.0%
Small Repairs/Handy man services	42	8.4%	110	22.0%
Meal preparation	25	5.0%	42	8.4%
Laundry Services	20	4.0%	40	8.0%
Home security services	14	2.8%	30	6.0%
Access to trusted traders	11	2.2%	42	8.4%
Managing adaptations and improvements	7	1.4%	28	5.6%
NONE OF THE ABOVE	359	71.8%	217	43.4%

72% of older people responded that they would NOT consider using any of the suggested services to support them to live independently.

7.4 Income and affordability

7.4.1 Affordability of current home

The majority of respondents (81%) said their current home is very or fairly easy to afford. 17% said their current home was just about affordable and 1% said their home was fairly or very difficult to afford. 1% of respondents own their homes outright.

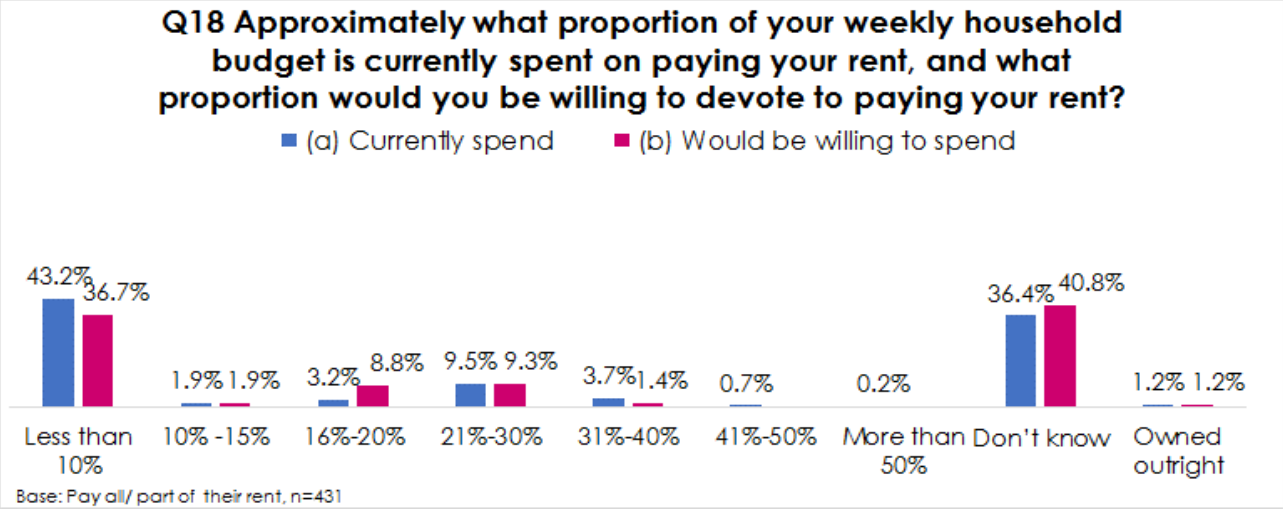


Analysis by age reveals that respondents aged 75 and over (64%) were less likely to say their home is very or fairly easy to afford compared to those aged 55-64 (89%) or aged 65-74 (83%).

9% of those in sheltered housing find their housing easy to afford compared to 91% of those not in sheltered housing.

7.4.2 Proportion of weekly household budget spent on rent

Respondents were then asked what proportion of their weekly household budget is spent on rent. 43% said they currently spend less than 10%, 19% said more than 10% and more than one third of respondents (36%) said they didn't know. When asked what they would be willing to spend, 37% said less than 10%, 21% said more than 10% and 41% said they didn't know.



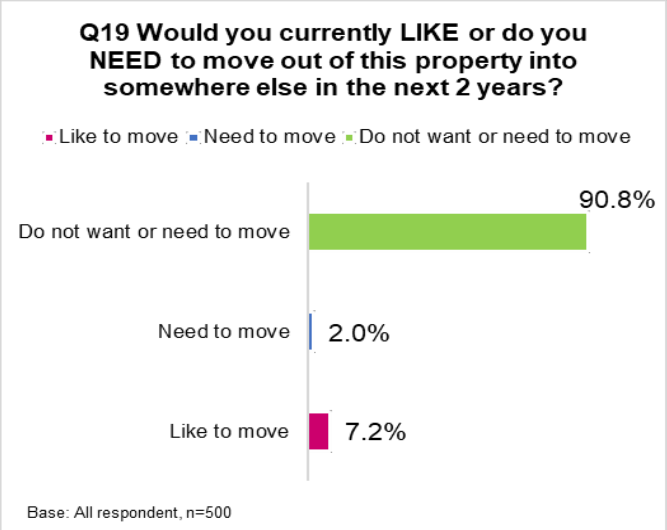
Residents living in sheltered accommodation (61%) spend a minimum of 21-30% of their budget on rent while 49% of respondents living in non-sheltered housing spend less than10%. The majority of respondents living in sheltered accommodation (87%) said they were willing to pay between 16-40% of their budget on rent while only 12% of respondents living in non-sheltered housing were willing to spend more than 10%.

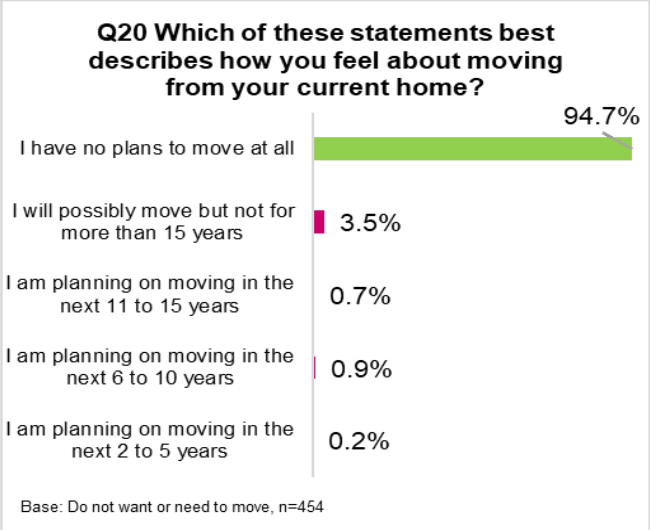
7.5 Future housing intensions

7.5.1 Moving intentions

The majority of respondents (91%) said they do not want or need to move home, 7% said they would like to move, and 2% said they need to move.

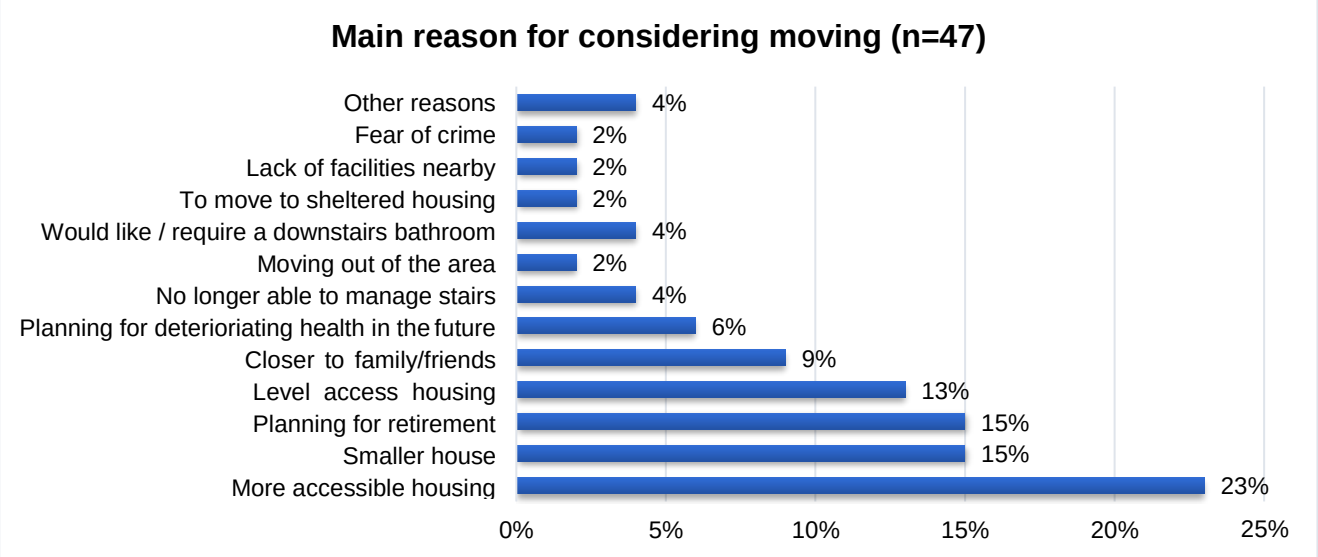
Nearly all respondents (95%) said they have no plans to move at all, this was followed by 4% who said they will possibly move but not for more than 15 years and 1% who are planning on moving in the next 6-10 years.





7.5.2 Main reason for considering moving

When asked to give their main reason for planning to move respondents said they would like a level access house (23%), a smaller house (15%), they are planning for retirement (15%), to get more accessible housing (13%) and to be closer to family/friends (9%).



Analysis by property type revealed that planning for retirement was more of a concern for tenants in non-sheltered housing (26%) than tenants in sheltered housing (13%). More than half of respondents in non-sheltered accommodation (54%) said they would like a smaller house.

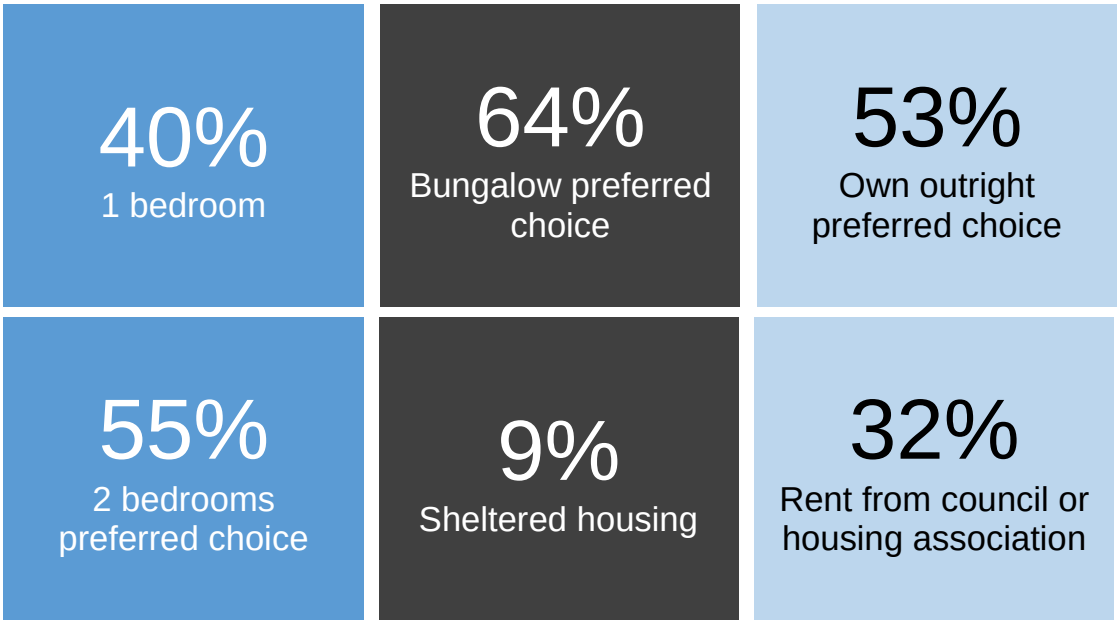
7.5.3 Housing preferences

Respondents were asked what type of property they would most like to move to. Bungalow was chosen as the preferred choice (64%), followed by flat (28%) as the second choice, 30% had no preference. In terms of bedrooms needed after moving, 40% of respondents said they needed one, 55% said they needed two and 4% said they needed three bedrooms.

Analysis by age revealed the majority of respondents aged 75 and over (77%) said they would only need one bedroom. This is in contrast to the majority of respondents aged 55-64 (73%) and 65-74 (68%) who said they would need two bedrooms. However, residents in sheltered housing (63%) were more likely to only need one bedroom than residents in non-sheltered housing (36%).

Necessity of two bedrooms was more of a concern for those living in mainstream housing (59%).

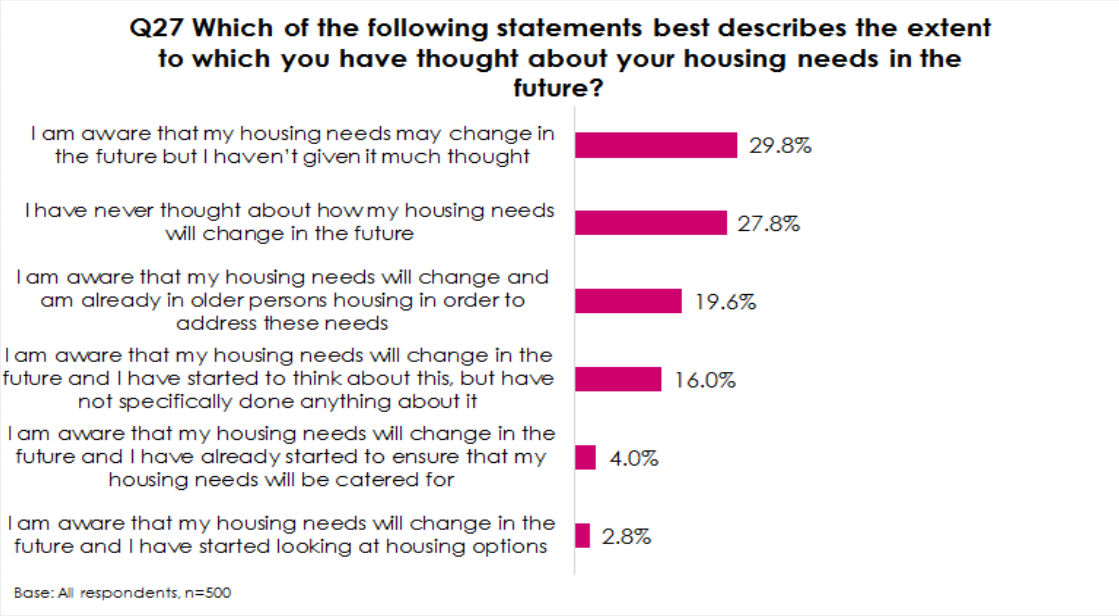
Just over half of respondents (53%) said they would need to own their home outright to move, 32% said they would like to move to a development with a Housing Association or Council and rent, and 15% said they did not know. Respondents aged 75 and over (46%) were more likely to say they would like to move to a development with a Housing Association or Council and rent than those aged 55-64 (33%) and aged 65-74 (21%). Owning outright was more of a concern for individuals aged 65-74 (74%) than those aged 55-64 (47%) and aged 75 and over (31%).



7.5.4 Thinking about housing need in the future

All respondents were asked to what extent have they thought about their housing needs in the future. 3 in 10 respondents said they were aware that their housing needs may change in the future but haven't given it much thought, 28% said they have never thought about how their housing needs will change in the future and one fifth said they are aware their housing needs will change and are already in older persons housing in order to address these needs.

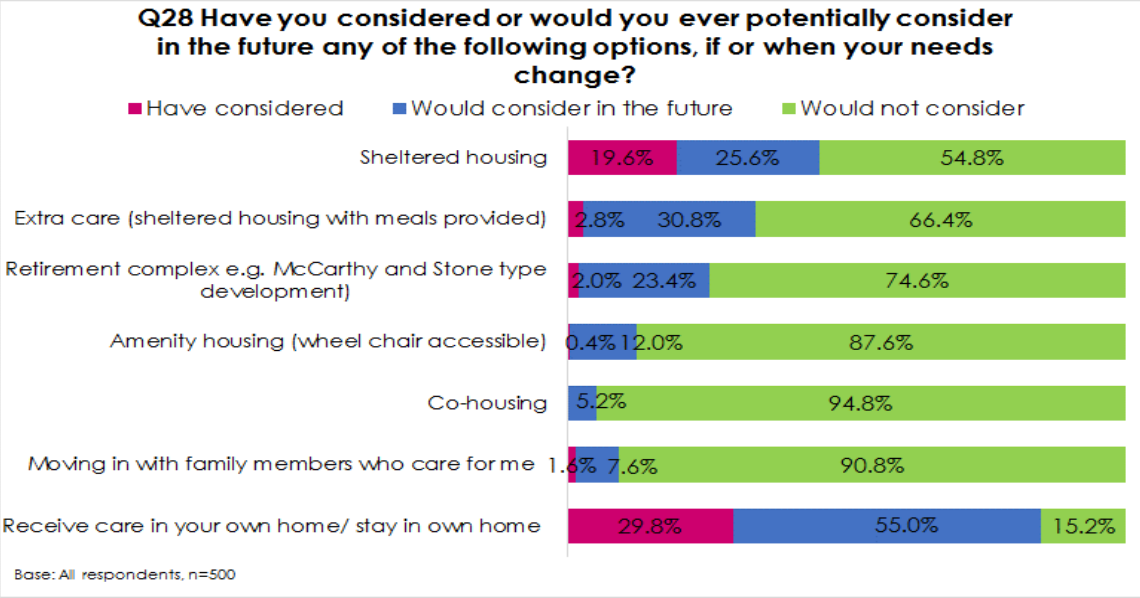
72% of respondents living in mainstream housing said they have either never thought about how their housing needs will change in the future.



Analysis by age revealed respondents aged 55-64 (44%) were most likely to have never thought about how their housing needs will change in the future while individuals aged 75 and over (47%) were most likely to be aware that their housing needs will change and are already in older persons housing in order to address these needs.

7.5.5 Potential options for future housing

The three housing options respondents have or would consider the most to meet future needs include receiving care in their own home (85%), sheltered housing (45%) and sheltered housing with meals provided (34%). The housing options which respondents would consider least are co-housing (5%) and moving in with family members (9%).

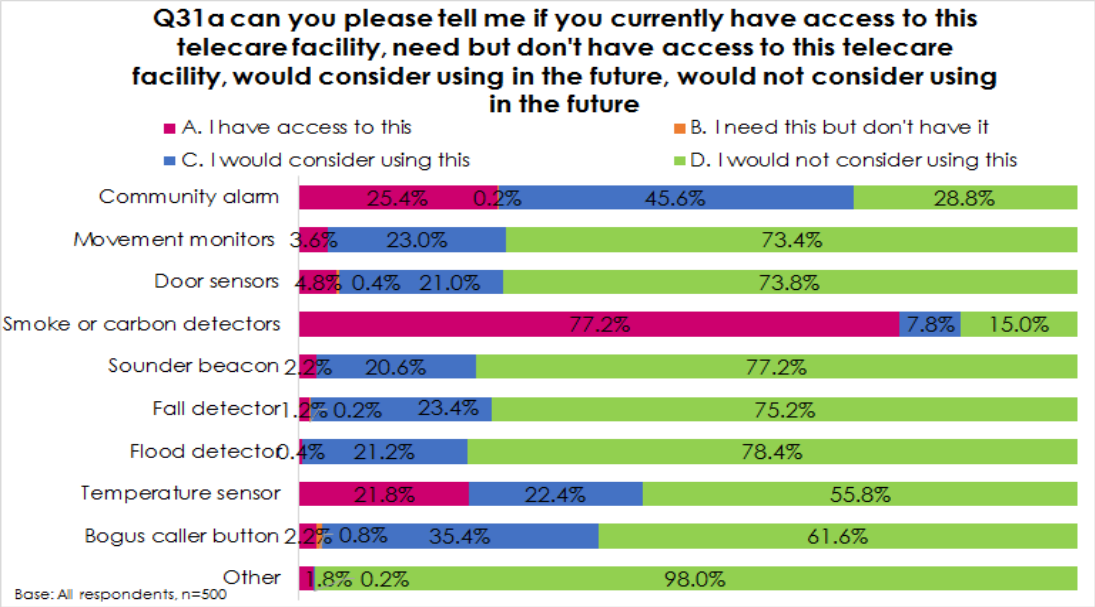


The majority of respondents (73%) said they have no other options, this was followed by those stating they haven't considered other options (14%) and those considering downsizing and more affordable housing (5%). When asked what their preferred option would be in the future if their needs change, respondents said they would like to receive care in their home own (77%), this was followed by sheltered housing (7%).

7.5.6 Telecare

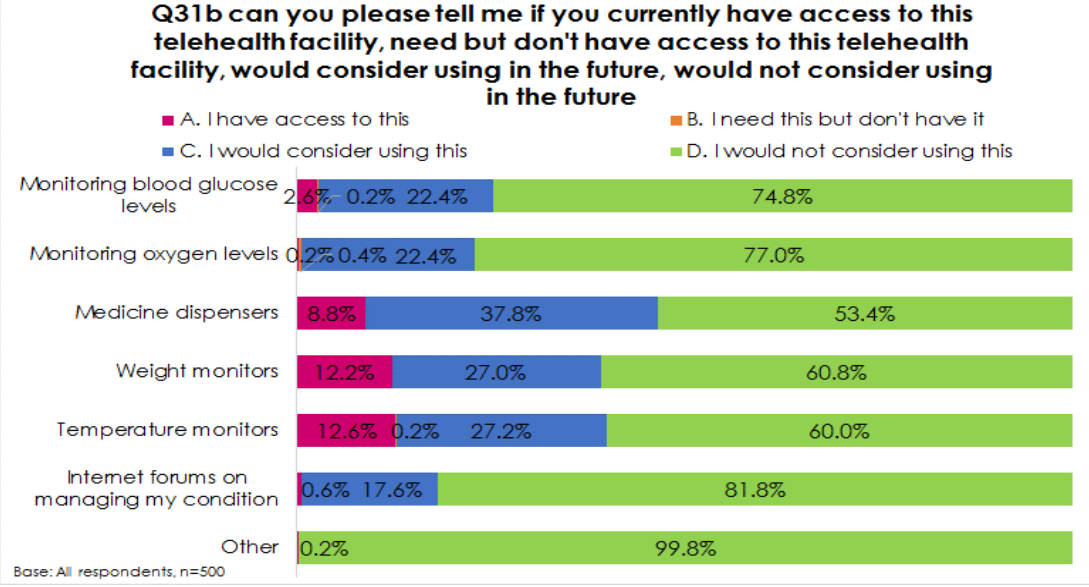
All respondents were asked about their attitudes towards telecare and telehealth facilities. In terms of current access, the majority of respondents (77%) said they have access to smoke and carbon detectors, this was followed by access to a community alarm (25%) and temperature sensors (22%).

In terms of considering using telecare facilities, 46% said they would consider using a community alarm, this was followed by a bogus caller button (35%), fall detectors (23%) and movement sensors (23%). 9 respondents also reported they would use a burglar alarm.



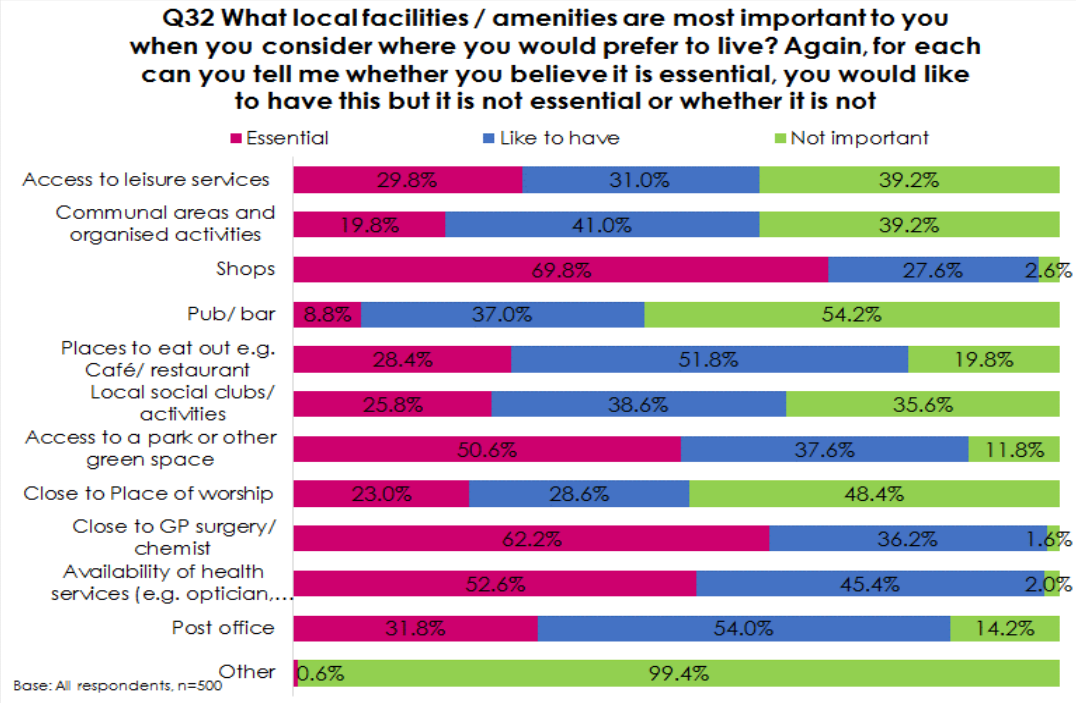
7.5.7 Telehealth

In terms of telehealth facilities, 13% said they have access to temperature monitors, 12% weight monitors and 9% medicine dispensers. The three facilities respondents would most consider using were medicine dispensers (38%), temperature monitors (27%) and weight monitors (27%).



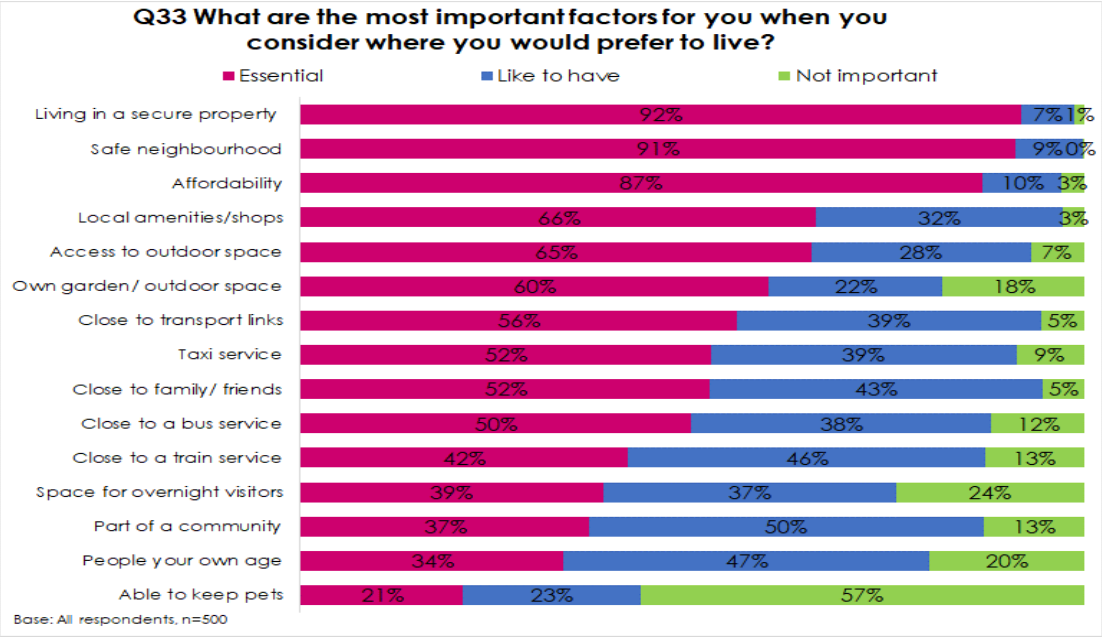
7.5.8 Important facilities/amenities

All respondents were asked what local facilities and amenities were most important when they consider where they would prefer to live. Shops were the most essential amenity (70%) followed by being close to a GP surgery and chemist (62%) and availability of health services (53%).



7.5.9 Important factors considered when considering where to live

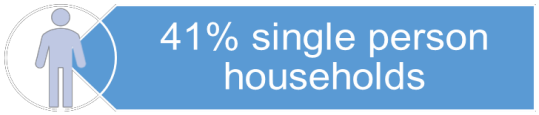
The three most essential factors chosen by respondents when they consider where they would prefer to live were living in a secure property (92%), living in a safe neighbourhood (91%) and affordability (87%). The three factors which respondents would most like to have but do not consider essential were being part of a community (50%), being close to people their own age to socialise with (47%) and being close to a train service (46%).



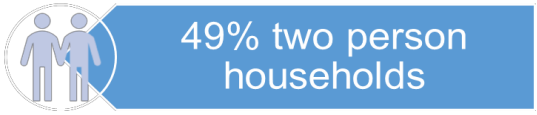
7.6 Households profile

Across the sample of older people interviewed, most households are made up of one adult (41%) followed by two adults both over 60 (49%).

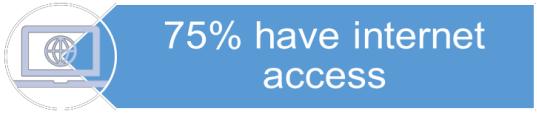
Individuals residing in sheltered housing (79%) were more likely to be the only adult in their household compared to those residing in non-sheltered housing (31%).



In terms of internet access, more than 7 in 10 respondents (73%) said they have broadband internet access at home.



31% said they have internet access through smartphone or other mobile device, 2% said they have access through some other method and 25% said they have no internet access.



Analysis by housing type shows that residents living in mainstream accommodation (84%) are significantly more likely to have internet access than those living in sheltered housing (39%).

Just over half of respondents (51%) said their main source of income is a state and private pension. This was followed by 25% who said their main source of income is earnings from employment, 13% said state pension, 6% said mainly benefits and 2% said earnings from employment and benefits. The majority of respondents (75%) did not provide an answer when asked about their total gross income. Of those who did respond, 70 people said their total gross income was below £25,000 and 52 people said above £25,000.

7.7 Customer Survey: Consultation Outcomes

A total of 500 face to face interviews were undertaken between 1 May and 26 June 2019 with a representative sample of residents of the East Dunbartonshire Council area. 100 of these interviews were undertaken with respondents living in sheltered accommodation and 400 with a representative sample of the wider population who were aged over 55. This delivers a statistical accuracy level pf +/-5% across East Dunbartonshire.

This research offers huge insight into the current circumstances, expectations and aspirations of older people in East Dunbartonshire. It offers EDC and EDHSCP credible evidence of what older people value and what they themselves want and need from housing, care and support services. Headline findings from the survey reveal that:

- 71% of those not living in sheltered housing have lived in their property for 11+ years, in comparison 50% of those in sheltered housing have moved in the last 5 years;
- 68% of those aged 55-74 owned their home outright, and 24% of those aged 55-64 were buying with loan/mortgage;
- All sheltered tenants were asked about how they became tenants, just under half (48%) said this was due to health reasons;
- The vast majority of respondents said they were very or fairly satisfied with their home (95%);
- 41% of survey respondents said that they themselves or anyone else in their households has a long-term illness, health problem or disability. This tended to be either a mobility or physical disability (27%) or a chronic disease (16%);
- The top three services respondents would use at the moment were general cleaning (16%), grass cutting and garden care (11%) and shopping services (10%). The top three services respondents would consider using in the future were the same, with 37% considering general cleaning, 23% considering grass cutting and garden care and 24% considering shopping services;
- The majority of respondents (81%) said their current home is very or fairly easy to afford;

- 43% said they currently spend less than 10% of their weekly budget on rent;
- The majority of respondents (91%) said they do not want or need to move home;
- When asked to give their main reason for planning to move respondents said they would like a level access house (23%), a smaller house (15%), they are planning for retirement (15%), to get more accessible housing (13%) and to be closer to family/friends (9%);
- In terms of bedrooms needed after moving, 40% of respondents said they needed one, 55% said they needed two and 4% said they needed three bedrooms;
- Respondents were asked what type of property they would most like to move to. Bungalow was chosen as the top choice (64%), followed by flat (28%) as the second choice, 30% had no preference;
- Just over half of respondents (53%) said they would need to own their home outright to move;
- The three housing options respondents have or would consider the most are receiving care in their own home (85%), sheltered housing (45%) and sheltered housing with meals provided (34%). The housing options which respondents would consider least are co-housing (5%) and moving in with family members (9%);
- All respondents were asked what local facilities and amenities were most important when they consider where they would prefer to live. Shops were considered to be the most essential amenity (70%) followed by being close to a GP surgery and chemist (62%) and availability of health services (53%); and
- In terms of housing type, individuals residing in sheltered housing (79%) were significantly more likely to be the only adult in their household compared to those residing in non-sheltered housing (31%).

The main issues identified that should inform the future planning, commissioning and delivery of housing, care and support services in East Dunbartonshire are as follows:

The vast majority of older people in East Dunbartonshire have lived in their current home for a long time, live in private housing and are satisfied with their home. They do not want or feel the need to move and describe their homes as affordable (80%).

As well as reporting high housing satisfaction, the majority of older people in East Dunbartonshire are living independently and well. Over 90% describe their homes as not placing any restrictions on their daily life or wellbeing and 70% would not consider themselves to have a need for services that could support independence.

Despite this hugely positive picture, a more concerning survey finding suggests that 72% of older people in East Dunbartonshire have never considered how their needs might change in the future and how they might meet those needs. Furthermore, 20% of older people feel they would not be eligible for any care and support for independent living or wellbeing. When questioned what they would want, that vast majority (85%) stated that their future preference would be to receive care and support at home.

These findings would suggest that older people in East Dunbartonshire anticipate staying put but would benefit significantly from more knowledge, information and advice on the range of preventative support services that would enable them to live independently and well for as long as possible.

There are a notable proportion of older people who have a life limiting condition or disability and there is survey evidence of at least 10% of this group experiencing housing unsuitability issues. Targeting adaptions, care or advice on age-exclusive alternative housing options will increasingly become vital interventions in meeting the needs of this group.

When asked about housing alternatives, older people (whilst wanting to stay at home) stated that they would be receptive to sheltered housing (45%) should this become a necessity. There is also evidence however, that current sheltered provision is rarely an option of choice for older people but is selected for health reasons, family influence or as a result of no alternatives. There is also evidence that current provision creates affordability pressures for some tenants. Reviewing the quality, cost and attractiveness of current

sheltered provision will therefore be an essential future asset management requirement for social landlords in East Dunbartonshire.

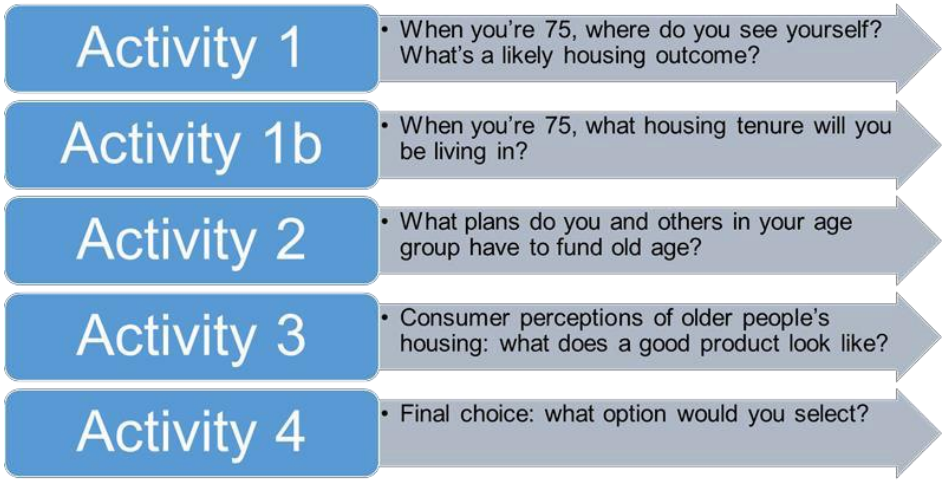
Older people in East Dunbartonshire are also receptive to market options which could meet their needs expressing preferences for bungalows and 2-bedroom homes. Older people value a sense of place and seek housing with connectivity to shops, health services and open, green space. These consumer preferences should influence the decision making of developers seeking to meet the needs of older people in East Dunbartonshire.

8 Engaging the next Generation of Older People in East Dunbartonshire: Interactive Workshops

A further aspect of the research methodology was to engage with people in East Dunbartonshire aged 45 to 60, to develop a picture of what the next generation of older people might want or need from future housing, care and support services in the future. Interactive workshop sessions were used as a basis to explore the housing expectations and aspirations of the next generation of older people in East Dunbartonshire by examining key issues including:

- Assessing how supporting others has shaped personal expectations of future housing and care wants and needs;
- Assessing level of realism regarding personal vision for future housing and care provision;
- Enquiring about future financial planning and how participants are arranging to fund older age; considering affordability, and views about wealth, housing equity and equity release;
- Developing a picture of what services may be required to support independent living and meet lifestyle aspirations and expectations;
- Considering preferences in relation to housing types, design, amenity and size and the extent to which moving from current home is essential, desirable or a potential;
- Considering the balance between remaining at home with support and moving for a more specialist service; and
- Assessing tenure aspirations and whether this shifts with increasing age.

To achieve this, Arneil Johnston undertook two interactive workshops with staff from East Dunbartonshire Council (EDC) and East Dunbartonshire Health and Social Care Partnership (EDHSCP) who were aged between 45-60. Each workshop focused on the following activities:

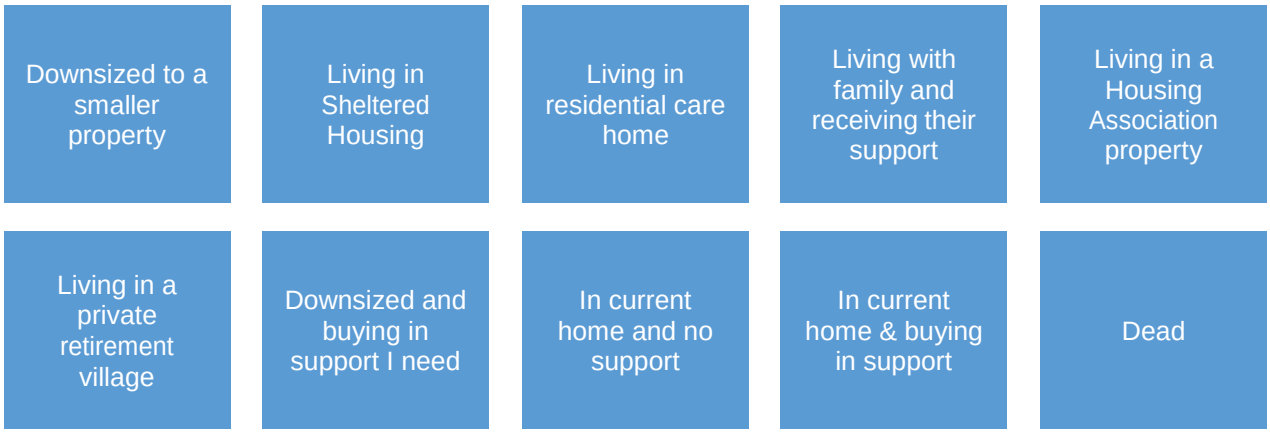


The outcomes of the workshops are detailed in the following Chapter.

8.1 What is a likely housing outcome for me?

In this first activity, participants were asked to envisage where they see themselves in terms their housing and care circumstances when they were 75. To inform this exercise, Arneil Johnston provided some context around current care and housing statistics both at a national level and from the Older People survey exercise; which illustrated that older people tend to move into a care setting at a much older age and then only stay there for a relatively short period of time.

Participants were then asked to discuss the following housing circumstances both in terms of the housing options that would be the 'most likely outcome' for them aged 75 and the housing outcome that would be their 'preferred outcome' :



The majority of participants suggested that they would most likely stay put in their current home with no support or would downsize to a smaller property without support. Social and family networks were recognised as being important and would have a bearing on whether staying put in their current home would be an option.

The emotional attachment to home was also highlighted as a key issue in the decision to move. Participants suggested that 75 can still be relatively young and many people's needs might not have drastically changed at that stage necessitating a new housing solution. They mentioned that people who are 60+ today are generally healthier and fitter than people who were 60+ a few generations ago.

> "My mum gets some support, but my dad doesn't. They have been able to remain in their home as they have neighbours and family close by. They have good access to doctors, pharmacies and clinics, so for me it's not about what the housing looks like, it's about people being able to access what they need."

However, participants also recognised that their plans might change as their or their family's circumstances change. Therefore, plans made as a couple may not be the decision if no longer part of a couple. It could also depend on what family members' needs are and house swapping might be an option to allow children to move into/return to the bigger family home and for them to downsize. Unanimously, participants identified the residential care home as their least likely housing option, reflective of the customer survey results.

> "Most people who are 75 aren't in care homes. I'm just three years away and I don't see that being a reality."

> "We bought our house as a retirement plan with the view of selling and downsizing in the future but that might get fast tracked if – god forbid, your other half is no longer there."

8.2 Activity 2: What housing tenure will I be living in?

Participants were asked what tenure they would like to live in and what tenure they expect to live in when they are 75, from the following options:

- Living in a property I own outright
- Living in a property I have a mortgage on
- Living in private rented property
- Living in a Housing Association property support
- Living with and being looked after by my family
- Living in specialist housing for older people

By far the greatest number in the group expected to and would like to live in a property they own outright which was reflected of the current tenure status of the majority of the participants (who were owner occupiers). However, for one participant who currently rented in the private sector, they highlighted a preference to move to the social rented sector expressing concerns about the long-term affordability of the private rented sector. They highlighted that this might be a greater concern moving forward for 'generation rent' and the increasing numbers of households living in the private rented sector.

> "If my landlord served me a Notice to Quit, I'd have to go to the council and would only get one offer of housing for anywhere in East Dunbartonshire which is no good for an older person. I've been offered two sheltered housing properties but I'm not ready to move to sheltered housing yet."

Participants were also asked to consider what factors would most and least likely influence the tenure options they would consider in future decision making about housing and to rank these as most and least important (see below).

Focus Group 1	Focus Group 2
What I can afford	What I can afford
The right location – connected to my family and wider network	The right location – connected to my family and wider network
The right location – connected to local amenities	The right location – connected to local amenities
Desire to remain in my current home	Desire to remain in my current home
Being in a community of older people (avoiding isolation)	The right size property for older age
The desire to own my own home	The desire to own my own home
The right size property for older age	Being in a community of older people (avoiding isolation)

Participants were mindful that their health situation will have the biggest bearing on their housing and care needs, and therefore would then be the greatest factor in determining future housing options, even before affordability. However, affordable alternatives for homeowners was highlighted as an important factor as people might want to move but the cost of properties that might be suitable would mean people are actually worse off in their older age.

> "That's the issue for us, I would like to move to more suitable housing as we have stairs but there is nothing available at the same value as my house. I don't have a lump sum so I'd be worse off financially especially with the cost of moving added in."

Location was also considered as a key factor, with both groups recognising that they may want to stay put in their current community with access to their existing support networks, but not necessarily in their current home. Support to move was also considered as it was recognised that moving is such a big upheaval and can be expensive and daunting for older people.

> "That's the issue with people in Lenzie at the moment, people in there late 80s living in big houses that aren't suitable but they don't want to move out of Lenzie and there is nothing else that suits their needs there."

> "People don't move and then something happens and they can't move. So care homes become more of a reality as their house is no longer suitable."

8.3 Activity 3: What plans are you making to fund your old age?

Participants discussed their plans to fund their old age with the majority having either clear plans or a rough idea of how they would meet housing and living costs.

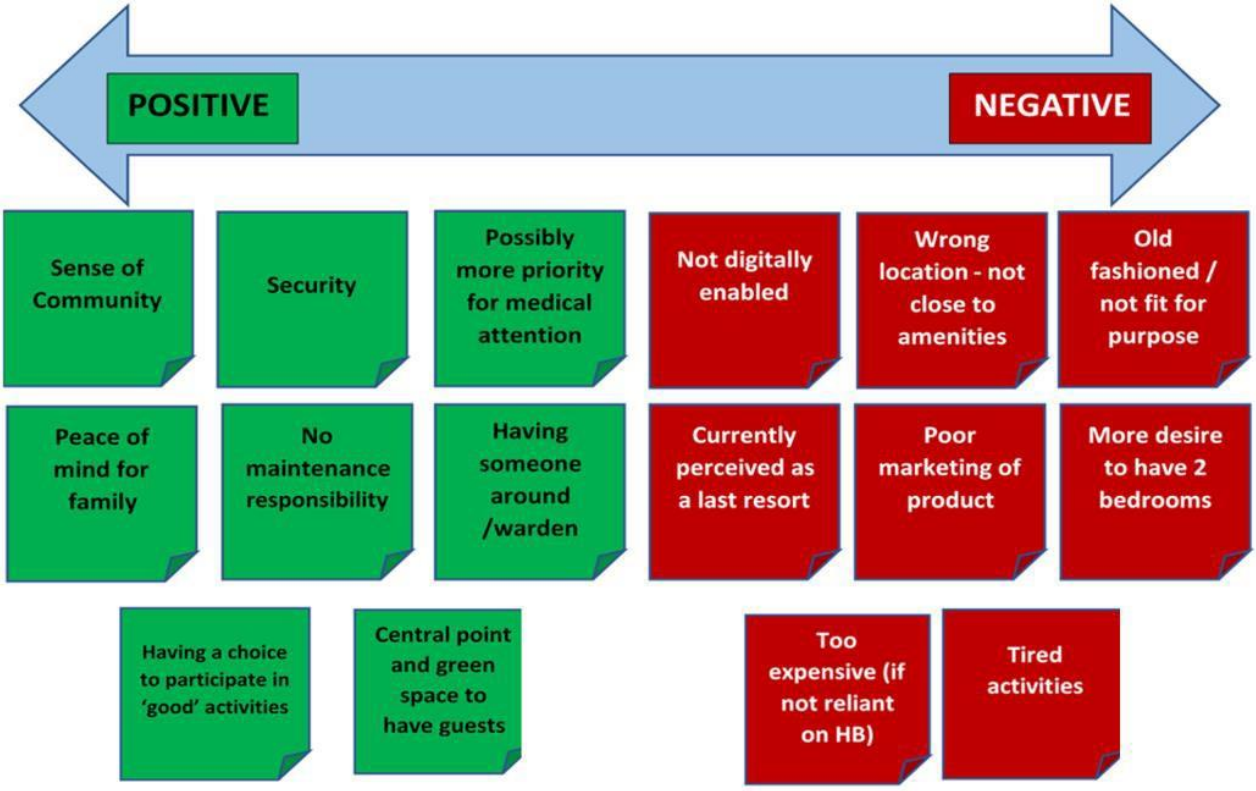
However, this outcome was probably reflective of the group all being made up of public servants and having access to affordable workplace pension schemes with good benefits. The majority of participants were planning to work past 'normal' retirement age and augment their pension provision. A small number of participants also had inheritance or savings that they could use.

"I started work at 18 in the public sector and I was made to put money into the pension, so I've had pension provision since then."

"I don't want to work into my retirement but I have to."

8.4 Activity 4: What should future housing for older people offer as a minimum?

Arneil Johnston facilitators asked participants about today's specialist housing provision for older people; what are the positive characteristics that would be a reason for using this and should therefore be retained in any future provision being planned or commissioned. Participants were also asked what the perceived negative characteristics of current older people housing are that should be addressed in any redesign or new developments.



Participants noted the following comments regarding current sheltered housing provision in East Dunbartonshire:

- *"The ones in East Dunbartonshire are all old"*
- *"There's one in Bishopbriggs next to the garden centre, it's up all the hills with nothing else round about it"*
- *"A lot of them are disassociated with local services"*
- *"Transport connections in East Dunbartonshire aren't particularly good so it's difficult to get to the places you need to"*
- *"That one in Bishopbriggs is £577 a month including services - that's not affordable"*
- *"Some of the older properties are teeny tiny"*
- *"The ones at Whitehill Close are hopeless, they're horrible"*

8.5 Activity 5: What kind of future are you looking for?

Participants discussed what their preferred housing options would be and what good would look like in terms of future housing solutions.

House type and design was viewed as an important factor to enable participants to live independently, and they recognised that flatted accommodation as well as bungalows could provide this. They highlighted the importance of flexible housing that could adapt to meet people's needs as their circumstances and health changes. They also highlighted the importance of technology enabled properties and having devices that are smart and not just for older people.

"Could make it social policy that all houses are futureproofed so it's not housing for older people it's housing for all people"

"Having broadband is a basic human right!"

There was no real desire to have onsite leisure facilities, in fact participants highlighted that this can add to the overall cost of housing and would therefore impact on affordability.

However, the location of appropriate housing and being close to existing facilities or having good transport links to enable access to amenities, were highlighted as key factors. Similarly, there is no real desire to have onsite care as this can be an added cost but knowing that care and support can be brought in if and when needed was reassuring.

8.6 Focus Groups Outcomes

The two staff focus groups were used to augment the face to face surveys and to provide qualitative information to support this study focusing on emerging and future housing, care and support needs of older people. The groups were mainly made up of owner occupiers and all were public service workers with access to affordable workplace pensions, which undoubtedly influenced the outcomes.

The key findings from the focus group discussion suggest:

- People expect to remain in their current home or will downsize but both options without support;
- There was consensus that residential care was the least likely housing option for them;
- There is recognition that while support is not expected or wanted, their health would ultimately be the determining factor for their housing needs;

- Key to remaining at home/staying put was the availability of social networks;
- The emotional attachment people have to their home should not be underestimated and may lead to resistance to accept other housing options;
- Allocation policies should consider the specific needs of older people in terms of location and connection to social networks which may reduce the demand on formal care arrangements;
- Affordability was a key consideration influencing tenure options with many ranking onsite amenities and care as low priority due to the increased costs. A lack of affordable alternatives for people in East Dunbartonshire was recognised with owner occupiers having a sense of having to stay put as there is no lower cost housing provision available and added to this the cost and hassle of moving;
- The desire to be close to or connected to services and amenities featured strong and more important than the type of housing, therefore future housing developments should place location as a key consideration;
- House type and design is an important factor to enable participants to live independently and housing design should be flexible to enable it to adapt to meet changing needs;
- All had workplace or private pensions to augment their state pensions however most expected to work past 'normal' retirement age but would prefer part time to full time work;
- Sheltered housing provision in East Dunbartonshire was viewed as particularly tired and unattractive. It was recognised there could be real benefits of sheltered housing if the product was modernised and marketed better. The added support costs drive up the costs and may not be needed at the point of entry so could deter people from choosing this option earlier if there's no flexibility with the additional support costs;
- Have tech enabled housing/devices was seen a basic requirement for specialist older people housing or indeed housing for all people regardless of age.

The main issues identified that should inform the future planning, commissioning and delivery of housing, care and support services in East Dunbartonshire are as follows:

Like the current generation of older people in East Dunbartonshire, the expectation of the next generation is that they will be able to 'stay put' in their current home and without care or support to enable independent living.

Despite this, the next generation are realistic. They see health as being the greatest determining factor in meeting future housing needs and recognise that options and choices will reflect this. It will be important that the emerging group of 'Third Agers' are proactively encouraged to become informed of the range of housing, care and support options available should their circumstances change. Encouraging informed pre-planning by proactively offering information and advice could become an important aspect of the East Dunbartonshire strategy to meet the housing, care and support needs of older people in the future. Given the importance of older people as a public policy issue on the Council, HSCP and Community Planning agenda, a coordinated effort to improve public consciousness of this issue is likely to be an important intervention in the longer term as preventative strategy to meet need.

Accessing affordable options to enable households to right-size using existing property capital, is seen as a key aspect of meeting the needs of the next generation of older people in East Dunbartonshire. This should become a priority in the planning and commissioning of future housing provision.

Technology enabled care and infrastructure is an expectation of the next generation of older people in East Dunbartonshire. Furthermore, a transformation of current sheltered provision will be required to meet the aspirations and expectations of future consumers in East Dunbartonshire.

9 Interviewing the Experts: Planners, Commissioners and Developers

The final aspect of the research methodology involved interviewing expert stakeholders to understand the challenges, opportunities and market issues that need to be considered in meeting the housing, care and support needs of older people in East Dunbartonshire. To achieve this, Arneil Johnston undertook a programme of interviews with expert stakeholders during Autumn 2019. This took the form of semi-structured telephone interviews and face to face interviews involving Public and Private housing providers, East Dunbartonshire Council, East Dunbartonshire HSCP, social housing and private housing developers.

The interviews were designed to ensure opportunities to engage in the consultation process were maximised. The interview was used as a basis to explore the challenges organisations face, views on what will be wanted/needed in the near future, views on current partnership structures and current strengths and weaknesses of the housing, care and support model.

Appendix 3 provides a full report of the Stakeholder interview programme.

9.1 Housing Association Developers and Providers

East Dunbartonshire is a highly competitive market that attracts strong land values across sites of all scales and locations. The market in the prime areas (Bearsden, Milngavie and Lenzie etc.) is generally dominated by medium scale housebuilders operating at the upper and luxury end of the market, (dominated by Cala and Robertson Homes and recently Miller Homes, Stewart Milne and Mactaggart and Mickel).

High values impact on the ability of affordable housing providers to access opportunities given the parameters on cost, driven by grant subsidy levels and private finance thresholds across the sector. Housing for older people is likely to include additional cost associated with (for example) lifts, wider corridors, common spaces (common rooms, scooter stores etc.). This places further pressure on costs for RSL developers of age-exclusive housing.

> "Access to land in East Dunbartonshire is often through partnership work with the private sector… in the absence of clearly defined policy on housing for older people to link Section 75 agreements, the ability to provide for this group's needs is somewhat hampered"

> "Our future new build plans need to have high levels of connectivity not just in terms of technology but also on a human level. They aim to see neighbourhoods designed for independent living and suitable, as people progressively get older"

There is a need to focus on independent living no matter who the client group is. Housing providers need to focus more on finding out what helps make people live more independently and then try to build this into their asset management strategy going forward e.g. mainstreaming adaptations into their stock maintenance plan.

When thinking about the production of Local Development Plans (LDP), stakeholders felt that specific targets can help deliver specialist types of housing but we need to be clearer about defining older people and the types and categories of provision that should be developed e.g. Angus Council had targets for age-exclusive provision but delivery is proving more challenging than expected due to lack of definitions on the form of housing to be developed.

There is a need to ensure housing for older people is in the right location, with access to the appropriate range of services. The most appropriate sites for housing for older people will be in highly accessible areas; well served by public transport, amenity, services, healthcare and retail provision. These sites are likely to be amongst the most attractive to the private house building market and attract very strong land values. As a

result, stakeholders suggested that the Local Development Plan could identify appropriate sites for older people's housing or a set of criteria which they would be required to meet. It was acknowledged however that targets may lead to inappropriate development being pushed through.

"Ideally for older persons housing we want sites to be at the centre of town to be close to all transport and hub facilities, but this might contradict Planning requirements when trying to designate sites"

"There is no distinction in planning terms within the residential use class. Planning, Housing and Health and Social Care policies should align to set out what is anticipated and guide the standards and requirements that are expected"

New Build Housing is more adaptable now and better able to future proof as people become older. Specialist housing with support may be necessary but budgets are being squeezed and very little housing of this type being developed by any of the new players in the East Dunbartonshire market. Discussions are limited between social housing providers and the East Dunbartonshire HSCP despite positive overtures in the Housing Contribution Statement.

Where good social housing providers/local authority forums exist, they should be able to work out ways of meeting identified need. However, social housing providers will always try to introduce a reasonable mix of housing provision within their developments.

9.2 East Dunbartonshire Council/HSCP

While there are gains in joining up some aspects of services, there are sections of health teams who are not familiar with the role that housing plays and can play. Many have no idea what housing assets are out there and available within their geographical area. There are still organisational barriers; cultural, funding barriers and communication barriers (especially for older people with complex needs who fall between services). Whilst there is an organisational commitment for change at a strategic level, in the main there are still budget silos with adaptations being the exception to this. It remains difficult to gain funding for 'prevention' type projects. There is a perception that 'Housing' is still not fully involved and dealing with crisis is taking over HSCP priorities.

It is still an ongoing challenge to spread the word about the potential housing contribution to health and social care intended outcomes. There are frustrations evident among some providers who feel they have solutions to delayed discharge cases, yet Partnerships are not taking these opportunities or do not recognise the important contribution that housing providers can offer.

There are a number of challenges faced in commissioning housing, support and care services for older people. Dealing with complex needs cases are difficult and a more collaborative approach is needed. There is still a lack of understanding at times of roles and responsibilities across services. The redesign of sheltered housing provision and support has meant in some instances an impact on sheltered housing officers and home support services. The availability of Capital and the ability of 'partnership' to draw on that is a challenge.

It is felt that housing providers have shown great flexibility in meeting current resource challenges e.g. in re-provisioning sheltered housing. Stakeholders suggest that there has been good work recently in building pathways for housing access into health and social work services. However, the pressure on providers is huge. The Third Sector used to have reserves to draw upon, but this is largely gone, and some are struggling to stay afloat. Now they are much more dependent on the commissioning from the statutory sector.

Some providers recognise that they need to do more with technology and also provide accommodation that can cope with motorised scooters. Properties in some cases need to be fully Wi-Fi enabled. Technology Enabled Care (TEC) is in its development stages at present. In the future EDHSCP should be in a better position to help older people self-manage with the help of greater TEC.

9.3 Private Housing Developers

The private developers interviewed indicated that they are certainly interested in providing more housing for sale which is suitable for older people. There is a gap in the market now vacated by McCarthy and Stone who may have created problems for themselves by purchasing sites that were not suitable for older persons provision and then wondered why they were not selling.

Homes for Scotland (Trade body to a number of Housing Developers) see a steady increase in awareness of age-exclusive housing options. They see their members beginning to re-evaluate their forward plans given the exit of McCarthy and Stone from the market. The Lifetime Homes standard already features prominently in new housing developments and many new homes already have good accessibility but perhaps developers could do more to advertise the fact. They also feel that many members would be responsive to any clients request for adaptations prior to moving in.

The challenge for private developers (as with RSL developers) is the availability and suitability of sites which are accessible to shops, transport and amenities. Homes for Scotland are supportive of consideration being given to targets for age-exclusive housing being set within Local Development Plans however, they feel that there must be clear transparency in setting targets i.e. developers would need to see evidence of market demand supporting any such targets.

> "To promote long-term settlement health while meeting the needs of an increasing and ageing population, new housing development must ensure the provision of affordable mid-market homes"

> "The solution is to release more sites for housing allocations to enable and facilitate the delivery of new homes. The strategy should be to focus on the delivery of smaller family housing, housing for down sizers and sites that can contribute to the present issues with affordability in the settlement"

Stakeholders expressed no resistance to local development plan targets, but developers highlighted the need for a specific design brief to ensure a level playing field with other builders and also to ensure the correct product is delivered for an ageing population. Private developers suggested that whilst they may not offer an age exclusive product, they will be giving greater consideration to future proofing homes better.

Developers see the Private Retirement Sector as a "huge growing market" especially in East Dunbartonshire where elderly owners are sitting on significant equity value in their homes. Homes for Scotland see a sizable increase in this market and indicate that we may see a greater mix across developments in the future ("there is bound to be more inter-generational housing and age friendly housing") and more homes that cater from youngest to oldest in the ageing population.

9.4 Expert Interview Outcomes

Arneil Johnston undertook a programme of interviews with expert stakeholders during Autumn 2019 to explore the challenges faced by planners, commissioners and developer; to identify views on what will be wanted/needed in housing, care and support provision and to assess current partnership and planning structures.

Stakeholders revealed that the policy and delivery context that impacts on the housing options and opportunities to meet the needs of an ageing population; is complex and changing. In their role as housing authorities, planning authorities, and health and care authorities, EDC and EDHSCP are seen as at the heart of solutions, and should be enabled with the tools, resources and certainty to realise their ambitions for people and places.

The main issues identified that should inform the future planning, commissioning and delivery of housing, care and support services in East Dunbartonshire are as follows:

It is important to create a planning framework and system that is appropriately supportive of developing a range of housing offers suitable for an ageing population.

High land values in East Dunbartonshire are impacting on the ability of both RSL and private developers to deliver lifetime or age exclusive housing options given the additional costs associated with this model. The Local Development Plan should consider inclusion of a clearly defined policy on older people's housing potentially linked to Section 75 agreements.

Setting targets for age exclusive provision with clear planning guidelines, standards and prototypes should be considered in the LDP. Specific design briefs and transparency around target assumptions should be included to aid delivery and encourage a level playing field for developers. Developers see the Private Retirement Sector as a "huge growing market" in East Dunbartonshire where older owners are sitting on significant equity value in their homes.

Age Friendly neighbourhood principles should be built into planning policies, integrating age friendly housing as part of healthy, inclusive mixed tenure housing developments.

Age exclusive housing which is 'care ready' should also be encouraged in local planning policy but is incumbent on the development of a partnership, funding and commissioning framework across EDC, RSLs and the EDHSCP. Building such partnerships will help to address the organisational, cultural, funding and communication barriers that persist across housing, health and social care partners. A partnership approach will also assist health services and professionals to appreciate the role that housing partners can play in meeting the needs of older people and enabling preventative activity.

Technology Enabled Care (TEC) is in its development stages at present. In the future EDC and EDHSCP should prioritise technology-based solutions to help older people self-manage with the help of greater TEC.

10 Conclusions and Recommendations

The unique partnership study commissioned by EDC (Housing and Land Use Planning Services) and EDHSCP, brings together public services, residents and stakeholders from the East Dunbartonshire operating area to identify how best housing, care and support models for older people can be planned, funded, delivered, made accessible and sustainable now and into the future.

East Dunbartonshire already benefits from higher life expectancy than the rest of Scotland but the proportion of people of pensionable age and over is predicted to grow by over 21% by 2036. An even higher growth is expected for the 75+ where the proportion is expected to increase by over 63% by 2036[50]. A rapid movement from 'Third Age' into a frail cohort is therefore on the horizon for planners, commissioners and service providers in the next 15 years.

The ageing population has already resulted in increased demand for health and social care services locally which, set against a backdrop of continued fiscal constraints, has led to significant pressures on delivery. Analysis from the customer survey highlights that the percentage of households with a health condition/disability increases to 67% for the age range 75+, up from 20% from the 50-64 age range.

With the expected surge in this particular demographic, EDC and EDHSCP have already recognised the need to critically examine how the needs of older people can be met and commissioned this research project to provide recommendations on the policy, practice, planning and delivery interventions they can collectively programme to meet the housing, health and support needs of older people in East Dunbartonshire. Specifically, recommendations should seek to answer the following two questions:

1. **How do we meet the needs of older people in mainstream housing?**
2. **How do we meet the needs of older people in age exclusive housing?**

Drawing on analysis of the East Dunbartonshire demographic context, a comprehensive literature and best practice review, a detailed evaluation of age exclusive housing options, and the direct input from 500 older people surveyed, two focus groups and stakeholder consultation; we will attempt to respond to these questions in this final chapter.

10.1 Meeting the needs of older people in mainstream housing

When it comes to planning for people's housing needs as they age, it is very important to ensure that sufficient energy is devoted to enabling people to 'stay put' in their current or other mainstream homes for as long as is practicable, because this accords with the preferences of the majority of older people in East Dunbartonshire as well as the latest thinking on ageing in the right place. Housing and housing-related services provide a relatively inexpensive and cost-effective way of enabling older people to live independently and well at home when compared with residential provision or hospital admission. Results from both the customer survey and focus groups highlight this is what older people in East Dunbartonshire want with the vast majority (95%) having no plans to move at all. However, it was widely acknowledged that the majority had never thought about their future housing needs even although they were aware that their needs might change.

As the national public policy and the latest thinking on defining age confirms, it is important for older people to be thinking about their housing needs in a proactive and informed way. Consideration needs to be given at a community planning level, how residents of East Dunbartonshire can be encouraged to plan for their housing future in the same way that they plan pensions for later life. This should be seen as a positive part of growing older and a helpful strategy to avoid decisions being made at a crisis point. This recommendation reinforces the latest thinking on 'Third Agers' and a need to proactively plan for future, care and support preferences. This strategy could well assist with the prevention agenda and dramatically improve the outcomes of the growing population of older people on the horizon. Suggestions on nudging public consciousness and activity in this area could include:

[50] NRS population projections, 2016 based

- A multi-agency promotional public awareness campaign and the development of pre-planning materials by EDC and EDHSCP;
- Regular articles in corporate Council newsletters and publications;
- Articles in tenants' newsletters;
- Community Council briefings and support to encourage uptake and engagement with pre-planning services;
- Third sector engagement in promoting pre-planning messages and services;
- Public awareness materials with Council tax billing (particularly in relation to downsizing options);
- Discussion at existing networks/forums/lunch clubs/walking groups/etc;
- Promotion at key locations - e.g. GP surgeries, dentists, gyms, churches, community centres etc; and
- HCSP/EDC staff awareness raising to assist residents with preplanning.

Further interventions to meet need in mainstream housing include investment in and public awareness raising of:

- Telecare and telehealth;
- Adaptations;
- Carer support;
- Downsizer/rightsizer models; and
- Homecare support.

10.1.1 Telecare and telehealth

The national Telehealth and Telecare delivery plan aims to increase provision and improve access to these services to help address the challenges presented with an ageing population. EDC sits well below the Scottish average in terms of telecare provision and has seen a decrease in the number of telecare packages provided by 44% between 2011 and 2017.

Consideration should be given to the following recommended actions:

- Assess the barriers to take up;
- Set and monitor targets for telecare/telehealth take up levels at a strategic partnership level;
- Review the impact of charging policies;
- Market the eligibility and benefits to EDC residents;
- Work with national partners to integrate this service into existing smart devices;
- Consider how predictive technology and Internet of Things capabilities can be incorporated into new build design briefs and in adaptations solutions; and
- Consider how carers can be supported through technology.

10.1.2 Adaptations

Housing adaptations make a vital contribution to supporting older people and disabled people to live safely, comfortably and independently at home and are one way that can make 'staying put' an option for older people should their needs change. EDC already has a range of mechanisms through which it provides adaptations through the Care and Repair scheme, adaptations to Council tenanted homes and Scheme of Assistance for private owners/renters. RSLs also provide adaptations to their tenants through funding from the Scottish Government. Estimates suggest that the number of older people requiring an adaptation may

increase by 60% between 2008 and 2033[51]. Research evidence identifies that 7% of older people in East Dunbartonshire with a life limiting condition or disability have an unmet need for housing adaptations.

Presently adaptations (or grants for adaptations) are provided on the recommendation of an occupational therapist assessment so this is a reactive rather than preventative service. This does not allow residents to prepare for changing needs and can often be a delay contributing factor to longer stay in hospital.

Consideration should be given to the following recommended actions:

- Assess the adequacy of all adaptation budgets including RSLs, EDC HRA, EDC general fund, health, scheme of assistance etc; compare historic spend levels to budget and assess whether resources need to be augmented and/or budget contributions proportionate and fair;
- Review adaptations waiting list time for EDC and partner RSLs;
- Consider adaptations policy and assess the feasibility and benefits of a preventative offering in addition to current arrangements;
- Review how a housing options model of information and advice could operate for older people in the East Dunbartonshire area;
- Consider how housing health check advice is made available to tenants of social landlords and private owners/renters;
- Consider how the HCSP can harness the recommendations and practice examples of the Adapting for Change project undertaken by the iHub (https://ihub.scot/improvement-programmes/place-home-and-housing/adapting-for-change/;
- Promote the availability and eligibility of the current arrangements (Care and Repair etc) particularly in relation to homeowners/private renters; and
- Review housing allocation policies to ensure they maximise opportunities to move to more suitable housing and if possible, at an earlier stage/age.

10.1.3 Carer Support

Carers provide an important role in the provision of care and support in the community and enable friends and family to remain in their own home and community. From the 2011 census data 11,374 individuals identified themselves as unpaid carers with 22% of them being aged 65+. Unpaid carers reduce the demand on formal care provision but the strain of caring can negatively impact on their own health and wellbeing. The introduction of self-directed support (SDS) offers more control and choice for people and can be used to assist carers financially.

Whilst survey and focus groups evidence suggest that there is no desire from older people to move in with family, social networks and informal support feature high in what would influence perceptions of positive housing outcomes.

To promote support to carers consideration should be given to:

- Reviewing take up levels of SDS and assessing if more could be done to promote payments to support carers;
- Review respite provision to support carers;
- Review housing allocation policies to maximise opportunities for households to move nearer to their support/family network; and
- Ensure age friendly neighbourhood principles are incorporated into planning policies, integrating age friendly housing as part of healthy, inclusive mixed tenure housing developments.

[51] The role of home adaptations in improving later life, Centre for Ageing Better/BRE/University of the West of England (November 2017)

10.1.4 Downsizer/Rightsizer Model

Homeownership is by far the largest sector in East Dunbartonshire accounting for over 80% of the housing stock. Dwelling types are more likely to be houses (79%) rather than flats (21%) and properties tend to be larger than that typical of Scotland with 71% having 4+ rooms compared to 56% nationally. With population dependency ratio projected to increase to 84% by 2037, options are undoubtedly needed to encourage older people out of under-occupied homes freeing up larger family homes for 'working age' households to move into.

Results from the older people survey noted that the vast majority of respondents would prefer to remain in their current home (91%). Of those who did state that they want or need to move home (9%) when asked about housing alternatives, 35% said they would be receptive to more accessible or smaller housing[52].

Discussion at the focus groups centered around the lack of local options to downsize into as a result of the limited availability of smaller and accessible properties in the locations older people wish to remain in. This concurs with The University of Sheffield's report that concluded that many households would be keen to downsize IF there were attractive options available in the right locations. The right-sizer model outlined in this research should be given serious consideration as part of any design guidelines associated with an LDP policy on older people's housing.

To promote the availability of downsizer and right sizer options consideration should be given to:

- Whether a downsizer/ rightsizer approach might form part of the EDHSCP strategy;
- What proportion of housing for older people is/should be included in the affordable housing supply programme and other tenure developments;
- How the next Local Development Plan can provide opportunity to allocate land and set policies to address the needs of older people;
- Partnership models with private developers and RSLs to develop more affordable retirement housing to offer different housing choices and tenure options including mid-market options;
- Promote the existence of the priority given to under occupying tenants and support available for tenants to assist with moving;
- Consider financial and non-financial support that could make moving less daunting and expensive for older people who could be encouraged to move;
- Promote the potential benefits of downsizing i.e. reduced energy costs; releasing equity; reduced council tax; less maintenance, etc;
- Consider if the Local Development Plan could identify appropriate sites for older people's housing, independent living schemes or a set of criteria/design guidelines which developers would be required to meet;
- Consider locations where there may be an acute lack of downsizer options and set appropriate development targets as part of an older people's housing policy in the LDP; and
- Review progress against Local Housing Strategy outcomes and assess barriers to progress at a partnership level.

10.1.5 Home care

East Dunbartonshire has one of the lowest proportions of over 65s receiving free personal care at home across the Clydeplan SDPA and the numbers in receipt of free personal care are decreasing in line with national trends. Nonetheless 4/10 of the 65+ aged households currently receive greater than 10 hours of care at home suggesting a rise in complexity of need of those who rely on commissioned services. Given the

[52] EDC Older People Survey 2019: Q22a What are the main reasons for planning to move? Main reasons: Smaller home (15%), Level access property (8%), Get more accessible housing (12%)

projected surge in number of the people 75 and over in the next 15 years (>60% by 2036) the demand for home care services is likely to increase significantly.

To stem the demand for home care the following should be considered:

- Review take up levels for SDS and explore barriers to take up;
- Consider if care and support delivery policies can be changed to assess frailty rather than age;
- Consider maximum and minimum thresholds for home care;
- Consider the promotion of privately funded home care options which can step up and down as required; and
- Review how housing, care and support services can collectively contribute to positive delayed discharge performance.

10.2 Meeting the needs of older people in age exclusive housing

Whilst many older people will be able to live healthy, fulfilled, independent lives and the extent of options for people to remain in mainstream housing can perhaps be expanded; there will come a time that support needs for some can no longer be met in a mainstream setting and people will need to move to age exclusive housing. As the elderly population increases, so too will the number of people dealing with long term ill health, disability and age-related conditions. Undoubtedly, new models of housing and care will need to be developed and existing models of delivery reviewed. It is clear that several models have the potential to generate significant public sector savings and if co-produced with older people themselves, will meet their aspirations and deliver better outcomes. The evidence that age exclusive housing (including extra care) can arrest the acceleration of frailty and promote independence and wellbeing should not be overlooked by planners, commissioners and service providers. There are many benefits to age exclusive housing provision and while negatives do exist, perhaps some of these can be addressed through the combined efforts of the three partners.

We need to consider that ageing in place may not always be the right decision for people and as such options to meet age inclusive housing include:

- Sheltered Housing;
- Extra care housing;
- Retirement housing; and
- Co-housing.

10.2.1 Sheltered Housing

This is by far the most common category of specialist housing in East Dunbartonshire accounting for 92% of current specialist provision. The support element of sheltered housing is one of its attractive features however, given the significant reductions in public funding this is often the element that has or is being eroded.

Aside from care at home options, customer survey respondents were more mindful to consider sheltered housing than any other option suggesting that it remains the most widely recognised solution and an attractive option for older people. The focus group participants could also see many benefits of this housing type such as security; a deliberate community, no maintenance responsibilities etc; but many drawbacks were also identified such as not digitally enabled, too small, too expensive, old fashioned or not in the right location. Participants were particularly scathing of the current sheltered housing complexes in East Dunbartonshire. Affordability was a concern for some respondents however studies highlight this is a lower cost option for the taxpayer.

Consideration should be given to the following actions:

- Review the common housing allocation policy to prioritise frailty as well as age so that housing support budgets are targeted to those most in need and therefore aligned to social care priorities;

- Develop joint housing and health needs assessments for older people applying for social housing;
- Test feasibility of the redevelopment/modernisation of EDC and RSL sheltered housing complexes and consider independent living units as an alternative housing option;
- Review funding models at an integrated health, social care and housing level to assess overall value for money options for the taxpayer;
- Test feasibility of rent pooling of service charges to make overall rental costs more affordable;
- Review of transport links/options to outlying sheltered housing provision complexes;
- Introduce technology and digital infrastructure into developments e.g. broadband, telehealth etc;
- Develop new build space standards for sheltered housing in SHIP funded projects and LDP planning policies on older people; and
- Better marketing of benefits of sheltered housing.

10.2.2 Extra Care Housing

Extra care is a step up from sheltered housing with the provision of 24-hour care services and usually the addition of a meals service and leisure facilities. It can be an expensive model of provision especially for self-funders however it can be designed to offer a range of tenure options including renting, ownership and shared ownership. Whilst complex to fund on both a capital and revenue basis, recent Scottish developments in Fife and the Scottish Border demonstrate that viable funding frameworks can be assembled.

The study undertaken by the Extra Care Charitable Trust found that, in particular, this form of age exclusive housing can have a positive impact and delay acceleration in frailty. Respondents from the older people's survey would consider this option before all other housing options such as retirement or amenity complexes.

Consideration should be given to the follow action:

- Commissioning agencies across health, social care and housing should review funding models that allow extra care housing to work on a long-term basis;
- Explore options to make extra care be made 'affordable' for self-funders or part self-funders perhaps through the provision of tenure options to allow equity release for homeowners to buy outright or a share and avoid/reduce basic rental costs;
- Assess how care provision at such complexes be linked to community care provision to avoid duplication or additional resources;
- Assess how existing sheltered housing might be repurposed as extra care housing where demand is falling and as a more cost-effective alternative to care homes; and
- Consider the adoption of HAPPI design principles in local planning guidance particularly in the design of age exclusive options such as extra care provision.

10.2.3 Retirement housing

There is some evidence of demand for retirement housing options in East Dunbartonshire. The 2019 survey results reveal that of those older people who would like or need to move, 25% would consider a retirement complex after sheltered housing (45%) and extra care (34%).

Developers see the Private Retirement Sector as a "huge growing market" especially in East Dunbartonshire where elderly owners are sitting on significant equity value in their homes. Homes for Scotland see a sizable increase in this market and indicate that we may see a greater mix across developments in the future.

Customer survey respondents ranked security of property, safe neighbourhood and affordability as their top three factors when considering where they want to live. Location also featured highly and was a greater consideration for future consumers. Much of the criticism of this type of existing provision was that homes

were remote and only for an older community. With housing and community so intrinsically linked, it will be essential for EDC and EDHSCP partners to think carefully about changing and designing communities that are more age-friendly and intergenerational.

Consideration should be given to the following actions:

- Age exclusive housing could be part of any new development in the same way there is a requirement for affordable housing quotas. The creation of an older people's housing policy in the LDP could be the mechanism for this;
- Better advertising of Lifetime Homes standard for new developments and encourage private developers to proactively market this amenity;
- Develop a housing options approach for older people to recognise retirement housing as an option and align to adaptation policies/services; and
- Explore the potential to decommission existing shelterd housing in pursuit of retirement housing provision.

10.2.4 Co-housing

This is still very much a niche market and older people survey respondents ranked this as a low preference only slightly more attractive than moving in with family members. It also ranked low with focus group participants however they were intrigued on how this might work and did want to know more about this option.

Given the health, financial profile and capacity of the older population in East Dunbartonshire, consideration should be given to the following actions:

- Review the co-housing examples given in more detail to assess if a viable option for East Dunbartonshire that can be a mainstream solution rather than a niche interest;
- Discuss with RSL partners and developers if there is merit in pursuing this as a realistic option in East Dunbartonshire; and
- Introduce a Register of Interest for residents considering this option.

10.3 Best Practice Recommendations

Aside from the framework of specific recommendations, which offer options on how best to meet the housing, care and support needs of older people in (i) mainstream housing and (ii) age exclusive housing; this research report makes a number of best practice recommendations which should influence the planning, commissioning and delivery interventions of partners in the short, medium and long term.

These recommendations arise from research analysis, feedback from older people in East Dunbartonshire and stakeholder opinion. They offer clear principles and innovative ideas to guide future strategy as follows:

- Improvements in life expectancy and health mean that categorising someone as old because they've turned 65 no longer makes sense. East Dunbartonshire Council and HSCP may wish to reflect on its own definition of 'older people' when considering how it applies policy interventions in delivering future housing, care and support services.
- East Dunbartonshire Council and HSCP may wish to reflect on the impact of specialist or age exclusive housing on improving the wellbeing and outcomes of older people who are frail. This might include considering whether access to specialist provision should focus on frailty scoring and less so on age criteria.
- East Dunbartonshire Council and HSCP should challenge this notion of ageing in place as a uniquely positive force in an older person's life and focus instead on ageing in the right place.
- Consideration needs to be given to how a personal outcomes approach can be embedded in future product design and service delivery thereby maximising choice. Activity on how 'Third Agers' can be

encouraged to engage in personal housing planning on a proactive basis should be a priority for partners.

- The potential cost savings that can result from employing preventative support services (PSS) centred on enabling independence among older people with low support needs are substantial. PSS can also prolong independent living among those with support needs who might otherwise require a move to age-exclusive housing settings. Investment in preventative support services should be a priority for EDC and EDHSCP planners and commissioners.
- New technology will be a key tool in driving the prevention agenda, particularly as the tele-health agenda gains traction across the country. Predictive technologies using Internet of Things capabilities have the potential to enable people to live independently at home for as long as they want with potential savings for health and care services.
- EDC and EDHSCP should consider more ways for RSLs and other housing providers to engage at a strategic level with the IJB to champion new models of delivery and secure appropriate investment.

- Age exclusive housing which is 'care ready' should be encouraged in local planning policy but is incumbent on the development of a partnership, funding and commissioning framework across EDC, RSLs and the EDHSCP. Building such partnerships will help to address the organisational, cultural, funding and communication barriers that persist across housing, health and social care partners. A partnership approach will also assist health services and professionals to appreciate the role that housing partners can play in meeting the needs of older people and enabling preventative activity.
- The Local Development Plan should consider inclusion of a clearly defined policy on older people's housing potentially linked to Section 75 agreements. Specific design briefs and transparency around target assumptions should be included to aid delivery and encourage a level playing field for developers. Developers see the Private Retirement Sector as a "huge growing market" in East Dunbartonshire where older owners are sitting on significant equity value in their homes.
- Age Friendly neighbourhood principles should be built into planning policies, integrating age friendly housing as part of healthy, inclusive mixed tenure housing developments.

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EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17 September 2020
Subject Title	East Dunbartonshire HSCP Annual Performance Report 2019-20
Report By	Caroline Sinclair, Interim Chief Officer and Chief Social Work Officer
Contact Officer	Alan Cairns, Planning, Performance & Quality Manager Alan.cairns2@ggc.scot.nhs.uk

Purpose of Report	To present and seek approval for the HSCP Annual Performance Report for the year 2019-20 that details progress in line with the Strategic Plan and National Health and Wellbeing Outcomes,

Recommendations	It is recommended that the HSCP Board: 1. Considers and approves the Annual Performance report 2019-20, as set out at **Appendix 1;**

Relevance to HSCP Board Strategic Plan	The Annual Performance Report measures and reports on progress in support of the Strategic Plan's Strategic Priorities. It achieves this by providing qualitative evidence in line with the relevant success measures and through the use of quantitative performance data, both national and local.

Implications for Health & Social Care Partnership

Human Resources:	None
Equalities:	None
Legal:	None
Financial:	The Annual Performance Report includes analysis on financial performance during 2019-20.
Economic Impact:	None
Sustainability:	None
Risk Implications:	None
Implications for East Dunbartonshire Council:	The Council has significant interests in the performance of the Partnership in pursuit of agreed objectives and priorities and in the quality of the delivery of agreed delegated functions and services.

Implications for NHS Greater Glasgow & Clyde:	The NHS Board has significant interests in the performance of the Partnership in pursuit of agreed objectives and priorities and in the quality of the delivery of agreed delegated functions and services.

Direction Required to Council, Health Board or Both	**Direction To:**	**Tick**
	1. No Direction Required	**X**
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

1.0 MAIN REPORT

1.1 Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 places an obligation on Integration Joint Boards to publish a performance report annually. The minimum contents of annual performance reports are prescribed by regulation and guidance and include:

a. An assessment of performance in relation to the national health and wellbeing outcomes
b. A description of the extent to which the arrangements set out in the strategic plan and the expenditure allocated in the financial statement have achieved, or contributed to achieving, the national health and wellbeing outcomes;
c. Information about the integration authority's performance against key indicators or measures in relation to the national health and wellbeing outcomes over the reporting year and 5 preceding years (where complete);
d. Financial planning and performance;
e. Best value in planning and carrying out integration functions;
f. Performance in respect of localities;
g. Inspection and regulation of services;
h. Any such other information related to assessing performance during the reporting year in planning and carrying out integration functions as the integration authority thinks fit.

1.2 At its meeting of 25 June 2020, the HSCP Board noted the deferment of the full statutory HSCP Annual Performance Report for 2019-20 due to the impact of the Covid-19 emergency and agreed to its later publication in the Autumn of 2020. In the absence of a full report, the HSCP Board considered an abridged performance report covering key performance indicators and measures for the 2019-20 period.

1.3 A full Annual Performance Report for 2019-20 is now set out at **Appendix 1** for consideration and approval.

1.4 This report continues the format of the 2018-19 report following positive feedback from the HSCP Board and Scottish Government on its content and structure. In addition to hard data and evidence in line with the HSCP Strategic Priorities and national outcomes, the document contains important content that highlights examples of the excellent work that is developed and delivered locally, to improve personal outcomes for the people we support.

1.5 HSCP Board members may recall last year that the Annual Performance Report 2018-19 was affected by late national publication of some hospital-based data. This resulted in a provisional Annual Performance Report being published in June 2019 with a final updated version being published in November 2019. In order to prevent this additional burden on HSCPs, Public Health Scotland have advised that Annual Performance Reports should this year report data (for affected indicators) for the calendar year 2019 as a proxy for 2019/20, as data for the full financial year will be incomplete and in some cases misleading. However previous years should be published with financial years as normal. This convention has therefore been applied to our Annual Performance Report 2019-20.

East Dunbartonshire
Health & Social Care
Partnership

ANNUAL PERFORMANCE REPORT

2019 - 2020

DRAFT: HSCP Board Version for Approval

CONTENTS

Introduction

In East Dunbartonshire we have integrated a wide range of health, social care and social work services for adults and children. The aim in so doing is that we can ensure people have access to the services and support they need, so that their care feels seamless to them, and so that they experience good outcomes and high standards of support. We are also looking to the future: integration requires services to be redesigned and improved, with a strong focus on prevention, quality and sustainability, so that we can continue to maintain our focus on reforming and improving people's experience of care.

All Health and Social Care Partnerships (HSCPs) are required to publish an Annual Performance Report on:

- the nine National Health & Wellbeing Outcomes;
- the development of locality planning and improvement
- financial performance and Best Value

In addition, we have included information on:

- Our progress in implementing our Health and Social Care Strategic Plan
- Our progress in making integration work
- Our performance as assessed through external inspection and regulation
- Good practice examples

The Coronavirus Pandemic

As you are reading this, the Coronavirus pandemic will be very much at the forefront of everyone's thoughts. Since March 2020, pressure on delivering health and social care has been particularly intense. This report covers the period to the end of March 2020, so most of the period affected by the pandemic will fall into next year's report. However, we would wish to extend our enormous gratitude to all the staff, partners and individuals in the HSCP and in the community more widely, for the enormous effort that they have made to maintain services to the people we support during this period. We would also wish to offer our sincere condolences to anyone who has lost a family member or friend, at this most challenging of times.

With the establishment of emergency arrangements during the period from mid-March 2020, some of the progress, activity and performance outlined in this 2019-20 will have been subsequently impacted. Our focus over the next 12-18 months will be to work with our partners and the people of East Dunbartonshire to re-establish services as quickly, safely and effectively as possible.

	Susan Murray Chair East Dunbartonshire HSCP Board		Caroline Sinclair Interim Chief Officer East Dunbartonshire HSCP

Part 1. The Health and Wellbeing Outcomes - Our Overall Performance

Each of the National Outcomes below has been assigned a "RAG" status to indicate the HSCP's assessment of overall performance during 2018/19. This is based on national and local indicators, and the achievements described within the report.

RAG KEY

- Positive performance
- Steady performance
- Performance below target

NATIONAL HEALTH & WELLBEING OUTCOMES	STATUS
People are able to look after and improve their own health and wellbeing and live in good health for longer.	
People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	
People who use health and social care services have positive experiences of those services, and have their dignity respected.	
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	
Health and social care services contribute to reducing health inequalities	
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.	
People who use health and social care services are safe from harm.	
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	
Resources are used effectively and efficiently in the provision of health and social care services.	

Part 2. The HSCP Strategic Plan: Our Progress

The East Dunbartonshire Health and Social Care Strategic Plan 2018-21 emphasises the need to plan and deliver services that contribute to better outcomes throughout people's lives. This approach 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 personal and social challenges.

Starting Well | Living Well | Ageing Well | Dying well

The Strategic Plan outlines 8 key priorities to be delivered over the life of the Plan, in pursuit of the National Health and Wellbeing Outcomes. This part of the Annual Performance Report will describe our progress towards achieving these priorities. 2018-19 was the first year of the Plan, so some initiatives are still at an early stage.

The priorities are as follows:

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

Service and partnership planning in areas of children and justice services are reported through the Integrated Children's Service Plan and Community Justice Outcome Improvement Plan, but key progress is also reported here and in Parts 4 and 5.

The relationship between the Strategic Plan's eight priorities and the National Health and Wellbeing Outcomes is set out at **Annex 1**.

Strategic Priority 1

Promote positive health and wellbeing, preventing ill-health, and building strong communities (National Outcomes 1 & 5)

Our Measures of Success	Our Achievements in 2019-20	Status
Reduce smoking prevalence.	The smoking cessation delivery programme is now managed centrally from Greater Glasgow & Clyde NHS. The national target for successful quits (12 weeks) in the 40% most deprived communities equates to 12 quits in East Dunbartonshire. In 2019-20, the service achieved 39 quits, more than three times the target level. The HSCP continues to lead and develop the East Dunbartonshire Tobacco Alliance, increasing the number of smoke free plays park areas, undertaking promotional and advisory campaigns raising the issue of the harm caused by tobacco and training awareness. The Alliance supported our Trading Standard colleagues in undertaken compliance visits to retailers, ensuring that all tobacco related sales were conducted as detailed within legislation.	On target Good progress
Increase the number of people meeting the national recommendation for physical activity, healthy eating and safer consumption of alcohol.	<u>Physical Activity Targets:</u> The national target for adults is *to achieve 150 minutes or more of physical activity per week*. The 2018 Health and Wellbeing Survey reported that only 53% of respondents were meeting the target. This compares to 71% as reported in the 2015 survey. The survey runs every three years. <u>Healthy Eating Targets:</u> The national target for adults is *to consume 5 portions of Fruit and Vegetables per day.* Self reported data from the 2018 HWB Survey indicated that 52% of respondents were meeting the target. This compares to 51% in the 2015 survey. Activity in 2019-20 to support these improvements was limited by resource capacity, but included: • Lifestyle programmes, for children; • ACES /Active Choices • Waist Winners	In progress In progress

Our Measures of Success	Our Achievements in 2019-20	Status
	• Live Active • Vitality and WALK • Preparation for Fluid, Food & Nutrition and Malnutrition Awareness programme (for staff). <u>Safer Consumption of Alcohol – National target for Delivery of Alcohol Brief Interventions (ABI's)</u> The HSCP was set a target to achieve 487 Alcohol Brief Interventions (ABIs). The HSCP achieved 610 ABIs which was 25% above target. The HSCP was the only Partnership area across NHS Greater Glasgow and Clyde to exceed their target.	On target
Increase levels of Breastfeeding rates.	The number of babies in East Dunbartonshire who are either exclusively or mixed breastfed at 6-8 weeks post birth, is increasing with 53% being recorded as such during 2019/20. The HSCP introduced a dedicated Breastfeeding support service this year, to support and increase the number of babies who are exclusively breastfed. Data from the first 6 month of operation indicates that the service has made a positive impact to babies being exclusively breastfeed from birth and to the development and bonding between parents and their babies. The HSCP has maintained its status as a UNICEF accredited Baby Friendly organisation, ensuring best practice standards are provided by HSCP staff when engaging and supporting mothers to breast feed.	Good progress
Improve dental health and increase Child Smile registrations.	100% of nurseries and Additional Support Needs schools were participating in the Childsmile Core Toothbrushing Programme together with 34 out of 35 primary schools. The oral health of children in East Dunbartonshire is better than the average for GG&C and Scotland as a whole. However, the most recent dental health data (Oct 2019) indicates a continued decline in oral health compared to previous survey results in 2018. Action taken (Prior to COVID-19): • The increased capacity for Dental Health Support Workers facilitated a	In progress

Our Measures of Success	Our Achievements in 2019-20	Status
	threefold increase in targeted home visits; • Improved targeted interventions to support families with dental registration; • Support to General Dental Practices (GDPs) to stamp the child's Red Book on registration; • Continued support for the Tooth Brush Monitoring Programme within Nurseries throughout East Dunbartonshire. The COVID-19 pandemic led to the cessation of all oral health improvement activities, with redeployment of many staff to other services.	
Maintain percentage of childhood immunisation uptake.	Statistics for childhood vaccinations released at March 2020 show very strong performance for 2019-20 with East Dunbartonshire maintaining its position amongst the areas with the highest level of uptake across all age-groups. Detailed information on this can be found here.	On target
Increase community payback orders (CPOs) with alcohol, drug and mental health requirements to promote healthy living and risk reduction.	Data reporting lag prevents analysis of 2019-20 performance in time for the publication of this report, but will be reflected next year against this baseline data. 2018-19 data: In East Dunbartonshire there were 154 CPOs. Of these, none involved alcohol, drug or mental health requirements. Of the 16,418 CPOs in Scotland, there were 196 alcohol, 139 drug and 36 mental health treatment requirements. With the exception of the residence requirement these are the 3 least utilised requirements of the 9 requirements across Scotland. In 2018/19 there were 2 Drug Treatment and Testing Orders (DTTOs). Activity: • Agreement via Alcohol & Drug Partnership to have drug/alcohol practitioner co-located in Justice Office; • Review of the referral pathway to increase efficiency and enable direct referral to the Foundry; • Workforce training for all criminal justice staff for promotion of healthy living; • In line with national guidance, work underway to establish a local protocol for Mental Health requirement.	Good progress

Strategic Priority 2

Enhance the quality of life and supporting independence for people, particularly those with long-term conditions (National Outcomes 2 & 3)

Our Measures of Success	Our Achievements in 2019-20	Status
Increase uptake of a variety of telecare / telehealth care solutions.	In 2019-20, we installed 542 new community alarms. This increased the number of people with a community alarm by over 75 users compared to 2018-19. This year has also seen the preparation for our transition from analogue to digital telecare, which should increase significantly the flexibility and functionality of a new generation of support. In addition we have commissioned a number of intensive technology assisted care packages, which safely increases levels of independence. These models have been very successful and will provide a model for future community-based support. We also established a Digital Health and Care Board in 19/20 to faciliate continuous improvement in our use of digital technology approaches to faciilate care and improved outcomes for people.	Good progress
Improve drug and alcohol referral to treatment waiting times.	The percentage of service users seen within 3 weeks, for the period ending March 2020 was 89%, just short of the 90% target. Although our performance in this area remains just short of target, it represents a significant improvement over the same period last year, which was 76%. Remaining performance issues are attributed to a combination of recording delays and staff capacity issues in the EDADS team. These are the subject of ongoing improvement action, in order to achieve and exceed the target.	Good progress
Improve psychological therapies referral to treatment waiting times.	Despite pressure with staffing resources within both Primary Care and Community Mental Health Team the target of individuals seen within 18 weeks of referral for psychological intervention has consistently performed above the target of 90%. In 2019-20, the team acheived 97.4% in this measure. The team is taking forward a test of change re-profiling the skill mix of the team to include a dedicated Cognitive Behavioural Therapy practitioner post to enable a more distributed and tiered approach to allocation of work within the team. This should help to maintain positive performance against the target.	On target

Our Measures of Success	Our Achievements in 2019-20	Status
Improve percentage of people newly diagnosed with dementia accessing post diagnostic support.	This measure supports the improvement of local post-diagnostic services as they work alongside and support people with a new diagnosis of dementia, and their family, in building a holistic and person-centred support plan. People with dementia benefit from an earlier diagnosis and access to the range of Post-Diagnostic Services (PDS), which enable the person and their family to understand and adjust to a diagnosis, connect better and navigate through services and plan for future care including anticipatory care planning. The team's performance has improved significantly over the course of the year in meeting its target of 90% of people receiving PDS within 12 weeks of diagnosis; from 72% in Quarter 1 to 93% in Quarter 4. Overall, performance was just short of target at 89%.	Good progress

Strategic Priority 3

Keep people out of hospital when care can be delivered closer to home (National Outcomes 2, 3 & 4)

Our Measures of Success	Our Achievements in 2019-20	Status
Reduce unplanned hospital admissions.	The HSCP has achieved a 11% reduction against a 2015/16 baseline The number of people being admitted unexpectedly to hospital is a key indicator of how well we are doing to maintain people in their own homes, particularly later in life. It is also a proxy indicator of the level of complexity being managed in the community, as secondary care clinicians continue to consider the majority of unplanned admissions of East Dunbartonshire residents as clinically appropriate. Numbers were relatively stable over the first quarter of the financial year, but pressures during the autumn were reflected in a move away from our local target. There was a significant reduction in admission from January 2020, with a particular downturn associated with the Coronavirus outbreak. This does not include Covid-related admissions. East Dunbartonshire ended the reporting year with the second lowest level of emergency admissions in Greater Glasgow and Clyde. Improvement activity has included the further development of community based	Good progress

Our Measures of Success	Our Achievements in 2019-20	Status
	rehabilitation, providing rapid assessment to assist in the prevention of admission. The Partnership will continue to work with NHSGGC colleagues to impact positively on admissions levels. Learning from the Covid-19 experience will also be used to inform improvement going forward, for example: digital consultations and a Community Assessment Centre model for emergency attendances.	
Reduce occupied bed days for unscheduled care.	The HSCP has achieved a 17% reduction against a 2015/16 baseline. This measure describes the number of bed days in secondary care used by patients who have been admitted unexpectedly. Our performance in 2019-20 initially showed sharp increase, but thereafter a reduction back towards target over the year. Local data indicates that East Dunbartonshire has the second lowest level of unscheduled bed days in Greater Glasgow and Clyde. Our primary focus continues to be on prevention of admission, where possible, so that unnecessary accrual of bed days is avoided. Improvement activity has also included daily scrutiny of emergency admissions and proactive work with identified wards to facilitate discharge. The reduction in bed days is a positive indication of progress in this regard.	Good progress
Reduce Accident & Emergency attendances.	The HSCP has seen a 3% increase in A&E attendances against a 2015/16 baseline. Attendances at the emergency departments (ED) continue to increase year on year. This is a national trend and ongoing pressure. East Dunbartonshire has the second lowest level of emergency department attendances across Greater Glasgow and Clyde. 62% of people who attended A&E were subsequently discharged, suggesting a significant number of those attending A&E could have had their needs met in the community or via self care. This is a challenge across Scotland which is being considered by Scottish Government and all public sector partners. Work continues to better understand the circumstances of those who frequently	In progress

Our Measures of Success	Our Achievements in 2019-20	Status
	attend the ED, to try and establish more proactive care planning. We continue our work around the Primary Care Improvement Plan, to recalibrate and sustain GP services. This will enable more flexible responses to patient need in the community although is likely to be significantly impacted in 2020/21 by the Covid-19 experience. We hope that increased focus on self care for people with long term conditions will also mean that people can manage their own health more proactively. We are working closely with secondary care colleagues around their introduction of redirection protocols to ensure that people who do not need to be at A&E are redirected to community services or self care timeously. We are also engaged in national conversations about programmes of public education regarding who service users should turn to for support when they are sick, injured, or in distress. Winter planning provided an opportunity to sharpen the focus on all these areas in order to help mitigate seasonal pressures we routinely see in all services, but the new context during and post Covid-19 will be impactful.	
Reduce bed days lost to discharges delayed.	The HSCP has seen a 13% increase in bed days lost to discharges delayed against a 2015/16 baseline. Progress in the first half of 2019-20 was very positive, with reductions in bed days lost to delayed discharge. The second half of the year was more challenging with the impact of the winter period. Overall, performance is broadly in line with the target for the year. Data for the period following March shows a marked reduction in delayed discharges due to Covid-19 emergency planning. Use of electronic operational activity "dashboards" now allow us to be better sighted on community patients who have been admitted to hospital so that we can respond more quickly, prior to these patients being deemed fit for discharge. We can also see patients who have been admitted who are not currently known to us, again allowing us to intervene early. In addition, all of the actions described in the previous indicator around prevention of admission are relevant to avoiding delayed discharges. We will continue to work creatively within the legal framework and support patients and their families to make choices timeously for ongoing care.	In progress

Our Measures of Success	Our Achievements in 2019-20	Status
	Home for Me (our integrated intensive community rehab and hospital discharge team) is now well established and coordinates our admission avoidance and discharge facilitation work across a range of services.	
Increase the percentage of last 6 months of life spent in the community.	The HSCP has achieved a 2% increase against a 2015/16 baseline. This positive performance has been achieved through a co-ordinated and planned approach to early identification of people with palliative and end of life care needs, building further on established integrated care models across community nursing, primary care and care at home services.	Good progress

Strategic Priority 4

Keep people out of hospital when care can be delivered closer to home (National Outcomes 1, 3, 4, 5 & 7)

Our Measures of Success	Our Achievements in 2019-20	Status
Increase the number of service users utilising self directed support options.	Through dedicated awareness raising and individual assessment and reviews, the number of service users being supported to make a decision about the right level of choice and control for them has increased in 2019-20 compared to last year. The majority of service users continue to choose to utilise SDS option 3.	Good progress
Increase the uptake of the income maximisation service.	The Income Maximisation Service offers financial health check and advice to families and/or older people who are identified as being in receipt of income that is below a set threshold. During 2019/20 the service received 259 referrals, generating over £919,720 worth of financial gain for people living within East Dunbartonshire. This equates to a cost benefit of £68:£1 for HSCP investment. There was a 2% increase in the number of referrals and a 17% increase in financial gain, compared to the previous year.	On target
Monitor the uptake of Healthy Start programme.	Healthy Start has undergone significant programme change over the past 12 months, with very limited data at an HSCP level. Moving forward Healthy Start will be replaced by a Vitamin D product which will be available free to ALL children,	In progress

Our Measures of Success	Our Achievements in 2019-20	Status
	initially under age one (to be extended to age 3 in the future), which should improve uptake monitoring.	
Increase the breastfeeding rates in deprived communities.	To help address low uptake within the most deprived areas of East Dunbartonshire, the HSCP was successful in applying for Scottish Government funding to commence a targeted Breast Feeding Pilot Programme in 2019. This programme enables continuity of breastfeeding support following transition from midwifery to the Health Visiting Service. The project provides Breast Feeding Support Workers who offer home visits and support to mothers to breastfeed and to the family to achieve their infant feeding plan. Progress during 2019-20 notes that the approach is embedding itself within practice and with breastfeeding mothers. The service has received referrals from 89% of Health Visitors with over 100 women having received 1:1 breastfeeding support as a result.	Good progress
Increase % of people released from a custodial sentence: • registered with a GP • have suitable accommodation • have had a benefits eligibility check	Data recording and reporting is not yet in place as it required a legal infomation sharing protocol (agreed in April 2020) in order to demonstrate progress against this measure. <u>Activity:</u> Now that the information protocol is in place between Criminal Justice and Scottish Prison Service, a pathway development is progressing via the community justice strategic partnership which enables critical information to be shared for short term prisoners being liberated from HMP Low Moss. The multi agency Prisoner Release Operational Group (PROG) was established April 2020 to address people's needs prior to their release from a custodial sentence, this includes accommodation; drugs and alcohol; benefits and provision of a mobile phone to allow them to be connected to vital services on release.	In progress

Strategic Priority 5

People have a positive experience of health and social care services (National Outcomes 1, 3 & 7)

Our Measures of Success	Our Achievements in 2019-20	Status
Monitor the number of complaints and comments.	The HSCP services handled a total of 84 complaints to conclusion between 1st April 2019 and 31th March 2020 (10 in Health services and 74 in Social Work / Social Care services). 68% of these were handled within the procedural timescales, which is due in part to the complexity of a number of multi-party complaints. However, this is below the level of performance we would wish to see and has been escalated for review and improvement.	In progress
Increase the percentage of service users satisfied with the quality of care provided.	In the 2018 Health and Social Care Experience Survey, 84% of respondents in East Dunbartonshire rated the quality of help, care or support services as either excellent or good. This showed a decrease from 86% in 2016, but still compares favourably with 80% nationally which places us in the top quartile nationally. The 2020 Survey has not yet reported due to Covid-19 impact. During 277 reviews of social care support in 2019-20, 97% of service users expressed satisfaction with the quality of care provided.	In progress
Increase the percentage of service users satisfied with their involvement in the design of their care provided.	During reviews of social care support in 2019-20, 97% of service users expressed satisfaction with their involvement in the design of their care, which is an increase on 2018-19 and on target.	On target
Increase the percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided.	In the 2018 Health and Social Care Experience Survey, 86% of respondents in East Dunbartonshire were satisfied that they had a say in how their help, care or support was provided. This demonstrated an increase from 84% in 2016 and compares very favourably with 76% nationally. The 2020 Survey has not yet reported due to Covid-19 impact.	On target

Strategic Priority 6

Promote independent living through the provision of suitable housing accommodation and support (National Outcomes 1 & 2)

Our Measures of Success	Our Achievements in 2019-20	Status
Increase the number of people receiving the 'Care of Gardens' Scheme.	The number of people signed up to the scheme declined between October 2018 and October 2019, from 469 users to 434 users. This represents a continued decline in uptake, which may be due to successive above-inflation increases in charges	In progress
Increase the number of people accessing the Care and Repair Service.	There were 3685 referrals for Care and Repair in 2018-19, which was 16% lower than in 2017-19, although higher than the internal targets set by the Care and Repair service. There was substantial organisational change and interruption to normal service during 2018-19, which led to a process of Council in-sourcing during 2019-20. This in-sourcing process resulted in further service impact, with only 1025 referrals during this period. With the in-sourcing process now complete, it is envisaged that the service will move forward positively in 2020-21.	In progress
Increase the percentage of our housing for Specialist Needs with Community Alarm or Telecare systems to 65% by 2021.	In addition to the progress made to increase uptake of telecare /telehealth care solutions outlines at Priority 2 (above), the HSCP approved an East Dunbartonshire Assistive Technology Strategy 2018-23, in 2018 which is now transitioning through the implementation phase to a wider Digital Health and Care Strategy, reflecting the rapid advancements in digital health and care opportunities to be maximised. In addition, the new Fair Access to Community Care policy maximises the use of assistive technologies in meeting eligible needs, including in supported accommodation. A mechanism to quantify uptake is not yet in place.	In progress

Strategic Priority 7

Improve support for Carers enabling them to continue in their caring role (National Outcomes 1, 3, 4, 5 & 6)

Our Measures of Success	Our Achievements in 2019-20	Status
Increase number of adult carers identified and completing an Adult Carers Support Plan.	2018-19 was the first year of Adult Carer Support Plans (ACSP) being in use. There were 1118 adult carers known to the HSCP in 2019-20, an increase of 36% since last year. Over the year 165 Adult Carer Support Plans have been commenced, an increase of 53% since last year. This demonstrates a significantly higher level of care identification and engagement in support planning. ACSPs may also be carried out by 3rd sector services. Numbers completed by these services are not included in this report.	Good progress
Increase number of young carers identified and completing a Young Persons Statement.	2018-19 was the first year of Young Persons Statements (YCS) being in use. In most circumstances YCSs would be carried out by Education Services or Carerslink, rather than by the HSCP, so numbers remain low with only two YCSs recorded for 2019-20. Numbers of YCSs completed by Carerslink or Education services are not included but it is planned that these will be included in future reports for a whole-system perspective.	In progress
Increase number of carers who feel supported to continue in their caring role.	In the 2018 Health and Social Care Experience Survey, 41% of carers felt supported to continue caring. This showed a decrease from 43% in 2016, but compares marginally more favourably compared with 38% nationally. The 2020 survey has not yet reported due to delays associated with Covid-19 impact. During 159 reviews of social care support in 2019-20, 94% of carers indicated that they felt supported to continue in their caring role, which was a marginal decrease from 96% the previous year but remains at a very high level.	In progress

Strategic Priority 8

Optimise efficiency, effectiveness and flexibility (National Outcomes 7, 8 & 9)

Our Measures of Success	Our Achievements in 2019-20	Status
Monitor Adult and Child protection measures.	Work has been undertaken to align the functions and activity of the Adult and Child Protection Committees where commonalities are present. As a result we now have joint subgroups producing a joint training calendar, publicity campaigns, and a joint approach to exploring Trafficking and Exploitation in East Dunbartonshire. There was also agreement to establish a Joint Independent Convenor role to chair both committees in 2020-21. 2019 -2020 was the first year of the newly implemented 3 year business plan for the Child Protection Committee. Audit activity continued with a focus on Inter-agency referral discussions (IRD) in preparation for the North Strathclyde Joint Investigative Interview Pilot. Continued monthly IRD audits will monitor progress into 2020-2021. CPC Subgroups have been working towards key priority areas for Child Protection including the implementation of new SMART Child's Plans and new referral paperwork as well as direct consultation with children and families. The Adult Protection Committee reviewed and extended its biennial business improvement plan to align with the timeframe for the national programme and the Child Protection Committee's 3-year improvement cycle. Adult Inter-agency Referral Discussion (IRD) processes were successfully piloted and implemented by the HSCP in partnership with Police Scotland. The annual multi-agency audit took place in March but it has not been possible to agree and implement any actions as a consequence of COVID-19 priorities. A new minute template was introduced which will improve monitoring of service user and partner agency participation in case conferences.	Good progress
Reduction of re-offending.	Both the reconviction rate and average number of reconvictions per offender have decreased over the past decade. Between 2006-07 and 2015-16, the reconviction rate for East and West Dunbartonshire decreased from 36.8% to 28.2%. In the same period, the average number of reconvictions per offender decreased by 29% from 0.66 to 0.47.	Good progress

	New Experimental statistics in the latest Reconviction bulletin based on local authority of residence indicates the reconviction rate for East Dunbartonshire is 17.2% with an average number of reconvictions per offender as 0.23. Data on convictions and reconvictions are a subset offending and reoffending and are a proxy measure of reoffending rates. Data reporting lag prevents analysis of 18-19 performance in time for the publication of this report, but will be reflected next year against this baseline data.	
Analyse and measure the impact and outcomes associated with the review and redesign of learning disability and mental health services.	Adult Learning Disability Review (progress to date): • Development and publication of an Adult Learning Disability Strategy with 6 Improvement Themes; • Development and approval of new Fair Access to Community Care Policy and updated Eligibility Criteria; • Development of learning disability day service and accommodation-based support redesign principles, to support detailed specifications; • Comprehensive consultation and engagement at all stages; • Approval to replace Kelvinbank day service with a new service at Allander, Milngavie; • Redesign of accommodation-based service ongoing. Mental Health: • Completion of an independently commissioned needs assessment of people experiencing mental ill health and substance misuse in East Dunbartonshire. This work will influence future commissioning and development of concurrent recovery treatment, aligned to GGC-wide national priorities. Online follow up and development sessions being supported by IHub; • Rapid acceleration of roll out and adoption of digital processes following evaluation of the Covid 19 response experience; • Roll out of new Suicide Prevention branding in East Dunbartonshire led by the National Suicide Prevention Leadership Group (NSPLG). This is due for launch in September 20. • Development of local Suicide Prevention Strategy and Action Plan including locations of concern and reviews of deaths by suicide.	Good progress

	• Development of joint virtual group-work programme between CMHT and Health Visiting staff based on Dr Chris Williams 'Enjoy your Baby' material, for women in the Postnatal period experiencing mild-moderate mental health difficulties utilising a self-management and CBT based model. • CMHT development of enhanced patient health checks.	
Monitor providers' compliance with contract monitoring framework.	• Reviewed contract monitoring approach to ensure limited resources are targeted more effectively towards underperforming services; • Established joint monitoring approach with Health colleagues across specific service areas including care homes - resulting in a more robust and integrated oversight of services	Good progress

Part 3. National and Local Performance Data

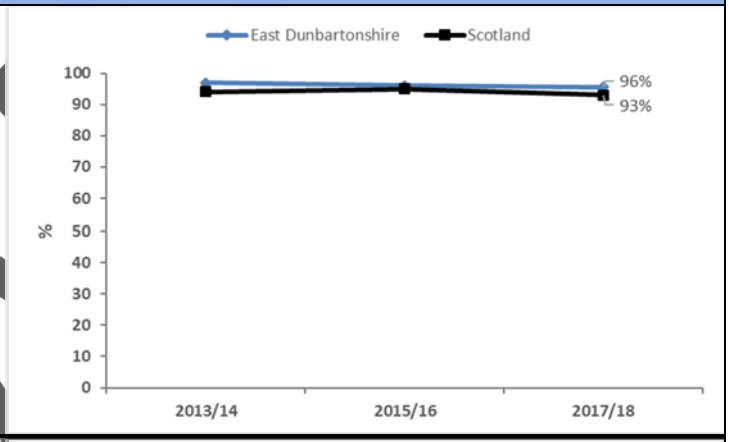
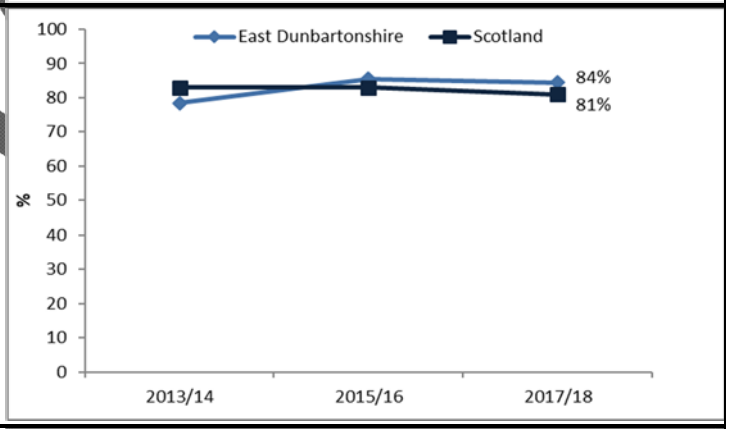
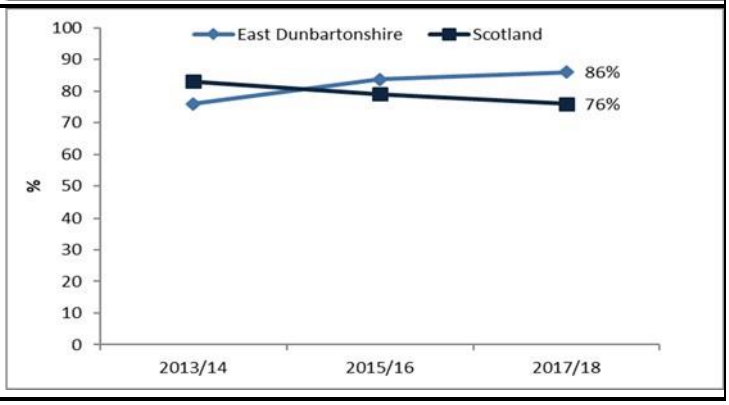
This section provides HSCP's performance against national core indicators.

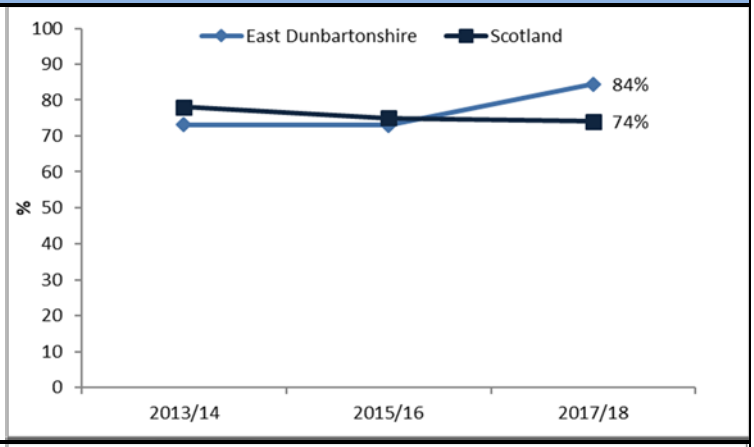
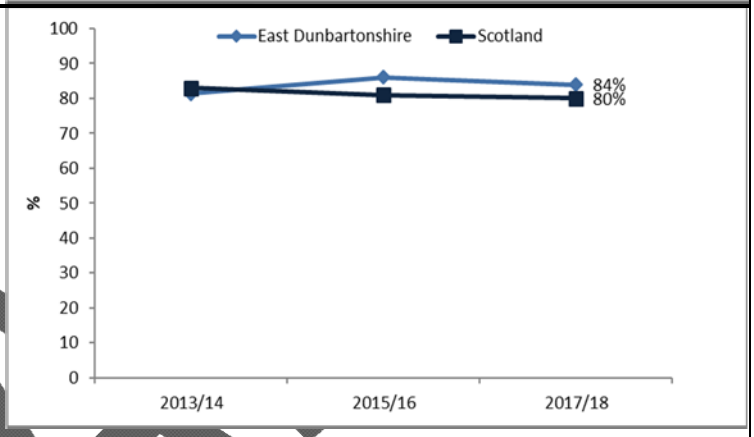
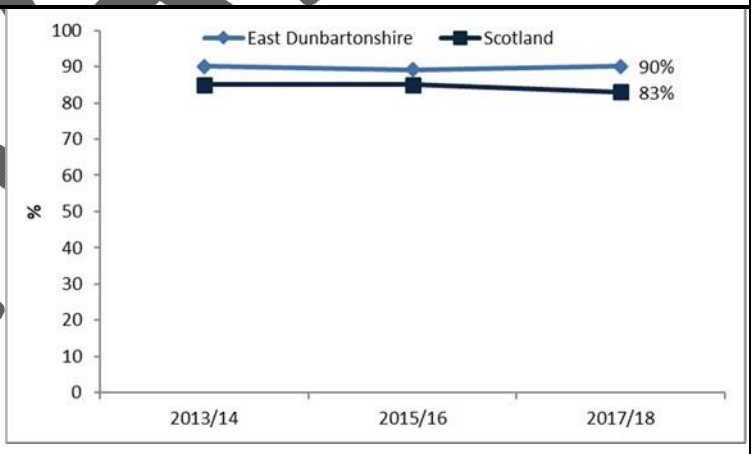
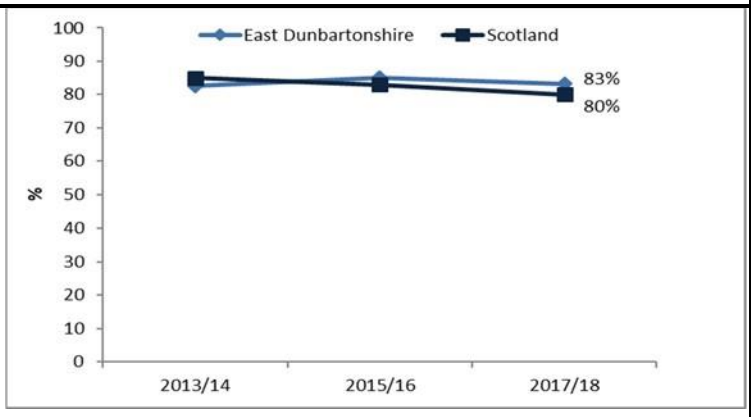
Notes:

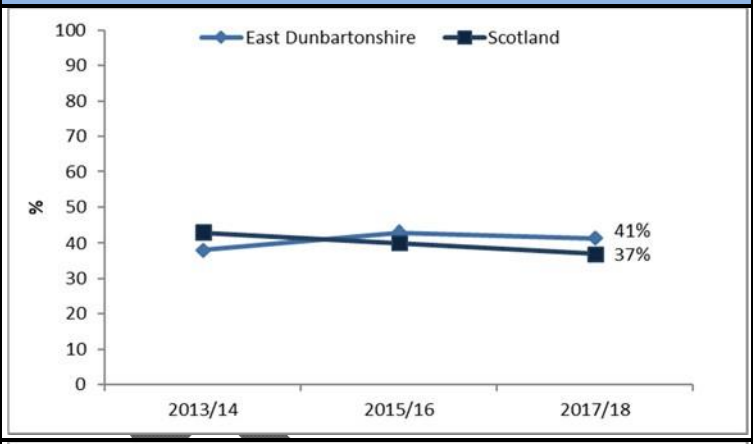
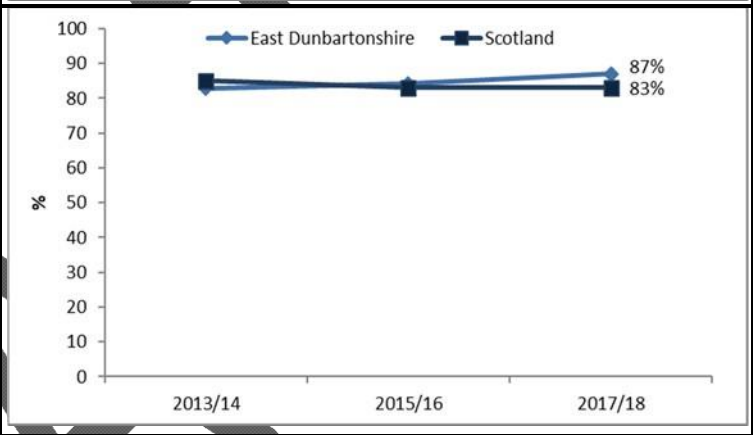
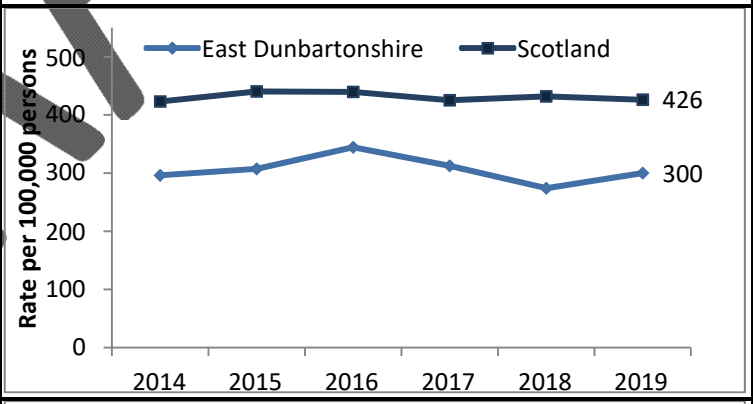
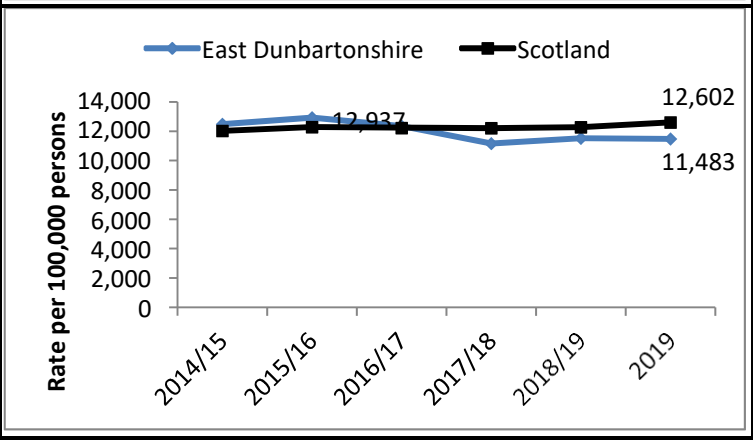
Indicators 1-9 are reported by a national biennial Health and Social Care Experience Survey that reports every two year. The most recent data for this is 2017-18.

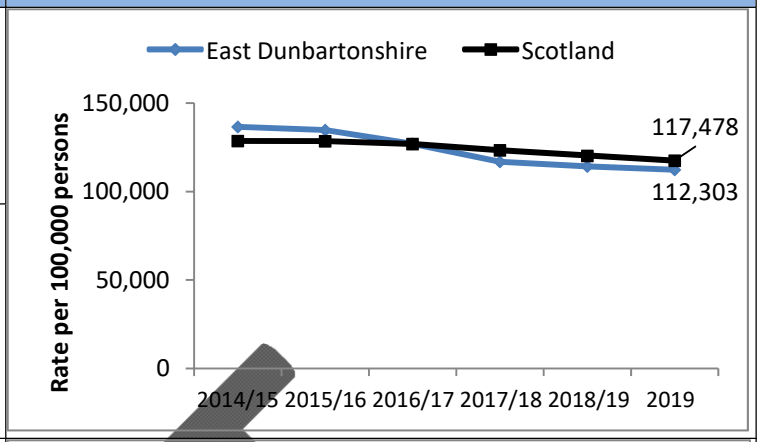
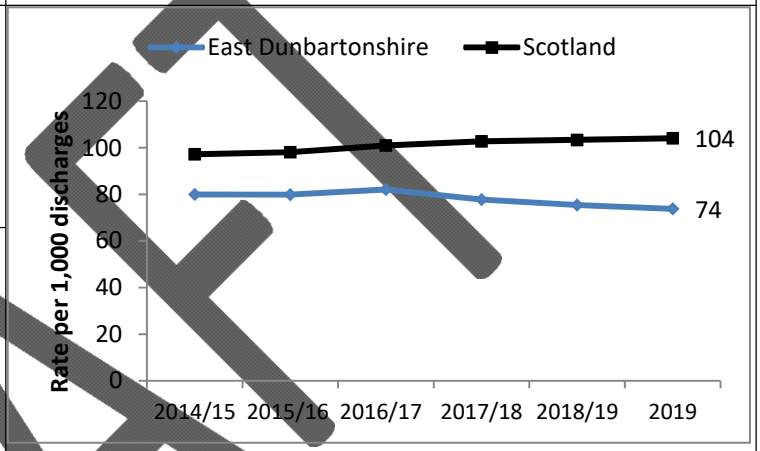
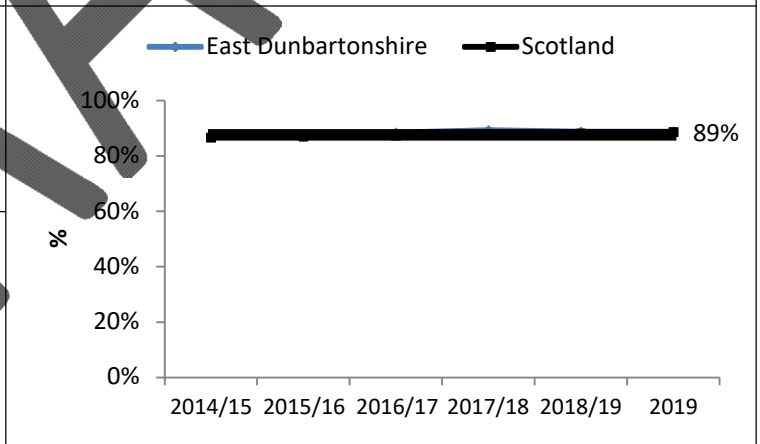
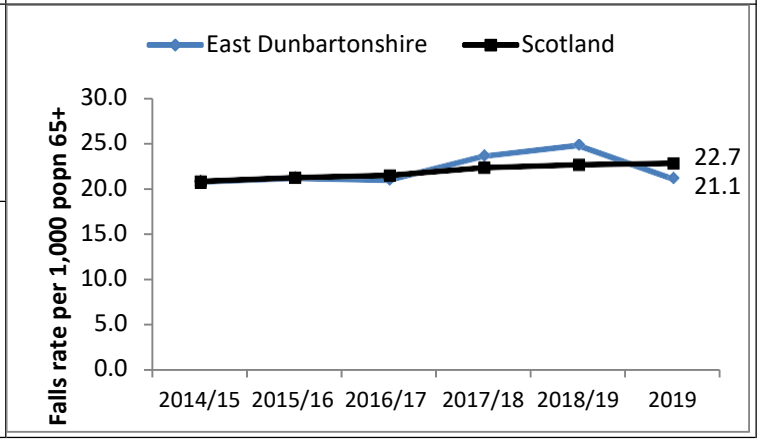
RAG KEY

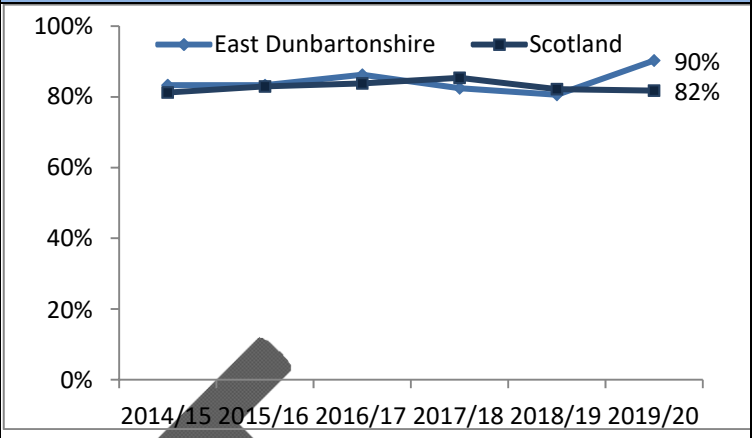
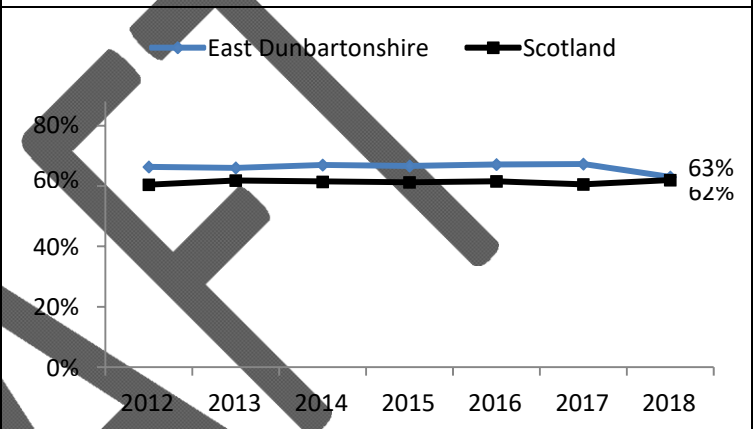
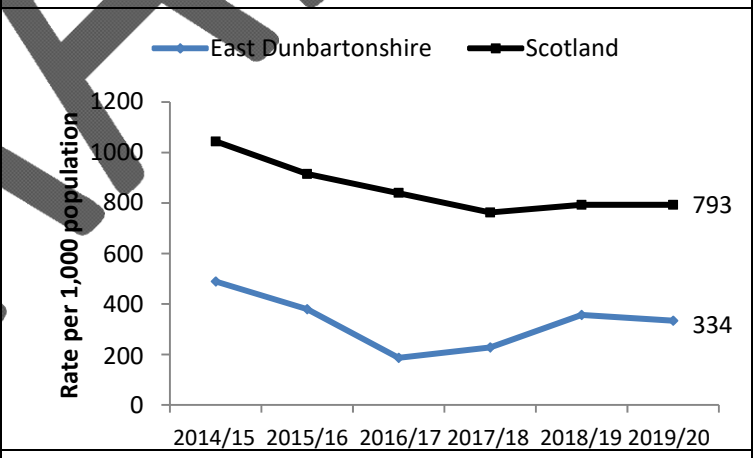
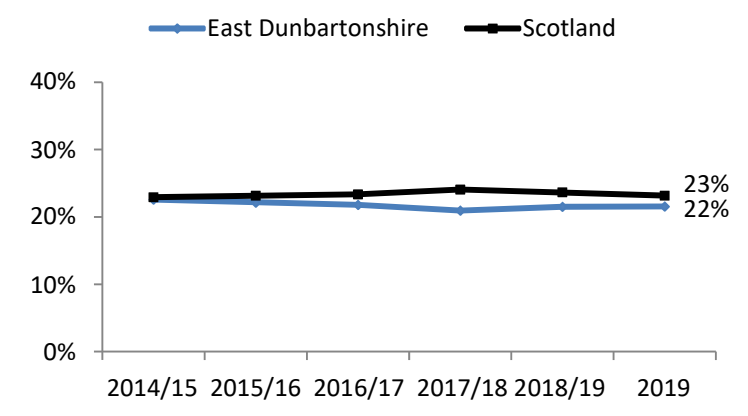
- Positive performance improved
- Performance steady (within 2% change). Arrow direction denotes improving/declining performance
- Negative performance

Indicator, Rating and Rank		Performance Trend
1) Percentage of adults able to look after their health very well or quite well (National Outcome 1) (Objective: increase)		
National ranking: 1	Amber	
2) Percentage of adults supported at home who agree that they are supported to live as independently as possible (National Outcome 2) (Objective: increase)		
National ranking: 1	Amber	
3) Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided (National Outcome 2, 3) (Objective: increase)		
National ranking: 1	Amber	

Indicator, Rating and Rank		Performance Trend
4) Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated (National Outcome 3, 9) (Objective: increase)		
National ranking: 3	Green	
5) Total percentage of adults receiving any care or support who rated it as excellent or good (National Outcome 3) (Objective: increase)		
National ranking: 6	Amber	
6) Percentage of people with positive experience of the care provided by their GP Practice (National Outcome 3) (Objective: increase)		
National ranking: 2	Amber	
7) Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life (National Outcome 4) (Objective: increase)		
National ranking: 7	Amber	

Indicator, Rating and Rank		Performance Trend
8) Total combined percentage of carers who feel supported to continue in their caring role (National Outcome 6) (Objective: increase)		
National ranking: 3	Amber	
9) Percentage of adults supported at home who agreed they felt safe (National Outcome 7) (Objective: increase)		
National ranking: 4	Green	
10) N/A		
11) Premature mortality rate for people aged under 75yrs per 100,000 persons (National Outcome 1,5) (Objective: decrease)		
National ranking: 2	Red	
12) Emergency admission rate (per 100,000 population) (National Outcome 1,2,4,5) (Objective: decrease)		
National ranking: 12	Amber	

Indicator, Rating and Rank		Performance Trend
13) Emergency bed day rate (per 100,000 population) (National Outcome 2,4,7) (Objective: decrease)		
National ranking: 14	Green	
14) Readmission to hospital within 28 days (per 1,000 population) (National Outcome 2,4,7,9) (Objective: decrease)		
National ranking: 3	Amber	
15) Proportion of last 6 months of life spent at home or in a community setting (National Outcome 2,3,9) (Objective: increase)		
National ranking: 16	Amber	
16) Falls rate per 1,000 population aged 65+ (National Outcome 2,4,7,9) (Objective: decrease)		
National ranking: 10	Green	

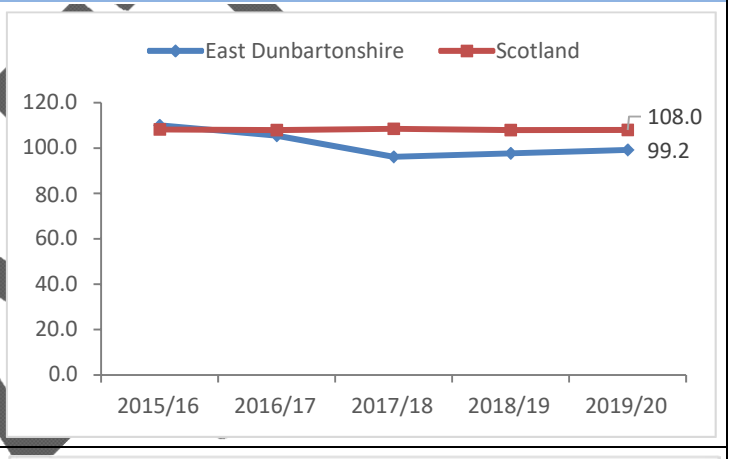
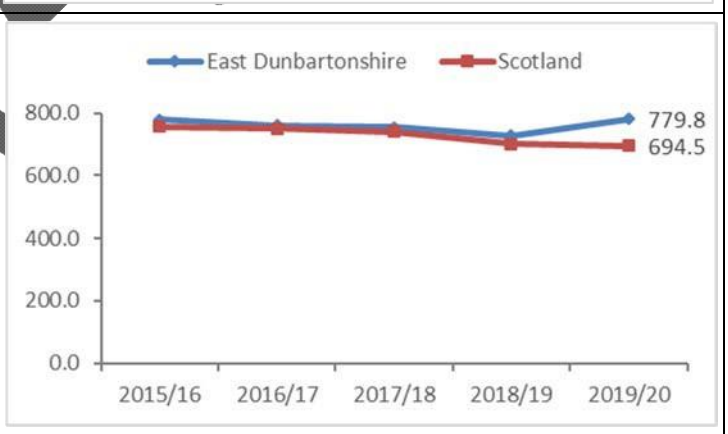
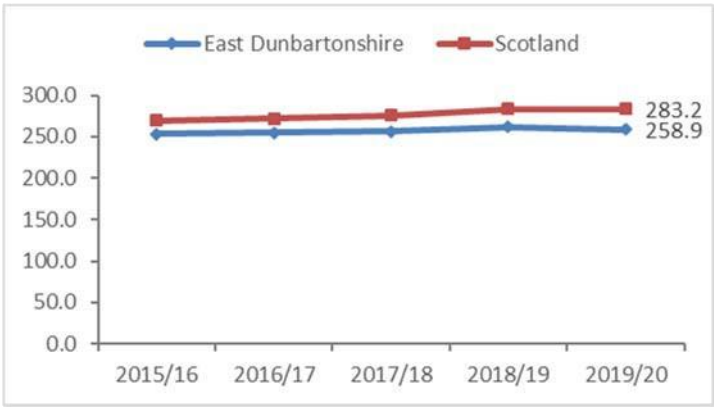
Indicator, Rating and Rank		Performance Trend
17) Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (National Outcome 3,4,7) (Objective: increase)		
National ranking: 6	Green	
18) Percentage of adults with intensive care needs receiving care at home (National Outcome 2) (Objective: increase)		
National ranking: 18	Red	
19) Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) (National Outcome 2,3,4,9) (Objective: decrease)		
National ranking: 5	Green	
20) Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency (National Outcome 2,4,7,9) (Objective: decrease)		
National ranking: 12	Amber	

Ministerial Strategic Group – Performance Measures

This section provides the data and RAG status of HSCP's performance against the Scottish Government's Ministerial Strategic Group's performance measures. Performance using the RAG rating is based upon comparison with the previous year. A chart showing comparative performance against the Scottish average is also provided.

RAG KEY

- Positive performance improved
- Performance steady (within 2% change) Arrow direction denotes improving/declining performance
- Negative performance

Indicator	Performance Trend
1. **Unplanned admissions** – rate per 1000 population (National Outcomes 1,2,3,4) (Objective: decrease)	
Amber	
2. **Unplanned bed days** - rate per 1000 population (National Outcomes 2,4,7) (Objective: decrease)	
Red	
3. **A&E attendances** - rate per 1000 population (National Outcomes 1,2,9) (Objective: decrease)	
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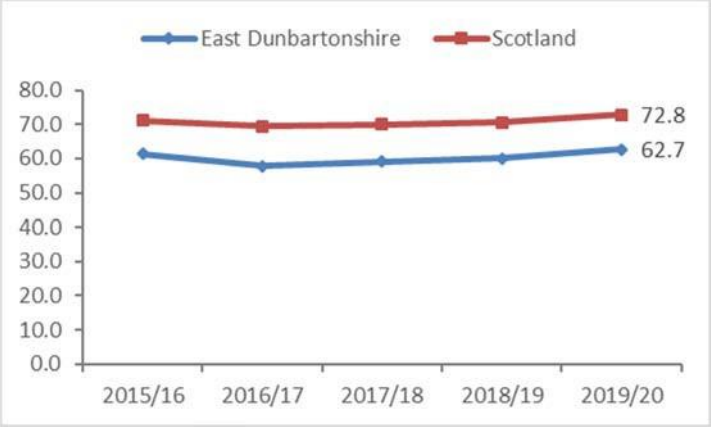
4. **Admissions from A&E** – rate per 1000 population (National Outcomes 1,2,3,4) (Objective: decrease)	
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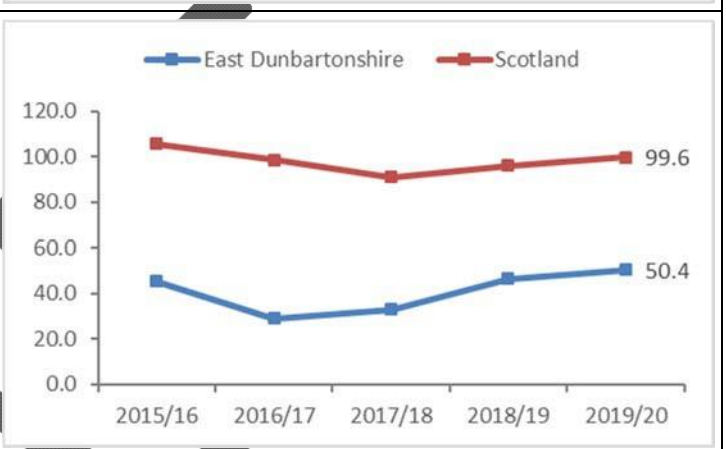
5. **Delayed discharge bed days** - rate per 1000 population (National Outcomes 2,3,4,9) (Objective: decrease)	
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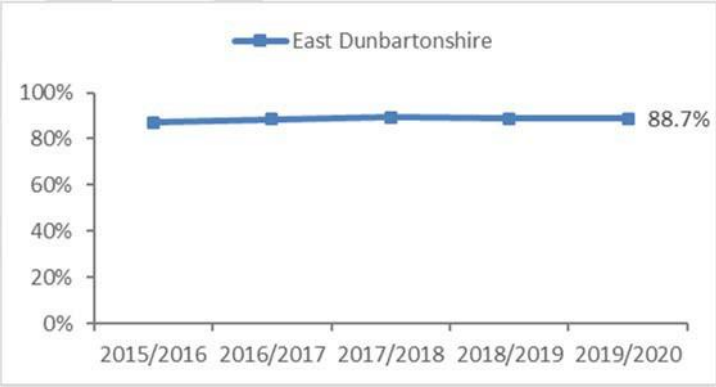
6. **Last 6 months of life spent at home or in a community setting** - rate per 1000 population (National Outcomes 2,3,9) (Objective: increase)	
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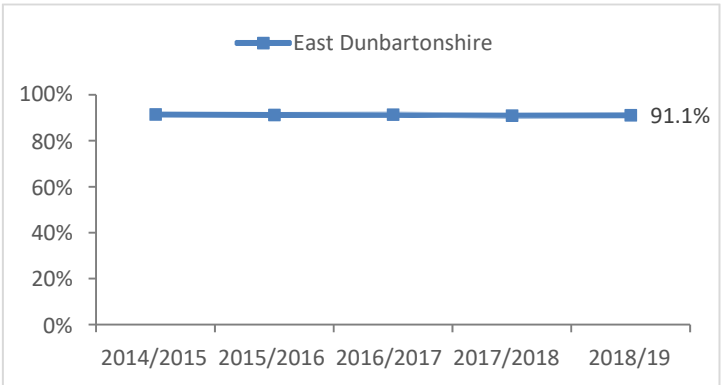
7. **Balance of Care** (% of population in community or institutional settings) - rate per 1000 population (National Outcomes 2,4,9) (Objective: increase)	
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Detailed data and charts regarding the HSCP performance during 2019/20 can be found in the Quarter Performance Reports published with the HSCP Board papers on our website: https://www.eastdunbarton.gov.uk/health-and-social-care/health-and-social-care-services/east-dunbartonshire-health-and-social-care

Local Performance Indicators and Targets: Statutory Functions and Outcomes

RAG KEY

On or above target

Within agreed variance of target

Below target

% of child care Integrated Comprehensive Assessments (ICA) for Scottish Children's Reporter Administration (SCRA) completed within target timescales (20 days), as per national target	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	64%	75%	87%		*On target*

% of first Child Protection review case conferences taking place within 3 months of registration	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	96%	95%	89%		Performance for the year was affected by below target compliance in Q4, due to the impact of Covid-19.

% of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	94%	100%	100%		*On target*

% of Adult Protection cases where the required timescales have been met	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	86%	95%	92%		Performance continues above 90% for the fifth quarter in a row, a trend which has not been seen since referral demand increased markedly in 2016. Improvement action continues, aimed at achieving target.

(Some variances can be due to small number changes)

% of customers (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	99%	95%	99%		*On target*

% of CJSW Reports submitted to court by due date	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	100%	95%	100%		*On target*

The % of individuals beginning a work placement within 7 working days of receiving a Community Payback Order	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	80%	80%	87%		*On target*

Percentage of people 65+ indicating satisfaction with their social interaction opportunities	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	95%	95%	94%		Performance has declined marginally below target for the first time in 2019-20, which will the subject of operational analysis and review.

Percentage of service users satisfied with their involvement in the design of their care packages	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	98%	95%	97%		*On target*

% of initial Child Protection Case Conferences taking place within 21 days from receipt of referral	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	87%	90%	85%		Performance for the year was affected by below target compliance in Q1 and Q2. Improvement action resulted in on-target performance in Q3 and Q4.

(Some variances can be due to small number changes)

% of Social Work Reports Submitted to Child Protection Case Conference	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	100%	100%	100%		*On target*

% of Court report requests allocated to a Social Worker within 2 Working Days of Receipt	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	97%	100%	100%		*On target*

Balance of Care for looked after children: % of children being looked after in the Community	Actual 2018-19	Target 2019-20	Actual 2019-20	Status	Comment
	85%	89%	87%		Performance has improved over the past 12 months but remains below target. Although the number of children looked after in community placements has been maintained, there has been an increase in residential placements resulting in a slight shift in the balance of care.

(Some variances can be due to small number changes)

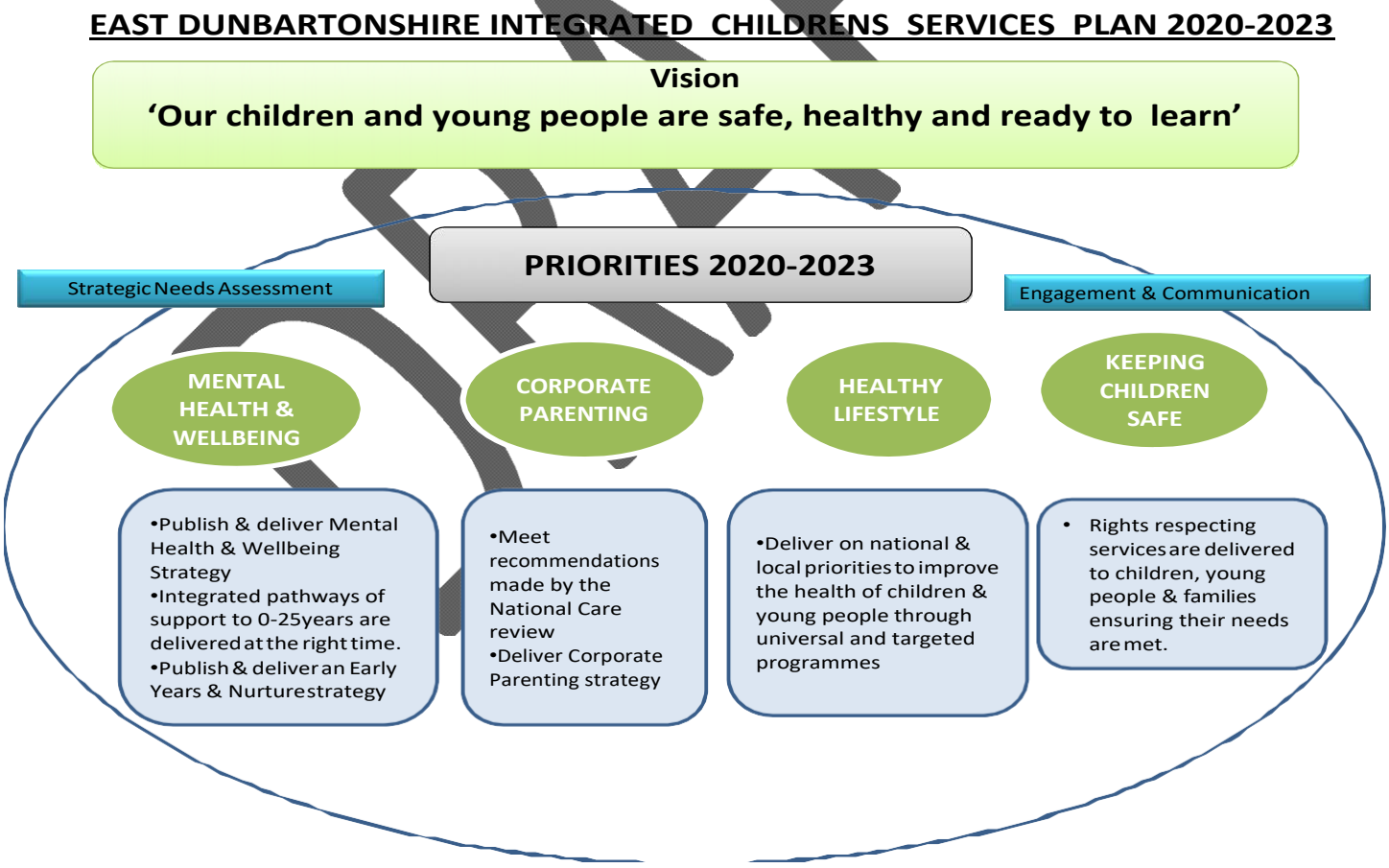
Part 4. Children's Services

The integrated planning of children's services is led overall by the Delivering for Children and Young People's Partnership (DCYPP), which involves all the individuals, agencies and services that work together to improve outcomes for children and young people in East Dunbartonshire. This is part of the work of the Community Planning Partnership (CPP) and is reported through the Council's annual Public Performance Report, as the CPP's lead body. The HSCP is a significant partner in the work of the DCYPP.

In addition to the DCYPP, a number of other planning arrangements are established and operated by (or involving) the HSCP, to support specific statutory duties, including the Child Protection Committee.

This year the East Dunbartonshire Integrated Children's Services Plan 2017-20 and planning processes were reviewed by The Scottish Government and the Chief Social Work Officer For Scotland. Feedback was positive.

In November 2019 work began on drafting the next 3 year Integrated Children's Services Plan. A consultation with key stakeholders identified key priority areas: please see draft below.



Work on the new Plan has been placed on hold due to the Coronavirus Pandemic. Work will resume as soon as possible and in line with the DCYPP agenda.

The business of the Child Protection Committee has continued to grow. This year our 5 test of changes groups reported that most improvement actions had been completed. This resulted in improvements to both Child Protection process and paperwork.

Other significant achievements were:

- ✓ All parents who completed the Triple P Positive Parenting Programme continued to report that their parenting skills improved resulting in a positive impact on family life and improved confidence;
- ✓ The 27-30 Month Review by Health Visitors assesses eight areas of children's development during the 27-30 month reviews. There was an above target uptake of this initiative in the last reporting year;
- ✓ The Daycare Childminding Service continues to provide valuable, nurture based services to support the most vulnerable children experiencing a crisis in their life, including care experienced children;
- ✓ "Excellent" (grade 6) evaluations by the Care Inspectorate were achieved for Ferndale Residential Services, Ferndale Outreach Services and the Community Support Team;
- ✓ Continued successful implementation and delivery of the Multi-agency Child Protection Training Strategy;
- ✓ Increased young person participation in throughcare and aftercare.

Part 5. Justice Services

Community Justice Scotland (CJS) was launched in 2016 by the Scottish Government supported by a national strategy, national outcomes and a performance and improvement framework. Locally, the East Dunbartonshire Community Justice Partnership (CJP) has a wide representation from the full range of statutory, independent and third sector partners. The CJP goes from strength to strength to deliver innovative approaches to reduce crime and its negative impact to build safer communities. An overarching focus of the CJP is how early intervention and prevention can help to reduce the cycle of re-offending and build safer communities. Justice social work services have contributed significantly to the Community Justice Outcome Improvement Plan 2018-19 along with all key partners in under local outcome 4: "East Dunbartonshire is a safe place in which to live, work and visit".

Justice Social Work

The three national outcomes for justice social work services inform the practices and interventions in East Dunbartonshire. To meet the public's needs for safety, justice and social inclusion all three should be addressed in unison. They also reflect the HSCP Strategic Priorities 1, 2 and 4.

1. Community safety and public protection
2. The reduction of re-offending
3. Social inclusion to support desistance from offending

Some key achievements in Justice in 2019/20:

- ✓ Criminal Justice won the overall HSCP Award at the Greater Glasgow & Clyde Health Board 'Celebrating Success Awards 2019'. This was for addressing a service gap by being a Scottish leader in commissioning, training and implementing an accredited intervention to target the risk of men who perpetrate domestic abuse against women, to address risk and build safer communities.
- ✓ Created new Treatment Manager post to establish a new groupwork service in order to quality assure delivery of accredited programmes aimed at addressing domestic and sexual violence, to enhance public protection.
- ✓ A co-produced Justice programme with Dr Beth Weaver from Strathclyde University to empower service user led service design.
- ✓ Training for Unpaid Work in new Community Justice professional training programme.
- ✓ Refreshed the Justice Website to improve local community communication with an electronic form for community citizens to requests unpaid work for the improvement of the East Dunbartonshire community.
- ✓ Commission and workforce training for all criminal justice staff in the use of Justice Outcome Star assessment tool. This electronic tool provides robust intervention plans to address risk and addresses a national gap to provide robust outcome reporting to improved service development.
- ✓ Established an information sharing protocol between Justice Service and Scottish Prison Service before setting up a multi-agency Prisoner Release Operational to address people's needs prior to their release from a custodial sentence, this includes drugs and alcohol; mental health and wellbeing.

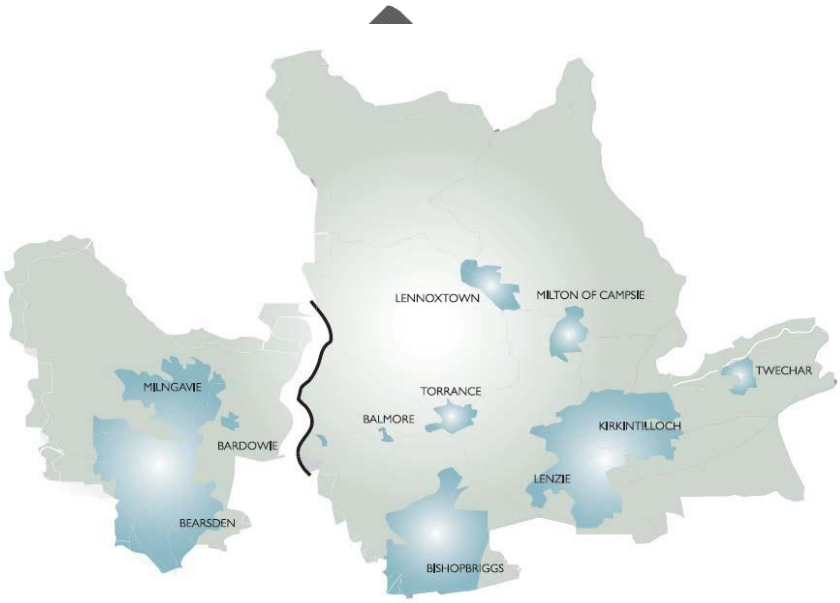
- ✓ Unpaid work service delivered a wide range of community projects throughout the year. This **totalled 17,000** hours of unpaid work invested in our communities. This equates to the value of around **£148,000** (based on National Living Wage at that time);
- ✓ Provided **269** criminal justice reports to Courts providing sentencing recommendations on public safety and community interventions;
- ✓ Justice Service managed **242 offenders** (201 previous year) on community payback orders with full assessment of health needs and risks. This was a **20% increase.**
- ✓ Justice provided **209** reports (109 previous year) to the Parole Board Scotland to aid the safe and successful reintegration into the community of people with serious convictions. This was a **97% increase**.
- ✓ Hosted the 2019 Community Justice East Dunbartonshire Conference focusing on safer communities;

Part 6. 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 relate to natural communities. They consist of:-

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

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.



Three Primary Care Clusters exist in Kirkintilloch and the Villages, Bishopbriggs and Auchinairn, and Bearsden and Milngavie. Most community health services are organised into either locality or cluster teams.

Locality Planning Groups: Priorities

Each group agreed a number of priorities for 2019-20. Progress in support of these priorities is set out below:

West Locality Priorities	Our Achievements in 2019-20	Status
Influencing supported housing and care home options	The group was involved in focus groups and interviews to support the identification of housing needs of older people and people with disabilities.	In progress
Proposal for new health and social care premises in west locality	The group assisted in developing a business case for new premises in the west.	In progress
Mental Health festival in Bearsden.	Undertook several workshops and stalls as part of a wider community event on mental health week in Bearsden.	Completed

East Locality Priorities	Our Achievements in 2019-20	Status
Community transport model	Representatives from the group are involved in developing a proposal for a community transport model to develop a shared asset to support our local communities	In progress
Health and wellbeing event	Over 20 organisations attended an activity and stalls event planned by the group to help raise awareness of local community services.	Completed
Informal Day Services	Two Local Area Coordinators have strong links with locality planning groups by providing information on local supports as an alternative to day care.	On-going

In the past year, the locality planning groups have had a period of review. The Strategic Joint Inspection of Adult Services in 2018-19 reported that the links between cluster working, locality planning and the operational delivery of services were under-developed. HSCP evaluation has also concluded that Locality Planning as it has been operating has been too strategic in focus and often duplicated the work of the Strategic Planning Group.

It is proposed therefore that Locality Planning should be more tactical in its approach whereby locality planning groups could use their collective experience and resources to help problem solve and maximise assets assisting practitioners to meet needs on both an individual and community-wide basis. It is recognised that there are structural and employer challenges to creating fully integrated teams, but that *collaboratives* are a step towards the ultimate goal that are pragmatic and achievable in the short term.

A structure that reaches across operational, tactical and strategic dimensions will be established during 2020-21, with clearer clarity of governance and outcome.

Part 7. Examples of Good Practice

An important aspect of performance reporting is to highlight examples of the excellent work that is developed and delivered to improve outcomes for people who need support. This section of the report reflects some of this good work, particularly in areas where success has been delivered through the integration of health, social care and wider public services working together.

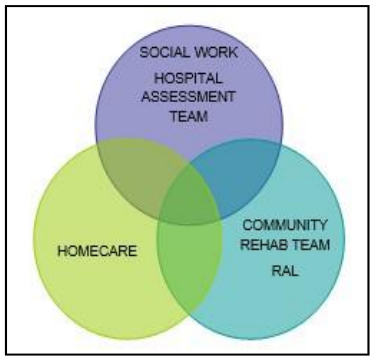
Home For Me

The new Home For Me Service is a collaboration between the Community Rehab Team, Social Work Hospital Assessment Team and Home Care. It has been a great success within East Dunbartonshire. It aims to promote independence, maintain people within their own homes and reduce reliance on care packages through provision of Home Care reablement supported by rehab and prevent avoidable hospital admissions.

Within the first 6 months of operation, results show an average reduction in home care visits from 3 to 1 per day, and an 82% reduction in home care hours. These reductions have been sustained at 3 and 6 month follow ups.

There have been over 150 GP rapid response and urgent referrals received with approximately 70% being able to be supported to remain at home. Based on an average length of stay of 5 days this represents a saving of over 500 bed days.

Close links have been made with acute hospitals, targeting orthopaedic wards in particular and pathways are in place to facilitate early supported discharges. An in-patient data "dashboard" has also been used to highlight East Dunbartonshire patients within the acute hospitals and a trial is in place within Care of the Elderly wards at Queen Elizabeth University Hospital, where a weekly list is sent, identifying patients previously known to CRT to support communication, sharing of information and support discharge planning.



There are plans to improve current pathways and target specific acute wards to reduce length of stay, as well as increasing uptake from GPs to reduce avoidable admissions.

Child Protection

Children and Families co-ordinated an improvement programme which was informed by a case file audit during 2019-20, as part of a process of self-evaluation and continuous improvement. Significant improvements have already been established in respect of Child Protection processes and paperwork. This work reports directly in to the Child Protection Committee.

Primary Care Improvement

The new Scottish General Medical Services contract was agreed in January 2018. The contract proposed a refocusing of the GP role as Expert Medical Generalist. In doing so it intended to build on the core strengths and values of General Practice whilst also seeking to deliver transformational change to enable sustainability in the face of rising demand, falling primary care workforce numbers and sub-optimal patient experience.

The contract aims to improve access for patients, improve population health, provide financial stability for GPs and reduce GP workload through the expansion of the multi-disciplinary team. The intended benefits for patients from the principles within the new contract are to help people access the right person, at the right place, at the right time.

A range of provisions were set out in the new contract and accompanying Memorandum of Understanding (MoU) on principles of service redesign, ring fenced resources to enable change to happen, new national and local oversight arrangements and agreed priorities. This included a commitment to develop a 3 year Primary Care Improvement Plan (PCIP) setting out how new Multi Disciplinary Teams (MDTs) would be created, working with practices to deliver primary care services. We are now in year three. Below provides some feedback on two services who have begun working in practices.

Advanced Practice Physiotherapist (APP)

Within the Bearsden & Milngavie cluster we have established an APP covering four GP Practices. Between March and July 2019, 1,080 APP appointments were available over the Practices, reducing pressure on available GP appointments. There was a 20% increase in patients being referred directly to the APP by the receptionist and only 39% of patients required onward referral.

Patient Feedback:

In truth this was the best and most professional experience I have had in the NHS'

'I found the advice very good; it made a lot of sense. Doing the exercises with them meant I was confident about doing them myself at home;

'Nice to have a physio in the surgery and get the right advice from the beginning"

Advanced Nurse Practitioner

East Dunbartonshire HSCP have one Advanced Nurse Practitioner (ANP) and one Trainee Advanced Nurse Practitioner (TANP). For the period July to December 2019 both the ANP and TANP carried out a total of 1,097 clinic consultation and 112 house calls, with a reduction in the need for GP review.

Simon Johnston, Advanced Practice Physio

Pharmacy

As part of the new GMS contract, there was investment in Pharmacy to allow more Pharmacists and Pharmacy Technicians to work in general practice to help reduce GP workload and improve patient care. It allowed GPs to focus on their role as expert medical generalists, improve clinical outcomes, have more appropriately distributed workload, address practice sustainability and support prescribing improvement work.

In East Dunbartonshire there are now Pharmacists is every practice and work is underway in building skill mix with Pharmacy Technicians and in the future Pharmacy Support Workers. GP feedback on the experience has been overwhelmingly positive.

Community Wellbeing Service

The Community Wellbeing Service, an initiative within primary care has continued to operate and support patients via face to face appointments and telephone support. Community Wellbeing Advisors (CWA's) have supported over 185 people to access local sources of support where their needs are social rather than medical, such as loneliness, housing issues and debt. CWA's can also provide specialist non-clinical support in specific areas such as mental health or management of long term conditions.

East Dunbartonshire Alcohol & Drug Service and Criminal Justice

East Dunbartonshire's Justice Social Work Service won 2019 Health and Social Care Awards. There were 41 nominations acknowledging success from across the HSCP for a total of six awards.

The Justice Social Work team won two of the six awards and the overall **winners in the Our Patients, customers and Service Users section and also in the Our Resources section.**

The awards were given for the excellent joint working between the two services and the co-location of addictions staff within the justice team to strengthen a public health perspective to justice and facilitate instant access to clients to enable their needs to be met.

Following on from their success at the East Dunbartonshire HSCP awards, the Justice team were nominated for an award at the Greater Glasgow & Clyde Health Board 'Celebrating Success Awards 2019' held at the Radisson Blu Hotel in Glasgow on 4th November.

The team successfully picked up the overall winner in this category for developing the **Up2U: Creating Healthy Relationships** domestic abuse perpetrator programme service to ensure robust community based sentences are available to the court and address crimes pertaining to domestic abuse.

District Nursing

Bishopbriggs District Nurses undertook a quality improvement project to increase the identification of patients with severe frailty on the District Nursing Caseload and to identify and record their preferred place of care. The team utilised the Rockwood frailty score to support identification of frailty. At the start of the project (Sept 2019) compliance with frailty scoring was 34%, by Dec 2019 compliance had increased to 84%. Feedback from the project so far is that the Rockwood frailty tool has enabled the team to identify patients, with severe frailty, and have meaningful conversations in a timely way.

Children and Family's Community Support Team

The Community Support Team is committed to continuous improvement and improving outcomes for vulnerable children and families in the community. As such, they recognise that engagement, consultation and participation are essential with all stakeholders, most notable with children, young people and their families. The Team developed a "Cycle of Participation" based on improvement science; this involves gathering views, listening to families, making small changes to practice in response and reviewing. This innovative work has led to positive feedback from service users and has been independently evaluated by The Care Inspectorate (Grade 6).

Corporate Parenting

There is a strong commitment to ensuring the East Dunbartonshire Corporate Parenting Strategy is implemented, this involves partnership working with a variety of stakeholders and partner agencies. One priority of the strategy is to ensure the statutory duties conferred by the Children and Young People (Scotland) Act 2014 are fully achieved in relation to Continuing Care and Care Leavers. Recognising the absolute value of working in partnership to achieve this, Children and Families staff applied to The Life Changes Trust to obtain a 3 year grant. The application was successful and we were able to create a post for a Young Person's Champion who will advocate for Looked After Children and ensure their outcomes are improved and equitable with others.

Part 8. Financial Performance

HSCP BOARD'S FINANCIAL POSITION AT 31 MARCH 2020

The activities of the HSCP are funded by EDC and NHS GG&C who agree their respective contributions which the partnership uses to deliver on the priorities set out in the Strategic Plan. The scope of budgets agreed for inclusion within the HSCP for 2019/20 from each of the partnership bodies were:-

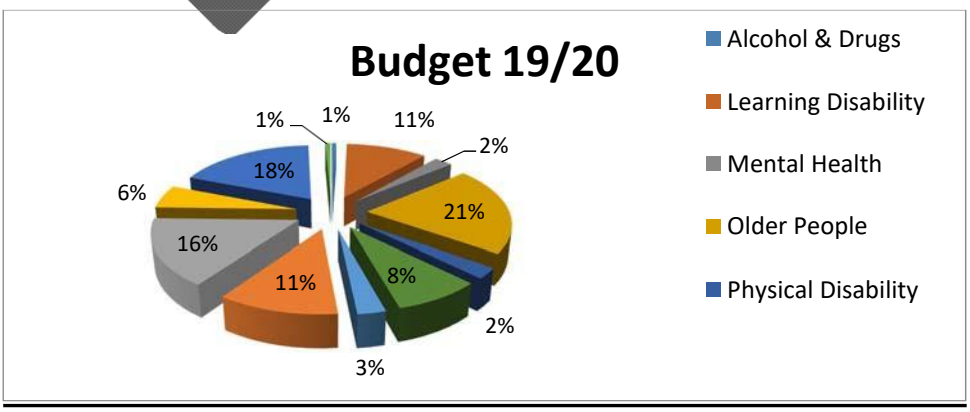
HSCP Board Budgets 2019/20 (from the 1st April 2019 to the 31st March 2020)

	Original Budget 19/20 £000	In Year Adjustments £000	Final Budget 19/20 £000
Functions Delegated by East Dunbartonshire Council	55,154	606	55,760
Functions Delegated by NHS GG&C	78,364	9,896	88,260
Set Aside – Share of Prescribed Acute functions	19,602	12,645	32,247
TOTAL	**153,120**	**23,147**	**176,267**

The increases to the original budget for 19/20 relate largely to non recurring funding allocations during the year relating to oral health, family health services and Scottish Government funding to support alcohol & drugs, primary care improvements and mental health monies. The increase to the set aside allocation relates to NHS GG&C now being in a position to report the set aside figures based on actual expenditure which has resulted in the restatement of 18/19 figures which were previously based on a notional budget figure. The notional budgets for set aside were based on NRAC activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

The budgets include an element of funding provided by the Scottish Government to deliver on the key outcomes for the Partnership in the form of delayed discharge (£0.5m), integrated care funding (£0.7m) and Social Care funding (£6.1m).

The budget is split across a range of services and care groups as depicted below:-



HOSTED SERVICES

The Health Budget includes an element relating to Oral Health Services (£9.8m) which is a service hosted by East Dunbartonshire HSCP and delivered across the other five partnership areas within NHS GG&C's boundaries.

The full extent of this budget is reflected in these accounts as prescribed within the Integration Scheme. There are services hosted within other NHS GG&C partnerships which have similar arrangements and which support the population of East Dunbartonshire such as Musculoskeletal Physiotherapy, Podiatry, and Continence Care.

The extent to which these services are consumed by the population of East Dunbartonshire is reflected below:-

2018/19 £000	Service Area	2019/20 £000
518	MSK Physio	556
62	Retinal Screening	59
563	Podiatry	578
333	Primary Care Support	342
357	Continence	372
633	Sexual Health	637
	Learning Disability – Tier 4	42
793	Mental Health Services	825
	Augmentative & Alternative Communications	25
800	Oral Health	809
907	Addiction	912
155	Prison Healthcare	164
193	Healthcare in Police Custody	193
2,361	General Psychiatry	2,301
	Learning Disability – In Patient	154
1,389	Old Age Psychiatry	1,204
9,064	**Total Cost of Services consumed within East Dunbartonshire**	**9,173**

SET ASIDE BUDGET

The set aside budget relates to certain prescribed acute services including Accident & Emergency, General Medicine, Respiratory care, Geriatric long stay care etc. where the redesign and development of preventative, community based services may have an impact and reduce the overall unplanned admissions to the acute sector, offering better outcomes for patients and service users.

Work continues to be progressed in relation to the sum set aside for hospital services; however, arrangements under the control of Integration Authorities are not yet operating as required by the legislation and statutory guidance. Each Health Board, in partnership with the Local Authority and Integration Authority, must fully implement the delegated hospital budget and set aside budget requirements of the legislation, in line with the statutory guidance published in June 2015. To date work has focused on the collation of data in relation to costs and activity. Moving forward work has now commenced on the

development of commissioning plans to support the implementation of set aside arrangements.

An allocation has been determined by NHS GG&C for East Dunbartonshire of £32.2m for 2019/20 in relation to these prescribed acute services. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

Locality Budgets

A small budget has been devolved to each locality (£5k each) to start to deliver on local priorities identified through the locality planning groups. A financial framework for each locality is under development which will seek to map the entirety of the partnership budget across each locality.

FINANCIAL PERFORMANCE 2019/20

The partnership's financial performance provides a deficit of £1.090m against the partnership funding available for 2019/20. The figure excludes transfers to /from reserves (mainly related to Scottish Government (SG) funding for specific priorities including Primary Care Improvements (PCIP), delivery of the Mental Health Strategy (MH), and Alcohol and Drugs partnership monies (ADP)).

The pressures on the partnership budget relate in the main to social work services of £1.9m which were mitigated in part through under spends on community health budgets of £0.8m with reserves applied to manage the remaining gap to deliver a balanced budget at the year end.

This required the transfer of £0.041m from general reserves and £1.049m from earmarked to ensure a balanced budget position for 19/20.

The financial out turn includes £0.4m of expenditure related to the emerging impact from Covid-19 for increased prescribing, personal protective equipment (PPE), community assessment centre set up, equipment and additional social care supports to support carers and as an alternative to day centres which closed during the pandemic. This was funded through additional monies made available from the SG.

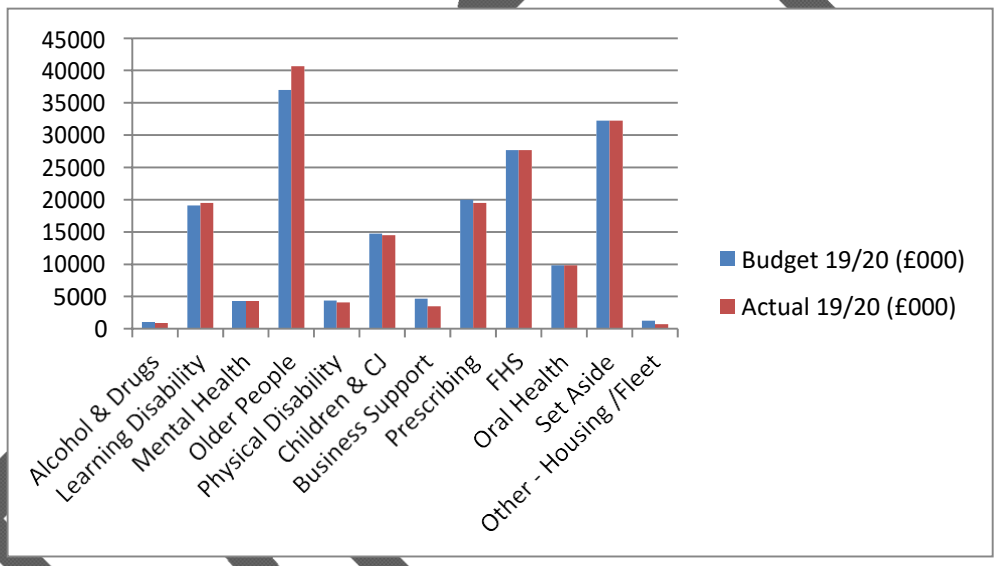
As part of the approval of the 2019/20 Budget in March 2019, the HSCP Board approved a Transformation and Service Redesign programme of £3.9m to deliver a balanced budget for the year. This was a hugely challenging programme to deliver in year and required a process of service review across a number of work-streams, consultation and engagement with key stakeholders and dependencies with complimentary work across a number of fronts. This led to slippage within the programme which caused budget pressures across the range of HSCP services but primarily within Older Peoples services where the focus of service redesign was targeted. In addition the demand increases for Older People's services resulted in this presenting as a significant area of budget pressure for the partnership during 2019/20.

A recovery plan was approved by the HSCP Board in September 2019 comprising robust vacancy management, limits to essential areas of spend only across the range of services delivered through the HSCP and identification of additional efficiency measures to be implemented throughout the year. The recovery plan did not extend to measures which delivered reductions in service provision, cessation of services or which would lead to a diminution in service performance such as in the areas of bed days occupied and delayed

discharges. The recovery plan delivered a positive contribution towards mitigating the anticipated budget pressures, however did not manage this completely.

This has had a significant impact on the available reserves of the partnership moving into future years with no general reserve available to act as a contingency to manage delivery of transformation and in year unplanned budget pressures, and earmarked reserves limited to those where funding has been made available by the Scottish Government for specific initiatives such as PCIP, Mental Health Action 15 and support to alcohol and drug services. A small balance remains to lever in transformational change, however this is limited and seed funding to deliver transformation will need to be sought from other sources where available. Limited reserves also increases the risk of having to rely on partner agency additional contributions beyond that agreed at the setting of the annual budget in March 2020. Any additional contribution may be on the basis of a loan which requires to be repaid in future years which serves to further the risk to the financial sustainability of the partnership and places a reliance on identifying extensive transformation activity or service reductions / cessations to deliver a balanced budget.

The partnership's financial performance across care groups is represented below:



The main areas of budget pressure for the HSCP during the year are set out below:

Older People Services (£3.3m over spend)

The overall pressures relate to ongoing demand and cost pressures exceeding the available budget for 2019/20, particularly in the area of older people's social care.

These were a result of adverse payroll variances particularly in relation to homecare as a consequence of reliance on overtime and use of agency to ensure continuity of service delivery to cover vacancies, sickness and absence; challenging savings plans predicated on the redesign of homecare services and which were not achieved in year; increased activity levels placing demand pressures on older people care homes, homecare, supported living and day-care (alternatives) and contractual increases in relation to the care at home framework and national care home contracts beyond that which was provided for within the budget. These pressures arose as a direct result of the growing demand from an ageing population requiring support from social work services to maintain independent living within the community or within a care home setting.

A review of care at home services during the year has determined that a locality based approach supported through a balance of usage of externally purchased services will deliver a sustainable care at home service going forward. This is in the process of being implemented internally with external provision subject to re-tendering exercise with resort to the national Scotland Excel Framework to deliver this element of the service.

Adults – Learning Disability, Mental Health, Addiction Services (£0.1m over spend)

There were some pressures in the area of learning disability in relation to the impact of the delay in delivering savings within the Pineview service, taxi provision to support individuals with a learning disability to access services and costs associated with agency staff to cover statutory mental health officer functions. This was offset through a downturn in residential accommodation within addiction recovery services, recharges for fleet provision and savings achieved through vacancies across community health services within this care group area. The implementation of the new Access to Transport policy and progression of the learning disability review will mitigate pressures in this area going forward.

Children & Families (£0.3m under spend)
There were some pressures in relation to externally purchased foster placements, kinship payments and health visiting staff costs, this was offset through robust vacancy management across Children's social work and residential services.

Business Support (£1.2m under spend)
There were some pressures on accommodation costs within the Kirkintilloch Health & Care Centre and Lennoxtown Hub, this was offset through additional funding above anticipated levels in relation to the improved health offer, continuing care, support to veterans, carers funding and the positive impact of improved bad debt provisions.

Prescribing (£0,5m under spend)
There are a number of points to note in respect of prescribing, namely:-

- The cost per drugs is increasing on average by 9.36% for East Dunbartonshire based on the types of drugs being dispensed and this is expected to continue.
- The overall performance on prescribing is being driven largely by volumes with an average decline in volumes over the year of 6% compared to that forecast at the budget planning stage.
- This is set in the context of increasing list sizes for East Dunbartonshire having seen an increase of 1.06% since the same period last year.
- There were savings from discounts (patented drugs) and discount clawback (generic drugs) in 2019/20 which had a positive impact on this budget

Other Services (£0.4m under spend)
There was a positive variation on other budgets delegated to the partnership relating to private sector housing grants and care & repair services delivered through the Council's housing service.

Partnership Reserves

As detailed above, there was additional funding allocated during the year from the Scottish Government to support the development and implementation of a number of key initiatives

which have been earmarked within reserves with planned expenditure during 2020/21. These provide for balances on earmarked reserves as set out below:

- Self Directed Support (SDS) £0.077m
- Integrated Care Funding £0.307m
- Primary Care Improvement Plan £0.196m
- Primary Care Cluster Funding £0.039m
- Action 15 Mental Health Strategy £0.108m
- Alcohol and Drugs Partnerships £0.038m
- Technology Enabled Care £0.011m
- Infant Feeding £0.013m
- CHW Henry Programme £0.015m
- **TOTAL** **£0.804m**

There was an overall reduction in the level of earmarked reserves of £1.05m over the course of the year due to the review and re-designation of a number of earmarked reserves related to Oral Health, Prescribing and Integrated Care Funding (£0.56m). This supported the general reserve position and ability to support a balanced position in year. Further monies were used in the delivery of the Scottish Government initiatives outlined above during 2019/20 (£0.49m).

There is a nil balance on partnership general reserves at the end of 2019/20.This provides no resilience for future years for managing in year financial pressures and any slippage in savings targets.

The total level of partnership reserves is now £0.804m.

Financial Planning

The HSCP continues to face significant financial pressures from demographic growth particularly amongst the elderly population placing demand on care at home and care home provision, pressures in relation to increasing numbers of children moving on into adult services generating demand, and increased cost pressures across a range of adult social care services. This will be compounded during 2020/21 due to anticipated costs associated with the re-tendering of the Care at Home Framework, increased costs associated with the national care home contract, pressures in the delivery of the Scottish Living wage, continued prescribing demand and cost pressures and extremely challenging savings plans associated with service redesign, income generation, fairer access and eligibility to services.

In setting the budget for 2020/21, the partnership had a funding gap of £6m following an analysis of cost pressures set against the funding available to support health and social care expenditure in East Dunbartonshire, this is set out in the table below:

	Delegated SW Functions (£m)	Delegated NHS Functions (£m)	Total HSCP (£m)
Recurring Budget 2019/20 (excl. Set aside)	54.838	81.802	136.640
Financial Pressures	7.645	1.942	9.587
2020/21 Budget Requirement	62.483	83.744	146.227
2020/21 Financial Settlement	56.768	83.405	140.173
Financial Challenge 20/21	5.715	0.339	6.054
Budget Savings 19/20 - F/Y Impact	(1.020)	(0.200)	(1.220)
Financial Challenge Measures	(0.577)	(0.339)	(0.916)
Efficiency Measures			
- turnover analysis	(0.445)	0.000	(0.445)
Transformation Plan 20/21	(0.701)	0.000	(0.701)
Residual Financial Gap 20/21	**2.973**	**(0.200)**	**2.773**

Savings plans of £3.2m were identified to mitigate the financial pressures which left a remaining gap of £2.8m to be funded through a process of collaborative working with Council Transformation Leads to identify further transformation activity to address the gap in full.

The Council continues to underwrite the delivery of the transformation programme. In the event of this being unachievable suitable provision will need to be made by the Council with the reserves position serving as the ultimate backstop.

The IJB may be asked to consider a recovery plan at a future date in order to achieve a balanced budget in the event that pressures extend beyond the assumptions set out in the financial plan for 2020/21. A range of options have been developed which focus on service reductions, extension to waiting times, placement management, staffing reductions, funding reductions to 3rd sector to align with statutory minimums and further charging options.

There has been a significant delay in progressing this work as a result of resources re-directed to manage the effects of the Covid-19 pandemic and this is expected to continue.

The HSCP, along with other HSCPs across Scotland, have developed a mobilisation plan to manage the impact of the pandemic along with a financial assessment of the likely costs associated with these planned responses. This includes the anticipated shortfall in the HSCP transformation planning for 2020/21.

This also includes an assessment of the impact of the national agreement on the level of uplift to be provided to support delivery of the Scottish Living Wage to staff within purchased care at home, housing support and daycare services. The level of funding provided through the Scottish Government to fund this initiative provided a cost pressure within East Dunbartonshire and an element of this has been reflected within mobilisation plans related to the difference between what would normally have been provided as an uplift and that agreed nationally.

The other areas of cost pressures arising from the pandemic relate to personal, protective equipment (PPE), additional costs to social care providers including staffing, PPE and sustainability support, development of a local assessment centre and cost to support carers, alternatives to daycare. It is assumed that the cost implications associated with

managing the Covid-19 pandemic will be met through funding form the Scottish Government. However this remains a key risk to the HSCP for 2020/21.

Both partner organisations continue to face significant financial challenge and these impact the consideration of the financial settlement to the partnership in the delivery of its key strategic priorities and the delivery of the services delegated to it.

The NHS settlement to the HSCP provided an uplift of 3%.on pays and general expenditure which provides a real terms increase on 2019/20 baseline funding.

The EDC settlement to the HSCP provided a flat cash position for pays and general expenditure with specific funding from the Scottish Government in relation to funding for health and social care totalling £100m across Scotland representing an additional £1.9m for the HSCP.

The challenging levels of savings on Partnership budgets is expected to continue for future years given the challenging financial settlements expected to both EDC and NHS GG&C.

The partnership is therefore planning for the period 2020/21 to 2024/25 for a potential funding gap of £3.4m to £21.4m (being best and worst case scenarios) in the context of reducing resources set against increasing cost and demand pressures and a 'do nothing' approach to service redesign. This represents the scale of the challenge to be met through transformation over the next 5 years.

The partnership will focus on a Transformation Plan for 2020/21 and beyond based upon a set of fundamental principles initiating a new way of working within health and social care services in East Dunbartonshire based around:

- Local and community led.
- Digital first.
- Shared ownership and shared care.
- Sustainable.
- Empowered practice
- Maximised independence.

Comparative Income and Expenditure

A comparison of HSCP income and expenditure over the years since integration in 2015-16 is set out at **Annex 4**.

BEST VALUE

In terms of best value, it is the duty of the IJB to secure best value as prescribed in Part 1 of the Local Government in Scotland Act 2003. The Scottish Government have developed a best value framework to support public bodies in considering their responsibilities to secure best value, the partnership has assessed itself against this framework and this is reviewed and updated annually. This is set out in **Annex 5.**

Part 9. Inspection and Regulation

1. Joint Strategic Inspection

East Dunbartonshire HSCP was the subject of a joint strategic inspection by the Care Inspectorate and Healthcare Improvement Scotland between November 2018 and February 2019. The purpose of the inspection was to evaluate how well we plan and commission services to achieve better outcomes for people.

The inspection looked not just at the work of the HSCP Board, but at the partnership working across agencies and services in East Dunbartonshire.

The aim was to ensure that we have the building blocks in place to plan, commission and deliver high quality services in a co-ordinated and sustainable way, namely:

- a shared vision
- leadership of strategy and direction
- a culture of collaboration and partnership
- effective governance structures
- a needs analysis on which to plan and jointly commission services
- robust mechanisms to engage with communities
- a plan for effective use of financial resources, and
- a coherent integrated workforce plan which includes a strategy for continuous professional development and shared learning

To do this, the inspection assessed the vision, values and culture across the partnership, including leadership of strategy and direction, the operational and strategic planning arrangements (including progress towards effective joint commissioning), and improvements the partnership is making in both health and social care, in respect of the services that are provided for all adults.

The focus of the inspection is on quality indicators 1, 6 and 9:

1.0 Key performance outcomes

6.0 Strategic planning and commissioning arrangements

9.0 Leadership and direction that promotes partnership

The final report was published on 30 July 2019. An Action Plan based upon the report's recommendations has been developed, with progress towards these actions outlined in **Annex 2** will be put in place to take forward any recommendations.

2. Service Inspections

Detail on Care Inspectorate evaluation grades relating to provided and arranged services is set out at **Annex 3**.

Part 10. Transformational Change

The HSCP Board and Strategic Planning Group are supported by a Transformation Board, which coordinates activity relating to the Transformation Plan, which allows the Strategic Planning Group and the HSCP Board to oversee how well these aspects of the Strategic Plan are being implemented. The Transformation Plan contains improvement initiatives that are:

- Aligned to delivery of financial efficiencies and Best Value;
- Arising from the introduction of new national policy or legislation with cross-cutting implications;
- Associated with public sector reform;

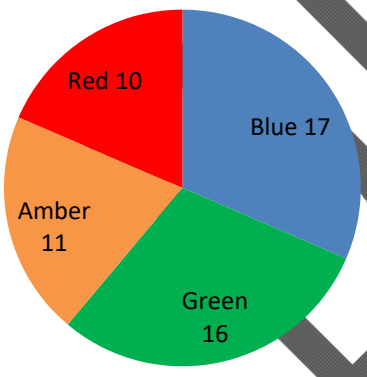
The Transformation Plan is separately reported, but key initiatives successfully delivered through this mechanism during 2018-19 include:

Initiative	Strategic Plan Priority	National Outcome
Initiative to increase fostering opportunities for delivery in East Dunbartonshire.	1, 8	4, 7, 8, 9
Review of all Looked After and Accommodated Placement to ensure their needs are met and placements provide best value	5, 8	4, 7, 9
Development of an updated Corporate Parenting Strategy and action plan	1, 8	3, 4, 5, 7, 9
Purchase and implement Carefirst Criminal Justice Service Module to facilitate improved data interrogation and more efficient and effective targeting of resources to identified areas of need.	8	9
Response to the Management of Offenders Act 2019 - Presumption Against Short Term Prison Sentences, by increasing robust community based alternatives to create efficient and effective ways to manage increased demand.	1, 4	9
Review of current sleepover arrangements in order to optimise individual levels of independence, ensure appropriate service delivery and to maximise opportunities for use of technological solutions.	6, 8	3, 4, 9
Kelvinbank enhanced day services: Review of arrangements for day services provision to support adults with learning disabilities and maximise opportunities for delivery through Kelvinbank.	2, 4, 5	2, 9
Review of Ordinary Residence – Mental Health: Review of support arrangements for individuals with a mental health condition to ensure costs are being met appropriately.	8	9
Review of Rosebank Allotments: Review of allotment provision to support individuals with mental health and addictions.	8	9

Review of resource capacity to support Learning Disability community health function.	8	9
Implementation of the Carers (Scotland) Act 2016	7	6
Implement The Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No. 2) Regulations 2018 (Frank's Law)	4	9
Maximising use of Technology Enabled Care: Review of alternatives for the demonstration of SMART technology.	2, 5	9
Review of respite: Review of entitlement to respite provision to ensure parity across older people's services.	1, 7	6, 9
Review of Ordinary Residence – Older People: Review of support arrangements for older people to ensure costs are being met appropriately.	1, 4	9
Review of Integrated Care Funding: Review of priorities funded through integrated care funding and mainlining of recurring projects.	1, 8	9
Review of Charging for Community Alarms:	8	9
Review of Charging for Day Services / Transport	8	9

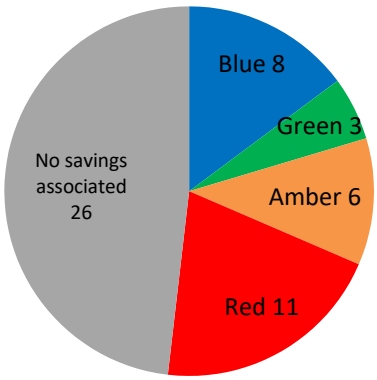
Transformation Plan: Project and Savings Progress Summaries for 2019-20

Project Progress – BRAG Rating:



Blue: Project complete
Green: On track
Amber: Some delay
Red: Significant difficulty or delay

Savings Progress – BRAG Rating:



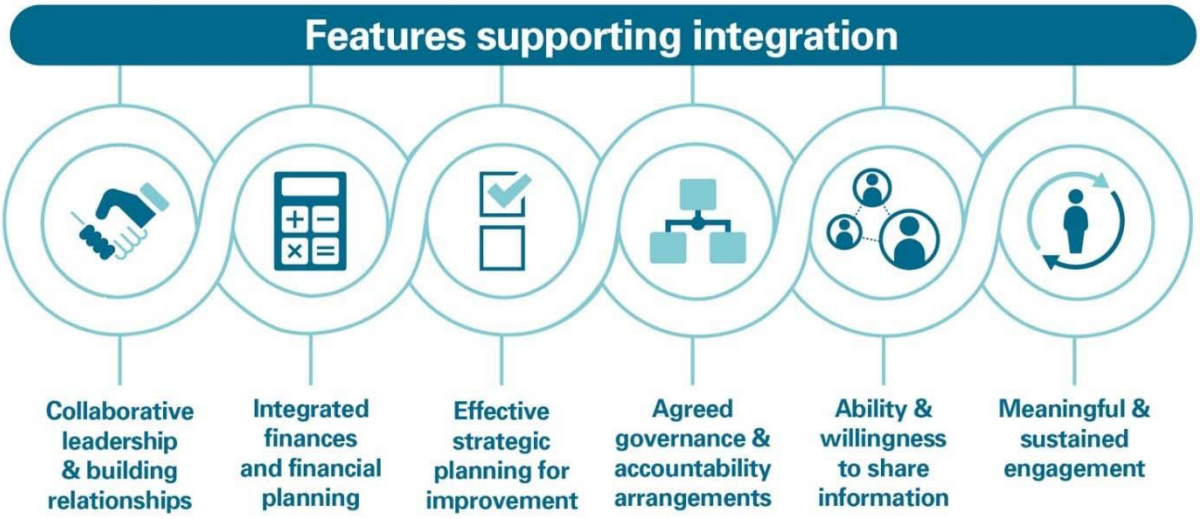
Blue: Full savings delivered
Green: Full savings expected
Amber: Partial savings expected
Red: No savings expected

Part 11. Making Integration Work

Audit Scotland produced a report into the progress of Health and Social Care Partnerships in November 2018. The report demonstrated that good progress is being made in many aspects, but that there is still a significant programme of work ahead:

> *"Integration Authorities (IAs) have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital. People at the end of their lives are also spending more time at home or in a homely setting, rather than in hospital. These improvements are welcome and show that integration can work within the current legislative framework, but Integration Authorities are operating in an extremely challenging environment and there is much more to be done."*
>
> *Audit Scotland, Health and Social Care Integration – Update on Progress, November 2018*

The Scottish Government's Strategic Leadership Group has proposed 25 areas for improvement, of which 22 apply to local Partnerships. These areas for improvement are arranged under a framework of six heading, as illustrated below:



A programme of work will be undertaken and reported separately to the HSCP Board on our progress against this improvement framework. A summary of some of the improvements we have made across these themes in 2018-19 is set out on the next page.

Features Supporting Integration: Progress

Progress to 2018-19	Progress in 2019-20	Current Actions
Collaborative leadership and building relationships		
• Collaborative Leadership in Practice (CLiP) being rolled out across the Partnership; • Workforce and Organisational Development Plan developed; • Regular HSCP Board development sessions; • Improved collaborative leadership with constituency bodies; • Improved Third Sector Interface representation at HSCP Board, Strategic Planning Group, Community Planning Partnership, Locality Planning Groups and on Service Planning Groups; • Strong consultative approaches with service and policy reviews; • Better preparatory engagement around efficiencies and financial planning.	• Review of all constituent body leadership training to identify ones for reciprocal access; • Enhanced collaboration across and between leadership and strategy forums of constituent bodies; • Development and publishing a formal Commissioning Strategy, linked to the HSCP Strategic Plan; • Enhanced engagement with providers via improved Providers' Forum, with support from iHub; • Improved engagement with larger national third sector providers.	• Joint Organisation Development Plan: collective approach to deliver improved processes and outcomes (interruption due to Coronavirus Pandemic)
Integrated finances and financial planning		
• Improved financial planning between HSCP and constituency bodies; • 2019-20 delegated budgets were agreed by end March 2019; • HSCP Board reserves policy in place;	• Regular meetings of finance and service delivery leads across the constituent bodies, to scrutinise the current and projected financial position of the HSCP; • Reviewed and improved financial	• Preparatory work to ensure that hospital budgets and set aside budget requirements are fully implemented within target timescales (interruption due to Coronavirus Pandemic).

Progress to 2018-19	Progress in 2019-20	Current Actions
• Regular in-year reporting and forecasting provided to the HSCP Board; • Pooled revenue budgeting has permitted flexible use of overall resources;	monitoring and reporting framework to support operational delivery across the NHS, HSCP and Council; • Development of a medium to long term financial plan to support the HSCP service delivery model; • Joint work towards agreeing annual budgets at appropriate points in the calendar year; • Maximising the opportunities for joint development sessions for individuals providing finance support. • Working across the partnership to understand expected future capital requirements for community services further and develop our mapping of the potential contribution of all agencies to delivering on a capital programme for fit for the future facilities in local communities, as far as possible, regardless of ownership of the asset.	• Review the existing HSCP reserves policy including consideration of strategies to re-establish reserves over time to replenish those that have been used to meet additional service demand to date; • Reviewing the support arrangements to the HSCP Chief Finance Officer with a view to streamlining and aligning arrangements and timing of reports where possible; • Revising our reporting format to the HSCP Board to reflect the totality of partnership resources collectively, as opposed to separate reporting of information for EDC and NHSGGC commissioned spend; • Reviewing the Council scheme of delegation to ensure appropriate HSCP officers are empowered to manage and deploy the resources in their remit directly and effectively.
Effective strategic planning for improvement		
• HSCP Strategic Plan 2018-21 published; • New Performance Management & Reporting Policy developed; • Learning Disability and Carers Strategies published;	• Improved approach to strategic planning to ensure we are able to identify earlier the likely support requirements associated with planned changes and consequent service delivery.	• Reviewing the Integration Scheme to reflect lessons learned through practice over the years of operation (interrupted by Coronavirus pandemic).

Progress to 2018-19	Progress in 2019-20	Current Actions
• Improved transformational and service planning arrangements established; • Improved partnership representation across the strategic and service planning arrangements.		• Developing locality level plans in partnership with the locality planning group members and with community planning partnership colleagues;
Governance and accountability arrangements		
• Established and improved reference and consultative arrangements to support the HSCP Board; • Regular development sessions to support the HSCP Board members; • Support to public, service user and carers on maximising and sustaining the representative role; • Revised processes to support Directions to constituent bodies; • Well established Clinical & Care Governance arrangements that span the totality of integrated functions;	• Links to actions completed above; • Established a programme of HSCP Board member development sessions on key areas of interest, agreed with Board members, to provide opportunity to outline and clarify accountabilities and responsibilities in areas of business; • Support to the HSCPB Chair to engage in the national Chair's Group; • Development of a programme of briefing and discussion opportunities with the Chair and senior management team of the HSCP to support effective agenda, Board business and whole system planning; • Development of national guidance on the issuing and monitoring of Directions issued by the HSCP Board, considering exemplar models from elsewhere; • Ongoing improvement and development of established biannual joint EDC and NHSGGC Operational Performance Review Meeting process, as a mechanism to support our approach to	• Further developing our programme of support to HSCP Board members that specifically includes the support requirements of the Chair; • Revising our local Clinical and care Governance arrangements in line with the outcome of national guidance (interrupted by Coronavirus pandemic); • Fully embedding the new Quality Management Framework in the work of the clinical and care governance group's scrutiny processes. • Approval and implementation of revised Directions procedures.

Progress to 2018-19	Progress in 2019-20	Current Actions
	Directions. • Development and approval of a formal HSCP Quality Management Framework; • Ensuring the Clinical and Care Governance committee has oversight of the quality and standards for all of our commissioned services by providing regular update reports	
Ability and willingness to share information		
• Annual Performance Report format developed and extended for 2018-19.	• Links to actions completed above	• Links to actions underway above
Meaningful and Sustained Engagement		
• Improved stakeholder involvement in strategic and service planning; • Strong communication and engagement practice to support strategy and policy development, and service redesign.	• Developed and present to the HSCP Board a refreshed HSCP engagement strategy that outlines our engagement opportunities for local communities in relation to strategic, local planning and transformation activities	• We will continue to identify opportunities for joined up consultation processes across NHSGGC, the HSCP and EDC, aligned to key strategies such as Moving Forward Together and EDC's Community wide planning arrangements. • To improve understanding, in the context of our revised engagement strategy, we will continue to work to expand the membership, representation and reach of our Patient, Service Users and Carers Group through increased direct and indirect participation

ANNEX 1: National Outcomes and Local Priorities

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. The table below cross-references these with HSCP's Strategic Priorities.

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

ANNEX 2: STRATEGIC JOINT INSPECTION OF ADULT SERVICES – ACTION PLAN

The inspection report was published on 30 July 2019 and can be accessed here. The areas for development identified through the inspection process and the actions agreed to address these are set out below.

1. The partnership should improve its approaches to performance measurement and management of:
- **national and local datasets**
- **teams, services and localities**
- **benchmarking**
- **qualitative data**
- **outcome-focused data.**

It should ensure that it uses relevant information to identify priority areas for self-evaluation and self-assessment, and drive identified improvements.

Action and Cross Referencing	Timescale	Progress: August 20
1 a) Implement the Performance Framework approach developed during 2018 – 2019	End September 2019	**COMPLETE:** • New annual, quarterly and monthly HSCP performance reports now established to support scrutiny, oversight and awareness at all levels; • New Service Performance Review process and schedule established for regular, inclusive and collective SMT oversight of operational services.
1 b) Develop an ISD work plan to support data reporting and analysis *This action is reflected in the HSCP SMT Action Plan at Financial Planning section*	End September 2019	**COMPLETE** ISD workplan developed and agreed

1 c) Work with EDC Performance Team via the Operational Reporting Requirements Group to put reporting actions in place to address areas ISD are unable to contribute to *This action is reflected in the HSCP SMT Action Plan at Financial Planning section*	October 2019	**COMPLETE:** Significant development work complete • Establishment of monthly social care performance reports on Pentana to support HSCP overall monthly performance report; • Preparation of new team activity reports that detail referrals allocations, assessments, reviews and closures by month. • Establishment of regular joint meetings between corporate performance support leads across the NHS and Council to promote integrated processes, awareness and communication. • Establishment of monthly service performance review sessions with SMT
1 d) Develop and implement a Quality Management Framework for use across the partnership and embed process for quality improvement across partnership team *This action is reflected in the MSG Action Plan at section 4.5*	14 November 2019 for QMF approval. Delivery thereafter as per framework actions.	**COMPLETE** QMF developed and presented to HSCP Board 14 November 2019
1 e) Work with the EDC Performance Team and Carefirst Team to explore how information in relation to meeting outcomes for individuals can be collated /aggregated and reported to inform service review and planning processes	End December 2019	**Slippage – good progress. Full implementation delayed by Coronavirus pandemic:** As part of the implementation of the Fair Access to Community Care (Adults) Policy, existing Support Plan and Review tools are being completely updated. As well as aligning more effectively with the policy framework, these new tools will more effectively set out the relationships between need, risk, eligible support, informal support and personal outcomes. The new tools have been operationally tested and are now proceeding to technical review by the Carefirst Team and EDC Corporate Performance Team during October, to ensure that electronic versions of these tools will permit reporting and aggregating of personal outcome achievement.

1 f) The national Chief Officers Group will work collectively to agree common framework and benchmarking processes to provide a consistent template for comparison and shared learning *This action is reflected in the MSG Action Plan at section 5.1*	Not yet set – needs to be discussed and agreed at national Cos meeting	No update, the National Chief Officers group has not yet commenced this work

2. The partnership should improve its strategic planning processes showing how:
- **SMART principles are met**
- **strategic and locality needs information is updated**
- **priorities are to be resourced**
- **organisational development planning will be taken forward**
- **fully costed action plans including plans for investment and disinvestment will be implemented based on identified future needs**
- **expected measurable outcomes will be delivered**

Action and Cross Referencing	Timescale	Progress: August 20
2 a) Review the approach to the structure and contents of HSCP's Strategic Plan with a view to taking a revised approach that addresses the issues highlighted for the next publication	For 2021 – 2024 plan	**On track** Will follow on from action 1f) above
2 b) The national Strategic Commissioning and Improvement Network will work collectively to review the approach to Strategic Commissioning Plans to identify best practice and learning in relation to the points highlighted for local adoption	For 2021 – 2024 plan	**On track** The Scottish Govt is consulting on a new Framework for Health and Social care, which will form the basis of this national work. East Dunbartonshire HSCP has contributed to national workshop development and discussion around these proposals.

2 c) As part of our Quality Management Framework establish expectations around formal updating of needs assessments to inform service planning and ensure scrutiny and reporting of same to Clinical and Care Governance Group *This action is a sub set of an action reflected in the MSG Action Plan at section 4.5*	14 November 2019 for QA Framework approval. Delivery thereafter as per framework actions.	**Quality Management Framework completed** Implementation by Clinical and Care Governance Group underway
Additional specific actions in relation to costed investment and disinvestment plans are set out in section 5 below		

3. The partnership should improve its approaches to engagement and involvement with stakeholders in relation to:
- **strategic and local planning**
- **transformation**
- **service redesign**
- **commissioning**
- **market facilitation.**

Action and Cross Referencing	Timescale	Progress: August 20
3 a) Develop a refreshed engagement strategy within the HSCP that includes engagement expectations in relation to strategic and local planning, and transformation *This action is reflected in the MSG Action Plan at section 1.3*	End September 2019	**COMPLETE:** A refreshed strategy has been developed and will be presented to the HSCP Board on 14 November 2019 for consideration/approval

3 b) Contribute to the Council's 10 stage service redesign review process to consider opportunities within process for engagement with service user / carers and care providers *This action is reflected in the MSG Action Plan at section 1.3*	End September 2019	**COMPLETE:** Approach to consultation and engagement with stakeholders as part of the Council's 10 stage review process discussed with Council Executive Officer lead and agreed this is to be considered on a case by case basis per each service review. Agreement achieved to incorporate consultation stages where required. Current review processes evidence of delivery of this action by including consultation and engagement stages. Formal re-writing of procedures to be undertaken aligned to receipt of updated new national guidance in due course.
Actions in relation to commissioning and market facilitation are set out in section 4 below		

4. The partnership should work closely with a full range of stakeholders to develop and implement a commissioning strategy and associated cross-sector market facilitation plans.		
Action and Cross Referencing	**Timescale**	**Progress: August 20**
4 a) Finalise the Commissioning Strategy • Liaise with appropriate stakeholders to conclude the strategy • Take the finalised strategy to the HSCP Board meeting in November for approval *This action is reflected in the MSG Action Plan at section 1.3*	14 November 2019	**COMPLETE:** Commissioning strategy complete and approved
4 b) Further develop Provider Forums by ensuring attendance of senior managers to update / engage on key priority areas under development	End November 2019	**COMPLETE:** Provider forums refreshed and further developed

This action is reflected in the MSG Action Plan at section 1.3		
4 c) Use local third sector interface to improve engagement with larger national third sector providers *This action is reflected in the MSG Action Plan at section 1.3*	End September 2019	**COMPLETE:** New arrangements established to involve and include larger national third sector providers.
4 d) Engage with IHub and through the provider forum to develop an approach to cross-market facilitation which delivers on the priorities set out in the Commissioning Strategy	End December 2019	**Slippage: good progress but work interrupted by Coronavirus pandemic**

5. The partnership should develop and implement a detailed long-term financial plan to ensure a sustainable financial position is achieved by the HSCP board		
Action and Cross Referencing	**Timescale**	**Progress: August 20**
5 a) Scope EDC Financial planning assumptions 5 b) Scope NHS GG&C financial planning assumptions 5 c) Scope service delivery activity and financial data to inform planning assumptions 5 d) Produce HSCP Medium Term Financial Plan *These actions are reflected in the MSG Action Plan at section 2.2*	End November 2019	**Work ongoing:** Substantial preparatory work has been undertaken to analyse current and projected demographic, demand and cost pressures across key service areas, in addition to the potential impacts of efficiencies and transformative service redesign. These analyses provide an evidential framework to support the long-term financial planning exercise.

ANNEX 3: CARE INSPECTORATE EVALUATIONS – LOCAL SERVICES

The Care Inspectorate is the national regulator for care services in Scotland. The Care Inspectorate inspects services and evaluates the quality of care they deliver in pursuance of the National Care Standards. They support improvement in individual services and across the care sector nationally.

The Care Inspectorate will award grades for certain 'quality themes' that they have assessed. These 'quality themes' cover the main areas of a service's work. How well the service performs in these areas will indicate how good the service is. One or more themes will be assessed, depending on the type of service and its performance history. A grade is given to each of the quality themes assessed using a six point grading scale, which works in this way:

Grade 6 – Excellent	Grade 3 – Adequate
Grade 5 – Very good	Grade 2 – Weak
Grade 4 – Good	Grade 1 – Unsatisfactory

The functions delegated to the HSCP Board include a statutory obligation to provide or arrange services to meet assessed care needs. The HSCP Board "directs" the Council to provide or arrange these services on its behalf. Some of these services are delivered directly by the Council and others are purchased from the third and independent sectors. It is important that the quality of the services we directly provide and those purchased are both of the highest quality. The Partnership works to improve its own services through direct management and operational oversight. Purchased services are subject to detailed specification and contract monitoring by the Partnership's Commissioning Team. The grades of the services delivered by the Council and those purchased by the Partnership are set out below. The grades below are the most recent assessed by the Care Inspectorate for services based in East Dunbartonshire.

The Care Inspectorate now applies new National Care Standards. These have introduced new quality themes which will eventually apply to all registered services. The Care Inspectorate has begun applying these new quality themes. In addition, an additional quality theme was added to inspect service response to Covid-19. The tables below have therefore separated out registered services by the framework of quality themes that were used as the basis of the inspections:

NEW INSPECTION MODEL:

Service	Wellbeing (previously Care & Support)	Leadership (previously Management & Leadership)	Staffing	Setting (previously Environment)	Care Planning (new Category)	Covid (new Category)
HSCP / Council In-house Services Registered as Care Homes						
Ferndale Care Home for Children & Young People	5	Not Assessed	Not Assessed	Not Assessed	6	Not Assessed
John Street House	5	Not Assessed	Not Assessed	Not Assessed	6	Not Assessed
Commissioned - Supported Accommodation						
Cornerstone Community Care	5	5	Not Assessed	Not Assessed	Not Assessed	Not Assessed

Care Homes	Wellbeing (previously Care & Support)	Leadership (previously Management & Leadership)	Staffing	Setting (previously Environment)	Care Planning (new Category)	Covid (new Category)
Commissioned - Nursing Care Homes						
Abbotsford House	5	Not Assessed	Not Assessed	Not Assessed	5	Not Assessed
Milngavie Manor	5	Not Assessed	Not Assessed	Not Assessed	5	Not Assessed

Care Homes	Wellbeing (previously Care & Support)	Leadership (previously Management & Leadership)	Staffing	Setting (previously Environment)	Care Planning (new Category)	Covid (new Category)
Antonine House	5	4	5	5	4	Not Assessed
Birdston Care Home	5	Not Assessed	Not Assessed	Not Assessed	5	Not Assessed
Buchanan House	3	3	3	4	4	Not Assessed
Buchanan Lodge	4	Not Assessed	Not Assessed	Not Assessed	4	Not Assessed
Campsie View	3	3	3	3	3	Not Assessed
Lillyburn	6	Not Assessed	Not Assessed	Not Assessed	5	Not Assessed
Mavisbank	3	3	3	3	3	Not Assessed
Mugdock	6	Not Assessed	Not assessed	Not assessed	5	Not Assessed
Springvale	3	3	3	4	3	Not Assessed
Westerton	4	Not Assessed	Not Assessed	Not Assessed	3	Not Assessed
Whitefield Lodge	4	4	4	4	3	Not Assessed
Springvale	3	3	3	4	3	2
Commissioned – Specialist Care Homes						
Ashfield	5	Not Assessed	Not Assessed	Not Assessed	5	Not assessed
Campsie Neurological Care Centre	4	4	4	4	4	2

PREVIOUS INSPECTION MODEL:

Service	Care and Support	Environment	Staffing	Management and Leadership
HSCP / Council In-house Services				
Milan Day Service	5	Not Applicable	5	Not Applicable
Kelvinbank Day Service	5	Not Applicable	5	Not Applicable
Homecare Service	3	Not Applicable	3	3
Meiklehill & Pineview	5	Not Applicable	Not Applicable	5
Fostering Service	5	Not Applicable	5	4
Adoption Service	4	Not Applicable	5	4
Community Support Team for Children and Families	5	Not Applicable	Not Applicable	6
Ferndale Outreach for Children & Young People	5	Not Applicable	5	Not Applicable
Commissioned - Supported Accommodation				
Key Housing Association (Group registration covers Milngavie, Kirkintilloch, Clydebank, Alexandria & Dalmuir)	5	Not Applicable	Not Applicable	5
Living Ambitions (Group registration covers Glasgow North & West Services)	5	Not Applicable	4	4
Orems Care Services	4	Not Assessed	4	Not Assessed
Quarriers (Phase 3)	4	Not Applicable	4	Not Applicable
Quarriers (Phase 2)	4	Not Applicable	4	4

Service	Care and Support	Environment	Staffing	Management and Leadership
Quarriers (Phase 1)	5	Not Applicable	Not Applicable	5
Real Life Options	5	Not Applicable	5	Not Applicable
The Richmond Fellowship Scotland	5	Not Applicable	Not Applicable	5

ANNEX 4: COMPARATIVE INCOME & EXPENDITURE 2015/16 – 2019/20

Objective Analysis****	2019/20	2018/19	2017/18	2016/17**	2015/16*
STRATEGIC / RESOURCES	3,042	3,205	3,648		
ADDICTIONS	1,285	1,360	1,253		
OLDER PEOPLE	39,410	36,916	34,531		
LEARNING DISABILITY	19,580	18,559	18,068		
PHYSICAL DISABILITY	4,067	4,042	4,003		
MENTAL HEALTH	5,155	5,129	5,349		
ADULT SERVICES				55,546	24,064
CHILDREN & FAMILIES	14,277	13,514	13,056	6,906	-
CRIMINAL JUSTICE	211	258	226		
OTHER - NON SW	817	946	1,198	959	597
COMMUNITY HEALTH SERVICES				9,123	7,222
ORAL HEALTH	9,835	9,899	9,632	10,217	5,913
FAMILY HEALTH SERVICES***	27,678	25,848	24,724	43,431	25,355
PRESCRIBING	19,484	19,072	19,473		
OPERATIONAL COSTS	270	246	234	201	17
Cost of Services Managed By East Dunbartonshire HSCP	145,111	138,995	135,394	126,383	63,168
Set Aside for Delegated Services provided to Acute Services	32,247	*27,471*	17,381	17,381	9,570
Total Cost of Services to East Dunbartonshire HSCP	177,358	166,466	152,775	143,764	72,738
NHS Greater Glasgow & Clyde	(120,508)	(111,583)	(99,721)	(96,797)	(48,067)
East Dunbartonshire Council	(55,760)	(52,690)	(51,910)	(50,963)	(26,059)
Taxation & Non Specific grant Income	(176,268)	(164,273)	(151,631)	(147,760)	(74,126)
(Surplus) or deficit on Provision of Services	1,090	2,193	1,144	(3,996)	(1,388)
Movement in Reserves	1,090	2,193	1,144	(3,843)	(1,388)

General Reserves	2019/20	2018/19	2017/18	2016/17	2015/16
Movement in General Reserves only****	41	916	1,703	(1,483)	(1,177)
Balance on Reserves	0	(41)	(957)	(2,660)	(1,177)

** Relates to part year from 3rd September 2015 to the 31st March 2016 for adult social work and community health services only.*
*** Relates to full year for adult social work and community health services and part year for inclusion of children's social work and criminal justice services from August 2016.*

*** Family health services includes prescribing for the years 2015/16 and 2016/17.

**** Objective analysis reflects care group split from 2017/18 onwards.

**** An additional £2.1m of re-designated earmarked reserves were used in addition to the balance within general reserves for 18/19 and £0.6m for 19/20.

***** Set aside for 18/19 was re -stated to reflect based on a much more detailed approach including actual spend and activity for each year.

ANNEX 5: ACHIEVEMENT OF BEST VALUE

Best Value Audit March 2020 – HSCP Evaluation		
1.	Who do you consider to be accountable for securing Best Value in the IJB	Integration Joint Board Integration Joint Board Performance, Audit & Risk Committee HSCP Chief Officer HSCP Chief Finance & Resources Officer Senior Management Team Extended Senior Management Team Parent Organisations around support services, assets and all staff who are involved in commissioning and procurement.
2.	How do you receive assurance that the services supporting the delivery of strategic plans are securing Best Value	Performance management reporting on a quarterly basis to IJB. Explicit links between financial and service planning through Transformation Board updates. Application of HSCP Performance Reporting and Quality Management Frameworks Monthly Performance Reports Annual Performance Report Audit and Inspection Reports Integration Joint Board Meetings – consideration of wide range of reports in furtherance of strategic planning priorities. Transformation Board scrutiny Finance and Planning Group (across partner organisations) Performance, Audit & Risk Committee scrutiny Clinical & Care Governance Group Strategic Planning Group Senior Management Team scrutiny (HSCP) Corporate Management Teams of the Health Board and Council Service specific performance updates to SMT on a monthly basis. Operational Performance Review: biennial scrutiny by CEOs of Council and Health Board Integrated Social Work Services Forum Business Improvement Planning (BIP) and How Good is our Service (HGIOS) reports to Council, including Local Government Benchmarking Framework analysis. The IJB also places reliance on the controls and procedures of our partner organisations in terms of Best Value delivery.

Best Value Audit March 2020 – HSCP Evaluation		
3.	Do you consider there to be a sufficient buy-in to the IJB's longer term vision from partner officers and members	Yes, the IJB has approved the 3 year Financial Plan aligned to its Strategic Plan which clearly sets out the direction of travel, work is about to commence on the next iteration of the Strategic Plan. There are challenges planning for the longer term because of annual budget settlements, however the HSCP is working to finalise a longer term financial plan supported by transformational activity to ensure sustainability going forward. The IJB has good joint working arrangements in place and has benefited from ongoing support, particularly in support of service redesign and transformation, from members and officers within our partner organisations over the past 12 months in order to deliver the IJBs longer term vision. Finance and Planning Group with partner organisation involvement to focus on budget performance, financial planning in support of delivery of strategic priorities. Regular meetings with respective partner organisation Chief Executives, Finance Leads and Chief Officer to focus on the HSCP financial position during 19/20. Quarterly OPR meetings with partner agency Chief Executives to focus on performance and good practice and any support required to progress initiatives.
4.	How is value for money demonstrated in the decisions made by the IJB	Monthly budget reports at service level and regular budget meetings with managers across the HSCP. IJB development sessions Chief Finance & Resources Officer Budget Monitoring Reports to the IJB Review of current commissioning arrangements across the HSCP to ensure compliance with Procurement rules through Parent Organisation processes in support of service delivery. All IJB papers carry a section that clearly outlines the financial implications of each proposal as well as other implications in terms of legal, HR, equality and diversity and linkage to the IJBs strategic objectives. The IJB engages in healthy debate and discussions around any proposed investment decisions and savings proposals, many of which are supported by additional IJB development sessions. In addition IJB directions to the Health Board and Council require them to deliver our services in line with our strategic priorities and Best Value principles – 'Optimise efficiency, effectiveness and flexibility'. This is in the process of being enhanced in light of the final strategic guidance on directions.

Best Value Audit March 2020 – HSCP Evaluation		
5.	Do you consider here to be a culture of continuous improvement?	The HSCP has an overarching Quality Management Framework that establishes a cultural and operational commitment to continuous improvement. The HSCP Clinical & Care Governance Group provides strategic leadership in developing a culture of continuous improvement with representation across all professional disciplines with a focus on improving the quality of services delivered throughout the partnership. There is a range of activity in this area: • A number of HSCP service areas now have service improvement plans in place and a focused approach to quality/continuous improvement (QI). Examples of these improvements are captured and reported through the Clinical & Care Governance Group and reported to the IJB. • The Public Service User and Carers group has been involved developing improvement activity on areas highlighted through engagement events. • In addition, a number of service review and redesign work strands are underway/or planned to maximise effectiveness, resources and improve the patient/service users journey across East Dunbartonshire. • The HSCP Transformation Plan is focussed on proactively developing our health and social care services in line with national direction and statutory requirements; optimising the opportunities joint and integrated working offers; and ensuring any service redesign is informed by a strategic planning and commissioning approach (subject to regular IJB reports). • HSCP Organisational Development and Training, Learning and Education resources support services in undertaking improvement activity. • A wide range of stakeholder consultation and engagement exercises, to evaluate the quality of customer experience and outcomes. • Regular service audits, both internal and arms length. • An extensive range of self-evaluation activity, for example case-file assessment against quality standards. • There are opportunities for teams to be involved in Quality Improvement development, which includes ongoing support and coaching for their improvement activity through our organisational development lead. • Workforce planning and OD/service improvement (SI) activity is planned, monitored and evaluated through our

Best Value Audit March 2020 – HSCP Evaluation		
		Workforce People and Change leads. • A Quality and Improvement Framework has been developed to support continuous improvement within the in-house Home Care Service. • A number of improvement actions are in place in response to the Strategic Services Inspection (2019) and the MSG self assessment framework as to where partnership are in delivery of integrated health and social care services.
6.	Have there been any service reviews undertaken since establishment – have improvements in services and/or reductions in pressures as a result of joint working?	A robust process for progressing service reviews is in place with support from the Council's transformation team. A number of reviews have been undertaken including: • Review of Integrated senior management structures – re focus of capacity within older people, adult and children's services to progress work to deliver on strategic priorities. Interim arrangement in place to support more effective scrutiny and oversight of service provision across these areas including development of a resource bureau model. • Homecare Review – concluded during 19/20 to undertake an objective and focused review of care at home services to identify improvements in service delivery and the sustainability of the service into the longer term. Initial service improvements made to support more effective discharge from and prevention of admission to hospital in line with strategic priorities, move to locality model, informed care at home framework requirements, roll out of CM2000 for externally purchased homecare to ensure best value on investment – revised model implemented in January 2020. • Review of Learning Disability Services - Whole System Review of services to support individuals with a learning disability including daycare provision and supported accommodation. Overarching Adult Learning Disability Strategy established that sets out redesign priorities. Fair access and resource allocation policy approved to manage current and future demand on a sustainable basis and to achieve Best Value. Day service element concluded with accommodation identified within the Allander development. Work underway to progress improvements and developments across LD in house and commissioned supported accommodation. Continued improvements in enhanced local daycare provision to negate need for expensive out of authority placements, review of alternative to sleepover arrangements through the use of technology, implementation of Fair Access to Community Care

Best Value Audit March 2020 – HSCP Evaluation		
		Policy. • Review of Fostering Placements – continued review of balance of externally purchased fostering placements resulted in an increase in ED foster carers and efficiencies on budget for this area. • Review of Planning and Commissioning function to focus on a strategic commissioning approach and deliver improvements in commissioning and contracting practices in line with procurement and legislative requirements. The HSCP is also participating in a number of reviews in collaboration with NHS GGC such as • Un scheduled Care Review • Mental Health Review and 5 year Strategy There are a number of planned service reviews to commence in support of service redesign and efficiencies as part of the transformation plan for 2020/21.
7.	Have identified improvement actions been prioritised in terms of those likely to have the greatest impact.	The oversight for any improvement activity identified through service review, inspection reports, incident reporting or complaints learning is through the Clinical and Care Governance Group. This is reported through the SMT, the Performance, Audit & Risk Committee and the IJB to ensure priority is afforded to progress areas of high risk with scope for most improvement. The Transformation Board has a role to consider and oversee service redesign and transformation which will deliver service improvement including robust business cases and progress reporting to ensure effective delivery in line with strategic planning priorities and quality care governance and professional standards.
8.	What steps are taken to ensure that quality of care and service provided is not compromised as a result of cost saving measures.	All savings proposals are subject to a full assessment which includes: • Alignment to Strategic Plan • Alignment to quality care governance and professional standards including risk assessment by Professional Lead • Equalities impact assessed • Risk assessment by responsible Heads of Service and mitigating actions introduced • Stakeholder engagement as appropriate Where possible, the HSCP look to take evidence based approaches or tests of change to ensure anticipated benefits are realised and there is no compromise to care.
9.	Is performance information reported to the board of	Regular budget and performance monitoring reports to the IJB give oversight of performance against agreed targets with narrative covering rationale, situational analysis and

Best Value Audit March 2020 – HSCP Evaluation		
	sufficient detail to enable value of money to be assessed	improvement actions for areas where performance is off target. These reports are presented quarterly as well as the detailed Annual Performance Report. Financial performance reported every cycle to IJB. Plans to revise format of performance report to include finance narrative to provide linkages of impact of performance on the partnership financial position. The Transformation Plan aligns key priorities for service redesign and transformation to the delivery of efficiency savings which are regularly reported through the Financial monitoring reports to the IJB and regular scrutiny of the transformation plan through the Performance, Audit and risk committee.
10.	How does the IJB ensure that management of resources (finances, workforce etc.) is effective and sustainable	Workforce and Organisational Development plan linked to strategic plan. Oversight through Staff Partnership Forum and reporting through the IJB. Service review process involves staff partnership representation for consideration of workforce issues. Regular budget and performance monitoring reports to the IJB give oversight of this performance. Financial planning updates to the IJB on budget setting for the partnership highlighting areas for service redesign, impact and key risks. Regular review and update on reserves positions as a means of providing contingency to manage any in year unplanned events. All IJB reports contain a section outlining the financial implications of each paper for consideration.

East Dunbartonshire Health & Social Care Partnership

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本文件可按要求翻譯成中文，如有此需要，請電 0300 123 4510。

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Agenda Item Number: 10.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17 September 2020
Subject Title	HSCP Quarter 1 Performance Report 2020-21
Report By	Caroline Sinclair, Interim Chief Officer and Chief Social Work Officer
Contact Officer	Alan Cairns, Planning, Performance & Quality Manager Alan.cairns2@ggc.scot.nhs.uk

Purpose of Report	The purpose of this report is to inform the Board of progress made against an agreed suite of performance targets and measures, relating to the delivery of the HSCP strategic priorities, for the period April to June (Quarter 1).

Recommendations	It is recommended that the Health & Social Care Partnership Board: 1. Note the content of this report, and; 2. Consider the Quarter 1 Performance Report 2019-20 at **Appendix 1**

Relevance to HSCP Board Strategic Plan	Quarterly performance reports contribute to HSCP Board scrutiny of performance and progress against the Strategic Plan priorities.

Implications for Health & Social Care Partnership

Human Resources	None
Equalities:	None
Financial:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Risk Implications:	None

Implications for East Dunbartonshire Council:	The report includes indicators and measures of quality and performance relating to services provided by the Council, under Direction of the HSCP Board.

Implications for NHS Greater Glasgow & Clyde:	The report includes indicators and measures of quality and performance relating to services provided by NHS Greater Glasgow and Clyde, under Direction of the HSCP Board.

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	☒
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0	**MAIN REPORT**
1.1	The 2020-21 Quarter 1 performance report at **Appendix 1** contains a range of performance information, most of which is available and complete for the full reporting period. However there are routine delays with the publication of validated data by Public Health Scotland, due to incomplete hospital-derived data in Section 3 of the report. The availability of some data for this period has also been delayed as a result of Covid-19 related service interruption and the timing of certain waiting times data publications. A verbal update will be provided at the HSCP Board meeting of 17 September in the event of the availability of more recent data at that time.
1.2	The Covid-19 pandemic impacts on a number of the performance metrics covering 2020-21, Quarter 1. With the diversion of health and social care resources to support the crisis response during lockdown, and the impact of social distancing on business-as-usual, presenting demand and activity reduced significantly during this period.
1.3	As a result of the pandemic, presenting need, demand, service activity, performance and impact have been significantly affected in ways that affect the metrics and interpretations that are normally used to measure performance. For example it would be inaccurate to attribute the degree of reduced emergency hospital attendance, admission and delayed discharge during the period since mid March 2020 to the success of the unscheduled care action plan, when significant impact has been due to Covid-19 emergency planning responses. RAG (red, amber and green) ratings are therefore avoided in these circumstances, as the lines of attribution and contribution are more complex and challenging. The individual indicators and measures have therefore been set out in the document with their own individual impact narratives. This approach will be maintained during the Recovery and Transition planning period, to avoid potential misdirection or misinterpretation.

East Dunbartonshire Health & Social Care Partnership

PERFORMANCE REPORT 2020-21 QUARTER 1

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SECTION 1
Introduction

This HSCP Quarterly Performance Report provides an agreed suite of measures that report on the progress of the priorities set out in the Strategic Plan. Information is reported from national and local NHS sources and East Dunbartonshire Council sources to provide the most up to date information available. For clarity and ease of access, the data are set out in defined sections in accordance with where the data are sourced and reported. However, all the indicators set out in Sections 3-5 are inter-dependant; for example, good performance in social or health care service targets can contribute to improved performance elsewhere across the whole system.

Each indicator is reported individually. Charts and tables are provided to display targets, trend data, and where available, improvement trajectories. A situational analysis is provided to describe activity over the reporting period, and improvement actions are provided for all indicators that are below target.

Covid-19 Pandemic Impact:

The Covid-19 outbreak impacts on a number of the performance metrics covering 2020-21 Quarter 1. With the diversion of health and social care resources to support the crisis response during lockdown, and the impact of social distancing on business-as-usual, service demand and activity reduced significantly during this period. The availability of some data for this period has also been delayed.

The HSCP has a Covid-19 Recovery and Transition Plan which informs the process of guiding service recovery through and out of the pandemic. This plan sets out the approach the partnership will take to transitional post emergency phase of the pandemic. During this recovery period we will be working across service areas in collaboration with partner organisations, service users and the wider community to gradually re-establish service provision to meet the needs of our residents.

The sections contained within this report are as listed and described below.

Section 2 Performance summary
This section provides a summary of status of all the performance indicators provided in this report by indicating which indicators have improved and which have declined.

Section 3 Health & Social Care Delivery Plan
The data for unscheduled acute care reported in this document is provided by National Services Scotland for the Ministerial Steering Group for Health & Social Care (MSG). This section provides the latest available data for those indicators identified as a priority by the MSG.

Section 4 Social Care Core Indicators
This is the updated report of the Social Care core dataset, provided by EDC Corporate Performance & Research team.

Section 5 NHS Local Delivery Plan (LDP) Indicators

LDP Standards refer to a suit of targets set annually by the Scottish Government, and which define performance levels that all Health Boards are expected to either sustain or improve.

Section 6 Children's Services Performance

This is the updated report of Children's Services performance, provided by EDC Corporate Performance & Research team.

Section 7 Criminal Justice Performance

This is the updated report of the Criminal Justice performance, provided by EDC Corporate Performance & Research team.

Section 8 Corporate Performance

Workforce sickness / absence, Personal Development Plans (PDP) & Personal Development Reviews (PDR) are monitored, and reported in this section

SECTION 2
Performance Summary at Q4

This section of the quarterly report normally ranks each of the performance indicators and measures that feature in the report against a range of headings as outlined below:

 Positive Performance (on target) improving

 Positive Performance (on target) declining

 Negative Performance (below target) improving

 Negative Performance (below target) declining

As a result of the Covid-19 pandemic, presenting need, demand, service activity, performance and impact have been significantly affected in ways that affect the metrics and interpretations that are normally used to measure performance. For example it would be inaccurate to attribute the degree of reduced emergency hospital attendance, admission and delayed discharge during the period since mid March 2020 to the impact of the unscheduled care action plan, when significant impact has been due to Covid-19 emergency planning responses. The individual indicators and measures have therefore been set out in the document with their own individual impact narratives. This approach will be maintained during the Recovery and Transition planning period, to avoid potential misdirection or misinterpretation.

The following targets relate to unscheduled acute care and focus on areas for which the HSCP has devolved responsibility. They are part of a suite of indicators set by the Scottish Government, and all HSCPs were invited to set out local objectives for each of the indicators. They are reported to and reviewed quarterly by the Scottish Government Ministerial Steering Group for Health & Community Care (MSG) to monitor the impact of integration. Delays can occur with completeness of hospital-based data, so these tables and charts are based upon the most recent reliable data relevant to the reporting period.

3.1 Emergency admissions
3.2 Unscheduled hospital bed days; acute specialities
3.3 Delayed Discharges
3.4 Accident & Emergency Attendances

3.1 Emergency Admissions

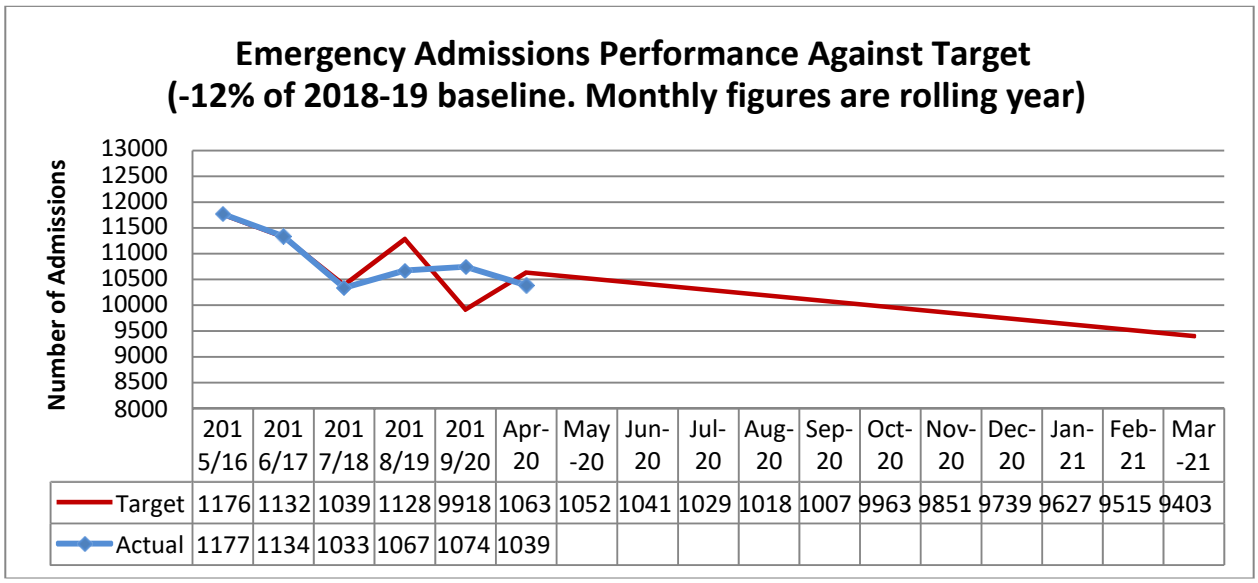
Rationale: Unplanned emergency acute admissions are focussed on reducing inappropriate use of hospital services and shifting the focus from a reliance on hospital care towards proactive support in the community setting. Aim = to minimise.

Table 3.1 Quarterly Number of Unplanned Acute Emergency Admissions

Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020-21	Target (2019-20)
2,707	2,662	2,719	2,629	n/a	2,480

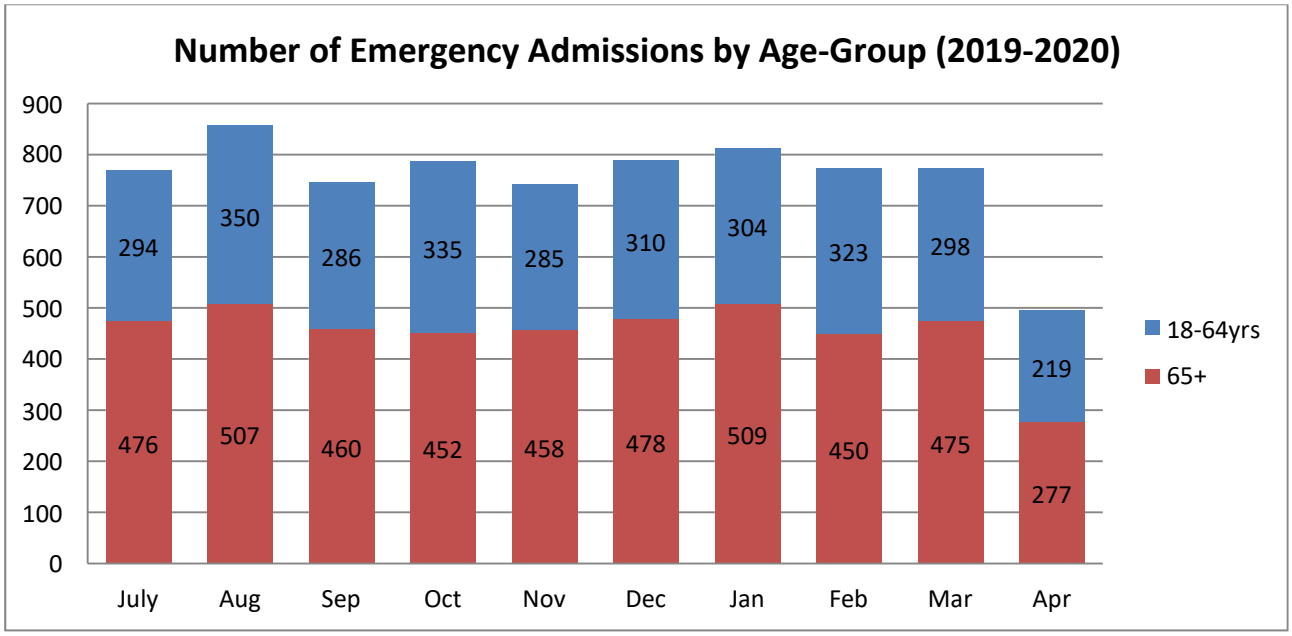
*Based on availability of complete data for quarter at time of report – subject to update.

Figure 3.1a Rolling Year Number of Unplanned Emergency Admissions*



*Based on availability of complete data for quarter at time of report – subject to update

Figure 3.1b Unplanned Emergency Admissions by Age Group



Situational Analysis:
The number of people being admitted unexpectedly to hospital is a key indicator of how well we are doing to maintain people in their own homes, particularly later in life. It is also a proxy indicator of the level of complexity being managed in the community, as secondary care clinicians continue to consider the majority of unplanned admissions of East Dunbartonshire residents as clinically appropriate.

The national source data publication extend only to April 2020, but the impact of the Covid-19 pandemic can be clearly seen with the reduction in emergency hospital admissions. Operational data indicates that this trend continued until June/July when the admissions levels began a return to an upward trend.

Improvement Actions:
The Partnership will continue to work with NHSGGC colleagues to impact positively on admissions levels. Improvement activity has included the further development of community based rehabilitation, providing rapid assessment to assist in the prevention of admission. Learning from the Covid-19 experience will also be used to inform improvement going forward in relation to looking collectively to see what arrangements should be retained and what can be explored further, for example: digital consultations, Community Assessment Centre model for emergency attendances etc.

3.2 Unscheduled hospital bed days; acute specialities

Rationale: Unscheduled hospital bed days are focussed on reducing inappropriate use of hospital services and shifting the focus from a reliance on hospital care towards proactive support in the community setting. Aim = to minimise

Table 3.2 Quarterly number of Unscheduled Hospital Bed Days

Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020-21	Target (2019-20)
21,870	19,484	20,438	21,283	n/a*	19,232

*Based on availability of complete data for quarter at time of report – subject to update.

Figure 3.2a Rolling year number of Unscheduled Hospital Bed Days

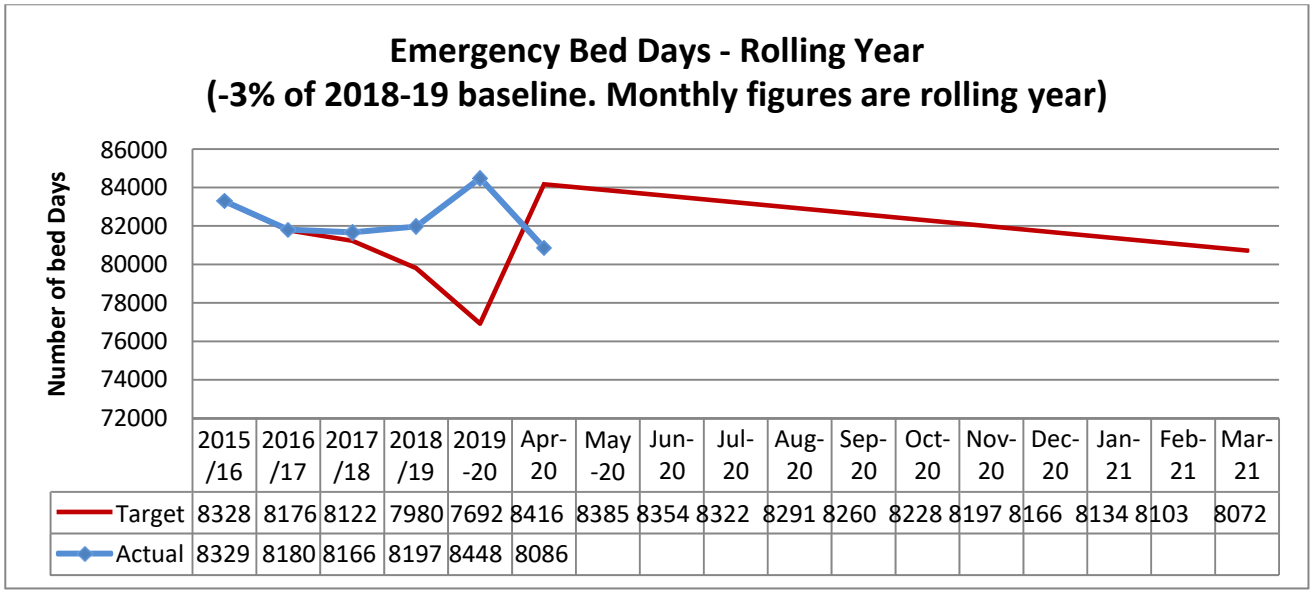
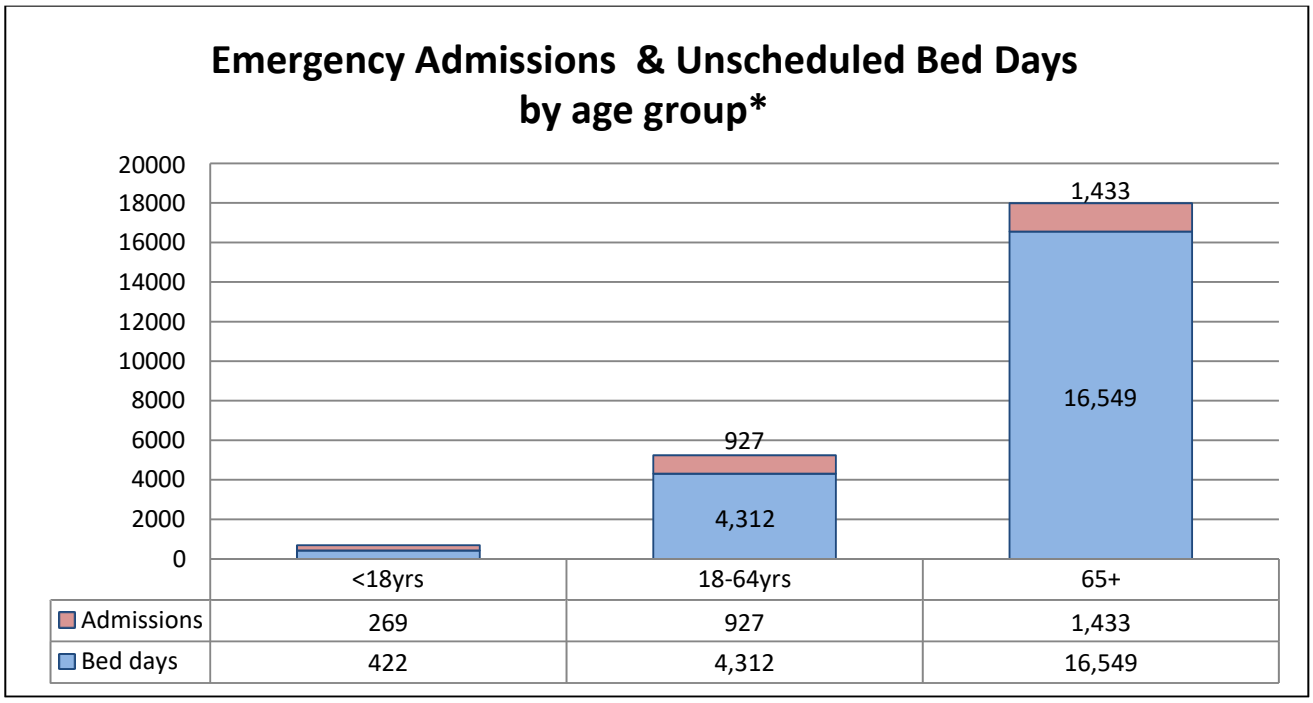


Figure 3.2b Number of Unscheduled Admissions/Hospital Bed Days by Age Group (January to March 19)



*Based on most recent complete 3 month data period

Situational Analysis:
This indicator describes the number of bed days in secondary care used by patients who have been admitted unexpectedly. Fig 3.2a shows a challenging trend over the past few years away from the target trajectory. The national source data publication extend only to April 2020, but the impact of the Covid-19 pandemic can be clearly seen with the reduction in unscheduled bed days. Operational data indicates that this trend continued until June/July when the admissions levels began a return to an upward trend.

Improvement Actions:
Our primary focus continues to be on prevention of admission, where possible, so that unnecessary accrual of bed days is avoided. This will continue to be an important component of managing hospital capacity through the pandemic. Improvement activity has included daily scrutiny of emergency admissions and proactive work with identified wards to facilitate discharge.

3.3 Delayed Discharges

Rationale: People who are ready for discharge will not remain in hospital unnecessarily. Aim = to minimise

Table 3.3 Quarterly Number of Delayed Discharge Bed Days

	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2020-21	Target (2019-20)
No. Bed Days	**917**	**1,286**	**1,592**	**1,663**	**n/a***	**1,208**

*Based on availability of complete data for quarter at time of report

Figure 3.3a Rolling year number of Delayed Discharge Bed Days

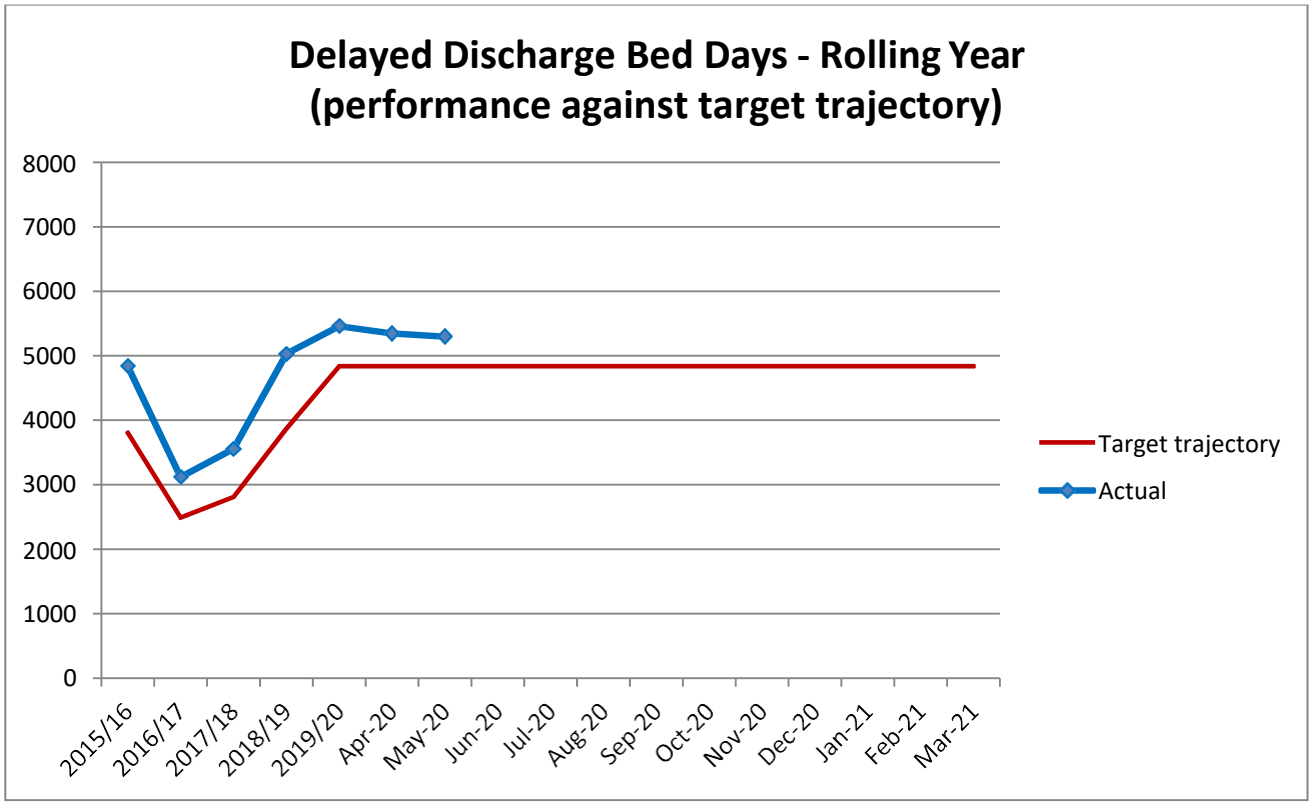
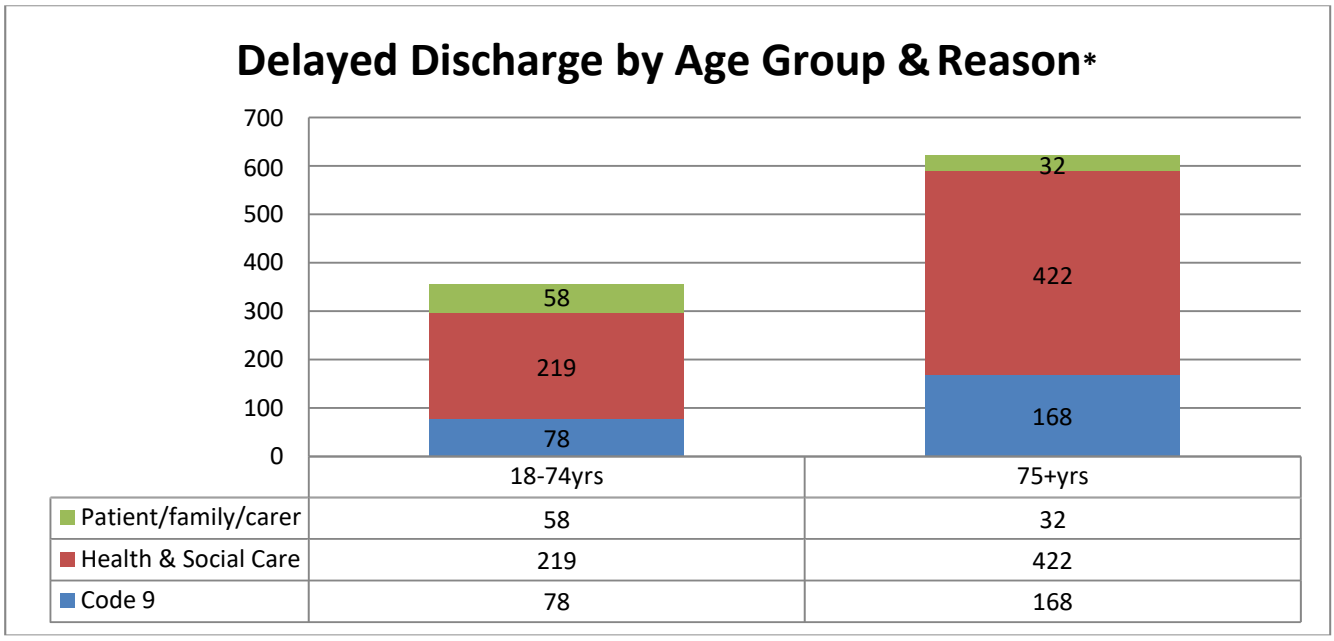


Figure 3.3b Number of Delayed Discharge by Age and Reason (Mar to May 20)



	18-74yrs	75+yrs
Patient/family/carer	58	32
Health & Social Care	219	422
Code 9	78	168

*Based on most recent complete 3 month data period

Situational Analysis:
Facilitating discharge from hospital when a patient is clinically fit to return home is an important component of the health and social care whole system. This ensures that people are supported safely at home where possible, reduces the loss of independence and allows hospital resources to be used for people in need of clinical care. This has been a particular focus during the period of the pandemic. Data for the period following March shows a marked reduction in delayed discharges due to Covid-19 emergency planning. Operational data indicate that delays are increasing again, particularly for reasons of incapacity and where guardianship is required. External scrutiny from the NHSGG&C Discharge Team indicates they are content all is being done by EDHSP in relation to delayed discharges. They recognise the specific challenge for us regarding complex cases because there is sustained throughput of our delayed patients, unless there are specific circumstances.

Improvement Actions:
Use of electronic operational activity "dashboards" now allow us to be better sighted on community patients who have been admitted to hospital so that we can respond more quickly, prior to these patients being deemed fit for discharge. We can also see patients who have been admitted who are not currently known to us, again allowing us to intervene early. In addition, all of the actions described in the previous indicator around prevention of admission are relevant to avoiding delayed discharges. We will continue to work creatively within the legal framework and support patients and their families to make choices timeously for ongoing care. Home for Me is now well established and coordinates our admission avoidance and discharge facilitation work across a range of services. There is also pan-GGC work ongoing to consider how best to manage delays associated with Adult with Incapacity legislation.

3.4 Accident & Emergency Attendances

Rationale: Accident & Emergency attendance is focussed on reducing inappropriate

use of hospital services and changing behaviours away from a reliance on hospital care towards the appropriate available support in the community setting. Aim = to minimise

Table 3.4 Quarterly Number A&E Attendances (all ages)

Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Q1 2019/20	Target (quarter)
7,358	7,451	7,205	6,028	n/a*	6,780

*Based on availability of complete data for quarter at time of report

Figure 3.4a Rolling year number of A&E Attendances

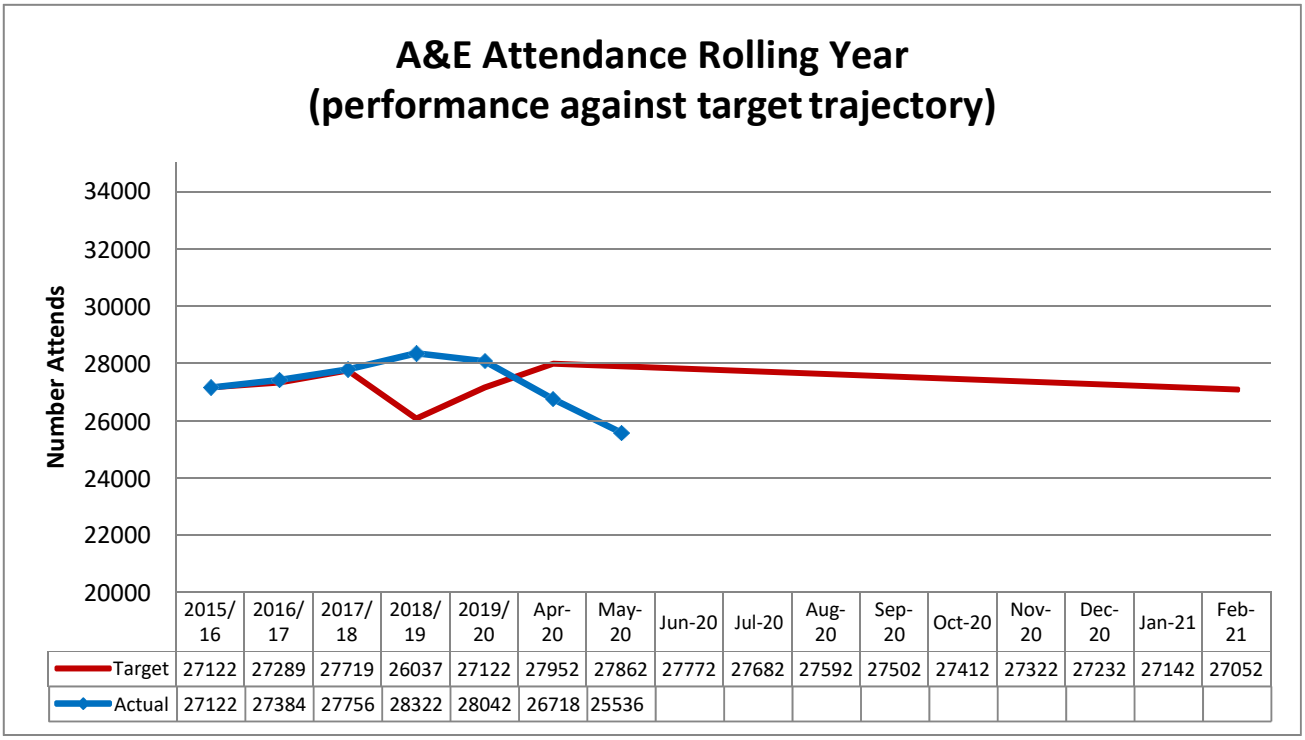
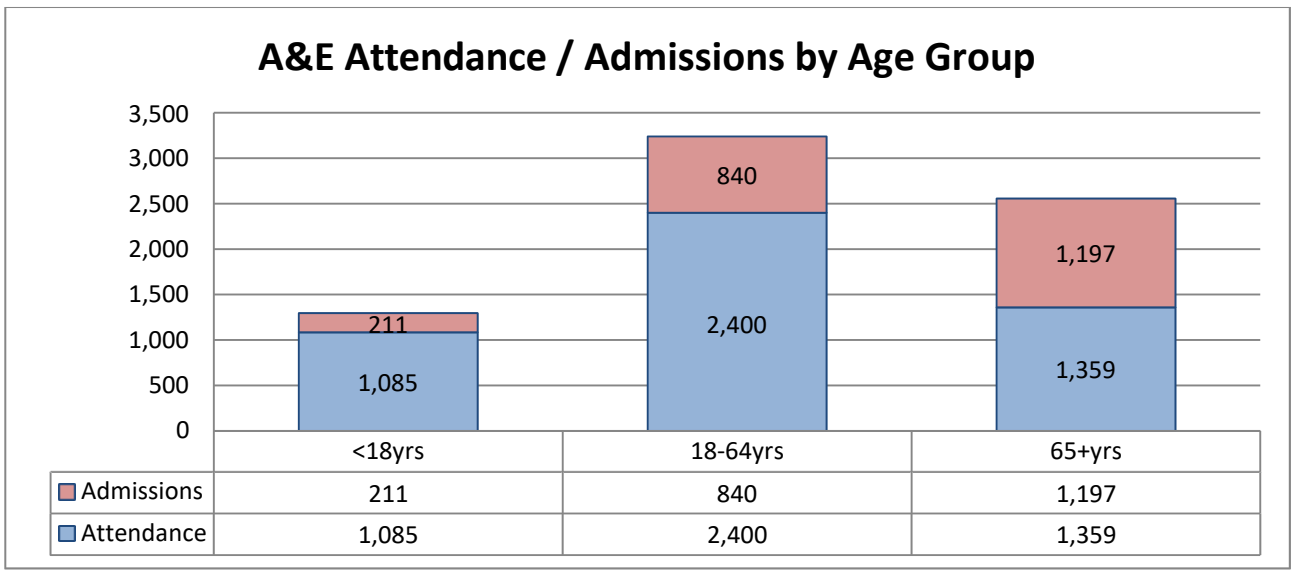


Figure 3.4b A&E Attendances Admitted to Hospital by Age Group (Dec - Mar 19)



Situational Analysis:
During 2019-20, East Dunbartonshire had the second lowest level of emergency department attendances across Greater Glasgow and Clyde. The data in figure 3.4b show the proportion of those who attended A&E who were subsequently discharged, suggesting a significant number of those attending A&E could have had their needs met in the community or via self care. This is a challenge across Scotland which is being considered by Scottish Government and all public sector partners.

In Quarter 1, the impact of the Covid-19 pandemic can be clearly seen with the reduction in emergency attendances at hospital. Operational data indicates that this trend continued until June/July when the levels began a return to an upward trend.

Improvement Actions:
From an HSCP perspective we continue our work around the Primary Care Improvement Plan, to recalibrate and sustain GP services. This will enable more flexible responses to patient need in the community although is likely to be significantly impacted in 2020/21 by the Covid-19 experience. We hope that increased focus on self care for people with long term conditions will also mean that people can manage their own health more proactively. We are working closely with secondary care colleagues around their introduction of redirection protocols to ensure that people who do not need to be at A&E are redirected to community services or self care timeously. We are also engaged in national conversations about programmes of public education regarding who service users should turn to for support when they are sick, injured, or in distress. Again, winter planning provided an opportunity to sharpen up our focus on all these areas in order to help mitigate seasonal pressures we routinely see in all services, but the new context during and post Covid-19 will be impactful.

SECTION 4
Social Care Core Indicators

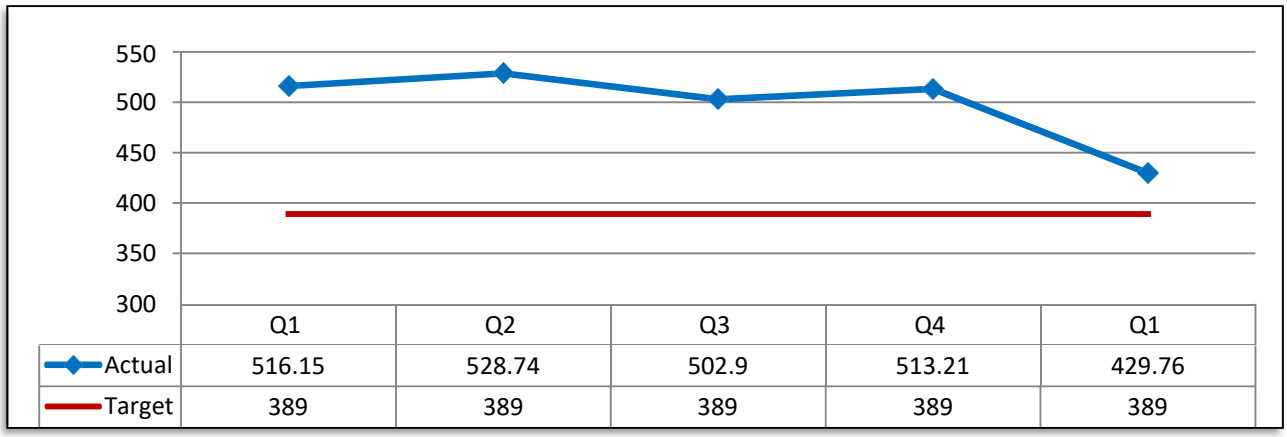
This section provides an updated report of Social Care core dataset and includes data collated by East Dunbartonshire Council Performance & Research Team. Although reported separately from the Health and Social Care data, the following indicators are integral to achieving the targets set out in Health and Social Care Delivery Plan and HSCP Unscheduled Care Plan.

4.1 Homecare hours per 1,000 population aged 65+yrs
4.2 People aged 65+yrs with intensive needs receiving care at home
4.3 Community assessment to service delivery timescale
4.4 Care home placements
4.5 Adult Protection inquiry to intervention timescales

4.1 Homecare hours per 1,000 population aged 65+yrs

Rationale: Key indicator required by Scottish Government to assist in the measurement of Balance of Care. Aim = to maximise in comparison to support in institutional settings

Figure 4.1 No. of Homecare Hours per 1,000 population 65+



	Q1	Q2	Q3	Q4	Q1
Actual	516.15	528.74	502.9	513.21	429.76
Target	389	389	389	389	389

Situational Analysis:
This indicator was first established nationally to measure the extent of community-based support, in comparison with institutional care. The number of homecare hours per 1000 population over 65 is above target. Whilst this demonstrates success in supporting people in the community, the increase is also a result of increased demand overall. Our analysis on the reasons for the increase point to the disproportionate increase in people aged 85+ in East Dunbartonshire, which has been the highest in Scotland over the past 10 years at +5% per year. We are projected to continue to have the fastest growing increase over the next 10 years. People aged 85+ overall have the greatest level need in terms of volume and intensity of older people's service. 2020-21 Quarter 1 data shows a marked decline which was due to a number of families who chose to provide informal care themselves during lockdown, when they were at home themselves and wished to minimise social contact with external carers. It is expected that this trend will gradually reverse with the relaxation of social distancing constraints and service recovery.

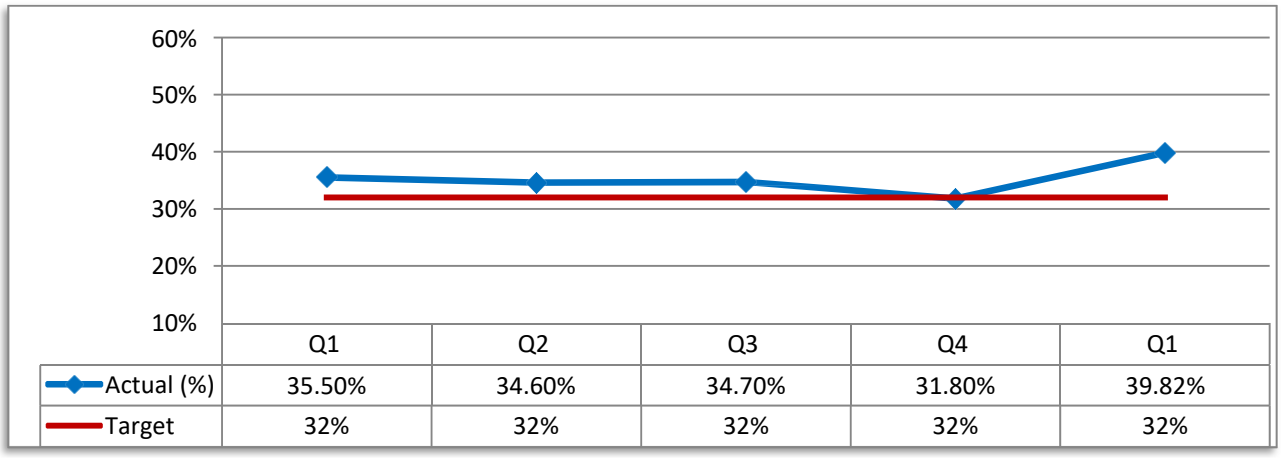
Improvement Action:
Homecare is a cornerstone service in the community health and social care landscape. Performance in relation to maintaining people in their own home, facilitating people to die in their preferred place of care and reducing the number of people living in long term care are all dependant on homecare. We are progressing well with implementing our homecare review which establishes new organisational and service model arrangements to meet future need in a sustainable way. We are also carrying out a significant service improvement plan in partnership with the Care Inspectorate. A recent in-depth analysis will also help us to consider how to most effectively manage the unprecedented increase in service demand.

The HSCP has developed a Covid-19 recovery plan for homecare services to inform the way through and out of the pandemic. This will ensure that services continue to be available for people with eligible needs and maximises care in the community.

4.2 People Aged 65+yrs with Intensive Needs Receiving Care at Home

Rationale: As the population ages, and the number of people with complex care needs increases, the need to provide appropriate care and support becomes even more important. This target assures that home care and support is available for people, particularly those with high levels of care needs. Aim = to maximise.

Figure 4.2 Percentage of People Aged 65+yrs with Intensive Needs Receiving Care at Home



	Q1	Q2	Q3	Q4	Q1
Actual (%)	35.50%	34.60%	34.70%	31.80%	39.82%
Target	32%	32%	32%	32%	32%

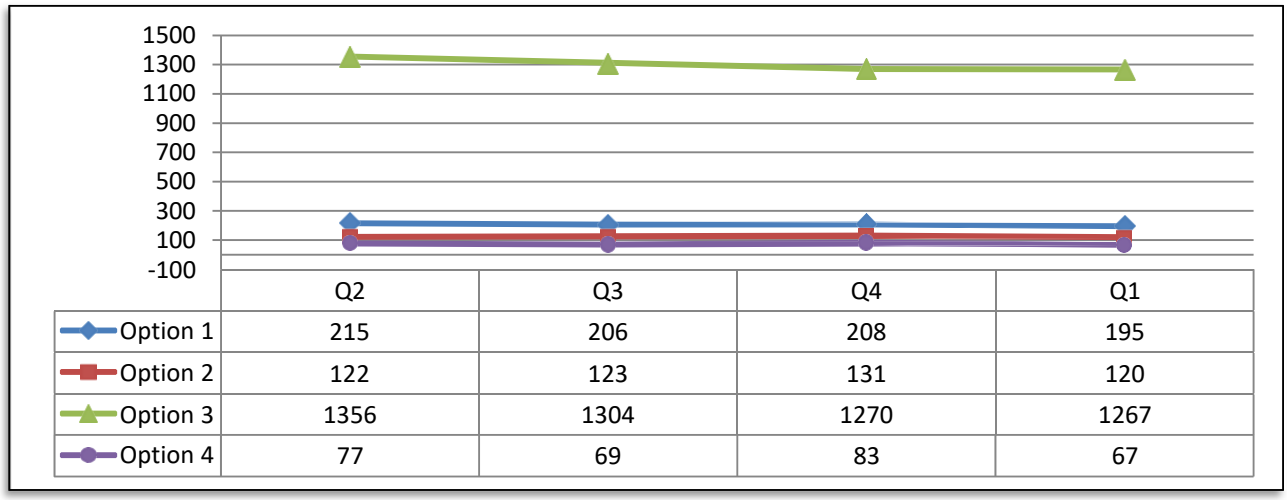
Situational Analysis:
This indicator measures the number of people over 65 receiving 10 hours or more of homecare per week, which is a measure of intensive support. Our policy is to support people with intensive care needs in the community as far as possible, traditionally the aim has been to maximise this value. However we also have to be mindful of the need to maximise independent living using "just enough" support rather than creating over-dependency. We have been consistently above target for this indicator over the past year, with an overall upward trend. 2020-21 Quarter 1 data shows an upturn in the figures which reflects the relative increase in the support of people in the community during the period of Covid-19 lockdown. At this time the emphasis was on care at home rather than in hospital or institutional settings.

Improvement Action:
Our intention is to maintain good, balanced performance in this area.

4.2b Systems supporting Care at Home

Rationale: The following indicators contribute partly to support the previous indicators. They are important in improving the balance of care and assisting people to remain independent in their own homes, but do not have specific targets.

4.2b(i) Number of people uptaking SDS options

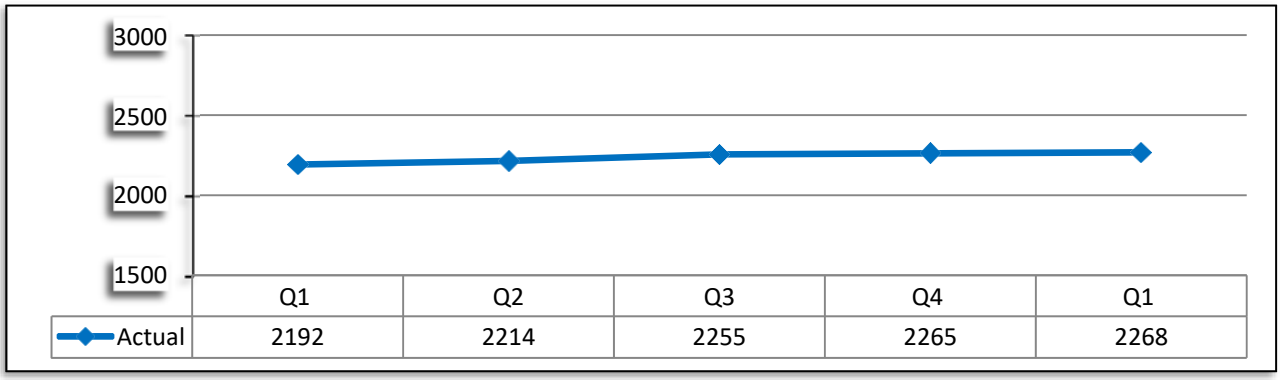


	Q2	Q3	Q4	Q1
Option 1	215	206	208	195
Option 2	122	123	131	120
Option 3	1356	1304	1270	1267
Option 4	77	69	83	67

Situational Analysis:
The indicators measure the number of people choosing Self Directed Support Options to direct their own support package. Their choice will be dependent upon the amount of control and responsibility that the customer or their family wish to take in arranging the delivery of care. None of the options are considered inferior to the other options and the statistics reflect customer choice. Despite some movement, the distribution of SDS choices is remaining broadly stable.

Improvement Action:
We will continue to ensure that we provide Self Directed Support training to Social Work and Health practitioners to instil confidence and knowledge about the options amongst the workforce. We will also continue to work in partnership with the Third Sector to raise awareness about self directed support to local communities, customers and carers to ensure that the benefits associated with each option are fully explained and recognised.

4.2b(ii) People Aged 75+yrs with a Telecare Package



	Q1	Q2	Q3	Q4	Q1
Actual	2192	2214	2255	2265	2268

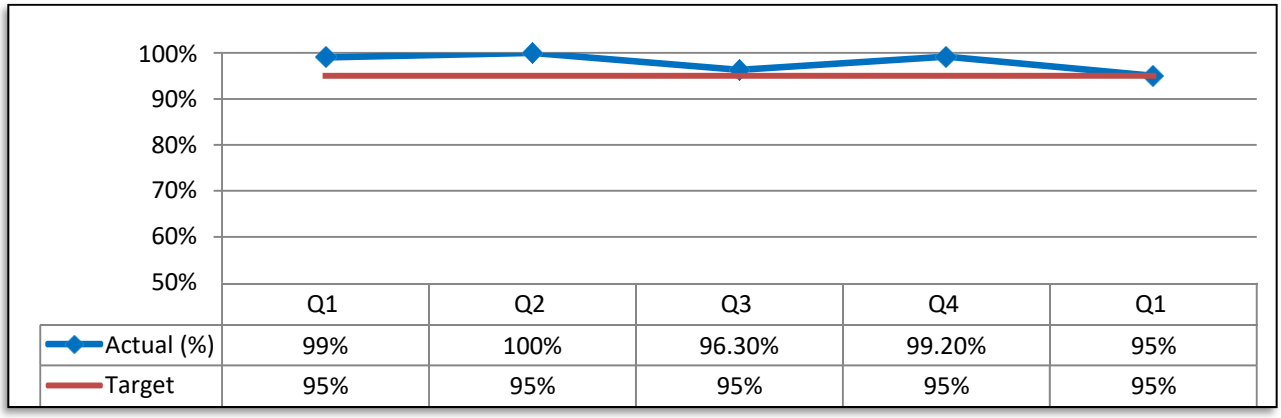
Situational Analysis:
There has been a consistent, gradual increase in the number of people aged 75 and over with a telecare package over the past 12 months. This is in line with expectations, as the population of people in East Dunbartonshire aged 75+ increases and telecare opportunities are maximised. *2020-21 Q1 figures were not available at time of publication.*

Improvement Action:
We continue to implement our Assistive Technology Strategy, seeking to link traditional telecare with telehealth monitoring and technology enabled care. A communication plan has been developed for this strategy to support increased workforce awareness of the opportunities technology can bring.

4.3 Community Care Assessment to Service Delivery Timescale

Rationale The HSCP has a duty to undertake community care assessments for those in need, and are responsible for developing packages of care to meet identified need. The national standard is to operate within a six week period from assessment to service delivery, which encourages efficiency and minimises delays for service-users. Aim = to maximise.

Figure 4.3 Percentage of service users (65+yrs) meeting 6wk target



	Q1	Q2	Q3	Q4	Q1
Actual (%)	99%	100%	96.30%	99.20%	95%
Target	95%	95%	95%	95%	95%

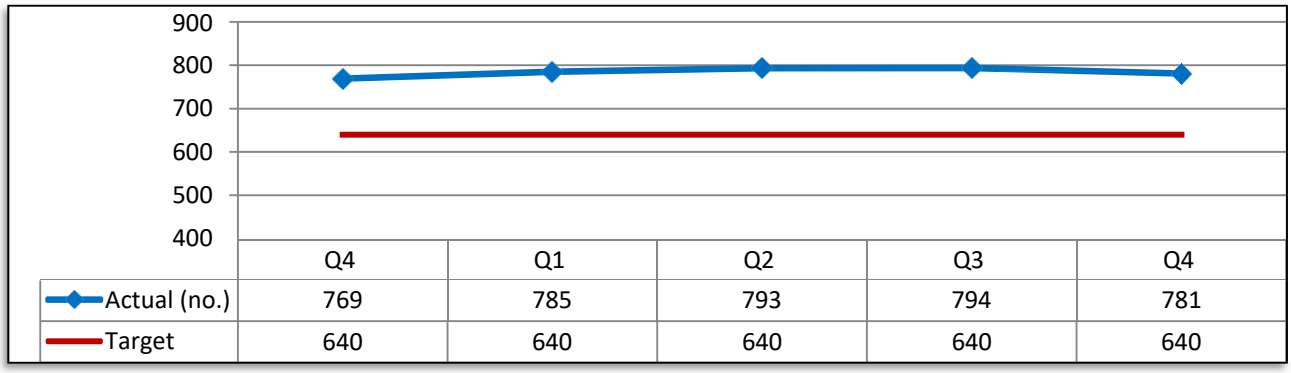
Situational Analysis:
While very many people receive services well within the 6 week target from the completion of their community care assessment, this measure ensures that we can track compliance with this national target timescale. We consistent score very highly with compliance levels of around 100%. The downturn in 2020-21 Q1 is a consequence of Covid-19 lockdown on the ability of staff to arrange services in the normal way.

Improvement Action:
The focus is to continue to deliver high levels of performance in this areas.

4.4 Care Home Placements

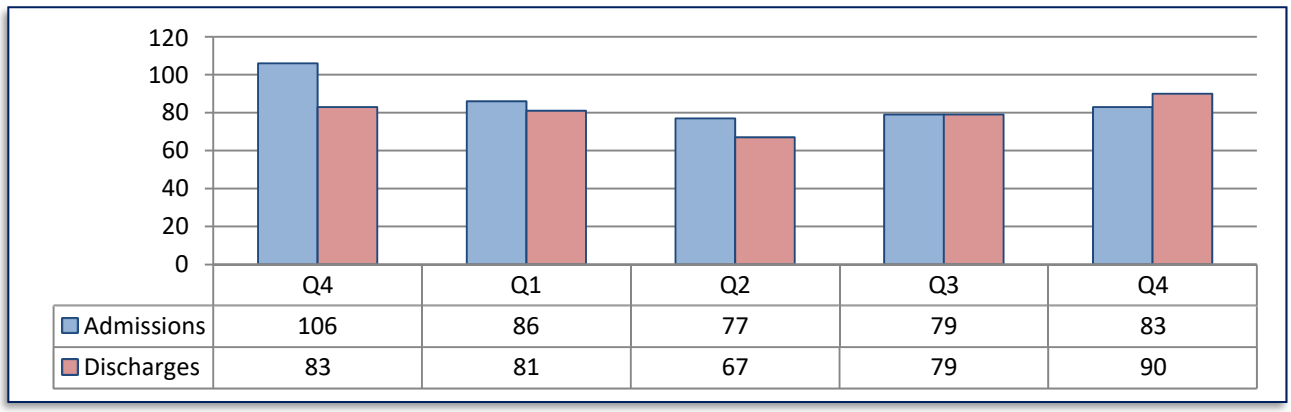
Rationale: Avoiding new permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Aim = to minimise.

Figure 4.4a Number of People Aged 65+yrs in Permanent Care Home Placements (snapshot)



	Q4	Q1	Q2	Q3	Q4
Actual (no.)	769	785	793	794	781
Target	640	640	640	640	640

Figure 4.4b Number of Care Home Admissions and Discharges (including deaths)



	Q4	Q1	Q2	Q3	Q4
Admissions	106	86	77	79	83
Discharges	83	81	67	79	90

Situational Analysis:
Care home admissions are determined at an individual level, based upon an assessment of support needs and with consideration to the balance of care and cost thresholds. The HSCP policy is to support people in the community for as long as possible, which is generally the preference of the individual concerned. National and local policy is also geared towards carefully balancing the use of care home admissions. Increases in care at home provision to older people demonstrate that this has been successful, but demand pressures continue across all service sectors.

The availability of care home admission and discharge data is generally subject to time lag, due to transactional processes and recording, so the most recent data relates to January to March 2020, but the highly challenging impact of Covid-19 on the care home sector during the early stages of lockdown can be seen in the balance of activity in Fig 4.4b.

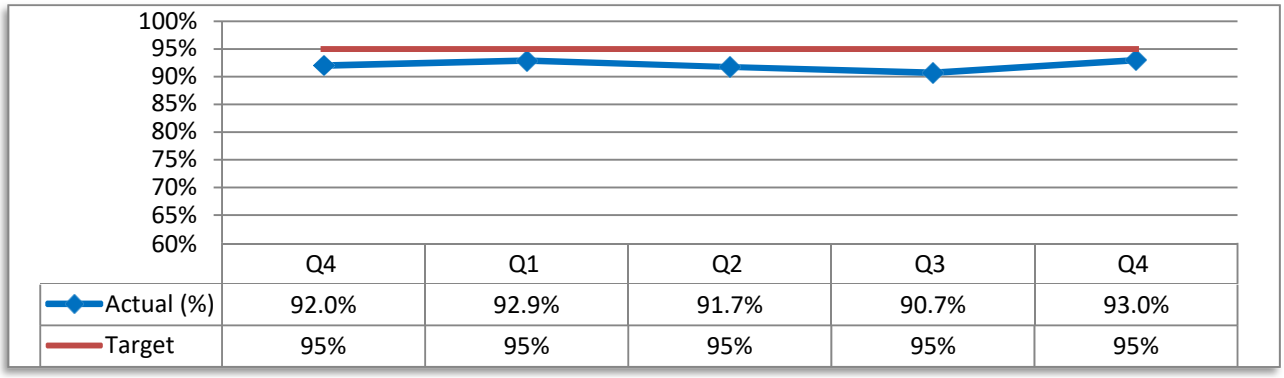
Improvement Action:
Work continues to analyse and manage care home admission pressures, taking into account the potential consequences, both personal and organisational, for decision-making.

4.5 Adult Protection Inquiry to Intervention Timescales

Rationale: The Health & Social Care Partnership have a statutory duty to make inquiries and intervene to support and protect adults at risk of harm. It is crucial that

such activities are carried out in a timely and effective fashion. This indicator measures the speed with which sequential ASP actions are taken against timescales laid out in local social work procedures. Aim = to maximise.

Figure 4.5 Percentage of Adult Protection cases where timescales were met



	Q4	Q1	Q2	Q3	Q4
Actual (%)	92.0%	92.9%	91.7%	90.7%	93.0%
Target	95%	95%	95%	95%	95%

Situational Analysis:
After a period of lower performance last year due to the impact of industrial action, performance has recovered to levels much closer to the target. However, increasing rates of referrals linked to a Large Scale Investigation undertaken during the year have also added to the overall workload in this area making consistent achievement of targets challenging. *2020-21 Q1 figures were not available at time of publication.*

Improvement Action:
Improvement action will continue to pursue achievement of compliance with target timescales. Performance is regularly scrutinised by the Adult Protection Committee to identify improvement opportunities and these are progressed where possible. An updated national performance reporting framework is anticipated during the coming year and reporting will be adjusted to meet this, if required.

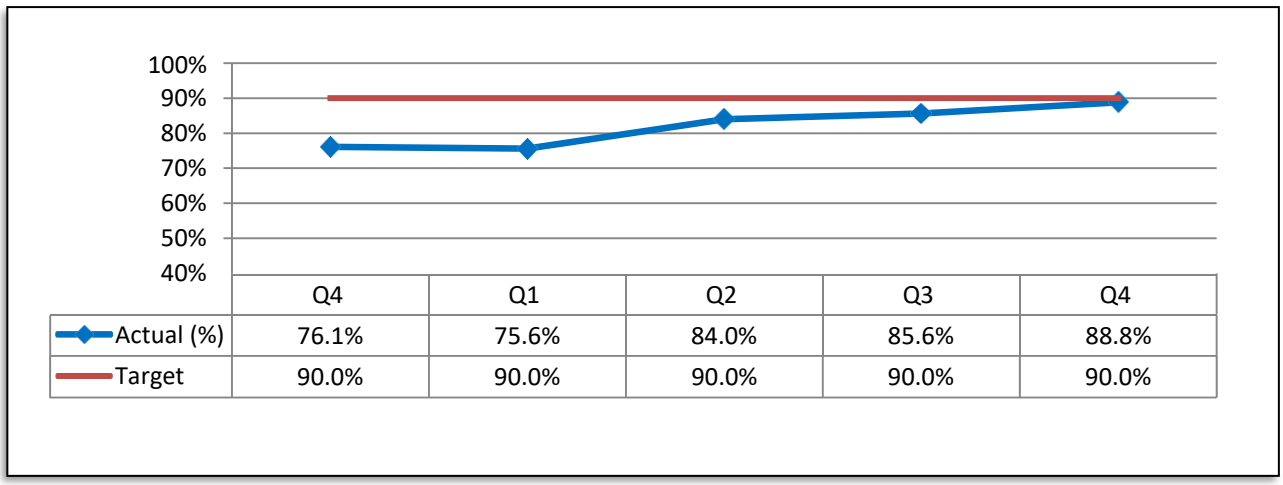
SECTION 5
Local Delivery Plan (Health) Standards

LDP Standards refer to a suit of targets, set by the Scottish Government, which define performance levels that all Health Boards are expected to either sustain or improve. This section reports on the Standards delivered by, or relevant to, the HSCP.

5.1 Drugs & Alcohol Treatment Waiting Times

Rationale: The 3 weeks from referral received to appropriate drug or alcohol treatment target was established to ensure more people recover from drug and alcohol problems so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy. The first stage in supporting people to recover from drug and alcohol problems is to provide a wide range of services and interventions for individuals and their families that are recovery-focused, good quality and that can be accessed when and where they are needed.

Figure 5.1 Percentage of People Waiting <3wks for Drug & Alcohol Treatment



	Q4	Q1	Q2	Q3	Q4
Actual (%)	76.1%	75.6%	84.0%	85.6%	88.8%
Target	90.0%	90.0%	90.0%	90.0%	90.0%

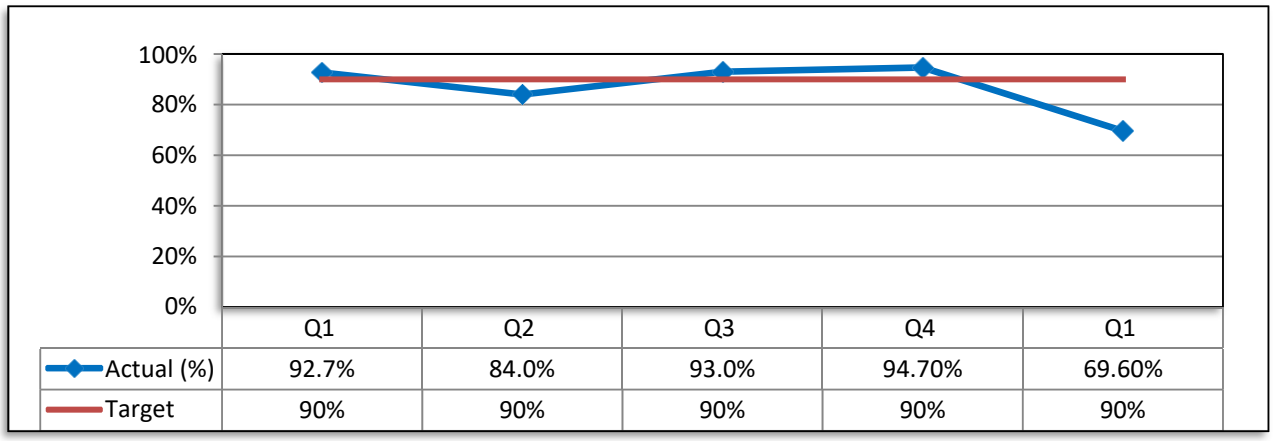
Situational Analysis:
2019-20 Quarter 1 waiting time performance data had not been published at the time of preparing this report. At Q4, performance was below target but showed continued improvement following progress at Q2 and again at Q3. The drug and alcohol team had been significantly impacted by staffing shortages during the last year due to long-term staff absence. Hard work by the team and the successful recruitment to the band 6 alcohol care and treatment nursing post have been instrumental in improving performance in this area.

Improvement Action:
The team will continue to work to maintain and further improve performance in this area. However the impact of Covid-19 constraints may be demonstrated in the data that emerges over the next few weeks.

5.2 Psychological Therapies Waiting Times

Rationale: Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services.

Figure 5.2 Percentage of People Waiting <18wks for Psychological Therapies



	Q1	Q2	Q3	Q4	Q1
Actual (%)	92.7%	84.0%	93.0%	94.70%	69.60%
Target	90%	90%	90%	90%	90%

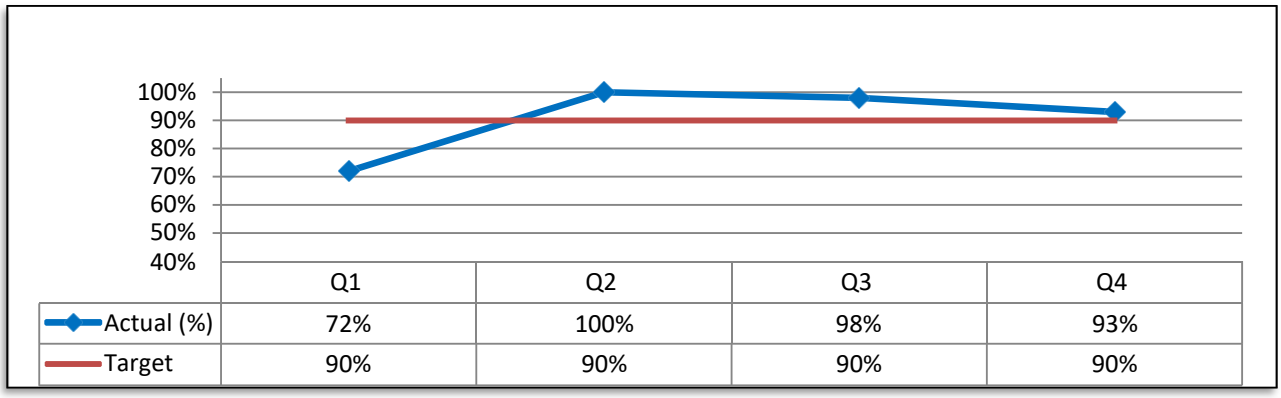
Situational Analysis:
This includes the Community, Primary and Older People's Mental Health Teams. Performance in the percentage of people seen within 18 weeks from referral to psychological therapy achieved target for the second half of 2019-20, but in quarter 1 of 2020-21, performance was significantly affected by the Covid-19 pandemic. This was particularly the case for the Older People's Mental Health Team, given the particular challenges in providing therapeutic support for this group of patients, during lockdown. Performance for the Community and Primary Mental Health Teams fell just short of target at 86.3%

Improvement Action:
The Mental Health Teams have developed Covid-19 Recovery and Transition plans to inform the way forward, to ensure that people continue to have access to therapeutic support. This will continue to included maximising digital methods where this works for patients.

5.3 Dementia Post Diagnostic Support (PDS)

Rationale: This Standard supports the improvement of local post-diagnostic services as they work alongside and support people with a new diagnosis of dementia, and their family, in building a holistic and person-centred support plan. People with dementia benefit from an earlier diagnosis and access to the range of post-diagnostic services, which enable the person and their family to understand and adjust to a diagnosis, connect better and navigate through services and plan for future care including anticipatory care planning.

Figure 5.3 Percentage of People Newly Diagnosed with Dementia Accessing PDS



	Q1	Q2	Q3	Q4
Actual (%)	72%	100%	98%	93%
Target	90%	90%	90%	90%

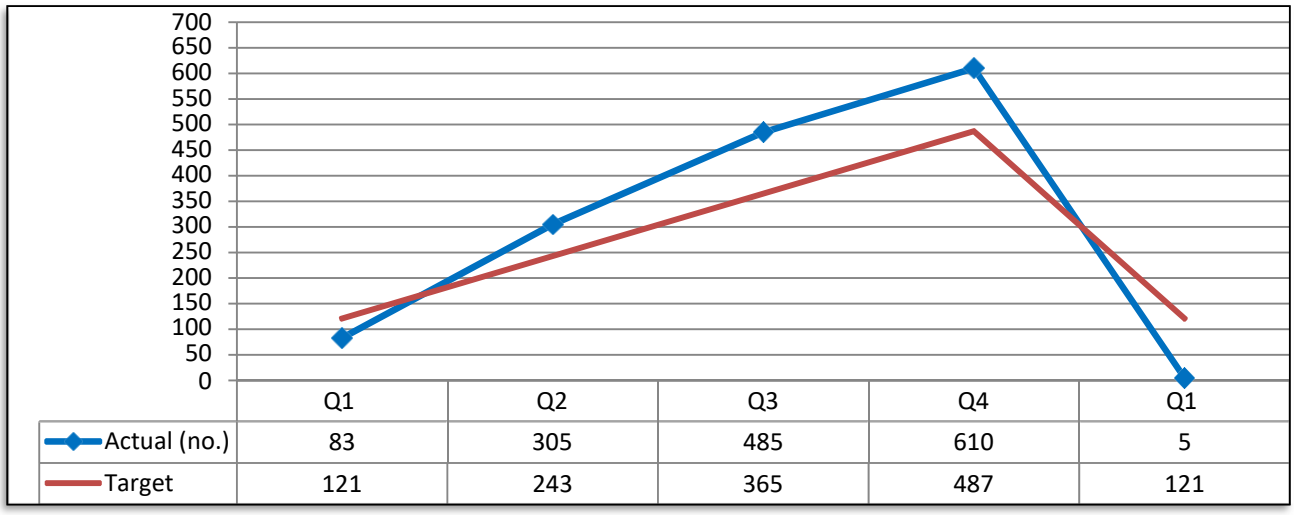
Situational Analysis:
This indicator examines how many patients are accessing PDS within 12 weeks of new diagnosis. Staffing shortages impacted significantly on the service's ability to achieve target levels of performance in Q1, but this has improved over the rest of the year, with performance above target. *2020-21 Q1 figures were not available at time of publication.*

Improvement Action:
Work will be ongoing to continue to sustain and improve performance in this area.

5.4 Alcohol Brief Interventions (ABIs)

Rationale: To sustain and embed alcohol brief interventions in the three priority settings of primary care, A&E and antenatal. This standard helps tackle hazardous and harmful drinking, which contributes significantly to Scotland's morbidity, mortality and social harm. Latest data suggests that alcohol-related hospital admissions have quadrupled since the early 1980s and mortality has doubled.

Figure 5.4 Total Number of ABIs delivered (cumulative)



	Q1	Q2	Q3	Q4	Q1
Actual (no.)	83	305	485	610	5
Target	121	243	365	487	121

Situational Analysis:
The target of 487 Alcohol Brief Interventions was achieved and exceeded by some margin over 2019-20. Fig 5.4 shows that the Q1 target of 121 ABIs was not achieved in this

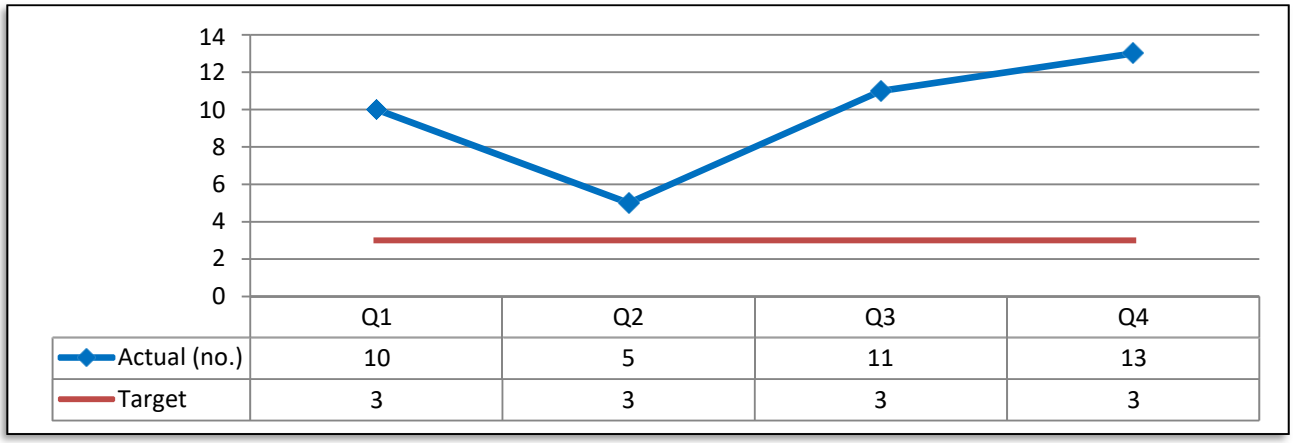
period. Indeed only 5 ABIs were delivered due to the severe impact of Covid-19 restrictions on these therapeutic interventions. Recovery plans are underway to steer the beginning of a return to previous levels of service, but continued social distancing will be impactful.

Improvement Action:
Recovery plans are underway to inform the return to previous levels of service. Alternative engagement methods will be maximised, such as use of digital, but continued social distancing will likely be impactful for a continued period of time.

5.5 Smoking Cessation

Rationale: To sustain and embed successful smoking quits at 12 weeks post quit, in the 40 per cent most deprived SIMD areas. This target sets out the key contribution of NHS Scotland to reduce the prevalence of smoking. Smoking has long been recognised as the biggest single cause of preventable ill-health and premature death. It is a key factor in health inequalities and is estimated to be linked to some 13,000 deaths and many more hospital admissions each year.

Figure 5.5 Smoking quits at 12 weeks post quit in the 40% most deprived areas



	Q1	Q2	Q3	Q4
Actual (no.)	10	5	11	13
Target	3	3	3	3

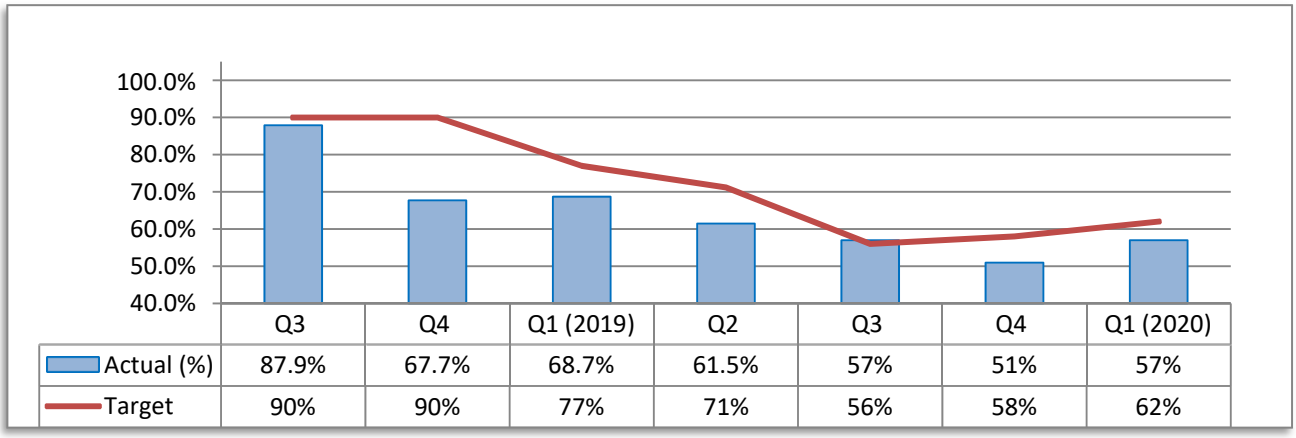
Situational Analysis:
Targets for smoking cessation are set centrally by NHSGGC and have been revised down for 2019-20, to reflect actual smoking rates. Performance with smoking cessation has improved over this period, to exceed the new target. Data only becomes available 12 weeks after the end of each reporting period, so Q4 is the most recent available data.

Improvement Action:
As of the February 2019, a full time HI Practitioner (Smoking Cessation) was recruited on a fixed-term contract (until March 2020) who works primarily within East Dunbartonshire as part of the QYW Community services. The postholder has a focus on raising awareness of the stop smoking services in East Dunbartonshire, delivering service and exploring service development opportunities. One of the objectives of this post is to improve performance against this target. The indications are that this approach impacted very positively upon uptake and success rates.

5.6 Child & Adolescent Mental Health Services (CAMHS) Waiting Times

Rationale: 90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral. Timely access to healthcare is a key measure of quality and that applies equally in respect of access to mental health services. Early action is more likely to result in full recovery and in the case of children and young people will also minimise the impact on other aspects of their development such as their education, so improving their wider social development outcomes.

Figure 5.6 Percentage of People Waiting <18wks for CAMHS



	Q3	Q4	Q1 (2019)	Q2	Q3	Q4	Q1 (2020)
Actual (%)	87.9%	67.7%	68.7%	61.5%	57%	51%	57%
Target	90%	90%	77%	71%	56%	58%	62%

Situational analysis:
NHSGG&C CAMHS aims to prioritise improvement on the Referral to Treatment (RTT) performance in a managed way that acknowledges the considerable task of balancing demand and capacity. Increases in demand over the last two years have had a significant impact on clinical capacity and we are working to resolve this as efficiently and safely as possible. At the end of quarter one, 24% of children on the waiting list have waited less than 18 weeks and 57% of children who started treatment had waited less than 18weeks.

Improvement Actions:

- Regular updates with CAMHS management and teams to ensure the most effective use of clinical capacity for the waiting list and open caseload throughout the COVID-19 Pandemic. This uses RAG patient status to prioritise new referrals and existing waiting list. Those children and young people waiting longest are being contacted to validate the referrals
- Regular monitoring of CAMHS clinical workforce and capacity available to the service through COVID-19 lockdown period.
- Linking with the Children and Young People's Mental Health Programme Board Performance Team to discuss options and aims of reducing the waiting list backlog, with a plan now developed.
- Implementation of Attend Anywhere to increase numbers of children seen and clinical capacity, and encourage teams to work efficiently to see children sooner. GGC are providing video calls proportionate to total appointments at a rate of double the UK CAMHS average.

- Implementation of the revised RTT guidelines to ensure recording of GGC CAMHS waiting lists is in line with the rest of the country (no proxy used). Currently GGC stop the clock at the 2nd appointment, which is not the standard across the country. This will move to a model where the clinician stops the clock when they start treatment, which is anticipated to be at first contact.
- A working group have now developed a waiting list initiative plan and this has been approved across the HSCPs. We will work closely with East Dunbartonshire HSCP to implement this plan and improve waiting times.

Agreed Trajectory until December 2020

Please note, that this trajectory is for GGC CAMHS and not specific to East Dunbartonshire. SCS Leadership and CAMHS management are closely monitoring this progress and aim to keep the service on track for a return to achieving the RTT target.

Quarter ending	**Sep 2019**	**Dec 2019**	**Mar 2020**	**Jun 2020**	**Sep 2020**	**Dec 2020**
Performance against the standard (%) – Children Waiting at Month End	71.2%	56%	58%	62%	71%	90%

SECTION 6
Children's Services Performance

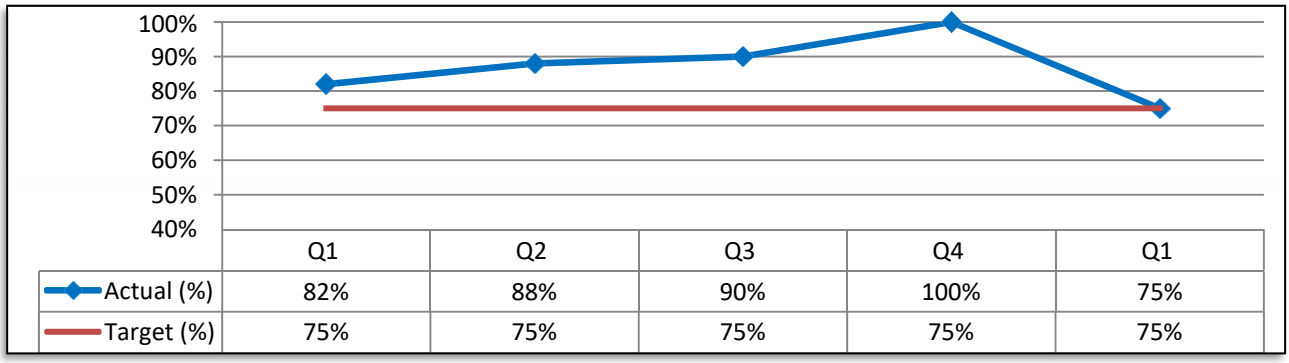
This section provides an updated report performance against key Children and Families indicators. The indicators reported are:

6.1 Child Care Integrated Assessments for Scottish Children Reported Administration timescales
6.2 Initial Child Protection Case Conferences timescales
6.3 First Child Protection review conferences timescales
6.4 Balance of care for Looked After Children
6.5 First Looked After & Accommodated reviews timescales
6.6 Children receiving 27-30 month Assessment

6.1 Child Care Integrated Assessments (ICA) for Scottish Children Reporters Administration (SCRA) Timescales

Rationale: This is a national target that is reported to (SCRA) and Scottish Government in accordance with time intervals. Aim = to maximise

Figure 6.1 Percentage of Child Care Integrated Assessments (ICA) for SCRA completed within 20 days



	Q1	Q2	Q3	Q4	Q1
Actual (%)	82%	88%	90%	100%	75%
Target (%)	75%	75%	75%	75%	75%

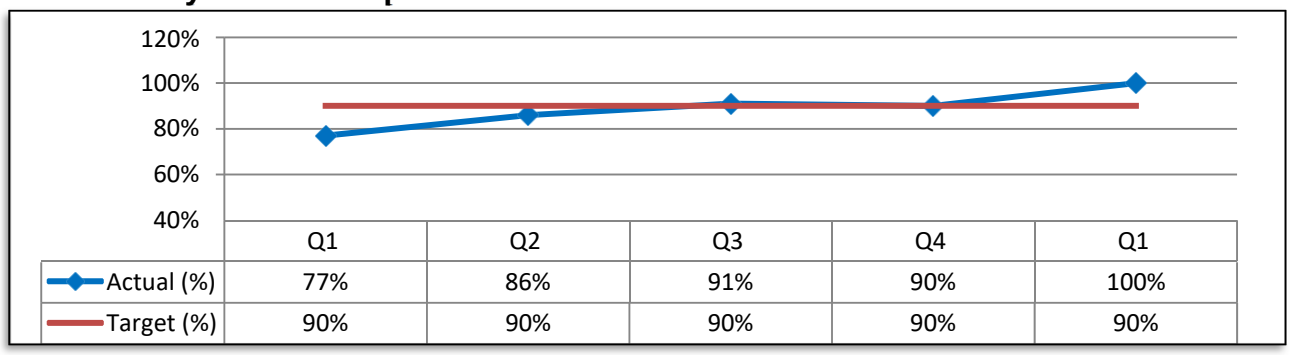
Situational Analysis:
Performance in 2019-20 improved markedly and positively exceeded the target whilst also improving each quarter. Q1 in 2020-21 has been a period of significant challenge due to Covid-19 constraints, resulting in a reduction in performance but the indicator remains on target. 8 ICA reports were submitted to SCRA during Q1, of which 2 were submitted late due to the impact of the pandemic.

Improvement Action:
To recover good performance.

6.2 Initial Child Protection Case Conferences Timescales

Rationale: Local standard and timescales set by East Dunbartonshire Child Protection Committee. Aim = to maximise

Figure 6.2 Percentage of Initial Child Protection Case Conferences taking place within 21 days from receipt of referral



	Q1	Q2	Q3	Q4	Q1
Actual (%)	77%	86%	91%	90%	100%
Target (%)	90%	90%	90%	90%	90%

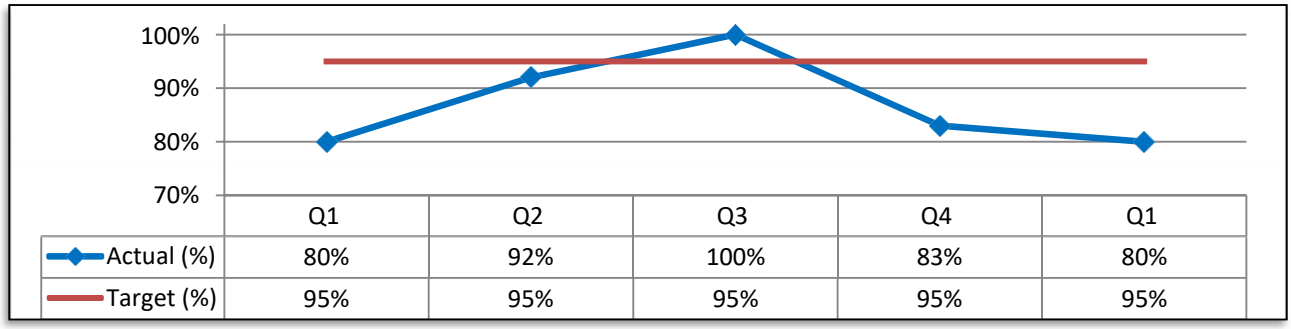
Situational Analysis:
Performance in 2019-20 Q1 and Q2 showed an improvement over a challenging performance result in the final quarter of 2018-19. This trajectory has been sustained, with performance achieving target in Q3 and Q4. These improvements were due to operational support changes that now have the date for Initial Child Protection Case Conferences arranged at the point of a CP investigation starting, to ensure better timescales are achieved. Progress in Q1 of this was particularly positive as it fell within the period most affected by Covid-19 lockdown. Child protection remained an organisational priority during this period, which can be seen in these figures.

Improvement Action:
To continue to embed revised operational procedures in order to sustain above target performance.

6.3 First Child Protection Review Conferences Timescales

Rationale: Local standard and timescales set by East Dunbartonshire Child Protection Committee. Aim = to maximise

Figure 6.3 Percentage of first review conferences taking place within 3 months of registration



	Q1	Q2	Q3	Q4	Q1
Actual (%)	80%	92%	100%	83%	80%
Target (%)	95%	95%	95%	95%	95%

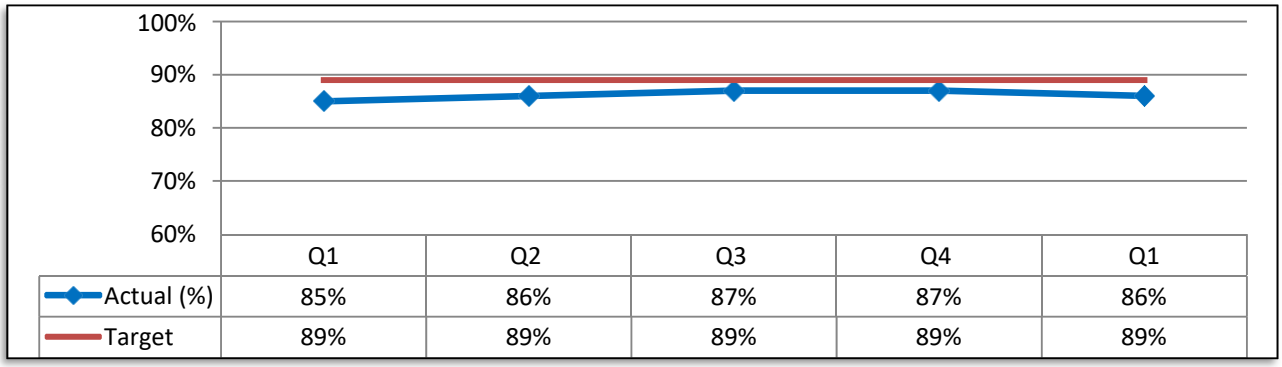
Situational Analysis:
Performance during Q1 has declined from the previous quarter and is below target. 10 first Child Protection Reviews took place during quarter 1 and 8 of these were within timescale. 2 Reviews were late as a result of the Covid-19 pandemic, however arrangements were put in place as quickly as possible to allow these meetings to happen virtually.

Improvement Action:
Team Managers will continue to maximise the achievement of Review Case Conferences timescales.

6.4 Balance of Care for Looked After Children

Rationale: National performance indicator reported to Scottish Government and monitored by Corporate Parenting Bodies. Aim = to maximise

Figure 6.4 Percentage of Children being Looked After in the Community



	Q1	Q2	Q3	Q4	Q1
Actual (%)	85%	86%	87%	87%	86%
Target	89%	89%	89%	89%	89%

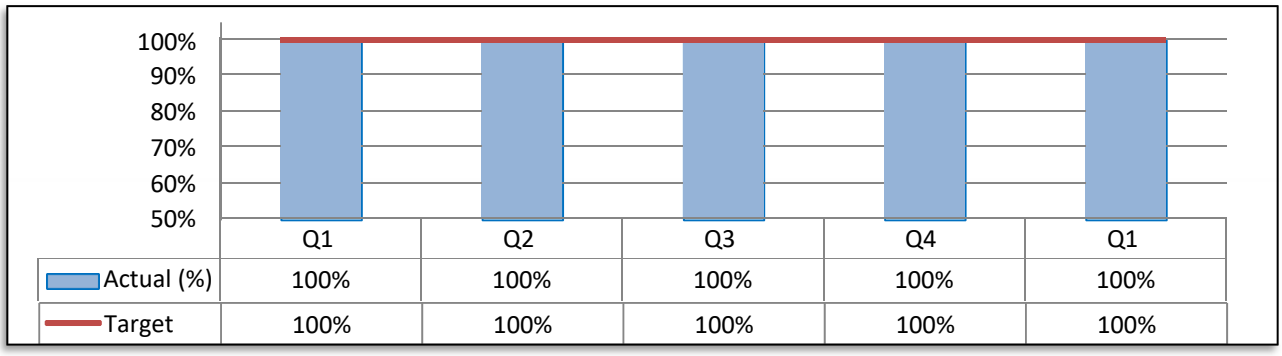
Situational Analysis:
Performance at the end of quarter 1 is slightly lower than the previous quarter and continues to be below the target figure. Although the number of children looked after in community placements has been maintained, there has been an increase in residential placements (1 child) meaning a slight shift in the balance of care.

Improvement Action:
Work continues to redress the balance of care by reviewing out of authority placements and continuing the Foster Carer recruitment campaign.

6.5 First Looked After & Accommodated (LAAC) Reviews Timescales

Rationale: This is a local standard reflecting best practice and reported to the Corporate Parenting Board

Figure 6.5 Percentage of first LAAC reviews taking place within 4 weeks of accommodation



	Q1	Q2	Q3	Q4	Q1
Actual (%)	100%	100%	100%	100%	100%
Target	100%	100%	100%	100%	100%

Situational Analysis:
Performance in Quarter 1 maintains 100% compliance with timescales. There were 6 first LAAC Reviews held during the quarter and all took place within the target timescale.

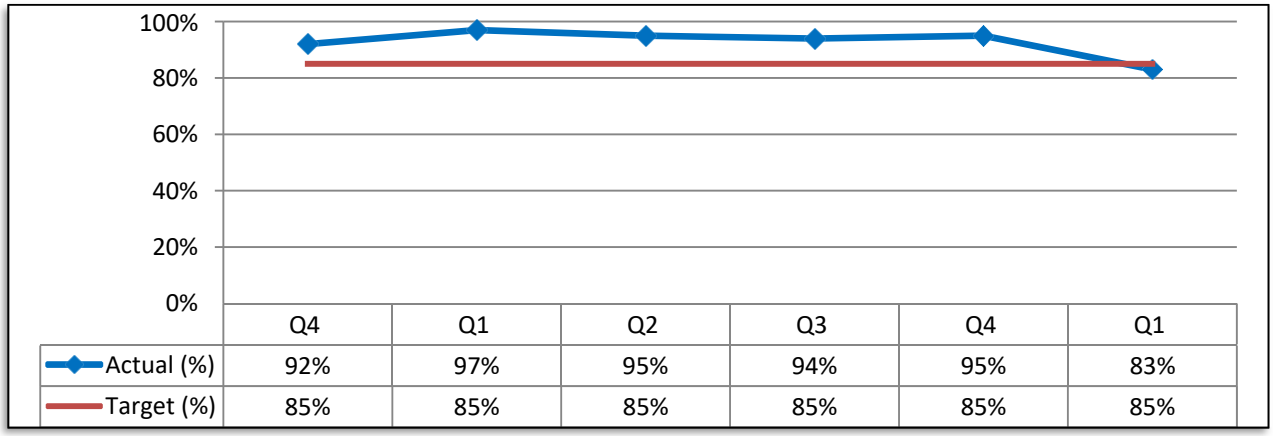
Improvement Action:
To maintain high levels of performance.

6.6 Children receiving 27-30 month Assessment

Rationale: The central purpose of the 27-30 month contact is to seek parental concerns to identify children whose social, emotional and behavioural development puts them at risk of adverse life course outcomes.
Having identified these children, interventions must be put in place to optimise child development in preparation for education. The plan is that wherever possible, children's needs should be met in time for them to benefit from universal nursery provision at age 3.

The Scottish Government target is that by 2020, at least 85% of children within each SIMD quintile of the CPP will have reached all of their developmental milestones at the time of their 27–30 month child health review.

Figure 6.6 Percentage of Children receiving 27-30 month assessment



	Q4	Q1	Q2	Q3	Q4	Q1
Actual (%)	92%	97%	95%	94%	95%	83%
Target (%)	85%	85%	85%	85%	85%	85%

Situational Analysis:
This indicator relates to early identification of children within the SIMD quintiles with additional developmental needs. Where additional needs are identified, children are referred to specialist services. Uptake of the 27-30 month assessment across East Dunbartonshire HSCP has been consistently high and above target. The Q1 figure reflects the impact of Covid-19 public health restrictions on the delivery of service during the lockdown period.

Improvement Action:
Monitor and continue to maximise performance. Data reports are monitored on a monthly basis at team meetings to support early identification of variances and allow improvement plans to be developed where required. Covid-19 service recovery planning is in place and will be followed to support these actions

SECTION 7
Criminal Justice Performance

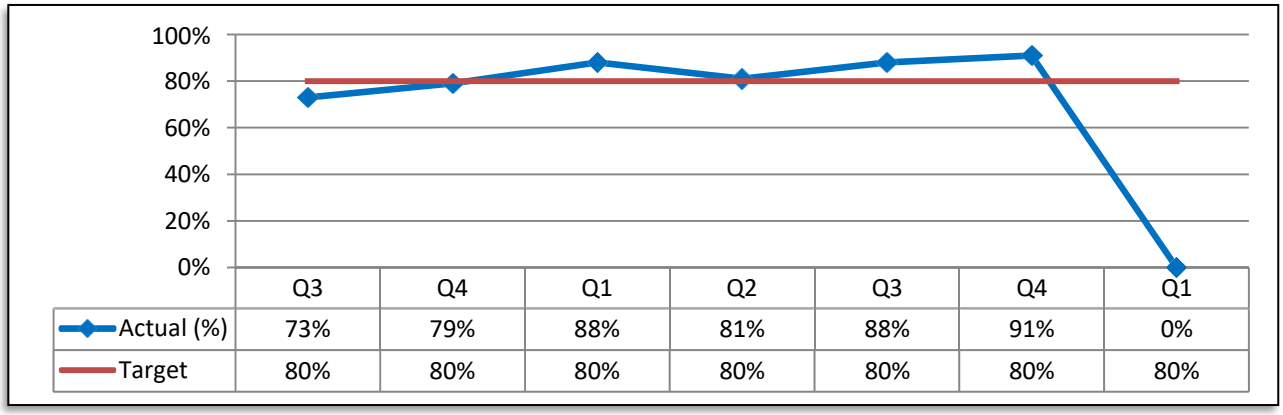
This section provides an updated report performance against key Criminal Justice indicators. The indicators reported are:

7.1 Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order
7.2 Percentage of CJSW reports submitted to Court by due date
7.3 Percentage of Court report requests allocated to a Social Worker within 2 Working Days of Receipt

7.1 Percentage of Individuals Beginning a Work Placement Within 7 Days of Receiving a Community Payback Order

Rationale: The CJSW service must take responsibility for individuals subject to a Community Payback Order beginning a work placement within 7 days.

Figure 7.1 Percentage of individuals beginning a work placement within 7 days



	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Actual (%)	73%	79%	88%	81%	88%	91%	0%
Target	80%	80%	80%	80%	80%	80%	80%

Situational Analysis:

A challenge always remains with this performance metric when service users who attend immediately after court but are then unable to commence due to further conviction, ill health with GP line, employment contract clashing with immediate start or if subject to an existing order which means the new order cannot commence until the original one is completed. These factors are out with control of the service. Nonetheless, performance has been consistently above target during 2019-20. During Q2, all work placements were suspended due to Covid-19 public health constraints.

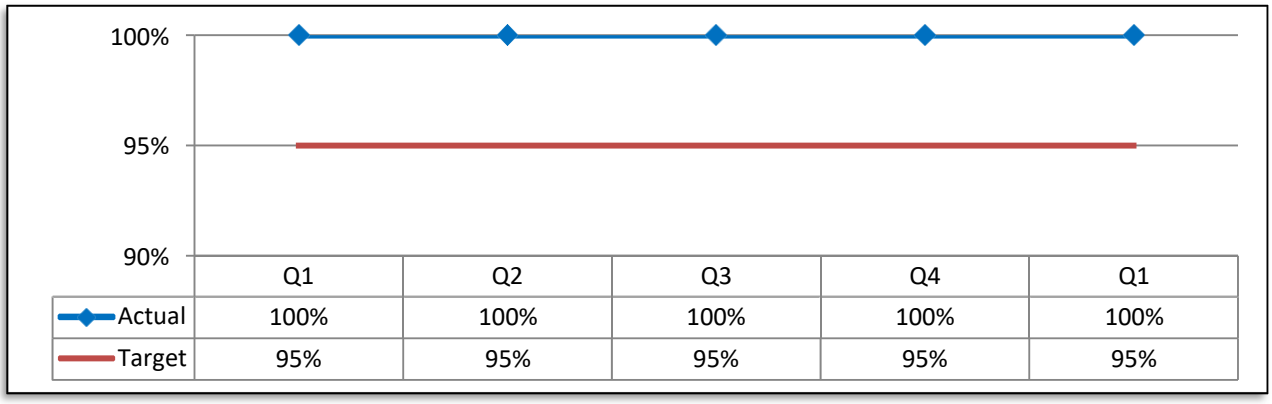
Improvement Action: The focus will be on the recovery of services in line with national and local public health guidance**.**

7.2 Percentage of CJSW Reports Submitted to Court by Due Date

Rationale: National Outcomes & Standards (2010) states that the court will receive reports electronically from the appropriate CJSW Service or court team (local to the court), no later than midday on the day before the court hearing.

Figure 7.2 Percentage of CJSW reports submitted to Court by due date

Rationale: National Outcomes & Standards (2010) stresses the importance of providing reports to courts by the due date, to facilitate smooth administrative support arrangements.



	Q1	Q2	Q3	Q4	Q1
Actual	100%	100%	100%	100%	100%
Target	95%	95%	95%	95%	95%

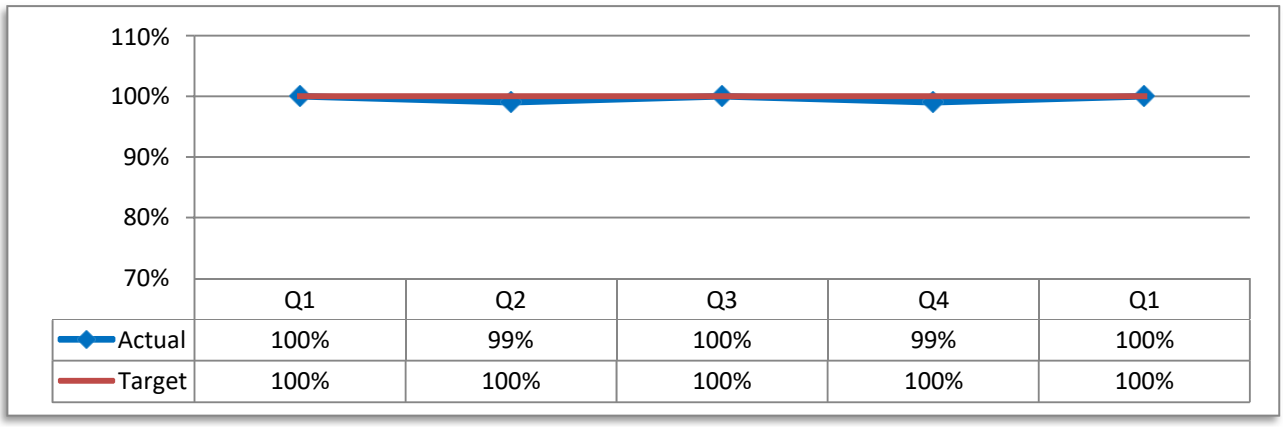
Situational Analysis: On target. All of 22 court reports were submitted on time during Q1.

Improvement Action: Monitor and maintain.

7.3 Percentage of Court Report Requests Allocated to a Social Worker within 2 Working Days of Receipt

Rationale: National Outcomes & Standards (2010) places responsibility on Criminal justice service to provide a fast, fair and flexible service ensuring the offenders have an allocated criminal justice worker within 24 hours of the Court imposing the community sentence.

7.3 Percentage of Court report requests allocated to a Social Worker within 2 Working Days of Receipt



	Q1	Q2	Q3	Q4	Q1
Actual	100%	99%	100%	99%	100%
Target	100%	100%	100%	100%	100%

Situational Analysis: Performance was delivered to 100% target during Q1.

Improvement Action: Monitor and maintain.

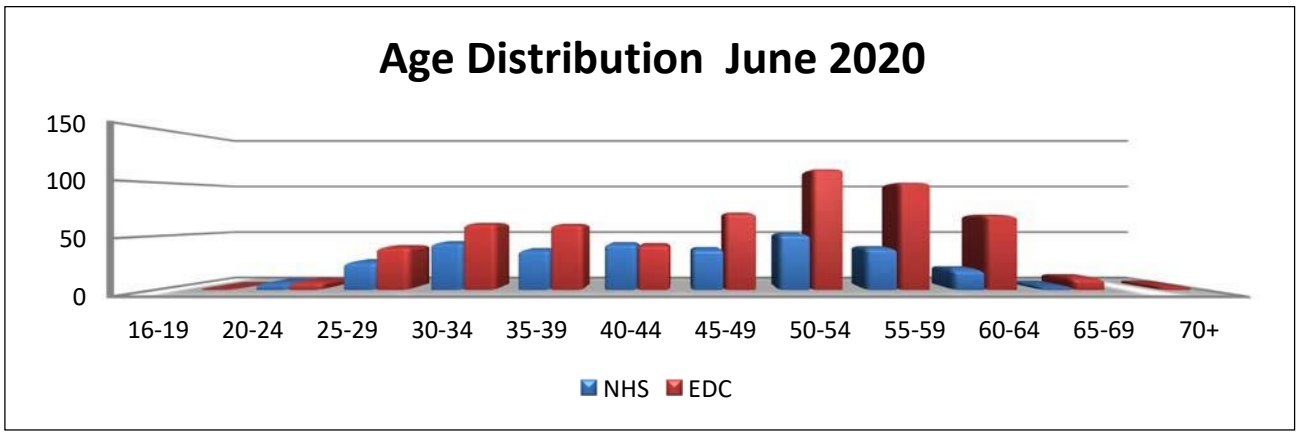
- Workforce Demographics
- Sickness / Absence Health Staff and Social Care Staff
- Knowledge & Skills Framework (KSF) / Personal Development Plan (PDP) / Personal Development Review (PDR)

8.1 Workforce Demographics

Employer	Headcount				WTE			
	Sept-19	Dec-19	Mar - 20	June - 20	Sept - 19	Dec-19	Mar - 20	June - 20
NHSGGC	283	294	297	307	238	247	250	256
EDC	584	579	583	584	490	485	491	493
Total	867	873	880	891	728	733	741	749

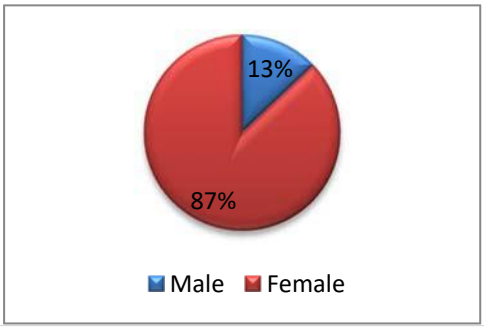
The picture on workforce shows a slight increase overall since March 2020 of 11 with an overall increase of 8 wte staffing. This picture shows that the partnership is working hard to accommodate flexible working for staff.

8.2 HSCP Staff by Age profile



The age profile shows that the majority of staff remains aged over 45yrs and that we have a very low number of staff less than 25yrs of age (16). This age range is not unexpected within the services that the HSCP provides, although as identified above, this high percentage of older staff might impact on the number of requests for a more flexible employment option.

8.3 Gender Profile



The gender ratio of female to male employed staff has remained the same for the first 3mths of 2020, with 85% of staff now being female.

8.4 Sickness / Absence Health and Social Care Staff

Average absence within EDC had reduced in the final quarter of 2019-20 and this has continued during the first quarter of 2020-21 even with the impact of covid-19. Overall absence is well managed within the HSCP and as identified the main contributing factor in both Health and Social Care for higher absence is aligned with staff moving from short term to longer term absence due to health conditions. There is a notional absence threshold of 4% across both East Dunbartonshire Council and NHSGGC.

Sickness / Absence %		
Month	**EDC**	**NHSGGC**
Oct 19	8.6	4.71
Nov 19	9.23	5.58
Dec 19	11.31	5.56
Jan -20	9.05	4.64
Feb 21	8.2	4.05
Mar 20	8.24	5
April 20	6.71	5.11
May 20	6.25	4.7
June 20	6.65	5.05
Average	**8.54**	**4.4**

8.5 KSF / PDP / PDR

KSF Activity	July 19	Aug 19	Sept -19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	April 20	May 20	Jun 20
Actual	**58.6**	**60**	**63.3**	**60.9**	**59.5**	**59**	**54.9**	**50.6**	**44.3**	**40.7**	**40.5**	**46.5**
Target	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**	**80**

KSF (Knowledge & Skills Framework) is the NHS staff review process to ensure that staff are competent to undertake the tasks associated with their role and have the appropriate learning and development planned across the year. Due to Covid-19 our progress towards the target figure has paused but should be narrowed by Q2.

8.6 Performance Development Review (PDR)

PDR		
Quarter	**% recorded**	**Target %**
Q2	68.27	75
Q3	73.1	80
Q4	82.44	85
Q1	1.03	65

PDR (Performance, Development Review) is the Council process for reviewing staff performance and aligning their learning and development to service objectives. Due to covid-19 some staff have been shielding, redeployed and working from home, therefore the recording and upload of PDR has not been an area of focus, and this is likely to continue over quarters 1 and 2.

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Agenda Item Number: 11.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17th September 2020
Subject Title	Financial Performance Budget 2020/21 – Month3
Report By	Jean Campbell, Chief Finance & Resources Officer Jean.Campbell2@ggc.scot.nhs.uk Tel: 0141 232 8216
Contact Officer	Jean Campbell, Chief Finance & Resources Officer

Purpose of Report	To update the Board on the financial performance of the partnership as at month 3 of 2020/21.

Recommendations	The Board is asked to: a. Note the projected Out turn position is reporting an over spend of £7.1m as at month 3 of 2020/21 based on the level of SG funding confirmed to support Covid expenditure to date. b. Note the progress to date on the achievement of the current, approved savings plan for 2020/21 as detailed in **(Appendix 1)**. **c.** Note the HSCP financial performance as detailed in (**Appendix 2).** d. Note the impact of Covid related expenditure during 2020/21

Relevance to HSCP Board Strategic Plan	The Strategic Plan is dependent on effective management of the partnership resources and directing monies in line with delivery of key priorities within the plan.

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	The financial performance to date is showing that the budget is under significant pressure as a result of Covid related costs and the impact of this on the delivery of savings and transformation during 20/21. In the event that these costs and impacts are fully funded by the Scottish Government (SG), the HSCP would deliver an under spend of £2.2m related to a significant downturn in care home and care at home placements. The HSCP does not hold any general reserves to mitigate these pressures in year.

Legal:	None

Economic Impact:	None

Sustainability:	The sustainability of the partnership in the context of the current financial position and lack of reserves require a fundamental change in the way health and social care services are delivered within East Dunbartonshire going forward in order to meet the financial challenges and deliver within the financial framework available to the partnership.

Risk Implications:	There are a number of financial risks moving into future years given the rising demand in the context of reducing budgets which will require a radical change in way health and social care services are delivered which will have an impact on services users / carers, third and independent sector providers and staffing. The risks are set out in paragraph 5.0.

Implications for East Dunbartonshire Council:	Effective management of the partnership budget will give assurances to the Council in terms of managing the partner agency's financial challenges.

Implications for NHS Greater Glasgow & Clyde:	Effective management of the partnership budget will give assurances to the Health Board in terms of managing the partner agency's financial challenges.

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	**X**

1.0 MAIN REPORT

Budget 2020/21

1.1 The budget for East Dunbartonshire HSCP was approved by the IJB on the 26th March 2020.This provided a total net budget for the year of £173.099m (including £32.944m related to the set aside budget). This included £3.2m of agreed savings (including management actions, turnover savings and transformation activity) and a £2.8m financial gap which required the identification of additional transformation activity to deliver a balanced budget for the year and moving forward into future financial years.

1.2 There have been a number of adjustments to the budget since the HSCP Board in March 2020 which has increased the annual budget for 20/21 to £175.9m. A breakdown of these adjustments are included as **Appendix 1.** These adjustments along with recurring funding streams identified during the year end process for 19/20 and in the initial monitoring periods of the budget for 20/21 have reduced the financial gap to £2.1m.

1.3 Due to Covid-19 revised governance arrangements the NHSGGC Board have yet to formally approve their budget offers to all six local partnerships, however the 3% uplift to HSCPs has been incorporated into their 2020/21 Financial Plan.

2.0 Partnership Performance Summary

2.1 The overall partnership position is showing an emerging projected year end over spend on directly managed partnership budgets of £7.1m at this point in the financial year. This includes expenditure of £9.4m related to the Covid response for which there is no confirmation of funding from SG beyond a commitment that all reasonable costs will be covered. In the event that funding is available to cover the full extent of these costs, the partnership would deliver an under spend on budget of £2.2m.

2.2 This represents a significant risk to the HSCP in the event that the full costs and impact related to Covid are not fully funded. The biggest element of risk within the mobilisation plan relates to the non-delivery of savings identified as part of the budget process for 2020/21 including a £2.1m gap to be funded through the identification of further transformation activity. Given the focus has been on responding to the Covid pandemic over recent months, then activity to deliver savings or identify further transformation has not progressed as planned and is unlikely to deliver the level of savings required to deliver a balanced budget through this approach alone.

2.3 The World Health Organisation (WHO) declared the Covid-19 virus a pandemic on the 11 March 2020. HSCPs, along with other public sector organisations, moved into business continuity mode as Scotland moved into “lockdown” on the 23 March 2020.

2.4 In an effort to capture the financial impact of Covid, the Scottish Government set up a process through the development of local mobilisation plans and associated financial trackers to estimate the cost of the pandemic. HSCP’s were required to submit these financial trackers through their respective NHS Boards and these

were submitted on a weekly basis during April / May moving to monthly submissions thereafter to the SG.

2.5 The process and underlying assumptions to capture cost information has been refined over the period since lockdown and these have been subject to scrutiny by the SG at a local and health board level and set against national benchmarks. This has informed the release of a number of tranches of funding to support aspects of the cost implications including support to deliver the Scottish Living Wage and £100m to support provider sustainability and additional cost pressures resulting from Covid.

2.6 The totality of the Local Mobilisation Plan expenditure for East Dunbartonshire is £11.3m. This continues to be an evolving picture and is heavily caveated as these costs will change as we move from high level assumptions, to more refined estimates as activity becomes clearer and through to actual costs incurred; the financial impacts and implications will continue to be reported to the IJB throughout the year.

2.7 The SG announced an initial tranche of funding on the 12th May 2020 of £50m of which £976k relates to East Dunbartonshire. A further tranche of £50m was announced on the 3rd August, the allocation of this funding has yet to be agreed, however, 50% of this funding has been allocated on the same basis as the first tranche. The remaining £25m will be released following scrutiny of the latest mobilisation returns to the SG. The above position assumes that this will be a similar allocation for East Dunbartonshire as the first tranche. The funding announced to date has been for the purposes of supporting the social care sector with additional costs related to Covid and specifically provider sustainability during this period. A breakdown of Covid related expenditure captured within the latest Local Mobilisation Plan (LMP) submission is set out in the table below:

H&SCP Costs	Revenue 2020/21	Body incurring cost (NHS or LA)
Personal protection equipment	590,366	NHS / LA
Testing for Virus	163,877	NHS
Additional staff Overtime and Enhancements	642,823	LA
Additional temporary staff spend - Student Nurses & AHP	18,325	NHS
Additional temporary staff spend - All Other	231,054	NHS / LA
Additional costs for externally provided services	4,111,548	LA
Additional costs to support carers	88,840	LA
Mental Health Services	151,708	NHS
Additional FHS Prescribing	103,000	NHS
Community Hubs	231,166	NHS
Loss of income	510,587	LA / NHS
Equipment & Sundries	65,440	NHS
Other - social care	605,452	LA
Other - alternatives to day care	38,287	LA
Other - support to vulnerable service users - food	1,890	LA
Offsetting cost reductions - HSCP	(293,110)	LA
Expected underachievement of savings (HSCP)	4,045,100	NHS / LA
Total Covid Expenditure	**11,306,353**	
Income:		
Share of £50m announced 12th May 2020	**(976,000)**	LA
Share of £25m announced 3rd August 2020	**(488,888)**	LA
Anticipated further share of £25m announced 3rd August 2020	**(488,000)**	LA
Net Expenditure	**9,353,465**	

2.8 In addition, funding was allocated to deliver a 3.3% uplift to the Scottish Living Wage (SLW) of £215k. The total cost to deliver this increase locally is expected to be £886k. The shortfall is reflected within the remaining £2.1m financial gap. The costs associated with the SLW have now been removed from the LMP returns.

2.9 Work continues through the regular LMP returns to SG to evidence the ongoing impact from Covid with an expectation that further tranches of funding will be made available. The risk that future funding allocations will not be sufficient to cover the full extent of Covid pressures is a significant one for the HSCP.

2.10 The projected year end overspend across care group areas is set out in the table below:

Care Group	Annual Budget (£000) Total	Total (Mth 3)
Mental Health, Learning Disability, Addictions & Health Improvement	25,934	(118)
Community Health & Care Services	43,604	11
Children & Criminal Justice Services	14,108	(1,078)
Business Support	(364)	(349)
Other Non SW - PSHG / Care & Repair/Fleet/COG	1,348	145
FHS - Prescribing	20,210	(420)
FHS - GMS / Other	28,034	0
Oral Health - hosted	10,059	0
Set Aside	32,944	0
Covid	0	(5,309)
TOTAL Per Care Group	**175,877**	**(7,117)**
Anticipated SG Income to support Covid	**0**	9,355
Projected Year End Variance	**175,877**	**2,238**

2.11 The main variances to budget identified at this stage in the financial year relate to:

- Mental Health, Learning Disability, Addiction Services (projected £0.118m overspend – this relates to a loss of income in respect of daycare and transport charging due to service closures during Covid both to other local authorities and to service users, this is reflected within the LMP for which income is expected from the SG. This is currently being offset by a downturn in care packages within this care group and some positive payroll variation due to reduced staffing levels within Pineview due to a void placement.
- Children & Criminal Justice Services (projected £1.1m overspend) – these relate to payroll pressures as a result of challenging turnover savings and a number of additional residential and fostering placements since agreeing the budget in March 2020. In addition the impact of delays in attaining budget savings related to the 'House Project' are reflected here.
- Prescribing (projected overspend of £0.420m) - Projected overspend on prescribing as a result of the short supply of Sertraline. Further risks exist around the tariff swap and likelihood of board wide/local savings which will not be achieved given pharmacy staff focussed on Covid efforts. There are also some risks around whether horizon scanning costs associated with the delivery of specific savings initiatives will materialise as some may not be implemented. Volumes for Q1 are down, however these should offset the repayment of monies from the SG to support prescribing pressures from 2019/20 of £344k in the expectation that a surge in March related to Covid would be followed by a downward trend on volumes during April / May 2020.

- Business Support (projected overspend £0.349m) – Projected overspend relates to a combination of accommodation pressures related to KHCC and Lennoxtown Hub where options for recurring funding are being reviewed. In addition the level of resource transfer from the NHS to local authority is less than expected due to assumed savings not being achieved on NHS prescribing.
- Community Health & Care Services (projected underspend of £0.011m) – This is showing a favourable variance at this stage related to a combination of slippage in recruitment on Elderly Mental Health Services and a significant downward trend in care home placements and care at home packages. This area is covering the full extent of the budget gap at this stage, however in the event that there is an upward trend in placements beyond predicted levels then this would present a pressure on the HSCP budget.

2.12 Housing Aids and Adaptations and Care of Gardens
There are a number of other budgets delegated to the HSCP related to private sector housing grants, care of gardens and fleet provision. These services are delivered within the Council through the Place, Neighbourhood & Corporate Assets Directorate.

2.11 The summary position for the period to 30 June 2020 is set out in the table below and projects a favourable variance on budget in respect of fleet provision and care of gardens. Both of these elements are reflected within the care group budgets to which they relate (care of Gardens – older people, Fleet – older people / adult services). These will now be monitored and reported through the HSCP Board to provide effective oversight on the performance of these budget areas:-

Care Group Analysis	Annual Budget 2020/21 £000	Forecast Full Year Spend £000	Forecast Full Year Variance	Variance %age
Private Sector Housing Grants	634	634	0	0%
Care & Repair	30	30	0	0%
Care of Gardens*	90	87	3	4%
Fleet *	593	452	141	24%
Net Expenditure	1,347	1,203	144	

** Included within care group budgets.*

2.12 The partnership no longer holds a contingency reserve to mitigate unexpected pressures during the year and will therefore be required to consider a recovery plan in the event that budget pressures materialise which cannot be reasonably managed in year due to demand and cost pressures as experienced in previous financial years.

2.13 This is compounded in 20/21 as a result of the budget approved for the HSCP including a financial gap of £2.8m. The mitigation of this gap was dependent on further work to identify transformation activity being progressed in collaboration

with Council colleagues. This work has had to post-poned as a result of the re-direction of leadership capacity to managing the impact of the Covid pandemic. The financial gap has reduced to £2.1m as a result of the application of a number of funding streams identified as part of year end processes and through revenue monitoring in the initial months of this year. However, this remains a risk to the HSCP in the event that SG funding is not sufficient to cover this aspect of Covid impact for 2020/21 and on a recurring basis moving into future financial years.

2.14 The consolidated position for the HSCP is set out in **Appendix 2**. The detailed budget monitoring reports for the NHS budgets and SW budgets delegated to the partnership are provided in **Appendix 3**.

3 Savings Programme 2020/21

There is a programme of service redesign and transformation which was approved as part of the Budget 20/21. Progress and assumptions against this programme are set out in **Appendix 4**.

4 Partnership Reserves

4.11 The position, as at the 31st March 2020, with regard to partnership reserves is set out below:-

Earmarked Reserves	
SG - SDS Training & Support (prior year)	77,000
SG - Integrated are / Delayed Discharge Funding (prior year)	307,000
SG - Primary Care Cluster Funding (prior year)	39,000
SG - Action 15 Mental Health	108,000
SG - Alcohol & Drug Partnership	38,000
SG - Primary Care Improvement Programme	78,000
SG - GP Premises	90,000
SG - PC SuUpport	27,000
TEC Funds	11,000
Infant Feeding	13,000
CHW Henry Programme	15,000
Total Earmarked	**803,000**
General reserves	-
Total Reserves	**803,000**

4.12 This provides for no general / contingency reserves to mitigate in year fluctuations in budget and £803k of earmarked reserves for specific initiatives for which the SG has provided funding for.

5 Financial Risks

5.1 The most significant risks that will require to be managed during 2020/21 are:

- Confirmation of Scottish Government funding to cover the additional costs and impact related to Covid as set out in the LMP submission.
- The ongoing impact of managing Covid as we move through the recovery phase and the recurring impact this may have on frailty for older people, mental health and addiction services moving forward.
- Delivery of the savings programme identified as part of the Budget process for 2020/21.
- Further transformation activity to be identified to mitigate the financial gap of £2.1m and recurring impact into future financial years.
- Prescribing budget which is extremely volatile and the single largest budget delegated to the HSCP – pressures experienced from drugs moving onto short supply plus a number of other factors which will have a bearing on this budget related to delivery of savings, tariff swap, volumes and further issues of short supply.
- Non-recurring funding related to the Dental Bundle £4.6m (still to be allocated from SG for 20/21) –there is a risk that full funding is not transferred and there is normally no uplift given on bundled funding which will have to be managed within Oral Hea;th services.
- Confirmation of funding from SG to support other strategic priorities including PCIP, ADP and MH Action 15 and potential impact assumed from Covid.
- Impact of Brexit is yet to be felt with expected impact on funding streams, staffing and the supply of goods and services.
- General Reserves – the lack of general reserves held by the partnership will provide limited ability to manage any in year financial pressures or smooth the impact of savings plans where there are unexpected delays in implementation. This will place a reliance on the constituent bodies to provide additional resource where management actions have been exhausted.
- Contractual Price increases – assumptions were built into the budget for contractual price increases, however these increases are subject to procurement processes for the care at home framework and the national care home contract respectively. The former has yet to be concluded and may present further increases, which given the scale of the budget involved could be significant.
- Un Scheduled Care - The pressures on acute budgets remains significant with a large element of this relating to pressure from un-scheduled care. If there is no continued improvement in partnership performance in this area (targeted reductions in occupied bed days) then there may be financial costs directed to partnerships in delivery of the board wide financial improvement plan.
- Children's Services - managing risk and vulnerability within Children's Services is placing significant demand pressures on kinship payments, external fostering placements and residential placements which will increase the risk of overspend which will impact on achieving a balanced year end position.
- Financial Systems – the ability to effectively monitor and manage the budgets for the partnership are based on information contained within the financial systems of both partner agencies. This information needs to be robust and current as reliance is placed on these systems for reporting budget performance to the Board and decisions on allocation of resources throughout the financial year.

East Dunbartonshire HSCP
Consolidated Budget Reconciliation 2020/21

2020/21 Budget Reconciliation	NHS £000	Local Authority £000	Total £000
Budget Approved at HSCP Board on 26 March 2020	**83.405**	**56.750**	**140.155**
Set Aside	32.944		32.944
Rollover Budget Adjustment	1.267		1.267
Period 3 Budget Adjustments			
PSHG / Care & Repair Adjustment to HSCP		0.664	0.664
SG - Scottish Living Wage Contribution	0.215		0.2145
Covid Funding - Tranche 1	0.977		0.9765
Covid - Return of 19-20 Allocation	-0.344		-0.344
			0
			0
			0
			0
			0
			0
			0
			0
			0
			0
			0
Revised 2020/21 Budget	118.463	57.414	175.877

East Dunbatonshire HSCP
Financial Planning 2020/21
Transformation 2020/21

Ref	Workstream	Action	Lead	Financial Impact 20/21 (£000) - per IJB 26th March 20	*Financial Impact 20/21 (£000) - 16th July 2020*	*Comments*
		19/20 Savings Cfwd				
19/20/01	Digital	CM2000 External Providers	Derrick	300	*0*	*Linked to the award of the Care at Home frameworkthrough SXL National contract - potential delay until 21/22*
19/20/02	Charging	Day Care /Transport Charging	Jean	50	*0*	*Daycare / tyransport services ceased during Covid and increase to daycare / transport charges delayed until 21/22.*
19/20/03	Policy	Fair Access to CC	David	200	*100*	*Review team partly established, consider deployment of staff to enhance review function in the short term following Covid response and resumption of planned services.*
19/20/04	Service Change	Transport Policy	Jean	50	*25*	*As above*
19/20/05	Charging	Fully Implement Exisiting Charging Policies	Jean	26	*0*	*As above*
19/20/06	New Model	Sleepovers	David	50	*25*	*As above*
19/20/07	Efficiency	3rd Sector Grants	Jean	185	*92.5*	*Engagement with 3rd sector delayed during Covid response - discussion to resume with lessons learned during Covid response to inform new ways of working across the sector.*
19/20/08	Service Change	Review of Daycare East	Derrick	25	*25*	*Daycare services ceased during Covid response, awaiting guidance on safe restart to congregate services - savings resulting from supplies & services / transport expenditure.*
19/20/09	Service Change	Review of Independent Mobility Assessment	Derrick	18	*9*	*Balance of saving into the equipment line- review work to resume following Covid response.*
19/20/10	Efficiency	Review Approach to Prescribing	Derrick	200	*0*	*Number of risks for prescribing for 20/21 - number of drugs moving onto short supply causing price increases, additional funding for 19/20 for 20% increase in March to be repaid in 20/21 as volumes for April / May show a compensating reduction - monitor closely and pharmacy sdtaff redeployed to Covid effort impacting delivery of local savings..*
19/20/11	Efficiency	Improved management of allocated fleet and pool cars	Derrick	30	*15*	*Anticipate increased mileage for homecare during Covid period and imp[act on ongoing transport provision in adherence to social distancing requirements.*
19/20/12	Service Change	Review staffing levels in registered services across HSCP	Claire	52.5	*26.25*	*Review of staffing levels in Ferndale, Pineview and John Street in progress (CC)*
19/20/13	Efficiency	Tighter Control of Equipment Ordering	Derrick	33	*33*	*In progress.*
19/20/14	Access	Re Invigorate On Line Asset Map	Derrick	0	*0*	*In progress - no savings anticiapted.*
19/20/15	Service Change	Review of MH / Addictions Commissioning following outcome of needs assessment	David	0	*0*	*Outcome of needs assessment not conclusive. Initial thinking around an over arching service with some services supporting this - develop and conclude new model locally (GH / LH / DA - end Sept 20)*
		Sub Total 19/20 Savings C/fwd		**1219.5**	***350.75***	
		Service Redesign 20/21				
20/21/01	Assets	Scope possible alternative accommodation options to meet the needs of throughcare / care leavers	Claire	400.0	*200.0*	*In progress - funding approved.*
20/21/02	Service Change	Withdraw from Canal Project	Claire	276.0	*276.0*	*Costs have now being met through housing department.*
20/21/03	Workforce / Practice	Upskill staff to provide evidence based interventions (Just Enough Support)	David	0.0		*Endowment application completed to progress training - no savings anticipated.*
20/21/04	Workforce / Practice	Upskill staff to provide evidence based interventions (Signs of	Claire	0.0		*As above*
20/21/05	Access	Develop Digital Access to service option	Derrick	0.0		*Scope further opportunities in light of new working during Covid - to be anchored through Digital Strategy Group (DP)*
20/21/06	Workforce / Practice	Develop and deliver locality based working with two teams	Derrick	0.0		*Review use of Milngavie Clinic in light of social distancing requirements (DP)*
20/21/07	Service Change	Deliver locality based access points and community led	Derrick	0.0		*As above*
20/21/08	Service Change	working	Caroline	25.0	*12.5*	*Linked to HSCP delivery model going forward*
20/21/09	Practice	Pilot family group decision making model	David	0.0		*Not progressed during Covid period*
20/21/10	New Models / Practice Enabler	Develop and implement resource management bureau for Adult and Older People Services	Derrick	0.0		*Re-visit paper and develop flowchart for RSG process and submit through SMT for approval and implementation (KG / SMcD / DA / DP)*
20/21/11	New Models / Practice	Scope potential for residential care beds in East Dun / new residential care home	Derrick Davi	tbc		*Business case on hold during Covid response*
20/21/12	Service Change	Evaluation of Care at Home revised service model	Derrick	0.0		*Full implementation of new model on hold during Covid period - establish evaluation 6 months after full implementation.*
20/21/13	Service Change	LD Supported Accomodation Review (In House Service)	David	0.0		*LD Review on hold during Covid response.*
20/21/14	Service Change	LD Supported Accomodation Review (Commissioned Services)	David	0.0		*LD Review on hold during Covid response.*
20/21/15	Digital	Digital alternative to homecare med prompt calls	Derrick	0.0		*Not viable given the lack of technology awareness of cohort and increased complexity of need limiting numbers of med calls only.*
20/21/16	New Model	Tailored Moving & Handling	Derrick	0.0		*In progress (DP)*
20/21/17	New Model	Implementation of East Dunbartonshire Strategic Cancer Partnership	Derrick	0.0		*Approved through HSCP Board and implementation in progress*
		Sub Total Service Redesign 20/21		**701.0**	***488.5***	
		TOTAL		**1,920.50**	**839.25**	

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Agenda Item Number: 12.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17th September 2020
Subject Title	East Dunbartonshire HSCP Clinical & Care Governance Annual Report
Report By	Paul Treon, Clinical Director
Contact Officer	Paul Treon, Clinical Director Paul.Treon@ggc.scot.nhs.uk Telephone: 0141 232 8237

Purpose of Report	To share the Clinical & Care Governance Annual Report with the HSCP Board. The report requires to be submitted annually to NHSGGC Clinical Governance Support Unit, to provide assurance to the Health Board, in respect of HSCP health & care services provided under direction by the Health Board & East Dunbartonshire Council, and operationally managed by the HSCP Chief Officer.

Recommendations	The Partnership Board is asked to: 1. note the content of the Draft Annual Performance Report – **Appendix 1**.

Relevance to HSCP Board Strategic Plan	None

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	None

Legal:	None.

Economic Impact:	None

Sustainability:	None

Risk Implications:	None

Implications for East Dunbartonshire Council:	None

Implications for NHS Greater Glasgow & Clyde:	None

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	**x**

East Dunbartonshire Health & Social Care Partnership

East Dunbartonshire

Health and Social Care Partnership

Annual Clinical & Care Governance Report
April 2019 - March 2020

Report by: Dr. Paul Treon, Clinical Director, East Dunbartonshire HSCP

East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS Greater Glasgow and Clyde

1. Introduction

1.1 East Dunbartonshire Health and Social Care Partnership (HSCP) was formed in 2015 and covers the geographical boundary of East Dunbartonshire with an estimated total population of 108,640 (National Records of Scotland).

1.2 The Governance within East Dunbartonshire HSCP is overseen through a bimonthly meeting of the Clinical and Care Governance Group (CCGG), chaired during this period by the Clinical Director (CD), Dr Lisa Williams until 31st December 2019, and then by the Chief Nurse (CN) Mrs Val Tierney. The membership of the group includes the CD, CN, Chief Officer (CO), Chief Social Work Officer (CSWO), Heads of Service (HoS) and Relevant Service Managers. The CCGG relates to both the HSCP core services and hosted services; these are the Oral Health Directorate and Specialist Children's Services. The HSCP are represented at both the Primary Care & Community Partnerships Governance Group and the Board Clinical Governance Forum, and also report to the Integration Joint Board (IJB).

1.3 Each year an annual report reflecting on the clinical & care governance (CCG) of the HSCP and the progress it has made in improving the quality of care is produced. The report is structured around the three main domains set out in the National Quality Strategy: 1. Patient / Service User Safety, 2. Clinical & Care Effectiveness, and 3. Person-Centred Care. This report will describe the main governance framework and demonstrate our work to improve the quality of care in our HSCP through a small selection of the activities and interventions. It is important to note that there is substantially more activity at personal, team, and service level arising from our collective commitment to provide a quality of care we can be proud of. This report can only reflect a small selection so is illustrative rather than comprehensive.

2. Patient / Service User Safety

2.1 Teams within the HSCP strive to deliver excellence in patient and service user safety, they seek to continuously review and improve on service delivery with safety in mind. Below are some examples of how teams have employed Quality Improvement (QI) skills, individual and team training, and educational workshops. They also demonstrate how teams worked collaboratively both locally and nationally; between community and secondary care; and with Health Improvement Scotland (HIS) to deliver improvements.

2.2 The Community Mental Health Team (CMHT) have developed a process to ensure a management plan is in place for service users identified as frequent Emergency Department (ED) attenders. The aim is to review treatment plans for any further needs; thereby optimising patient care, reducing future ED attendances and improving overall outcomes for patients.

2.3 Following a number of incidents relating to Ionising Radiation Medical Exposure (IRMER) the Oral Health Directorate (OHD) launched a root cause analysis and commissioned QI work in collaboration with eHealth and Medical Physics to identify and correct issues. Dissemination of the outcomes

permitted correction to radiography equipment across the Public Dental Service (PDS) and dialogue with HIS ensured the correct approach was taken to minimise risk to patients.

2.4 Training and improved knowledge/networks play a vital role in reducing harm to our children. A Child Protection development day took place for all Children & Families Social Work staff with input from partner agencies. Workers who attended felt they gained better working knowledge of the child protection systems as well as an increased understanding of partners' roles.

2.5 A 'Red Bag Pathway' was delivered in Care Homes, improving links between Hospitals and Care Homes. The red bag, travels with the resident from the home to hospital, and has all relevant information relating to the individual including their Anticipatory Care Plan, current medications and clothing. This allows the hospital team to plan, treat and discharge the individual more effectively and efficiently.

2.6 A Care Home Support Team was established during 2019. The aim of the team is to use a multi-disciplinary approach to improve resident outcomes. This is achieved by sharing information and creating a targeted approach to support Care Homes.

2.7 The Pharmacy team have been involved in delivering training to carers around administration of patient's medications; this improves safety for those patients who rely on carers to administer medications, particularly where multiple medications are prescribed.

2.8 The Care at Home service ensured a rapid and effective response for service users by focusing on having a responsive, flexible team in each locality. Staffing and supervision levels were also increased.

3. Clinical & Care Effectiveness

3.1 Teams have worked throughout the reported year to continue to deliver services using evidence based approaches and building on experience and patient/service user preferences. Teams have used QI techniques including audit, tests of change and surveys to review services and deliver new initiatives. HSCP Teams also carry out Significant Clinical Incident (SCI) reviews to inform service review and improvements. The examples below show a drive to work to both professionally agreed standards and nationally set targets.

3.2 To provide a timely, effective and safe triage of self-referrals, the Primary Care Mental Health Team (PCMHT) implemented a telephone response which includes a risk assessment process.

3.3 A Staff Nurse rotation was introduced between PCMHT & CMHT in 2019. The programme gives staff nurses the opportunity to enhance skills, knowledge and experience across the services. It allows flexibility within the teams to rotate staff if required. The programme

also improves the interface between the teams.

3.4 The CMHT have introduced a streamlined Clozapine clinic. Service users, attending the clinic, now receive a full physical health check along with their Clozapine prescription. This offers a more holistic and effective approach to care.

3.5 The Public Dental Service (PDS) have participated in the Dentistry Safety Climate Survey. This national exercise was implemented to provide a platform for open dialogue within dental teams. Feedback from the teams produced a report for the service, from which potential quality improvement project work was identified for action over the following 2 years.

3.6 Our Child Protection Committee (CPC) established multiagency test of change groups tasked with improving 5 key process areas. All improvements were implemented using the Plan, Do, Study, Act (PDSA) model for change, allowing for regular review and improvements while progressing whole system change.

3.7 Monthly Alcohol and Drug related death review meetings are held to discuss and review all deaths within the service. These discussions are an opportunity for reflection and learning development. This has enabled team learning such as the need for regular physical health screening for all patients. Agreed outcomes are recorded and uploaded to Datix as part of SCI reporting.

3.8 The Children & Families Team carry out UNICEF UK Baby Friendly Initiative audits of all staff and mothers every 6 months to ensure the ongoing delivery of evidence based, high quality care. The excellent results supported the team in achieving of the UNICEF Gold Sustainability Award.

3.9 The Children & Families Team and Health Improvement Team worked together to secure Scottish Government Funding to support a Breast Feeding Project across East Dunbartonshire. The aim of the project is to support mothers to breast feed their babies for as long as they wish; with a particular aim of improving breast feeding rates at 8 weeks by 10%. This is in line with the Scottish Government stretch aim. Initial evaluation of the project is very positive from both parents and staff.

3.10 The Community Rehabilitation Team (CRT) have embedded a range of assessments; including environmental, Nutritional Screening Tool (MUST), Tinetti, Falls and medication assessments; into practice to maximise patient safety, enabling independent living and keeping service users well in their own homes for longer.

3.11 The Care Home Liaison Nurses (CHLNs) were granted access to the NHS Greater Glasgow &Clyde (GGC) hospital admission dashboard enabling them to identify local residents who have been admitted. This data is used to facilitate early supported discharge, if appropriate, and to support Care Homes with person centred Anticipatory Care Plans.

3.12 The Older People's Mental Health Team (OPMHT), CRT and District Nursing (DN) services undertook a QI project; the aim of which was to identify service users with severe frailty and record their preferred place of care. This was completed using the Rockwood Frailty Score. Leading on from this initiative the teams are now part of the National Living and Dying Well Frailty Collaborative which aims to reduce unscheduled care across primary and secondary care. Locally this includes MDT meetings with General Practitioners (GPs) targeted at offering holistic reviews of patients identified as at risk.

3.13 The Pharmacy Team have been reviewing service users who have recently been discharged from hospital with multiple new medications to ensure they are able to manage safely at home and arrange appropriate alternative medication solutions if required.

3.14 A new quality assurance system has been introduced within the Care at Home service to ensure recording mechanisms, , assessments, supervisions and improvement activities are reviewed on a regular basis and thereby support planning.

3.15 The Justice Social Work team worked with Portsmouth City Council & Up2U to develop the Creating Healthy Relationships Domestic Abuse Perpetrator Programme. Up2U is an innovative, evidence based, perpetrator programme supported by a Quality Assurance Group. The programme is aimed at men who use domestic abuse behaviours in their intimate partner relationships. As part of the UP2U programme Justice Social Work Services will contact non-abusive partners, allowing support workers to provide a range of information regarding specialist agencies.

3.16 The OPMHT duty system was harmonised and adopted a service-wide approach. The work undertaken promoted team cohesion and identity promoting safe and effective practice.

4. Person-centred care

4.1 The services delivered, and hosted by, East Dunbartonshire HSCP aim to use formal and informal patient/user feedback to guide improvement. This section gives some examples of how services have tried to deliver a model of care that keeps the patient /user as the focus; this includes development of services for harder to reach people, redesign of services to be more user friendly and improved working between teams and disciplines to deliver in a more streamlined manner,

4.2 Both the CMHT and Alcohol & Drug Recovery Service (ADRS) are working together to develop a Trauma service approach: involving redeveloping clinical spaces to create a trauma sensitive environment.

4.3 Within the CMHT a general assessment rota has been developed; ensuring a responsive service to tackle waiting times and increase

capacity. An MDT approach is embedded resulting in the service offering earlier Mental Health Assessment, Treatment & Discharge.

4.4 Within Mental Health Services, a post has been introduced to support psychological therapies for less engaged groups; and will work alongside the Health Visitors and OPMHT, aiming to reduce waiting times and establish cohesive group working within the service.

4.5 The Survive and Thrive programme provided within the CMHT; is an educational course for individuals who have lived through abuse (physical, sexual, emotional, neglect or domestic), which has an ongoing impact on their quality of life, mood and/or ability to manage on a daily basis. The service provides information on the nature of abuse and trauma, how it affects people physically and psychologically and provides information on coping strategies.

4.6 The Systems Training for Emotional Predictability & Problem Solving (STEPPS) is a group approach for patients with a Borderline Personality Disorder & Emotionally Unstable Personality disorder. This is a 20-week program where service users receive weekly support from the team & discuss learned skills. A session is also offered to family members/carers, to support the service user with their recovery.

4.7 Cognitive Behavioural Therapy (CBT) in Action class is a 7 week programme to increase the understanding of anxiety and low mood and helps service users develop techniques on how to manage their mental health difficulties and gives the opportunity to access psychological therapies. Following completion of the class, participants are encouraged to complete a survey which is used to shape future sessions.

4.8 A Perinatal Mental Health Network was established in 2019 by members of the Children & Families Team and The CMHT to support the transformation & development of local perinatal mental health. Enhanced training was provided to members of the Children & Families Team and additional online resources have been identified and incorporated into practice to support mothers identified with mental health issues.

4.9 PCMHT use service user feedback to guide service delivery improvements. As a result of a, the service now offer both early morning and evening clinics, accommodating the needs of the service users, predominantly of the working population.

4.10 The PCMHT experience of using technology to guide and support patients through Computerised Cognitive Behavioural Therapy (CCBT), in addition to existing interventions, has been positive. The programme offers a wider range of treatment choices to patients; improving access to therapies and removing barriers to compliance; such as work, poor physical health or child care issues.

4.11 The Oral Health Directorate (OHD) have undertaken a large QI programme to reduce waiting times for children requiring extraction under general anaesthetic (GA). Multiple work streams have sought to address the challenges of anaesthetist recruitment and theatre list cancellations; including offering patients appointments at a local dental practice and exploring alternative anaesthetic options, such as inhalational sedation, CBT and atraumatic local anaesthetic methods.

4.12 Children can be subjects of police investigations, both as victims and witnesses. Their treatment via courts has been consistent with an adult approach, failing to consider how traumatising this may be for a child. In response to this there has been an increasing focus on developing a child centred approach to child interviews. This process is known as a Joint Investigative Interview (JII); where police and social work interview the child together. As part of the North Strathclyde Partnership group, implementing a new approach and model for JII, the HSCP have committed one dedicated social worker to this pilot. In conjunction with this, agencies have committed to developing their Interagency Referral Discussions (IRD), adopting a consistent approach across partners and local authorities. This process allows information to be gathered and shared between services helping to inform initial assessment and decision making as to whether a child or young person is in need of further protective measures such as a child protection investigation. It has also improved partnership working and most importantly, outcomes for the most vulnerable children and young people.

4.13 UNICEF UK Baby Friendly Gold Award promotes safe, effective, person centred care and supports parents with up-to-date evidence based practice regarding infant feeding, relationships and brain development. The Children & Families Team secured the Award in 2018 and were successfully reaccredited in 2019.Locally in East Dunbartonshire the feedback received from parents has been extremely positive with 95% satisfaction with support received from the Children & Families Team. The Children and Families service also provide the First Steps Parenting Programme which is a unique bespoke service. Following parent feedback the programme was revised in 2019 to support the addition of baby massage. Evidence suggests that routine touch and massage can lead to improved physiological, cognitive, emotional and social development for infants.

4.14 Starting Solids Group are delivered routinely in the community by members of the Children & Families Team and Dietician Colleagues from NHSGG&C to support parents with their children's transition from milk to solid food.

4.15 The CRT have been working with service users, their families and carers to understand the Health and Social Care System, finding the systems difficult to understand and navigate. By supporting service users with this, the team has helped to manage expectations and reduce anxiety.

4.16 The CRT are delivering supported Discharge in partnership with the Care at Home Team, with a specialist remit for reablement, and Hospital Team

focussed on safe early discharge. This has been a significant development and maximises ability for service users to remain at home safely post-discharge.

4.17 There are a growing number of positive examples of pre-habilitation, whereby patients are supported to get better outcomes following planned surgery. The CRT now provide a pre-habilitation service to build and increase strength, balance and ability with their service users prior to surgery; resulting in better outcomes post-surgery.

4.18 The DN Team patient feedback questionnaire for 2019 indicated high levels of satisfaction; in particular care that was needed was delivered as and when it was needed, this includes the Community Diabetic Specialist Nursing Service. Similarly, positive feedback was received relating to End of Life Care, including 87% of patients on the Palliative Care Register having died in their preferred place of care.

4.19 Our residential services have reviewed and changed their support plan format, creating a step by step guide on the way that individuals with a learning disability like to be supported in a pictorial manner, using photographs of the individuals themselves. The Care Inspectorate (CI) has identified this as a demonstration of the service collaborating with people to develop and influence their own support plans.

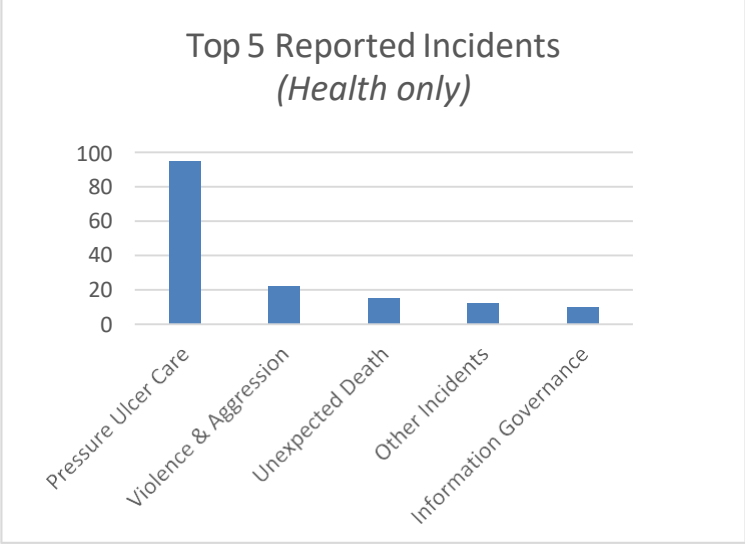
4.20 The Primary Care Team have continued to work; with Cluster Quality Leads (CQLs) and Local Medical Committee (LMC) colleagues to deliver on the Primary Care Improvement Plan (PCIP); as part of the Tri-partite arrangement. Progress to date includes the introduction of Advanced Nurse Practitioners (ANPs) to help deliver unscheduled care in the Kirkintilloch & Lennoxtown GP Cluster; Advanced Physiotherapy Practitioners (APPs) offering an alternative to GP consultation for musculoskeletal complaints in the Bearsden & Milngavie GP Cluster; a Community Treatment and Care (CTAC) Service providing phlebotomy and treatment room level care in the Bishopbriggs & Auchinairn GP cluster; enhancement of the pharmacy team delivering an improved medications management service; and roll out of the Well Being Workers to cover all local practices. Work has also commencement of the Vaccination Transformation Programme (VTP): including; full delivery of housebound influenza immunisations; a pilot of 2-5year old pre-school influenza immunisations on behalf of the board in the Bearsden & Milngavie GP cluster with delivery across all local practices; delivery of immunisations to all primary school aged children; and pregnant women <20 weeks gestation through GGC boardwide programmes. The HSCP has worked alongside CQLs to improve signposting by community staff to ensure patients are directed efficiently to the most appropriate person to manage their issue, at the most suitable place and time. With the expansion of the traditional primary care team, work has been done to create a streamlined and effective MDT and to ensure good working between practice and HSCP employed staff.

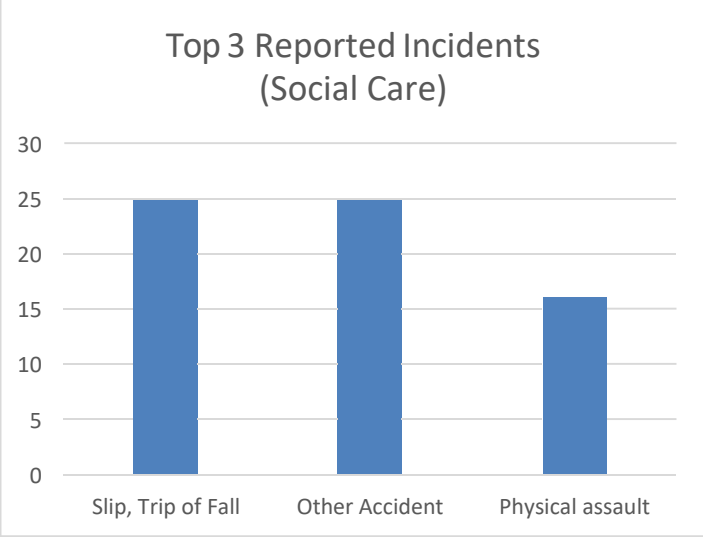
5. Incident Reporting

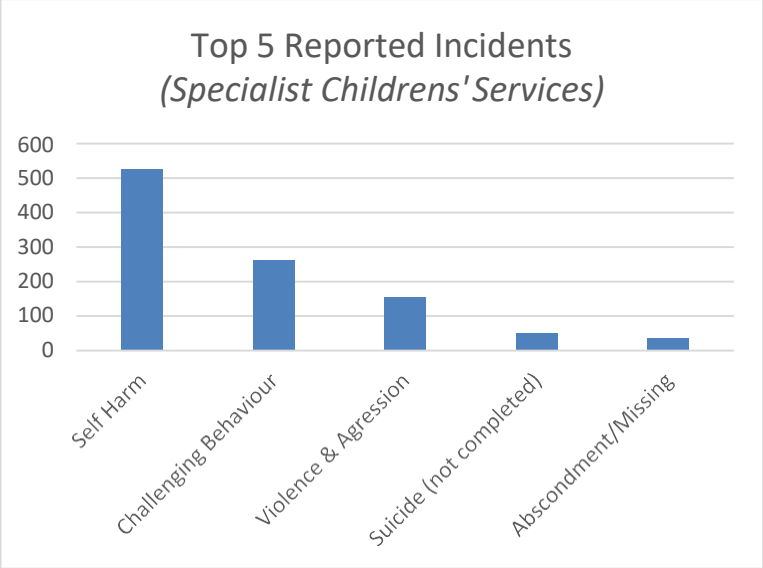
5.1 The reporting of incidents forms part of the Risk Management Strategy and is recognised as a means of improving the quality of patient care and minimising risk. The open reporting of even minor incidents allows weaknesses to be identified in the system, customs and practices to be changed and retraining of staff where necessary. All incidents, whether they involve patients/service users, relatives, visitors, staff, contractors, volunteers or the general public are reported. Due to the size and structure of the organisation, incidents are generally reported through two main streams with non-clinical incidents reviewed by Health and Safety; and clinical incidents reviewed by Clinical Risk.

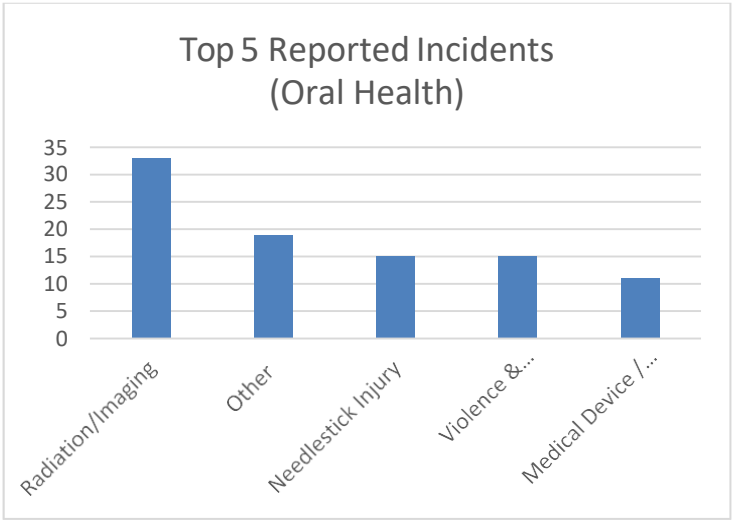
5.2 During this reporting period there were a total of 373 incidents which were recorded in East Dunbartonshire HSCP.

5.3 East Dunbartonshire HSCP also hosts the Primary Care element of the OHD & Specialist Children's Services (SCS). These incidents are also recorded on the Datix Incident Recording System. During 2019, the total amount of incidents reported for both hosted services were 1,306. The tables below show a breakdown of the top 5 reported incidents for HSCP and hosted services:









5.4 Significant Incidents are events deemed at director level to be sufficiently serious to warrant a formal investigation reportable to relevant Directorate/Partnership Senior Management with investigation monitored by the appropriate Health and Safety or Clinical Governance Forum. Usually it would involve the risk of death or serious injury / ill-health, major damage to property, loss of a service, create a major health risk, or be a threat to the strategic objectives of the partnership. All actions identified within SCIs are allocated clear timescales for improvement and monitored through the governance structure; to ensure these actions are met and improvements made. Any areas off good practice are also highlighted.

5.5 Ten SCIs were reported across East Dunbartonshire HSCP between April 2019 and March 2020. Two of these have since closed with the remaining 8 currently under review.

5.6 The table below provides the investigation outcome codes of the two closed SCIs which have concluded.

Code	Definition	SCIs
1	Appropriate care: well planned and delivered	-
2	Issues identified but they did not contribute to the event	1
3	Issues identified which may have caused or contributed to the event	1
4	Issues identified that directly related to the cause of the event	-

6. Complaints

6.1 East Dunbartonshire HSCP aims to provide the highest quality services possible through the delivery of safe, effective and person-centred care. Whilst the vast majority of service users have a good experience, we do not underestimate the emotional, and sometimes physical, impact on service

users and families who have a less positive experience. It is therefore essential that we produce open, honest and empathetic responses to complaints consistently across the partnership. Our complaints policies and procedures help us to listen effectively to what people are telling us about our services, and to act with purpose on what we hear. It enables us to put things right when things go wrong, and to learn and take action so that the same problems do not happen again.

6.2 East Dunbartonshire HSCP and hosted services received a total of 181 complaints. A breakdown for each service is shown below.

Service	No. Of Complaints
Health	10
Social Care	69
Oral Health Directorate (Primary Care)	7
Specialist Children's Services	95

6.3 Of the complaints shown in the above table, the following outcomes were determined.

	Fully upheld	Partially upheld	Not upheld	withdrawn	Consent not received
Health	1	1	7	1	0
Social Care	16	19	31	2	1
OHD	1	2	4	0	0
SCS	26		69	0	0

6.4 Recommendations of "fully upheld" and "partially upheld" complaints in health related complaints are reviewed by the CCGG to ensure appropriate action is taken.

6.5 Social Care complaints are also reviewed at the CCGG. All Social Care complaints are reported via the Complaints Management System (CMS). Outwith the number, stage, area and outcome of complaint, the system is unable to provide further information in relation to lessons learned and actions taken. The complaints department are currently in discussions to see if the system can be updated to include this information. This will then be monitored at CCGG and mirror the health complaints process.

7. Key Inspections & Reviews during 2019

7.1 To ensure services are providing the highest quality of care, the CCGG monitor all inspections carried out by the Care Inspectorate (CI) for all our registered & Care Home Services. Following inspection, the CI will grade various topics including quality of care & support to quality of management &

leadership. If a service is graded 3 or below, the CCGG will review and look to provide support to increase and sustain a high level of service for service users.

7.2 During 2019 the partnership received an inspection of the effectiveness of its strategic planning. The outcome was published on 30th July 2019 and is available on the CIs website. The inspection looked not just at the work of the HSCP, but at the partnership's working across agencies and services in the East Dunbartonshire HSCP area. The aim was to assess the extent to which the right and necessary building blocks are in place to plan, commission and deliver high quality services in a co-ordinated and sustainable way. The key building blocks are as follows:

- a shared vision
- leadership of strategy and direction
- a culture of collaboration and partnership
- effective governance structures
- a needs analysis on which to plan and jointly commission services
- robust mechanisms to engage with communities
- a plan for effective use of financial resources
- a coherent integrated workforce plan which includes a strategy for continuous professional development and shared learning

Overall, inspectors fed back that they could see progress achieved, and continuing to be worked towards in the journey of integration; with planning and delivery of integrated services. However, grading in a number of areas was impacted by the view that a number of the required developments were still at a relatively early stage and could not yet be said to be fully embedded. This is an inevitable factor of the timing of the inspection which is very much a 'snap shot' in time, of what is a dynamic and constantly evolving position.

The inspection process results are graded in three main quality indicators taken from the CIs QI Framework. The grades received were as follows:

- Key performance outcomes – Good
- Strategic planning and commissioning arrangements – Adequate
- Leadership and direction that promotes partnership – Adequate

An action plan was developed in response to the improvement areas identified and this is now being delivered.

7.3 During the year the partnership was also required to undertake a self-evaluation of progress with delivering the Scottish Government's integration agenda. This followed the format of a report by Audit Scotland which identified the following six core factors that were felt to be essential to the effective delivery of integrated services.

- Collaborative Leadership and Building Relationships;

- Integrated Finances and Financial Planning;
- Effective Strategic Planning for Improvement;
- Agree Governance and Accountability Arrangements;
- Ability and Willingness to Share Information; and
- Meaningful and Sustained Engagement.

The partnership assessed itself as having made good progress in most areas, but acknowledged more was yet to be done. An action plan was developed in response to the self-assessment and is currently being delivered. One area the partnership did consider to be well developed was the joined up approach to CCG.

8. Strategies introduced during 2019

8.1 In March 2019 the HSCP Board approved the local Carers Strategy 2019-22. This was a requirement of the Carers (Scotland) Act 2016. It also approved a new Fair Access to Community Care (Adults) Eligibility Criteria and associated Policies. The goal of this refresh of the policy base was to ensure access to services was equitable and resources were effectively targeted on meeting the needs of the most vulnerable in the community.

8.2 During the year a full strategic review of the partnership's Care at Home service was undertaken and revised staffing and service delivery arrangements were agreed which are being implemented from January 2020.

8.3 The partnership also implemented The Community Care (Personal Care and Nursing Care) (Scotland) Amendment (No. 2) Regulations 2018, which is more commonly referred to as Frank's Law. This extends the right to Free Personal and Nursing Care to adults who are aged under 65, finally addressing a long standing inequity there had been in relation to this right.

9. Key Successes / Case Studies from 2019/20

9.1 OHD

A SCI commenced within the Public Dental Service (PDS) following the case of a patient visiting the Emergency Dental Treatment Centre where a staff member was unable to diagnose a jaw fracture. The fracture was identified by another staff member at a follow-up appointment. Although the delayed diagnosis did not impact upon the patient outcome, this fell short of the level of care the service aims to provide.

The SCI process enabled a safe environment to learn from the event. In addition to reflective learning for the clinician involved, the service was able to review and update the training for staff. This culminated in an educational event for the staff to update their knowledge on orofacial injuries, diagnosis and management.

9.2 Pharmacy

A patient and their carer were keen to use a blister pack; however the pharmacist advised that this would not help with managing medication in the patient's situation. The pharmacist spent time educating the patient and spouse (carer) on what each medication was for, adjusting the times of administration to make it more manageable. The pharmacist called the patient and carer regularly to offer support until they were confident with both managing and ordering the prescribed medications.

9.3 Care Home Liaison Service

A care home resident who had had 7 admissions to hospital in 2019 was reviewed by a CHLN to assess the reasons for admission. The case was discussed with Care Home staff and measures to reduce admission were considered and put in place. This included involving a dietician to amend the Percutaneous Endoscopic Gastrostomy (PEG) feeding regime to reduce the risk of aspiration; and supporting the development of a Care Plan for staff to follow if any issues developed with the PEG Tube, allowing this to be managed more often and confidently in the community setting. The patient did not require any further admissions to hospital to date.

9.4 Local Area Coordinators

Our Local Area Coordinators worked with a local third sector organisation who provides a befriending service to increase volunteering opportunities and helped to identify additional group sessions in areas where a higher proportion of befriending needs had been identified.

10. Conclusion

10.1 This is intended as a highlight report to give an overview of the extensive activity taking place within the HSCP and hosted services on a daily basis. CCG arrangements will continue to evolve in line with new guidance to ensure that the residents of East Dunbartonshire continue to be delivered a high level of service; which is safe, evidence based and person centred. The partnership will continue to use a range of tools to aid service review and deliver service changes: including, but not limited to, QI work, SCI reviews and case studies. The HSCP as a whole will continue to review incidents that occur and complaints received to seek and guide areas for improvement.

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Agenda Item Number: 13.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	September 2020
Subject Title	Workforce Planning 2020
Report By	Tom Quinn, Head of Human Resources Tom.Quinn@ggc.scot.nhs.uk Tel : 0141 232 8237
Contact Officer	Tom Quinn, Head of Human Resources Tom.Quinn@ggc.scot.nhs.uk

Purpose of Report	To provide the 6 monthly update on workforce demographics for the HSCP and update on the Workforce Action Plan for 2020-21 In addition this report provides an update on the Scottish Government Guidance for Workforce planning across Health & Social Care service and the revised actions by the Health & Social Care Partnership to develop and publish a 3yrs Workforce Plan for 2022-25 which aligns with our Strategic Plan.

Recommendations	The HSCP Board is asked to: 1. To note the workforce demographics and action plan update 2. To note the revised actions to develop a robust workforce plan that meets with the Scottish Government Guidance and aligns with the 2022-25 Strategic Plan 3. To seek a progress report on the development of the workforce plan in January 2021

Relevance to HSCP Board Strategic Plan	Workforce Plan to be aligned with the HSCP Strategic Plan for 2022-25.

Implications for Health & Social Care Partnership

Human Resources	Information is cascaded to staff through the partnership via Our News

Equalities:	The final workforce plan will be subject to EQIA

Financial:	N/A

Legal:	The development of the workforce plan will meet the requirements set out by Scottish Government

Economic Impact:	N/A

Sustainability:	N/A

Risk Implications:	Potential to highlight Implications for supply and demand of workforce across the Health & Social Care Sector

Implications for East Dunbartonshire Council:	Will outline Workforce requirements for 2022-25

Implications for NHS Greater Glasgow & Clyde:	Will outline Workforce requirements for 2022-2025

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	**X**
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0	**MAIN REPORT**
1.1	**Appendix 1** provides an overview of the workforce demographics of the HSCP at 30 June 2020 at Section 4.
1.2	The report highlights that the HSCP has only one member of staff under the age of 20 and only 15 staff under the age of 25. This age distribution is not unexpected given that a high majority of staff have a formal university level qualification or are in part time work. This shows no change since our report in March 2020
1.3	The highest distribution of staff is in the age range 45-60, with the highest incidence of staff between 55-60yrs.
1.4	There has been a slight increase in the gender balance with the number of male staff employed decreasing by 2% since the Dec 2019 report.
1.5	The distribution of Full-time to Part Time working remains consistent at nearly 50%
1.6	Almost 50% of staff (48%) are engaged in activity focused on our Older People services, with 25% engaged in Adult services and 22% in Children and Criminal Justice, with 5% in support functions.
2.0	The updated action plan in section 5 of **Appendix 1** highlights the progress being made to achieve the expected outcomes.
2.1	The main identified actions are on target to be achieved within the year to 31 March 2021
2.2	Work is currently underway to identify any challenges for 2020-21 as a result of changes from COVID-19 activity.
2.3	The HSCP Staff for has been meeting 2 weekly during the period May –July 20 and now monthly to ensure engagement in the arrangements being made for staff and services during the pandemic response
2.4	The HSCP has implemented a Wellbeing Group to support staff during the pandemic and disseminate information on both local and national activity.
3.0	Scottish Government's guidance on Workforce Planning for the Health & Social Care Sector for implementation from 2021 (which was reported to the Board in March 20) has been revised and they will now only require a one year plan covering 2021-22. The proposed 3yr planning cycle will now start with the 2022-25 workforce plan.
3.1	We have been advised by Scottish Government staff that a revised circular will be forthcoming which will provide a standardised template for completing.
3.2	**Appendix 2** outlines our initial action plan to ensure compliance with the Scottish Government Guidance as originally advised in January 2020

4.1 The HSCP will re-establish its workforce planning group which will include local Managers, staff side colleagues and representatives of the 3rd sector.

4.2 The workforce group will report to the HSCP Board on progress in March 2021.

Appendix 1 East Dunbartonshire HSCP Workforce Plan

Appendix 2 East Dunbartonshire HSCP Workforce Plan 2021-2022 (Time Line)

Appendix 1 – Workforce: East Dunbartonshire HSCP Workforce Plan

Section Four

East Dunbartonshire HSCP Workforce

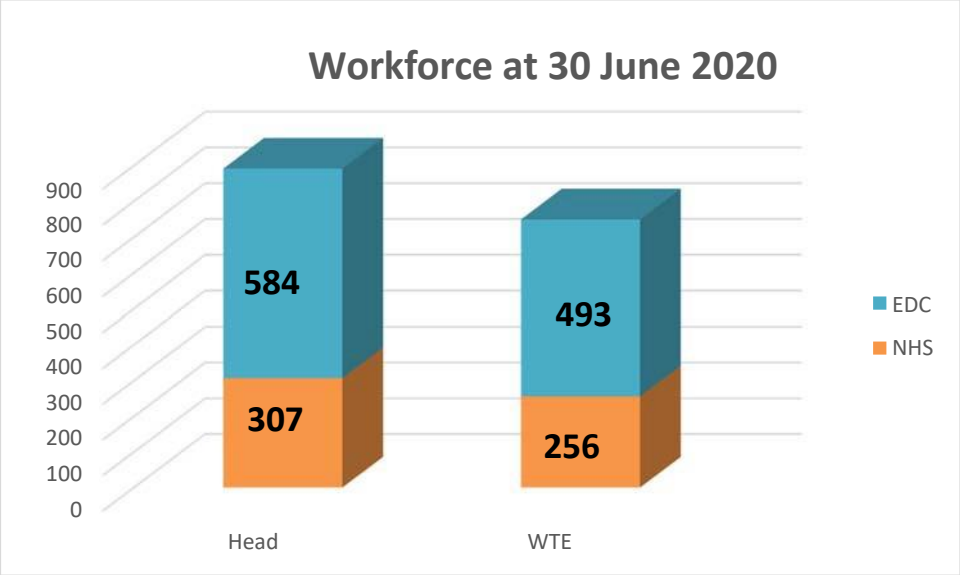
4. Current Workforce

4.1.1 This plan looks only at the staff directly working in the HSCP and employed by either East Dunbartonshire Council or NHS Greater Glasgow and Clyde. These figures are based on the available workforce at 30 June 2020.

4.1.2 Separate workforce plans are available for Oral Health for which East Dunbartonshire HSCP provides the hosting arrangements for the Primary Care Dental Service on behalf of NHSGGC

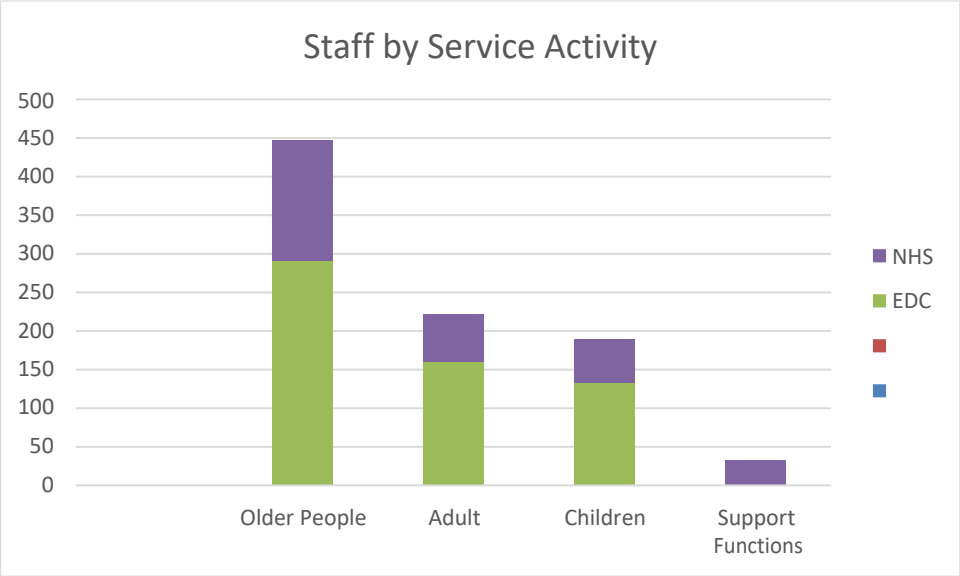
4.1.3 East Dunbartonshire HSCP had 891 staff delivering services at 30 June 2020, an increase of 11 since March 2020, of the 891 staff, 584 are directly employed by East Dunbartonshire Council and a further 307 are employed by NHS Greater Glasgow and Clyde.

Graph A - East Dunbartonshire HSCP – Workforce at 30 June 2020



4.1.4 Our workforce is distributed across the 4 care groups as identified below. Further work is required to look at the entry level qualifications required by these occupational groups as we look to maximise the opportunities for employment within the HSCP.

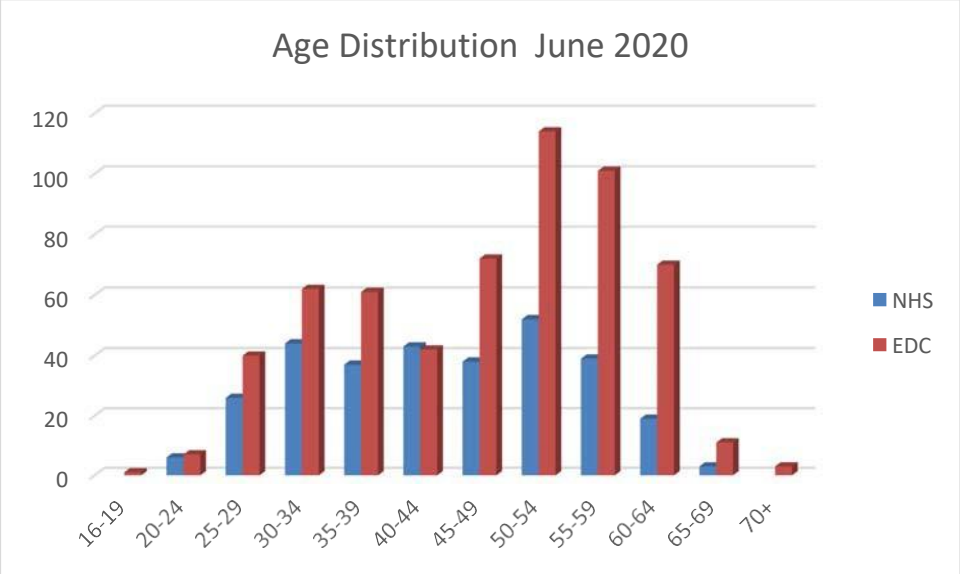
Service Area		EDC	NHS
Older People		286	156
Adult		158	62
Children and Criminal Justice		135	56
Support functions			33



4.1.5 In looking at the age profile (Graph B), it is clear that the majority of staff are in the age band of 45-65yrs of age, with the highest incidence in the 50-54 age group. We also have a high percentage of staff who are aged over 60yrs of age.

4.1.6 This is in contrast to a relatively low number of staff under the age of 25yrs (16 staff). Further work is being undertaken to look at the staff roles and qualifications required to see if this is the main reason for the relatively low number of staff under 25.

Graph B: Age Distribution Profile

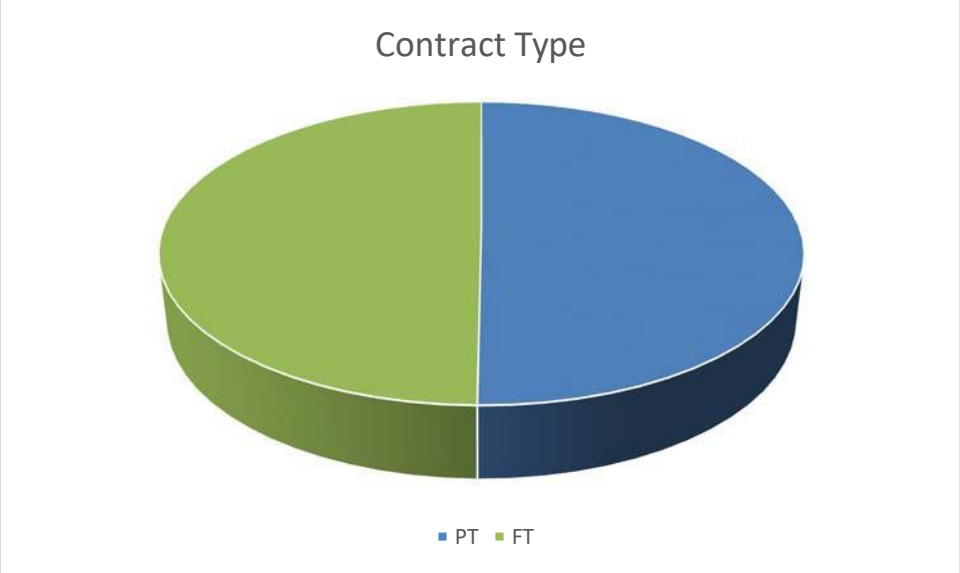


4.2 Work patterns

4.2.1 An overview of working patterns highlights an unusual almost 50:50 split between full time and part time posts

4.2.2 This unusual split is predominantly due to the working pattern of our Home Carers who work either 30hrs or less which is classified as part time.

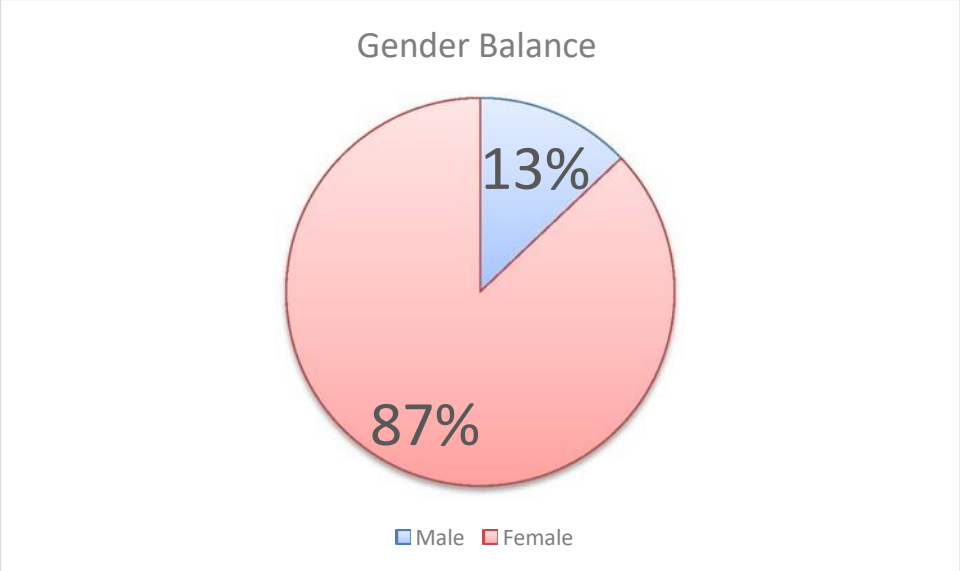
Graph C: Full-Time and Part Time split at 30 June 20.



4.3. Gender Demographics

4.3.1 Our workforce as demonstrated in Graph D is predominantly female, with 87% female which is not unexpected within a health and social care workforce, however this is a 2% decrease in the number of male staff employed in the HSCP since December 2019

Graph D: Gender demographic at 30 June 2020



4.3.2 This variation in the gender balance of our workforce does not at this time provide any difficulties in our service deliver models, however as our expectation is for increase in isolation either through disability or age, we need to be mindful of providing gender balanced services.

Section Five

Workforce Action Plan

Section 5 – Workforce Action plan

Workforce Plan ref	Service Area	2018-19 Actions	Lead	Review	Comments
1.4.11	General	The HSCP will further develop our workforce plan in line with emerging Scottish Government guidance during 2020.	TQ	Sept 2020	Scottish Government has revised the guidance that was received in late January 2020 and the HSCP is now only required to produce a 1yr plan for 2021-22 and a full 3yr workforce plan for 2022-25.
1.4.14	General	The current workforce co-ordination group which has key stakeholder involvement will become a reference group to assist with the on-going development and review of the plan	TQ	Sept 2020	The previous workforce co-ordination group will be refreshed with a clear Terms of Reference to achieve expectation from the Scottish Government guidance
1.4.19	General	6mthly reviews of the workforce plans associated action plan will be taken to the HSCP Board and 3mthly to the SMT and Staff Forum.	TQ	Sept 2020	On target, Quarterly reports have gone to the SMT and SPF with reference to the HSCP Board through the SPF Minutes
1.8.1	General	6monthly updates of the Organisational Development Plan will be taken to the SMT & Staff Forum. and Co-ordination group	LT	Dec 2020	On target, Quarterly reports have gone to the SMT and SPF with reference to the HSCP Board through the SPF Minutes
3.2	Children Services	The HSCP will continue to participate in the national workforce tool for nursing in children services on an annual basis.	LH	Dec 2020	Staff undertook input activity in Nov 2019, the results have been shared with the local team. These will be used as the basis for the Safe staffing

					legislation. The annual update is due in Nov 2020.
		The HSCP will continue to review staffing levels in line with agreed national targets based on caseload weighting and set against the NHSGGC recruitment strategy.	LH	Dec 2020	Work is currently on-going within NHSGGC to look at HV numbers and weighting. Locally the service has risk assessed and implemented an abridged version of the universal pathway. This work continues through COVID
3.2.2	Children Services	As part of NHSGGC School Health review a targeted model of care delivery is being implemented across 3 domains in line with the National Framework for School Health. These will include Emotional Health & Wellbeing, Child Protection and Transitions. An NHSGG&C Training and Development Plan has been established to support the implementation of this work. East Dunbartonshire has seconded a member of staff for 1 year to undertake the SCPHN Course School Health.	LH	Dec 2020	Member of staff has successfully completed the SCPHN course and a second member of staff is now undertaking the course in 2020-21. Work continues to develop a robust model with additional resources likely from Scottish Government.
3.2.4	Children Services	We continue to review and respond to the impact of the service change in the delivery of Pre 5 immunisation services. On-going monitoring ensures that it meets the needs of the local community and that immunisation rates are maintained.	LH	Sept 2020	No additional resources required at this time. Process will be kept under review. Work is ongoing to support the identification of suitable accommodation to allow full implementation of a community based model across the HSCP.

3.2.5	Children Services	We will review our current staffing structures in line with the recommendation of the service review of our provision of Looked After and Accommodated supports to ensure that children are cared for at home or as close to home as is appropriate.	CC	Sept 2020	Work continues to review the provision of looked after and accommodated children and young people within East Dunbartonshire.
3.2.8	Children Services	We will look at the learning needs of staff if we develop a dedicated pathway for people with a disability in transition from children to adult services.	CC	Dec 2020	Work has not progressed as the learning disability review is not complete.
3.3.1	Adult Services	We will review our current staffing structures in line with the recommendation of the service review of learning disability services presently underway	CS	Dec 2020	Work continues on the Learning Disability Review and associated workforce requirements.
3.3.4	Adult Services	We will look at to improve the integrated leadership at service delivery level to maximise the benefits that integrated services offer to service users and their carers.	CS	Dec 2020	This is a key activity for the HSCP during 2020. The HSCP will look to agree a set of guiding principles that will support the activity and can be agreed by both employers.
3.3.6	Adult Services	We will review our Mental Health Officer workforce to ensure appropriate remuneration to support our ability to	CS	Sept 2020	Process now complete and recommendation developed for implementation during 2020

		retain qualified MHOs in operational capacities.			
3.4.1	Older People	We will recruit to, maintain and build on the opportunities to support service users in care provider services through our Care Home Liaison service.	LC	Dec 2020	Posts recruited and addition resource has been agreed within the PCiP This work will be reviewed in light of any further guidance from Scottish Government as a result of revised advice and support procedures
3.4.3	Older People	We will look to review our rehabilitation pathways in line with our review of admissions and discharge procedures.	FM	Dec 2020	New model underway, including additional resources
3.5.1	General Practice	We will work with stakeholders to recruit, train and develop the identified supports through the Primary Care Improvement Plan	DP	Sept 2020	Work currently underway to agree the 2020-21 plan and associated recruitment activity required
3.5.2	District Nursing	We will review our staffing structures and supports in line with Excellence in Care, building on work being undertaken NHSGGC wide and through our own structures	LC	Sept 2020	Local group been established to support outcome of the NHSGGC process and provide opportunity for us to influence the NHSGGC process. (Paused at present)
3.8.1	Organisational development	We will develop local programmes to support the development of leadership skills with our service delivery managers and team leaders.	LT	Dec 2020	Work currently paused due to Covid -19

	Organisational development	We will explore the potential to deliver Just Enough Support training to assessing staff in adult and older people's services as an investment in updating staff skills and supporting staff to practice in line with our new Fair Access to Community Care policy	CS	Sept 2020	Bid to be submitted to Endowment Fund to enable delivery of training
	Organisational development	We will explore the potential to deliver Signs of Safety training to assessing staff in children's services as an investment in updating staff skills and supporting staff to practice in a manner that supports children and young people to be cared for safely at home, or as close to home as appropriate in line with our aspirations for to our Looked After and Looked After and Accommodated children.	CC	Sept 2020	Agreement require for utilisation of identified funding for this approach
May 2020	Staff Wellbeing	We will develop a local group to support staff wellbeing – especially their mental health wellbeing during 2020-22	TQ	Dec 2020	Group established and providing pro-active material for staff and managers

Appendix 2:

Briefing paper: East Dunbartonshire HSCP – Workforce Plan 2021-22 (Time Line)

To enable us to begin the work to engage with key stakeholders and collate the relevant data to inform the development of the 2021-22 HSCP Workforce Plan and the base line work for the 2022-25 plan the indicative time line below is presented as a guide.

Nos	Activity	By Who	Date
1	Align 2020-21 Workforce Action plan with existing activity and areas highlighted in the 2020-21 Transformation Plan	TQ/CS	August 2020
2	Draft Time line for 2021-22 plan – presented to SMT	TQ	September 2020
3	Updated position at 30 June 2020 – presented to HSCP Board Which will include the 2020-21 Action Plan	TQ	Sept 2020
4	Establish Workforce Reference Group to oversee the development of the 2022-25 Workforce Plan	TQ/CS	September 2020
5	Updated report to SMT on progress	TQ	Dec 2020
6	Align and merge work with the strategic planning process for the 2022-25 strategic plan	TQ/CS	January 2021
7	Updated position at 31 Dec 2020– presented to SMT Which will effectively inform the 2021-22 Action Plan	TQ	February 2021
8	Draft Time line for 2022-25 plan – presented to HSCP Board	TQ	March 2021
9	Draft Time line for 2022-25 plan – presented to SPG	TQ	April / May 2021

Agenda Item Number: 14.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	September 2020
Subject Title	Public, Service User & Carer (PSUC) Representative Support Group
Report By	Martin Brickley (Service User Representative) / Jenny Proctor (Carers Representative)
Contact Officer	David Radford Health Improvement & Inequalities Manager David.radford@ggc.scot.nhs.uk Telephone: 0141 355 2391

Purpose of Report	The report describes the processes and actions undertaken in the development of the Public, Service User & Carer Representatives Support Group (PSUC)

Recommendations	It is recommended that the HSCP Board note the progress of the Public, Service User & Carer Representatives Support Group.

Relevance to HSCP Board Strategic Plan	The report supports the ongoing commitment to engage with the Service Users and Carers in shaping the delivery of the HSCP priorities as detailed within the Strategic Plan.

Implications for Health & Social Care Partnership

Human Resources	None

Equalities:	None

Financial:	None

Legal:	None

Economic Impact:	None

Sustainability:	None

Risk Implications:	None

Implications for East Dunbartonshire Council:	None

Implications for NHS Greater Glasgow & Clyde:	None

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	**x**
	2. East Dunbartonshire Council	☐
	3. NHS Greater Glasgow & Clyde	☐
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	☐

1.0	**Main Report**
1.1	The attached report details the actions and progress of the PSUCRSG, highlighting their progress as detailed in **Appendix 1**.
2.0 SUMMARY	
2.1	The PSUC have held 3 meetings in 2020, the last meeting took place on the 8 July 2020 and was held on Microsoft Teams.
2.2	At the latest PSUC meeting, the members received a presentation from Gillian Notman (HSCP Change and Redesign Manager / Occupational Therapy Professional Advisor) on issues relating to East Dunbartonshire HSCP premises review.
2.3	PSUC group have reviewed their 2020/1 draft action plan and this has been revised to include the importance of communications in emergency situations and to link in with the HSCP business continuity plan.
2.4	The PSUC group have been advocates towards sharing positive information with East Dunbartonshire residents and have created and distributed 3 Covid-19 information sheets to date.
2.5	The PSUC group members have reported that there is a nervousness amongst service users and carers in returning to General Practice and Primary Care
2.6	Members are planning the development of a promotional video, with information sheets, in preparing Service Users and Carers to return to Primary Care and General Practice.

2.7	The 'Return to Practice' video aims to describe what Service Users and Carers can expect once they return to their GP and /or Primary Care appointments, with any changes that they may experience.
3.1	It is recommended that the HSCP Board: ▪ Note the progress of the Public, Service User & Carer Representatives Support Group.

Appendix 1

Public Service User and Carer Support Group – 08 July 2020 – Virtual Meeting

Attending; Karen Albrow, David Bain, Suzanne McGlennan Briggs, Martin Brickley, Gordon Cox, Sandra Docherty, Linda Jolly, Fiona McManus, Michael Rankin

Apologies; Avril Jamieson, Mary Kennedy, Indira Pole, Jenny Proctor, Frances Slorance

HSCP Staff in attendance; David Radford, Gillian Notman and Anthony Craig
Action points agreed at meeting:

Action	By who	When	G	A	R
PSUC members to identify ideas for inclusion within the next PSUC Newsletter. All to respond to AC by email	PSUC / AC	By (15/07/2020)			
Include a Carers column highlighting local information within next Newsletter	AC	By (22/07/2020)			
HSCP officer to continue with the scoping out/sourcing of East Dun POA figures for all age groups (Office of Public Guardian)	AC	By (01/08/2020?) - Ongoing			
PSUC group have requested that their 2020/21 Action Plan – reflects communications, engagement during public health emergencies, linking in with HSCP business continuity plan	AC	By (01/08/2020)			
PSUC group have requested that HSCP officer liaise with Interim Head of Children's Services to scope current patient/parent participation pathways and to invite to next meeting.	AC	By (01/08/2020)			
PSUC members agreed to devise and develop a video supporting 'service users' transition back into Primary Care and General Practice settings.	PSUC / AC	By 08/07/20			

PSUC members to send to HSCP officer, questions from a Service User / Carer perspective to assist the HSCP in creating public awareness video supporting 'service users' transition back into Primary Care and General Practice settings. 'What to expect'	PSUC Members and AC	By (22/07/2020) (15/08/2020)			
HSCP officer to communicate with NHS GGC Patient Experience Manager on hospital visiting procedures, patients nutritional pathways and current and future plans for those with a chronic disease and their care navigation	AC	By (22/07/2020)			

Agenda Item Number: 15.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Meeting	17th September 2020
Subject Title	East Dunbartonshire Draft Performance, Audit & Risk Committee Minutes of the 18 June 2020
Report By	Jean Campbell, Chief Finance & Resources Officer Jean.Campbell2@ggc.scot.nhs.uk Telephone : 0141 232 8216
Contact Officer	Jean Campbell, Chief Finance & Resources Officer

Purpose of Report	To provide the Board with an update on the business of the Performance, Audit & Risk Committee held on the 18th June 2020.

Recommendations	The Integration Joint Board is asked to: a. Note the contents of the minute Performance, Audit & Risk Committee held on the 18th June 2020 – **Appendix 1**.

Relevance to HSCP Board Strategic Plan	This committee provides support to the IJB in its responsibilities for issues of performance, risk, control and governance and associated assurance through a process of constructive challenge and provides a robust framework within which the objectives within the Strategic Plan are delivered.

Implications for Health & Social Care Partnership

Human Resources	None
Equalities:	N/A
Financial:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Risk Implications:	N/A
Implications for East Dunbartonshire Council:	N/A

Implications for NHS Greater Glasgow & Clyde:	N/A

Direction Required to Council, Health Board or Both	**Direction To:**	
	1. No Direction Required	**x**
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

Agenda Item: 15a.

Minutes of
East Dunbartonshire HSCP Performance, Audit & Risk Committee Meeting
Date: Thursday 18 June 2020 11.00 – 12.30
Location: Via Cisco Webex

Present:	**Jacqueline Forbes (Chair)**	**(JF)**	**Ian Ritchie**	**(IR)**
	Susan Murray	**(SM)**	**Jean Campbell**	**(JC)**
	Caroline Sinclair	**(CS)**	**Peter Lindsay**	**(PL)**
	Derrick Pearce	**(DP)**	**Alan Moir**	**(AM)**
	Gillian McConnachie	**(GM)**	**Kenneth McFall**	**(KM)**
	Mags McGuire	**(MM)**	**Martin Cunningham**	**(MC)**
In attendance:	**Kirsty Gilliland (Minutes)**		**(KG)**	
	Siobhan McGinley (Minutes)		**(SMc)**	

No.	Topic	Action by
1.	**Welcome and Apologies**	
	Chair welcomed all, no apologies noted. As this was the first Performance, Audit & Risk Committee Meeting to take place via Cisco Webex, JF ran through some housekeeping first of all.	
2.	**Minutes of previous meeting – 17 March 2020**	
	JF queried the awaited feedback from Audit Scotland on the Audit Fee on page one of the last minute. JC commented that there was no feedback available yet, it has been raised at national level however she would endeavor to gather this to update the committee when available. SM queried the Internal Audit Progress Update on page 2, specifically the penultimate paragraph regarding a business case. It appeared unclear if it was SMT or CO who was taking ownership of this. JC will clarify in due course. JF asked about the provision of the additional column in the Annual Business Development Plan at page 3. JC will look to develop this. No further amendments were noted.	**JC** **JC** **JC**
3.	**EDC Annual Internal Audit Report 2019/20**	
	The group noted the content of the report and paper. This report provides an overall opinion concluding on the adequacy and effectiveness of the Council's framework of governance, risk management and control. This assurance is then provided to the Health & Social Care Partnership for those systems under its strategic control. Internal Audit, in reaching its opinion, noted risks raised by the team in the current and previous years relating to contractual frameworks regarding social work commissioning, contract management, review of care plans within timescales and segregation of duties within the payroll process. Individually, these risks do not significantly impair the Council's systems of internal control but they will continue to be kept under review with auditors monitoring compliance with the agreed actions as part of an established six monthly cycle. Management have reported progress towards mitigation of these issues and auditors will support ongoing improvements where required as part of the 2020/21 audit programme. The statement concluded that reasonable assurance can be placed upon the adequacy and effectiveness of the internal control systems in the year to 31 March 2020. IR had suggested that a more comprehensive report was needed as the content reflects only that of the Council, not the Health side so effectively it only reported on one set of accounts.	

	GM explained that Government input ought to be considered when HSCP Auditors are following a later timescale. JC advised that this year's position is submitted at a later date as combined accounts of the HSCP Board (IJB), the Board will see combined report and auditors will monitor both separately. There will be a deficit going into the next year 20/21. Out of the number of audits that were planned, 6 were not completed due to additional audits being requested during the year but it was unclear how many remained outstanding at the year end. Other than COVID 19, financial sustainability was highlighted as a significant risk.	
4.	**EDC Internal Audit Planning 2020/21**	
	The paper was noted by all. GM explained this was an overview of the planning process and made reference to the last paragraph (1.21) 1.21 With continuing demand and financial pressures, areas of risk within the HSCP provide a focus for internal audit activity, with the Audit & Risk Manager of the Council providing a dual role as the Chief Internal Auditor of the H&SCP. The specific areas of Social Work Charging, HSCP Directions, Home Care, Carefirst Data Controls and Children's services ring fences funds have been identified for audit. An additional audit will be performed on HSCP Key Controls, with an exact area of focus to be determined following the conclusion of ongoing internal audit and management work in relation to Social Work Contract Awarding. Questions were welcomed and IR asked whether the fact that HSCP keeps control, has this impacted on the deficit. GM responded by saying that transformation is needed going forward to investigate what happened and whether Key Controls will remain with HSCP. JF voiced similar concerns with regards to timing and how it will be possible for Key Controls to resolve problems sooner. JC spoke to the committee on this. Lessons learned from last year will be implemented including more frequent reporting to be done on the more volatile areas and done in partnership with CFO in EDC.	
5.	**Draft Annual Report and Accounts 2019/20**	
	The papers were acknowledged by the committee. It was apparent the partnership incurred a deficit of £0.2m during 2019/20. This includes the impact of additional Scottish Government Funding throughout the year which will be taken to ear marked reserves and allocated for the purpose the funding was provided. The actual over spend on services is therefore nearer £0.6m, after adjusting for the impact of this specific funding. This represents a positive movement from that reported in Month 10 of £1.3m (Month 10 projected a £1.9m deficit) and relates in the main to : Fleet recharges - £141k Outcome of audits related to direct payment refunds - £217k Housing recharges services lower than budgeted levels - £386k Recharges for bad debt provision less than anticipated - £265k Prescribing costs - £98k Downturn in care packages in final periods of the year - £90k Downturn in kinship, fostering and residential costs - £37k Other positive movement in relation to NHS community expenditure - £70k There are no remaining general reserves and the level of earmarked reserves remaining is £0.8m and covers specific funding provided by the SG in relation to: ○ Self Directed Support (SDS) £0.077m ○ Integrated Care Funding £0.307m ○ Primary Care Improvement Plan £0.195m	

	○ Primary Care Cluster Funding £0.039m ○ Action 15 Mental Health Strategy £0.108m ○ Alcohol and Drugs Partnerships £0.038m ○ Technology Enabled Care £0.011m ○ Infant Feeding £0.013m In order to balance the budget for 2019/20, the HSCP had already provided for the re-designation of earmarked reserves in respect of Prescribing (£145k) and Oral Health (£200k) and following a review of earmarked reserves at year end, re-designated a further (£218k) related to monies set aside to support transformation and service redesign. The HSCP also applied the limited general reserves available of (£41k) which provides a total of £0.6m applied from reserves to balance the year end position. Figures from other service areas detailed below: ○ Older People Services (£2.8m over spend) ○ Adults – Learning Disability, Mental Health, Addiction Services (£0.1m under spend) ○ Children & Families (£0.3m under spend) ○ Business Support (£1.3m under spend) ○ Prescribing (£0.5m under spend) ○ Other Services (£0.4m under spend) One of the bad debt contributors was an invoice from GCC, currently sitting with the legal team and who GCC have accepted responsibility for so this will be a slight recoup. Any savings in the large spend areas such as care providers, will be looking to recoup. There are measures and elements of the transformation plan which will allow for better tracking of budget. IR questioned whether this will enable any issues to be picked up as they happen rather than waiting till year end to tackle. It is hoped that work around more regular Audits will reduce variation levels. CS advised on the importance of assurance to members relating to job security via SMT. Service delivery must remain a priority. CS and JF thanked JC for provided such a comprehensive report.	
6.	**PARC Report Covid-19 Impact in Unscheduled Care**	
	The paper was acknowledged by all. The report provides a high level overview of the impact of the Covid-19 on the unscheduled care agenda facing East Dunbartonshire HSCP. Various charts and graphs illustrated the following areas: • East Dunbartonshire HSCP A&E Attendances 5th Jan -24th May 2020 • East Dunbartonshire A&E Conversion to Hospital Admission % 15th March -24th May • East Dunbartonshire HSCP Emergency Admissions 5th January – 17 May • East Dunbartonshire Number of Delayed Discharge Bed Days May 2019 – May 2020 • GG&C Delayed Discharge Bed Days Rate per 1,000 May 2019 -May 2020 DP discussed the caveat around A&E attendances, where initially numbers had fallen considerably between 8 March and 29 March, this number is slowly but steadily on the rise. March to April saw a sharp fall in Delayed Discharges which could be interpreted as family members wanting to care for their relatives at home or the need for beds for COVID positive patients to fill. East Dunbartonshire had the third lowest level of Delayed Discharge Bed Days in the Board area. A slight increase in A&E Conversion To Hospital was noted compared to what was recorded at the same time in 2018 and 2019. East Dunbartonshire HSCP Emergency Admissions fell significantly between 15 and 29 March which mirrors data around East Dunbartonshire HSCP A&E Attendances during the same period. Discussion around this drop in A&E attendance took place and concluded it could be due to human behaviour i.e. people wanting to stay away from A&E due to outbreak, fear among the general public. Rehabilitation services may be impacted going forward as the use of alcohol and drugs may be on the increase due to lockdown.	

7.	**Future Agenda Items**	
	• Care Inspectorate reports • Transformation reporting – learning/recovery reports • Care Homes – work brought about as an impact of COVID 19 • Prescribing Development session around Care Homes	
8.	**A.O.C.B**	
	• Virtual development session following HSCP Board meeting regarding care homes • Prescribing trends	
9.	**Date of Next Meeting**	
	28 September 2020, 12 noon	

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Agenda Item: 16.

East Dunbartonshire HSCP Board Agenda Planner
Meetings – March 2020 to January 2021

Updated 31/08/2020

Standing items (every meeting)
Declaration of Interests
Minutes of last meeting (CS)
Chief Officers Report (CS)
HSCP Board development Session – 23rd September 2020 9am – 10.30am
Unscheduled care
Prescribing
Primary Care Improvement Plan
HSCP Board Agenda Items – 17 September 2020
Seminar Topic – Autism Strategy (Richard Murphy)
Workforce Update
Performance Reports
Financial Reports
Transition/Recovery Planning
Clinical and Care Governance Annual Report
HSCP Strategic Plan 2021 – 2023 Development and Consultation Process
HSCP Board development Session – Thursday 5th November 2020 10am – 12pm via MS Teams
Transformation Plan
HSCP Strategic Plan 2021 – 2023 Priorities
HSCP Board Agenda Items – 12 November 2020
Sexual Health Service Review Implementation Plan (agreed at Board meeting January)

Records Management Plan
Performance Reports
Financial Reports
Transition/Recovery Planning
Chief Social Work Officers Annual Report
Corporate Risk Register
HSCP Board Agenda Items – 21 January 2021
Topic Specific Seminar to be agreed.
Performance Reports
Financial Reports
Transition/Recovery Planning
HSCP Strategic Plan 2021 – 2023 Draft
HSCP Board development Session – Tuesday 2nd February 2021 2pm – 4pm via MS Teams
HSCP Strategic Plan 2021 – 2023 Development of Final Version

ED HSCP BOARD - DISTRIBUTION LIST		
ED HSCP BOARD MEMBERS - VOTING		
Name	**Designation**	
Susan Murray	Chair - EDC Elected member	1
Jacqueline Forbes	Vice Chair -EDC Elected member	1
Sheila Mechan	EDC Elected member	1
Alan Moir	EDC Elected member	1
Ketki Miles	NHS non-executive Board Member	1
Ian Ritchie	NHS non-executive Board Member	1
ED HSCP BOARD MEMBERS - NON VOTING		
Caroline Sinclair	Interim Chief Officer	1
Jean Campbell	Chief Finance & Resources Officer	1
Alex Meikle	Voluntary Sector Representative	1
Martin Brickley	Service User Representative	1
Jenny Proctor	Carers Representative	1
Leanne Connell	Chief Nurse Representative	1
Andrew McCready	Trades Union Representative	1
Craig Bell	Trades Union Representative	1
Paul Treon	Clinical Director for HSCP	1
Adam Bowman	Acute Services Representative	1
ED HSCP SUPPORT OFFICERS - FOR INFORMATION		
Linda Tindall	Organisational Development Lead	**e-copy only**
Gillian McConnachie	Chief Internal Auditor HSCP	**e-copy only**
Karen Donnelly	EDC Chief Solicitor and Monitoring Officer	**Paper copy / e-copy**
Martin Cunnigham	EDC Corporate Governance Manager	7
John Hamilton	Head of NHS Board Administration	**e-copy only**
Lisa Johnston	General Manager, Oral Health Directorate	**Paper copy / e-copy**
Tom Quinn	Head of Human Resources	**e-copy only**
Derrick Pearce	Head of Community Health and Care Services	**1**
Claire Carthy	Interim Head of Children's Services & Criminal Justice	**1**
For information only (Substitutes)		
Councillor Mohrag Fischer	EDC Elected member	**e-copy only**
Councillor Graeme McGinnigle	EDC Elected member	**e-copy only**
Councillor Rosie O'Neil	EDC Elected member	**e-copy only**
Suzanne McGlennan Briggs	Carers Representative	**1 copy**
Mary Kennedy	Service User Representative	**1 copy**