North Lanarkshire Community Capacity Building and Carer Support Strategy 2018/23

"Softening the Lines"

VANL Voluntary Action North Lanarkshire

www.voluntaryactionnorthlanarkshire.org.uk

Contents

1. Introduction

Community capacity building is defined by the Scottish Government as;

"measures that strengthen the collective ability of a community. This includes activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and leading roles in the development of their communities".

For some time prior to and since the Public Bodies Joint Working (Scotland) Act 2014, (the legislation which brought about formal Health & Social Care Integration), the Third Sector in North Lanarkshire has been engaged as a full and valued partner in the strategic planning and operational delivery of information, advice, supports and services that help the people of North Lanarkshire to realise their personal outcomes and improve the quality of their lives. The primary area of focus of the Community Capacity Building and Carers' Support (CCB&CS) programme, which is overseen by Voluntary Action North Lanarkshire, has been and will continue to be, Prevention and Anticipatory Care. The sector has built an excellent reputation and national profile in terms of innovation, delivery, reliability, good governance and evidencing of outcomes both at individual and community levels.

Across North Lanarkshire there are some 872 organisations who contribute to our programme outcomes by helping people to live safer, healthier more independent lives, involving a conservative estimate of 2,390 staff and 10,000 volunteers. (S*ource: H&SCNL Integrated Workforce Plan: 2017*)

This 5 year strategy, builds on the CCB&CS strategy for the financial year 2017/18 and describes the potential expansion of the contribution made by the Third Sector towards realising the ambitions of Health and Social Care North Lanarkshire (H&SCNL). These are described in its Strategic Plan, and in the document setting out its commissioning intentions, "Achieving Integration" as follows;

*"The **purpose** of Health & Social Care North Lanarkshire integration is simple. We want people to live Safer, Healthier, Independent Lives".*

*"Our **goal** is to work with communities to prevent ill health and social harm and support people and their carers to better manage their own health and wellbeing"*

*"…people have told us they would prefer to be cared for at home as long as possible and if they go into hospital to be there for as short a time as possible. Therefore we will look to **enhance community services including the supports and services provided by the Third Sector**, so that people can be cared for locally… This will provide better outcomes for all care groups"*

Although not specifically stated within these ambitions, the integration arrangements relate to people of all ages including Children and Young People.

It is important for the reader to be clear that this strategy also relates to people of all ages and to recognise that the overarching aims, priority areas of focus and key enablers (set out in section 7) will support children and young people as well as adults. We may not be used to thinking in this way due to our focus on supporting mainly older people over a number of years, however most if not all of our aims, priorities and enablers such as prevention of isolation and loneliness; tackling inequalities; prevention; having choice and control; information and advice; support for carers (including young carers); access to transport etc. are as relevant to children and young people as they are to the rest of our population.

It is recognised that in order to succeed in realising these ambitions, H&SCNL through its CCB&CS strategy, must harness the potential impact of the third sector and make full use of all available community assets.

This 5 year CCB&CS strategy describes some major changes in the medium to long term around areas for new developments (the inclusion of children and young people being one of these); expansion of existing areas of work; a move to a more strategic funding model; an expansion of the scope of our governance arrangements; and potential new ways of thinking about and organising the programme.

Of course, expansion of Community Capacity and Carers' Support will require expansion and development of the volunteer workforce and the paid workforce who support them as both are critical to the current and future success of the entire programme.

Whilst adhering strictly to the principles on which our CCB&CS programme is built, this strategy seeks to make clearer the links between the programme and specific areas of focus within Health & Social Care North Lanarkshire in order that the contribution that is made towards these objectives is made clearer in the evaluation e.g. work with High Health Gain Individuals; Self Directed Support etc

As H&SCNL implements its locality arrangements, it is anticipated that the teams in these localities will become fully integrated across both health and social care **and** in terms of the advice, supports and services provided by the Third Sector so that these important inputs, including support for carers, become part of the mainstream rather than sitting to the side.

The default position will be that the H&SCNL localities will manage all of the services being delivered in their areas unless there is a clear reason why that shouldn't happen. It will still make sense for some services to be organised and managed at an area level or indeed in some cases a regional level. Where this is the agreed model, there will be accountability to each locality for the delivery of these services in a way that meets the specific needs of their populations.

It is expected that there will be a simplification in terms of the numbers of services that people have to negotiate and inevitably some blurring of roles within the statutory sector and this should also happen to a similar extent across sectors, so that whilst health care, social care, the third sector and the independent sector continue to provide their own unique contributions, the lines between them are softened. This integration at locality level will allow faster and better access for people to the right information, support and care they need, efficiently and effectively, at the right time, in the right place and in the right way without the need for referral between services.

All of the work that flows from this strategy will continue to be designed and implemented via a development approach based on the agreed principles set out below.

- At its heart, CCB&CS will be based around a **Personal Outcomes Focus**
- To ensure that CCB&CS operates within a strategic plan rather than as an ad hoc funded programme, the work will be organised within a **Programme Approach** (see Table 1 on page 6)
- It will address **Strategic Priorities** across North Lanarkshire identified through Joint Strategic Needs Assessment
- It will be developed through a **Locality Planning** process to ensure responsiveness to community needs
- It will be **Co-Produced** with Communities along with Public and Independent Sector partners
- The need for **Carers' Support** will be a priority
- All of the above will be carried out within a **Robust Governance** system

In relation to the final bullet point above, one of our greatest strengths has been the development of our current governance system which ensures that all of the investment in CCB&CS is used to best effect; is delivered through organisations and groups who can demonstrate good business practices; and can demonstrate outcomes which link to NL Wide and National outcomes. This system however currently only governs an estimated 50% of the entire Third Sector contribution when those investments made directly by the NHS or Local Authority to Third Sector organisations are taken into consideration. This relates mainly to organisations aligned with Children's Services, Mental Health and Addiction Services and/or some of the national Third Sector providers.

It is hoped that recognition of this robust governance approach and the benefits of expanding its scope to cover all of the Third Sector activity taking place in North Lanarkshire, would in future allow the transfer of all associated budgets, where feasible, to be managed and governed under these arrangements. This would allow us to look across the whole sector, ensuring that delivery is as effective, efficient, flexible and adaptable as possible to deliver improved outcomes and at the same time, deliver excellent value for money.

The success of the CCB&CS programme and the model adopted in North Lanarkshire, has been highly dependent upon the central co-ordination and support provided by VANL. The role of VANL has involved the drawing together of representation across the Third Sector; liaison with public and independent sector partners; design and delivery of the co-ordinated programme approach; development and maintenance of robust governance arrangements including administration of all of the associated finances; and development and maintenance of the monitoring and reporting arrangements.

This has also benefitted organisations receiving funding through the programme as they, where required, have been supported to ensure their systems and processes are robust and that their contribution can be linked to the programme outcomes as well as the personal outcomes of those who receive the support.

The approach adopted by VANL has demonstrated the value and contribution of a Third Sector Interface Body that is able to operate in such an enabling role as a full partner.

The strategy will set out the potential development over the coming 5 years in as much detail as possible, however we also need to recognise and value the considerable flexibility that the CCB&CS programme offers H&SCNL and the citizens of North Lanarkshire at individual, locality and organisational levels to respond much more quickly to the changing circumstances that our communities find themselves in.

Table 1 – Programme Approach

As indicated above we will continue to develop and deliver CCB&CS using a programme approach. This can be described under the following 4 pillars which will allow us to describe and capture all of the diverse work that is undertaken within a framework that is flexible and adaptable to new and emerging needs.

Community Support Programme	Locality Development Programme	Enabling Support Services	Carer Support Services
Prevention; Anticipatory Care; Tackling Isolation and Loneliness; Befriending; Physical Activity; Community Food; Community Based Palliative Care; Intergenerational Work; Dementia Support; Advocacy	Interventions, Services, and Supports designed to meet specific needs of local communities and neighbourhoods	Community Transport; Volunteer Recruitment and Development; Community Capacity Building	Delivery of Direct and Indirect Carer Support; Mainstreaming of Carer Support

2. Strategic Context

There are many other strategies or processes that are relevant to this strategy. The following are considered to be the most relevant.

- Integration of Health & Social Care and the associated 9 National Outcomes
- Children and Young People (Scotland) Act (2014) –there are 18 requirements of this act, several of which are delegated to the local authority, NHS, education etc. Our work within the Children's Services Partnership will contribute to meeting these requirements.
- UN Convention of the Rights of the Child –These rights are referred to in the above act
- Children's Services Planning – Realigning Children's Services Programme (2017/18)
- Community Planning including the Framework for Third Sector Connectivity to Community Planning in North Lanarkshire 2015-18 and the North Lanarkshire Partnership's Local Outcomes Improvement Plan (LOIP)
- Community Empowerment Act
- Carers'(Scotland) Act
- Community Justice

- Human Rights Act
- Child Poverty Bill
- Strategic Role of the Third Sector Interface
- Inequalities, Prevention and Anticipatory Care Strategy (North Lanarkshire)

3. Strategic Vision

The CCB&CS Strategy has been written in support of the vision shared with H&SCNL namely that the people of North Lanarkshire will achieve their full potential through;

- Living safe, healthy and independent lives in their communities
- Receiving the right information, support and care they need , efficiently and effectively, at the right time, in the right place and in the right way
- Ensuring that North Lanarkshire is the best place in Scotland to grow up

The key aims of this strategy over the next 5 years can be summarised as follows;

a) Expand the scale and scope of the provision of community based preventative and anticipatory care services in line with the requirements of the Health & Social Care North Lanarkshire Strategy
b) Ensure that the programme activity reflects the needs of the whole population including Children and Young People
c) Ensure that every effort is made to design supports and services that prevent people from having to access formal services unnecessarily or prematurely
d) Explore the best model for integration of the Third sector within integrated locality arrangements
e) Harness the full scope of the third sector provision in North Lanarkshire, delivering preventative and anticipatory care services as part of those integrated arrangements.
f) Act as the main vehicle for the delivery of indirect and direct carers' support and promote the mainstreaming of this support
g) Expand the proportion of Third Sector activity which is governed through the CCB&CS Programme arrangements. This refers to that provided by local and national organisations for children and young people and adults of all ages,
h) Refresh our governance arrangements in light of changes to the structures and processes of H&SCNL
i) Agree a Strategic Funding Model with H&SCNL to allow for a longer and therefore more efficient and effective planning cycle

4. Strategic Investment & Resources

In order to make the fullest possible contribution to improving the lives of the whole population within North Lanarkshire, the planning of third sector services and supports and how they are funded must take place as a core element of the H&SCNL Strategic Planning process and be seen as being at least of equal value to other aspects of the system.

The sector has been successful in gaining financial support from H&SCNL and its predecessors over a number of years and has been able to demonstrate the impact of this funding, as well as the considerable resources leveraged from other sources. (***On average every £1 invested results in £3 being leveraged from elsewhere***). These resources have been welcomed, however the integration of health and social care, by design, now gives us the best opportunity yet to look more strategically at how the whole system and (for the purposes of this strategy), the third sector is resourced.

This is particularly required as we explore the need to shift the balance away from providing faster, more effective statutory services towards our shared goal of prevention focused on improving people's health and wellbeing by improving their life circumstances and by empowering individuals and communities to be more cohesive, resilient and self-reliant.

The following table sets out what H&SCNL have described as their 'success measures' and it is clear when considering the previous paragraph, this strategy overall and the success of the CCB&CS programme to date, that the third sector has a key part to play in progressing these.

Health and Social Care North Lanarkshire – Success Measures			
1	We improve outcomes for people	10	People only access hospital when they need to
2	People are healthier	11	People are discharged from hospital as soon as they are able
3	Children are given the best start in life	12	More people can choose to die at home
4	People are fully included in decisions that affect them	13	Carers receive the support they need and feel supported
5	We play our full part in reducing inequalities within our communities	14	We improve outcomes for offenders, communities and victims
6	People are less reliant on services and are able to live independently	15	Our data provides an accurate assessment of the needs of our communities
7	People are better able to manage their own conditions	16	Multi-agency teams function well within communities
8	People receive the right support and services for their individual needs	17	We work within available finances and resources
9	Preventative measures reduce long-term health conditions	18	Staff feel valued and that their work is worthwhile

Similarly, CCB&CS will be key to the delivery of H&SCNL's 6 strategic priorities which are;

- Addressing inequalities
- Prevention and early intervention
- Person centred support
- Effective, safe, quality and timely care
- Making sure the whole system works efficiently
- Maximising our assets

The current investment of £1.14m in the CCB&CS programme, represents only 0.20% of the H&SC budget of £550m. It is our aim to work with H&SCNL to see this increased by way of an agreed strategic investment plan covering the lifetime of this strategy. Although it is anticipated that the overall resource available to H&SCNL will be subject to cost pressures and further budget reductions over the next 3 financial years, in this challenging climate, expansion of investment in the third

sector could provide some of the solutions, in terms of how we sustain the provision of the necessary advice, supports and services that the population require whilst shifting the balance and the focus away from service use towards prevention and resilience as mentioned above.

Whilst recognising and acknowledging the financial pressures across the whole system, it would be our ambition that the budget allocated to the CCB&CS programme could increase by 20% per annum over the next 5 years to £2.7m, which would represent a shift from 0.20% to 0.49% of the current budget.

5. Assessment of Local Needs

An important part of preparation for strategy development is to look at the needs of the population who will be supported by it. To do so, we have utilised information from the Joint Strategic needs Assessment undertaken by Health & Social Care North Lanarkshire to support the development of their Strategic Plan and Commissioning Intentions.

This is set out in some detail in our previous strategy covering 2017/18 copies of which can be accessed via the "contact us" section of the VANL website. Contact Us

This data clearly demonstrate the health and social inequalities that exist when North Lanarkshire is compared to Scotland and that also exist when we compare our own localities. Improving health through preventative inputs and reducing inequalities has been and will remain a major focus for the Third Sector and for Health & Social Care North Lanarkshire.

To assist planning at local level, Locality Profiles have been produced which summarise the health and wellbeing indicators in each locality and set out a list of priority areas based on those. The profiles provide a baseline of health and social care information to inform integration and will need to be revisited each time we review this and subsequent CCB&CS strategies.

The profiles include information on the context and geography of each locality; levels of deprivation; housing; provision of local services; community assets; needs assessment data; demographics; care provision etc.

Information is also provided on health behaviours and inequalities, such as information on smoking, obesity, alcohol and drug use, mental health and wellbeing etc.

Information from Carers' Health Needs surveys carried out in the 3 years to March 2016 has also been included in the profiles.

6. Development of the Strategy

We have developed this strategy to set out the work that will be undertaken over the next 5 years aimed at ensuring that children; adults; those with issues around mental health and addictions; people who are frail; people whose lives are adversely affected by long term health problems; and others who may be vulnerable and/or isolated within our communities; are supported to live as best they can whilst retaining their independence and their ability to exercise choice and control over their lives.

To achieve this we will focus on preventative and anticipatory approaches which improve quality of life outcomes for individuals; support individuals and their communities to become more resilient; build Community Capacity based on local intelligence; whilst empowering those individuals and communities. The programme will assist people and communities to improve their health and wellbeing and will support a reduction in the inequalities experienced by many of North Lanarkshire's citizens.

Improving health and wellbeing, life circumstances, and increasing community capacity and resilience, is a long term goal. What we do now will influence what we need to do in 10 years' time which is one reason why we need to ensure that we invest in children and young people who by then will be young adults. Current investment in early years aspires to impact positively on adult lives and to ensure that as far as possible young people transition into adulthood having had equal access to opportunities.

To date, we have had great success focussing on specific care groups, themes and localities however as our understanding of Community Capacity Building and Carers' Support has developed it has become clear that the majority of people do not wish to be defined by their age or condition and therefore we intend to move away from the care group based approach. This does not mean that there will not be a place in our strategy for peer support or specific work around care groups but rather that the default position will be to mainstream as much of the advice, supports and services that we provide so that we aim firstly to reconnect people with their communities and the assets that exist within them rather than creating condition or age specific activities.

With this in mind, we will ensure that the locality consortia structure is linked to the emerging Locality Planning Groups, so that a condition specific focus is maintained where appropriate; that all third sector supports are fully and easily accessible locally; and that we are aware of issues which may affect how specific groups access their communities.

Prevention and Reduction of Isolation and Loneliness

A major overarching focus of this strategy, will be the prevention of and reduction in isolation and loneliness which is a major issue across all of our existing strands of work whether it be due to age, frailty, long term conditions, mental health, addiction, poverty, lack of transport or any other cause. Recent research demonstrates the adverse physical as well as psychological harm that isolation and loneliness can cause and we believe there is a strong link between social isolation and high resource use in a cohort of those identified as "High Health Gain Individuals".

Loneliness and physical health

- Loneliness increases the likelihood of mortality by 26% (Holt-Lunstad, 2015)
- The effect of loneliness and isolation on mortality is comparable to the impact of well-known risk factors such as obesity, and has a similar influence as cigarette smoking (Holt-Lunstad, 2010)
- Loneliness is associated with an increased risk of developing coronary heart disease and stroke (Valtorta et al, 2016)
- Loneliness increases the risk of high blood pressure (Hawkley et al, 2010)
- Lonely individuals are also at higher risk of the onset of disability (Lund et al, 2010)

Loneliness and mental health

- Loneliness puts individuals at greater risk of cognitive decline (James et al, 2011)
- One study concludes lonely people have a 64% increased chance of developing clinical dementia (Holwerda et al, 2012)

- Lonely individuals are more prone to depression (Cacioppo et al, 2006) (Green et al, 1992)
- Loneliness and low social interaction are predictive of suicide in older age (O'Connell et al, 2004)

Maintaining independence

Academic research is clear that preventing and alleviating loneliness is vital to enabling older people to remain as independent as possible. Lonely individuals are more likely to:

- Visit their GP, have higher use of medication, higher incidence of falls and increased risk factors for long term care (Cohen, 2006)
- Undergo early entry into residential or nursing care (Russell et al, 1997)
- Use accident and emergency services independent of chronic illness. (Geller, Janson, McGovern and Valdini, 1999)

High Health Gain individuals are a group of people (2.4% of the North Lanarkshire Population) who currently consume around 54% of the Health & Social Care resource. Clearly, many of these individuals have clinical needs which are so complex, their high resource use will continue. That said, there are known to be individuals within the overall cohort whose pattern of service use and the outcomes from their various contacts suggest that they may be using service contacts as a substitute for normal social interaction due to isolation or other issues that have not been addressed successfully. This is backed up by some of the studies referenced above. Even a small reduction in their resource use could release a significant amount of pressure on services. Rather than focus on their individual use of resources however, our aim would be to work with those individuals to improve their quality of life by reconnecting them with their communities, thus reducing their isolation and loneliness and as a by-product, we believe their reliance on services will reduce.

All of the above, combined with specific work around avoiding potentially preventable admissions; supporting better management of Long Term Conditions; and improving people's experience on discharge from hospital, will also have a positive impact on key pressures in acute services such as A&E Attendance, Unscheduled Admissions and Delayed Discharges.

7. Priority Areas

Sections 9 and 10 on pages 13 and 20 set out "Opportunities for Further Development of Supports and Services" and "Potential Existing Areas for Expansion/Development/Change". Whilst all of these areas are important and we will require to address them, we have identified a list of priority areas as follows.

Overarching Aims
• Prevention of Isolation and Loneliness • Addressing Inequalities

Priority Areas of Focus
• Support for Children and Young People • Support for High Health Gain Individuals • Promoting Self-Management • Carers Support • Physical Activity

- Community Food
- Locality Activity Programmes
- Community Connections
- Home Visiting and Befriending

Key Enablers
• Community Transport • Volunteer Recruitment and Development • Strategic Investment • Governance Review

8. Addressing Inequalities

Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. They represent thousands of unnecessary premature deaths every year in Scotland, and for men in the most deprived areas nearly 24 fewer years spent in 'good health'. The difference in life expectancy between those living in some of our least deprived communities compared with those living in some of our most deprived communities is stark with a 13 year and a 9 year difference between men and women respectively.
Although the above is a description of **health** inequalities, it is recognised that these are driven by or coexist with a range of other inequalities including;

- Uneven distribution of wealth, income and power
- Poverty
- Poor housing
- Lack of educational and learning opportunities
- Lack of employment opportunities
- Environmental causes
- Discrimination
- Poor access to supports and services

North Lanarkshire Health & Social Care Partnership has produced an *Inequalities, Prevention and Anticipatory Care Strategy* to guide the input of the localities, communities and key partners to the prevention agenda and to develop a locality focused delivery plan to support achievement of the commitments therein.

The strategy recognises that the role of the third sector and the CCB&CS programme will be vital to the success of this approach which aims to develop supports and services that are designed to;

- Reduce inequality; break the cycle of deprivation; and support our most vulnerable communities
- Harness the assets in communities in order to improve health, wellbeing and inclusion
- Develop population based approaches to promote both physical and mental health and wellbeing
- Develop, promote and enable self-help, utilise technology and reduce the communities' reliance upon services
- Communicate effectively with communities and challenge existing perceptions

regarding the use of services
- Provide anticipatory care programmes to prevent future ill health and demand upon services
- Contribute to the development of the environment in North Lanarkshire that is conducive to, and promotes good health and wellbeing
- Support staff to achieve good health and wellbeing
- Utilise change management, where appropriate, and an outcomes framework to monitor the impact

The *Inequalities, Prevention and Anticipatory Care Strategy* suggests a list of priority areas which include;

- A focus on locality priorities
- Delivery of pan North Lanarkshire prevention programmes through localities
- Early intervention and anticipatory care
- Self Help – Including promotion of MLE and Disabled Go
- Supporting vulnerable population groups
- Developing communities through an assets based approach

All of the above are echoed in this CCB&CS strategy.

In North Lanarkshire a significant number of people live in deprived communities and there are also groups of people who are vulnerable due to specific circumstances and needs. It is known that life expectancy and health outcomes are often worse for these people and so to improve outcomes across all our communities there is a need to focus on addressing this inequality.

Vulnerable populations such as homeless people, looked after children and those with severe and enduring mental health problems have poorer life outcomes when compared with the general population. The fact that people are living for longer is to be welcomed, however the ageing population, particularly if they are not supported to live well, present the single biggest challenge to health and social care in the 21st century. As the population ages, the number of people whose lives are impacted upon by multiple long term conditions is increasing.

If we don't change what we are doing, the demand on health and social care services and third sector provision is going to grow significantly. If we wish to reduce demand on services we can only do that by reducing inequalities through enabling people to achieve their full potential, maintain their wellbeing and lead longer healthier lives. Reduction in service demand rather than being the focus, will result as a by-product of reducing inequalities.

Expanding the work flowing from the CCB&CS strategy will be critical and will support the desired outcomes by working with individuals and communities to promote health and wellbeing; community cohesion and resilience; and to prevent and reduce isolation and loneliness.

9. Opportunities for Development

Although a huge range of excellent work can be identified and evidenced within the current programme, there are as many if not more opportunities to develop new approaches to CCB&CS; to expand on existing areas of work; and to look at new ways of structuring the programme to ensure that we meet service and organisational outcomes for ourselves and our partners as a by-product of meeting personal outcomes, as suggested above.

Some potential areas for development and specific focus are set out below.

a) Preventing and Reducing Isolation and Loneliness

As mentioned earlier, there is a huge emerging overarching theme of people experiencing isolation and loneliness. This is likely to include people who are possibly using service contacts as a substitute for normal social interaction or through fear and anxiety as a symptom of loneliness and isolation.

Research into social isolation is producing some interesting data suggesting that loneliness and social isolation are harmful to our physical and mental health and that social networks and friendships not only have an impact on reducing the risk of mortality or of development of certain diseases, but that they also help individuals to recover when they do fall ill.

Having a strong focus on identifying and ending isolation and loneliness in our communities would capture and help to support a lot of individuals who are currently not known to us and/or who could appear across a range of our existing care groups and themes.

Identifying individuals will be through a variety of current means that exist within the Third Sector and through examination of available data e.g. High Health Gain Individuals; individuals who make frequent calls to community alarms seeking reassurance etc; but critically, we will be relying on staff within H&SCNL to make referrals where they believe a person is isolated and lonely. This would also allow staff in Acute services; GPs; Out of hours services etc to refer people who they believe fall into this category.

As well as referrals from staff within H&SCNL, we need to support local people and organisations to gain a greater awareness of the individuals across all age groups within their localities who may be isolated and lonely and to engage with them to reconnect with their community or access support.

We will also, as discussed in more detail in section 9(c), continue to signpost and support people to use the Making Life Easier (MLE) web based resource which has a huge array of information linking people into third sector supports. The VANL Locator Tool which helps people to locate voluntary organisations within their own area is integrated within the MLE resource.

b) Support for Children and Young People

Work that we do now and in future will be consistent with the following statement of vision and values from the NL Children's Services Plan.

Our vision

Our children and young people will be safe, healthy, active, nurtured, responsible, respected, achieving and included so they can realise their potential and grow to be successful learners, confident individuals, effective contributors and responsible citizens.

Everyone has a part to play in achieving our vision for children and young people in North Lanarkshire.

We will provide a broad range of services and supports to meet the needs of all children. For the majority, this will be within our universal services. Some children will require additional supports and a small number will need specialist or intensive services to meet their needs.
Our governance will be transparent and accountable.

Our values

1. *Children, young people and families are stakeholders and partners in the planning and delivery of children's services.*
2. *All children and young people are included, irrespective of health, gender, ethnic origin, age, sexual orientation, economic circumstances, religion or belief.*
3. *We promote and safeguard the rights of children and young people and make sure everybody is aware of these rights and understand what they are, as expressed in the United Nations Convention of the Rights of the Child.*
4. ***Getting it Right for Every Child** is our approach to working with children and young people.*

   ***We are child centred** - children are viewed as individuals and their wider world is recognised.*
   ***Shift to prevention** - we seek to identify difficulties and solutions as early as possible to prevent more or bigger problems in the future.*
   ***Partnership** - we work together to ensure children, young people and families get the support they need when they need it.*

5. *We take an asset based approach that recognises and builds on the strengths that already exist within children, young people, their families and communities.*
6. *We promote resilience in those experiencing adversity.*
7. *We work together to reduce inequalities and the impact of poverty on children and families.*
8. *Our actions are informed by evidence, or contribute to an evidence base and new ideas are tested and evaluated.*
9. *We gather information to identify the needs of children, young people and families in North Lanarkshire, determine what is important, decide where we target our resources, and identify how we can improve.*

It is within families and communities in North Lanarkshire that the shared vision for children and young people will be realised.

It is also within families and communities that there can be both positive and adverse impacts on the wellbeing of children and young people and the experiences of and within childhood will influence their ability to lead healthy independent lives as adults.

In our work with children, young people and families we recognise the opportunities for prevention and intervention at the earliest possible stage whether through universal provision, anticipating risk and recognising early signs of difficulty or providing support as early as possible. The positive impacts of this investment are long term, as children and young people enter their adult lives.

The third sector is active at all levels within the Children's Services Partnership. It therefore has a significant role in North Lanarkshire in the development of Children's Services Planning and the delivery of the 'Getting it Right for Every Child' (GIRFEC) provisions within the Children and Young

People's (Scotland) Act 2014. These provisions support the delivery of national outcomes for children and young people.

This activity and planning is currently being supported locally by the National Third Sector GIRFEC Project (which will come to an end in March 2018). The project outcomes are **promotion of** the third sector contribution; to **support** that contribution by ensuring that the sector has the necessary information, tools and resources it requires; continued **collaboration** within the sector and with statutory colleagues to strengthen the planning and delivery of Children's Services.

A recent report on findings from the project as they relate to North Lanarkshire, emphasises the key strengths the Third Sector brings to this area of work such as having a clear role which is carried out effectively; strong representation across the network; strong relationships and respect at operational and strategic levels; willingness and drive to use community resources and third sector data; delivery of effective early interventions; and targeted crisis management, all of which support improved outcomes for children, families and young people.

In order to further improve upon the significant contribution that the sector makes, we will look to implement the list of recommendations in the report such as raising the profile of co-production; improving data and information to demonstrate quality, variety and impact; improve relevant information in Locator Tool; make a coordinated offer to schools under the Pupil Equity Fund; establish clear links to the 'named person' role; ensure that the Third Sector are recognised as a key contributor to the delivery of early intervention and prevention programmes.

Other potential improvement actions can be grouped as follows;

- Develop links and relationships with localities, local head teachers and school boards in order to become part of their 'Network of Support' and to encourage integration of approaches
- Describe and develop Third Sector capacity and capability re e.g. one off commissions for individuals; bespoke elements of SDS packages etc
- Make communities, statutory partners and H&SCNL and Third Sector staff more aware of the contribution made by CCB&CS programme through its focus on prevention
- Describe and strengthen links to C&F Network and Justice Network; SACRO; Victim Support
- Support the initiatives outlined in the "Edges of Care" proposal, targeted at supporting vulnerable children
- Explore the potential benefits of supporting local organisations to consider joint funding bids to reduce competition for the same funds e.g. Big Lottery; Robertson's Trust etc. to avoid unnecessary duplication; and to reduce bureaucracy
- Build relationships with local head teachers and school boards so that approaches involving H&SCNL and Education can be integrated
- Support appropriate engagement and involvement of children and young people to ensure their voices are heard and use their personal stories to educate others

c) High Health Gain Individuals

The Joint Strategic Needs Assessment demonstrated that 2.4% of the population of North Lanarkshire utilise 54% of the Health & Social Care resource. It is anticipated that the quality of life experienced by this group will be poor and that their numerous contacts with social work; GPs; Accident and Emergency; Out of Hours Services etc. will not result in improved clinical or personal outcomes.

There may be a group of individuals within this cohort whose needs are so extreme that we cannot reduce their reliance on services however it is believed that there may be other groups who could be engaged in a different way, many of whom are known to have issues with mental health and substance misuse. The cohort is also likely to include people with specific long term conditions such as Chronic Obstructive Pulmonary Disease, who may be prone to panicking when alone when they perceive that their condition is worsening and a group where carer support will be a factor. The cohort would also include some of those who may be using service contacts as a substitute for social contact as described in section a) above.

If we could effect a 10% reduction in service use amongst these individuals through different approaches based on improving their lives, we would in theory reduce the usage of the whole Health and Social Care system by 5%.

There are several examples of potential work or work already being progressed with this cohort where CCB&CS will/should play a significant part, e.g.

- Distress Brief Interventions
- Case management of people with significant long term conditions
- Specific work on Chronic Obstructive Pulmonary Disease and other conditions where people can often panic overnight and be admitted unnecessarily where a face to face contact at home from a volunteer might prevent this.
- Related befriending activity by day could keep the person connected to their community and encourage them to seek help or support earlier in the day and help them to develop coping strategies for the out of hours period
- More support for the carers of these individuals to help them to cope better in times of stress and to help them intervene to support real or perceived crises

It is our intention also to use information from the Making Life Easier system (25% of use of MLE is out of hours), to identify more clearly the types of difficulties people are enquiring about during the night and direct them to sleep management techniques or services they can approach the next day e.g. help for anxiety, sleeping problems, carers supports etc.

The general focus on isolation and loneliness is expected to be a powerful preventative measure with regard to unnecessary service use by this specific group who in general have complex health and social needs. Supporting them to connect with their communities at an earlier stage, should reduce or prevent future reliance on service contacts which will in turn have a major impact across the whole system in terms of service pressures. It will make sense to use an improvement approach and to start work as soon as possible with a small group from within this cohort (perhaps 10 individuals) to test the concept and evaluate its impact. We have been offered assistance from the evaluation team within H&SCNL to look at the outcomes of such a test of change should we be enabled to undertake it. Once positive outcomes are demonstrated, the numbers could gradually expand whilst we undertake ongoing evaluation on quality of life outcomes, impact on service use and economic factors.

d) Promoting Self-Management

Self-management is the name given to an approach which aims to enable people living with long term conditions to manage their own health and put them in control of their care.
The Government's Strategy for self-management strategy **'**Gaun Yersel', was written by people with long term conditions in partnership with the Health and Social Care Alliance Scotland.

The strategy highlights 5 key stages where people need support: Diagnosis; living for today; progression; transitions; and end of life. It also reports that the key to successful self-management is in the hands of the person with the condition and people who receive self-management support are significantly less likely to experience complications related to their condition and the need for healthcare intervention.

Self-management is a key component for the success for the Scottish Government's Quality Strategy, which sets out a 2020 Vision for a safe, effective and person-centred health service. This strategy promotes a shift in the delivery of care to a model that engages, empowers and supports people in a partnership approach with their healthcare professionals, carers and community.

As mentioned earlier, there is an opportunity for the third sector to take a greater role in promoting self-management through the promotion and facilitation of self-help resources such as Making Life Easier (MLE) https://www.makinglifeeasier.org.uk/. Although the term self-management applies to people who have one or more long term conditions our approach will be to try and support people earlier in their journey and perhaps prevent some of these conditions from developing.

This web based resource has been developed by Health and Social Care North Lanarkshire and their partners; providing a gateway into services for the people living across our six localities.

The Making Life Easier expert apps can provide help and support on a wide variety of difficulties or concerns. There are supports available for well-being areas including mental health (http://www.elament.org.uk/), financial concerns, difficulties with daily activities, addiction, memory issues as well as a specific app to support Carers.

A self-assessment results in personalised solutions, including hints and tips from experts and signposting and access to hundreds of local resources. People can also be matched to a wide selection of equipment which is provided free of charge from H&SCNL.

The Disabled Go website (https://www.disabledgo.com/organisations/north-lanarkshire-council) enhances the above approach by providing disabled people with information on accessibility at a huge number of venues across North Lanarkshire including accessible toilets and changing places; community venues; entertainment, culture and leisure venues; public and professional services; retail and shopping; travel and accommodation.
The use of MLE and other associated resources will be supported by the Third Sector in the following ways;

- Promoting the use of MLE and the Locator tool in support of one of our key priorities, which is Prevention.
- Making people aware of MLE and its benefits through contacts with community groups etc
- Release of staff to receive training on MLE
- Providing feedback on the system to assist future development
- Identification of MLE experts within each locality to act as champions and assist others
- Consider how to remove barriers for those people who may not have internet access e.g. no wi-fi or mobile signal; poverty related issues re affordability of data etc

Making Life Easier makes use of the work developed by Professor Peter Gore on the “Life Curve” which is a predictive tool that allows us to identify the early signs of decline and to then support individuals to get back to an appropriate level of function for their age and stage of life. This will allow us to have an impact upstream at the earliest possible opportunity and will have a positive

impact on people's ability to retain functionality while aging with the knock on effects of better quality of life and less need for support and care.

In addition to the above, as detailed in section 10 (g), Making Life Easier, linking to Scotland's Active and Independent Living Programme (a three year Allied Health Professions-led national improvement programme), has been designed in order to offer personalised solutions for all individuals that would benefit from increasing their physical activity. This means that people can support themselves to have better health and wellbeing through increased physical activity.

e) Self-Directed Support

The Social Care (Self-directed Support) (Scotland) Act was passed in 2013 and the duties came into force in April 2014.

The values and principles in the Act are: involvement; informed choice; collaboration; the right to be treated with dignity and the right to participate in society.

Self-Directed Support is a helpful approach which offers people greater choice and control over their own lives and brings about a shift in the balance of power between individuals and organisations. This fits very well with the principles under which the third sector operates, supporting individuals to utilize the widest possible range of available supports focusing firstly on their own personal resources, the capacity of their own networks, community based supports, sources of information and advice, technology and so on.

The provision of individual budgets has been the focus of much of the discussions around SDS and these can be immensely helpful to enable some people to achieve their personal outcomes, however they are not necessary to obtain the full benefits of the approach and are likely to be taken up by small numbers of people.

The key role for the third sector in SDS is to ensure that we are promoting and supporting the significant opportunities afforded to individuals through SDS, in partnership with H&SCNL. By providing and promoting a range of easily accessible community activities from which people can self-select, we will enable them to exercise choice and control over their own lives and potentially reduce unnecessary service use.

There are also opportunities for the sector to deliver bespoke interventions for individuals.

f) Promoting Independence through Informal Support

In the first year of this 5 year strategy, as integrated locality teams continue to develop, there is an opportunity to explore the boundaries and 'soften the lines' between third sector and statutory sector provision of supports to enable people to maintain their independence, to be more resilient and to live for as long as possible in their own homes.

These supports and the specific role of the Third Sector in delivering them, would need to be defined and agreed as part of a process. This will provide an opportunity to think creatively about the ways in which we can promote and facilitate individuals and communities to retain their independence in proactive ways. Such supports would be characterised as being simpler and more straightforward inputs that do not require to be delivered by a statutory service. It would be extremely important in defining and agreeing these supports to ensure they were not at a level where they could be perceived as substitution of statutory services. For the purposes of this strategy they will be referred

to as 'informal' supports. As well as improving people's lives and maintaining or restoring their independence, these supports have the potential to relieve pressure on statutory services.

In Support at Home services for example, there are significant demands and pressures in terms of the growing numbers of referrals for people with complex support needs who require intensive, specialised assistance. At the same time, there are people who are referred for Support at Home (usually through the hospital discharge process) who do not need such high levels of support and whose needs could potentially be met through informal support from the third sector.

Many of these referrals are thought to be generated by attempts to ensure people's safety on discharge, combined with a lack of current knowledge of the person's home circumstances and availability of supports from existing community assets. Ironically, the over provision of care services as opposed to informal supports can actually harm the person whose safety we wish to ensure, as they can become less independent as a result of this process.

Informal support from the third sector would also be an option for those who may no longer require a Support at Home service following strengths based interventions such as re-ablement, as a result of which, people are receiving packages of support based on what they can do, rather than what they can't do.

These informal supports can also be provided long before a person may get to the stage of becoming unwell or requiring a hospital admission and early intervention of this type will have a major preventative impact. If these supports are organised and delivered through third sector integration within locality teams, then the positive benefits are likely to be magnified.

This idea also links very well with our current approach to befriending, which allows a period of time for people to be supported, in an informal way, to reconnect to their communities and to be signposted to and supported to access, a range of options that will allow them to maintain or establish social contacts, learn, relearn or enhance essential life skills, improve their health and wellbeing and as a result, become more resilient and more able to retain their independence.

From another perspective, as funding pressures in the statutory sector continue to be an issue, the eligibility criteria for formal services are becoming more rigorous, with the result that people who do not fall into the very high or high priority categories may not get the support they require. This is understandable given the need to prioritise the available resource, however it is likely that as a result, those in the medium and low categories of priority will progress more quickly to higher priority, creating a vicious circle. Again there is an opportunity to explore what informal supports could be provided by the third sector to maintain or improve the outcomes for these individuals.

Making Life Easier (and the Life Curve) give us an opportunity, at a much earlier stage, to begin to identify individuals requiring informal supports in order to improve or maintain their health and well-being. Following an MLE self-assessment the individual would receive personalised matching to solutions including signposting directly to the third sector or a variety of advice available from the third sector on how to self-manage.

10.Potential Existing Areas for Expansion/Development/Change

In support of the strategic vision of H&SCNL (set out in section 3), it seems likely that we will have to see significant expansion in the following areas;

a) Information/Advice/Signposting

This will continue to be an important focus as we aim to ensure people are able to access all available supports. The Third Sector and our partners must embrace the role of "Community Connectors" via routine face to face contacts in whatever role and by encouraging and supporting people to utilise online resources such as Making Life Easier and the Locator Tool.

The development of third sector Champions of Making Life Easier will support this agenda and help to promote a culture of self-management across our workforce and into our communities.

A key role for the sector is to support people in the short term to make use of the plethora of information advice and signposting that is available, particularly where this supports self-help; self-assessment; self-management of health conditions or social prescribing.

A variety of link workers currently exist or are being developed, usually related to a specific area of service e.g. GP Link Workers; Mental Health Link Workers; Locality Link workers etc. It will be important to ensure that we do not miss the opportunity to consider combining some of these roles to increase the scope and range of what can be achieved through this workforce whilst not losing the expected outcomes specific to the care groups to which these posts are aligned.

b) Locality Activity Programme

This has been an important element of the overall programme so far, allowing the Locality Consortia to address locally identified needs. In extending this area and expanding the range of supports and activity in localities, we will need to ensure that there is adequate scrutiny of the extent to which those locally identified needs and the work that follows, fit with the overall Joint Strategic Needs Assessment, have an evidence base and are appropriately evaluated to ensure they can demonstrate positive impact.

There may also occasionally be some circumstances where the localities will require direction in terms of specific priorities that are agreed to be critical across all.

It will be important that localities retain full control of these programmes in order that they address specific local needs, however there is an opportunity for us to take a more collegiate approach, working collaboratively through the NL Wide Consortium to test and adapt a variety of models so that we can learn and improve our effectiveness and impact through shared learning, where the local context allows. This will also be informed by and aligned to the work and priorities of the Locality Planning Groups, to which the Local Activity Programmes will be closely linked.

c) Recovery Oriented System of Care

In order to maintain a focus on improved personal outcomes, we will consider how the CCB&CS strategy can support a recovery model. This relates mainly but not exclusively to people whose lives are affected by poor Mental Health and/or Addiction. The focus will be on how we can ensure our services are responsive enough and designed to enable people to move through treatment and support and empower them to sustain their recovery taking into consideration their and their family's views and expectations in the process. This links to section 9(e) above on Promoting Independence through Informal Support.

The third sector will continue to link with addiction services to promote awareness and reduce the stigma experienced by people with addiction issues e.g. working with local consortia and linking with the Locality Planning groups.

This is in line with the Scottish Government's quality principles which underpin the national 'Quality Improvement Framework' for drugs and alcohol in particular "the greater integration of public services at a local level driven by better partnership collaboration and effective local delivery".

d) Carer Support Programme

Although there is no one definition of Carers' Support, in the context of this strategy and its overall approach, it can best be described as supporting carers to achieve their personal outcomes and to have their identified needs met, so that they are enabled to continue their caring role. This support should allow them to have a life alongside caring and maintain as good a quality of life for themselves as possible.

Maintaining and improving support to carers remains a key priority for Health & Social Care North Lanarkshire. For some time, a good infrastructure of support including direct and indirect support has been available in NL for carers of all ages. There is an existing commitment that 50% of the activity of the CCB&CS programme will have a positive impact on Carers' outcomes. Given the number of carers in North Lanarkshire and the increased numbers of people being supported in communities, we will need to look at how we expand this work while at the same time supporting implementation of the new Carers' Act.

The Act introduces the right to a new Adult Carer Support Plan (ACSP) or Young Carer Statement (YCS) based on the preventative approach to identify each carer's personal outcomes and needs for support. This will improve access to support for adult and young carers.

These plans/statements will encourage meaningful conversations with individual carers to understand personal needs and outcomes. This is also reflected in the requirement to involve carers in hospital discharge processes.

Statutory Partners are being encouraged to work collaboratively with the third sector in developing their models for preparing both ACSPs and YCSs. It would be up to the responsible local authority to decide whether it wishes to commission third sector partners to undertake the function of preparing individual ACSPs or YCSs

By ensuring more personalised and effective delivery of support to carers, the Act seeks to address the issues that may reduce or impede the wellbeing and positive outcomes for Scotland's carers. Improving the physical and emotional wellbeing of carers also benefits those being cared for and can help to sustain good caring relationships.

The Act introduces a duty to set local eligibility criteria frameworks. These frameworks will help to determine the level of support to be provided to carers based on their identified needs. Since prevention and early intervention are at the heart of the carer support system, if the carer's needs do not meet the local eligibility criteria, then it is recommended that other preventative supports provided in the community such as advice and information, emotional support, carer training, short breaks and welfare benefits checks to maximise income still be considered. These services are currently provided by the third sector.

Local carer strategies will also be developed which will set out the provision of services to adult and young carers in each Health & Social Care Partnership. These carer strategies will also set out plans for how carers are identified and how they receive information about local support in their area. The third sector has been identified as having a key role to play in carer identification.

There is also a requirement for carers and carer representatives to be involved in the preparation of short breaks services statements and planning of carer services, sharing their caring experiences and knowledge with those responsible for providing these services. Partnerships are being encouraged to foster innovative approaches to provide short breaks that seek to maximise the potential of voluntary and third sector contribution. Community-led approaches could be considered in extending the range and providing a good choice of high-quality short breaks to carers to meet their personal outcomes.

A separate carers' charter will be published setting out the rights of carers as provided for under the Act.

Building on our strengths based approach, we will also need to consider how carers access and benefit from universal services such as education, leisure and transport.

The act also requires statutory partners to consider how community-based support can be further developed to support carers. This includes services provided by carers' centres and the wider third sector.

Although the duties in relation to the act are placed on statutory partners, it would be expected that health, social care and third sector professionals would work together to ensure that patients and carers are supported.

As well as supporting implementation of the act, we also need to work towards carers' support being mainstreamed, so that provision of information and advice, or support to access it, and signposting to appropriate services, are seen as an integral part of everyone's role or at least embedded within integrated teams at locality level. Making Life Easier will be a component of this process and has an application, specifically designed by the third sector, for carers in our communities. The application provides a wide array of information and advice as well as providing personalised solutions such as signposting to individual third sector supports.

e) Palliative Care

Considerable work has been undertaken to date to support people with palliative care needs to be at home and living positive lives for as long as possible; supporting more people to die at home; and providing respite for carers. The work to date has been very positively received as reflected in many case studies and is very cost effective, however it is recognised that there is still a huge and growing unmet need.

The Community Palliative Care Project in North Lanarkshire is currently supporting people with life limiting conditions and their carers within their own homes. The team consists of a nurse co-ordinator, complementary therapists and volunteer befrienders. The main focus is on anticipatory care to assist people to maintain the maximum possible quality of life for as long as possible.

The main source of referrals are from community Macmillan nurses, GP's and district nurses who are identifying people in the last weeks /months of life. The circumstances of these people and their carers are often very uncertain and they need intense levels of time, reassurance and information.

The nurse coordinator can have up to 12 new referrals each week. The emotional support and signposting at this stage is paramount to delivery of a supportive palliative service that compliments other existing services.

The service has the potential to expand its scope to support people whose conditions are non-malignant e.g. neurological conditions, heart failure and respiratory conditions.

An expansion of the input from befriending services would be required in order to ensure that people receiving palliative and end of life care were able to remain connected to their communities for longer, which is known to improve their personal outcomes. Befrienders could also contribute to the development and organisation of community peer support groups.

By increasing the availability of befrienders to work alongside increased nursing support and complementary therapists, more people could be supported on a 1:1 basis at home. This will encourage self-management of anxieties, development of anticipatory care and above all, support people by reconnecting them into other community assets and services. Nursing staff would develop a follow up programme and also offer bereavement support visits.

f) Community Transport

Community transport has been shown to be an essential enabler in allowing people to access the extensive range of supports provided through the CCB&CS Programme and is a priority area within H&SCNL's commissioning intentions for 2018/19.

It is also seen as critical in terms of re-engaging people with their communities, with social opportunities and employment. Community transport also provides employment locally and improves the employability of its volunteers. It is therefore another area where, inevitably, expansion will be necessary.

Training provided by GBT CT consists of MiDAS (minibus driver awareness scheme) PATS (passenger assistance training) and D1 minibus licence (in partnership with SPT PSP programme).

The service is much more sophisticated than it is sometimes viewed with a wide range of different clients with different needs being supported by the service. Recent examples include

- a successful outcome for a double amputee who could not be accommodated by the patient transport service but was able to attend an appointment with assistance from Community Transport who have wheelchair accessible vehicles which can be operated by one person
- support to a young adult who needed to travel to a physiotherapy appointment, was unable to access public transport and unable to afford a £70 taxi fare. The person was transported at a cost to them of £18
- support to older people to access community facilities, shops, clubs, clinical appointments etc. where they would otherwise be able to attend as they do not use public transport due to safety concerns e.g. drivers unwilling to wait until they sit down before moving off.

Many of the clients are carers who are isolated and lonely and who otherwise would not be able to get a break from their caring role to socialise with others. The ability to support the cared for person in some of the ways described above also provides respite for the carers.

In addition to the core Community Transport functions, the NL services have been expanding to work more in partnership with H&SCNL; NLC; NHSL and SPT. Through these partnerships we have provided a shuttle service for patients of St Andrew's Hospice for the duration of their decant to Wester Moffat Hospital and are currently providing transport for patients on discharge from NHSL hospitals from a central base at Monkland's Hospital. In addition the service also provides transport

to support Winter Planning. These partnership activities improve services to the public, provide more flexibility and reduce costs to the statutory sector organisations.

There are other areas that are currently under discussion to expand this partnership work which has great potential however without an appropriate level of resource, this expansion will not be possible as it would impact on delivery of our core service and its outcomes.

The service also provides a range of training internally and to partner organisations e.g. Passenger Assistant Training; CPC (Certificate of Professional Competence).

To support the overall CCB&CS strategy, it is estimated that a significant increase in drivers and vehicles will be required with a commensurate increase in management and admin support. This will support the expected year on year growth in activity in the core business of around 10% which would see current passenger journeys rise from 18,000 to 29,000 not including any activity that subsequently comes from the partnership work with H&SCNL, NHS (including Winter Planning), NLC and SPT which will require separate resourcing. Passenger numbers alone do not reflect the diversity or quality of the services offered by Community Transport, rather they illustrate the level of demand for transport that is more focused on the individual passenger's requirements than public transport services.

g) Physical Activity

Those linked to sports and physical activity, are the largest single group of volunteers.

Scotland's National Physical Activity strategy 'Let's Make Scotland More Active' sets out the vision that **"People in Scotland will enjoy the benefits of having a physically active life."**

In doing more physical activity, we will develop the health-related areas of our fitness. These are cardiovascular fitness (our heart, lungs and circulatory systems), muscle strength and stamina, flexibility and body composition (percentage of body fat). There are also skill-related areas of fitness such as power, speed, agility, co-ordination, balance and reaction time. These are important for keeping us safe particularly as we get older e.g. falls prevention.

Scotland's former Chief Medical Officer, Sir Harry Burns, indicated that sport and physical activity are ***"public health's best buy"***. In addition, physical inactivity has been described as Scotland's second biggest killer by Dr. Andrew Murray, who was the Scottish Government's Physical Activity expert, further describing physical inactivity as being responsible for more deaths than 'smoking, diabetes and obesity combined'.

The latest Scottish Health Survey (2016), shows that North Lanarkshire has one of the highest prevalence of overweight and obese adults (73%) in Scotland. Physical activity has a positive impact in preventing and treating obesity and well over 20 chronic conditions, including, heart disease, diabetes and a number of cancers and other serious conditions.

Physical activity is promoted/provided by the third sector directly e.g. through sports clubs; dance clubs etc but also through other social activities that have a physical component e.g. gardening. It is

not solely about getting fit and does not necessarily involve vigorous exercise. We do get fitter as we get more active but the goal for good health is to increase the amount of physical activity that we do.

By the same token, taking part in physical activity in groups can also be a good way of making and maintaining social contact and supporting our overall aim of reducing isolation and loneliness.

The main aims of CCB&CS with regard to physical activity therefore are;

- to encourage people to be more active so that they achieve the associated health and wellbeing benefits
- to make opportunities to be more active accessible an attractive to everyone
- to make these affordable
- to encourage ownership of this agenda at locality level
- to make use of community assets including sports facilities and other community locations that can be used for physical activity
- to motivate as many people as possible to take part
- to educate and inform people about the benefits and the links with improved diet
- promote forms of physical activity and sports which also provide opportunities for social contact thereby helping to reduce isolation and loneliness
- reduce health inequalities
- primary prevention related to a variety of health conditions including cardiovascular disease; diabetes; obesity etc.

The third sector, in conjunction with partners in North Lanarkshire Leisure, CultureNL and North Lanarkshire Council's Countryside and Landscape sections have a crucial role to play in ill health prevention, rehabilitation and treatment to positively and proactively address the health issues referred to earlier. Along with other key partners, such as Getting Better Together Shotts, a number of ground breaking initiatives and programmes have been put in place which have maintained North Lanarkshire's position at the forefront of collaborative health promotion work in Scotland.

Such programmes and initiatives include:

- Active Health – Physical activity referral programme
- Weigh to Go
- Mini-movers
- Healthy Families
- Friday Night Project
- Saturday Sports Scene
- Mental Health Improvement through Badminton and a range of other sport and activities
- Walking football for the over 50's; and
- Street Soccer

Given their proven health and wellbeing returns, every effort should be made to extend the scope, scale and depth of all of the above programmes.
The sector will also link with the "**Our Natural Health Service**" initiative being launched in 2018 which will develop greater cross sectoral working to maximise the contribution of Lanarkshire's outdoors to a healthier, more active population. There are obvious links to community capacity building & the Third Sector including volunteering, community transport, mentoring, outdoor learning etc. with the potential to reduce pressure on H&SC services. There are also links to reducing

inequalities, self-management, prevention & reduction of long term conditions & prevention of isolation & loneliness.

To complement all of the above, we would look to develop **'Health and Wellbeing Lifestyle Champions'** responsible for delivering physical activity; sport; as well as information, advice, guidance and demonstrations related to health and good nutrition. These would be targeted at those communities most difficult to engage with and would operate in local community settings with a medium term aim of connecting people to existing services, facilities and programmes available in North Lanarkshire and developing and supporting local champions from within those communities.

h) Community Food (Making Positive Health Choices)

Provision of supports to help our citizens to improve their diet through the Community Food service is an essential component in terms of improving physical and mental health and wellbeing.

The main aims and outcomes of CCB&CS with regard to Community Food, "Making Positive Health Choices", are similar to those associated with physical activity

- to encourage people (as early in life as possible) to eat better food so that they achieve the associated health and wellbeing benefits
- to make healthy food choices more accessible and attractive to everyone and more affordable
- to enable people to overcome barriers to making positive food choices e.g. adapted cookery classes for people with physical disability or learning difficulties
- to encourage a locality approach to promoting healthier eating
- to make use of community assets including community venues that can be used to allow people to learn about food and to learn cooking skills
- to motivate as many people as possible to engage in changing their eating habits
- to educate and inform people about the benefits and the links with physical activity
- reduce health inequalities
- primary prevention related to a variety of health conditions including cardiovascular disease; diabetes; obesity etc
- continue with current role of third sector in giving pre-birth advice and vitamins; weaning advice; encouraging healthy choices; anti-poverty approaches

Some current successful interventions include;

Provision of **Nutrition and Cooking classes -** these are non-threatening activities used for engaging a wide range of people to help them address or manage both their physical health and their mental wellbeing. As a by-product, the social interactions during classes can increase self-esteem and reduce isolation and loneliness which can also provide a break from a caring role. Classes can also improve nutritional knowledge, cooking skills, budgeting and confidence, which contribute to positive lifestyle outcomes. These classes have also been used as a stepping stone to integrate people into other groups within their communities or onto further education.

Potential developments over the coming 5 years include;

Tailored Healthy Eating Courses - Recently we have trialled some new approaches aimed at supporting people to make a positive difference to their lives as part of self-management of long – term conditions e.g.;

- There is a higher than average prevalence of diabetes in North Lanarkshire. If not managed well it can lead to serious complications and long-term disabilities such as blindness, loss of limbs, renal failure etc. Evaluation of a course delivered in Airdrie demonstrated increased cooking skills; less reliance on convenience foods; improved knowledge of labelling; increased consumption of fruit and veg and increased activity levels. Some participants were less dependent on diabetes medication post course.

Looked after and accommodated children: We have developed a tool-kit with our partners which is intended to support work with staff, young people and their carers through "big chef, little chef" interventions and cooking/nutrition classes.

Healthy Eating Champions have been introduced in the past 12 months to good effect however managing and training them will require a dedicated resource in order to ensure a successful future roll out.

i) Home Visiting and Befriending

A major area of focus and success for CCB&CS, has been Home Visiting and Befriending and it is clear that in order to support the ambition within this strategy to focus on preventing isolation and loneliness, these services need to be expanded. The current services are provided by a mixture of local and national organisations and have had very positive outcomes for people of all age groups who access them, including carers.

One of our key strategic aims is to ensure that everything we do, where possible;

- Is based on a Personal Outcomes Approach
- Is focussed on a person's strengths and abilities
- Helps them to achieve specific goals
- Encourages independence
- Supports people to connect with their own communities

Home Visiting and Befriending describes a range of time limited one to one interventions designed to support people back into their communities and to reconnect them with local community assets; resources; opportunities for employment; training; social inclusion etc. This is designed to help them to become/remain more self-reliant, more resilient and independent.

These services also currently provide essential respite for carers. Many of the enquiries that befriending organisations receive are for befrienders to sit with the cared-for, while their carers go shopping, attend appointments or just have time to themselves to recuperate.

It is important to recognise that such relationships can, if not managed appropriately, create dependency for individuals. As a rule, interventions therefore need to be time limited with an initial engagement that lasts around 12 weeks in most circumstances. The time span of contact though, needs to be flexible around the individual and the purpose of the intervention. As we move through the spectrum of interventions, this can expand up to one year in some specific circumstances.

In this area of activity, the one to one relationship is crucial however there may be aspects of the individual's support where purposeful engagement in local groups is appropriate supporting the overall aim of the individual being able to exercise choice and control over their own life.

Where there are individuals who are isolated and lonely who are also largely housebound and for whom there are clearly no alternative options, a longer term befriending relationship based largely

on social interaction may be considered appropriate and may include social visits to their home, support to attend social groups and/or telephone befriending. In such circumstances, in the longer term, we need to harness the potential of local communities, to provide these supports 'naturally'.

At both ends of the spectrum, the focus remains on the individual, their personal outcomes, helping them to use and develop their strengths and retain as much choice and control over their lives as possible. Recognising that demand for these supports could be very high, we may need to look at inclusion criteria and priority groups

In year one of the strategy, we will continue to work with stakeholders across North Lanarkshire to describe in more detail, the model and components of a future service, what these components are expected to deliver in terms of outcomes, the associated values that will underpin our activity and will then ask localities to work towards making these available within their own areas, dependent on available funding. In doing so we will look across North Lanarkshire and reassess the relative merits of current services to ensure that the best practice from all of the models is made available and that the future model is clearly articulated including resource implications.

We will also explore the potential to streamline some of the managerial aspects to the service such as co-ordination, recruitment, training and development etc although day to day supervision and support would remain within a locality.

In the locality with the longest experience of providing these services there are currently around 60 one to one befriending matches at any given time, with potential (subject to funding) to expand this to around 120 in the next 5 years. If this was replicated across all 6 localities then around 800 people could be supported in this way.

It is critical that consideration is given to a more strategic funding approach to support continuation of this new model as discussed in section 4.

j) Dementia Support

North Lanarkshire has been involved in ground breaking work through its role as a Dementia Demonstrator Site and the setting up of initiatives such as Dementia Cafes. It has also supported Town Centres; churches; schools; businesses; GP Surgeries and other local organisations to gain Dementia Friendly status.

The aims of these initiatives have been to enable people living with Dementia to remain engaged with their communities; to reduce isolation and loneliness; and potentially to slow the progression of the disease. Given the expected growth in the >75 population and consequent rise in the numbers of people living with dementia, work in this area will have to expand accordingly.

Guided by the Scottish National Dementia Strategy 2017-2020 the key areas of focus locally for people living with dementia and their carers include:

- Raising awareness of dementia
- Development of a Dementia Friendly Communities Toolkit
- Support for people living with dementia and their carers e.g. through dementia cafes
- Carer Education
- Home visiting and befriending

- Provision of information, advice and signposting.
- Post diagnostic support
- Supporting staff and volunteers to develop the necessary knowledge and understanding to ensure services and supports are dementia friendly
- Providing them also with the essential skills to deal with distressed behaviour
- Development of new dementia friendly activities
- Promoting the creation of dementia friendly environments
- Raising awareness of how to reduce the risk of developing dementia

k) Advocacy

The approach in relation to the development of advocacy services has been designed to complement and add value to the commissioned advocacy services through North Lanarkshire Council. This has included:

- Provision of resources to expand the range of existing paid advocacy services – expand existing contract activity.
- Development of a pool of volunteer advocacy workers that will complement the existing contract activity and extend the range of community based provision.
- Ensuring services are available across North Lanarkshire and link with localities.

<u>Other Current Priorities</u>

- **Provision of a coherent North Lanarkshire wide approach** which covers the whole population and is representative of all of the community. North Lanarkshire currently has three advocacy specialist organisations who meet up quarterly as an Advocacy Network :

    - Who Cares Scotland – children and young people
    - North Lanarkshire Advocacy (Equals Say) – adults 16 -64
    - Equals Advocacy –older adults 65 and over

- **Focus on reaching people at an earlier stage** before they are subject to legislative intervention.
- **Targeting people who are unconnected to services at present** to ensure that people are kept independent for longer
- **Increased independence and self-management** by encouraging service users / carers to use powers of attorney, advance statements, self-directed support etc.
- **Increased Community Capacity** by providing training and awareness sessions using the recently developed advocacy training module encouraging individuals who live and work in the local community to become volunteers and advocacy champions.

l) Community Justice

The introduction of The Community Justice (Scotland) Act 2016 triggered the disestablishment of Lanarkshire Community Justice Authority and the establishment of a new North Lanarkshire Community Justice Partnership within the community planning structure of North Lanarkshire Partnership. Voluntary Action North Lanarkshire (mandated by North Lanarkshire Voluntary Sector Partnership Group) represents the third sector at North Lanarkshire Community Justice Partnership.

In 2016, to further expand the sphere of the local third sector's involvement and influence in the Community Justice agenda, two Third Sector Community Justice Networks were launched, operating

as endorsed Networks of North Lanarkshire Community Justice Partnership. North Lanarkshire Third Sector Reducing Reoffending Network (chaired by Sacro) and North Lanarkshire Third Sector Victim Services and Engagers Network (chaired by Victim Support Scotland) attracted significant levels of membership from third sector organisations during their initial year of operation. Both Networks have helped establish linear connectivity between grassroots third sector organisations and service users and members of North Lanarkshire Community Justice Partnership.

Since 2016-17, Third Sector Community Justice Network member organisations have been notable contributors to the development of the North Lanarkshire Community Justice Outcome Improvement Plan 2017-20. Launched in April 2017, this is the key strategic operating document, with the third sector scheduled to lead on implementation of a number of key targets and outcomes on behalf of the Partnership over a three-year period.

m) Workforce and Volunteer Development

With such an ambitious strategy for CCB&CS and with planned expansion into a wider range of interventions which align third sector supports with the priorities of HSCNL, it is essential that we are able to recruit more volunteers.

As well as increasing capacity in terms of numbers, volunteer development will also be crucial.

Staff and volunteers in the third sector are a highly trained, skilled and flexible workforce whose work is rigorously evaluated and governed and who hold a set of common values, similar to those of statutory sector colleagues. It will be important to continue to work towards these values being fully aligned. Our workforce will also require to have the opportunity to update their skills and knowledge where necessary to be consistent with the aims, objectives and priorities within this strategy and to enable them to best support the citizens of North Lanarkshire. This should be in a way which is consistent, proportionate to their role and relevant to their own and their organisations' values and staff development priorities.

This gives us an opportunity to co-ordinate access to joint training, aligned with the values based ambition of the workforce development plan of HSCNL. This will include the further role out of Equal Partners In Care, falls pathway training, addictions level 1, ROSC and Making Life Easier.

Volunteer development also needs to maximise personal development for volunteers (e.g. increased employability; self-confidence etc.) and keep this in focus as a valued outcome in its own right. This contributes to the local community and makes volunteering a more attractive option.

We will also undertake focussed work to ensure that organisations – especially smaller organisations and community groups – are able to retain, support and develop their own volunteers thus building their capacity to be more sustainable.

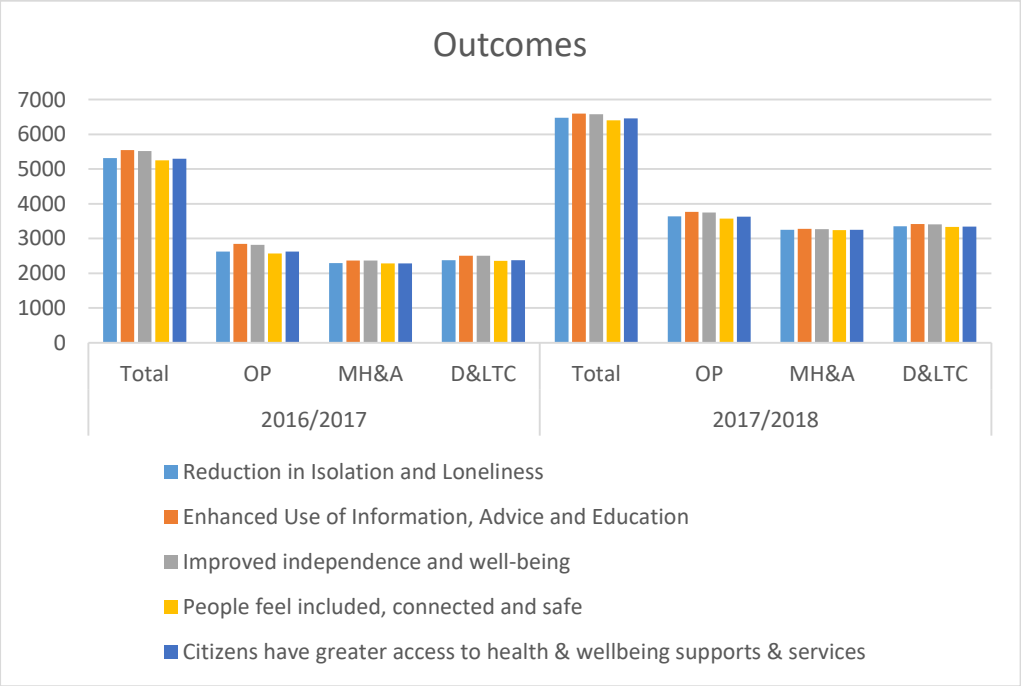
It will also be important to look at the communication needs of staff and volunteers across localities and to support this VANL have developed a CCB&CS Platform which enables all of the partners to share information at the same time and to collaborate and work together more easily through integrating relevant communication and sharing ideas.

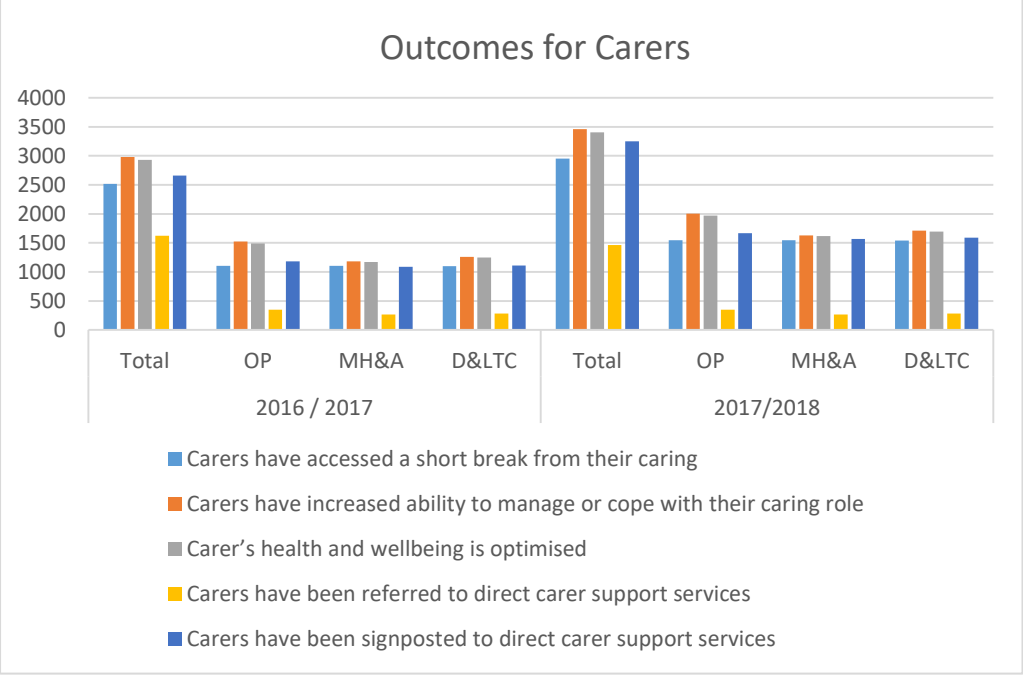
As a response to feedback received over the last 12 months from CCB&CS partners, new features have been implemented to the platform enabling members of the public to access information directly at source, significantly faster and more accurately, via the new Community Connector Tool which allows all CCB&CS Partners to publish their own information to the public.

In order to take advantage of the continuing rise in the numbers of people who are able to access the internet on the go, the CCB&CS Platform and its Community Connector are compatible with Mobile devices, Tablets and desktop PC's.

11.Anticipated Outputs and Outcomes

It is anticipated that with current levels of funding we can continue to achieve the outcomes evidenced through our evaluation framework and through H&SCNL's Contribution analysis. The graphs below show the outcomes that were achieved in the financial years 2016/17 and targets for 2017/18.





Whilst all of the above headings are relevant and give a good sense of the contribution the programme makes, we are currently looking at a review of the evaluation framework to ensure it captures the outcomes relevant to expanded or new areas of focus in a way that remains robust, proportionate and aligned to the outcomes of the HSCNL Strategic Plan. If implemented, specific impacts will need to be demonstrated around;

- Prevention of isolation and loneliness
- Work with High Health Gain individuals (perhaps through test of change)
- Promoting use of MLE and associated resources
- Contribution to SDS including bespoke supports and interventions
- Expansion of "informal supports" and the impact on personal outcomes; life curve; statutory provision
- Children and Young People
- Proposed changes to Home Visiting and Befriending/Community Connectors

12. Monitoring and Evaluation Framework

One of the principles of this and previous strategies is that all of the current and planned activity linked to CCB&CS must link back to the Joint Commissioning Plan of Health & Social Care North Lanarkshire which in turn must demonstrate links to the 9 National Health & Wellbeing Outcomes (set out below) and the National Delivery Plan where appropriate.

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 for 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 wellbeing.

Outcome 7: People who use health and 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

These links can be clearly evidenced, based both on activity generated from current investment and the further funding leveraged as a result. Monitoring of the programme outcomes is undertaken quarterly and reported annually to the HSCNL JIB.

The production of this strategy has given us an ideal opportunity to review our Evaluation Framework to ensure that it is fit for purpose; proportionate; and that it can be populated and reported on without impacting adversely on staff time.

Throughout the development of the strategy, we have been considering these aspects and have been having early discussions internally and with Health & Social Care North Lanarkshire to ensure that we are able to maintain and improve the level and quality of data collection. Our aspiration is to commission a new online platform to make it easier to gather and collate the necessary breadth of quantitative and qualitative data.

13. Governance Review

Although the CCB&CS governance arrangements have served us well over a number of years and remain an exemplar of how the Third Sector can demonstrate value for money, efficiency, effectiveness and probity, we will review these arrangements, firstly to consider whether they can be improved and also in light of changes to the structures within H&SCNL as a consequence of its Integrated Service Review Board report.

This review will take place in year one of the strategy implementation (2018/19).

14. Implementation and Transitional Arrangements

Following approval of this 5 year strategy we will be in ongoing dialogue with H&SCNL aimed at clarifying which of the areas of potential new or expanded inputs they wish to commission via the CCB&CS programme in order to improve the lives of North Lanarkshire citizens, whilst at the same time supporting the delivery of the Joint Strategic Commissioning Intentions.

The dialogue will also address the need for strategic investment to facilitate growth in the range and volume of information, advice, support and services to be provided through the strategy and the need to further shift the balance of resources towards CCB&CS.

Implementation will be taken forward through the North Lanarkshire Joint Consortium, overseen by the CCB&CS Group under the governance of the CCB&CS Governance Sub Group.

Once the availability of resources for 2018/19 and subsequent years becomes clear, we will produce a commissioning plan setting out existing areas to be reviewed, any new supports and services to be commissioned and any that will be stopped.

2018 will be a transitional year in which we will review and adapt existing provision whilst planning implementation of any newly commissioned work.