APPENDIX 3

East Ayrshire
Community Plan
2015 - 2030

Delivery Plan for Wellbeing

2018 - 2021

Wellbeing

Key Priorities

- Children and young people, including those in early years, and their carers are supported to be active, healthy and reach their potential at all life stages
- All residents are given the opportunity to improve their wellbeing, to lead an active, healthy life and to make positive lifestyle choices
- Older people and adults who require support and their carers are included and empowered to live the healthiest life possible
- Communities are supported to address the impact that inequalities has on the health and wellbeing of our residents

Policy Context

Since the 2015-2018 Wellbeing Delivery Plan was produced there has been significant change in the policy for improving wellbeing.

The changes include the national 'Programme for Government', 'Realistic Medicine', the 'Health and Social Care Delivery Plan' and the 'What Matters to You?' campaign.

The Programme for Government has an ambition for Scotland to be the best place in the world to grow up, and the best place in the world to be cared for and to be healthy.

The 'Health and Social Care Delivery Plan' brings together a range of separate policy strands into one coherent plan. The aim is one of high quality services, focused on prevention, early intervention and supported self-management. When people need hospital care, the aim is for day surgery to be the norm, and when stays need to be longer, the aim is for people to be discharged as swiftly as it is safe to do so.

The planning and delivery of health and social care must be based on the principles of well-coordinated care that is timely and appropriate to people's needs, where we reduce inappropriate use of hospital services and shift resources to primary and community care.

'Realistic Medicine' and 'What Matters to You?' puts the person receiving health and care at the centre of decision making and a personalised approach to care and support. 'What Matters to You?' is about having conversations about care and support with people to arrive at decisions that are right for them. The aim is to address waste and unwarranted variation while managing risks and innovating to improve. This involves using the skills and knowledge of the workforce to maintain health and to prevent, identify and treat ill-health.

The implications of the Government's Welfare Reform programme and the roll-out of Universal Credit in East Ayrshire will be significant. There are concerns that the reduction in welfare spending will impact negatively on income inequality, poverty and child poverty and on equality groups, including impacts on women and people with disabilities. It is projected that welfare spending in Scotland will be reduced by around £0.9 billion by 2020/21 as a direct result of these reforms, which equates to a loss per working age adult in East Ayrshire of £299 per annum (Source: Scottish Parliament (2014) 'Report on the Impact of the Welfare Reform'). This reduction in incomes for individuals and families in receipt of benefits will likely exacerbate the already significant levels of poverty, including fuel poverty, which exist across East Ayrshire and have a detrimental impact on the physical and mental health and wellbeing of those living in situations of poverty.

Transformation

Analysis of the financial context points to considerable challenges. Through a combination of ongoing fiscal consolidation at the UK level, a relatively fragile economic environment and major policy commitments to be paid for, the resources available to fund many public services will continue to be squeezed.

Changes in the balance and scale of public spending, how public services are delivered and prioritised, and the way in which devolved revenues are raised, are all likely to be required. Continuing as before is not an option if Scotland's devolved budget is to be sustainable in the long term. The UK Government's current spending plans indicate that public spending will reduce each year for the foreseeable future.

In this context public bodies are taking forward Transformation Strategies.

NHS Ayrshire and Arran Transformational Change Improvement Plan 2017-2020 and associated Delivery Plan 2017/18. This is the local delivery plan for NHS services and includes delegated services. It describes how transformational change programmes will deliver improvements designed to meet the needs of the local population http://www.nhsaaa.net/media/2260/20170626bmp07.pdf

East Ayrshire Council's Transformation Strategy has been developed through an inclusive and participatory conversation on our future in through the Vibrant Voices engagement programme. The Transformation Strategy will focus on empowering communities to be more closely involved in local service provision. Initial considerations are of a smaller council employing fewer people while maintaining high quality services, engaged and enabling communities to share decision making and jointly deliver services. The future Council will be an agile, modern, digital and data-driven one, using data to focus on improvement and understand and reduce demand through prevention and early intervention. There will be a need to challenge traditional approaches, to engage broadly to unlock collective knowledge, skills and experience to better serve communities.

A fairer, kinder and connected East Ayrshire, with people at the heart of everything we do http://docs.east-ayrshire.gov.uk/r/?f=http://docs.east-ayrshire.gov.uk/CRPADMMIN/2012%20AGENDAS/CABINET/21%20FEBRUARY%202018/transformation%20strategy%20report%20-%20february%202018.pdf

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Strategic Vision and Priorities

The Community Planning Partnership vision is:

East Ayrshire is a place with strong, safe and vibrant communities where everyone has a good quality of life and access to opportunities, choices and high quality services which are sustainable, accessible and meet people's needs.

To support the Wellbeing Delivery Plan, the Integration Joint Board vision is:

Working together with all of our Communities to improve and sustain wellbeing, care and promote equity.

For the Wellbeing Theme of the Community Plan 2015-2030 the following Key Priorities are agreed.

- Children and young people, including those in early years, and their carers are supported to be active, healthy and to reach their potential at all life stages.
- All residents are given the opportunity to improve their wellbeing, to lead an active, healthy life and to make positive lifestyle choices.
- Older people and adults who require support and their carers are included and empowered to live the healthiest life possible.
- Communities are supported to address the impact that inequalities has on the health and wellbeing of our residents.

Developing the Wellbeing Delivery Plan 2018-21

The Health and Social Care Partnership leads on the Wellbeing Theme of the Community Plan 2015-2030 as devolved by the Community Planning Partnership. The Wellbeing Delivery Group fulfils this role and is a broad partnership with membership comprising of senior officers from Public Health, Education Services, Police Scotland, Scottish Fire and Rescue, the Alcohol and Drug Partnership, Health and Social Care Partnership, Vibrant Communities and Third Sector Interface. Wellbeing delivery is not the preserve of partners within the Delivery Group, it is a shared responsibility. The Wellbeing Delivery Plan represents the added value of working across all Community Planning Partners to contribute to the 'triple aim' of 'Better Care', 'Better Health' and 'Better Value'.

In 2017/18, members of the Wellbeing Delivery Group held four focus groups and a formal review session to shape the 2018-2021 Wellbeing Delivery Plan. The Delivery Group recognised that good progress has been made in developing a shared vision and focus, with partnerships and relationships strengthened since the 2015-2018 Plan. The Delivery Group assessment was that a real difference is

being made in a number of areas, with strong commitment but a need for more focused collective action. The Delivery Group viewed locality planning as critical to making a difference in communities and improving strategic connections.

The Wellbeing Delivery Group review looked at the critical wellbeing issues that collective leadership can add value to and identified these as:

- Shared responsibility and collective action;
- Improved connections and communication across other Delivery Plan themes;
- Prevention and early intervention;
- Addressing attitudinal and cultural factors that impact negatively on wellbeing – building resilience;
- Developing a multi-faceted plan of action across life-stages and health literacy;
- Connecting locality planning and strategic planning, and;
- Considering the impact and opportunities from digital technology.

The Group noted a strong history of working together to develop healthier, stronger communities and judged partners as well placed to tackle the next stage with individuals and communities. This will involve building on relationships, the assets of community-based teams and involving all Community Planning Partners. During the course of the Wellbeing Delivery Plan 2018-21, there will be a focus on social isolation, working-age wellbeing, the environmental factors that affect wellbeing and a specific focus on relationships with alcohol. We will draw on best practice, lived experience, working across the life-course and advocating for change where policy or practice impacts negatively on wellbeing. Measuring impact through personal outcomes and personal stories will feature alongside key feedback measures.

The full range of wellbeing issues will continue to be monitored and action taken but we will focus on a smaller number of key areas where the collective effort of Community Planning Partners can makes the biggest difference over the next three years. There will be a focus on strengths, relationships and the potential of people as citizens, living within communities that are caring and compassionate towards each other. Locality Planning will be critical to taking forward the Wellbeing Delivery Plan 2018-2021.

The Wellbeing Delivery Plan must be about concerted effort on significant determinants of health and the influence of this on wellbeing. In the 2018-2021 Delivery Plan we have simplified our approach. There are fewer and more focused areas that we want to take action on across Community Planning Partners.

From the Wellbeing Delivery Group review these can be summarised as:

- Starting Well; and
- Living Well.

Purpose of the Wellbeing Delivery Plan

Inequalities and differential wellbeing outcomes are not inevitable and are an issue of public health, economic and social justice. That is why the Wellbeing Delivery Plan is so important. The Wellbeing Delivery Plan has a number of key functions:

- Providing clarity for partners in relation to the agreed priorities for the next three years;
- Providing a mechanism for partners to embed priorities in their own organisations and in the networks that they participate in; and
- Providing a forum for taking collective action at a strategic level to address wellbeing priorities.

The Wellbeing Delivery Group review carried out in 2017/18 identified ambitious long-term objectives of tackling child poverty, tackling stigma, creating a fairer and healthier place, integrated transport, opportunities for quality employment, responsive and accessible services, and empowered caring communities.

There has been significant progress during the 2015-2018 Wellbeing Delivery Plan and this can be seen in a number of key measures. However, it is the case that further progress is required. There are substantial challenges to continuing to improve the wellbeing of our residents. Too many people develop long-term conditions that impact on their quality of life. Our relationship with alcohol continues to have substantial negative consequences for children, young people, families and communities. Healthy weight, good diet and physical activity in East Ayrshire are below comparable partnerships and Scotland as whole. Poorer wellbeing outcomes are more likely in our more deprived communities.

The Wellbeing Delivery Plan will have a concerted focus on a smaller number of key themes to make a meaningful difference to the lives of the people of East Ayrshire. We will be focused on these issues. Factors affecting wellbeing are complex and interrelated. No one agency can deliver on these objectives on its own. This is a shared responsibility and requires collective leadership, partnership, collaboration and action across Wellbeing, Economy and Skills, and Safer Communities. Through Community Planning Partners coalescing around and working together on key wellbeing issues, we will maximise collective effort and, through improving the wellbeing of our residents, more effectively manage demand while continuing to deliver the best outcomes. All of our activity must maintain consistent attention on the impact of poverty on our communities and our ambition to reduce child poverty.

As a Community Planning Partnership we seek to:

- **MITIGATE** the impact of inequalities through provision of support and delivery of services;
- work to **PREVENT** individuals and communities experiencing inequalities; and
- take action and influence to **UNDO** the root causes of inequalities.

In all of our strategic decision making we will pay 'due regard' to how we can reduce inequality of outcome caused by socio-economic disadvantage and embed this thinking into everyday practice.

Linked Plans

The Wellbeing Delivery Plan does not aim to capture every priority for improving wellbeing. A range of delivery plans and strategies which impact on improving health and wellbeing sit alongside this Wellbeing Delivery Plan. Robust oversight arrangements are in place for progressing these.

- The Integration Joint Board's Strategic Plan for 2018-2021 sets out how we plan and deliver improvement linked to the national outcomes and integration principles;
- The Children and Young People's Service Plan 2017-2020 sets out a combined vision for the Children and Young People's Strategic Partnership and the Child Protection Committee;
- Adult Protection Committee;
- Alcohol and Drugs Partnership Delivery Plan (Monitored by the Alcohol and Drugs Partnership);
- East Ayrshire Violence Against Women Strategic Plan - Violence Against Women Partnership; and
- Joint Child Health and Wellbeing Statement - NHS Ayrshire and Arran;
- Community Justice Plan for Ayrshire - Community Justice Ayrshire;
- Pan-Ayrshire Health Improvement Plans, and;
- Financial Inclusion Strategy - Financial Inclusion Group.

The Strategic Plan 2018-2021 set the strategic commissioning direction of East Ayrshire Integration Joint Board over the planning period. The progress of this will be taken forward and monitored through the Integration Joint Board and its supporting arrangements, including reporting to East Ayrshire Council and NHS Ayrshire and Arran.

The Health and Social Care Partnership Strategic Plan for 2018-2021 will focus on the following https://www.east-ayrshire.gov.uk/Resources/PDF/E/EAHSCP-Strategic-Plan-2018-21.pdf:

- Scaling up our work on prevention and early intervention across all ages;
- Supporting New Models of Care and building capacity in Primary and Community Care;
- Ongoing partnership engagement about meeting challenges and creating opportunities, and;
- Transformation to ensure sustainability.

The Children and Young People's Strategic Partnership is delegated the responsibility for delivering the Children and Young People's Service Plan on behalf of the Community Planning Partnership.

Why Starting Well?

It is widely recognised that the early years are of crucial importance and can affect an individual's future health, wellbeing and life chances. Our approach is to identify and respond to strengths and to empower people, families/cares and communities to be in control of their lives, with access to opportunities and services (where required). This means shifting resources from crisis intervention to family and community support, which facilitates earliest possible identification of the need for additional support. Prevention and early intervention are the key to managing demand for more intensive supports.

There are considerable strengths for us to build on. There is a strong commitment to delivering the best start in life for all children and young people. We have a strong track record as a Corporate Parent and this is framed in a common shared language of Getting it Right for Every Child (GIRFEC). There is commitment to achieving equality in educational outcomes for every child and in closing the poverty-related attainment gap. In recent years, attainment in literacy and numeracy has increased from 78.9% in 2012 to 85.4% in 2016 (at SCQF Level 4), from 53.3% to 64.2% (at SCQF Level 5) and from 25.0% to 25.4% (at SCQF Level 6). Progress has been made in securing improvement in wellbeing outcomes across a range of child and maternal health measures. The numbers of looked after children have shown an overall decline in the last three years. This reflects the strategic approach in East Ayrshire, which has sought to stabilise the numbers of looked after children since 2009.

Some young people do not enjoy as good a start as their peers or as Community Planning partners would aspire to. Children living in households with an income below 60% of average earnings currently sits at 26.5% and is one of the highest of all partnership areas in Scotland. The impact of alcohol and drug use in our communities is considerable. Partners recognise the need to further improve.

Priority areas within our Children and Young Peoples Service Plan 2017-2020 include stretch aims for looked after children and young people - aspiring to ensure that there is no discernible difference between outcomes for our looked after children and their peers, redesigning and delivering services that shift resources to early intervention and prevention and to improve SHANARRI outcomes with a particular focus on improving breastfeeding, reducing smoking and alcohol consumption in pregnancy, identifying neglect and improving physical activity.

Why Living Well?

East Ayrshire residents are living longer with life expectancy increasing over the long term from 75.8 to 76.5 for men and 79.7 to 79.8 for women. The majority of adults and older people live independently without care or support within our communities. We have an ageing population and this represents success in improving our environment, advances in technology, support and treatment. At the same time, changes in our population, if they continue as they are, will result in significant increases in demand as the number of older people and people living with long-term conditions increases.

Many people are living with multiple long-term conditions that are preventable. This has consequences for the wellbeing of our residents. Deaths that can be attributed to smoking tobacco are significantly higher in East Ayrshire than across Scotland. We have a higher than average rate of alcohol-related hospital stays. Per head of population, the number of people being admitted to hospital for long-term conditions such as asthma, Chronic Obstructive Pulmonary Disease (COPD) and coronary heart disease is significantly greater than for the rest of Scotland. We also have higher levels of prescribing of medicines related to anxiety and depression.

Being unemployed or being in employment which is insecure or low-income can lead to higher risk of poor physical health, mental health and long-term conditions. There can be barriers to employment for people with disabilities. Over 15 per cent of our adult population is income deprived compared to 12 per cent for Scotland as a whole. The impact of welfare reform is expected to be considerable as 13.9 per cent of the population are in receipt of out of work benefits. Social isolation and loneliness has emerged as a particular priority through locality planning.

We want to empower and support individuals and communities to have choice, control and responsibility for their support and wellbeing. Building capacity for support in communities is a core part of the vision of a fairer, kinder and connected East Ayrshire. This will be central to addressing the challenges we have in managing demand for formal health and care services.

Empowering communities, families and individuals through preventative, early intervention and self-care approaches will be a key focus. Partners will prioritise work on self-care and health literacy initiative. Activity over the 2018-2021 period will include partnership engagement across communities to develop community led solutions to combat social isolation. There will be a focus on workforce development and increasing skills to support people to manage long-term conditions. We want to add life to years through intergenerational work and purposeful activity. Where formal support is needed, people will experience joined-up, integrated care and support. The role of unpaid carers will be recognised and supported, and we will work to ensure that carers have a life outwith caring.

Living well is about dying well too. Most people would prefer to die in their usual place of residence but can spend long periods of time in hospital at their end of life. The direction is for increasing choice over options and having compassionate conversations about end of life and palliative care.

Principles/Approach/Our Way of Working

- Tackling inequalities;
- Prevention and early intervention;
- Empowering communities, families and individuals to apply their strengths, skills and assets in improving wellbeing for all; and
- Care and support services are joined up, of high quality and accessible to those that requires them.

LOCAL OUTCOME 1	STARTING WELL

Links to Local Outcomes Improvement Plan • National Outcome(s)	**National Outcome 5: Our children have the best start in life and are ready to succeed** **National Outcome 7: We have tackled the significant inequalities in Scottish society** **National Outcome 8: We have improved the life chances for children, young people and families at risk** **National Outcome 16: Our public services are high quality, continually improving, efficient and responsive to our local people's needs**

PRIORITY	Children have the best start in life

Actions	
1.	**Children and Young People's Service Plan** We will make an active contribution to all wellbeing aspects of the delivery of the stretch aims set out in the Children and Young People's Service Plan 2017-20.
2.	**Protecting Children** We will support effective delivery of all wellbeing elements of the Child Protection Committee's prioritised areas of neglect, Internet Safety and Safeguarding.
3.	**Corporate Parenting** We will ensure that wellbeing partners play their part in the Corporate Parenting ambition of there being no discernible difference between outcomes for our looked after children and their peers.
4.	**Multi Agency Action Plans** Implementation of supporting multi-agency action plans linked to the Children and Young People's Service Plan 2017-20 and covering GIRFEC Practice Model; Emotional Health and Well Being; the Whole Systems Approach; Kinship Care; Corporate Parenting; Best Start in Life (Early Learning and Child Care Plan) and Young Carers.
5.	**Universal Services** Build on the strengths of the Health Visiting Universal Pathway, Education Services and Community Led Action Plans to connect up partners, communities and strategic planning.
6.	**Enablers** Implement a 'Wellbeing Champion' role from the membership of the Wellbeing Delivery Group to influence direction in partnerships related to Starting Well. Starting Well 'Champion' to develop a work programme and provide regular progress reports to the Wellbeing Group.

	Measures of Success Indicator(s) - (Frequency/Type/Source)	Baseline	'Progress' Target/s to 2021	'End' Target/s Direction of travel
1.	By 2020, participation by children and young people in extra-curricular, community sporting and physical activity (out with schools) will have grown by 15% (Source: EAC, Vibrant Communities, annual).	95,075 (2016-17)	**Increase** to 109,336	**Maintain** at 109,336
2.	Encourage early identification of neglect by increasing the number of non-police referrals to social work which identify neglect as the main concern (Source: HSCP information systems, annual).	Baseline determined Y1	**Increase** by agreed %	**Increase** by agreed %
3.	By 2020, reduce the percentage of pregnant women drinking 1+ units of alcohol per day by 50% (Baseline 30.8%, Scottish Average 6.4%) (Source: ISD, annual).	30.8%	**Reduce** to 15.4% by 2020	**Reduce** to Scottish Average
4.	By 2020, reduce the number of mothers smoking during pregnancy by 25% (Baseline 24.4% 2012-15, Scottish Average 18.5%) (Source: ISD, annual).	24.4%	**Reduce** to 18.3% by 2020	**Reduce** to 16.3%
5.	By 2020, the % of babies exclusively breastfed at 6-8 week review will be 28.2% (current Scottish average) (Baseline 14.7%, Scottish average 28.2%) (Source: ISD, annual).	14.7% (2015/16)	**Increase** to 28.2% by 2020	**Increase** to 28.2% by 2020
6.	By 2020, increase the percentage of 0-2 year olds registered with a dentist to 60%. (Baseline is 46.5%, national average 48.3%) (Source: ISD, annual).	46.5% (2016)	**Increase** to 60% by 2020	**Maintain** at 60%
7.	By 2020, the number of referrals to CAMHS will have a fallen by 20% (Source: CAMHS service, annual).	604 (2016)	**Reduce** to under 500 by 2020	**Maintain** at 500
8.	We aspire to ensure that all of our children are included in the education system. As a first step, by 2020, the rate of exclusions per 1,000 pupils across all schools in East Ayrshire will be reduced by 30% (Source: EAC, Education Services, annual).	Baseline 43.0 (2015/16)	**Reduce** to 28.8	**Reduce** to upper quartile
9.	By 2020, 100% of school pupils aged 10-18 and Ayrshire College students aged 15-18, will have accessed age-appropriate safety programmes related to online safety, allowing them to enjoy the internet, whilst showing resilience and an ability to take advantage of the positive opportunities the internet has to offer (Source: EAC/Ayrshire College, annual).	Baseline determined Y1	**Increase** to 100% by 2020	**Maintain** at 100%
10.	By 2020, we will endeavour to achieve all educational stretch aim targets set at local level for our looked after children (Source: EAC, Education Services, annual).	Reported through Economy and Skills Delivery Plan		

LOCAL OUTCOME 2	LIVING WELL

Links to Local Outcomes Improvement Plan • National Outcome(s)	**National Outcome 6: We live longer, healthier lives** **National Outcome 7: We have tackled the significant inequalities in Scottish society** **National Outcome 9: We live our lives safe from crime, disorder and danger** **National Outcome 15: Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it** **National Outcome 16: Our public services are high quality, continually improving, efficient and responsive to our local people's needs**

PRIORITY	**People are able to look after and improve their own health and wellbeing and live in good health for longer**

Actions	
1.	**A Healthier Future** • Scale-up universal prevention and early intervention work across Alcohol, Tobacco, Obesity and Mental Health (ATOM), with a focus on enabling more children and adults to have healthy weight, be physically active, and tackling stigma and addressing our relationship with alcohol. • Develop action plans across the ATOM themes of creating the environment, coproduction with communities, and service support. • Develop knowledge and skills of our workforce in the use of self-management and health literacy tools. • Develop and implement a communications strategy to ensure consistency in health and wellbeing messages. • Recruit and train peer researchers in localities to provide insight into what matters most for people's wellbeing in localities. • Establish a self-care campaign to increase awareness of the steps people can take to improve their wellbeing and reduce preventable ill-health.
2.	**A Connected East Ayrshire** • Work with the voluntary and community sector to develop capacity and solutions to combat loneliness and social isolation as part of creating a fair, kind and connected East Ayrshire. • Promote on-line/digital resources that connect people with community assets and sources of support in communities, including financial inclusion.

Actions	
	• Empower individuals and families to access and use technology to maximise independence and reduce need for formal supports by rolling-out 'Think TEC First' campaign. • Work across financial inclusion partners to offset the impact of Welfare Reform in our communities, including participation in the 'Menu for Change' programme aimed at tackling food insecurity. • Engage with unpaid carers in the coproduction and implementation of the East Ayrshire Carers Strategy 2018-21.
3.	**Work and Wellbeing** • Improve links between wellbeing and the range of employability supports through a health and wellbeing literacy programme and Community Connectors. • Act as exemplar models in supporting pathways to employability. • Increase participation in education, employment and training for people with learning disabilities, mental health problems and long-term conditions.
4.	**Integrated Supports** • Integrated models of care, including embedding the new multi-disciplinary front door arrangements in Community Health and Care. • Implement the East Ayrshire Models of Care Programme for Rehabilitation and Reablement. • Continue to redesign intermediate care at home services, modernise day hospitals and develop community based rehabilitation. • Work together to reduce the levels of delayed discharges, ensure services are in place to facilitate early discharge and avoid preventable admissions in the first place. • Develop and implement the Primary Care Improvement Plan in line with the new GP contract and Memorandum of Understanding.
5.	**Dying Well** • Improve coordination of end of life care with regard to sharing patient information and good practice. • Support practitioners across partners to have quality conversations with people, families and carers on end of life choices and planning. • Ensure that all staff involved in end of life care receive appropriate training to support the best possible quality of end of life care.
6.	**Enablers** • Prepare a comprehensive workforce plan across partners. • Implement a 'Wellbeing Champion' role from the membership of the Wellbeing Delivery Group to influence direction in partnerships related to the priority areas for Living Well. • Living Well 'Champions' to develop work programmes and provide regular progress reports to the Wellbeing Group.

Measures of Success Indicator(s) - (Frequency/Type/Source)		Baseline	'Progress' Target/s to 2021	'End' Target/s Direction of travel
1.	Percentage of adults able to look after their health very well or quite well (Source: Health and Care Experience Survey, bi-annual supplemented locally).	94% (2015/16)	**Increase** to 95%	**Increase** to 96%
2.	Percentage of adults supported at home who agree that they are supported to live as independently as possible (Source: Health and Care Experience Survey, bi-annual supplemented locally).	88% (2015/16)	**Increase** to 89%	**Increase** to 90%
3.	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided (Source: Health and Care Experience Survey, bi-annual supplemented locally).	79% (2015/16)	**Increase** to 83%	**Increase** to 88%
4.	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated (Source: Health and Care Experience Survey, bi-annual supplemented locally).	81% (2015/16)	**Increase** to 82%	**Increase** to 83%
5.	Percentage of adults receiving any care or support who rate it as excellent or good (Source: Health and Care Experience Survey, bi-annual supplemented locally).	86% (2015/16)	**Increase** to 88%	**Maintain** at 88%
6.	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (Source: Health and Care Experience Survey, bi-annual supplemented locally).	85% (2015/16)	**Increase** to 86%	**Increase** to 87%
7.	Percentage of carers who feel supported to continue in their caring role (Source: Health and Care Experience Survey, bi-annual supplemented locally).	51% (2015/16)	**Increase** to 55%	**Increase** to 60%
8.	Rate of emergency bed days for adults (Source: ISD, annual).	121,232 (2015/16)	**Reduce** by 4%	**Maintain** at 4% reduction level
9.	Readmissions to hospital within 28 days of discharge (Source: ISD, annual).	10.2% (2015/16)	**Reduce** to 9.2%	**Reduce** to 8.2%
10.	Number of days people spend in hospital when they are ready to be discharged (Source: ISD, annual).	6,043 (2015/16)	**Reduce** by 20%	**Reduce** to 1,173 bed days lost based on aim to discharge within 72 hours
11.	Proportion of last 6 months of life spent at home or in community setting (Source: ISD, annual).	86.6% (2013/14)	**Increase** to 89.4%	**Increase** to 91.7%
12.	Proportion of care services graded 'good' (4) or better in Care Inspectorate	86%	**Increase** to 87%	**Increase** to 88%

Measures of Success Indicator(s) - (Frequency/Type/Source)		Baseline	'Progress' Target/s to 2021	'End' Target/s Direction of travel
	Inspections (Source: Care Inspectorate, annual).	(2015/16)		
13.	Rate for alcohol related hospital stays per 100,000 population (Source: ISD, annual).	803.9 (2013/14)	**Reduction** to 790 per 100,000 population	**Reduction** to 697 per 100,000 population by 2030
14.	Number of bed days per 1,000 population for long term conditions (asthma, COPD, heart failure, diabetes) (Source: ISD, annual).	9,523 (2013/14)	**Reduction** to 8,877	**Reduction** to 8,712
15.	Life expectancy at birth – males/females (Source: NRS, annual).	75.8 years males 79.7 years females (2011-2013)	**Increase** to 76 years in male life expectancy **Increase** to 80 years in female life expectancy	**Increase** to 77 years in male life expectancy **Increase** to 81 years in female life expectancy
16.	Close the gap in the employment rate between the overall employment rate and the rate for people with learning disabilities, mental health problems and long-term conditions (Source: SCLD/Nomis, annual).	Established Year 1	**Reduce** to benchmark level	**Reduced**
17.	Rate for general acute and day case stays with a diagnosis of drug misuse per 100,000 population (Source: ISD, annual)	257.2 (2014/15)	**Reduction** to 230 per 100,000	**Reduction** to 182 per 100,000 by 2030