INVERCLYDE HSCP
Health and Social Care Partnership

Inverclyde Health and Social Care Partnership (HSCP)

Annual Performance Report 2023 - 2024

Inverclyde council

NHS Greater Glasgow and Clyde

Greenock Ocean Terminal, Inverclyde's new cruise ship visitor centre and community facility was officially opened on 25 August 2023. The project, led by Inverclyde Council, is part of the £1 billion Glasgow City Region City Deal funded by the Scottish and UK governments, with contributions from Peel Ports and the George Wyllie Foundation via Dunard Fund. The facility features an arrivals and departures hall, Scott's restaurant and bar, and the Wyllieum, an exhibition and gallery space due to open in 2024, paying tribute to famous artist George Wyllie who worked in Greenock and lived in Gourock.

Photo: David Barbour Photography Find out more about what Inverclyde has to offer at **discoverinverclyde.com**

This document can be made available in other languages, large print, and audio format upon request.

Arabic
هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

Cantonese
本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Gaelic
Tha an sgrìobhainn seo cuideachd ri fhaotainn ann an cànanan eile, clò nas motha agus air teip ma tha sibh ga iarraidh.

Hindi
अनुरोध पर यह दस्तावेज़ अन्य भाषाओं में, बड़े अक्षरों की छपाई और सुनने वाले माध्यम पर भी उपलब्ध है

Kurdisch
Li ser daxwazê ev belge dikare bi zimanên din, çapa mezin, û formata dengî peyda bibe.

Mandarin
本文件也可应要求，制作成其它语文或特大字体版本，也可制作成录音带。

Polish
Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formacie audio.

Punjabi
ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿਚ, ਵੱਡੇ ਅੱਖਰਾਂ ਵਿਚ ਅਤੇ ਆਡੀਓ ਟੇਪ 'ਤੇ ਰਿਕਰਾਡ ਹੋਇਆ ਵੀ ਮੰਗ ਕੇ ਲਿਆ ਜਾ ਸਕਦਾ ਹੈ।

Soraini
ئەم بەڵگەنامەیە دەتوانرێت بە زمانەکانی تر و چاپی گەورە و فۆرماتێکی دەنگی لەسەر داواکاری بەردەست بکرێت.

Tigrinya
እዚ ሰነድ እዚ ብኻልኦ ቋንቋታት፡ ብዓቢ ፊደላትን ብድምጺ ቅርጽን ምስ ዝሕተት ክቕርብ ይኽእል።

Urdu
درخواست پر یہ دستاویز دیگر زبانوں میں، بڑے حروف کی چھپائی اور سننے والے ذرائع پر بھی میسر ہے۔

Ukrainian
За запитом цей документ може бути доступний іншими мовами, великим шрифтом та аудіоформатом.

Inverclyde HSCP, Clyde Square, Greenock, PA15 1NB ☎ 01475 715365

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Foreword

Kate Rocks
Chief Officer of
Inverclyde HSCP

Welcome to our Annual Performance Report (APR). This is our eighth report and reflects the progress in 2023/2024 within Inverclyde Health and Social Care Partnership (HSCP). Over the past five years, our Strategic Plan 2019-2024 guided us with the focus being on our Six-Big Actions to improve health and wellbeing in Inverclyde.

This report is evidence that there is much to be proud of in Inverclyde, however it also highlights that Inverclyde Health and Social Care Partnership has challenges ahead. The past few years has been a particularly challenging time for our community and for the Health and Social Care Partnership. We are still recovering from the impact of the COVID19 Pandemic and have all felt the pressure of the national cost-of living crisis. The outcome of these factors has made a significant negative impact and legacy for the people of Inverclyde.

We have seen that the physical and mental health of our community has been adversely impacted, and alongside the national cost-of-living crisis has deepened the longstanding inequalities in Inverclyde. Despite this and the challenges we have faced, we are proud here in Inverclyde that we have made positive achievements in supporting the health and wellbeing of local people, we made a difference to thousands of people, families and carers in 2023/2024. This is down to the resilience and dedication of our health and social care staff and the excellent partnership working with our third sector colleagues and partners.

Our Annual Performance Report can only ever provide a snapshot of the performance across Inverclyde Health and Social Care Partnership and hopefully this report will provide some of the key performance and operational highlights we have achieved throughout 2023/2024. We will publish our new Strategic Partnership Plan (our Strategic Commissioning Plan) in Spring 2024, our new Strategic Partnership Plan recognises that we are not in the same place as we were before the pandemic and as such our strategic approach must change. We make a commitment to continually review our performance and develop our performance management arrangements in line with our new Strategic Priorities and with the aim of improving our performance to achieve better outcomes for our community.

The Health and Social Care Partnership and partners continue to be ambitious for our communities and this report highlights the positive outcomes the integration of health and social care services can have on our people and families.

It has been a privilege to lead the partnership through 2023/2024 and I continue to be proud of the work we do in and across Inverclyde.

Kate Rocks

Chief Officer

Inverclyde HSCP

SECTION 1: INTRODUCTION

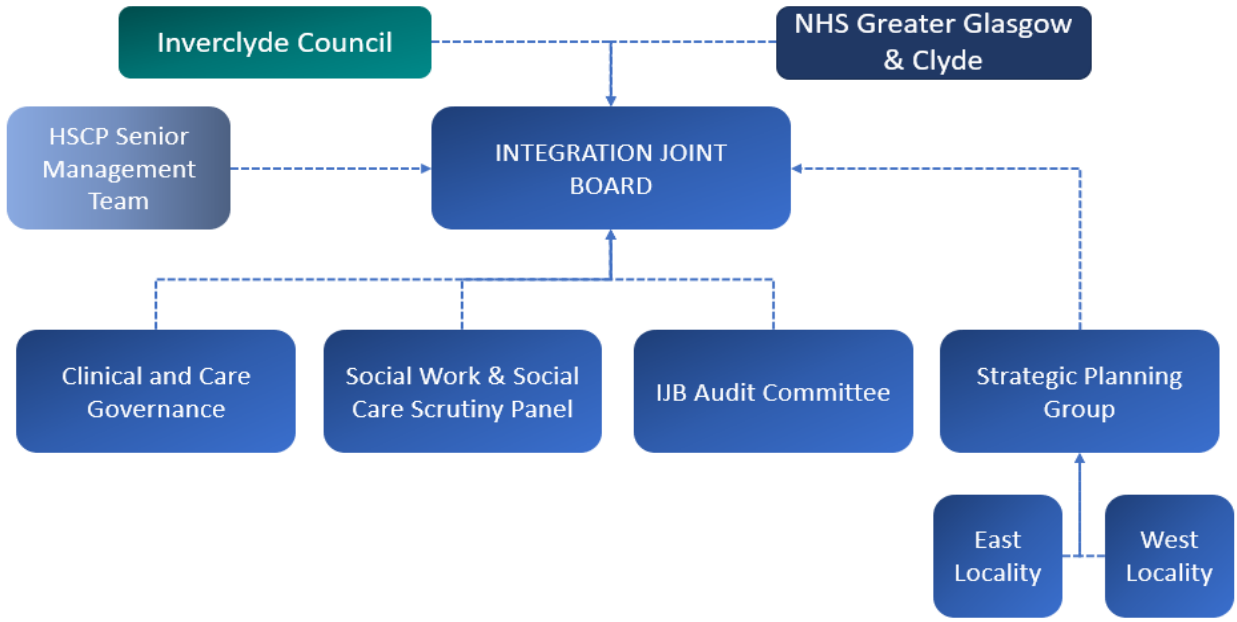
The Public Bodies (Joint Working) (Scotland) Act 2014 places an obligation on Integration Joint Boards (IJB) to publish an annual performance report at the end of July each year. This report should cover the previous service year (from April to March), and evidence how the IJB has made progress towards local health and care priorities and the nine national health and wellbeing outcomes.

This is the eighth report for Inverclyde IJB and in it we reflect on the last year (2023/2024) and considers the progress made in delivering the actions set out in our Strategic Plan, 'Improving Lives' (2019-2024), reflects on key service developments and innovation that has shone through; and reviews our performance against agreed National Integration Indicators (NII) and those indicators specified by the Ministerial Steering Group (MSG) for Health and Community Care.

IJB Governance

The image below shows the governance structure of Inverclyde IJB, highlighting its relationship with the parent organisations of Inverclyde Council and NHS Greater Glasgow and Clyde and identifies some of the key governance and strategic groups that support it.

Fig 1.1: Inverclyde Health and Social Care Partnership – Governance Structure



Structure of this report

The key components of this report are:

Section 1 - Introduction and overview of Inverclyde Health and Social Care Partnership. This also includes our high-level demographic information, an overview of our resources, services and the strategic vision as set out in our Strategic Plan

Section 2 – Presents scorecards detailing Key performance information in relation the national and local outcomes, and examples from across the Health and Social Care Partnership services as how we have been working to deliver our strategic priorities over the past 12 months. The section will include:

- Scorecards / Performance data / Trends
- National Integration Indicators (NII), Ministerial Steering Group (MSG), Local Government Benchmarking Framework (LGBF), Six big actions, Outcomes framework

Section 3 – Our improvement Journey, highlights examples of progress made towards the 6 Big-Actions from across the Health and Social Care Partnership. This section is organised by each big action and includes service narrative, infographics and case studies.

This section will also highlight the output of Care Inspectorate activity undertaken over the reporting year.

Section 4 - Financial information and best value.

Section 5 – Presents information on how we have engaged and encouraged participation with our local people, our communities, and stakeholders.

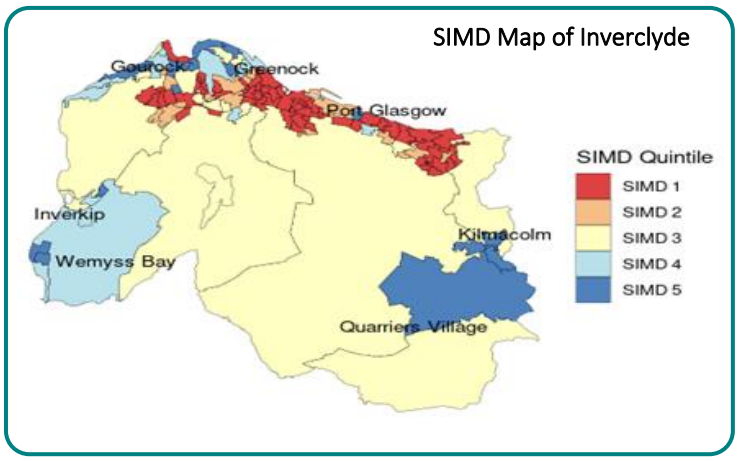
Appendix -

Overview of Inverclyde Health and Social Care Partnership

Inverclyde Health and Social Care Partnership is one of six partnerships operating within the NHS Greater Glasgow and Clyde Health Board area. We work closely with our fellow partnerships and continue to build on new and existing relationships with a focus on sharing good practice, developing, and delivering consistent approaches to working with our colleagues in acute hospital services. Inverclyde's population is spread in the main across the three towns of Greenock, Port Glasgow and Gourock with the remainder of the population living in the villages of Inverkip, Wemyss Bay, Kilmacolm and Quarriers Village.

Our local challenges

The level of poverty and inequality in Inverclyde is stark. According to the Scottish Index of Multiple Deprivation (SIMD), the levels of poverty and deprivation in Inverclyde are, proportionately amongst the highest in Scotland. It reports that **43%** of local people live in areas that are among the most deprived in the country (SIMD 1). This is second only to Glasgow, where 44% of the population live in SIMD 1 areas.



People living in those areas are more at risk of the negative impacts of poverty and deprivation. As a result, they are more likely to experience several adverse outcomes, including physical health challenges, complex long-term medical conditions, negative mental health and wellbeing, social exclusion, and food insecurity.

While levels of poverty and deprivation are high in Inverclyde, they are not spread evenly among the population. As figure 1.1 shows, areas of high deprivation are not dispersed across Inverclyde, instead high deprivation areas are clustered across specific communities, particularly in Port Glasgow and the East End of Greenock.

As a result, levels of inequality in Inverclyde are high with many people and communities experiencing significantly less positive social, economic and health and wellbeing outcomes than residents in least deprived areas.

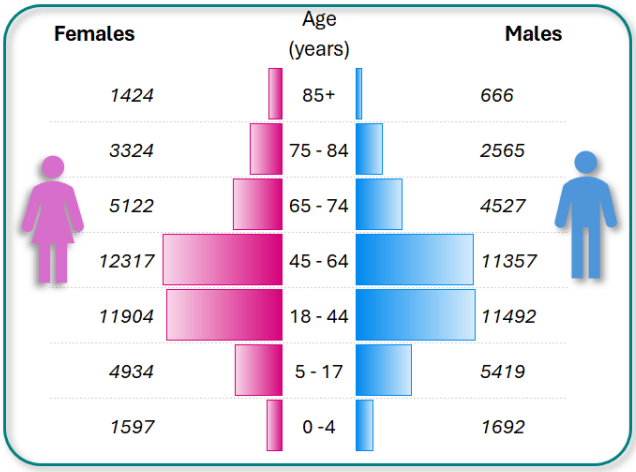
Inverclyde Today

The following section provides some key information about Inverclyde, Including local demographics and health and care demographics. A snapshot infographic from our Strategic Needs Assessment has also been provided at appendix 3.

Population

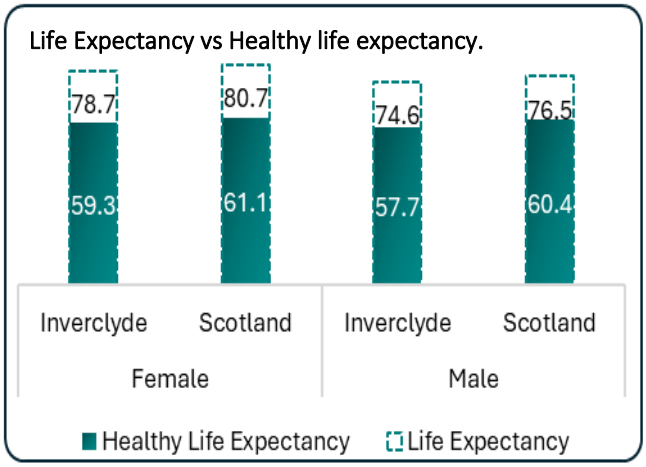
The latest population estimates for Inverclyde were published by National Records for Scotland (NRS) in March 2023, estimating for mid-year 2022.

Overall, Inverclyde had an estimated total population of **78,340**. This accounts for only 1.4% of Scotland's total. Like other places in Scotland, the population of Inverclyde has decreased over the past few years. This is expected to continue with the local population expected to decrease by a further 3.2% by 2028. The image opposite, shows the breakdown of the local population by Sex and key age group. Overall, females account for **52%** of the local population.



Life and Healthy Expectancy

For the latest reporting period, it has been reported that for both men and women living in Inverclyde, their life expectancy is lower than that of the Scottish average. In Inverclyde, women have a life expectancy of 78.7 (against 80.7 across Scotland), with male life expectancy reported as 74.6 (with 76.5 reported for Scotland).

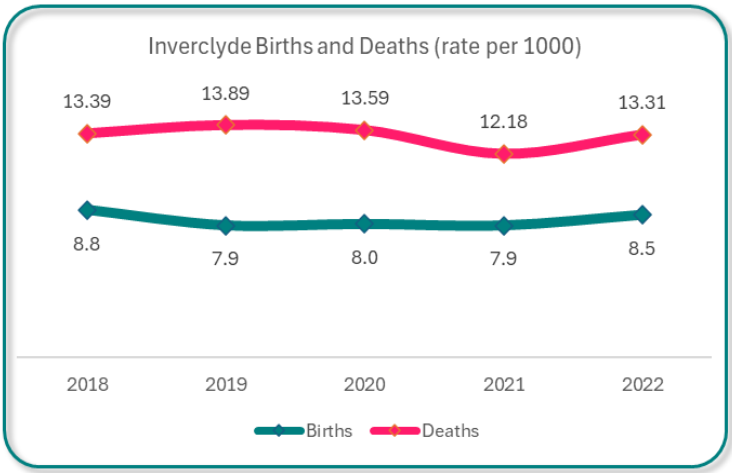


Like overall life expectancy, the Healthy life Expectancy of people in Inverclyde is lower than the Scottish average. The healthy life expectancy of females living in Inverclyde is 59.3 years, compared to 61.1 years for Scotland as a whole. Males in Inverclyde have a healthy life expectancy of 57.7 years, again lower than the Scottish figure of 60.4)

Births and Deaths

NRS reported an increase in the local birth rate in Inverclyde, rising to 8.5 births (crude rate per 1000 of the local population). This is compared to 7.9 reported in 2021. At 8.5, the birth rate in Inverclyde was slightly lower than the overall Scottish figure of 8.6.

NRS also reported an increase in the rate of deaths in Inverclyde, rising to 13.31 per 1000 (age-sex standardised rate). This compares to 12.18 per thousand reported in 2021.



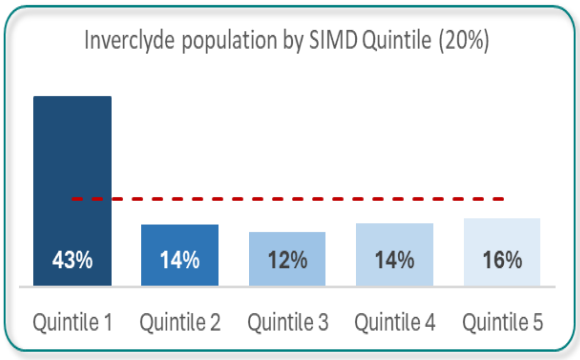
Again, the rate of deaths in Inverclyde is higher than 11.52 reported for Scotland as a whole.

The chart opposite demonstrates how the Inverclyde death rate has been continually higher than the birth rate over the past five years. This is a contributing factor to the local population decline.

Deprivation

As highlighted before (page 7) Inverclyde faces a significant challenge in the form of poverty and deprivation. The most recent Scottish Index of Multiple Deprivation (SIMD) figures (2020) highlight that **43%** of the local population live in areas that are considered the most deprived in Scotland.

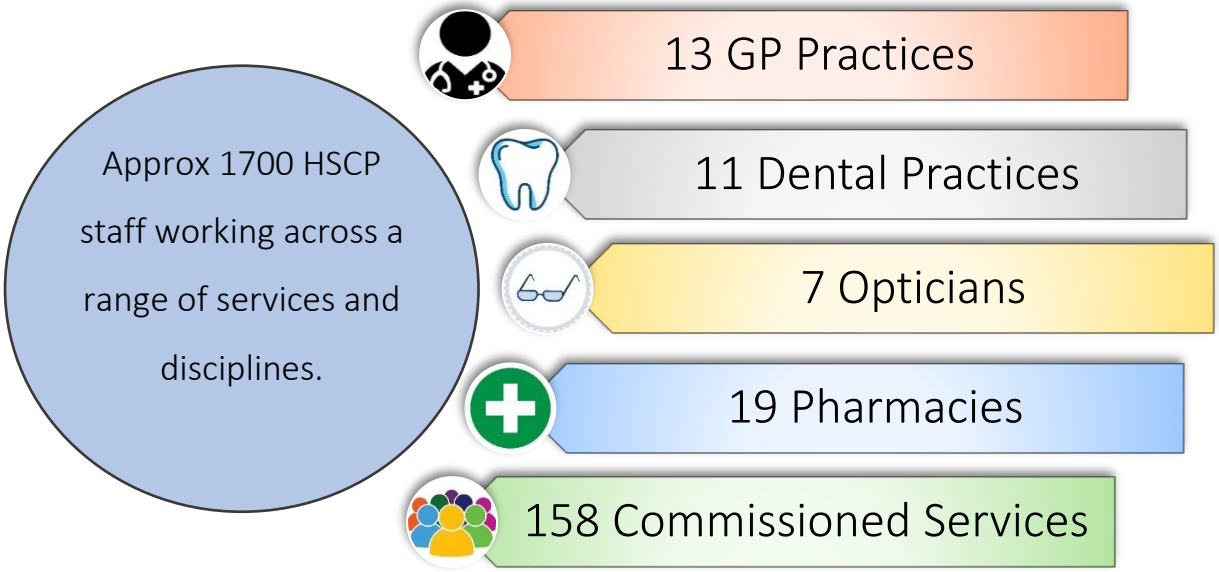
The image opposite demonstrates the breakdown of quintiles in Inverclyde. As highlighted, over 40% of the local population live in the most deprived quintile, with the rest of the population more evenly distributed across the other four.



In addition, child poverty in Inverclyde is amongst the highest in Scotland, with almost 1 in 4 (24%) of local young people affected.

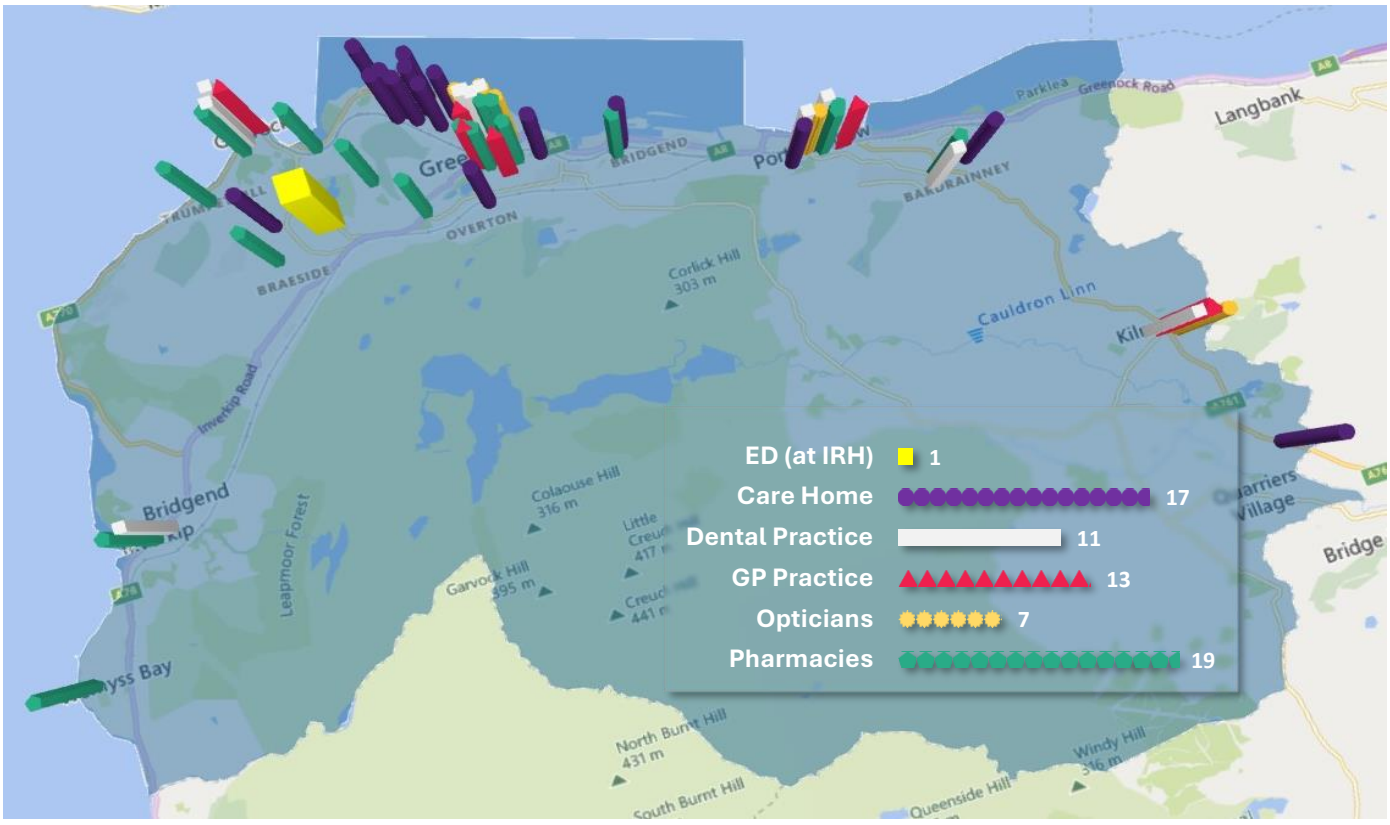
Our resources

The HSCP delivers an extensive range of services across primary care, health and social care and through several commissioned services.



Services Map

The graphic below shows the map of services available across Inverclyde, provided or commissioned by the Health and Social Care Partnership.



Strategic Direction

Inverclyde Integration Joint Board set out through its five-year Strategic Plan (2019-24) and the Six Big Actions, our ambitions, and our vision. This plan set the direction for how we would deliver our services to improve the health and wellbeing of local people. The Big Actions gave a focused view of Inverclyde's health and care priorities and how services would support our communities. The big actions were:

Big Action 1: Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health	Big Action 2: A Nurturing Inverclyde will give our Children and Young People the Best Start in Life	Big Action 3: Together we will Protect Our Population
Big Action 4: We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living	Big Action 5: Together we will reduce the use of, and harm from alcohol, tobacco and drugs	Big Action 6: We will build on the strengths of our people and our community

These big actions reflected the many conversations we had with people across Inverclyde including our professional colleagues; staff; those who use our services including carers; and our children and young people across all sectors and services. Within Inverclyde we fully support the national ambition of ensuring that people get the right care, at the right time, in the right place and from the right service or professional.

The five-year plan was refreshed throughout 2022/23 to reflect updated priorities and key deliverables for 2023/24. The refreshed plan retained the Six Big Actions which link clearly with the nine National Outcomes for Scotland and the National Outcome Framework for Children, Young People and Community Justice.

Our refreshed Strategic Plan and associated Implementation Plan and Performance Framework led the IJB forward for 2023/24 and plans are already underway for development of the next Strategic Plan for 2024/25 onwards. The refreshed plan and associated documents can be accessed here Strategies, Policies and Plans - Inverclyde Council

Our Vision

Through our services, our support and local collaboration we hope that all people in Inverclyde, can live a full, healthy life and face no barriers to accessing opportunities or achieving positive outcomes. This is captured in our Vision, which is:

Inverclyde is a caring and compassionate community, working together to address inequalities and assist everyone to live active, healthy, and fulfilling lives.

We recognise that local challenges and barriers exist that may prevent people from realising this vision. The Inverclyde Adult Health and Wellbeing Survey (Feb 2024) produced by NHS Greater Glasgow and Clyde, has highlighted that post pandemic the local inequalities in Inverclyde has increased. These inequalities must be addressed if we are to improve the health, wellbeing, and life chances of local people.

We are ambitious for our people in Inverclyde and recognise our responsibilities to improving health and social care outcomes.

The challenges will not be overcome by continuing to do things the same way they have always been done. We will work differently, together, along with other key partners, to improve services, improve health and wellbeing outcomes and focus on reducing inequalities. This will contribute to our vision that Inverclyde is a caring and compassionate community working together to address inequalities and assist people to live active, healthy, and fulfilling lives.

Going forward

The five-year strategic plan, 'Improving lives,' expired in March 2024. This has now been succeeded by a new Strategic Partnership Plan, 'People and Partnership's, Making a Difference.' This new plan, and it is agreed priorities will inform the strategic direction of Inverclyde HSCP over the next three years (2023-27).

As a result, this will be the final Annual Performance Report, reporting against the 'Improving Lives' strategic plan and the Six-Big Actions.

Our new strategic plan can be found on our website, https://www.inverclyde.gov.uk/assets/attach/17175/Inverclyde_HSCP_Strategic-Partnership-Plan-2024-27-IJB-Approved-.pdf

SECTION 2: PERFORMANCE

This section of the report will focus on our key performance over the 2023/24 service year and provides a range of national and local data and activity, including examples of innovation structured around our Six Big Actions.

National Reporting Obligations

We require to report on the nine National Health and Wellbeing Outcomes for adult health and social care services, and the national outcomes for Children, Families and Justice. Again, are all structured and reported using our Six Big Actions. Appendix 1 (page 65) shows all the National Outcomes.

This section contains information on

- the 23 National Integration Indicators (NII).
- the Ministerial Steering Group (MSG) Indicators.
- the Local Government Benchmarking Framework (LGBF).
- Inverclyde HSCP Local Performance Indicators.

The following scorecards have been collated to show how Inverclyde Health and Social Care Partnership has performed against a variety of measures in the last year. This year's performance has been compared against previous years and against the rest of Scotland as a benchmark. The following table shows what is included in the scorecards and how to interpret the information.

Column	Description		
Indicator	Description of the measure being shown. Type of measure also shown (Total, %, Rate per 1,000 population)		
Rate	The most recent measure for Inverclyde HSCP (2022/23 or otherwise specified)		
Difference from Previous Year (%)	Percentage change in last year of recording.	●	Performance has improved since the previous year
		▲	Performance has stayed the same since the previous
		◆	Performance has declined since the previous year
Difference from Scottish Rate	Percentage difference from the most recent Scottish average.	●	Performance is better than the Scottish average
		▲	Performance is the same as the Scottish average
		◆	Performance is below the Scottish average
HSCP Rank	Ranks Inverclyde within the 31 HSCPs across Scotland. Rank 1 is the highest rate, Rank 31 is the lowest rate. The colour shows whether or not a high rank signals good performance or bad performance. NOTE: For the LGBF indicators - these are ranked 1 to 32 for the Local Authorities instead of 31 HSCPs. **Rank 1 for LGBF indicators signifies the best performing area, as per the LGBF website.**	●	Performance ranks in the top 16 HSCPs across Scotland
		▲	Performance ranks between 17 and 25 of the HSCPs
		◆	Performance ranks in the bottom 7 HSCPs across Scotland
5-year Trend	A spark-line chart showing the trend in Inverclyde in the past 5 years. The red dots represent the highest and lowest points		

National Integration Indicators

Supporting the nine national Health and Wellbeing Outcomes (outlined in appendix A) are 23 National Integration Indicators against which the performance of all HSCPs in Scotland is measured, the data for these is provided by Public Health Scotland on behalf of the Scottish Government. These indicators are grouped into two types of complementary measures:

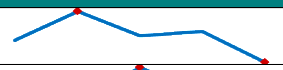
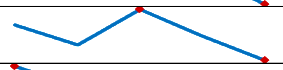
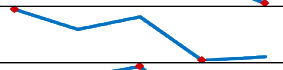
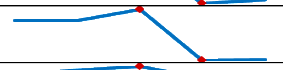
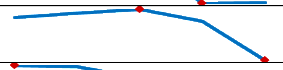
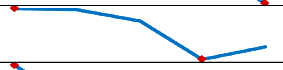
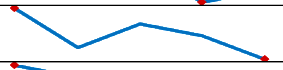
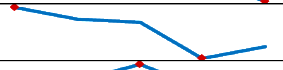
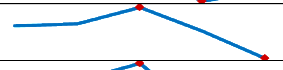
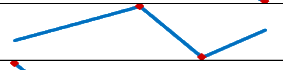
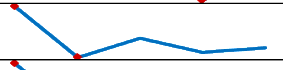
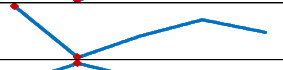
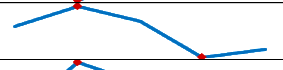
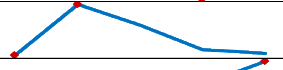
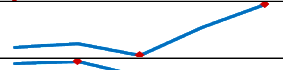
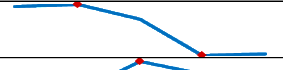
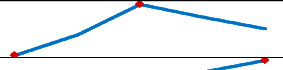
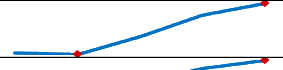
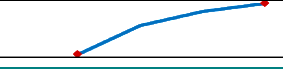
1. Outcome indicators based on survey feedback- The Health and Care Experience survey (HACE) is sent to a random sample of patients who are registered with a GP practice in Scotland. Updated every two years - most recent data is 2023/24.

2. Data indicators- Primarily sourced from Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. In accordance with Public Health Scotland recommendations, the most recent reporting period available is calendar year 2023; this ensures that these indicators are based on the most complete and robust data currently available.

The most recent data for these indicators is shown in the scorecard overleaf, but some key points to note are:

- ✓ Measures sourced from Health and Care Experience survey have been updated for the 2023/24 period. For seven of the nine outcomes measures, Inverclyde Health and Social Care Partnership ranks well against other HSCP areas. We also have performed better than Scotland as whole against six of the measures.
- ✓ When comparing to the last reported performance, Inverclyde Health and Social Care Partnership has performed better against four of the measures but has not achieved the same level of performance for the remaining five measures.
- ✓ To note is indicator 1, relating to adults' perception of looking after their health. For this indicator, Inverclyde under-performed against the previous reporting period, compared unfavourably with Scotland as a whole and ranked 26 among all Scottish Health and Social Care Partnership s. This indicates an area for focused improvement.
- ✓ For the 10 data indicators, Inverclyde Health and Social Care Partnership performed the same as, or better than Scotland as a whole for five indicators and ranked unfavourably against other HSCP against six measures.
- ✓ While we ranked unfavourably with other Health and Social Care Partnerships for the Emergency Bed Day Rate, Inverclyde experienced an improvement in performance in this area.
- ✓ For both indicators, percentage of adults with intensive needs receiving Care at Home, and Number of Days people (75+) spend in hospital when they are ready to be discharged, despite performing poorer than the previous reporting period, Inverclyde Health and Social Care Partnership compares favourably with Scotland and ranks well among all HSCPS.

National Integration Indicators

Indicator Number	Indicator	Value	Difference from Previous Year (%)	Difference from Scotland (%)	HSCP Rank	5 Year Trend (spark line)	Most recent data
1	Percentage of adults able to look after their health very well or quite well	88.9%	-1.2%	-1.7%	26		2023/24
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	75.9%	-7.0%	+3.5%	13		2023/24
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	67.8%	+1.1%	+8.2%	6		2023/24
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	68.7%	+0.1%	+7.3%	5		2023/24
5	Total % of adults receiving any care or support who rated it as excellent or good	70.7%	-10.6%	+0.7%	16		2023/24
6	Percentage of people with positive experience of the care provided by their GP practice	65.0%	+6.3%	-3.6%	22		2023/24
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	73.6%	-6.0%	+3.9%	10		2023/24
8	Total combined percentage of carers who feel supported to continue in their caring role	31.9%	+3.2%	+0.7%	15		2023/24
9	Percentage of adults supported at home who agreed they felt safe	72.7%	-9.2%	0.0%	16		2023/24
11	Premature mortality rate for people under age 75 per 100,000 persons	541.9	+6.5%	+22.6%	28		2022
12	Emergency admission rate (per 100,000 population) for adults (18+)	12,689	+2.0%	+8.4%	19		2023
13	Emergency bed day rate (per 100,000 population) for adults (18+)	148,350	-3.8%	+31.4%	30		2023
14	Emergency readmissions to hospital for adults (18+) within 28 days of discharge (per 1,000 discharges)	79.2	+4.3%	-23.8%	5		2023
15	Proportion of last 6 months of life spent at home or in a community setting	87.7%	-0.1%	-1.4%	29		2023
16	Falls rate per 1,000 population aged 65+	25.7	+8.1%	+11.7%	26		2023
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	80.6%	+0.2%	+3.6%	15		2023/24
18	Percentage of adults with intensive care needs receiving care at home	67.4%	-1.0%	+2.6%	13		2023
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	553.8	+20.5%	-38.6%	9		2023/24
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	25.3%	+0.4%	+1.3%	24		2019/20

Ministerial Steering Group (MSG) Indicators

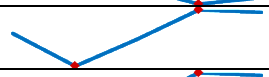
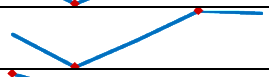
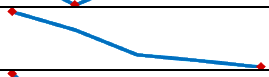
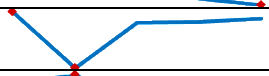
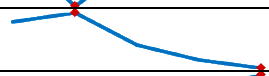
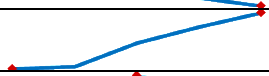
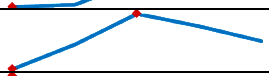
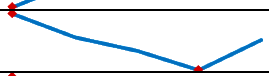
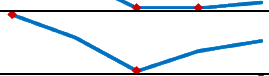
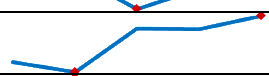
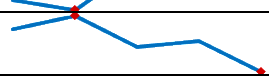
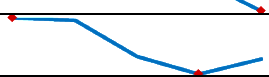
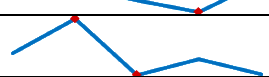
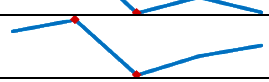
The MSG Performance indicators provide a focus on hospital-based performance within Health and Social Care Partnership areas, specifically around Unscheduled Care such as Accident and Emergency attends, Emergency Admissions and Unplanned Bed Days (in hospital).

The Ministerial Strategic Group (MSG) data is based on a patient's postcode. When an instance of Unscheduled Care occurs (i.e., an individual attends Emergency Department), the individual's postcode is recorded and is used to assign to the relevant Health and Social Care Partnership. The MSG performance data is produced monthly by Public Health Scotland but has a three-month time lapse due to the collection and cleansing of the data.

These indicators are used extensively by services to predict surges in demand and to plan our services effectively. The information provided in the following Scorecard is the most recent annual figures available. Some key points to note are:

- ✓ There has been a 2.8% increase in emergency admissions compared to the previous reporting period. While our rate of admissions is above Scottish average, Inverclyde has seen an improving trend over the past five years.
- ✓ Inverclyde has made modest improvements on the overall number of unplanned bed days compared to the previous year but continues to compare unfavourably with Scotland as a whole. This is also true for unplanned Mental Health Admissions. However, while the number of unplanned admissions for Geriatric Long Stays has increased, Inverclyde compares favourably against Scotland as a whole.
- ✓ Inverclyde has seen a decrease in the number of people seen within the 4hr target at the emergency department, however, we compare favourably to Scotland as a whole and Rank 9th against other Health and Social Care Partnership areas.
- ✓ Similarly, the number of delayed discharges has increased for 2023/24, but again Inverclyde has performed better than Scotland as a whole, and again is ranked 9th among Health and Social Care Partnership s.
- ✓ In terms of palliative care, while there was modest decrease in the number of people supported in the last six-months of life at home, Inverclyde performed better than Scotland as a whole and ranked 4th against all HSCPs. For those supported in a Care Home, Inverclyde performed better than the Scottish Average and achieved a rank of 2nd amongst all Health and Social Care Partnership.

Ministerial Steering Group (MSG) Indicators

Indicator Number	Indicator	Value	Difference from Previous Year (%)	Difference from Scotland (%)	HSCP Rank	5 Year Trend	Most recent data
1	Number of emergency admissions (18+)	7,555	+2.8%	+1.6%	17		2023
2a	Number of unplanned bed days - Acute (all ages)	79,663	-0.8%	+32.4%	27		2023
2b	Number of unplanned bed days - Geriatric Long Stay (all ages)	303	+98.0%	-88.9%	NA		2023
2c	Number of unplanned bed days - Mental Health (all ages)	18,321	-7.1%	+29.3%	26		2023
3a	Number of A&E attendances (all ages)	29,908	+2.0%	+40.2%	31		2023/24
3b	A&E % Seen within 4 hrs	76.2%	-2.4%	+8.0%	9		2023/24
4	Number of delayed discharge bed days (Age 18+)	6,562	+25.2%	-32.3%	9		2023/24
5	% of Last Six Months of Life by Setting (Community - all ages)	87.8%	-0.7%	-1.2%	27		2022/23
5	% of Last Six Months of Life by Setting (Hospice / PCU - all ages)	0.6%	+0.3%	+0.3%	23		2022/23
5	% of Last Six Months of Life by Setting (Community Hospital - all ages)	0.0%	+0.0%	-1.5%	6		2022/23
5	% of Last Six Months of Life by Setting (Large Hospital - all ages)	11.5%	+0.4%	+2.5%	28		2022/23
6	Balance of Care: % of pop in community or institutional settings (Home unsupported - 65+)	89.6%	+0.3%	-2.4%	29		2022/23
6	Balance of Care: % of pop in community or institutional settings (Home supported - 65+)	5.9%	-0.5%	+1.6%	4		2022/23
6	Balance of Care: % of pop in community or institutional settings (Care home - 65+)	3.3%	+0.1%	+0.6%	2		2022/23
6	Balance of Care: % of pop in community or institutional settings (Hospice / PCU - 65+)	0.02%	+0.01%	+0.01%	26		2022/23
6	Balance of Care: % of pop in community or institutional settings (Community hospital - 65+)	0.0%	-0.0%	-0.1%	5		2022/23
6	Balance of Care: % of pop in community or institutional settings (Large hospital - 65+)	1.2%	+0.0%	+0.3%	29		2022/23

The Local Government Benchmarking Framework (LGBF)

The Local Government Benchmarking Framework (LGBF), published by the Improvement Service, is a high-level benchmarking tool which aims to develop better measurement and comparable data as a catalyst for improving services, targeting resources to areas of greatest impact and enhancing public accountability.

The framework provides high-level 'can openers' which are designed to focus questions on why variations in cost and performance are occurring between similar councils. The Local Government Benchmarking Framework helps councils compare their performance against a suite of efficiency, output and outcome indicators that cover all areas of local government activity.

Several of the indicators are for services delivered by the Health and Social Care Partnership (children and adult services) therefore included within this HSCP Annual Performance Report. Further detail on the indicators can be found on the Local Government Benchmarking Framework website: Benchmarking | Benchmarking (improvementservice.org.uk)

Some key points to note are:

- ✓ The gross cost of children in a residential setting has decreased by 25% compared to 2022/23. Inverclyde also compares favourably with Scotland, with average costs almost 18% higher than Inverclyde.
- ✓ Alternately, the cost of children cared for in a community setting has increased compared to the previous reporting period. However, for this indicator Inverclyde still performs better than Scotland as whole and is ranked 9th across all Local Government Benchmarking Frameworks.
- ✓ Inverclyde has experienced a modest improvement against the number of children reaching developmental milestones but compares unfavourably to Scotland as a whole. This can in part be attributed to the high levels of local child poverty.
- ✓ Inverclyde reported no child protection registrations with 18 months for the latest reporting period, this translates to a 10.4% reduction on the previous reporting year and ranks Inverclyde 1st for this indicator across Scotland.
- ✓ There was an 4.1% increase in Direct Payments and Personalised Budgets, comparing favourably to Scotland as a whole and ranking Inverclyde 4th across all local authorities.
- ✓ 2023/24 reported an increase in the cost of care at home per hour. The Inverclyde rate was reported as higher than the Scottish average and we ranked 25 across all local authorities.
- ✓ Inverclyde performed unfavourably for the weekly cost of residential care for those over 65years.

The Local Government Benchmarking Framework (LGBF)

Indicator Number	Indicator	Value	Difference from Previous Year (%)	Difference from Scotland (%)	Local Authority Rank	5 Year Trend (spark line)	Most recent data
CHN8a	The Gross Cost of "Children Looked After" in Residential Based Services per Child per Week	£ 3,946	-25.1%	-17.9%	11		2022/23
CHN8b	The Gross Cost of "children looked after" in a community setting per child per week	£ 342	+45.4%	-19.0%	9		2022/23
CHN9	Percentage of children being looked after in the community	81.2%	-5.1%	-8.0%	26		2022/23
CHN17	Percentage of children meeting developmental milestones	75.1%	+0.9%	-6.9%	29		2022/23
CHN22	Percentage of child protection re-registrations within 18 months	0.0%	-10.4%	-5.6%	1		2022/23
CHN23	Percentage LAC with more than 1 placement in the last year	14.0%	+4.0%	-3.2%	11		2022/23
CHN24	Percentage of children living in poverty (after housing costs)	24.4%	+6.1%	+1.8%	21		2021/22
SW01	Home care costs per hour for people aged 65 or over	£ 48.08	+11.1%	+57.9%	27		2022/23
SW02	Direct Payments and Managed Personalised Budgets spend on adults 18+ as a percentage of total social work spend on adults 18+	11.8%	+4.1%	+3.1%	4		2022/23
SW03a	Percentage of people aged 65 or over with long-term care needs receiving personal care at home	65.0%	-2.3%	+3.5%	8		2022/23
SW04b	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	79.6%	-3.2%	+1.5%	12		2021/22
SW04c	Percentage of adults supported at home who agree that they are supported to live as independently as possible	82.9%	-7.7%	+4.1%	7		2021/22
SW04d	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	66.7%	-15.1%	-3.9%	25		2021/22
SW04e	Percentage of carers who feel supported to continue in their caring role	28.7%	-10.2%	-1.0%	21		2021/22
SW05	Residential costs per week per resident for people aged 65 or over	£ 733	+17.9%	+7.2%	27		2022/23
SW06	Rate of readmission to hospital within 28 days per 1,000 discharges	78	-13.5%	-22.9%	5		2022/23
SW07	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	80.0%	-5.1%	+5.0%	11		2022/23
SW08	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)	460	+57.7%	-50.0%	7		2022/23

Big Action Indicators

During 2023/24, a performance framework made up of local and national key indicators had been developed for each big action. As this is a relatively new dataset, some data is not available for previous years, however going forward progress against performance will be monitored. Scorecards are provided below for each of the Six-Big Actions:

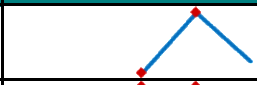
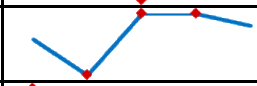
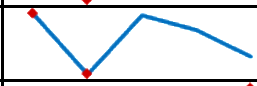
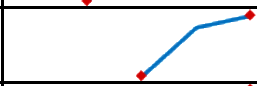
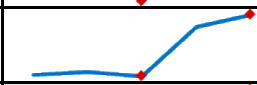
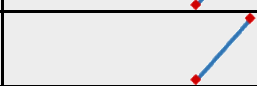
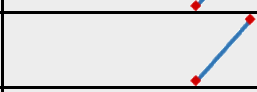
Big Action 1: Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health	Big Action 2: A Nurturing Inverclyde will give our Children and Young People the Best Start in Life	Big Action 3: Together we will Protect Our Population
Big Action 4: We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living	Big Action 5: Together we will reduce the use of, and harm from alcohol, tobacco and drugs	Big Action 6: We will build on the strengths of our people and our community

Each action Scorecard is preceded with summary narrative highlighting some of the key aspects of the indicators provided.

Big Action 1: Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health

- The number of referrals to Primary Care Community Link Workers seen a % decrease in 2023/24. 1,417 people were referred to the service during the year against the 1,533 reported in 2022/23. However, the 2023/24 referral figure is higher than the 1,387 initially achieved in 2021/22.
- During 2023/34, 84% of referrals to Psychological Therapies were seen within the 18 week target time. This is a decrease of the 91% from the previous year.
- There was a decrease in the number of referrals to Post Diagnostic Support for Dementia, with 85 people being referred during 2023/24. There has been a decreasing trend for this indicator over the past two years.
- Over the past two years, we have seen increases in referrals to the Distress Brief Intervention Programme, with a 14.4% increase reported for the service year, and in New and Returning Referrals to Advice Services, with an 18% increase in the past year.
- The number of Cost of Living Payments provided to local people is a relatively new indicator, initially reporting in 2022/23. Between, 2022/23 and 2023/24, the number of payments has increase by 465.8% to 2,269 across Inverclyde. In 2022/23 data was only reported from the start of February 2023 to 31st March 2023. This data is also provided by SIMD Quintile. Each quintile experienced an increase in the number of people receiving payments. Also, as anticipated, the greatest volume of payments were made in Quintile 1 data-zones, the most deprived. This supports the goals of the partnership in ensuring we are focussing resource and support in the right areas.

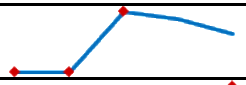
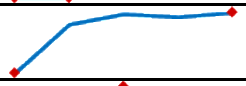
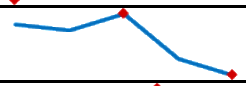
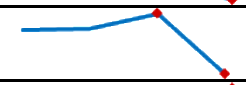
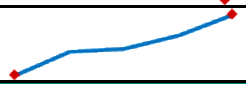
Big Action 1: SCORECARD

Indicator Number	Indicator	Value	Difference from Previous Year (%)	5 Year Trend (spark line)	Most recent data
SPI 1.1	Number of referrals to Primary Care Community Link Workers	1,417	-7.6%		2023/24
SPI 1.2	Psychological Therapies: - Percentage of patients seen within 18 week RTT target	84.0%	-7.0%		2023/24
SPI 1.3	Number of referrals to PDS (Post Diagnostic Support Dementia)	85	-29.2%		2023/24
SPI 1.4	Number of referrals to Distress Brief Interventions (DBI) programme	494	+14.4%		2023/24
SPI 1.5	Number of new and returning service users to Advice Services	2,507	+18.1%		2023/24
SPI 1.6	Number of cost of living support payments made (broken by SIMD area) (TOTAL)	2269	465.8%		2023/24
SPI 1.6 (a)	Number of cost of living support payments made (broken by SIMD area) (SIMD 1)	1706	464.9%		2023/24
SPI 1.6 (b)	Number of cost of living support payments made (broken by SIMD area) (SIMD 2)	219	329.4%		2023/24
SPI 1.6 (c)	Number of cost of living support payments made (broken by SIMD area) (SIMD 3)	200	952.6%		2023/24
SPI 1.6 (d)	Number of cost of living support payments made (broken by SIMD area) (SIMD 4)	43	126.3%		2023/24
SPI 1.6 (e)	Number of cost of living support payments made (broken by SIMD area) (SIMD 5)	16	60.0%		2023/24
SPI 1.6 (f)	Number of cost of living support payments made (broken by SIMD area) (Not Known)	85	-		2023/24

Big Action 2: A Nurturing Inverclyde will give our Children and Young People the Best Start in Life

- This was the first year of reporting the number of Looked After Children medicals carried out. Over the year, 61 medicals were carried out within the 6 week timescale.
- During 2023/34, there was a 9.5% decrease in the number of formerly looked after young people in continuing care. This is possibly reflective of the support provide to young people during the aftercare period.
- During the year, Child and Adolescent Mental Health Services (CAMHS) continued their high standard by supporting 99.6% of young people to be treated within the target of 18 weeks from referral.
- Throughout 2023/24, 72% of young people who were required to be looked after away from home, were able to be cared for in Inverclyde. This is a slight decrease of 3% compared to the previous year.
- Over the past year, we have seen a 2.5% increase in the number of women exclusively breastfeeding their babies at the first visit. This makes up 23.2% of all women who gave birth during the year.

Big Action 2: SCORECARD

Indicator Number	Indicator	Value	Difference from Previous Year (%)	5 Year Trend (spark line)	Most recent data
SPI 2.1	Number of LAC medicals carried (access of 6 weeks referral to treatment)	61	-	-	2023/24
SPI 2.2	Number of young people in receipt of continuing care	19	-9.5%		2023/24
SPI 2.3	Percentage of referral to treatment time target met for Children & Young People in Inverclyde, Children and Adolescent Mental Health Services (CAMHS)	99.6%	+1.1%		2023/24
SPI 2.4	Percentage of looked after children and young people who require to be cared away from home, who continue to reside in Inverclyde	72.0%	-3.0%		2023/24
SPI 2.5	Percentage of children vaccinated for MMR	90.0%	-2.0%		2023/24
SPI 2.6	Percentage of woman breastfeeding exclusively at first visit in Inverclyde	23.2%	+2.5%		2022/23

Big Action 3: Together we will Protect Our Population

- During 2023/24 we have seen a 6.1% increase in the number of referrals to Children's Services that progress to a Child Protection Investigation. This an increase of five referrals against the previous year but is in line with overall trends.

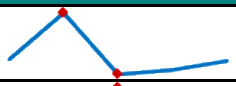
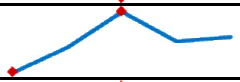
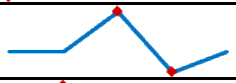
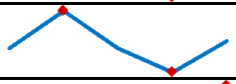
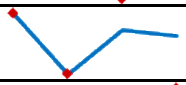
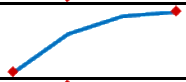
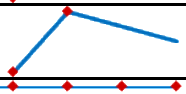
- The Inverclyde Health and Social Care Partnership has seen a 33% increase over the past year in the number of Adult Protection Plans that have been put in place following and Adult Protection Case Conference.

- In enhancing trauma informed approaches across the Health and Social Care Partnership, 357 staff and colleagues in partner organisations have now been trained in trauma informed practice. This represents a 389% increase on the previous year.

- In Justice Services, it has been reported that 10,674hours of unpaid work has been completed in communities across Inverclyde over the service year.

- In terms of Community Payback Orders, 72% of all orders were successfully completed in the past year.

Big Action 3: SCORECARD

Indicator Number	Indicator	Value	Difference from Previous Year (%)	5 Year Trend (spark line)	Most recent data
SPI 3.1	Number of referrals received by Children's Social Work that progress to a child protection investigation	87	+6.1%		2023/24
SPI 3.2	Percentage of initial Child Protection Case Conferences held within 28 days from notification of concern	14.0%	+1.0%		2023/24
SPI 3.3	Number of Adult Protection Case Conferences that convert to an Adult Protection Plan	4	+33.3%		2023/24
SPI 3.4	Number of Adult Protection Investigations completed within 10 days of referral	13	+44.4%		2023/24
SPI 3.5	Number of staff and partner organisations trained in trauma informed practice	357	+389.0%		2023/24
SPI 3.6	Number of unpaid work hours completed	10,674	-11.5%		2022/23
SPI 3.7	Percentage of Community Payback Orders (CPOs) successfully completed	72.0%	+1.0%		2022/23
SPI 3.8	Percentage of Integrated case management (ICM) Case Conferences attended by community justice social workers for offenders in SPS custody	98%	-1.0%		2022/23
SPI 3.9	Percentage of MAPPA level 2 and 3 meetings convened within timescales (as specified in national guidance)	100%	0.0%		2023/24

Big Action 4: We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living

- The total number of people referred to Access 1st for early intervention support increased by 14% in 2023/24 to 3,373. This follows an increasing trend in recent years and demonstrating the Health and Social Care Partnerships commitment to support people at the earliest possible stage.

- During 2023/24, there were 95,531 Community Alarm Activations across Inverclyde. While reported to be a 60.9% decrease on the previous year, it should be noted that during 2022/23, there was a significant amount of Test Activations resulting from the Analogue to Digital Switchover, resulting in the previous year's figures being artificially inflated. When comparing the most recent year to 2021/22, there has been a 9.5% increase in activations.

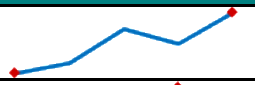
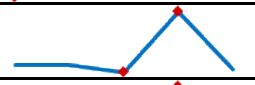
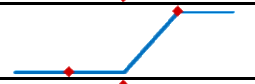
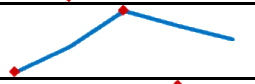
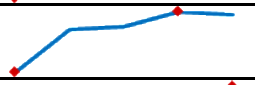
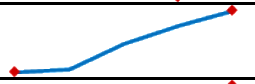
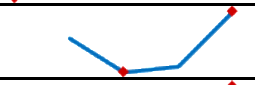
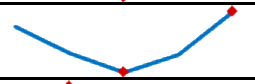
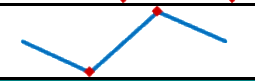
- Over the service year, the Health and Social Care Partnership increased the number of adult Carer Support Plans completed by 11.9%, this demonstrates the Partnership's ongoing commitment to support local carers in their caring role.

- The partnership has seen a rise in the number of bed days used as a result of delayed discharge. This is on ongoing area of focus for the Health and Social Care Partnership with daily reports provided to Senior Management and programmes of work in place to prevent admission and facilitated faster discharge.

- The Health and Social Care Partnership delivered a significant increase in the number of Anticipatory Care Plans (now known as 'Future Care Plans') completed during the service year, this demonstrates the Health and Social Care Partnership s commitment to support those with the most complex care needs over the long-term.

- While there appears to be a decrease in the number of Housing 1st Tenancies, it should be noted that overall numbers are small and the percentage of 16.7% is the result of one less person compared to 2022/23.

Big Action 4: SCORECARD

Indicator Number	Indicator	Value	Difference from Previous Year (%)	5 Year Trend (spark line)	Most recent data
SPI 4.1	Number of referrals for Early Intervention Support (Access 1st)	3,373	+14.1%		2023/24
SPI 4.2	Number of community alarm activations	95,531	-60.9%		2023/24
SPI 4.3	Number of people self-directing their care through receiving direct payments and other forms of SDS	2,983	-0.4%		2023/24
SPI 4.4	Percentage of adults with intensive care needs receiving care at home	67.4%	-1.0%		2023
SPI 4.5	Number of completed specialist housing reports	163	-1.8%		2023/24
SPI 4.6	Number of new adult carer support plans completed	141	+11.9%		2023/24
SPI 4.7	Number of delayed discharge bed days 18+	6,562	+25.2%		2023/24
SPI 4.8	Number of Anticipatory Care Plans (ACPs) completed	74	+221.7%		2023/24
SPI 4.9	Number of advice enquiries that support and maintain tenancy sustainability	470	+18.7%		2023/24
SPI 4.10	Number of housing 1st tenancies supported	5	-16.7%		2023/24
SPI 4.11	Number of external placements for adults with learning disabilities	13	-7.1%		2023/24

Big Action 5: Together we will reduce the use of, and harm from alcohol, tobacco and drugs

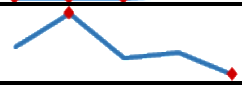
- During 2023/24 Alcohol and Drug Recovery Service has maintained its standard of people receiving treatment within three weeks of referral. Over the year, 96% of people referred received treatment within 3 weeks.

- For both the number of people beginning MAT treatment with the reporting period, increased over the past year to 22 people. In addition, the overall caseload of people receiving support, also increased during 2023/24.

- Over the past year, InverclydeAlcohol and Drug Recovery Services have improved their commitment to ensuring people who are considered at high risk of drug related harms are confidently identified and supported. During 2023/24, the volume of people assessed as being high risk increase by 20%.

- In 2023/24 ADRS provided funding to 12 people for a residential rehabilitation placements. This follows a year on year positive trend and represents a 200% increase in people receiving the support.

- The number of people reported to have successfully stopped smoking in the most deprived SIMD areas has decreased in recent years, with 33 people reporting having quit in the past year, compared to 50 the year before.

Indicator Number	Indicator	Value	Difference from Previous Year (%)	5 Year Trend (spark line)	Most recent data
SPI 5.1	Percentage of people beginning alcohol and drug recovery treatment within 3 weeks of referral	96.0%	0.0%		2023/24
SPI 5.2	Number of people who started on MAT treatment within the reporting period	22	+10.0%		2023/24
SPI 5.3	Current MAT Caseload, as at reporting date (Total number of people currently receiving MAT treatment)	698	+10.97%		2023/24
SPI 5.4	Total number of people identified as being at high risk of drug-related harm who are assessed within reporting period	72	+20.0%		2023/24
SPI 5.5	Number of people funded for residential rehabilitation	12	+200.0%		2023/24
SPI 5.6	Number of smokers supported to successfully stop smoking in most deprived SIMD data zones (20% most deprived)	33	-34.0%		2022/23

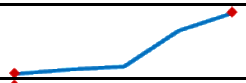
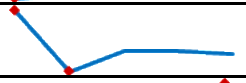
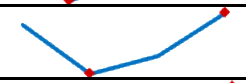
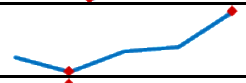
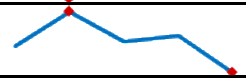
Big Action 6: We will build on the strengths of our people and our community

- Inverclyde Health and Social Care Partnership continues to support the wellbeing of staff and actively promotes a range of wellbeing activities for staff. Since the pandemic, numbers of activities promoted have exceed 100 each year, however, exact numbers of are difficult to quantify.

- The use of Care Opinion as an engagement and feedback tool has expanded since its launch. During 2023/24 there were 122 registered feedback reports made by people who have been support by Health and Social Care Partnership services. This represents an increase of almost 30% on the previous year. Active promotion of the tool is ongoing, with Care Opinion being presented to a range of local governance and strategic groups.

- During 2023/24, the number of contracts Commissioned to the 3rd Sector increased by over 50%, to 91. This has followed a period of increase over the past few years and shows a positive trend in collaboration and joint working with third sector partners.

- The percentage of adults able to look after their own health very well, or quite well is an indicator for the National Health and Wellbeing Outcomes. More information on these can be found on page 17.

Indicator Number	Indicator	Value	Difference from Previous Year (%)	5 Year Trend (spark line)	Most recent data
SPI 6.1	Number of wellbeing Activities promoted to staff	100+	-	-	2023/24
SPI 6.2	Number of registered feedback reports on Care Opinion	122	+29.8%		2023/24
SPI 6.3	Percentage of Staff Completing iMatter feedback	51.0%	-3.0%		2023/24
SPI 6.4	Percentage of HSCP complaints received and responded to within timescale	42.0%	-58.0%		2023/24
SPI 6.5	Number of new 3rd sector commissioned contracts	91	+51.7%		2023/24
SPI 6.6	Percentage of adults able to look after their health very well or quite well	88.9%	-1.2%		2023/24

SECTION 3: OUR IMPROVEMENT JOURNEY

Our Strategic Plan set the blueprint for services to improve health and wellbeing. The Big Actions gave a focused view of Inverclyde's peoples priorities and how services would support our communities.

The following section of the report will focus on our key performance across 2023/24 and will provide examples of innovation structured around our Six Big Actions – colour coded as per each Big Action.

Big Action 1:
Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health

Big Action 2:
A Nurturing Inverclyde will give our Children and Young People the Best Start in Life

Big Action 3:
Together we will Protect Our Population

Big Action 4:
We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living

Big Action 5:
Together we will reduce the use of, and harm from alcohol, tobacco and drugs

Big Action 6:
We will build on the strengths of our people and our community

Big Action 1 – Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health

National Outcomes relating to this Big Action	
1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	People, including those with disabilities or long-term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
5	Health and social care services contribute to reducing health inequalities.

Mental Health and Substance Use: Improving Our Response in Inverclyde

Inverclyde Substance Use and Mental Health services are working in partnership with Healthcare Improvement Scotland (HIS) to develop a test of change aimed at improving outcomes and experiences for individuals with urgent care needs and their families. This programme is funded by the Scottish Government at a national level with local sponsorship from NHS Greater Glasgow and Clyde.

The programme will seek to better understand the service user journey and identify potential improvements that can be made through redesign. It will work to develop and implement an integrated approach to delivering mental health and substance use services (building on lessons from the COVID19 response) through meaningful co-design and co-production approaches with those who access support.

It works with areas to develop and implement an integrated approach to delivering mental health and substance use services.

The programme will also identify and share good practice, innovation and learning across Scotland, to help inform improvements in other Mental Health and Substance Use services.

By using a range of research methods and exercise, and hosting development sessions with colleagues across Inverclyde, key priority areas of focus for test of change have been identified. These are

Priority Areas

- Providing the right care, at the right time in the right place.
- Identifying urgent care needs at first point of contact.
- Improving pathways between community services and inpatient psychiatric unit.
- Improving discharge planning.
- Improve partnership working across all partners.
- Improve staff knowledge.

Proposed Test of Change

- Implement shared care planning between Community Response Service and Alcohol and Drug Recovery Service (ADRS).
- Implement a screening tool within psychiatric inpatient settings for substance use.
- Enhance discharge planning in collaboration with Community Response Service, ADRS and third sector/voluntary organisations.

Improved Outcomes for People and Services

- Shared care plans can streamline processes that bring in the right care at the right time for the person.
- Communication around changes in a person's situation can allow for faster and more coordinated responses.
- A multi-disciplinary approach will provide a greater pool of knowledge and experience to draw from, resulting in better support across both mental health and substance use needs.
- Decisions about care after the urgent care response will be made jointly and cover a wider range of needs.
- Support continuity of care while in an inpatient setting
- Provide support for people experiencing withdrawal and other symptoms linked to substance use.
- Reduce readmission rates through improved ongoing support.
- Allow Addiction Liaison team to identify additional (substance use related) needs while on the ward.
- Provide an opportunity for ward staff to get advice and support about managing substance use needs during their stay.

- People will be provided with targeted mental health support following an inpatient stay that will reduce the need for readmission.
- Provide a basis for longer term person-centred support.
- Joined up conversations focussed on support, rather than discharge management will allow for more holistic support, engaging third sector services, and better follow up care.
- Meet Medication Assisted Treatment Standards 9 and Rapid Review Recommendations.
- Improve staff knowledge and skills around substance use and resources.

Mental Health Strategy Implementation Group

The Inverclyde Mental Health Strategy Implementation Group has been established to ensure a local focus for the implementation of the refreshed NHS Greater Glasgow and Clyde Mental Health Strategy. The group will consider how the Mental Health Strategy can be effectively implemented in Inverclyde, ensuring robust improvement plans are agreed. These plans will be informed through recommendations from national partners such as Care Inspectorate, Health Improvement Scotland and Mental Welfare Commission. The group will help to ensure local services are person centred, trauma informed, effective, efficient and that our resources are appropriately placed.

The remit of the Steering Group is to.

- Identify and agree key activities, deliverables and the financial framework for the implementation of service improvements.
- Refocus and revise work-streams to ensure an appropriate plan of work is in place to implement the outcomes of the work streams as part of the refreshed strategy.
- Take full account of issues raised by work streams.
- Ensure firm and transparent decisions are made.
- Ensure risk management and performance monitoring processes are established and routinely reviewed.
- Ensure an appropriate communication plan is developed and implemented.
- Ensure engagement with service users and carers and the wider community is a key component of all work streams.
- Develop a Quality Assurance process across all services.

Guiding Principles to ensure service developments are focused on.

- Prevention, Early Intervention and Health Improvement
- Recovery Oriented and Trauma Aware
- Continuous Improvement
- Maximising Independence
- Sustainable High-Quality Care

Expected Outcomes

- An active planner will be developed to design, develop and modernise Adult and Older Adult Mental Health Services for serving local population needs.

- Monitoring and evaluation processes will be embedded.
- Frontline staff will have a greater awareness, understanding and involvement of GGC Mental Health Strategy developments.
- Clarification and assessment n/ review of professional and statutory roles across all integrated services
- New initiatives and ideas that are positively impacting on service delivery and patient outcomes will be shared and spread.
- Service improvements will the need to consider local community needs and service interfaces.
- We will improve and ensure ongoing review of Service User/Carer Feedback
- We will develop a subgroup to ensure proactive planning, ongoing monitoring and review of Commissioned Services and third sector Partnership Working

Mental Health Falls Improvement Project

A multidisciplinary team of staff were established to undertake a thematic review of all falls that have occurred in the two older adult Mental Health Inpatient wards. Preliminary findings indicate the need for an improvement plan to address emerging themes around systems and processes and environmental factors.

The aim is to reduce the number of falls we have in our hospital by 30% and to reduce the harm sustained from falls.

To help implement improvements the wards will implement the Falling Stars initiative. The Falling Stars initiative was created through a Fall's collaborative with Leadership and Quality in Healthcare Royal College of Physicians of Ireland and the Health and Safety Executive Quality and Patient Safety Directorate and has already been successfully adopted within other Mental Health wards across NHSGGC. The initiative will form part of a quality improvement action plan, which will be implemented by Autumn 2024.

Continuous Intervention

NHS GGC Continuous Intervention Policy was influenced and informed by the guidance from Healthcare Improvement Scotland (HIS) *"From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care."* Although the policy remains in draft format, there has been steady progress made through the three short life working groups to enable the implementation of the policy: a policy group, activity boxes group and a training group. All groups have key stakeholders from across Inverclyde Mental Health services.

These three groups are overseen by the Mental Health Policy Implementation Steering Group, which reports into the Mental Health Clinical Governance Group. A Continuous Intervention Policy Implementation and Monitoring Group has also been established which has an overview of the implementation plan and timeline and this will also report into the Mental Health Clinical Governance Group. The plan is to implement aspects of the policy in a phased way, with wards being identified as pilot sites to help implement and refine this significant change in how we manage patient care and safety. Patient Activity / safety boxes will promote meaningful activity and engagement between patients and staff and will be tested as part of the pilot. In addition to this, staff training is being developed to assist staff with the transition in how we apply the new policy in practice.

The full implementation of the Continuous Intervention Policy and Practice Guidance is dependent on the review of the draft policy being concluded and ratified through the Mental Health Clinical Governance Group. This has been delayed, however is hoped to be fully implemented later this year.

Use of supplementary Nursing staff

Safe and effective staffing relies on several key components which includes having a whole time equivalent that reflects the correct numbers and skill mix of staff within each ward. There has always been a requirement to use supplementary staff to fill shortfalls created during periods of reduced staffing levels, for example due to sickness, and when high levels of patient activity are being experienced. Supplementary staffing has always been requested in line with the Nursing and Midwifery Rostering policy via an agreed escalation model. This often results in the use of Agency Staff.

There has been a concerted effort since Autumn 2023 to reduce the use of Agency staff. This has been achieved via a combination of internal and external recruitment, with 700+ new Bank staff being recruited across NHS Greater Glasgow and Clyde who have been site anchored to each hospital site during a 3-month induction period to achieve the statutory and mandatory training required. As a result, there has been no use of Agency staff in Mental Health Inpatient services in Inverclyde since April 2024. As a comparison, the service used 527 Agency shifts in April 2023, which is testament to the significant efforts that have been made to reduce Agency staff use and help to employ a workforce that is suitably skilled to meet the complex needs of the patients in our care.

Health Improvement Planning (and use of social media)

People are taking more of an active role in maintaining or improving their health and are more receptive to helpful information than in previous years. To build on this opportunity, social media platforms were launched in NHS Greater Glasgow and Clyde in September 2020 by our Health Visiting Staff, Laura Gordon, Laura O'Donnell with support from Lisa Eardley. Platforms included Facebook, Twitter and Instagram, with the team regularly supporting virtual, information including the following topics.

Inverclyde Health Visiting Team Facebook

Inverclyde Health Visiting Team Instagram

Inverclyde Health Visiting Team Twitter

Breastfeeding Friendly Inverclyde Facebook

- Health Promotion
- Child Development
- Wellbeing and Mental Health, and
- Home Safety with Community Support and Resources.

All the information has been verified and is from trusted, reliable sources promoting trust in the resources provided, and have used both imagination and their skills to generate engaging posts.

Engagement has grown with over 4,500 followers with active shares of posts generating over 20,000 likes and shares.

A first for the Inverclyde Health Visiting Team was the launch of their social media presence to support local communities within health and care. Annual feedback from the users of this platform has been positive and progressive, showing examples of innovation and of meeting the needs of the Inverclyde population whilst underpinning Scotland's '2030 Nursing Vision'.
https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/07/nursing-2030-vision-9781788511001/documents/00522376-pdf/00522376-pdf/govscot%3Adocument/00522376.pdf

Since the launch they have had some famous likes, shares and interactions from various places and pages. The most recent interaction was from Annabel Karmel MBE, who works in the field of child nutrition and a leading UK female entrepreneur and bestselling international Author.

Posts from Inverclyde are often shared by a number of other popular professional groups, including:

- The Good Egg Guild
- Scottish Women's Aid
- The Royal Society for the Prevention of Accidents
- The Scottish Cot Death Trust
- Parent Club Scotland
- Home start UK Wide
- Eric children's bowel and bladder charity
- SAMH
- Many Health Visiting and Family Nurse Partnership pages UK wide.

The teams support, skills and knowledge has been accessed by multiple agencies within Inverclyde, Greater Glasgow and Clyde and across Scotland with many meetings to share their expertise on setting up similar platforms. Inverclyde is leading the way!

It has also been inclusive to many of our 'New to Scotland' families who have been able to see what groups are available to themselves within the Inverclyde community. They have reported feeling more included by being able to access this page and for our Muslim families' posts have been shared to support Ramadan Mubarak and Eid.

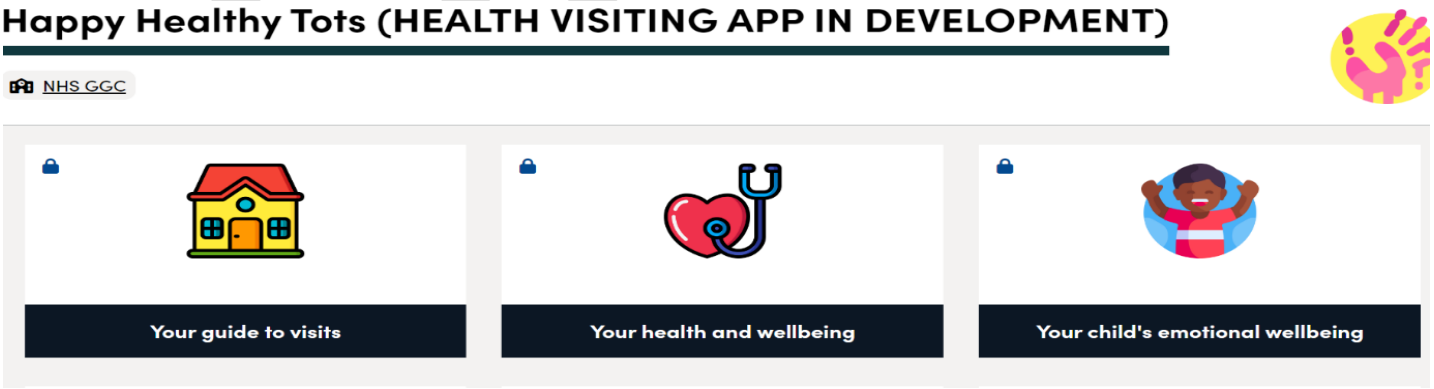
The community has benefited from many daily posts to support mental health, community groups, safety of children, supporting engagement and involvement.

Big Action 2 – A Nurturing Inverclyde will give our Children and Young People the Best Start in Life

National Outcomes relating to this Big Action	
1	People are able to look after and improve their own health and wellbeing and live in good health for longer
7	People using health and social care services are safe from harm
10	Our children have the best start in life and are ready to succeed
11	Our young people are successful learners, confident individuals, effective contributors, and responsible citizens
12	We have improved the life chances for children, young people, and families at risk

Happy Healthy Tots

Health visitors distribute large amounts of NHS approved paper copies of health promotion resources at various points in the Health Visiting Universal Pathway. These provide evidence-based information regarding wellbeing and development of children, childhood assessments, common childhood concerns/difficulties, immunisations, and local resources which all support parents making informed choices as they raise their children. There is an acknowledgement however that parents are sourcing information on the web, which is not always evidence based, reliable, or current and indeed that the virtual domain is now a globally accepted main source of our client's health related information. Further to this there are economic pressures which promote adopting workload strategies that are cost efficient and environmentally friendly whilst in-keeping with global trends, allowing clients to source approved information, at the right time, in an efficient and easily accessible way.



Inverclyde Health Visiting Team Lead Laura Gordon and Senior Nurse Morag MacPhail recognised the need for modernisation of health promotion in line with societal changes and promoted the development of a Health Visiting App to ensure a one stop resource for families of ratified, accessible, and up to date information. It was postulated that failure to take this step would have put children's health and well-being at risk for the following reasons.

- Not developing an App leaves parents vulnerable when sourcing information and in a quandary regarding what strategies or information to implement.
- With no App, there could be dangerous choices made and delay with parents accessing recommended pathways and supports if they follow rogue advice on the web.
- Interpretation of Information can be open to misinterpretation.

Initially the thinking was that it would be an Inverclyde project, however the proposal generated significant interest across Greater Glasgow and Clyde (GGC) and with support from the Right Decision Service, Knowledge Services and the digital team, a board wide multidisciplinary team was brought together to develop the vision. There was agreement that the need was for a citizens App which means it would be easy read format, supports inclusion and is less likely to lead to misinterpretation. There are a series of tiles where information is hosted, and a local information one for area specific information. Other key features are that; There is no facility for sharing of personal information, it is available in the top ten most used languages, for those with vision difficulties there is an option for the text to be spoken, and best of all, once downloaded to the clients phone there is no ongoing need for data, therefore with no credit on your mobile, the information can still be accessed. Word of the APP has spread UK wide and there has been much interest and requests for information as a result.

A poll was conducted, and the name Happy Healthy Tots was the winner. We are nearing completion and expect to launch in the next month or two. We will be further developing the App going forward and hope to include local practice reels and videos.

Infant Feeding

Despite all the health benefits associated with breastfeeding for mothers and babies, in Inverclyde approximately 47% choose to breast feed at birth and the number of women continuing to feed past the six-eight-week assessment have historically been the lowest in Scotland.

Poverty and an entrenched formula feeding culture were often the reasons stated for this. There is no doubt that throughout Greater Glasgow and Clyde younger women and those from less affluent backgrounds are less likely to breastfeed. However, following a large survey of local women and families it became clear that lack of information antenatally and support postnatally could also impact.

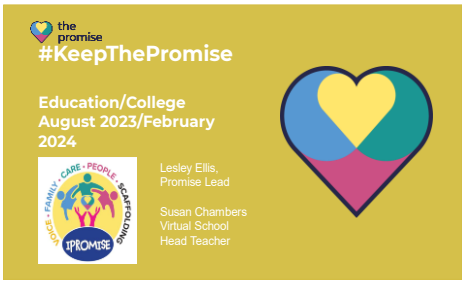
Funding was secured from the Scottish Program for Government (PfG) to provide antenatal education to families and intensive postnatal support for all breastfeeding women discharged from hospital. In addition, two further projects collaborating with women with long term medical conditions or disabilities and with young women registered with the Family Nurse Partnership (FNP) also commenced.

This additional support has seen an increase of 3% of babies receiving any breastmilk in 2023 at 34% compared to 31% in 2022.

Poverty in relation to formula milk was also reported as an issue nation-wide. The Health and Social Care Partnership's response to this was to develop and disseminate a robust Pathway for the Emergency supply of formula in line with the Scottish Government and UNICEF Baby Friendly requirements. In addition, funding was secured to purchase and supply breastfeeding pumps to women.

The Promise

Inverclyde Health and Social Care Partnership are committed to keeping The Promise and ensuring children and young people have good childhoods. We continue to focus on three priority areas – Good Childhoods, Whole Family Support and Supporting the Workforce.



HSCP and Education services work together to raise awareness of the Promise and specific education outcomes from plan 2021-24 were extended from primary and secondary education to West College Scotland. This was extremely well received and discussion of action going forward. West College Scotland are now represented on iPromise Board.

In December, our Promise Lead had the opportunity to attend an event with Promise Scotland facilitated by Siblings Reunited (STAR) which looked at how we provide better family time to our children and young people and families. Exploration of creating the right space and environment and doing things differently.

I Promise in Hearings

Children's hearing event was held in the Beacon with 53 in attendance. The purpose was to provide an opportunity for relationship building with all partner agencies and to discuss how we improve our hearings for our children, young people and families. The iPromise in Hearings Steering group, chaired by Lesley Ellis, Promise Lead and Ken McKinlay CHS has been instrumental in progressing change.

Each person was invited to discuss their role in preparing for a hearing and then topics. We shared views of our young people as to how we can do better.

Corporate Parenting Training

We partnered up with Who Cares to deliver our first Corporate Training event. This was well attended by our elected members and Ruth Binks, Corporate Director and all partners including housing.

WHO CARES? SCOTLAND
EQUALITY | RESPECT | LOVE

Language awareness - Podcasts

Due to the improvement to our language around care experienced the iPromise Team were asked to participate in a podcast to share how we have changed our language and the impact this has had on our care experienced community.

Link: Lesley and Erin from Inverclyde talk about the negative impact language can have on young people

The LENS Project

During 2023/24, we worked with The LENS, an organisation that supports services and businesses to adopt an intrapreneurial mindset. Embedding this mindset helps to promote improvement through innovation. The Lens Project partnered with Inverclyde Health and Social Care Partnership, including The I Promise Team to develop an 'Ideas to Action' Programme which supports Inverclyde's vision and ambition to deliver The Promise and improve outcomes for our children and young people. As part of the programme, the Health and Social Care Partnership pledged £50,000 to develop and test up to six ideas

THE LENS
Valuing Ideas.
Inspiring People.
Powering Innovation.

An initial launch event in September 2023, attended by over 60 social work, health and education staff, delivered the key messages of the Ideas to Action programme. Key messages were emphasised regarding the Programme as a capacity building and development opportunity for people and their ideas. This was designed to generate creative and innovative ideas, supporting our commitment to keep The Promise with over 52 ideas being heard and an inspired workforce. Following the launch, 12 applications were submitted by staff for the Ideas to Action Programme and shortlisted by a Project Team. All applicants were given feedback, rationale, and routes for their ideas with six ideas chosen for the developing ideas workshops.

The 'developing ideas' workshops focused on business storytelling, modelling and value proposition, prototyping and securing investment. There were also opportunities for local children, young people and families to be involved in the project design.

The workshops culminated in an Investment Event on 7th December 2023, with each team pitching their idea to an investment panel in the hope of securing financial or organisational support. Six ideas were presented where and all were considered to have development potential, with financial investment being provided to four, those ideas are:

- **Feel Good Fund:** create bespoke experiences in our children's houses by investing in relationships, equipment and activities where anything is possible.
- **Home from Home:** provide improved family time space as a 'home from home' for relationships to thrive in an environment made for families.
- **The Practice Pad:** provide independent living skills to our young people at an earlier stage and support them to practice living on their own in a safe, supported environment, before they take on a tenancy.
- **Throughcare Hub:** a person-centred, flexible, and supportive environment for young people to learn new skills, gain qualifications and grow in confidence at their own pace.

The other ideas, that will be organisationally supported are:

- **Connected 2 Care:** earlier, meaningful relationships with our families, bridging the disconnect, building trust, resilience, and support before crisis.
- **It Takes A Village:** a community-based approach to provide practical support, life skills and ongoing nurturing, to support our young people as they navigate their own lives.

Award

Aileen Wilson, Team Lead for Residential services won the Inverclyde Health and Social Care Partnership Leader of the Year award in February 2024 at a ceremony in The Beacon. This award qualified Aileen to be shortlisted for the wider NHSGGC Celebrating Success Staff Awards ceremony to be held in Spring 2024 in the Radisson Blue Hotel in Glasgow where she won the overall Inverclyde Health and Social Care Partnership Award Staff Award 2023/24 for Leader of the Year. A well-deserved accolade in recognition of Aileen's commitment to delivering the Promise and improving outcomes for the children and young people of Inverclyde.

Sidestep

We have commenced work with Action for Children who deliver the Sidestep project for young people aged between 11-18 years who are at risk of involvement in serious organised crime, being coerced or manipulated into criminal exploitation. We provide one-to-one and group sessions delivering focus work to promote positive choices and consequential thinking. Staff identify the young person's needs and interests and create an individual action plan to ensure they provide intensive targeted support, offering diversionary activities. The project will also work alongside families to address vulnerabilities and strengthen family relationships to help reduce their criminal activity.

Big Action 3 – Together we will Protect Our Population

National Outcomes relating to this Big Action	
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
7	People using health and social care services are safe from harm
13	Community safety and public protection.
14	The reduction of reoffending.
15	Social inclusion to support desistance from offending.

Children 1st

Throughout 2023/24, the Health and Social Care Partnership worked collaboratively with Children 1st to develop and deliver a number of positive programmes to improve support for local children, young people and families. In a positive example of joint working, three Children 1st Family Wellbeing Workers have been co-located with the Health and Social Care Partnership Request for Assistance Team with the following aims:

- Strengthen family capacity and develop family-based solutions
- Deliver Family Group Decision Making
- Provide family support
- Deliver trauma-informed interventions.

Underpinning the Family Wellbeing Service is the goal to support families with additional concerns to avoid statutory involvement, such as child protection or children becoming looked after.

The Wellbeing Service provides a range of supports to local families, depending on their needs and concerns. For example, many families have been supported to improve their financial wellbeing, which has been greatly impacted by the cost-of-living crisis. To date, the Children 1st Financial Wellbeing Service reached the families of 64 children and young people in Inverclyde, reporting to have managed £12,092 of total debt and maximised income of £50,773.

Many of the approaches adopted by the service are family-centric, such as Family Group Decision Making (FGDM), which helps wider families to come together to agree a family plan to support their child/children, before a life-changing decision is made about their future. To date Children 1st has supported 14 Inverclyde families through Family Group Decision Making, and a further 18 families have participated in restorative family meetings.

Another positive example of joint family activity is 'Bide Oot' which gives families the opportunity to experience the benefits of bringing together outdoor education and long-term family support. During the past year, four Inverclyde families attended Bide Oot, being fully support by Children 1st before and after their trip. Those who have experienced Bide Oot say it has helped them:

- ★ strengthen relationships,
- ★ build their confidence,
- ★ build long-term positive impact on their mental health, relationships, and emotional wellbeing.

So far, in total 32 families, with 84 children and young people, have been supported by Children 1st in Inverclyde. Furthermore, no children of families who developed family plans as a result of Family Wellbeing supports required statutory interventions.

Justice Partnership Developments

The Inverclyde Community Justice Partnership, in partnership with Justice Social Work and Scottish Prison Service delivered their annual development day at HMP Greenock in September 2023. Scottish Prison Service staff and current prisoners participated in the day which led to several workstreams being identified for the partnership to progress. Concerns about unscheduled release from custody have been progressed via the Clinical and Care Governance Group who have supported the proposal to establish a short-life, multi-agency working group to explore possible local solutions to this concern.

Women in Justice Project

In keeping with the Trauma informed principles of collaboration, choice, and empowerment, the Women in Justice Project established a Women in Justice Support Group (WJSG), which meets every Tuesday. The women, all of whom have lived or living experience of the Justice System, have determined the structure of the Group themselves. As well as seeking opportunities for peer support and networking the women also requested sessions focused on problems inherent in female offending. This has included areas such as domestic abuse, healthy/unhealthy relationships, anger management, emotional regulation, substance misuse issues and homelessness.

Staff endeavour to make it as easy as possible for the women to attend the Group, which can include covering travel costs or providing food and drinks. Whilst attendance rates can vary reflecting some of the women's chaotic and difficult lifestyles, there has been greater stability and enthusiasm over the past year around what the Group is able to offer.

The Group has been motivated to improve the experience of other women in the Justice System and have taken the lead on developing "Attending Court" and "Community Sentencing Options" leaflets to raise awareness and understanding for women about what happens when they attend Court and are being sentenced for offending behaviour. The leaflets aim to remove the barriers that can be created by "legal speak" and improve understanding of what community-based disposals are available to sentencers. These leaflets have been placed in the Court building and have been widely circulated across Health and Social Care Partnership, Council and third sector organisations.

Moving forward attention has turned to sustainability, with staff currently looking at ways in which this level of support can continue beyond the life of the Project. One option being explored is to create another Women in Justice Support Group (WJSG2). The intention would be for this second group to act as a "feeder" group into the existing Group (WJSG1) with the rationale behind this being:

- ➢ WJSG1 is continually evolving as new women join,

- new women coming into WJSG1 can disrupt the dynamic of the Group and, indeed, some women drop out at this stage as it can be a little repetitive,
- staff would like the women themselves to facilitate WJSG1 in the future (with ongoing support) and work toward getting this Group constituted and sitting out with Justice landscape,
- WJSG2 would adopt the current format and women would be able to move through and into WJSG1 if they wanted. This would give the women an option for support out with the Justice System when they feel ready – thus avoiding any cliff edges and allowing the women to shape a different identity away from the negative labels which can be associated with a Justice context.

Although the above thinking around the development of a second Group is in its early stages, staff are excited about possibility of developing a pipeline approach that is supportive of transitioning women out of the Justice System and involving non-justice partners in helping the women shape what this might look like. As has been the case throughout the Project, the women themselves will always have the final say in any proposals and future direction of travel.

Big Action 4 – We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living

National Outcomes relating to this Big Action	
1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
6	People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
7	People using health and social care services are safe from harm

Maximising Independence

Maximising Independence commenced in November 2022. Its purpose is to work in partnership to support people in Inverclyde to keep well age well, build their resilience, and live independently for longer - through preventive approaches and earlier intervention.

For 2023-24 the priority has been to support people to 'self-manage' their health and wellbeing. This is based on engagement findings, and in response to significant increases in the number people in Inverclyde living with long term health conditions.

Opportunities to enhance self-management support have been identified across the system. Small scale testing is targeting people at different ages and stages in their lives. Work streams were identified through engagement with services and organisations that support self-management and the public, as well as external organisations from whom we can learn.

Impact is monitored using measures specific to each project. Each measure tracks to one or more of a set of programme outcomes for individuals, staff, services and the Scottish Prison Service. The aim is to build evidence of progress towards the outcomes.
Some of the programmes delivered as part of Maximising Independence are detailed below

Making Early Contact Count (MECC) Test of Change

What we hope to accomplish: When people experience early functional decline, they are motivated and supported to make small changes in their lives that can make a positive difference to their longer-term health and wellbeing.

Change idea: a 'Living Well' brief consultation – a 'good' conversation focusing on their best hopes, their strengths, and positive changes they want to make. The target population is people accessing our services earlier, who are still largely independent and not in crisis.

Partners: Care and Support at Home, Community Occupational Therapy, Rehabilitation and Reablement Service (RES) and Access 1st.

Living Well in Inverclyde

What we hope to accomplish: People living with long term conditions take more control of their lives and keep well by using strategies and skills that work for them.

Change idea: face-to-face lifestyle management courses (Living Well) for people struggling to live well with long term health conditions and experiencing non-condition-specific symptoms such as fatigue, chronic pain, physical inactivity and stress.

Partners: this workstream is led by third sector partners, Your Voice, working with Community Learning and Development and Community Occupational Therapy.

Functional Fitness MOT Collaborative

What we hope to accomplish: inactive citizens become more active, active citizens stay active throughout life, and increased wellbeing and resilience through physical activity.

Change idea: a targeted, brief behaviour change intervention to inform people over 50 about the fitness necessary for independent living. It introduces the physical activity guidelines for health and provides an age-friendly motivational discussion about local opportunities to become more active.

Partners: Community Occupational Therapy, RES, Your Voice, Riverclyde Homes, Inverclyde Bothy, Branchton Community Centre, Community Learning Disability Team, Inverkip Hub and Morton in the Community.

Chronic Obstructive Pulmonary Disease Pilot

Our unscheduled care operational group analysed our frequent attender's data, this is a small population of patients who utilise our Accident & Emergency Department regularly, the top 20 frequent attenders with Chronic Obstructive Pulmonary Disease (COPD) were identified to participate in a pilot of using Docobo, a remote home monitoring to support self-manage of COPD:

- Seven patients signed up to Docobo for self-management.
- Eight patients were assessed but deemed unsuitable for Docobo.
- Two patients refused to participate.

Baseline data was collected for three months prior to patient commencing Docobo to establish A&E Attendances without Admission, Chronic Obstructive Pulmonary Disease Admissions and Number of Bed Days. Patients were commenced on Docobo and the same data was collected for three months.

Results

- 81% reduction in A&E Attendances without admission
- 80% reduction in COPD Admissions
- 64.3% reduction in the number of bed days.

Learning Disabilities Health Checks

In 2022 the Scottish Government implemented "The Annual Health Checks for People with Learning Disabilities (Scotland) Directions 2022". This direction imposed a duty on health boards to offer all individuals with a learning disability, or who identify as having a learning disability, an annual health check to reduce the significant health inequalities associated with this population.

"While it may be too early to say the Health Check programme has saved lives, there are indicators of health needs being identified."

Within NHS Greater Glasgow and Clyde a board-wide learning disability health check team was established, based in East Dunbartonshire. The team includes seven learning disability nursing posts, one team administrator and a service manager. From January 8th to 28th March 2024 the team undertook health checks within the Inverclyde area, using facilities provided at the Fitzgerald Centre (adult day opportunities base).

- 262 of 547 service users with a LD received an opt-in invitation.
- 80% of this invited = 212 health checks were completed

Those patients who did not formally opt out or failed to attend were all contacted or visited by social workers from Inverclyde's Community Learning Disability Team (CLDT).

The outcomes so far from this piece of work include the identification of significant numbers of hearing/ear care issues, referrals for dental or optician appointments, identification of gastro-intestinal or bowel issues, advice given about pain or bone health (see attached bar chart). Social care needs, including Adult Support and Protection concerns were identified and appropriate referrals made to the Community Learning Disability Team.

A review conducted by the Clinical Director for Learning Disability on a random sample of 60 patients who had been referred onto primary care after their Learning Disability Health Check examined their clinical notes:

- 50% of those referred had been issued a new prescription.
- Seven patients were referred with one-off high blood pressure, and this led to a change in treatment for four patients.
- Eight patients were referred onward from primary care to secondary care services such as gynaecology or ear syringing.
- one patient was referred urgently for suspected cancer.

Community Treatment and Care Services (CTAC)

From October 2023, Community Nursing has seen the successful transition from historical Treatment Rooms to our new branding of Community Treatment and Care Services (CTAC). CTAC Nursing care is now delivered within our Community Treatment and Care Services centres in Greenock, Gourock and Port Glasgow Health Centres for more complex nursing care including ear care, management of minor injuries and dressings, suture removal. Whilst a Health Care Support Worker (HCSW) model is delivered directly to and within GP Practices. This model provides 92% of GP Practices Community Treatment and Care Services care including bloods/phlebotomy, chronic disease monitoring, and biometric measurements namely Blood Pressure (BP), height, Body Mass Index (BMI), and weight. Our final phase of GP Practice Health Care Support Worker model in Practice will be embedded in autumn 2024.

General Practice Community Treatment and Care clinics deliver care including Discharge Medicine Services (DMS), disease-modifying anti-rheumatic drugs (DMARDs), Electrocardiograms (ECGs), Phlebotomy, biometric collection, urine dips, Diabetic foot checks, BP home monitoring. We currently do not have a platform that allows performance data to be generated easily due to the multiple IT systems that are used across General Practice, CTAC. This is something that is being focused on at a Board level with local attempts to establish an interim measure to provide a more detailed picture of activity. Innovative Practice through this period includes a diabetic foot check as part of Chronic Disease Management (CDM) monitoring, gold standard ulcer assessment clinic and the introduction of remote monitoring of blood pressures.

- 17,000 referrals received through CTAC.
- 8000 additional hours of clinical time for the community
- 97 CTAC clinics per month = 1160 clinics in 12-month period

Vaccination Alignment

The alignment of vaccinations under the umbrella of Community Treatment and Care commenced in December 2023 with the appointment of a Nurse Team Lead managing both services. This allow vaccinations to be incorporated within the Nursing structure rather than a separate entity. As we move forward into April 2024 onwards this alignment will continue to evolve as a permanent workforce is developed. A snapshot of activity for period April 2023 – March 2024 is as follows:

- The travel vaccination service is managed by NHS Greater Glasgow and Clyde, during this period 198 travel risk assessments were carried out with 369 vaccinations.
- There were 104 non routine vaccinations administered in community clinics.
- Within care homes 57 Pneumococcal, 60 Shingrix, 1 Zostavax were administered.
- Within community homes 72 Pneumococcal, 134 Shingrix, 30 Zostavax, five further non routine vaccinations.
- The local team delivering care home and housebound vaccinations administered 2263 COVID19 vaccinations, with a further 256 staff vaccinated.
- With regards to flu the team administered 2246 and 243 staff.
- The overall picture of COVID19 and Flu uptake is detailed as follows:

Further information and statistics on our vaccination programme can be found at appendix 4.

Within the context of the wider vaccination transformation programme, we continue to strive for bringing vaccinations to our population and not the population to the vaccinations. Creating more accessible platforms for our residents to access vaccination resources, information and support locally. This will continue to be the focus moving in April 2024, working with our colleagues in Public Health at NHS Greater Glasgow and Clyde to deliver the vaccination programmes to safeguard our communities.

Winter campaign through period September 2023 – March 2024

Community Link Worker

The service continues to have a high engagement rate of 92% and this is to be commended.

Our Community Link Worker (CLW) model continue to be the social prescribing hub for many non-clinical issues and presentations, again safely diverting from GPs to a professional therefore in keeping with our right care, right place ethos. The cost-of-living situation, post-pandemic and housing issue have significantly impacted Inverclyde residents. This has been reflected in this year's statistical information and the biggest indicator has been a significant increase in the number of encounters/contacts the Community Link Workers have had with patients, and subsequent onward referrals, as they have supported patients with a wide range of complex issues.

1307 Patients were seen by a Community Link Worker, with 2193 reasons giving for referral to see a Community Link Worker. Top referral reasons include financial problems accounting for 307 referrals, stress related problems generating 296, housing problems noted for 253 referrals and social prescribing support for mental health from 196 of those referrals.

- 1417 new referrals in 2023/24 - 1307 people seen by CLW.
- 7746 encounters by service (⌂ by 2641 from previous year)
- 4102 referrals to other services (⌂ by 628 from previous year)

Care Homes and Care Home Assurance Tool (CHAT)

Care Home Assurance Tool (CHAT) visits took place across all Adult and Older People's Care homes Inverclyde in 2023 as per NHSGGC Standard Operating Procedures (SOP) in response to national guidance. Care Home Assurance Tool visits are approached in a consistent, collaborative way that promotes partnership with care homes to achieve high quality care that enables residents to live their best life aligned to what matters to them. Care Home Assurance Tool visits are person centred, supportive and collaborative in their approach.

It should be noted that care assurance visits are just one part of the supportive framework around care homes and sit alongside Health and Social Care Partnership (HSCP) day to day relationships with individual care homes, HSCP Collaborative Care Home Support Team meetings (CCHST) and the Care Home Assurance Group.

Outputs from the assurance visits were analysed to collate emerging themes, including what care homes are doing well and where improvement work is required.

Areas of strength identified.

- All care homes visited showed a high level of compliance against the Infection Prevention and Control criteria and visiting staff commented that the homes were visibly clean.
- Overall, there was a lot of good practice evidenced in relation to resident health and care needs, which the assurance teams were impressed with.
- Homes were noted to have homely atmospheres with residents' rooms personalised with their own belongings and in some instances décor and furniture.
- Positive and caring interactions were observed between staff and residents, it was clear that staff knew residents well.
- Activities were observed to be in progress in many of the homes which residents were clearly enjoying, good care plans were observed which articulated 1-1 interests, preferences and identified goals.
- Both MUST 5 and Confirmation of death training are no longer areas of concern noted by the homes or visiting teams.
- There have only been one home report issues with provision of service from GPs to the homes reported, which is an improvement from last year.
- Staff reported strong and visible leadership from their managers.
- Many homes have staff who have worked with them for significant periods of time.

There were a few areas in some of the homes visited where the review team noted that further work remains necessary to support all homes to achieve consistently high standards. These areas of improvement are listed below and are all included in the action plans for those individual homes. Staff reported that they felt supported by their management teams and were happy in their roles. There were only a couple of homes who have experienced management changes but in the main management teams have remained stable.

Areas for improvement

- Cleaning schedules did not always cover all the areas being cleaned.
- In a couple of homes, it was felt that a deeper clean was required of all areas or specific areas.

- Some of the homes were noted to be "tired" in their décor and appearance which makes good Infection Prevention Control difficult.
- Several homes were noted to have equipment which was needing to be replaced – e.g. shower chairs with rusty wheels.
- Regular mattress and pillow checks with replacements as required.
- There are a few homes who continue to have training requirements, however there is no theme to this. A couple of homes are working to set up robust audit systems to be able to evidence good practice and improve standards of documentation.
- Recruitment of staff is an ongoing issue for many of the homes as per the national picture.

Recommendation to be taken forward for next visits to refine the Care Home Assurance Tool process.

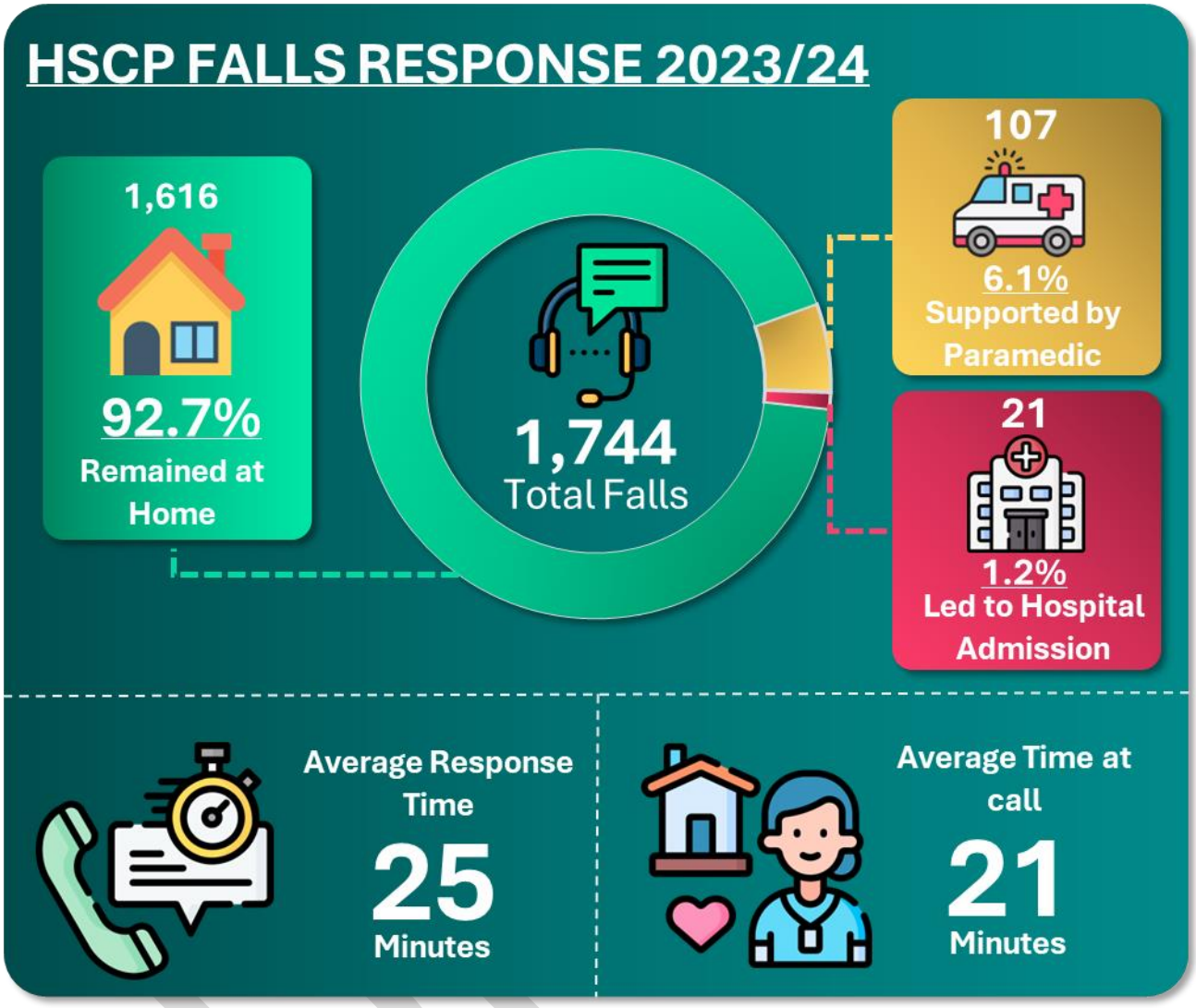
- To continue to work to increase ownership and monitoring of the progress against identified improvement actions on the overarching action plan. Working to gain updates from the homes between visits to assist with the monitoring of these improvements.
- To explore further the recurring themes of cleaning schedules and Mandatory training through the Collaborative Care Home Support Team and in collaboration with commissioning colleagues to identify how the Health and Social Care Partnership can support the homes to address these areas of concern.
- To participate in the Care Home Assurance Tool review process and roll out the new tool when available.

Examples of Good Practice:

- ✓ Activities coordinators were very enthusiastic about their role within the care home and described participating in shows for the residents (such as Abba theme nights and bingo nights) that they know the residents enjoy.
- ✓ Staff had a good relationship and understanding of individualised resident needs.
- ✓ During our visit, the staff and manager discussed and gave good examples of patient centred care. Staff had been on virtual training where they had to wear a headset and it demonstrated what the environment looked like to a resident with dementia.
- ✓ The care home has a resident ambassador to help new residents settle in which is a nice touch and reinforces a real sense of community.
- ✓ One staff member had previously worked in the community, and when she visited someone in the home she was so impressed by the staff and how homely it felt that she decided to apply for a job.
- ✓ Staff talked about supporting one resident to complete a book about their self to give to her daughter describing who she was, her life experiences, feelings and what was important to her.
- ✓ All residents have nice things that are personal to me boxes outside their bedroom doors on the wall which families are encouraged to fill it was clear that some families have spent time filling these with mementoes.
- ✓ Staff are assisting one gentleman to place a headstone on his mother's grave and a trip is being planned for him to the visit and see this.

Responding to Falls

During 2023/24, Inverclyde Health and Social Care Partnership responded to over 1,700 people who had experienced a fall. The infographic below shows how we performed in this area and highlights the great work done locally to prevent hospital admission and support people to be care for and remain at home.



Call before you Convey

The Health and Social Care Partnership conducted a *Call Before You Convey* pilot from December 2023 to March 2024. All care homes for older people were offered palliative care training with six homes attending and all were invited to attend a *Virtual Ward* each week. The Virtual Ward is held online each Thursday and has clinical representation from Health and Social Care Partnership community nursing and Ardgowan Hospice with an open invite to all care homes who wish to come and discuss residents who are receiving end of life care. The aim is to support Care Homes with the necessary clinical and practical advice and support which enables a resident to be cared for and die within their own home and reduce unnecessary conveyance to secondary care on weekends.

During this time, 27 residents were discussed at the Virtual Ward and five visits were made to care homes by the Advanced Nurse Practitioner (ANP) on weekends. Whilst we were unable to evidence a reduction in conveyance on weekends, several improvements have been identified:

- Improved palliative care skills and improved relationship with Ardgowan hospice from the homes accessing the training and an increase in use of the professional clinical advice line at Ardgowan by the same homes.
- Improvement in planning and anticipating needs, for example earlier prescribing of *Just in Case* medicines.
- Additional support provided by Health and Social Care Partnership nurses around difficult conversations with families at end of life, use of do not attempt cardiopulmonary resuscitation.

There is now a plan to expand the clinical indications which can be supported on a weekend and a further round of training will be offered.

Housing Options and Homelessness Advice Service (HOHAS)

J is one of our longest open cases, with his current homeless application dating back to September 2021. Prior to this he had frequented the service multiple times, and this is majorly down to recurring offending, having been in and out of prison most of his adult life. Previous homelessness applications were closed because of a prison sentence or alternatively, lost contact etc. and his current section 5 referral has additionally had to be restarted due to a stay in remand during his current case.

J describes himself as institutionalised and said that he was known to "taking panic attacks and that because I knew I was getting out of the jail and I didn't know what was happening", that "people would rather be in the jail than be running about the streets homeless". He stated that he knew of people purposefully offending to go back to jail and while he himself had not gotten to this stage he had "felt like it a few times."

"People would rather be in the jail than be running about the streets homeless."

"I have been in the Inverclyde Centre over the years and never had that help," going on to describe the help he has received as "bang on."

J has a long history of substance use and is known to the local ADRS team and additionally suffers with health issues like epilepsy and a brain injury which causes issues with his memory.

In June 2023, J was identified as a potential Housing First candidate and put forward to the team for support. At this current time, his support is 4 hours per week, however it is the plan to increase this once he moves onto his settled tenancy.

Support has been particularly good for J. He continues to actively engage, reflecting "I have been in the Inverclyde Centre over the years and never had that help," going on to describe the help he has received as "bang on." Support has helped him to attend doctor's appointments, community groups, sort his benefit situation and "simple run of the mill things you would get complacent in", saying that he often struggled to stay on top of general housekeeping but that he has "noticed a big difference" in the support received from the service.

It was out of character for J to accept this support, stating "over the years I'd have knocked it [the support] back" but that by accepting support he built trust with his worker. He is additionally being supported by the local Inverclyde Faith in Throughcare charity and said they had a big part in helping J stay out of prison and that there was partnership working between his rapid rehousing support worker and the charity. J said that in the past that if he "got passed a few months [being out of the prison], I was doing well" but that his "last sentence was three years ago, which is brilliant."

He has now started a college course and leads a small football team in his spare time. Without support J said, "I don't think college would have happened, I don't think I would have stuck at the football."

In terms of housing situation, J and his girlfriend have said "where we are now is ideal for us…. [we are] hoping to keep it," and that they "couldn't be in a better area." This however is a temporary accommodation placement, but the service is looking into the possibility of flipping this tenancy to permanent accommodation when the opportunity arises. In terms of general housing management J has assured "I've got a routine set" and that him and his partner are "doing our best to keep it tidy" and that this was a marked improvement from the kept condition of their previous temporary accommodation placement.

"I've got a routine set" …… "Doing our best to keep it tidy."

J has described the service as "taking on my case hands on."

Big Action 5 – Together we will reduce the use of, and harm from alcohol, tobacco and drugs

National Outcomes relating to this Big Action	
1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
7	People using health and social care services are safe from harm

Inverclyde Alcohol & Drugs Recovery Service: Assertive In-Reach- Creating new pathways for people in crisis.

During 2023/24, a report conducted by the Inverclyde Addiction Liaison Team within Inverclyde Alcohol and Drug Recovery Services (ADRS) identified a need for a more assertive outreach approach to be taken to improve engagement through GP practices, as feedback has indicated, there has been a historic difficulty in engaging individuals in services from Port Glasgow into other areas of Inverclyde, and within the patient group who would benefit from Medication Assisted Treatment (MAT). To help address this, a decision was made to access CORRA funding for a test-of-change pilot that operationalised the existing Addiction Liaison Team as a primary care Outreach Service. Its aim was to target Inverclyde's increasing population of hard to engage and hidden individuals in need of support from services within Port Glasgow Health Centre.

In terms of impact, the Addiction Liaison Team has developed change in referral routes to service for individuals requiring treatment and support with their alcohol and/or drug use.

While the team has received 846 referrals total from all referral routes, including via Emergency Department and Scottish Ambulance Service, the team continue to receive referrals from GP practises engaging with this test-of-change, with an average of twenty-five appropriate cases being referred quarterly. Audit of two newly adopted clinics within GP practises has shown a reduction in hospital attendance and change to engagement with services following intervention received from the addiction liaison team. Previous service reports from acute hospital referrals have shown between April and December, 134 did not wish or require an onward referral to ADRS. Instead, accepting advice, information on self- guided support and self – referral routes to service. Additional resources to the team have enabled the service to offer outreach support post hospital discharge to individuals who decline onward referral to Alcohol and Drug Recovery Services. This has enhanced engagement with harm reduction supports and optimised service engagement efforts.

In terms of next steps, information from the pilot is being reviewed for individual's experiencing alcohol and/or drug issues attending out of hours services. Joint discussions are on-going with current local emergency response services to determine the need for out of hours addiction support. The service is now keen to expand the approach to all Primary Care cluster areas within Inverclyde.

Inverclyde Alcohol and Drug Recovery Service Medication Assisted Treatment Standards update May 2024

Inverclyde ADRS and Alcohol and Drug Partnership (ADP), continue to implement and embed the Medication Assisted Treatment (MAT) Standards ensuring consistent delivery of safe, accessible high-quality care and treatment for people within Inverclyde experiencing harm from substance use. The Standards adopt a rights-based approach, ensuring individuals have choice in their treatment and are empowered to access the right support for where they are in their recovery journey. Scottish Government bench marking has indicated Inverclyde has achieved the **highest** scores awarded at this time for implementation and delivery of all Medication Assisted Treatment standards, green for Medication Assisted Treatment 1-5 and provisional green for 6 - 10.

Governance for the MAT action plan lies locally with Inverclyde Alcohol and Drug Partnership and centrally within NHS Greater Glasgow and Clyde board-wide steering groups. This ensures consistency in implementation of approaches that uphold the human rights of individuals and their families when engaging with substance use support services. This partnership approach to governance and delivery has resulted in positive service improvements in proactive identification of individuals at risk of harm and proactive care planning to reduce risks from complex and co-occurring support needs. Moving forward it is recommended partners across all health care, social care and justice settings engage with the revision of the Inverclyde Medication Assisted Treatment Action Plan for reporting period 2024-2025.

Future recommended actions are broadly captured under themes of:

- Improving information sharing protocols (including actions on revision of drug death monitoring and review group membership).
- Optimising service capacity for proactive identification of individuals at risk of harm.
- Optimising access to independent advocacy for vulnerable individuals.
- Trauma-informed and trauma responsive people and services.
- Improving pathways (including targeted operationalisation of the revised Mental Health and Alcohol and Drug Recovery Service interface document)
- Optimising engagement with primary care

The table below, shows the current progress towards Inverclyde's Medication Assisted Treatment Standards. It demonstrates that across all standards performance has improved between March 2023 and 2024.

No.	MAT STANDARD	RAGB STATUS AT MARCH 2023	RAGB STATUS AT MARCH 2024

1	All people accessing services have the option to start MAT from same day of presentation	Provisional Green	Green
2	All people make an informed choice on what medication to use for MAT and the most appropriate dose.	Green	Green
3	All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.	Provisional Green	Green
4	All people can access evidence-based harm reduction at the point of MAT delivery.	Provisional Green	Green
5	All people receive support to remain in treatment for as long as requested	Green	Green
6	The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychological interventions (tier 2); and supports individuals to grow social networks.	Amber	Provisional Green
7	All people have the option of MAT shared with Primary Care	Amber	Provisional Green
8	All people have access to independent advocacy and support for housing, welfare, and income needs	Amber	Provisional Green
9	All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery	Provisional Amber	Provisional Green
10	All people receive trauma informed care.	Provisional Amber	Provisional Green

Moving Forward and next steps

To further help progress towards the standards, over the next year we will aim to:

- The Alcohol and Drug Partnership have ringfence budget to employee a Medication Assisted Treatment specific advocate who will be employed through Circles Advocacy. We are currently working with our commissioning team within the Partnership to modify the contract currently in place and will work to bring someone in to provide an independent advocacy service as part of a modification to the existing contract.
- We will improve promotion around Independent Advocacy and ensure people accessing Recovery Services know their rights and are aware of what support is in place for them to be able to have their voice heard.
- We will improve our referral pathway between Alcohol and Drug Recovery Service and Circles Independent Advocacy – the Alcohol and Drug Partnership will work to support both services in achieving this.
- We shall aim to embed independent advocacy services within our Alcohol and Drug Partnership structure and have staff employed that feed into our local networks and working groups to ensure a collective approach across the board.

Residential Rehabilitation Pathways Team

The Inverclyde Residential Rehabilitation Pathways Team is an Inverclyde Alcohol and Drug Partnership (ADP) collaborative development between Turning Point Scotland (TPS) and Inverclyde Alcohol and Drug Recovery Service (ADRS). The team consists of one senior addiction nurse from Alcohol and Drug Recovery Service, lead practitioner and business support from Turning Point Scotland. The team aims to engage, develop and improve pathways for people accessing residential rehabilitation and provide a smooth transition following residential rehabilitation into the local community and support services.
The role of the Residential Rehabilitation Pathways Team is to work in partnership with individuals, their families, Inverclyde Alcohol and Drug Recovery Service, Turning Point Scotland and other partners to develop a model of recovery which provides fast and appropriate access to help, care and treatment options that includes residential rehabilitation and remove any barriers to this.

The Scottish Government has committed to giving all Alcohol and Drug Partnerships additional monies to support the use of residential rehabilitation until March 2026. The team will have access to this Alcohol and Drug Partnership funding for residential placements and any necessary detox/crisis intervention, enabling funding decision to be made quickly. The criteria to access residential rehabilitation is that:

- People have a long-standing drug and/or alcohol issue for a period of years as opposed to months.
- People need to be committed to actively participate in a residential programme; and
- Agree to participate in recovery focused community activities following discharge from their residential rehabilitation placement.

Context and Background

In her statement to the Scottish Parliament on 20th January 2021, the First Minister set out additional investment as part of a National Mission to reduce drug deaths which included an immediate investment of £5 million pounds in the 20-21 financial year. A significant proportion of this is to increase the number of residential placements and associated aftercare to ensure there is capacity to meet demand.

Inverclyde Alcohol and Drug Partnership is committed to the delivery of services underpinned by the vision of Rights, Respect and Recovery Strategy (SG, 2019): *Scotland is a country where we live long, healthy and active lives regardless of where we come from and where individuals, families and communities:*

- *Have the right to health and life-free from the harms of alcohol and drugs.*
- *Are treated with dignity and respect.*
- *Are fully supported within communities to find their own type of recovery.*

Progress to date

The senior addiction nurse commenced in post in April 2023. Several attempts have been made to recruit the lead practitioner and business support however the post remains vacant at this time. Despite this the nurse has progressed the pathway and successfully supported 20 people to access residential rehabilitation placements. Out of the 20 individuals supported to access residential rehabilitation placements, 14 were male and 6 female.

60% of referrals to residential rehabilitation resulted in successful admissions. Among these 12 individuals, six self-discharged early, five remain in their placements at present and one completed their full placement.

75% of residential rehabilitation placements were funded by Inverclyde Alcohol and Drug Partnership (IADP), with the remaining 25% from non-ADP sources.

Big Action 6 – We will build on the strengths of our people and our community

National Outcomes relating to this Big Action	
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9	Resources are used effectively and efficiently in the provision of health and social care services

HSCP Workforce

One of our most important assets for Inverclyde Health and Social Care Partnership is our staff; the people who work with us and help deliver health and social care services to local people every day. Across all our service areas, the Health and Social Care Partnership has a workforce of approximately 1,700 people. We recognise that if local people are to achieve the outcomes that matter to them, then they need to have access to a confident and skilled workforce.

Our Workforce Plan (2022-25) (which can be found here Strategies, Policies and Plans - Inverclyde Council) sets out our key workforce strengths and challenges under the current financial pressures and how we will develop to meet the changing health and social care needs of local people. We want our staff to feel that their wellbeing needs are being met, that they know their work is meaningful and they are valued and supported to carry out their role. This plan follows the follows the five pillars of workforce planning, Plan, Attract, Employ, Train, and Nurture, as set out by the National Workforce Strategy for Health and Social Care in Scotland.

Health and care (Staffing) Scotland Act

Inverclyde Health and Social Care Partnership are working towards the implementation of the Health and Care (Staffing) Scotland Act (HCSSA) from 1st April 2024. The aims of the act are to enable safe and high-quality care and improved outcomes for those experiencing healthcare or care services through the provision of appropriate staffing. This means: **Having the right people, in the right place, with the right skills at the right time.**

Health and wellbeing of staff

We commenced Homecare Wellbeing Sessions in March 2024 and have plans for further sessions in April, May and July. The format is a drop in session and is arranged for each team/area where staff were able to drop in and take some time to stop, breathe and chat, have a sandwich, cake and cuppa with an opportunity to speak to some local supports and organisations including Health Improvement Team, Scotwest Credit Union, Inverclyde Leisure, Compassionate Inverclyde, Parklea (where they were able to make up a planter and take it away with them); they could have a massage/hints and tips for good posture/how to manage Musculoskeletal issues (with Geraldine Charleston, Massage Therapist - pictured). And most importantly, they got to take away some freebies – tote bag, coffee cup, water bottle, sweets, keyring, ice scraper, pen.

Training Board

Throughout the course of this year several initiatives designed to support the recruitment and retention of staff have been progressed.

Grow Our Own

Following design work last year, a "*Grow Our Own"* Initiative has been implemented with nine paraprofessionals securing support to obtain a social work qualification. 3 members of staff will complete a post graduate qualification and be ready to work as qualified social workers within 2 years. A further six members of staff will commence on an undergraduate pathway and will all be able to work as social workers over the next 3-4 years. As well as funding the course fees this initiative has allowed talented staff to pursue a qualification without the worry of reducing their salary or their job security – two of the main barriers identified by paraprofessionals considering a professional qualification. In addition to financial support plans are in place for appropriate peer support, learning and study support and to ensure the provision of high-quality practice learning placements. The *Grow Our Own* initiative is a long-term plan to provide stability across the social work workforce and address the national challenges in social work recruitment. It is a clear commitment to hard working talented staff across the Health and Social Care Partnership who have ambitions to progress into qualified social work roles. Following feedback from this first cohort of candidate's plans are being made to support other candidates next year.

New Qualified Social Workers

A further initiative of the training board has been to attract newly qualified social workers to Inverclyde. Over the last year we have offered financial incentives for candidates who have completed their MSc qualification. The Health and Social Care Partnership has reimbursed the final year of fees for appropriate candidates who have been successful at interview. This has been offered to five candidates this year all of whom have committed to remining in Inverclyde for at least three years. Payments have ranged from £2000 to £10,000 depending on the circumstances of the candidate.

Staff Experience

The Training Board continues to work on initiatives to improve the experience of staff working across the Health and Social Care Partnership. During a facilitated development session with representatives from all sections of the Partnership priority actions and areas of work were agreed and workstreams set up to

progress. Of note is a workstream to enhance the induction programme for new employees coming to work in Health and Social Care Partnership services as well as shared training opportunities across different services within the organisation.

Overall, the Training Board is providing a forum to progress ongoing initiatives to ensure Inverclyde is an employer of choice and has long term plans to address social work and social care recruitment and retention. There has been commitment of time and support from the Senior Management Team (SMT) as well as agreed and flexible financial resource to support the main aims of the Board.

Developing our Primary Care Workforce

Investing in, supporting and increasing our workforces understanding and awareness of services is pivotal to our patients accessing the right care in the right place. Through various engagement routes, we have provided online engagement sessions, staff information stalls, attendance at team meetings and dissemination of materials.

To complement this we have provided training, of our 115 GP reception workforce, 39% have attended our care navigation training. Further sessions are scheduled into autumn of 2024 to train our remaining workforce and roll out this signposting model to our Health and Social Care Partnership workforce to create a consistent and standard approach to signposting.

Maximising Independence - Workforce Development

What we hope to accomplish: a workforce with the mindset, knowledge, skills and confidence to support self-management effectively – enabling people to take greater responsibility for, and have more control over, their health and wellbeing.

Change idea: a tool-kit of 'supporting self-management' learning resources, and a cross-sector community of practice focused on supporting self-management.

Progress.

- relevant available learning resources have been mapped.
- staff participating in tests of change have received training in key approaches to support self-management.
- supporting self-management is included in Care at Home staff induction.
- an online community of practice has been created for all practitioners to connect, learn, share, develop and collaborate to support self-management – 65 services are currently represented.

*Partner*s: Health Improvement Team, Training Board and Primary Care Transformation.

The programme is using the Model for Improvement, so adjustments are constantly being made within projects, in response to learning from testing. By November 2024, findings and lessons learned will provide an indication of approaches to implement, spread, develop, or explore further.

Mental Health Practice Development Support Nurse

The service is in the process of recruiting a Practice Development Support Nurse (PDSN) who will have a direct role in supporting professional and practice development of nursing staff on all aspects of mental health nursing. The PDSN will provide a clinically visible presence and work across inpatient and community mental health services. Historically this has been a shared post with Renfrewshire and it is hoped that the post being ring fenced to Inverclyde will help to contribute to and embed quality and good practice across Mental Health services in Inverclyde.

The Practice Development Support Nurse will:

- ✓ Share good practice across in-patient and community nursing services in line with National, Board and local standards.
- ✓ Be responsible for delivering developed clinical and evidence-based nursing practice in line with agreed priorities, standards, policies and guidance, ensuring that nurses of all grades participate in the process.
- ✓ Facilitate the dissemination of new and updated polices and guidance, auditing application in practice.
- ✓ Support the Practice Development Nurse to deliver national, board and service strategies and priorities.
- ✓ Facilitate workshops, training and education in line with service and local priorities.
- ✓ Contribute to the development, implementation and evaluation of clinical guidelines, procedures and policies and the monitoring of clinical standards.
- ✓ Maintain effective communication with all members of the multi-disciplinary team.

Mental Health Advanced Nurse Practitioner (ANP)

The Advanced Nurse Practitioner (ANP) team have been established over the past 2 years for mental health inpatient services, helping to develop and transform nursing roles and alleviate workload pressures due to medical staffing shortages. The 2 trainee Advanced Nurse Practitioners who commenced in September 2022, were joined by a Lead Advanced Nurse Practitioner in October 2023.

The Advanced Nurse Practitioners:

- ✓ Attend ward rounds with members of the multidisciplinary team, often taking the lead on recording reviews, decisions and actions.
- ✓ Respond to unscheduled activity from all 5 wards in the absence of the ward doctors when on leave/ on call in other hospitals.
- ✓ Prescribe treatment and order tests/investigations for patients.
- ✓ Provide education sessions for our ward staff and junior doctors.
- ✓ Conduct annual physical health assessments for long term patients.
- ✓ Provide advice and support for staff and take lead in highly charged situations.
- ✓ Lead on Significant Adverse Event reviews (Lead Advanced Nurse Practitioner)
- ✓ Increase patient safety and improve continuity of care for patients and reduce waiting times to be seen.

The Advanced Nurse Practitioner service has been welcomed by nursing staff. Anonymous feedback forms from staff highlight the success of the service in the absence of ward doctors. One example of feedback states “I can’t praise the team highly enough and find them more attentive than some junior doctors. Their conduct is exemplary, and they know the limits of their knowledge and are not afraid to seek advice. Overall, a welcome reliable addition to Inverclyde services.” Another feedback example received stated “Helpful when duty Dr not around, visible and active on the ward. Happy to help with any tasks, offering advice and support where needed.” The team is continually adapting to meet service needs with early discussions taking place to collaborate with the Crisis Team, seeking to reduce bed shortages."

With the two trainee Advanced Nurse Practitioners expected to qualify by Autumn of this year; the service will evaluate how best to harness and align the skills of the team across inpatient and community services to meet the current and future needs of Mental Health services in Inverclyde.

Development of ‘After 5’ Services

To help provide greater support to the people of Inverclyde, we have taken steps to enhance the availability of many of our services out-with the traditional 9-5 office hours. It was evident from discussions for people who access our services and local people, that quite often, Health and Social Care Partnership services are needed in the evenings and on weekends. The section below provides an example of some of the services that are now available after 5 ‘o’clock.

Alcohol and Drug Services

Statistics are being reviewed of current out of hour’s attendances for individual’s experiencing alcohol and/or drug issues. Joint discussions are on-going with current local emergency response services to determine the need for out of hours addiction support. The service is now keen to expand to all Primary care cluster areas within Inverclyde.

Service user and staff questionnaires remain on-going focusing on individual’s opinions and views of accessing alcohol and drug treatment and support within the evenings and weekends including out of hours access to support.

Rehabilitation and Enablement Service: Out Of Hours Team

Inverclyde Rehabilitation and Enablement Team have extended their service to 7 days a week and extending service hours to 7pm each day. This approach enhances and supports the Health and Social Care Partnership’s existing Out of Hours teams and provides a greater availability of services to local people. The service aims to support people with care needs to remain safely at home where possible. Before this enhancement of service, all rehabilitation support was provided during traditional office hours of 9-to-5. Providing this support into the evening will have a positive impact on those in receipt of the care. Currently we have introduced Allied Health Professional (AHP) support (i.e Physiotherapist & Occupational Therapist) to this service alongside our Rehabilitation Health Care Support Worker Team at weekends. Moving forward we are hopeful and anticipate by 2025 to extend AHP cover into evenings also to provide this expertise and support across our 7 day service.

Young People

Our intensive support model works with children and young people who are at the highest risk of being accommodated due to risk of harm, including within the community. Over the past year the service has enhanced its model to provide support across seven days including evenings and weekends. In delivering the intensive support model, the service will:

- Create meaningful relationships with children, young people and families
- Help families to recognise, and build on their strengths
- Support families to create wider support networks with family and friends
- Ensure that children and young people and their families are listened to and meaningfully and appropriately involved in the assessment, decision-making and planning about their care and support.

This flexible approach provides opportunities to support children, young people and families in creative ways to reduce risk, build confidence, and promote safety and resilience. The model seeks to deliver a range of outcomes with children, young people and families to:

- reduce the number of children and young people locally who need to be looked after.
- support children and young people to return and remain with their families, feeling safe and nurtured.
- reduce the impact of social inequalities on children and young people, and
- support a nurturing transition to adulthood.

Call before you Convey

Details of our call before you convey service, an excellent example of support to people out-with office hours, are provide on page 45.

Care Opinion

Care Opinion is an online tool where the people of Inverclyde can share their experiences of health or care services. It is safe and simple to share stories of care and to view others stories also. The public, services and regulators can see how stories are leading to change. Inverclyde Health and Social Care Partnership passionately believes that by sharing honest experiences of care, we learn to see the world differently. Working together, we can all help make care better.

In partnership with Care Opinion we provide an online platform so that

- **people can share** honest feedback easily and without fear.
- **stories are directed** to wherever they can help make a difference, and
- **everyone can see** how and where services are listening and changing in response.
- **Inverclyde Health and Social Care Partnership** want residents and users of services to have every opportunity to give feedback and actively promote use of Care Opinion

The examples provided below are direct excerpts from Care Opinion. All names have been maintained.

Story A - My husband damaged his back and broke his hip after suffering three strokes. Which had a big impact on his physical abilities, his confidence and emotional wellbeing. He was referred to Physio at Inverclyde Centre for Independent Living who encouraged him to come along to a physio group with people of a similar age and various physical disabilities.

My husband was very unsure at first of going, however once attending this physio group, he became motivated, he enjoyed meeting the other people doing the exercises, which not only helped his physical abilities, his confidence and wellbeing was increased, giving him the help and encouragement required to allow him to make the best of his life. I feel if these groups were to continue weekly (not just for a short block) people like my husband would have a place to go to allow him to meet others as well as helping his physical and emotional wellbeing needs.

This group also helped me as an unpaid carer to enable me to talk to the physio and support physios, learn about the other groups which were there to help and support me.

Story B - From the moment our dad was being discharged home for end-of-life care, the staff made us feel reassured and at ease, from the staff in G North at Inverclyde Royal Hospital to Nicole and Margaret who helped us plan a speedy discharge home with all the equipment.

Once our dad got home, he was able to be cared for by ourselves, his family, alongside the district nurses. The hybrid team were amazing in everything they have done for us, and we even managed to get a few laughs at such a difficult time (David, David, Jacqueline, Mhairi and Gisha). Our dad would have loved this.

The overnight district nurses were a God send at 1 a.m. and helped us, as a family, cope through until the morning, knowing that we had support throughout the night when it was difficult (Sandy, Sandra, Lisa, Morag, Theresa, Bridget and Gemma). They gave us time and listened to us at every visit, whilst delivering top class nursing care to our dad.
Hospice Advanced Nurse Practitioner Monica supported us and visited our dad at home. Janice at Ardgowan Hospice helped support younger members of the family too. The twilight team of district nurses were available at any time and always knowing they were not far away made it easier. They reassured us that they were at the end of the phone. Cochrane district nursing team (Claire, Lesleyann, Sharon, Lucy, Heather, Ann, Cath, Collette and Arlene) were all amazing. Angela the phlebotomist was also incredibly supportive.

The community alarm team were very quick to respond and the care at home team also supported our dad prior to his condition deteriorating. The district nursing managers (Linda and Neil) supported our dad at home and personally visited him. To all the others within Inverclyde who supported our 87-year-old father to live his best life - thank you.

To the medical staff who took time to care for our dad - thank you. To the management teams within Inverclyde Health and Social Care Partnership, we will be eternally grateful for all your help and your wonderful team of staff who provided our dad with compassionate, exemplary, person-centred care.

Thank you ♡

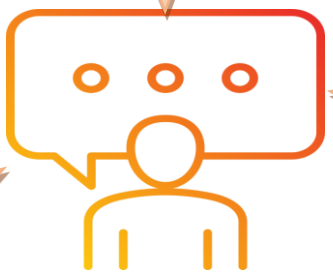
Direct Quotes from different stories

I was most impressed by the Health Visitors willingness to take the time to listen to me.

I do not know what I would have done without the help from the carers and the lovely Physio.

Nicki and her team were amazing, always encouraging and supporting me to do exercises that was within my capability; they took the time to listen to me and took on board how I was feeling.

I found the services mentioned (physio, podiatry, OT) both helpful, beneficial, with happy cheerful staff whose attitude always shone through while in attendance.



Care Inspectorate Activity

In October 2023, the Care Inspectorate and Healthcare Improvement Scotland (HIS) advised of their intention to jointly inspect health and social care services for adults in the Inverclyde Health and Social Care Partnership area, with a focus on services for people living with mental illness and their unpaid carers.

Inspection activity formally commenced on 23rd October 2023 and considered the following question:

> "How effectively is the partnership working together, strategically and operationally, to deliver seamless services that achieve good health and wellbeing outcomes for adults?"

Inspection activities included.

- compilation of a position statement and supporting evidence by the Health and Social Care Partnership.
- engagement with people living with mental illness and their unpaid carers.
- a survey of staff in the Health and Social Care Partnership, third and independent sector agencies.
- a review of selected health and social work records.
- conversations with selected individuals and groups of professionals, including some of the people whose records were reviewed and the staff groups that support them.
- scrutiny focus group sessions including frontline staff, senior managers, strategic leaders, third sector partners, commissioned service and homelessness staff.
- four partnership meetings throughout the inspection between the inspection team and senior managers to discuss progress and findings.
- two informal observational visits were conducted by the Inspection Team; one to the Greenock Health Centre and one to the Community Mental Health Team within Crown House. The visits were facilitated by the Service Manager, Learning Disability (Health Centre) and the Service Manager, Mental Health (Crown House) and the feedback indicated that both visits went very well and that the Inspectors found them informative and helpful.

Inspectors highlighted the following key strengths:

- Most people living with mental illness in Inverclyde had positive experiences of health and social care services that contributed to good outcomes for their health, wellbeing and quality of life.
- The partnership's vision focused on inclusion and compassion. It was committed to investing in community-based early intervention and prevention initiatives to support whole population mental health and wellbeing.
- Leaders promoted a collaborative culture, which was understood by staff and communities. Longstanding integrated and co-located services provided a good basis for the provision of seamless services.
- The partnership had robust contract commissioning processes and there were good relationships with providers.

The final report of the Inspection is expected to be completed early May 2024 and will be available on The Care Inspectorate website Site Search (careinspectorate.com)

The total number of external commissioned providers inspected during 2023/2024 was forty-four. These included inspections to Older People Care Homes, Care at Home providers, Supported Living providers and Children and Family providers. Seven providers were inspected on more than one occasion resulting in fifty-two inspections taking place.

Service Inspections

Of the 44 services that were inspected during their initial visit:

- 16 of the services inspected were Inverclyde area.
- 28 of the services inspected were of out of area services.
- 12 services improved their grades.
- 22 of the services maintained their grades.
- Ten of the services grades decreased.
- Seven of the 44 services had a second follow up visit to review.

Seven services had two or more inspections carried out with an initial decrease. Of these:

- One service had three inspections. They increased their grades on their second visit and increased those grades further on their third visit.
- Six services had two inspections and increased their grades. on their second visit.

For the 16 inspections undertaken in the Inverclyde Area:

- Three services increased their grades.
- Eight services maintained their
- Five services had a decrease in their

Of the five services who received a decrease on their grades.

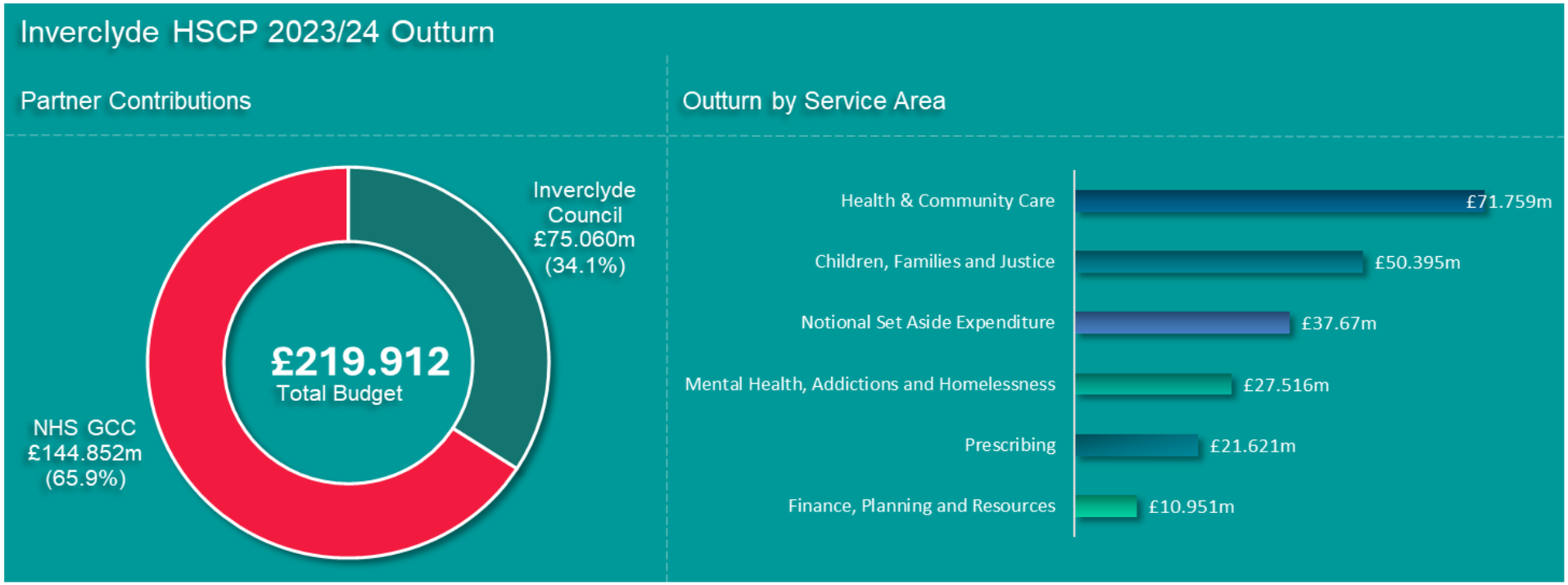
- One changed from 'Excellent' to 'Very Good.'
- Two changed from 'Very Good' to 'Good.'
- One changed from 'Good' to
- One changed from 'Adequate' to 'Weak'

From the initial inspections in Inverclyde the Care Inspectorate made 52 areas of improvement and 27 requirements made.

SECTION 4: FINANCE AND BEST VALUE

Inverclyde IJB Financial Summary by Service

On 25th March 2024, the Integration Joint Board approved a two-year budget including £5.2m of planned savings and efficiencies over the budget years 2024/25 and 2025/26, along with the use of £0.7m of reserves in 2024/25 to meet the remaining budget gap for the year. The 2023/24 IJB expenditure is demonstrated in the image below:



Inverclyde IJB Financial Challenges of 2023/24

The Partnership was overspent by £0.843m in 2023/24 at the financial year end. Existing Smoothing Reserves were used to offset this for 2023/24. On the Social Care side of the budget overspends of £3.380m were incurred mainly within Children and Families for Residential Placements, Fostering, Adoption and Kinship supports. This is partially offset by underspends of £2.946m mainly in Client Support costs across adult services, vacancies in most services and over-recovery of client income in Adult Services. On the Health side of the budget overspends of £1.764m were incurred within the Prescribing budget. This is partially offset by underspends due to vacancies across the Health side of the Health and Social Care Partnership.

At the start of the year the Health and Social Care Partnership had a smoothing reserves balance of £6.592m. This is to facilitate managing services of a volatile nature and a contingency for any pay award deficits. During the year a total of £3.676m has been drawn down for these purposes. In addition, a specific severance cost reserve of £1.492m has been created as part of the budget setting process to pay for any voluntary redundancy costs incurred as part of the 2024/26 savings programme. This leaves a total smoothing reserve balance of £4,408 available for use in 2024/25 onwards in addition to our savings plan.

The Integration Joint Board continued to hold a Transformation Fund for the purposes of funding projects and activities which will realise future efficiencies for the Partnership. A closing balance of £1.326m was recorded.

Reserves are held for Winter Pressures/Planning amounting to £1.735m across various workstreams. £0.525m net expenditure was incurred in 2023/24 financial year, with the remaining £1.21m to be utilised to ease pressure on care services in 2024/25.

General Reserves of £1.561m are also held for the partnership.

Overall opening reserves of £24.262m were held at 1 April 2023. During the year £10.130m of Earmarked Reserves were used to fund specific spend and projects. An additional £5.155m was added to Earmarked Reserves including £0.709m allocated to general reserve as part of the budget process approved by the IJB to temporarily fund the 24/25 as part of the overall approved savings.

- The Set Aside budget set for 2023/24 is £37.670m. The Set aside arrangement results in a balanced position each year end.
  - The Set Aside budget is the amount “set aside” for each IJB’s consumption of large hospital services.
  - Initial Set Aside base budgets for each IJB were based on their historic use of certain Acute Services including A&E Inpatient and Outpatient, general medicine, Rehab medicine, Respiratory medicine and geriatric medicine.
  - Legislation sets out that Integration Authorities are responsible for the strategic planning of hospital services most associated with the emergency care pathway along with primary and community health care and social care.
  - The Set Aside functions and how they are used and managed going forward are heavily tied into the commissioning/market facilitation work that is ongoing.

SECTION 5: PEOPLE AND LOCALITIES

Participation and Engagement

Inverclyde Health and Social Care Partnership is passionate about the health and wellbeing of all local people and committed to delivering high quality health and social care services and improving the ways our people and communities can be involved in decision-making that affects them, we want to do things differently when engaging with our communities. We know that by working together in partnership our care providers can transform the experience of people who use our services as well as the experience of those who deliver them. The Planning With People (www.gov.scot) guidance helps us achieve that widely and with consistency.

This year we consulted with local people, communities and partners as part of the process of developing our new Strategic Commissioning Plan. Following an initial engagement and development period last year, we identified the Health and Social Care Partnership Vision and four Strategic (key) Priorities to progress from 2024-2027.

Engaging and listening to communities, staff and partners was key in determining the Health and Social Care Partnership's strategic priorities. Our engagement with service users and carers, our people, local networks and forums is a continuous process, ensuring views from all sectors of our community are captured and shared to support and inform local decisions making.

Mechanisms for capturing feedback included:

- Proactive feedback from the people of Inverclyde via face-to-face contact with practitioners and officers of Health and Social Care Partnership, advisory networks, user groups, independent, third and voluntary sectors; surveys; and national experience surveys.
- Responsive feedback in the form of complaints, care opinion feedback and reported incidents.
- The contributions of our Strategic Planning Group (SPG), Locality Planning Groups (LPGs), Advisory Networks, user and carer groups to ensure that service user experience is at the centre of the Health and Social Care Partnership's work.
- Regular stakeholder and community engagement events and exercises.

The process of consultation supporting the preparation of the Inverclyde Health and Social Care Partnership Strategic Commissioning Plan 2024-2027 was in four main parts.

1) Obtaining views on the understanding and effectiveness of the previous Strategic Plan 2019-2024, highlighting the (September – November 2023)

2) Obtaining views on what the main challenges are for the Health and Social Care Partnership, to help inform our themes for development and improvement. (September 2023 – February 2024)

3) Obtaining views on the needs of our people from our communities, our Integration Joint Board, Strategic Planning Group and workforce (alongside the needs assessment) (September 2023 – February 2024)

4) Obtaining views on the draft Health and Social Care Partnership Strategic Priorities (January-February 2024)

Other examples of participation are below and a copy of findings reports can be found as follows [Participation Feedback - Inverclyde Council]

Primary Care Improvement Plan (PCIP) Engagement

We will continue to work with our wider primary care partners to implement the Primary Care Improvement Plan in line with Primary Care Transformation. The Memorandum of Understanding (MOU) for period April 2023 – March 2024 has been very much focused on introducing skill mix into teams, embedding a right care, right place ethos.

Population Engagement

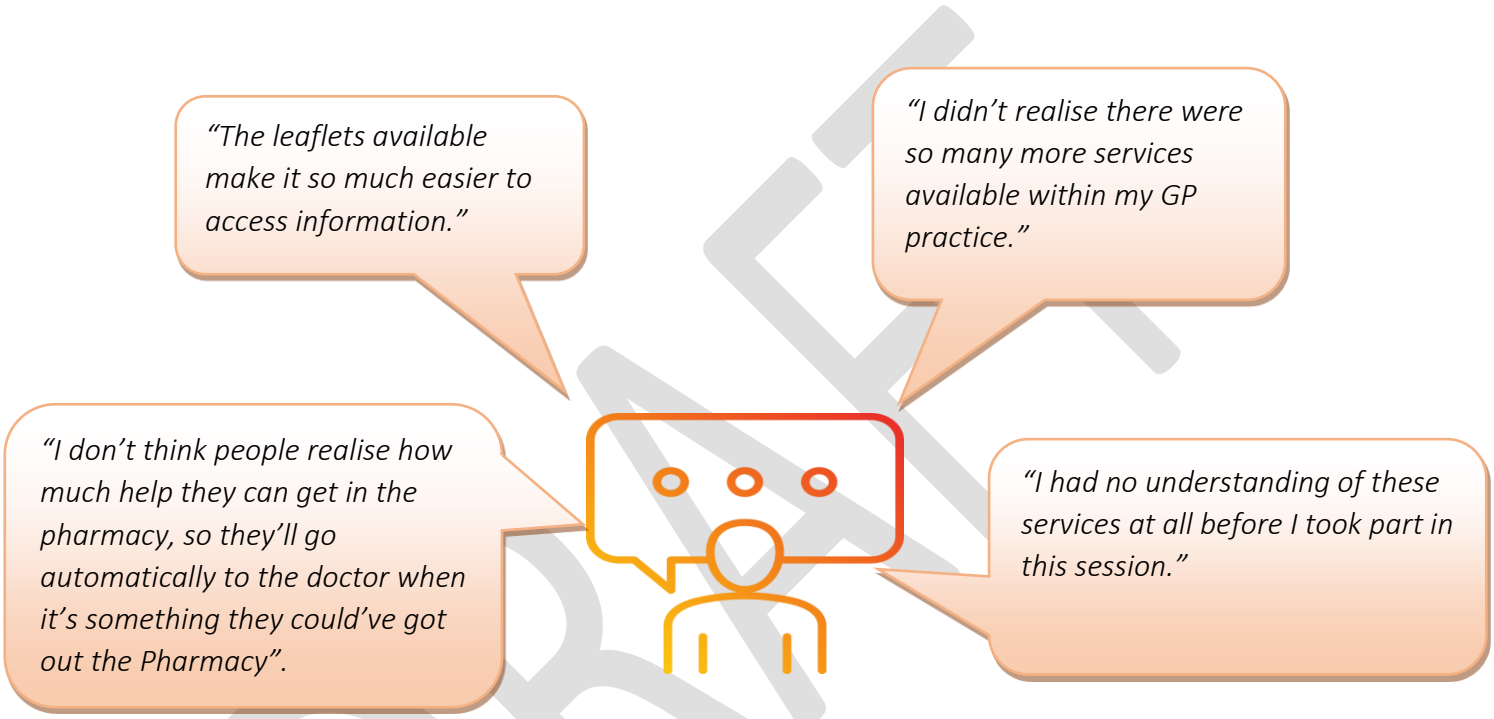
Working with our third sector partner Your Voice, we have shared our local Primary Care Transformation journey through the creation of a Primary Care Transformation brand, film, materials, Primary Care Guide, social media assets and community engagement. We have raised awareness and gained feedback from our population through Partnering with foodbanks, leisure, libraries, community centres, garden centres and many more community settings to cascade our messages and raise the profile of Primary Care, services, resources and support our population, developing our Linktree, this now hosts our materials, surveys, film and other useful reference points and resources. [Inverclyde Primary Care | Facebook | Linktree]

We made use of social media platforms and digital billboards to convey our right care, right place messages and the transformation of Primary Care and associated services to our communities. In addition to this we.

- Engaged with 35 Community Groups
- Attended at 28 Public Information Stalls
- 1004 population surveys completed.
- Delivered 39,367 Primary Care Guides to Inverclyde households.

- Of the 1004 population surveys completed 67.1% (996) indicated that they were aware of the meaning of Primary Care prior to this engagement exercise.
- 78% (784) accessed their GP for help, advice, support for their health and wellbeing.
- Awareness of services demonstrated that 77.5% were most aware of Community Pharmacy services, of those 50% had attended a Community Pharmacy for advice and support. A positive culture shift in the use of Community Pharmacy services.

Positive feedback



Barriers were also noted, which will provide a useful tool for service improvement including digital access i.e. online booking and cancellation options, withdrawal of bus services proving challenging for patients attending health centres. The intention is to progress feedback with a 'You said, we did' model to give back to our community positive feedback and progression updates based on their comments through this engagement exercise.

Locality Planning: 2023-24 update

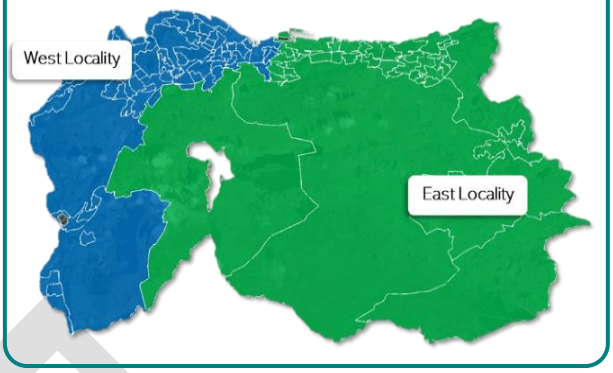
We have continued to improve and enhance our approaches to locality planning. Locality planning is a key mechanism for Health and Social Care Partnership to help ensure that through voices, needs and aspirations of local communities are at the heart of our decisions making. Locality planning groups are essential parts of our strategic planning and service improvement processes.

Over the course of the year, we have focused on establishing our two localities, **East Locality** (covering the communities of Kilmacolm, Port Glasgow and East Greenock, and **West Locality** (covering Greenock Central, Greenock West, Gourock, Inverkip and Wemyss Bay).

During the year, we undertook activity setting the groundwork for the locality groups, this included:

- Identifying locality Chair-people for each group.
- Establishing a core group of members, with representation from local people, service user and carers reps, third sector partners and Health and Social Care Partnership staff.
- Producing and agreeing a working Terms of Reference for each group.

Fig 6.1 – Inverclyde Locality Map



Group meetings will take place every three months. To date, each locality has had the opportunity to provide feedback on local and regional strategies and been informed about recent developments in the Health and Social Care Partnership. Some examples include:

- Providing feedback on Greater Glasgow and Clyde's review of Out of Hours services.
- Supporting the development of the Health and Social Care Partnership's new Strategic Plan by participating on locality-based discussions around the proposed strategic priorities.
- Invited to comment on the review of Care at Home Services, and Homelessness Service.
- Receiving a presentation on Care Opinion, learning about its value as a tool to provide meaningful feedback on an individual's experience of Health and Care services.

Going forward, we will continue to strengthen the role of our locality groups by establishing clear reporting pathways back into the overall strategic planning structures of the Health and Social Care Partnership. In addition, next steps for the group include:

- Enhancing membership and representation.
- Updating locality profiles to highlight the key strengths and needs in each area.
- Identifying locality-based priorities for action

Information on how you can participate in our locality discussions can be found on our website.
HSCP Locality Planning Groups (LPGs) - Inverclyde Council

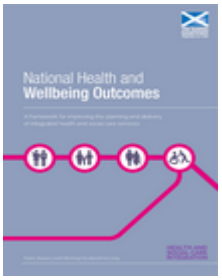
Children & Young People Participation / Proud2Care Network

A youth led film was produced to support and encourage children and young people to go along to their Hearings meetings. The Film was written, directed and produced by young people in partnership with the iPromise in Hearings Working Group which has been listening to children and young people to work together to deliver change.

Appendix

Appendix A: National Outcomes

National Health and Wellbeing Outcomes



1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long-term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including support to reduce any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

National Outcomes for Children

10. Our children have the best start in life and are ready to succeed.
11. Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
12. We have improved the life chances for children, young people and families at risk.

National Outcomes for Criminal Justice

13. Prevent and reduce further offending by reducing its underlying causes.
14. Safely and effectively manage those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all.

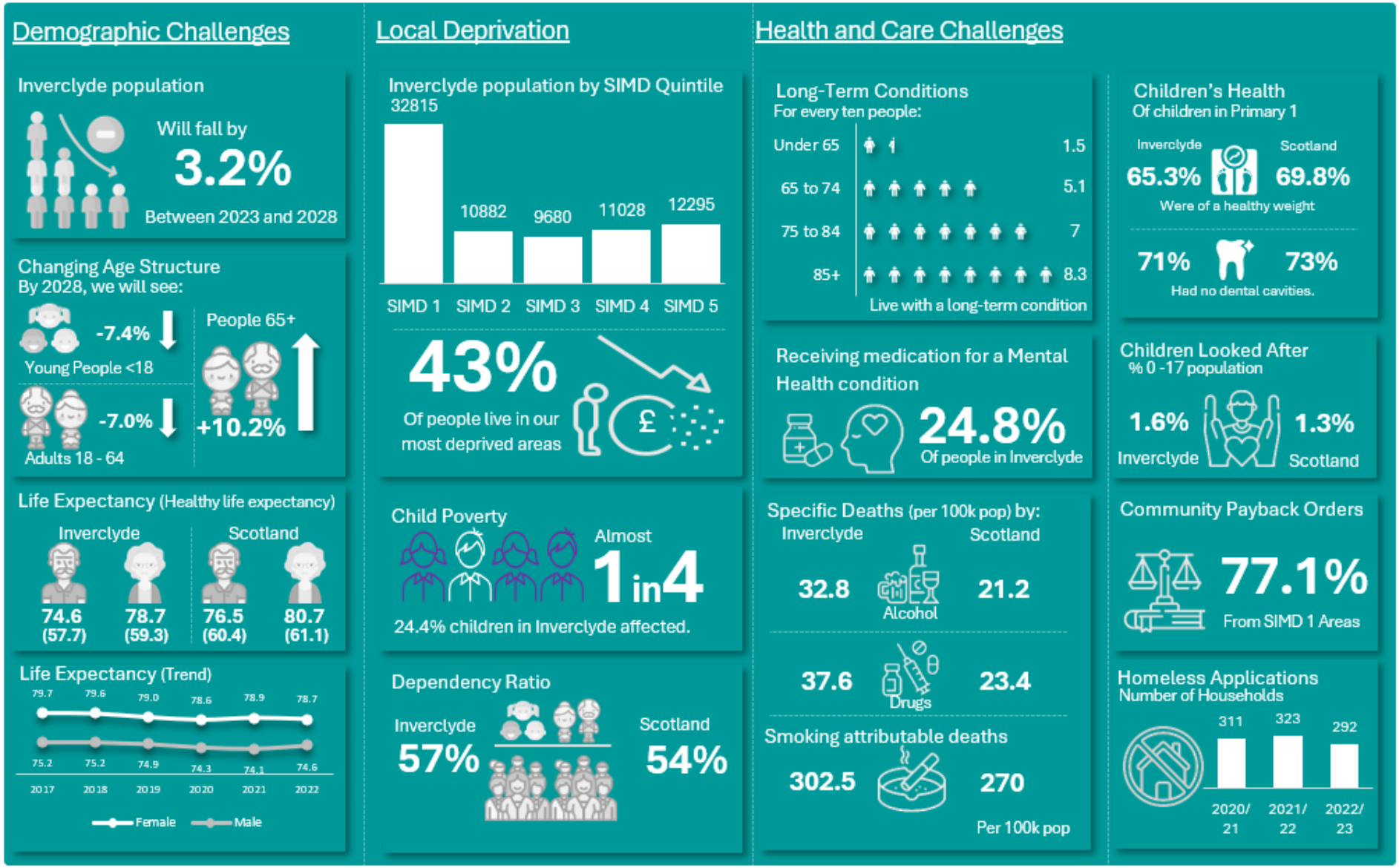
Appendix 2: Glossary of Abbreviations

A&E	Accident and Emergency department
AAU	Acute Assessment Unit
ADPM	Advanced Dementia Practice Model
ADP	Alcohol and Drugs Partnership
ADRS	Alcohol and Drug Recovery Service
APR	Annual Performance Report
ARC	Association for Real Change
AWI	Adults with Incapacity
BF	Breast Feeding
CCHST	Collaborative Care Home Support Team
CHAT	Care Home Assurance Tool
CJSW	Criminal Justice Social Work
CLW	Community Link Worker
CMHT	Community Mental Health Team
CORRA	
CPO	Community Payback Order
CTAC	Community Treatment and Care Services
DNA	Did Not Attend
DZ	Data Zone
ERA	Environmental Risk Assessment
GGC	Greater Glasgow and Clyde
GP	General Practitioner
HEPMA	Hospital Electronic Prescribing and Medicines Administration
HIS	Healthcare Improvement Scotland
HSCP	Health and Social Care Partnership
HLE	Healthy Life Expectancy

IJB	Integration Joint Board
ICC	Inverclyde Carers Centre
IRD	Initial Referral Discussions
IPCU	Intensive Psychiatric Care Unit
LPG	Locality Planning Group
MAPPA	Multi-Agency Public Protection Arrangements
MAT	Medication Assisted Treatment
MHAU	Mental Health Assessment Units
MHO	Mental Health Officer
MMR	Measles, Mumps and Rubella
MSG	Ministerial Steering Group
NHS	National Health Service
NRS	National Records for Scotland
OPMHT	Older Peoples Mental Health Team
OST	Opiate Substitute Treatment
PCIP	Primary Care Improvement Plan
PCMHT	Primary Care Mental Health Team
PDS	Post Diagnostic Support
PHS	Public Health Scotland
RFA	Request for Assistance
RSL	Registered Social Landlord
SAS	Scottish Ambulance Service
SDS	Self-Directed Support
SIMD	Scottish Index of Multiple Deprivation
SMR	Scottish Morbidity Record
SNIPS	Special Needs in Pregnancy Service
SPG	Strategic Planning Group

SOP	Standard Operating Procedure
TEC	Technology Enabled Care
TU5	Thrive under 5

Appendix 3: Needs Assessment Infographic



Below shows a readable description of the infographics provided on page 24.

Demographic Challenges

1. Shows that the population of Inverclyde will fall by 3.2% between 2023 and 2028.
2. Shows, that while the population is falling, we will see a fall of 7.4% in the number of people under 18, a 7% fall in adults aged between 18 and 64, and an increase of 10.2% in those aged 65+
3. Shows that male life expectancy in Inverclyde is 74.6 years, lower than the Scotland average of 76.5. It shows a life expectancy of women in Inverclyde of 78.7, again lower than the Scottish Average of 80.7.
4. Shows that male healthy life expectancy in Inverclyde is 57.7 years, lower than the Scotland average of 60.4. It shows a healthy life expectancy of women in Inverclyde of 59.3, again lower than the Scottish Average of 61.1.
5. Shows the falling life expectancy trend for both males and females in Inverclyde between 2017 and 2022.

Local Deprivation

6. Shows the distribution of the Inverclyde population by SIMD Quintile. With SIMD Quintile with 32,815 people, SIMD 2 with 10,882 people, SIMD 3 with 9,680 people, SIMD 4 with 11,028 people, and SIMD 5 with 12,295 people.
7. Shows that 43% of the Inverclyde population live in the most deprived Quintile 1 areas.
8. Shows that 24.4% of children in Inverclyde live in poverty. Almost 1 in 4 children.
9. Shows the dependency ration for Inverclyde is 57%. Greater than the Scotland figure of 54%.

Health and Care Challenges

10. Shows that for every ten people:
    - Aged under 65, 1.5 has a long-term condition.
    - Aged between 65 to 74, 5.1 has a long-term condition.
    - Aged between 75 to 84, 7 has a long-term condition.
    - Over 85, 8.3 has a long-term condition.

11. Shows that 24.8% of the local population is receiving medication for some form of mental health condition.
12. Shows that in Inverclyde, as a rate per 100,000, 32.8 people died because of alcohol use, compared to 21.2 in Scotland.
13. Shows that in Inverclyde, as a rate per 100,000, 37.6 people died because of drug use, compared to 23.4 in Scotland.
14. Shows that In Inverclyde, as a rate per 100,000, 302.5 deaths were attributed to smoking, compared to 270 across Scotland.
15. Shows that in Inverclyde 65.3% of primary one school children were of a healthy weight, compared to 69.8% across Scotland.
16. Shows that in Inverclyde 71% of primary one school children had no dental cavities, compared to 73% across Scotland.
17. Shows that of the 0–17-year-old population in Inverclyde, 1.6% were looked after compared to 1.3% across Scotland.
18. Shows that in Inverclyde 77.1% of Community Payback Orders were from people living in Inverclyde's most deprived SIMD quintile one areas.

19. Shows the number of Homelessness Applications received in Inverclyde by number of Households. It shows 311 applications in 2020/21, 323 applications in 2021/22, and 292 applications in 2022/23.

Appendix 4: Vaccination Statistics

Inverclyde HSCP - COVID19Uptake				Inverclyde HSCP - Flu Uptake			
Cohort	Vaccinated	Population	% Uptake	Cohort	Vaccinated	Population	% Uptake
Age 75+	5,995	7,559	79.30%	Age 75+	6,002	7,559	79.40%
Age 65 - 74	5,426	8,877	61.10%	Age 65 - 74	5,513	8,877	62.10%
Older People Care Home Residents	520	597	87.10%	Age 50 - 64	3,055	10,874	28.10%
Frontline Healthcare Workers	297	1,332	22.30%	Older People Care Home Residents	534	597	89.40%
Weakened Immune System	1,179	2,168	54.40%	Weakened Immune System	1,264	2,145	58.90%
At Risk 12 to 64	3,249	11,489	28.30%	All Health Care Workers	252	1,190	21.20%
At Risk 5 to 11	26	487	5.30%	At Risk age 18-64	4,132	13,057	31.60%
At Risk 6 months to 2 years	0	93	0.00%	All Social Care Workers	151	1476	10.20%
All Social Care Workers	254	2214	11.50%				
	16,946	34,816	48.67%		20,903	45,775	45.66%

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