AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date: 12th June 2017**
Report By:	**Louise Long** **Corporate Director, (Chief Officer)** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No: IJB/24/2017/HW**
Contact Officer:	**Helen Watson** **Head of Service** **Strategy and Support Services**	**Contact No: 01475 715285**
Subject:	**ANNUAL PERFORMANCE REPORT 2016-2017**	

1.0 PURPOSE

1.1 The purpose of this report is to provide an update to the Inverclyde Integration Joint Board members on the overall performance of Inverclyde Health & Social Care Partnership.

1.2 The reporting period is for 1st April to 31st March 2017.

2.0 SUMMARY

2.1 The report summarises Inverclyde's performance in relation to the nine National Wellbeing Outcomes.

2.2 The report also measures Inverclyde's performance against the 23 National Core Integration Indicators and shows comparison with the Scottish average.

2.3 Separate measures specifically relevant for Children's Services and Criminal Justice have been included.

2.4 The report is structured to show how Inverclyde Health and Social Care Partnership is actively *Improving Lives* for the people of Inverclyde.

3.0 RECOMMENDATIONS

3.1 That the Inverclyde Integration Joint Board members review and approve the Annual Performance Report. Members are also requested to acknowledge the improvements achieved in the first year of the partnership and the foundations that have been established to continue to drive forward transformational change.

Louise Long
Corporate Director, (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires that an Annual Performance Report is produced and presented to Integration Joint Boards (IJB), highlighting performance on delivering the nine National Wellbeing Outcomes, as measured against delivery of the 23 National Indicators.

4.2 The data for the 23 indicators is provided by ISD Scotland, and must be reported. However HSCPs can also include supplementary information, although this must also relate to the National Wellbeing Outcomes.

4.3 The Annual Performance Report has been compiled to be easy to understand, and uses graphics to illustrate performance. It also includes some brief case studies to help illustrate why the indicators matter to the lives of our citizens.

5.0 IMPLICATIONS

FINANCE

There are no financial implications from this report.

5.1 **Financial Implications**:

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

5.2 There are no legal implications from this report

HUMAN RESOURCES

5.3 There are no implications from this report

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

There are no specific equality issues contained within this report.

	YES (see attached appendix)
X	NO –

5.4.1 **How does this report address our Equality Outcomes?**

The intelligence contained in this report reflects on the performance of the HSCP against the equality outcomes.

a) **People, including individuals from the protected characteristic groups, can access HSCP services.**

The report provides both qualitative and quantitative data on contacts, presentations, referrals and activity on behalf of or directly with service users. This includes those with protected characteristics and people in our community who are harder to reach.

b) **Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.**

Consistent high standards are expected for services addressing the full range of vulnerabilities without discrimination or stigma

c) **People with protected characteristics feel safe within their communities.**

The report demonstrates our performance in keeping service users safe from harm and providing support to enable people to feel safe in their communities and localities.

d) **People with protected characteristics feel included in the planning and developing of services.**

The performance of the HSCP in relation to inclusion of people with protected characteristics is captured in the report. There are many campaigns and innovative ways to get people involved in the development of the HSCP services. These include direct service involvement, the advisory networks, surveys, communications and with policy and planning development. Service user, carers, partners and other stakeholders are represented on our Integration Joint Board, Strategic Planning Group and in our planning forums across all service areas. Feedback is used continuously to improve overall planning and performance.

e) **HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.**

Quarterly Service Reviews are used to inform discussions around the delivery of services to people with protected characteristics.

f) **Opportunities to support Learning Disability service users experiencing gender based violence are maximised**.

The Annual Performance Report contains intelligence relating to all service user groups including people with Learning Disability.

g) **Positive attitudes towards the resettled refugee community in Inverclyde are promoted.**

The Annual Performance Report contains intelligence relating to all service user groups including people from the resettled refugee community.

5.5 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

There are no clinical or care governance implications

5.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

The report summarises Inverclyde's performance in relation to the nine National Wellbeing Outcomes providing specific examples across all nine Outcomes

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

Specific examples are provided in section two of the report.

b) **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.**

Specific examples are provided in section two of the report.

c) **People who use health and social care services have positive experiences of those services, and have their dignity respected.**

Specific examples are provided in section two of the report.

d) **Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.**

Specific examples are provided in section two of the report.

e) **Health and social care services contribute to reducing health inequalities.**

Specific examples are provided in section two of the report.

f) **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.**

Specific examples are provided in section two of the report.

g) **People using health and social care services are safe from harm.**

Specific examples are provided in section two of the report.

h) **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.**

Specific examples are provided in section two of the report.

i) **Resources are used effectively in the provision of Health and Social Care.**

Specific examples are provided in section two of the report.

6.0 CONSULTATION

6.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

7.0 LIST OF BACKGROUND PAPERS

7.1 None

INVERCLYDE HSCP
Health and Social Care Partnership

Inverclyde Health and Social Care Partnership

Annual Performance Report 2016-17

Welcome by Louise Long - Chief Officer Inverclyde HSCP

I would like to welcome you to Inverclyde Health and Social Care Partnership's first Annual Performance Report.

This report will focus predominantly on Inverclyde HSCP's performance for the period April 2016 March 2017 but will include additional relevant information.

Although this is a time of challenge in Health and Social Care Services it also offers great opportunity to work together to make difference to our communities in:

- delivering services that support children to build happy, healthier lives and
- that allow families to flourish and
- provide care of elderly and vulnerable residents when they most need it.

We are very proud of the staff, partners and carers who have worked to help us build a strong foundation which will be pivotal to our success. Moving services forward we will be innovative within financial challenges ahead. The quality of people, the strengths of partnership help us to feel confident about the future.

We will publish an Annual Performance Report each year showing what we have achieved and the impact we are having on achieving our Vision of ***Improving Lives*** through our four key Values of ensuring:

- ***We put people first;***
- ***We work better together;***
- ***We strive to do better;***
- **We *are accountable***

Ultimately, these principles will guide us to deliver better outcomes, as measured against the national framework.

Louise Long
Corporate Director (Chief Officer)
Inverclyde HSCP, Municipal Buildings, Clyde Square, Greenock, PA15 1LY

Contents

Context

Inverclyde HSCP is built on our established integration arrangements (through the former CHCP), and was set up in response to the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, often referred to as the integration legislation.

In Inverclyde we have an 'all-inclusive' health and social care partnership. This means that we have gone beyond the statutory requirement of adult services to include services for Children and Families and Criminal Justice.

Much of what was required by the integration legislation was already in place in Inverclyde, so we had firm foundations to build on. This has allowed us to migrate relatively smoothly from our CHCP arrangements into the new legal entity status.

The integration legislation and its associated guidance requires that every HSCP produces a Strategic Plan, outlining what services would be included, noting key objectives and how partnerships will deliver improvements. Progress on those commitments is gauged by the Annual Performance Report.

Our first Strategic Plan was published in March 2016 outlining our vision of ***'Improving Lives'.*** This vision is underpinned by the values that:

- *We put people first;*
- *We work better together;*
- *We strive to do better;*
- *We are accountable*

In our Strategic Plan we stated that we would measure our success or otherwise, based on the extent to which we made a positive difference in the lives of the people we serve.

As our Strategic Plan is a statement of intent designed to illustrate the approach we will take to consolidate our aims, we identified key themes that run through all of our planning. There are five of these themes, which we term as our strategic commissioning themes. These are:

- Employability and meaningful activity
- Recovery and support to live independently
- Early intervention, prevention and re-ablement
- Support for families
- Inclusion and empowerment

By commissioning services with these themes in mind, we aim to improve the things that really matter to the people who use our services.

Our aim of *'Improving Lives'* can only be achieved through a combination of supports that the HSCP can deliver and the arrays of other supports that already exist within the

communities of Inverclyde. From unpaid family carers and volunteers to a range of third sector organisations, Inverclyde benefits from a strong sense of social justice and community spirit that has a crucial role in shaping our desired future.

With this in mind, this performance report depicts the improvements we have achieved in our first year and the strong foundations we have established and continue to build to drive forward transformational change.

Section 1: Structure of the Report

The report summarises Inverclyde HSCP's performance in relation to the nine National Wellbeing Outcomes. These are:

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 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.

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 in the provision of health and social care services.

To support the nine national Wellbeing Outcomes, there are 23 National Integration Indicators against which the performance of all HSCPs in Scotland must be measured.

Within this report, these indicators have been aligned to the relevant national wellbeing outcomes and our performance in these is shown as a comparison with the Scottish average.

Separate measures specifically relevant for Children's Services and Criminal Justice have been included in section four of this report.

Finally, we have attempted to highlight throughout the report how our achievements are aligned with our overall 5 Strategic Commissioning themes noted on page 4.

Section 2: National Wellbeing Outcomes and the National Integration Indicators

There are 23 National Integration Indicators upon which each HSCP is measured and the data for these is provided by the Information Services Division (ISD) of the NHS on behalf of the Scottish Government.

The indicators have been, or will be developed from national data sources so that the measurement approach is consistent across all Scottish HSCPs. These indicators can be grouped into two types of complementary measures: outcome indicators based on survey feedback and indicators derived from organisational or system data.

Within this report this data is presented and aligned to the nine National Wellbeing Outcomes. The images for comparing performance in relation to the Scottish average are as follows:

	Performance is equal or better than the Scottish average
	Performance is close to the Scottish average
	Performance is below the Scottish average

The data presented against the National Indicators is the most up-to-date as released by ISD in April 2017.

National Wellbeing Outcome 1

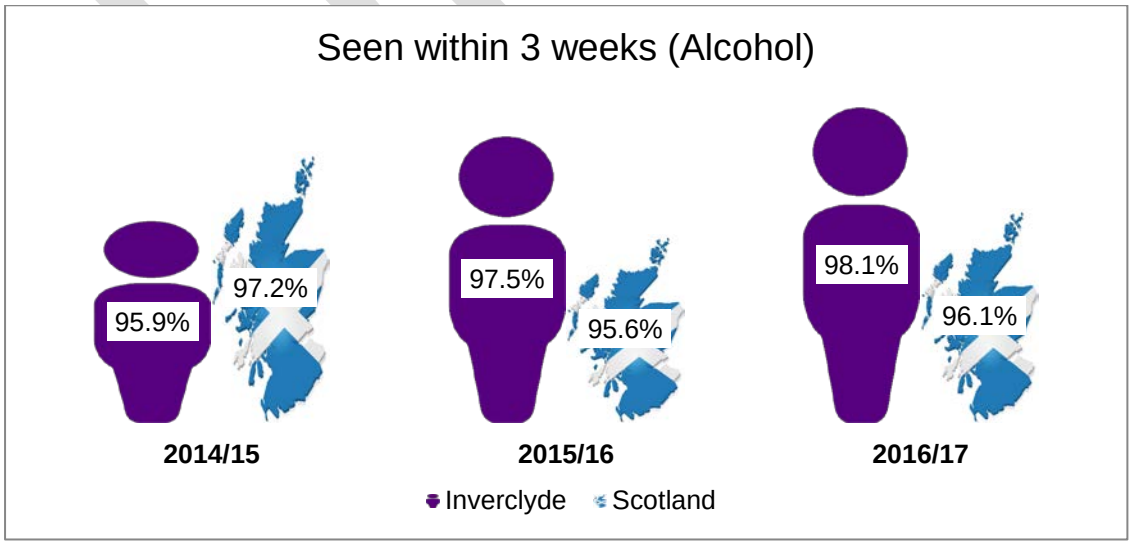
- People are able to look after and improve their own health and wellbeing and live in good health for longer

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
1	Percentage of adults able to look after their health very well or quite well	90.00%	93.85%	
12	Emergency admission rate (per 100,000 population)	14971.97	11873.75	
13	Emergency bed day rate (per 100,000 population)	132718.06	106531.26	
14	Readmission to hospital within 28 days (per 1,000 population)	91.24	95.65	

When people need support, it is important that they are seen as early as possible in order that they can begin to take control, look after and improve their own health. A national target has been set that states “90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery”. Seeing people quickly gets them onto a journey of recovery sooner and we hope this will lead to better outcomes.

Addictions - Alcohol

We have consistently outperformed this target in alcohol in the last 2 years and exceeded the Scottish average as is shown in the graphic below.

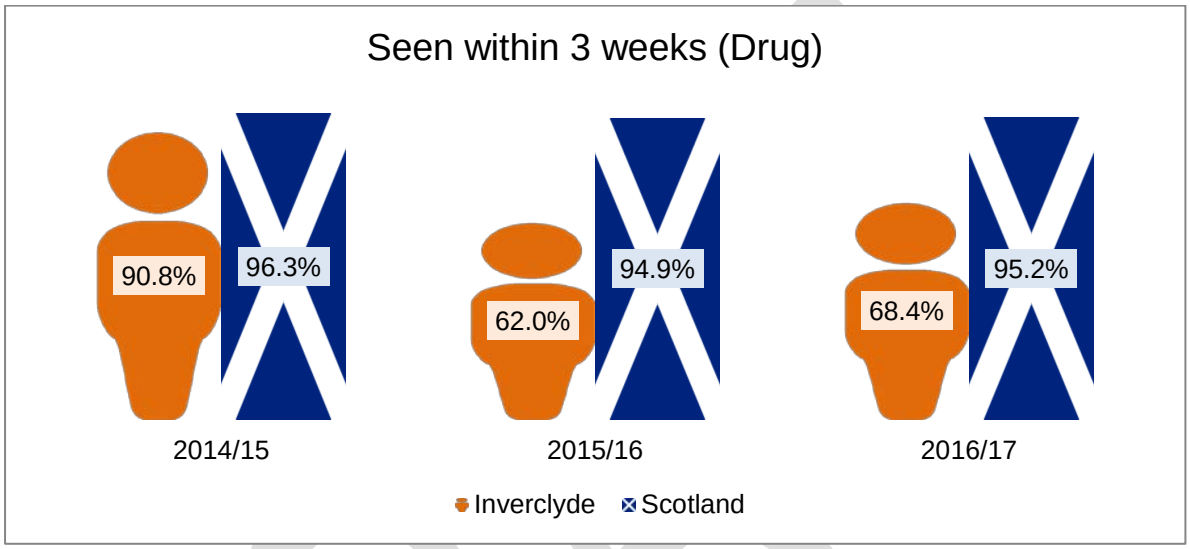


Addictions - Drugs

In 2015/16 the performance against the 90% target dropped. This was against a backdrop of an increase in the number of referrals therefore we reshaped our service to respond to changes in demand.

As a result, we prioritised certain cases (for example people with child care responsibilities and those injecting). These cases were seen promptly, while other cases were signposted to more appropriate services.

By taking a more targeted and focused approach, the graphic below demonstrates that performance against waiting times is improving.



The following case study is a real life example of how we are supporting the people of Inverclyde to look after and improve their own health and wellbeing.

Case Study – Family Response Service

K is a single parent, age 56 who lives alone. She has a diagnosis of Bipolar and is supported by a psychiatrist and a CPN. Having Bipolar often leaves **K** vulnerable and powerless, which affects her ability to manage her son's behaviour. He has a diagnosis of schizophrenia and is addicted to high levels of amphetamines and is supported by the Integrated Drugs Service.

K has been subject to Adult Support and Protection procedures where concerns were raised and recorded about her vulnerability and her being at risk of harm from her son who has financially and emotionally abused her. **K** is very much aware of her rights under this legislation; however, she declined statutory intervention after being given full information about her options and choices.

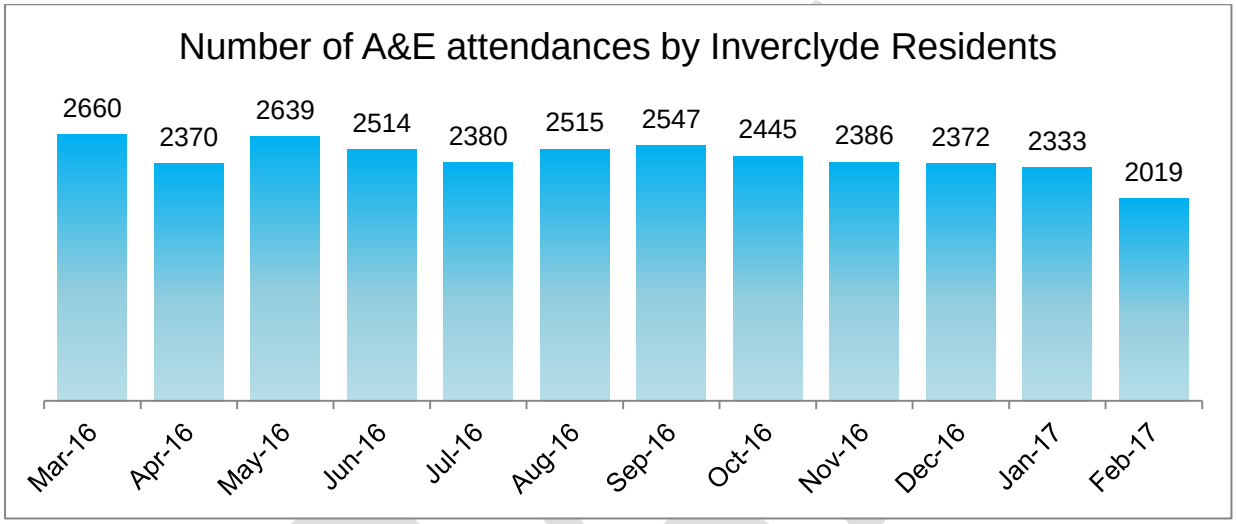
Additionally **K** has literacy needs and is a compulsive shopper. Her financial circumstances are partly supervised by her brother.

K is provided with advice and guidance on how to manage her son's behaviour. The aim is to help her recognise that modifying her own behaviour could effect change in that of her son. It also helps **K** feel more in control and less helpless. However this is extremely challenging as **K**'s mental health governs her mood on a daily basis and affects her ability to manage everyday tasks. The son is also able to manipulate her which she fully recognises.

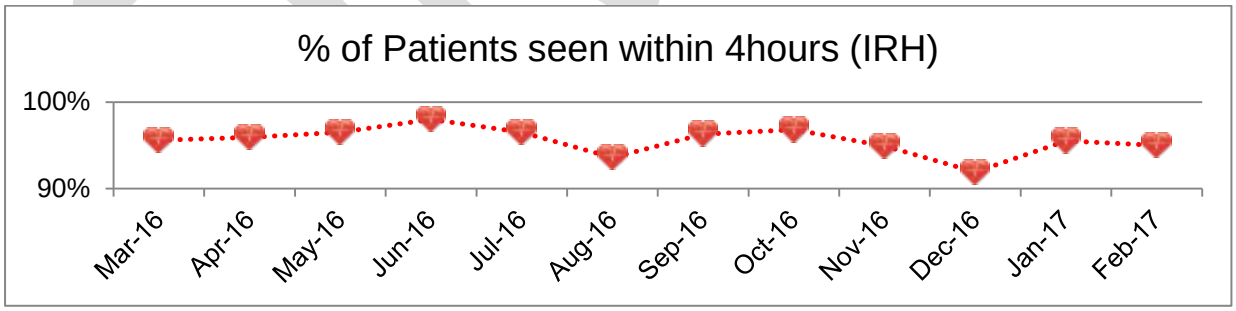
K attends Drop-In every week which supports individuals who are affected by a loved one's drug addiction and enjoys and benefits from attending the gym 2-3 times a week.
K has a befriender, is a registered carer and attends a Family Support Group.

Accident and Emergency (A&E)

Accident and Emergency Services are among the most expensive provided by public money. To get the best value from this we want to ensure that A&E is used only by those who really need that level of service. We know that A&E can be used as a convenient "drop-in" service which is not the best use of A&E. We therefore aim to reduce the numbers of people attending. This will be achieved by helping people know *how* to contact the right service for assistance rather than inappropriate presentations being made at Accident & Emergency. The graph below shows how we are progressing with this aim.



With regard to the nationally set 4 hour maximum waiting time target, Inverclyde Royal Hospital Accident & Emergency department consistently saw over 90% of patients within this timeline.



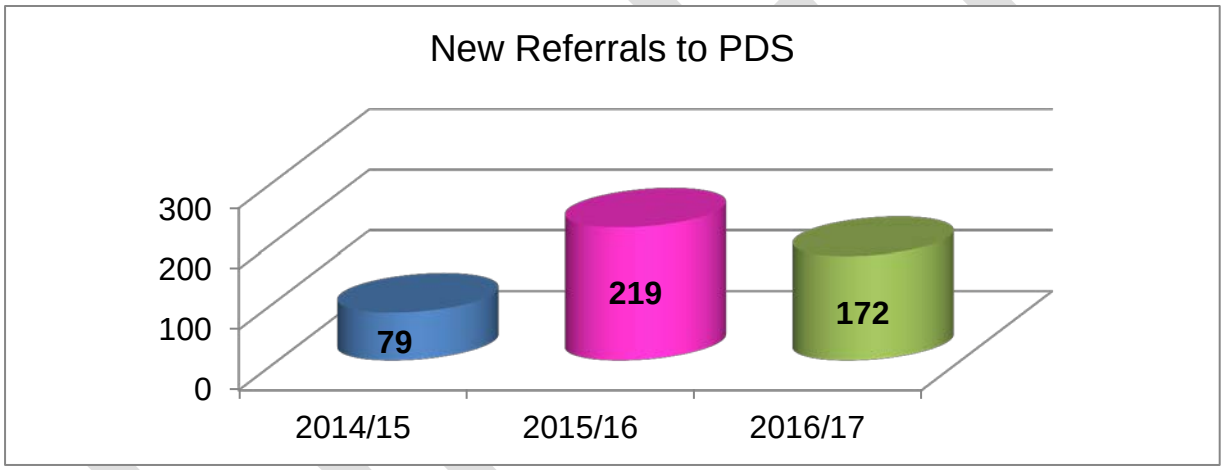
Further examples of relevant activity towards achieving this Wellbeing Outcome are reflected within:

Dementia Post Diagnostic Support (PDS)

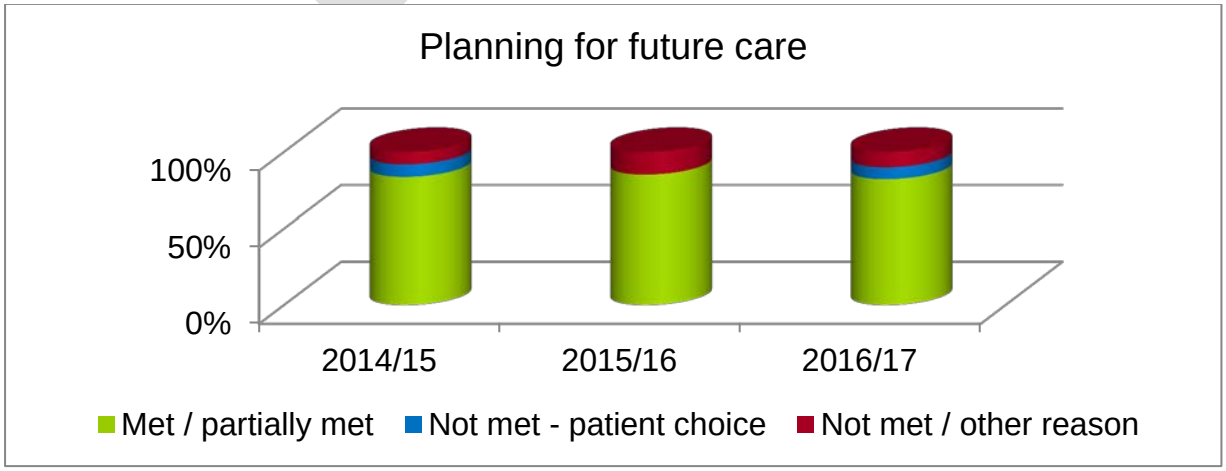
The Scottish Government set out a goal for people who were diagnosed with dementia that "by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan."

In Inverclyde we implemented this plan in 2014 and in the three years it has been operating we have worked with 470 people newly diagnosed and their families. This has had a positive impact in the life of these families in the five areas of:

- Understanding the illness and managing symptoms
- Planning for future care
- Peer support
- Supporting community connections
- Planning for future decision-making.



Of those people who completed 12 months of PDS there has been a high percentage who have achieved a positive outcome in 'Planning for Future Care' - over 80% in each of the last 3 years – key performance in supporting people to look after and improve their own health.



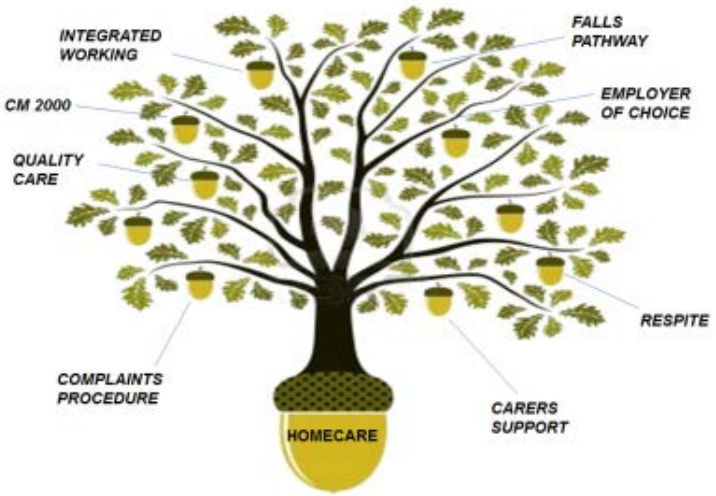
National Wellbeing Outcome 2

- People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	88.32%	83.61%	
15	Proportion of last 6 months of life spent at home or in a community setting	84.88%	86.84%	
18	Percentage of adults with intensive care needs receiving care at home	63.11%	61.56%	
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	243.90	915.03	
21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	Indicator under development (ISD)		
22	Percentage of people who are discharged from hospital within 72 hours of being ready	Indicator under development (ISD)		

Care at Home

Our Care at Home service provides care and support to those who require assistance to remain independent at home for as long as possible. Investing in this preventative support helps reduce unnecessary admission to hospital and is a key intervention to achieving this Wellbeing Outcome.



In **2015-16** our Care at Home service provided support to over 1200 people in Inverclyde with the most support being provided for those aged 65 and over - the majority of whom have long term conditions and/or are frail.

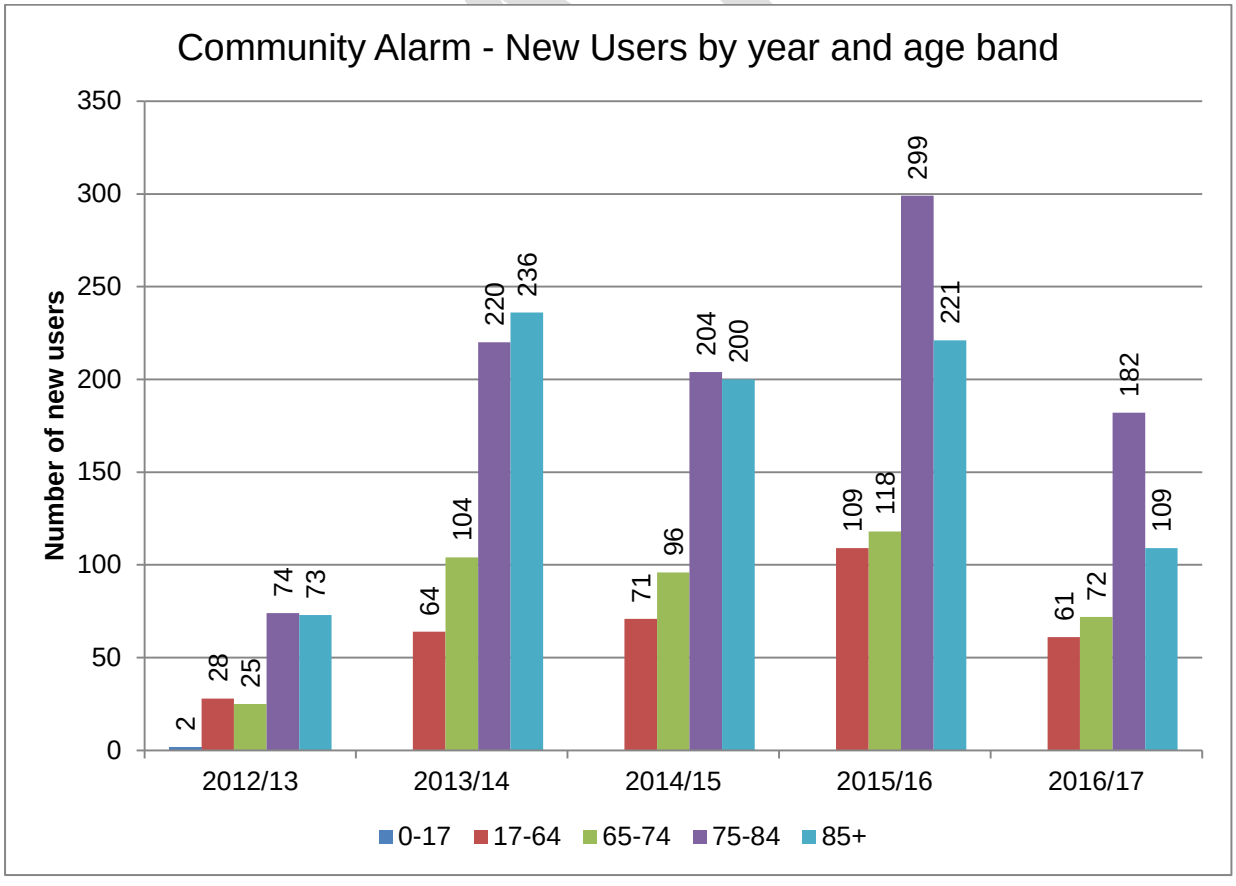
Average hours of Care at Home provided per week for 65 and over people

7 hrs 43 minutes

Number of people age 65 and over receiving Care at Home

1,155 people

With our **Technology Enabled Care (TEC)** we supported over 2,500 Inverclyde residents with community alarms in 2015/16 and 2016/17, enabling them to remain in their homes with support that is *'available when they need it'*. As depicted in the graph although we continue to provide this service across all age groups, this service is a key enabler in supporting our older residents to remain in their own homes.



Case Study

Mrs **X** is an 86 year old lady who has dementia and lives with her brother. A reablement assessment was requested as her family were really worried about her due to her Alzheimer's progressing. They were increasingly thinking she may have to move to a care home.

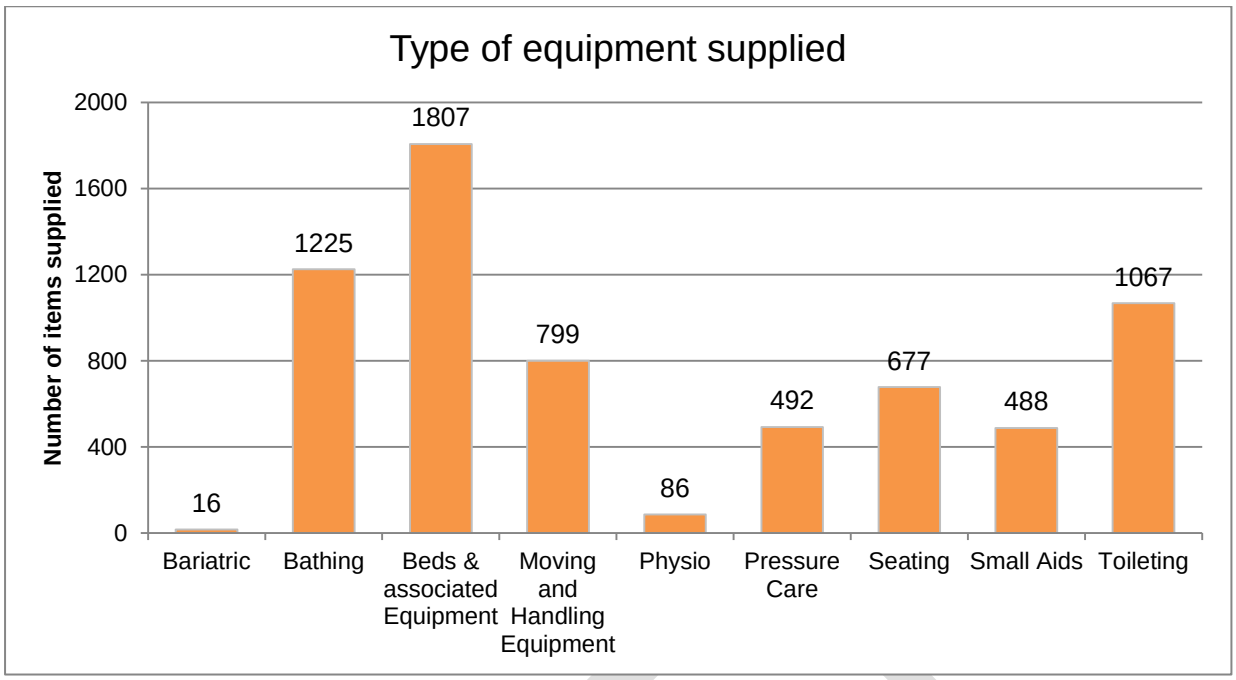
In addition, to support Mrs **X**'s brother the offer of a carer's assessment was made to help any specific issues for him.

At the weekly feedback meeting the home carers reported she was dishevelled when they visited in the morning and appeared sleepy. Her walking in the afternoons was getting worse and they were worried about her falling. Her GP had visited and she didn't have any infections and we were at a loss as to what had caused the change.

The iCare system was put in to monitor Mrs **X'**s movements within her home and it was found she was walking around her home throughout the night and returning to bed around 6am. This resulted in her being tired in the morning when the home carers visited. We moved her morning visit to late-morning to allow her to have a proper sleep and when the home carers visited she appeared more rested and her mobility remained good throughout the day.

A further key area in supporting residents to remain as independent as possible is **Aids for Daily Living (ADL) equipment.**

In 2016-17 we provided over 6,000 items of ADL equipment to Inverclyde residents who had a physical need. This equipment ranges from hospital beds with pressure care mattresses and patient hoists, to simple seats for use in a shower. An Occupational Therapist (OT) or District Nurse (DN) carries out an assessment for equipment.


Type of equipment supplied
Number of items supplied
2000
1600
1200
800
400
0
16
1225
1807
799
86
492
677
488
1067
Bariatric
Bathing
Beds & associated Equipment
Moving and Handling Equipment
Physio
Pressure Care
Seating
Small Aids
Toileting

Case Study

N is a young woman in her late 20s whom the Community Occupational Therapy Service has been working with for many years. **N** has Spina Bifida and is a full time wheelchair user. When the OT first met **N** she was living with her parents, who were very anxious about **N** moving on from the family home. The OT worked with the whole family and initially offered practical support around accessing a college then a university placement.

N is a confident young woman who is keen to live an independent life. The OT who works with **N** completed housing applications for wheelchair accessible accommodation and worked with her landlords to adapt her home to ensure that it was fully accessible. **N**'s parents were anxious around her taking this step but with support from OT, Telecare and Reablement, she now lives in her own home. Her parents are very proud of **N** and all she has achieved.

N has a care package, and through Self Directed Support she employs her own personal assistants. Initially she was anxious around the responsibilities relating to being an employer, but was supported by her OT to gain the confidence in directing her own choices and care, and to see her Personal Assistants as facilitators to support her to live her life well.

N's confidence has grown. She is taking on the world and has gained the ability to challenge any barriers that she comes across. The services are still involved however they now work in partnership with her to find solutions to any difficulties she experiences. N has had a work placement, has been in employment and is now considering further higher education.

Case Study

Mr **H** is an 80 year old man discharged from the Inverclyde Royal Hospital (IRH) following admission with air in the chest causing breathing problems. Prior to becoming unwell he was able to get around using a 4 wheeled walker and was independent with all his self-care. His discharge from the IRH was an irregular discharge in that he discharged himself rather than being discharged by a doctor. The referral to community team from the GP for a Step Up bed admission was requested to prevent a further hospital admission due to poor mobility and inability to self-care.

The Rehabilitation and Enablement Service (RES) provided a same day Occupational Therapy (OT) and Physiotherapy (PT) to assess Mr **H**.

Following the assessment the best option for Mr **H** and his family was for him to remain in his own home. Mrs **H** was initially very anxious about her husband's health and felt that he should still be in hospital until a doctor discharged him. The OT and PT called in urgent support from the Re-ablement Team and visited Mr **H** daily. They discussed all small improvements with Mr and Mrs **H** and ensured that everyone was working in the same way to get the very best outcomes. Mrs **H** was also offered a carer's assessment.

The initial requirement was for two home carers for a full package of care. The goals set in conjunction with Mr **H** and his wife to work on were: getting up and down from his chair, bed and toilet; to improve his mobility; to return to independence with self-care activities, and to be able to get in and out of his home independently.

After a period of rehabilitation in his own home, Mr **H** regained the ability to transfer and mobilise independently with his 4 wheeled walker and he was able to manage to get in and out of his home with the support of his family.

As Mr **H** improved, the OT and PT worked alongside the Re-ablement staff who were able to offer daily practice of the therapy goals set. As a result further rehabilitation gains were made with this joint working approach. The home care package was able to be reduced to twice a day and over time stopped altogether. when Mr H regained independence with his personal care tasks.

National Wellbeing Outcome 3

- People who use Health and Social Care services have positive experiences of those services, and have their dignity respected

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	85.40%	78.82%	
5	Total % of adults receiving any care or support who rated it as excellent or good	83.68%	81.10%	
6	Percentage of people with positive experience of the care provided by their GP practice	87.09%	86.78%	

Self-Directed Support (SDS)

SDS allows people to choose how their support is provided to them by giving them as much on-going control as they want over the individual budget spent on their support.

The SDS Options are:

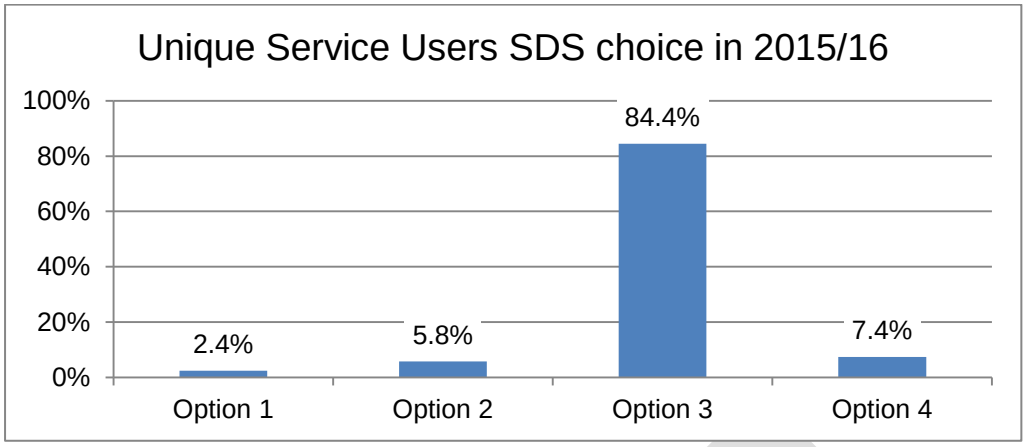
Option One: A direct payment is made to the service user allowing him/her to purchase their own support. The service user can employ a personal assistant or buy a service from a care organisation. This option provides the most choice and control.

Option Two: The service user can choose a care organisation they want to provide the support with the HSCP arranging to pay for this support. This option offers choice and control but less responsibility for managing.

Option Three: The HSCP will arrange support from an appropriate provider after full discussions with the service user. The service user has no responsibility for arranging support and has less choice and control.

Option Four: The service user can use a mixture of all options to arrange care and support. This choice allows the service user to decide which elements they wish to have direct control over and for which they wish the HSCP to have responsibility.

Uptake across these options during 2015-16 was as follows:



2,163 people chose how they would like their care provided in 2015/16

As is shown from the figures, the option most popular to date is Option 3.

We are currently working on further promoting Self Directed Support and the various options available to service users.

National Wellbeing Outcome 4

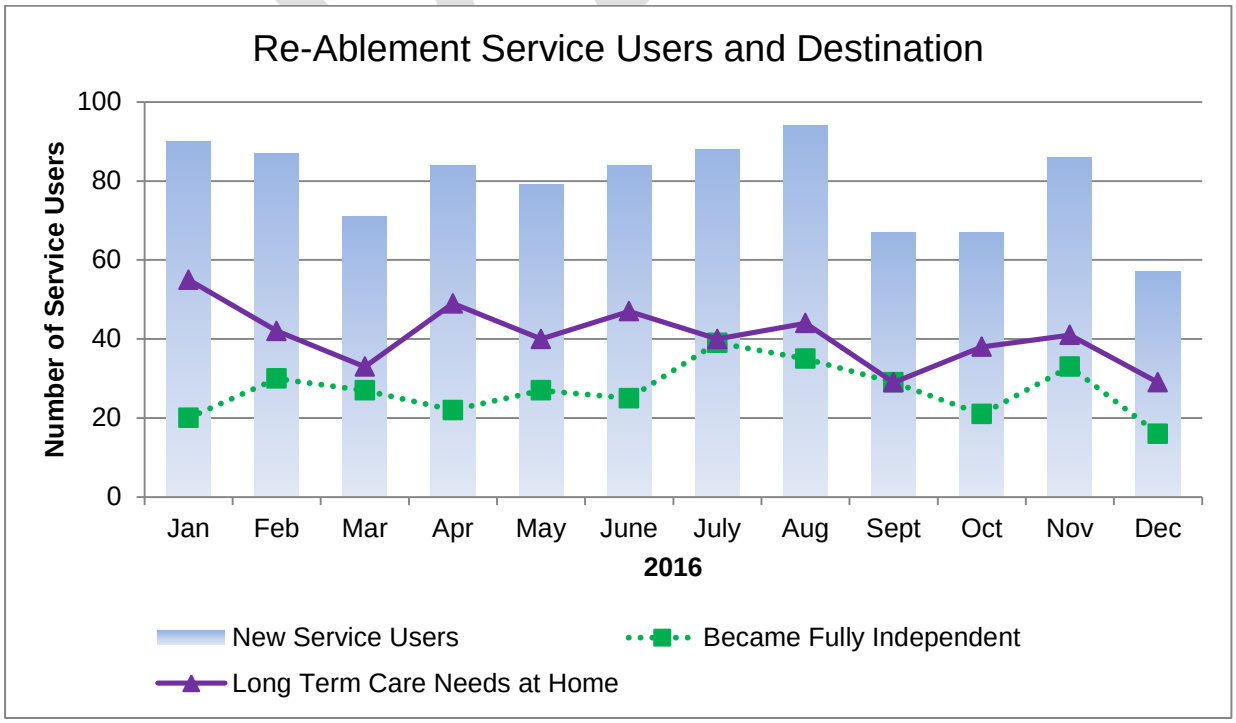
- Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
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	88.39%	83.83%	

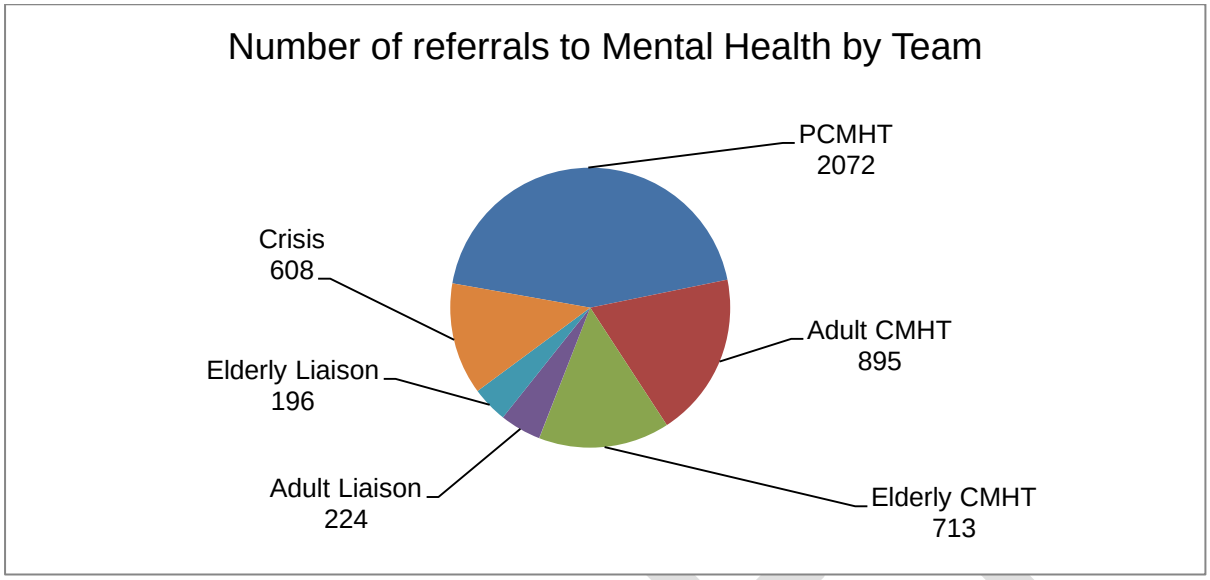
An example of how we are performing against this Wellbeing Outcome and the national indicators is evidenced in **Re-ablement.**

This service provides an initial quick intervention (for up to 6 weeks) to assist people to remain or become independent after being discharged from hospital, overcoming an illness or other notable life incident by using a combination of Occupational Therapy, Physiotherapy, physical disability aids and housing adaptations. Bringing this service in at the earliest opportunity helps to maintain and improve Inverclyde residents' ability to remain as independent as possible.

In 2016 (Jan to Dec) 954 new people were referred to the re-ablement service. Of these, 323 (33.9%) became fully independent after receiving the service with 487 (51%) moving on to receive a Care at Home service.



Within our **Mental Health Services** there were a total of 4,708 referrals throughout 2016/17. Every referral involves an assessment to identify the most appropriate intervention to help support each person and improve their overall quality of life. How the referrals were distributed across the various teams is shown in the graph below:



Our **Primary Care Mental Health Team** (PCMHT) offers a service for those individuals who have mild to moderate mental health problems issues and offers up to twelve sessions of treatment. People are able to self-refer, which has proven to be an effective option and accounts for over 65% of all referrals into the service. The largest users of this service are younger adults aged between 18 and 35 years.

CRISIS – is an out-of-hours quick response service to prevent those people experiencing a crisis having to attend the emergency department in order to have a mental health assessment undertaken.

Our **Community Mental Health Team** (CMHT) works in partnership with families and carers, primary care and other agencies to design, implement and oversee comprehensive packages of health and social care, to support people with complex mental health needs. We deliver this support in environments that are suitable to the individuals and their carers.

The aims of the Community Mental Health Team are to:

- Reduce the stigma associated with mental illness.
- Work in partnership with service users and carers.
- Provide assessment, diagnosis and treatment, working within relevant Mental Health legislative processes.
- Focus upon improving the mental and physical well-being of service users.

Consideration and planning for discharge from the team is an integral part of on-going care planning following discussion with the service user, and where appropriate carers, other professionals or agencies are involved in their care.

The following case study is a real life example of how we are helping to maintain or improve the quality of life of people who use these services.

Case Study

AM is a 62 year old woman who became known to services in the early 1990s when she was admitted to short stay psychiatric ward for symptoms of schizophrenia. This followed the break-up of her marriage and the death of her mother. After placing her 2 children in the care of her father, her health deteriorated to the extent that she was hospitalised under the Mental Health Act.

Her erratic mental health continued for the next 18 years with numerous admissions to the psychiatric unit. In 2012 as her mental health stabilised, it was agreed by health and social care staff, and reluctantly by the client herself, that she would benefit from support within Inverclyde Association for Mental Health (IAMH) residential unit. A Compulsory Treatment Order (CTO) was in place, ensuring her compliance with the treatment plan and services.

Over the next 18 months she gained knowledge, skills, confidence and most importantly the insight and coping strategies to care for and manage her illness and symptoms. With staff support she was empowered to voice her own opinions to medical staff with regards to her preferred treatments for her illness. She also recognised that she required structure to her day and was referred to attend In-Work Services (IAMH social enterprise) where she participated as a trainee within the project.

AM continued to improve and take back control of her life and was referred for her own tenancy. She was re-housed in 2014 with IAMH continuing to provide support. Her engagement and compliance with services led to her CTO being revoked in 2015 and her support package being reduced.

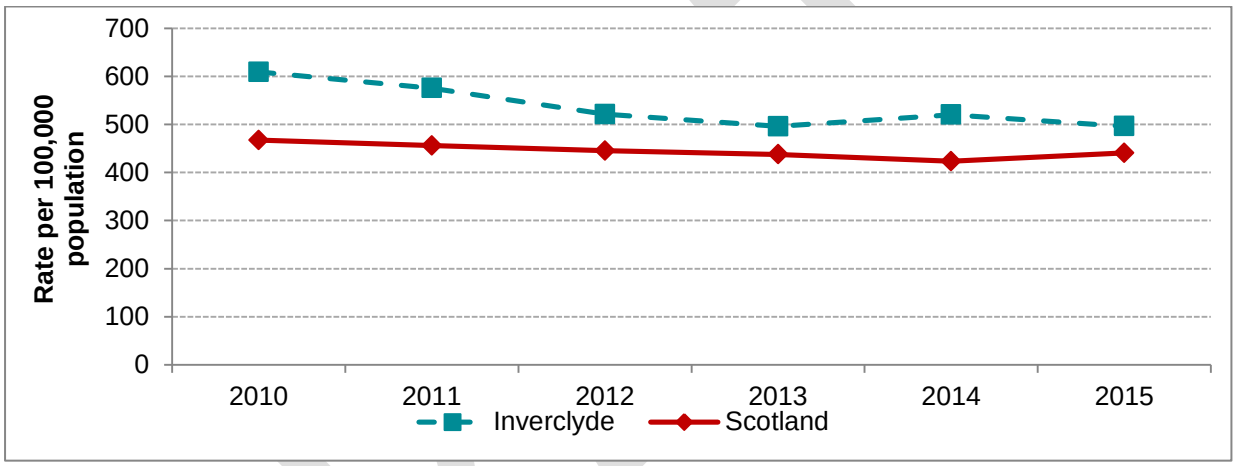
AM has a good insight to her illness and can identify triggers and engage her coping strategies to prevent hospital admission. She has now taken up hobbies such as Tai Chi and guitar lessons. She has become an active member within the community with the support of Your Voice. She participates in various group work and activities which enables her to support others with mental health problems.

National Wellbeing Outcome 5

- Health and Social Care services contribute to reducing Health Inequalities

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
11	Premature mortality rate per 100,000 persons	496.30	440.50	

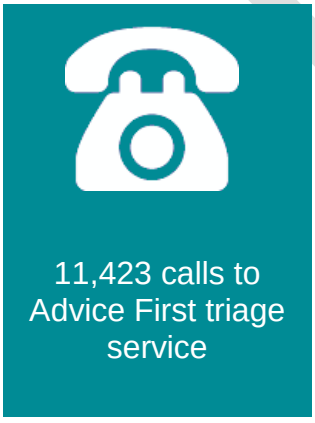
We have been steadily reducing our premature mortality rate over the last few years and are now closer to the Scottish Average. This is a complex indicator because the causes of premature mortality are many, and are underpinned by social, health and economic inequalities.

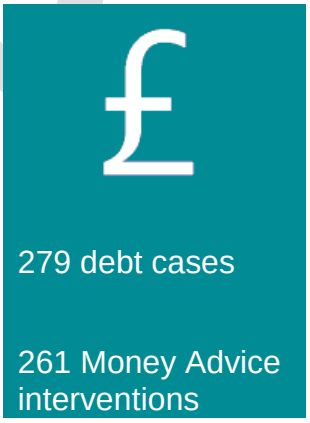


European age-standardised mortality rate per 100,000 for people aged under 75 years.
Source: National Records for Scotland (NRS)

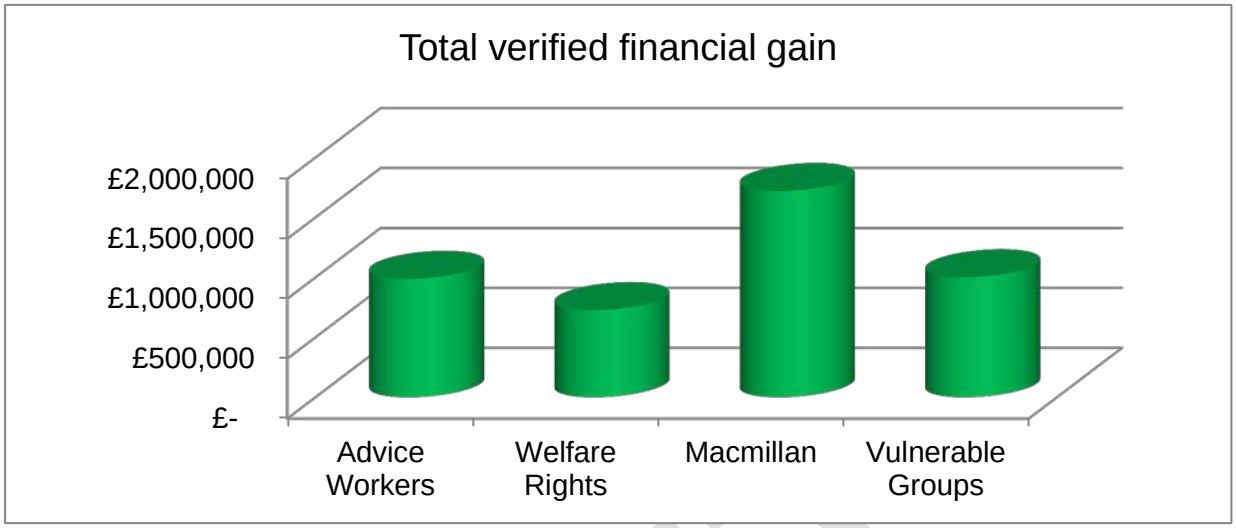
In Inverclyde, our approach to **Addressing Inequalities** is multi-faceted. Within this report, by way of illustration, we have focused on financial inequality.

Our **Advice First Service** handles a vast range of enquiries including debt advice, benefits advice, welfare rights appeals and debt resolution. In 2015/16 we provided…





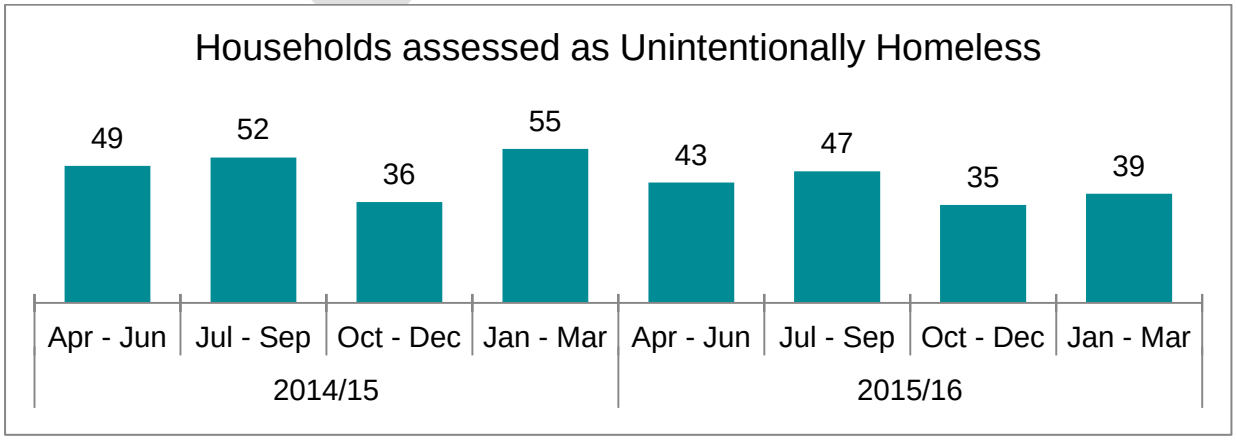
Working with local people and other organisations we gained over £4 million for Inverclyde Residents.



Working towards reducing Health Inequalities, we have also undertaken a range of activities that are designed to resolve **Homelessness** as quickly as possible and, ideally, prevent this altogether.

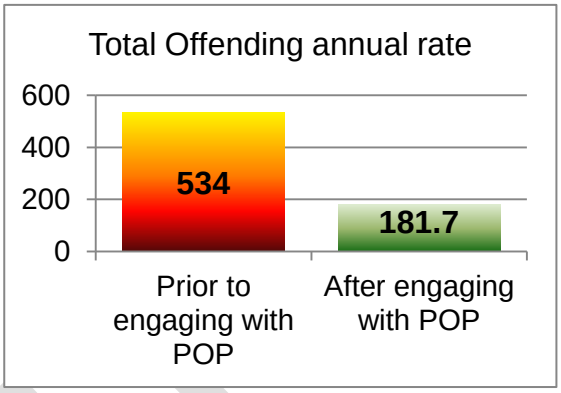
Figures for the last 2 years show the number of approaches to the service for advice and support (also referred to as 'Housing Options') to prevent homelessness.

	Number of households approaching the Service	Of all homeless households - number with children	Number of young people (aged 16-19)
2014/15	**1053**	**38**	**116**
2015/16	**924**	**61**	**99**

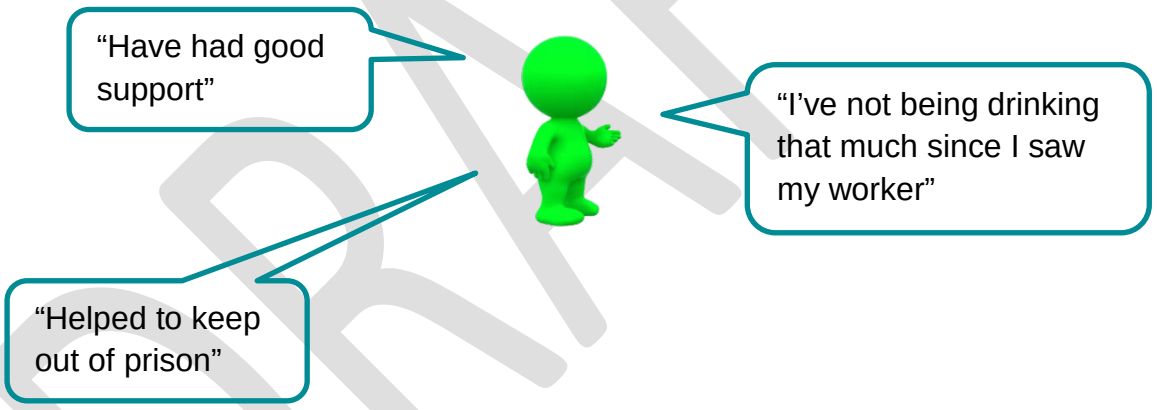


A further example of our approach to achieving this outcome is demonstrated by our **Persistent Offenders Partnership (POP).**

For some people the standard approach to addiction recovery does not work as their lifestyle is more chaotic and frequently involves a form of criminal activity. To address this we began our Persistent Offenders Partnership in 2010/11 with Inverclyde and Renfrewshire Councils, Procurator Fiscal, Police, Addictions Services and NHS Greater Glasgow and Clyde. This became a local project in 2014 whereby we work with the police to reduce offending and addiction.



Since the start of the project over 130 people have engaged with the Persistent Offenders Partnership, with a positive impact having been made in the lives of not only the Service Users, but the community as a whole.



Case Study - POP

D is a female who became involved with the POP service after her life spiralled out of control. She had long term drug dependency, 55 criminal convictions, 4 imprisonments, moved home 57 times, was homeless on 3 occasions and in poor physical and mental health. Due to these reasons she had no family contact or any community engagement.

After joining the programme, **D** stopped offending, received treatment for her addiction, has maintained a secure tenancy and is engaging with health services. **D** now has good family relationships and is actively involved in her community.

National Wellbeing Outcome 6

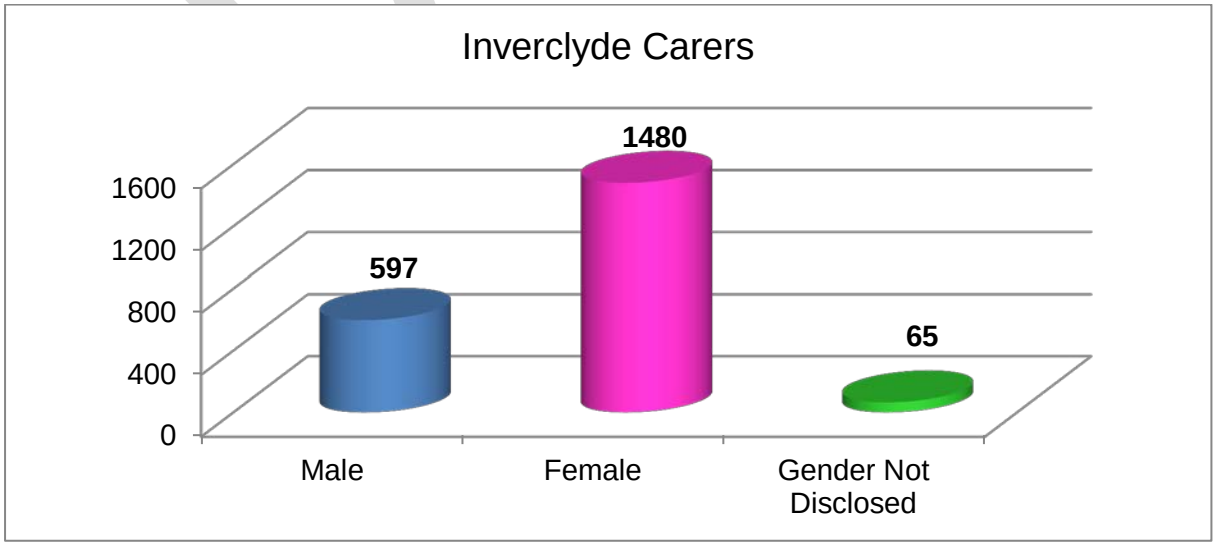
- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
8	Total combined percentage of carers who feel supported to continue in their caring role	45.72%	41.18%	

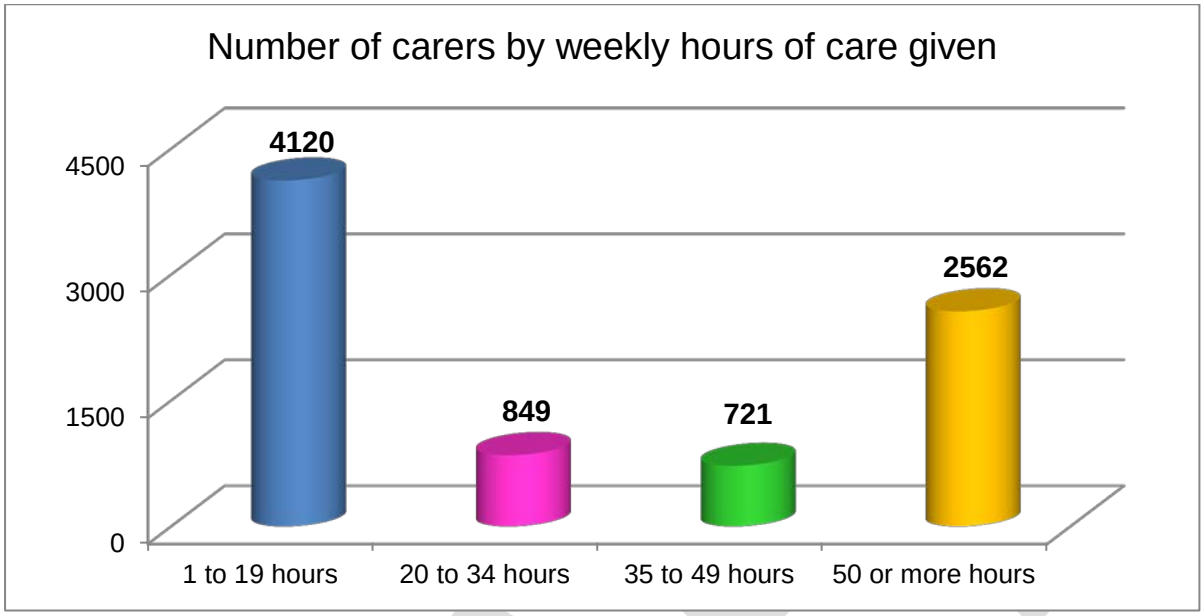
Inverclyde HSCP has continued to make progress locally through our interagency approach to supporting all carers. However, more work is required to ensure all carers have a healthy, active and fulfilling life of their own. Inverclyde HSCP is fully committed, working with carers as equal partners, to ensure this is achieved.

"I am what you categorise as a 'hidden carer'. I don't really recognise that I am a carer for my partner but others tell me I am and I'm aware that my partner needs my support. I'm not sure how you will identify or encourage "hidden carers" to be recognised. I am aware that it is very important that "hidden carers" have support. Also and I am interested in this but feel embarrassed to admit I need help"

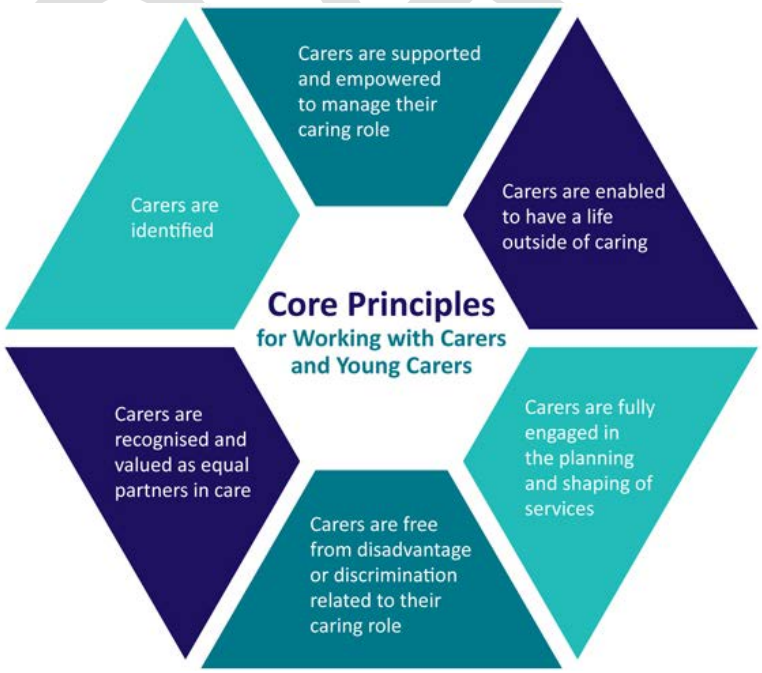
Information held by the Inverclyde Carers' Centre on the number of carers registered as at 22/01/2016 was:



In the 2011 Scottish Census 8,252 Inverclyde citizens identified themselves as carers, so around a quarter of adult carers are registered with the Carers' Centre. As demonstrated in the table below over 2,500 of the overall number of carers deliver 50 hours or more of care each week.



Our Carer and Young Carer Strategy 2017-2022 aims to support better wellbeing outcomes for carers through supporting them to engage in activities that they want to pursue, rather than being "trapped" by their caring roles.



A copy of the Inverclyde Carer & Young Carer Strategy 2017-2022 is available on the Inverclyde Council website:

http://www.inverclyde.gov.uk/health-and-social-care/support-for-carers/inverclyde-carer-young-carer-strategy-2017-2022

National Wellbeing Outcome 7

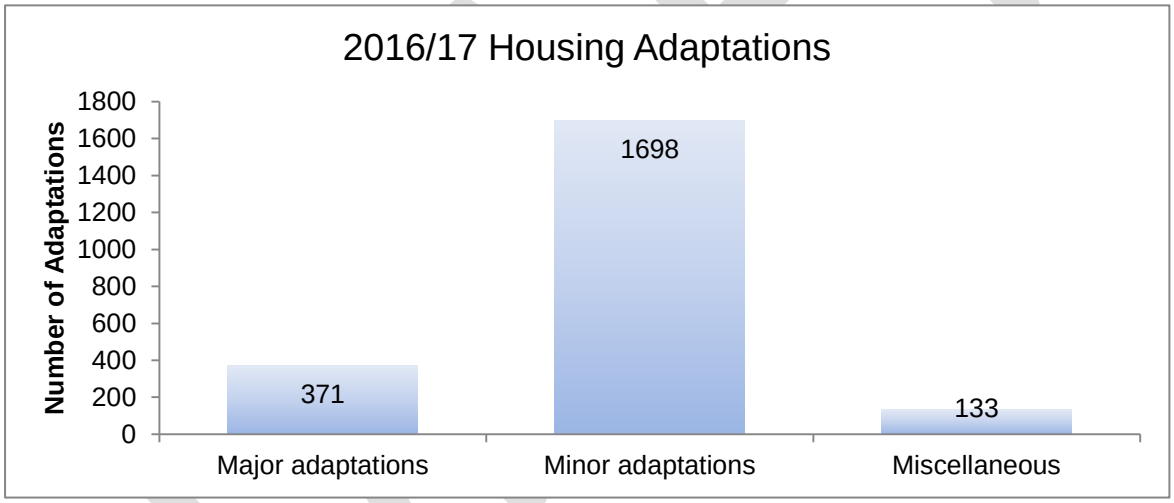
- People using health and social care services are safe from harm

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
9	Percentage of adults supported at home who agreed they felt safe	87.21%	84.23%	
16	Falls rate per 1,000 population aged 65+	24.73	20.96	

An example of activity aligned to this outcome is reflected in the number of housing adaptations we have undertaken.

In 2016/17 we arranged for 2,202 adaptations to assist people to remain independent in their own homes. Of these adaptations almost half (49%) were for grab rails.

The adaptations range from various types of handrails to the more complex such as stair lifts.



Further evidence of how we ensuring people who use health and social care services are safe from harm is reflected in our Falls Project.

Following a national review highlighting shortfalls in the then current management of Falls, the Scottish Government published “The prevention of and management of falls in the community- a framework for action for Scotland 2014/2016”.

Examples of statistics on falls are:

- Third of people over the age of 65 years will have at least one or more fall in the next year
- Over 60% of older people who fall, will fall again within one year
- One in ten falls results in serious injury, such as broken bones or head injury
- 50% of those who sustain a hip fracture will never walk unaided again.

In order to address the negative impact of falls on people, Inverclyde HSCP began a Falls Project locally in 2016.

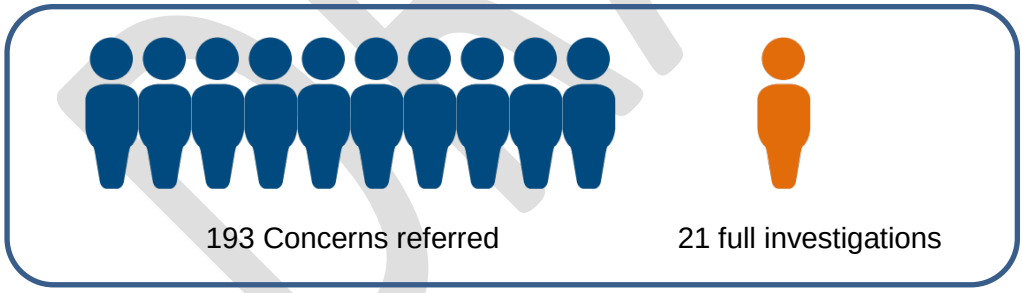
Currently around 78% of all falls attended by the Scottish Ambulance Service (1,080 falls from January 2016 to April 2017) were conveyed to hospital. By working on improving the integration pathways we aim to reduce this to 65% by appropriate referral to community services who would then provide a prompt assessment and begin arranging support as required.

Inverclyde HSCP Falls Project aims to:

- Promote and embed the local Inverclyde community falls pathway
- Agree appropriate assessment tools and implement their use across the HSCP
- Ensure the referral pathways are robust
- Implement and evaluate a strength and balance class for frail fallers in Inverclyde
- Improve the pathway for fallers identified by the community alarm service in Inverclyde
- Identify training resources for falls in conjunction with community falls leads in Inverclyde.

Also, some people with particular vulnerabilities need formalised protection to ensure that they are kept safe from harm. During 2016/17, 193 Adult Protection concerns were referred to the HSCP.

After an initial review 21 of these concerns - or about 10% - were progressed to a full investigation.



The on-going priorities of the Adult Protection Committee are:

- Raising awareness of adult support and protection by engaging, involving and supporting the local community. Service user and carer representatives continue to be valued members of the Adult Protection Committee (APC).
- Ensuring the multi-agency workforce has the necessary skills and knowledge, and access to relevant procedures, guidance and protocols to meet their responsibilities under the Adult Support and Protection (Scotland) Act 2007.
- Having a particular focus on quality assurance and the impact of activity.

By focussing on these priorities our Adult Protection Committee ensures that people within Inverclyde HSCP are indeed safe from harm.

National Wellbeing Outcome 8

- People who work in Health and Social Care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
10	Percentage of staff who say they would recommend their workplace as a good place to work	Indicator under development (ISD)		

While the national indicator is still being developed, other work has been on-going to realise this outcome. In February 2016, Inverclyde was the first HSCP in Scotland to volunteer to participate in a new staff engagement tool termed – iMatter.

iMatter involves surveys completed by staff and then the system generates reports for teams showing how well supported each team feels. This is in line with enabling staff to have a voice in what needs to change or improve so that their customers experience better outcomes.

The iMatter work also supports our values.

We put people first - we want to improve the lives of our workforce, local people and our partners across Inverclyde

We work better together - we are committed to a culture which promotes innovation and challenge; we will work together to shared objectives, common values and priorities

We will strive to do better - we will build a competent, confident and valued workforce; we will take responsibility of our areas of work

We are accountable - we value staff and the people we work with. Everyone is encouraged to make a positive contribution to service improvement and delivery

Why does employee engagement matter in Inverclyde HSCP? It results in:

- Higher staff morale and motivation
- Less absenteeism and stress
- Greater efficiency, productivity and effectiveness

"A workplace approach designed to ensure employees are committed to their organisations' goals and values, motivated to organisation success, and are able at the same time to enhance their own sense of well-being".

[*Engaging for Success 2009 authors; Nita Clarke and David MacLeod*]

"Imatter gives the staff a voice in how the service moves forward"

"We had a very good completion rate of 80%!"

"Imatter is a real chance to make the team feel valued, to make the team feel part of a process"

"I'm very keen that the action plan is taken forward as a team process; it's not about the team lead deciding what will happen. It's eliciting and engaging with the team itself to come up with the ideas"

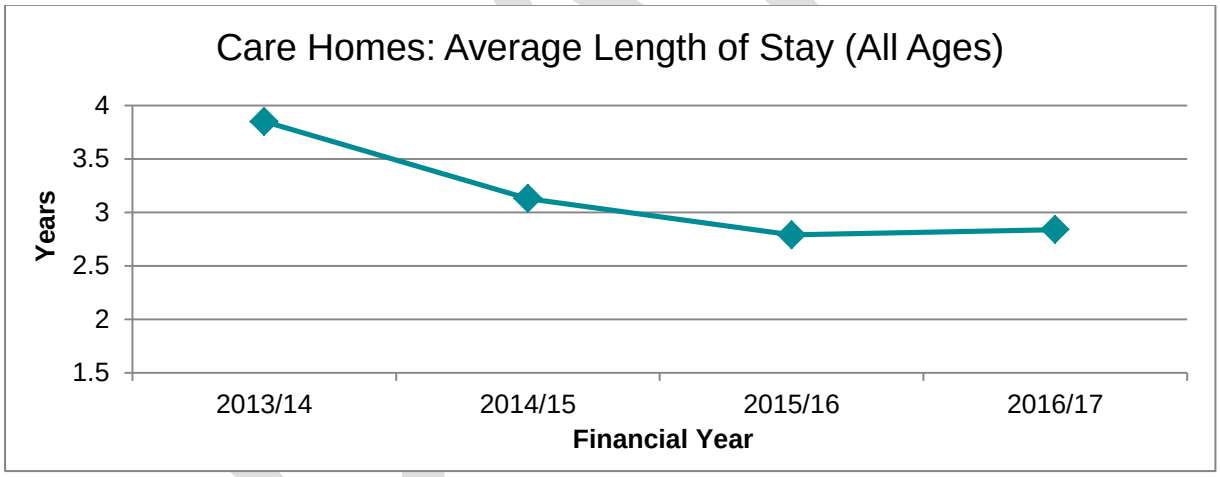
"If morale drops then this leads to a decrease in the sense of wellbeing which can ultimately affect the 'frontline' – the people who use our services."

National Wellbeing Outcome 9

- Resources are used effectively and efficiently in the provision of health and social care services

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79.15%	75.39%	
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	85.05%	82.94%	
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	20.64%	21.41%	
23	Expenditure on end of life care, cost in last 6 months per death	Indicator under development (ISD)		

Our performance in relation to reducing the length of time that people need support in a Care Home is an example of how we are progressing with this outcome.



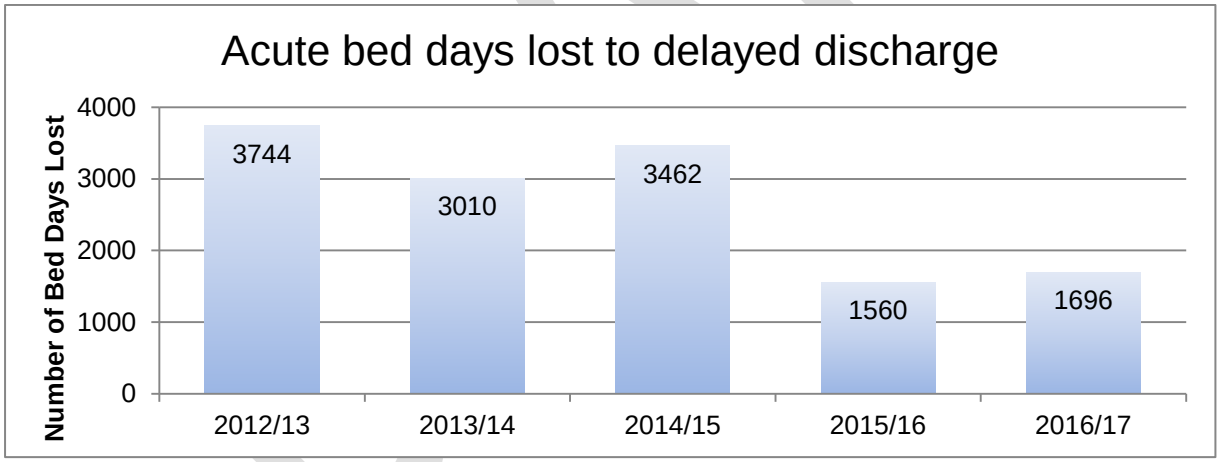
We continue to see on-going and sustained improvements in the average length of stay in care homes reflecting the impact of community based services, improved assessment processes and admission to care homes largely being for end of life care. In 2013/14, on average, people who entered a care home could expect to spend that last four years of their lives there. By 2016/17, that had reduced to just over two and a half years, but importantly, 40% of older adults admitted to long term care placement passed away within that calendar year. This means that we are supporting people to stay in their own homes for longer than ever before, with care home admission only being used when all other options have been exhausted.

As part of our drive to support people in their own homes, we are mindful that a stay in hospital can sometimes present challenges for the person to get back home as quickly as possible. Delayed hospital discharge can have a negative effect on the person

who, in most cases, would much rather not be in hospital. Remaining in a hospital setting can result in individuals becoming institutionalised and losing confidence. We therefore need to change perception and expectations with a focus on the actual ability of each individual rather than the disability. Earlier discharge can help lead to complete restoration to former or indeed improved levels of functioning. In addition, there is a considerable cost involved with delayed hospital discharges – hospitals are an expensive type of accommodation!

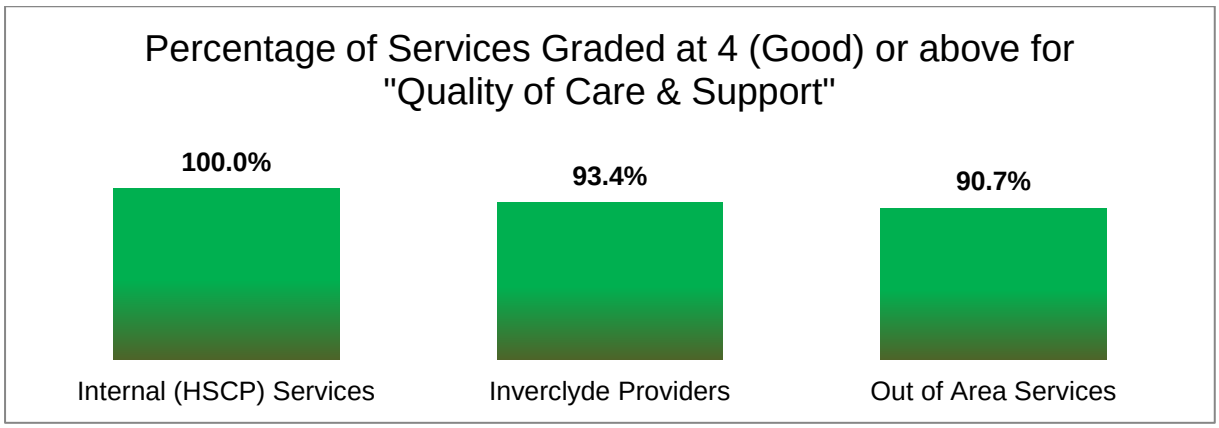
In Inverclyde, our work in this area has resulted in a continued downward trend of bed days lost due to delays in discharge from acute hospital setting. Performance against the delayed discharge target in Inverclyde has been positive for some time, as has the reducing number of bed days occupied for older people. There were 104 individuals (equating to 6.9% of all discharges) which required social care support and whose hospital discharges were delayed in the year April 2016 to March 2017. These account for the identified bed days lost.

Working with colleagues at Inverclyde Royal Hospital we continue to demonstrate the effectiveness of early commencement of assessments to identify future care needs and achieve an appropriate, timely and safe discharge. The result is that the majority of individuals are assessed and discharged home as soon as they are deemed medically fit for discharge, including those requiring a home care package or a residential care placement.



Quality of Care

When we commission care for our citizens, it is important that we get the best possible quality for the money at our disposal. Services that are either delivered by the HSCP or commissioned with care providers continue to receive a high grading from the **Care Inspectorate**. Our approach ensures that we have some of the best care provision in the country.


Percentage of Services Graded at 4 (Good) or above for "Quality of Care & Support"
100.0%
93.4%
90.7%
Internal (HSCP) Services
Inverclyde Providers
Out of Area Services

Section 3: Health and Care Experience Survey

The Health and Care Experience Survey is undertaken by the Scottish Government and asks about people's experiences of accessing and using Primary Care services. It was widened in 2013/14 to include aspects of care, support and caring that support the principles underpinning the integration of health and care in Scotland, outlined in the Public Bodies (Joint Working) (Scotland) Act 2014.

The surveys are sent out directly to people registered with GP practices in the area. The most recent data shows an increase in the numbers sent out but a reduction in those returned.

	Number surveys sent	Number Surveys returned	Return %
2013/14	10,816	1,872	17.3%
2015/16	13,401	1,974	14.8%

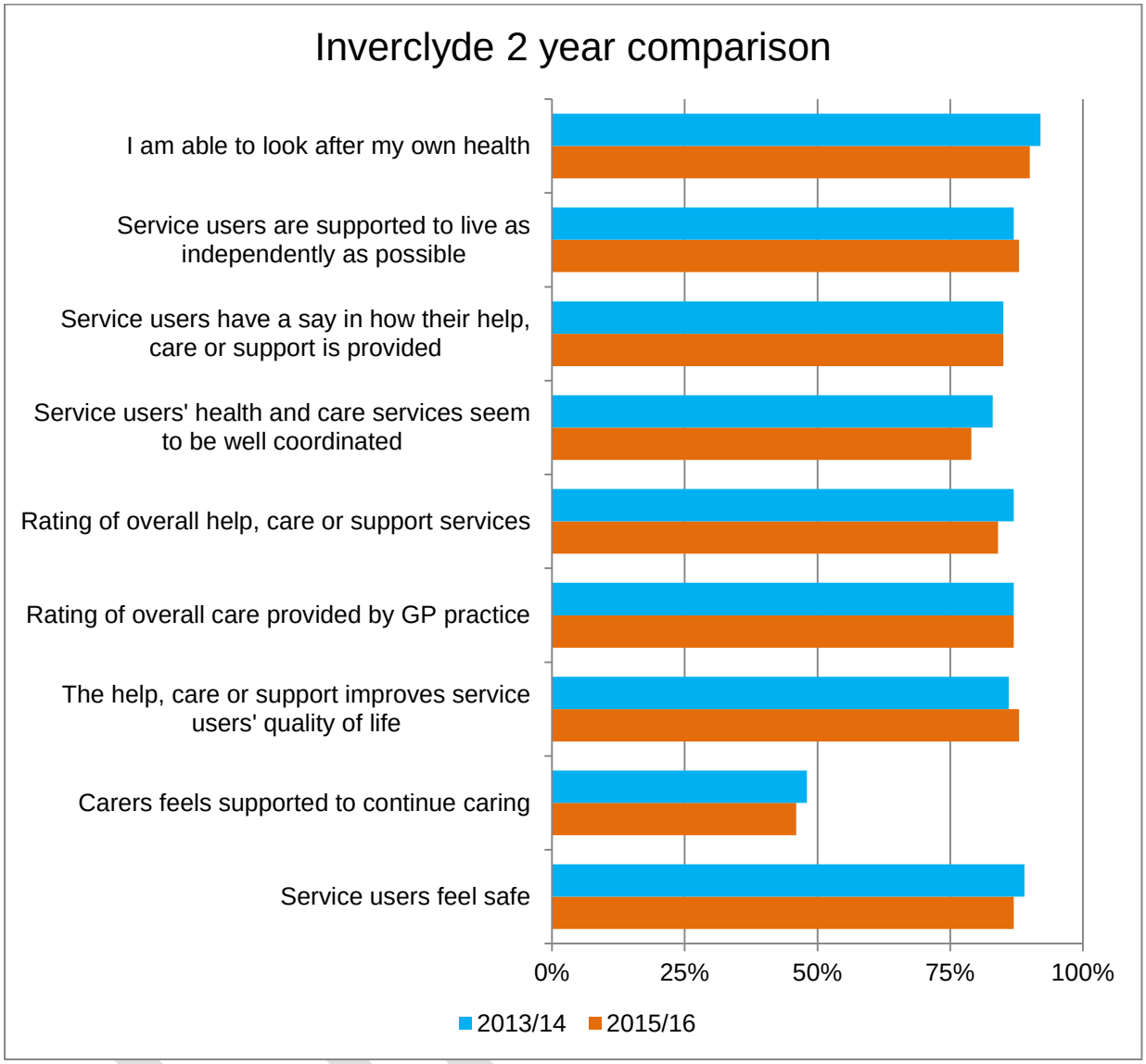
The following chart reflects our performance during 13/14 and 15/16 (the most up to date).

		% Positive 2013/14	% Positive 2015/16	Comparison to the Scotland average (2015/16)
1	I am able to look after my own health	92%	90%	-4% 
2	Service users are supported to live as independently as possible	87%	88%	5% 
3	Service users have a say in how their help, care or support is provided	85%	85%	7% 
4	Service users' health and care services seem to be well coordinated	83%	79%	4% 
5	Rating of overall help, care or support services	87%	84%	3% 
6	Rating of overall care provided by GP practice	87%	87%	0% 
7	The help, care or support improves service users' quality of life	86%	88%	5% 
8	Carers feels supported to continue caring	48%	46%	5% 
9	Service users feel safe	89%	87%	3% 

In 2015/16 we performed at or better than the Scottish average in 8 of the 9 indicators.

Compared to the 2013/14 survey we improved or remained the same in 4 out of 9 indicators.

Comparing the results of the 2 surveys carried out we can see there are only minor changes.



Section 4: Children's Services and Criminal Justice

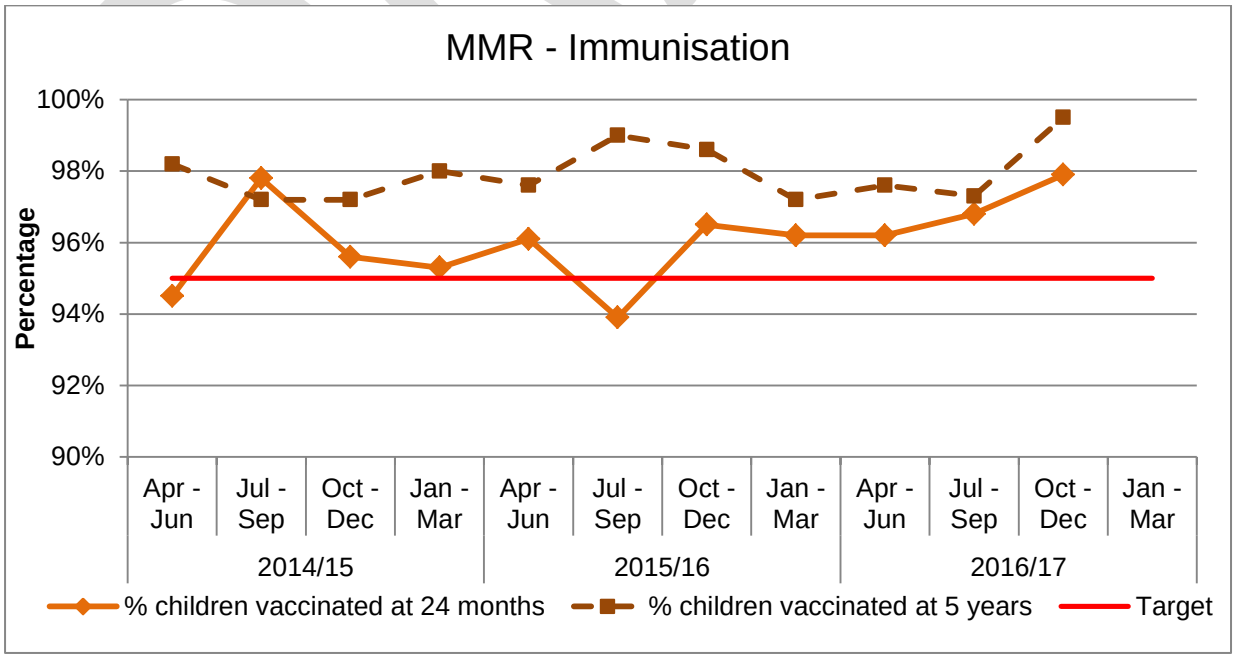
National Outcomes for Children	
10	Our children have the best possible start in life.
11	Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
12	We have improved the life chances for children, young people and families at risk.

"Nurturing Inverclyde" places our children at the centre of the Community Planning Partnership (the Inverclyde Alliance), in recognition that every child grows up to become a citizen and part of a local community. Moreover, **'Getting it right for Every Child, Citizen and Community'**, will be achieved through working in partnership to create a confident and inclusive Inverclyde with safe, sustainable, healthy, nurtured communities; a thriving, prosperous economy; active citizens who are achieving, resilient, respected, responsible, included and able to make a positive contribution to the area.

Children in Inverclyde receive the best start in life.

One way to gauge a healthy child population is to consider immunisation levels for common diseases. Uptake also indicates a shared responsibility amongst communities to protect children and prevent the spread of illness.

In respect of Measles, Mumps and Rubella immunisations (MMR), at age 5 we are consistently above target. For MMR at 24 months, we have largely exceeded the target of 95%.

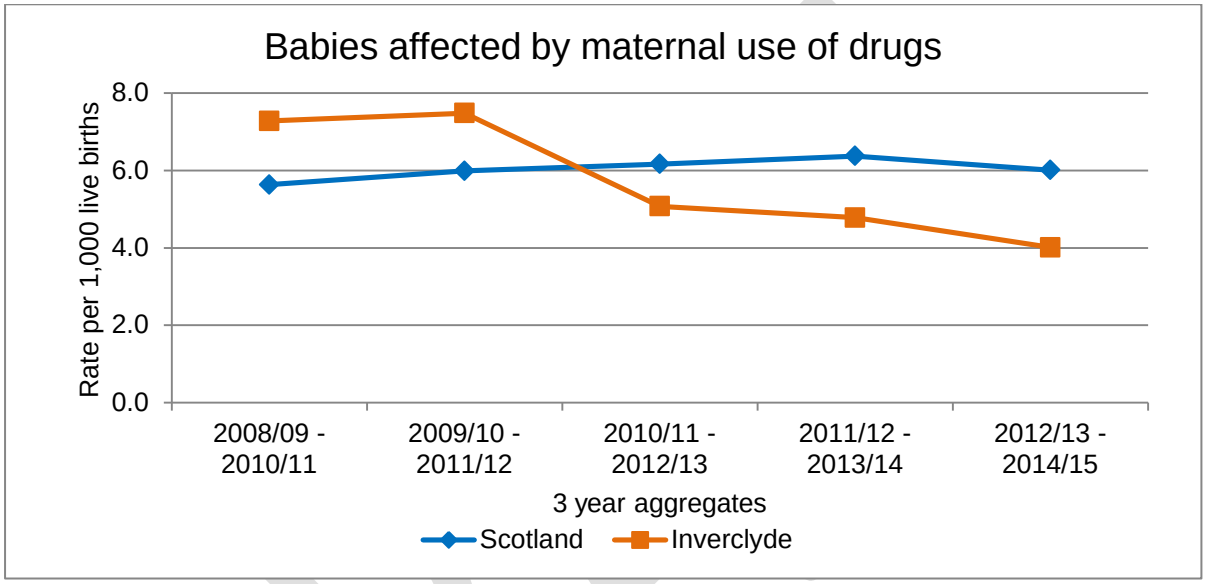


Higher % = better performance

Babies affected by maternal use of drugs

Inevitably, babies will be affected if their mothers are using drugs, and this could lead to poorer outcomes for the child. We work closely with mothers in this category and both rate and absolute numbers have been on a downward trend in Inverclyde over the 2008/09 - 2014/15 periods.

Comparing Inverclyde with Scotland as a whole, Inverclyde has a considerably lower rate of babies affected by maternal drug misuse than Scotland. This is within the context of Inverclyde having considerably high estimated drug misuse prevalence rates when compared to Scotland as a whole.

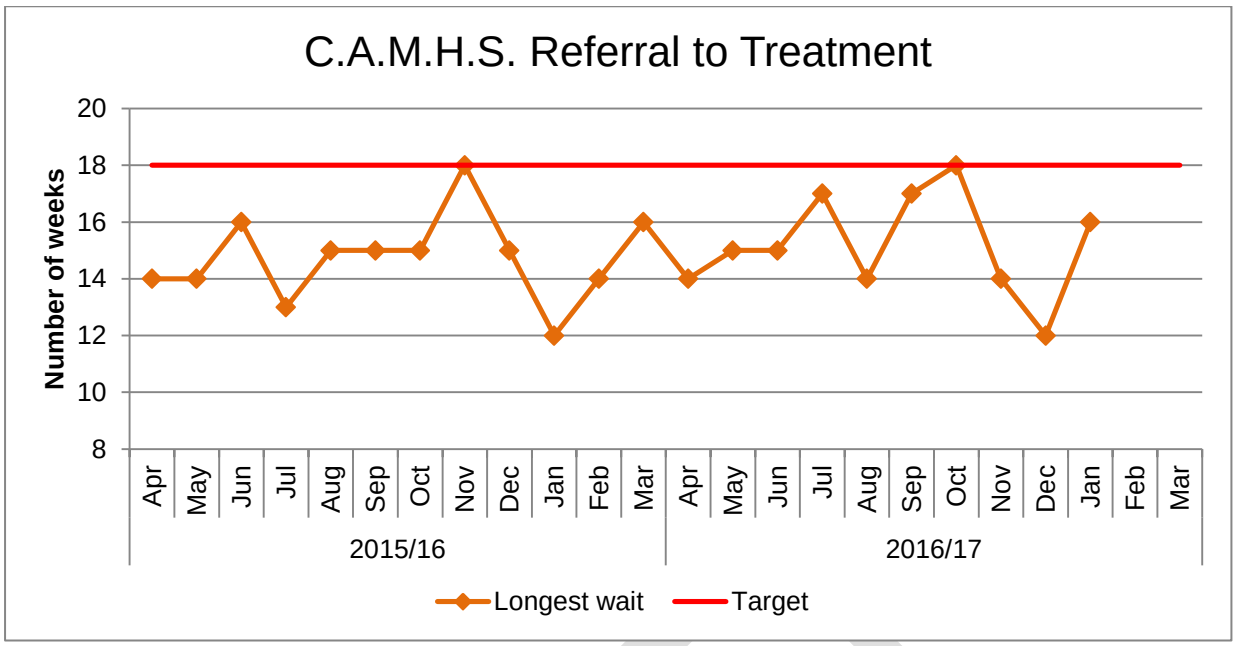


Lower number = better performance

Child and Adolescent Mental Health Services (CAMHS)

The target of 90% of young people referred to child and adolescent mental health to have begun their treatment within 18 weeks of referral has regularly been exceeded since the beginning of 2015, with 100% having commenced treatment within this timescale. In addition, more than 92% of those referred for psychological therapy started treatment within 18 weeks. This is in excess of the 90% target set for Greater Glasgow & Clyde.

Overall there were 380 referrals made to the CAMHS team from April 2016 to January 2017 with 271 (71.3%) being suitable and accepted by the team. All of the accepted referrals were seen within the required 18 week time period. As shown from the chart below, we have either met or exceeded this target.



Lower numbers = better performance.

We know that inequalities are persistent and often intergenerational, and we do not claim to have all the answers. However, by directing our collective resources – both people and money – towards supporting early years, children and young people, and the most vulnerable across all of our communities to have their voices heard, we believe that we can work together to deliver better and more equal outcomes.

Criminal Justice

National Outcomes for Justice	
13	Community safety and public protection.
14	The reduction of reoffending.
15	Social inclusion to support desistance from offending.

The Criminal Justice Service continues to have a positive impact in the local community through the delivery of various programmes including Community Payback Orders (CPO), Multi Agency Public Protection Arrangements (MAPPA) and women's programmes.

Unpaid Work Requirements provide an opportunity for individuals to pay back to their community through participation in work placements organised by Criminal Justice Social Work Services. This can be particularly challenging for those individuals with little or no work experience and/or poor physical or mental health.

In addition, the 'other activity' component of Unpaid Work enables Criminal Justice Social Work Services to support individuals with their interpersonal, educational and vocational skills with the aim of assisting them in their efforts to desist from further offending. This "whole person" approach aims to improve outcomes, not only for those under the supervision of the service, but also for wider communities.

The graphics below show some Community Payback Order statistics over the last 3 years.

The Unpaid Work Service plans activity for the benefit of individuals, organisations and public areas within Inverclyde. A variety of tasks are undertaken including gardening, painting, joinery and grounds work.

The feedback from those who receive this service has been positive.

“Community Payback is a great service which has been invaluable to us.”

[A new social enterprise]

“This service could not have been better from start to finish. The supervisor and his team could not have been improved on.”

[Mrs C.]

“This project involved a large amount of heavy manual labour. It helped make an area accessible for adults with disabilities. This project was long overdue and it was only completed and accomplished thanks to the community payback team”

[A local charity]

Case Study – Women's Service

L is a single woman, aged 48, who lives alone, has a son aged 20 with whom she has had no contact for 12 years. She has a history of physical and sexual abuse and was in care as a child. She also has a history of alcohol-related anti-social behaviour and non-compliance with services. **L** also had unmet physical and mental health needs.

L was placed on a Community Payback Order (CPO) following an incident of alcohol-related anti-social behaviour. The CPO contained requirements that she would be under the supervision of a Criminal Justice Social Worker and cooperate with the Women's Service for 12 months. Initial cooperation was poor and this put **L** at risk of a prison sentence as a result.

Working closely with the allocated social worker, the Integrated Criminal Justice Social Work Women's Service support worker focused initially on **L**'s pressing practical needs, namely housing. Multi-agency discussions took place at the Women's Service Case Review Group, who reviewed the needs of **L** along with the risk she was at and devised an action plan. **L** was under legal threat of eviction due to her behaviour and had been avoiding dealing with this issue. Her support worker liaised closely with the housing authority and obtained legal representation. She set up a string of meetings and her skills and tenacity ensured that these meetings were not derailed by **L**. In the event, the Court was sufficiently impressed by **L**'s progress that she was not evicted, but her tenancy is at immediate threat over the next year should there be any further instances of anti-social behaviour. Her support worker has used this to further motivate **L**.

Capitalising on the trust built up during this process, **L**'s support worker persuaded her to cooperate with Alcohol Services. **L** began attending three times per week and has now been sober for over a month.

Psychiatric issues underlie **L**'s alcohol difficulties, but she cannot access local mental health services until she has been abstinent of alcohol for 6 months. This remains a goal and her support worker linked in with **L**'s GP and accompanied her to appointments. Her support worker also took her to a specialist clinic to address other health needs.

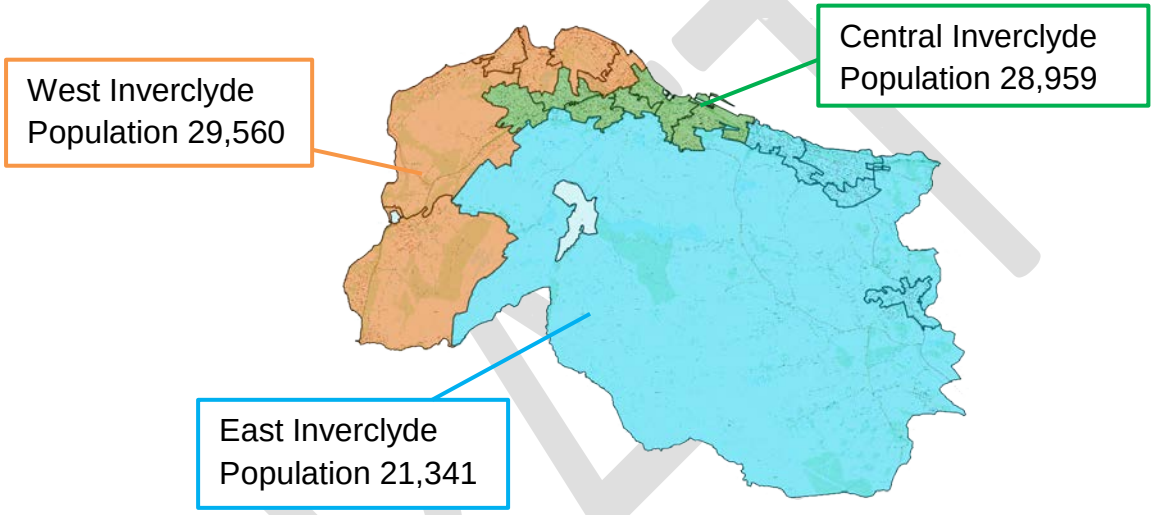
L's CPO has ended, but she has chosen to remain involved with the Women's Service on a voluntary basis. She remains, however, a vulnerable woman with complex needs. **L** still needs support in many basic tasks which she would have previously avoided, but is now safer in the community and is gradually becoming more confident and optimistic in outlook. She ascribes this to the support she has received through the Women's Service, its links with other agencies and the perseverance and skills of her support worker.

Section 5: Locality Planning

Background

The integration legislation requires that HSCPs have at least two localities. The Community Empowerment (Scotland) Act 2015 requires Community Planning Partnerships to work with localities too. In Inverclyde we have merged these requirements to three wellbeing localities, defined by communities themselves. These are East Inverclyde, Central Inverclyde and West Inverclyde.

Inverclyde Wellbeing Localities



In respect of locality planning, it is our intention to develop Locality Planning Arrangements spanning the requirements for place–based planning, profiling and engagement across our Community Planning Partnership, the Inverclyde Alliance.

Our Approach

The Inverclyde Alliance Board is required to create a Local Outcomes Improvement Plan (LOIP) by October 2017. Each new LOIP must demonstrate a clear, evidence-based and robust understanding of local needs, circumstances and aspirations of its local communities. This should demonstrate understanding of how these vary across different places and population groups in its area.

The LOIP should then translate this understanding into a genuine plan which reflects the CPP's priorities for improving outcomes and tackling inequalities in localities.

The HSCP, as a key Community Planning Partner, will align its locality planning to the Inverclyde Alliance LOIP.

Section 6: Innovation

New Ways of Working

Background

In late 2015, Inverclyde HSCP was chosen to work closely with the Scottish Government as a national test area for New Ways of Working in Primary Care. General Practice, or GP services, are a vital part of improving health and wellbeing, keeping people safe and well, and supporting people to remain in their own homes and active in their communities for longer.

Demand for primary care is increasing and has reached a critical level which needs to be proactively managed to ensure sustainability of primary care and best outcomes for patients, particularly via collaborative working across all providers of health and social care.

Cluster Working

In this first year of the HSCP we have begun the process of supporting GPs to work in clusters to share ideas and learning, and have facilitated primary care staff engagement in the national Collaborative Leadership in Practice Programme.

By working together local GPs have developed a number of ideas to improve outcomes for the people of Inverclyde.

New Ways- Choose the Right Service

All Inverclyde GPs, and the wider primary care teams in GP surgeries, have engaged in New Ways. We are delighted with this level of participation as it is testament to the good working relationships we have locally. We are undertaking 'tests of change' to see what will work in one area or right across Inverclyde to improve the efficiency, effectiveness and person centeredness of services.

An example of our innovative approach is our partnership work with Your Voice to develop our "Choose the Right Service" campaign.

The overall aim of this initiative is to raise public awareness and direct patients more appropriately to services that are best placed to support their health and social care needs. This means that people are more likely to see the right person, in the right place, and at the right time. Earlier treatment usually supports a better end result.

Further examples of tests of change are:

- Aiming to reduce musculoskeletal presentations to the GP by making an advanced physiotherapist practitioner available.

- Managing home visits more effectively and reducing GP home visits if they are not really needed, or could be safely managed by other members of the Primary Care Team.

- Introducing a Drop-In Community Phlebotomy (drawing blood for testing) clinic.

- Introducing Advanced Nurse Practitioners (ANP) - the ANP will work within the Community Nursing Service responding to exacerbations of chronic illness and minor illness/injuries.

- Having Specialist Paramedics to reduce home visits for GPs by using this role to deal with unscheduled home visit requests.

- Piloting an extension of the Prescribing Team's clinical and medicines management activities to include pharmacist led clinics, the authorisation of special requests for prescribed medicines and review of immediate discharge letters from acute hospital and outpatient letters.

- Pharmacy First Pilot - Inverclyde Pharmacy First Service is a test service that extends the Minor Ailments Service to all patients and adds a small range of common clinical conditions. The objective is to provide timely and appropriate assessment and treatment of these common conditions and identify patients who require onward referral to other services.

Improving services requires "*thinking outside the box*". The following examples of recent developments in Inverclyde HSCP showcase our approach to achieving change that makes a real difference in people's lives.

❖ **Care…About Physical Activity (CAPA)**

There is considerable research about the wide range of health and wellbeing benefits from physical activity for older people. Research also tells us that there is a steady decline in activity with increasing age and frailty, which has a huge impact on an older person's quality of life.

A key to promoting physical activity is the way in which it can be built into daily living. Being physically active is not the same as taking part in an organised exercise class or walking group, important as they are. It is about opportunities to move more often.

In line with our drive to improve outcomes for our citizens, in January 2017 we submitted a bid to the Care Inspectorate to bring this innovative programme to Inverclyde. That bid was successful. Engaging in this programme will promote two of our strategic aims:

- Communities are stronger, responsible and more able to identify, articulate and take action on the need to bring about improvement in community life;
- The health of local people is improved, combating health, inequality and promoting healthy lifestyles.

The challenges of integrating health and social care cannot be met by the NHS and Local Authority alone therefore Inverclyde HSCP has invested in nurturing the local relationships between the statutory, third and independent sectors to ensure there is a broader contribution to the achievement of outcomes from the wider partnership.

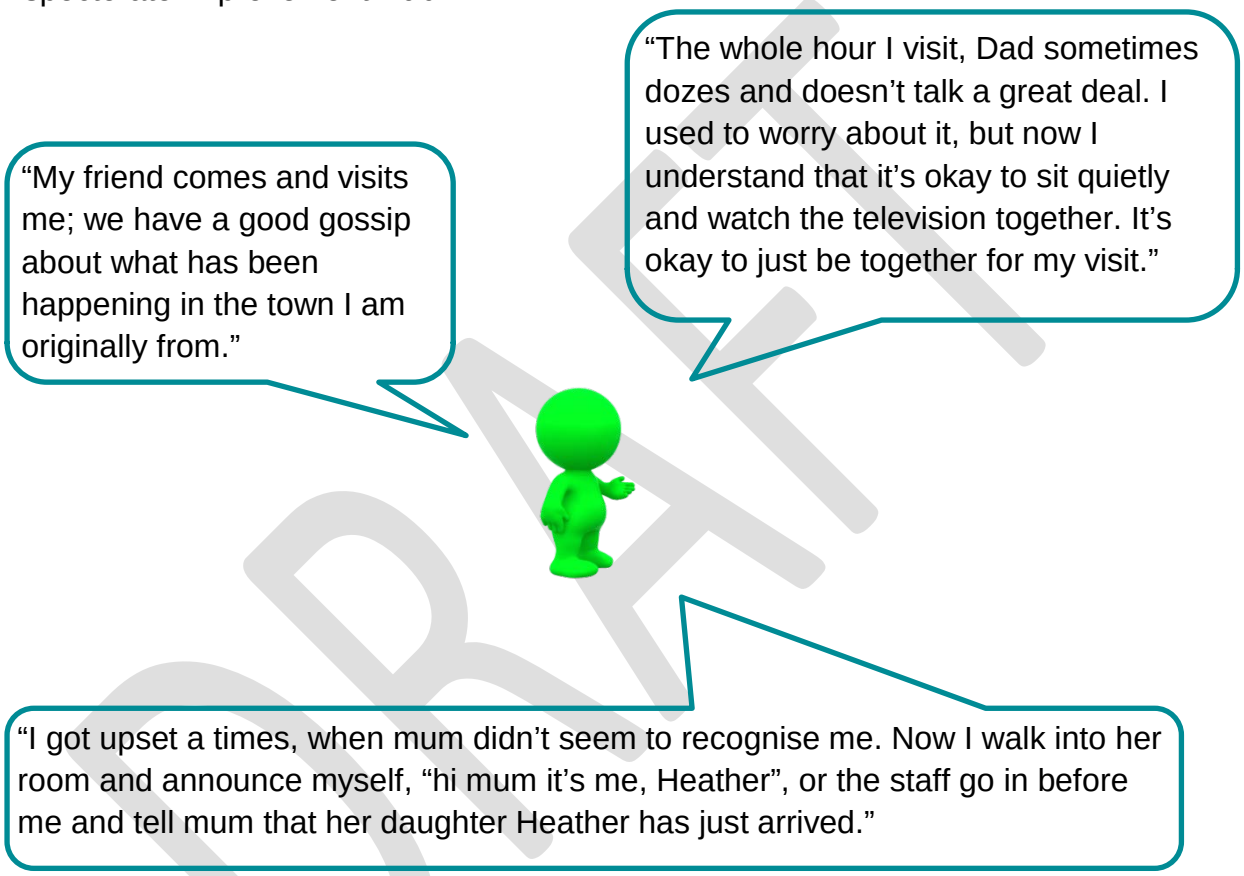
Inverclyde HSCP is committed to demonstrating improvement by making best use of the information available to us. Being selected to participate in the CAPA improvement programme is a testament to our commitment of '*Getting it right for every Child, Citizen and Community*'.

❖ **Come On In**

Over the past year a collaborative of the Care Inspectorate; Care Home residents and their families; care home staff, and HSCP staff have been working to reflect on and seek methods of improving the experience of visiting care homes.

As a consequence of this work, the collaborative has developed a resource which will support improvement on the visiting experience.

The group has sourced funding for the printing of the resource which will be distributed nationally, and alongside the booklet version it will be available on the Care Inspectorate Improvement Hub.



❖ **Orchard View**

Modernising mental health services in Inverclyde is a key objective and has included investment and development in our community services and our inpatient facilities.

We have commissioned a new build facility - **Orchard View** - which will provide high quality accommodation for adults and older people who require continuing mental healthcare. Orchard View will provide a safe, interesting and dignified living environment comprising of two ward areas:

- Oak is a twelve bed ward with sitting rooms, social spaces and a secure landscaped courtyard.

- Willow accommodates thirty beds, also built around a landscaped courtyard. This will meet the needs of patients with dementia who have multiple and complex medical needs.

The building includes a café area within an atrium that will provide an opportunity for activities that include the local community. The landscaping around the building will enable patients and their families access to other green spaces within the grounds. It is intended to create an orchard which will enhance the whole healthcare campus; hence the name of the development.

The project has involved staff, service users and carers in the design of the building to ensure that **Orchard View** meets the needs and aspirations of people living and working here in the future.

This initiative is a positive example of how we are adopting an outcome focused approach in our commissioning of services by thinking about the most effective way to plan care and support and thinking about how changes will improve the lives for the people of Inverclyde.

The new build is due for completion in late summer 2017.

❖ Compassionate Inverclyde

Compassionate Inverclyde is an innovative, multi-agency, community-wide initiative which aims to build a compassionate community in Inverclyde by encouraging an ethos that end-of-life is the responsibility of the whole community and not just one part of it (such as the NHS).

A number of agencies are signed up to Compassionate Inverclyde, including:

- the HSCP
- Inverclyde Council
- Carers
- third sector organisations
- Police Scotland
- the independent care sector
- community representatives
- faith organisations and others.

The programme is led by Ardgowan Hospice.

There are many strands to the initiative, including No One Dies Alone (NODA) and Absent Friends which are in the process of development and will focus heavily on deploying and training volunteers to develop community led responses to palliative care. It is envisaged that Compassionate Inverclyde will contribute to the Acute Service Review.

A successful launch of the initiative was held at the Beacon Arts Centre in March 2017 which was opened by the Scottish Governments' Communities Minister, Aileen Campbell.

To date the initiative has been unfunded and has developed through the voluntary efforts and in-kind contributions of the partner agencies, but represents another example of working together for better outcomes.

Chief Officer's Concluding Remarks

In this first year of the Integration Legislation, all Health and Social Care Partnerships (HSCPs) are required to publish an Annual Performance Report, showcasing our progress in delivering the National Wellbeing Outcomes.

The focus on outcomes - rather than the traditional focus on systems and processes – gives us an opportunity to channel our thinking towards the things that matter to the people who use our services. We have tried to reinforce the context throughout this report, explaining why each indicator is important.

With this in mind and aware of the wide audience who may read our report, we have tried to use a format that is easy to read and visibly shows how and where we are indeed making a difference and ultimately *improving the lives* of the citizens of Inverclyde. The case studies included are real life examples of how we are achieving our Vision.

At the outset of this report I mentioned that this time of challenge also offered us the opportunity to work together to make a difference and I would welcome your views on the overall format and content of this report.

I look forward to next year where I can reflect back on this report and the further progress and achievements Inverclyde HSCP will have made for the people of Inverclyde.

Louise Long
Corporate Director (Chief Officer)
Inverclyde HSCP, Municipal Buildings
Clyde Square, Greenock
PA15 1LY

Appendix 1: Performance at a Glance:

The 23 National Indicators

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
1	Percentage of adults able to look after their health very well or quite well	90.00%	93.85%	
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	88.32%	83.61%	
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	85.40%	78.82%	
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79.15%	75.39%	
5	Total % of adults receiving any care or support who rated it as excellent or good	83.68%	81.10%	
6	Percentage of people with positive experience of the care provided by their GP practice	87.09%	86.78%	
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	88.39%	83.83%	
8	Total combined percentage of carers who feel supported to continue in their caring role	45.72%	41.18%	
9	Percentage of adults supported at home who agreed they felt safe	87.21%	84.23%	
10	Percentage of staff who say they would recommend their workplace as a good place to work	Indicator under development (ISD)		
11	Premature mortality rate per 100,000 persons	496.3	440.5	
12	Emergency admission rate (per 100,000 population)	14971.97	11873.75	

13	Emergency bed day rate (per 100,000 population)	132718.06	106531.26	
14	Readmission to hospital within 28 days (per 1,000 population)	91.24	95.65	
15	Proportion of last 6 months of life spent at home or in a community setting	84.88%	86.84%	
16	Falls rate per 1,000 population aged 65+	24.73	20.96	
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	85.05%	82.94%	
18	Percentage of adults with intensive care needs receiving care at home	63.11%	61.56%	
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	243.9	915.03	
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	20.64%	21.41%	
21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	Indicator under development (ISD)		
22	Percentage of people who are discharged from hospital within 72 hours of being ready	Indicator under development (ISD)		
23	Expenditure on end of life care, cost in last 6 months per death	Indicator under development (ISD)		

The data presented against these National Indicators is the most up-to-date as released by ISD in April 2017.

Appendix 2: Glossary of abbreviations

A&E	Accident and Emergency department
ADL	Aids for Daily Living
APC	Adult Protection Committee
CAMHS	Child and Adolescent Mental Health Services
CAPA	Care…About Physical Activity
CECBN	Community Engagement and Capacity Building Network
CHCP	Community Health and Care Partnership
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CPO	Community Payback Orders
CPP	Community Planning Partnership
CQL	Cluster Quality Lead
CTO	Compulsory Treatment Order
DN	District Nurse
GG&C	Greater Glasgow and Clyde Health Board
GP	General Practitioner
HSCP	Health and Social Care Partnership
IAMH	Inverclyde Association for Mental Health
ISD	Information Services Division (NHS)
LOIP	Local Outcomes Improvement Plan
MAPPA	Multi Agency Public Protection Arrangements
MMR	Measles, Mumps and Rubella
MSK	Musculoskeletal
NHS	National Health Service
NODA	No One Dies Alone
OT	Occupational Therapist
PCMHT	Primary Care Mental Health Team
PDS	Post Diagnostic Support (for Dementia)
POP	Persistent Offenders Partnership
PQL	Practice Quality Lead
SDS	Self-Directed Support
SPP	Specialist Paramedic Practitioners
TEC	Technology Enabled Care

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

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।

Urdu

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

Inverclyde HSCP, Clyde Square, Greenock, PA15 1NB

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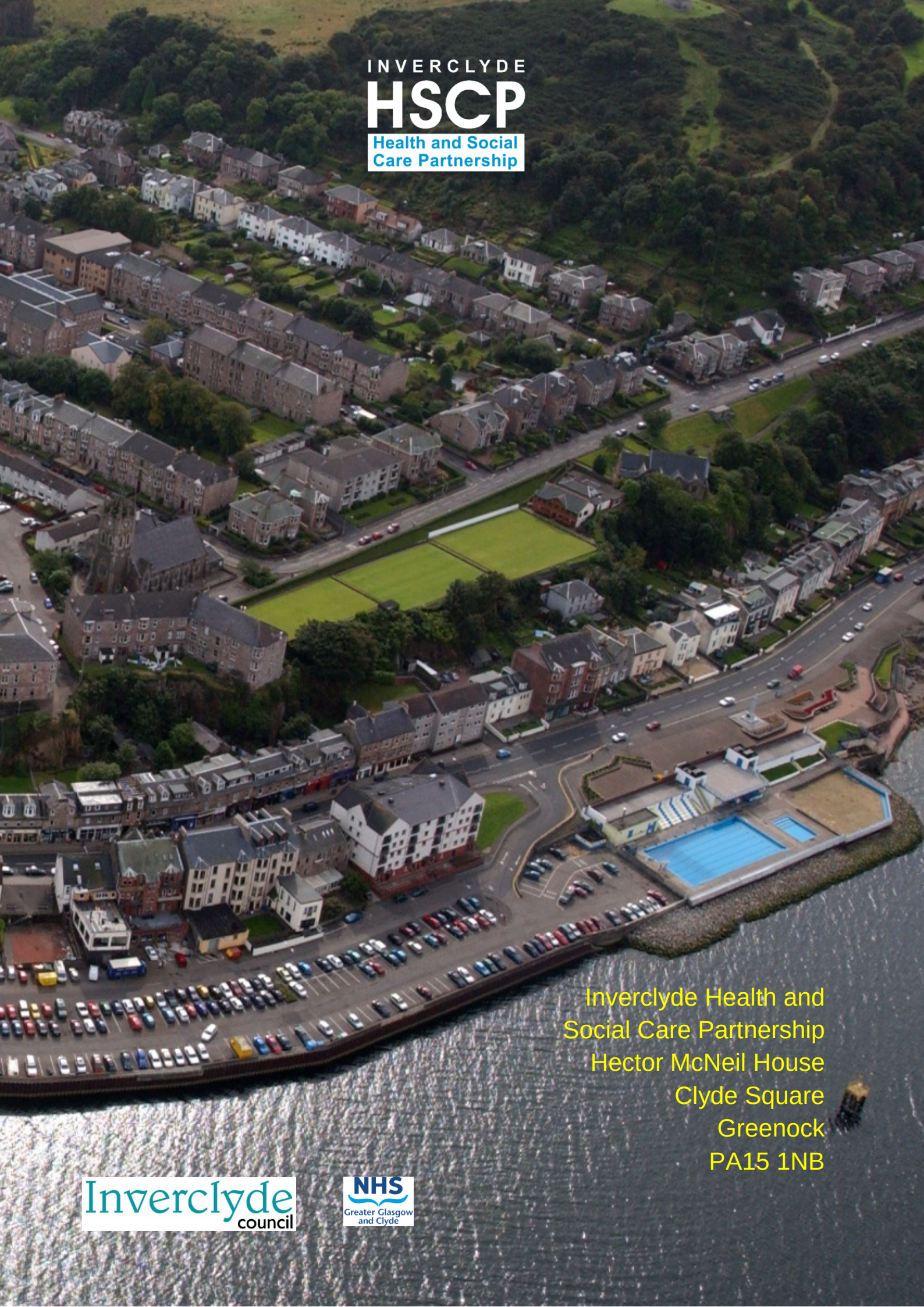
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