AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**12 June 2017**
Report By:	**Louise Long** **Corporate Director, (Chief Officer)** **Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/28/2017/HW**
Contact Officer:	**Helen Watson** **Head of Service** **Strategy and Support Services**	**Contact No:**	**01475 715285**
Subject:	**INVERCLYDE HSCP PEOPLE PLAN 2017-2020**		

1.0 PURPOSE

1.1 The purpose of this report is to present our first People Plan to the Inverclyde Integration Joint Board members for approval.

2.0 SUMMARY

2.1 The People Plan has been developed in a co-produced way with a wide range of stakeholders, and is ambitious in its scope.

2.2 It considers the workforce that is engaged in the delivery of health and social care, across the statutory, third and independent sectors in Inverclyde. Importantly it also includes unpaid carers and volunteers, who are a vital aspect of the care economy.

2.3 We acknowledge that this is a unique approach, and because of this, the data that we would really like to have had is not all currently available. We will work over the coming years to improve the data quality, but we believe that we have sufficient information at this stage to start planning for the future.

2.4 The report is structured to show the workforce in four general tiers. These are:

- Tier 1: People who are registered with a regulatory or professional body to deliver health and social care as an individual professional practitioner.
- Tier 2: People who deliver health and social care in Inverclyde, but are not specifically registered to do so as a practitioner.
- Tier 3 (a): People who contribute to the provision of health and social care in Inverclyde in the course of their work. Those whose day to day role is not directly related to health or social care, but who contribute indirectly including people who work as part of the third sector. This includes jobs and roles that would come under the umbrellas of administrative, clerical and support services.
- Tier 3 (b): People who contribute to the provision of health and social care in a voluntary, non-employed capacity to an individual directly or to people who are not relatives.
- Tier 4: People who contribute and can make a difference to outcomes for service users. Those in the community who indirectly contribute to the outcomes of local people. Amongst this group are shop workers, bus drivers, taxi drivers, hairdressers, bank staff, community centres, and resources centres. Health and social care is not the primary focus of such people and their roles, but by the way they carry out their jobs, they make a difference to people's lives.

2.5 As we move through the tiers, there are bigger gaps in our knowledge, but the principles still apply and data quality will improve over time.

3.0 RECOMMENDATIONS

3.1 That the Inverclyde Integration Joint Board members review and approve the first Inverclyde People Plan.

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 a workforce plan is produced and presented to Integration Joint Boards (IJB), highlighting the structure of our workforce. In Inverclyde we are keen to promote a more inclusive approach, based on our pilot work on the Equal Partners in Care (EPiC) Programme, whereby we recognise that delivering the National Wellbeing Outcomes will require co-ordinated efforts across the entire health and social care workforce, and not just the HSCP.

4.2 On that basis, when we talk about the workforce we mean a collection of people, groups, organisations, carers, families, volunteers, neighbours and communities who directly provide or in other ways contribute to the delivery of health and social care.

This includes*:*

- Inverclyde HSCP,
- Inverclyde Council,
- NHS Greater Glasgow and Clyde Health Board
- the workforce of people who practise in, or support the delivery of health and social work services (including volunteers);
- Partners in the secondary care (hospital) sector;
- Partners in primary care such as GPs Dentists, Pharmacists and Optometrists;
- Carers and families as partners in the delivery of care and support, who may require support in their own right.
- The Scottish Prison Service;
- Partner organisations in the Community Planning Partnership – Inverclyde Alliance - as partners with whom we work to improve Inverclyde as a place to live and work;
- Partners in the third, independent and statutory sectors, with whom we commission and organise health and social care service delivery;
- Communities across Inverclyde; the people to whom we are accountable;
- Individual users of services as partners in the planning of their own care and support;

4.3 The People Plan considers these contributors in the context of four tiers, specifically:

- Tier 1: People who are registered with a regulatory or professional body to deliver health and social care as an individual professional practitioner.
- Tier 2: People who deliver health and social care in Inverclyde, but are not specifically registered to do so as a practitioner.
- Tier 3 (a): People who contribute to the provision of health and social care in Inverclyde in the course of their work. Those whose day to day role is not directly related to health or social care, but who contribute indirectly including people who work as part of the third sector. This includes jobs and roles that would come under the umbrellas of administrative, clerical and support services.
- Tier 3 (b): People who contribute to the provision of health and social care in a voluntary, non-employed capacity to an individual directly or to people who are not relatives.
- Tier 4: People who contribute and can make a difference to outcomes for service users. Those in the community who indirectly contribute to the outcomes of local people. Amongst this group are shop workers, bus drivers, taxi drivers, hairdressers, bank staff, community centres, and resources centres. Health and social care is not the primary focus of such people and their roles, but by the way they carry out their jobs, they make a difference to people's lives.

4.4 The Plan also considers some of our key challenges that have been reported to the IJB in other contexts (such as our ageing population; depopulation of working-aged people etc.). These challenges point to a need to transform the way we deliver support, maximising all of our assets to design out any duplication of effort, and to focus on the types of support that will deliver better outcomes for the people who rely on our support (rather than organisational measures).

4.5 As we move forward with the Plan, we will also develop options for what the future health and social care workforce might look like. What the key skills for the future will be, and how all sectors work more closely to deliver outcomes.

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 at this time, although the report has an inherent ambition to extend rights and opportunities across all sectors of the workforce, as defined within the Plan.

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?**

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

The principles of this Plan support improved support to all people who need it, including those with protected characteristics.

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

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

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

The Plan supports developing a consistent approach across all sectors, 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 commitment of the HSCP in relation to inclusion of people with protected characteristics is captured in the Plan.

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

The Plan aims to extend this outcome across the entire health and care economy in Inverclyde.

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

The Plan does not directly address this outcome.

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

The Plan does not directly address this outcome.

5.5 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

There are no clinical or care governance implications at this time.

5.6 **NATIONAL WELLBEING OUTCOMES**

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

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

The ethos of enabling more people to support individuals at different levels of need should facilitate earlier intervention and more effective supported self-management.

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.**

The ethos of enabling more people to support individuals at different levels of need should facilitate earlier intervention and greater independence at home or in a homely setting.

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

By extending our principles across the entire caring community, we anticipate that people will have more positive experiences of services and support.

d) **Health and social care services are centred on helping to maintain or improve the**

quality of life of people who use those services.

This outcome is one of the key drivers of the People Plan.

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

This outcome is one of the key drivers of the People Plan.

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.**

Unpaid carers and volunteers will have access to training, development and professional networks.

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

By extending and sharing training across sectors, staff will become more adept across all sectors at keeping people who use services safe from harm.

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.**

Staff networks will improve across sectors, and all those involved in the delivery of health and social care should feel more informed and better equipped to deliver a good, quality service.

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

By reducing duplication we will use our resources more effectively.

6.0 CONSULTATION

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

7.0 LIST OF BACKGROUND PAPERS

7.1 None.

People Plan 2017- 2020

Principal Author:	Martin McGarrity Integration Facilitator
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Approved by:	
Date approved:	
Date for Review:	
Version:	1.0
Replaces previous version:	

Contents

SECTION 1: OVERVIEW

1.1 INTRODUCTION:

1.1.1 The Inverclyde Health and Social Care Partnership (HSCP) Strategic Plan (2016-19) sets out our vision of improving lives Inverclyde Council | Health and Social Care Partnership Strategic Plan.

1.1.2 Everything we do to deliver that vision relies on our workforce, and this People Plan is a sub-set of our overarching Strategic Plan. As such, the People Plan sets out how we will support, develop and grow the capacity and abilities of all the people who contribute to the delivery of health and social care in Inverclyde. The paid HSCP workforce includes people with a range of health and social care backgrounds who are committed to working together in a single organisation, to improve the outcomes of those people who need health and social care support.

1.1.3 We recognise though that the health and social care workforce extends beyond the paid staff within the HSCP. There are many individuals and organisations that make up the overall workforce delivering health and social care in Inverclyde. These include unpaid carers and volunteers, providers in the third and independent sectors, as well as wider roles that indirectly support the delivery of good care and ultimately better outcomes.

1.1.4 By considering all of these aspects, we need to approach workforce planning taking account of all the people who are part of this complex landscape, ensuring that we recognise all of the contributions, and support and sustain these as we move forward. This more inclusive approach goes far beyond traditional workforce planning approaches, and for this reason we have developed this People Plan – a plan that recognises and supports all of the people who contribute to improving lives in Inverclyde.

1.2 CORE VALUES AND PRINCIPLES

1.2.1 The Strategic Plan reinforces the values and principles that underpin our identity, and it is important to us that all of the Inverclyde health and social care workforce – paid and unpaid - subscribes to these. Chart A outlines these values, highlighting how they contribute to our vision of improving lives.

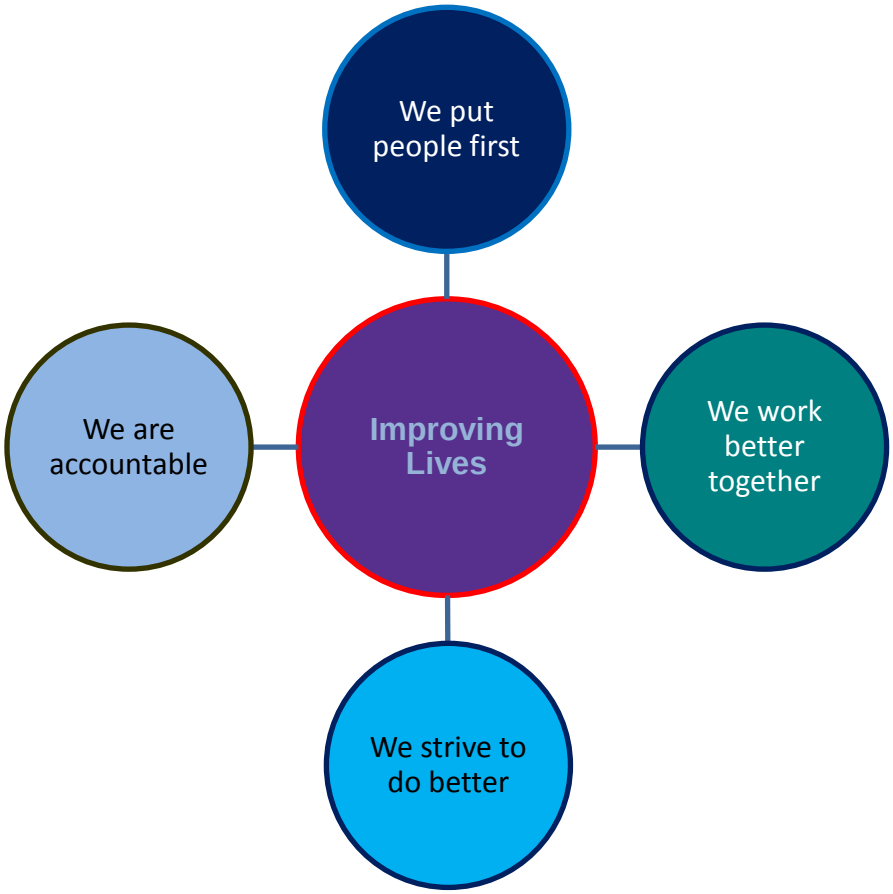


Chart A: Our vision and core values

1.2.2 These values are woven through all of our strategic and operational plans within our overarching Strategic Plan document wallet, so it is fitting that they should also underpin our People Plan. These interlink and can be cross referenced with regulatory and scrutiny body codes of practice and professional standards.

1.2.3 The national policy direction has shifted away from the traditional approach of measuring systems and processes within organisations. Instead, we now need to show that we are making a positive difference to the lives of the people we support. This means we need to think differently. We need to think about what will improve outcomes, and what workforce we will need to make it happen.

1.2.4 In respect of services for adults, our core values, professional codes of practice and standards align themselves to the Scottish Government's nine national wellbeing outcomes. Our core values and principles also apply to services for children and families, as indicated in the Inverclyde Alliance's Integrated Children's Services Plan [include web link], and these values and principles support our commitment to achieving the National Outcomes for Children.

1.2.5 In addition to these strands, we also have a legal requirement to adhere to the National Outcomes and Standards for Social Work Services in the Criminal Justice System, as demonstrated in the Inverclyde Community Justice Outcomes Improvement Plan, 2017-2022 http://www.inverclyde.gov.uk/health-and-social-care/criminal-justice. The National Wellbeing Outcomes for adults; the National Outcomes for Children, and the National Outcomes and Standards for Social Work Services in the Criminal Justice System are included at appendix 1.

1.2.6 Our future workforce will be shaped to deliver on these outcomes, and our performance will be measured against them too - the HSCP will be "***accountable"*** for their successful delivery. We strongly believe that successful delivery can only be brought about by recognising, supporting and co-ordinating all of the inputs, by all of the people recognised in this People Plan.

1.3 CREATING THE PLAN

1.3.1 The Inverclyde People Plan has been created in close liaison with our partners and stakeholders, with significant input from the Strategic Planning Group. This approach has helped us to:

- Define the plan;
- Start to identify what change will look like;
- Describe the present workforce;
- Outline the workforce we will need, in order to deliver the National Wellbeing Outcomes in Inverclyde;
- Highlight what actions we need to take to deliver the future workforce and;
- Detail how change will be implemented, monitored and reviewed over the next three years.

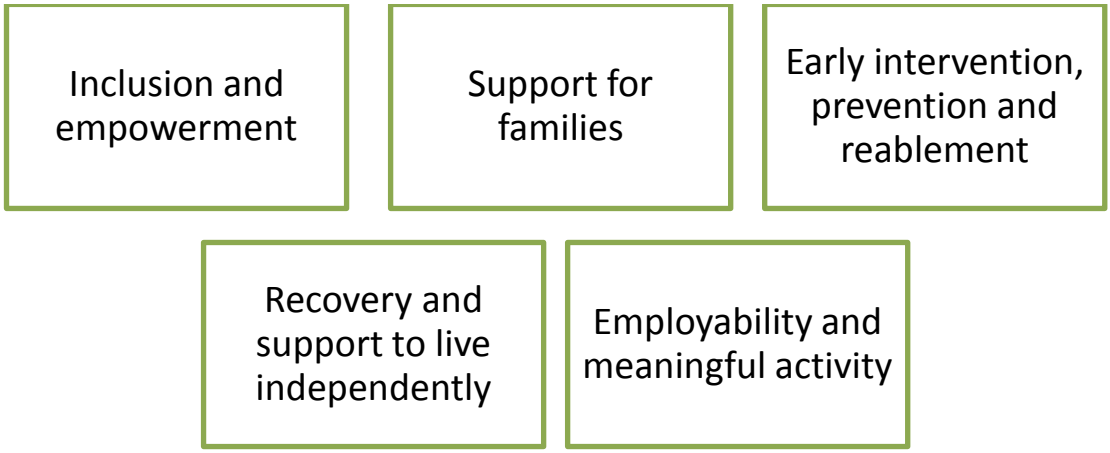
1.3.2 As part of this, we have undertaken an initial mapping of the entire current health and social care workforce (appendix 2). This has helped us to prepare for potential gaps in staffing numbers, and professional knowledge or skills that will be required to meet future demand.

1.3.3 We have taken an Inverclyde-wide partnership approach to the development of our People Plan. Our long-established collaborative approach breathes life into our strategic value of ***"working better together"*** with our local statutory, independent, voluntary, third and housing sector partners as well as unpaid carers and Trades Unions, all of whom make a significant contribution to ensure that Inverclyde is a safe, secure and healthy place to live and work. Underpinning this is a need to attract people to a career in health and social care and to sustain the workforce by ensuring rates of pay as well as terms and conditions of employment are competitive and fair.

1.4 COMMISSIONING FOR OUTCOMES

1.4.1 The Integration Legislation heralded an important shift in policy direction ***away*** from the traditional focus on the systems and processes of public sector organisations, and ***towards*** better outcomes for the people who use our services. In other words, we shouldn't be judged on how much we do, but rather, we should be judged on how much of a difference we've made to people's lives. This shift presents exciting opportunities to think about and do things differently.

1.4.2 We have to change how we think about ourselves and our services – away from the traditional service-specific models, and more towards the outcomes that will improve the day-to-day lives of Inverclyde people. This is because traditional approaches can reinforce traditional thinking. The Strategic Planning Group has considered how we might support this shift in thinking, and has agreed five themes that should apply to all services regardless of whether or not they're focused on a single client group, illness or condition. The five themes are:



1.4.3 These themes change how we approach commissioning and can open up a wider, more inclusive way of working. They also mean that our workforce can begin to identify the skills and experience they have, and think about these in a much bigger context (rather than just focusing on the care group that they currently work with). We will be commissioning with these themes in mind, rather than commissioning what we've always commissioned. Our commissioning will be driven by a need to deliver the outcomes at appendix 1, and the five themes will help us to think across traditional service and client-group boundaries. That is vital if we are to think about the Inverclyde health and social care workforce in the round – including all sectors.

SECTION 2: IDENTIFYING THE WORKFORCE – OUR PEOPLE

2.1 WHO IS INCLUDED IN THE PEOPLE PLAN?

2.1.1 To deliver improved outcomes, we believe that working together as a unified workforce is the key to bring about successful change and better outcomes for individuals, carers, families, localities and communities in our area.

2.1.2 National and local research indicates that the most challenging issues that people experience in Inverclyde are caused by factors that go far beyond the reach of health and social care services.

2.1.3 So, on that basis, when we talk about the workforce we mean as a collection of people, groups, organisations, carers, families, volunteers, neighbours and communities who directly provide or in other ways contribute to the delivery of health and social care.

This includes:

- Inverclyde HSCP
- Inverclyde Council,
- NHS Greater Glasgow and Clyde Health Board
- the workforce of people who practice in, or support the delivery of health and social work services (including volunteers);
- Partners in the secondary care (hospital) sector;
- Partners in primary care such as GPs Dentists, Pharmacists and Optometrists;
- Carers and families as partners in the delivery of care and support, who may require support in their own right.
- The Scottish Prison Service;
- Partner organisations in the Community Planning Partnership – Inverclyde Alliance - as partners with whom we work to improve Inverclyde as a place to live and work;
- Partners in the third, independent and statutory sectors, with whom we commission and organise health and social care service delivery;
- Communities across Inverclyde; the people to whom we are accountable;
- Individual users of services as partners in the planning of their own care and support.

2.1.4 Delivering all of the outcomes at appendix 1 will be challenging, but essential if we are to fulfil our ambition of improving lives. We also recognise that there will never be a time when we can say that the job is complete. 'Improving lives' is a continuous agenda, and co-ordinating of all of the various inputs and supports needs to continually improve so that we can anticipate the future workforce – both paid and unpaid - that will be needed to deliver services.

2.1.5 The first steps towards this ambition have already been taken as part of the development of this People Plan. A partnership and collaborative approach has been taken to carefully consider the needs of our local population through the Strategic Needs Assessment included in the document wallet of our Strategic Plan. Our current and future commissioning intentions will be highlighted within the Market Facilitation and Commissioning Plan, due for completion in August 2017. The intentions will reflect our assessment of what we will need to commission – and just as importantly, what we will need to de-commission - in order to meet future anticipated needs. Out of that, we will begin to scope the skills and qualities needed in our workforce to meet those needs.

2.1.6 In recognising the full spectrum of contributors to health and social care, we acknowledge that our People Plan approach is highly ambitious. In order to try to simplify the complexity, we have defined the workforce in to four tiers (see Chart B).

Chart B

Tier 1

People who are registered with a regulatory or professional body to deliver health and social care as an individual professional practitioner

These members of staff have completed professional qualifications and are registered with a regulatory body to enable them to perform the job for which they are employed. This group includes medical staff, nurses and midwives, allied health professions, social workers, and healthcare scientists.

Tier 2

People who deliver health and social care in Inverclyde, but are not specifically registered to do so as a practitioner

This category includes those who are employed to provide a service that is directly involved in health and social care, including people who work directly for the HSCP or as part of the third or independent sectors. It also includes unpaid familial carers.

Tier 3

This tier has been divided into two parts:

(a) People who contribute to the provision of health and social care in Inverclyde in the course of their work
Those whose day to day role is not directly related to health or social care, but who contribute indirectly including people who work directly for the HSCP or as part of the third sector. This includes jobs and roles that would come under the umbrellas of administrative, clerical and support services.

(b) People who contribute to the provision of health and social care in a voluntary, non-employed capacity to an individual directly or to people who are not relatives.

Tier 4

People who contribute and can make a difference to outcomes for service users.

Those in the community who indirectly contribute to the outcomes of local people. Amongst this group are shop workers, bus drivers, taxi drivers, hairdressers, bank staff, community centres, and resources centres. Health and social care is not the primary focus of such people and their roles, but by the way they carry out their jobs, they make a difference to people's lives.

2.1.7 Each of these tiers will have a degree of overlap – paid staff can also have roles as volunteers or unpaid carers; or some volunteers might also have a role in the wider community supports, for example. As this is our first People Plan, we have not attempted to disaggregate roles, so there might be an element of double-counting. However we believe that it is important to recognise the full inputs of our people, and will work to refine the model of counting as part of the implementation of the People Plan. Tables 1, 2, 3 and 4 outline the people that are currently delivering these tiers. Over the lifespan of this People Plan we will work to understand the components of the tiers better, and work to develop each of the tiers in the contexts of the outcomes at appendix 1, and our five Strategic Commissioning Themes as detailed at page 6.

2.1.8 Importantly, our aspiration is to be collaborative in how we develop our services and plan for the future. We are committed to looking widely at the outcomes that service users want to achieve and how we can build on the positive assets already present in our communities to help them to achieve these.

2.1.9 Carers and volunteers are vital and valued partners in the successful achievement of individual and community outcomes, so recognition is given in the People Plan to this committed and unpaid workforce. It is also recognised that sustaining this valuable unpaid workforce entails providing support, guidance, training and development to enable them to continue and sustain their role.

2.1.10 These tables provide an overview of what we know about our people resources in Inverclyde. We accept that this information is not complete and there are gaps in what we know, but this represents a starting point for us to start thinking about the communities of Inverclyde, and how we can strengthen the connections to get the best out of our local people and assets.

TABLE 1 – Registered and Professional Health and Social Care Staff

Our People	Statutory Agencies		Care at Home External Providers		External Care Home Providers		Other External Providers	
WTE – Whole Time Equivalent **HC** – Headcount	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**
Adult Nursing/District Nursing/ Practice Nurses/ Triage Nurses	88.9	109					1.6	60 2
Social Work Assistants/ Social Workers / Senior Social Workers	97.9	114						
Staff in Care Homes / Residential	6.5	8				730		
Child-minding/ Day Care of Children Staff / Play Specialists	0.6	1						160
Community Children's Nursing / Health Visiting / School Nursing / Specialist Nursing	50.2	63						
Consultants (Medical)	12.2	13						
Counsellors / Psychologists	11.6	14						
Mental Health / Addictions Workers	259.3	283						
Criminal Justice Addictions / Development	1.5	2						
Dieticians / Occupational Therapists / Physiotherapists / Podiatrists / Phlebotomists / Community Pharmacists / Speech & Language Therapists / Staff and associate specialist grades/ Team Leaders / Therapy Technicians	115.7	139						
General Practitioners							50.8	65
Health promotion/ improvement	23.3	27						
Healthcare assistant / Housing Support/Care at home/ Multi-skilled / Co-ordinators / Service Officers / Support Workers / Senior Support Workers / Homemakers /Information Workers / Resource Workers	503.2	684		570				
Total	**1170.9**	**1457**		**570**		**730**	**52.4**	**287**

TABLE 2: People who deliver health and social care in Inverclyde, but are not specifically registered to do so as a practitioner.

Partners and Stakeholders	**Statutory Agencies**		**Care at Home External Providers**		**External Care Home Providers**		**Other External Providers**	
WTE – Whole Time Equivalent **HC** – Headcount	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**
Training & Assessment Staff	6.3	7						
Managers of Projects & Services /Unit Managers/ Other Managers	42.1	47						
Accommodation Services Officers	8.1	13						
Business Support staff /Analysts / Co-ordinators	363.8	482						
Total	**420.3**	**549**						

TABLE 3A: People who contribute to the provision of health and social care in Inverclyde in the course of their work. Those whose day to day role is not directly related to health or social care, but who contribute indirectly including people who work as part of the third sector. This includes jobs and roles that would come under the umbrellas of administrative, clerical and support services.

Partners and stakeholders	**Statutory Agencies**		**Care at Home External Providers**		**External Care Home Providers**		**Other External Providers**	
WTE – Whole Time Equivalent **HC** – Headcount	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**
Care and Repair Staff etc.								
Community learning and Development/Community Work Staff								
Fire and Rescue Staff	114.0	120						
Housing Support Workers/ Housing Officers	311.1							
Nursery Staff	276.0							
Police Officers and staff	671.0							
Registered Child Minders		61						
Safer Communities Staff								
Teachers	742.0							
Total	**2114.1**	**181 + ?**						

TABLE 3B: People who contribute to the provision of health and social care in a voluntary, non-employed capacity to an individual directly or to people who are not relatives.

	Statutory Agencies		**Care at Home External Providers**		**External Care Home Providers**		**Other External Providers**	
WTE – Whole Time Equivalent **HC** – Headcount	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**	**WTE**	**HC**
Adult day care								30
Care home						530		
Child care agency								20
Community care forum								12
Community programme								3
Day care for children								90
Drugs and alcohol programme								8
Fostering service								10
Personal and social care								10
Residential Child care								60
Total						530		243

TABLE 4: People who contribute and can make a difference to outcomes for service users. Those in the community who indirectly contribute to the outcomes of local people. Amongst this group are shop workers, bus drivers, taxi drivers, hairdressers, bank staff, community centres, and resources centres. Health and social care is not the primary focus of such people and their roles, but by the way they carry out their jobs, they make a difference to people's lives.

Shop workers		4,500	-	-
Bus drivers	Transportation and storage	1,000	-	-
Taxi drivers		-	-	-
Council staff	Customer Service Centre	-	-	-
	Refuse Collection	-	-	-
	Parks maintenance	-	-	-
Total		**5,500 + ?**	**-**	**-**

2.1.11 As can be seen from tables 1-4, there are notable gaps in our information. We believe that as we implement the plan, we will begin to gather more information which will help us towards a more complete picture of the people involved in improving lives. It is likely that we will never achieve a fully accurate picture, as workforce flow is constantly moving, and some of the detail we would like cannot be provided for a number of reasons. Other organisations do not necessarily hold their information in the format we are using, or they might be reluctant to share information about their workforce as this could be seen as commercially sensitive. That said, if we can achieve a "broad brush" picture of what supports are potentially embedded in our people and in our communities, we can begin to describe the different ways that the full potential can be harnessed and implemented.

SECTION 3: KEY CHALLENGES

3.1 Key Challenges

3.1.1 The key challenges we face, if we are to deliver on the nine National Wellbeing Outcomes and ultimately improve lives in Inverclyde, are summarised in this section.

3.1.2 The population in Inverclyde is falling. Since 2000, the total population has fallen by an average of 342 people each year. Population projections estimate that the average annual decrease in the population will be approximately 640 people a year between 2016 and 2037, meaning that there will be just over 65,000 people living in Inverclyde in 2037.

3.2 Our Population

3.2.1 The population of Inverclyde is getting older. It is predicted that those of working age (16–64) will see a decrease from 64% in 2012 to 52% by 2037. However, in contrast, those aged 65+ will increase from 19% in 2012 to 34% of our total population by 2037. It is likely that our older people will require higher levels of support and use of resources. Table C below provides a full breakdown of age groups.

CHART C Population projections to 2037

Age Group	2012		2022		2032		2037	
	Number	%	Number	%	Number	%	Number	%
0-15	13,403	17%	12,295	16%	10,348	15%	9,171	14%
16-49	34,949	43%	27,579	37%	24,149	35%	22,152	34%
50-64	17,127	21%	17,745	24%	12,996	19%	11,597	18%
65-75	8,198	10%	9,263	12%	10,953	16%	10,202	16%
75+	7,003	9%	8,404	11%	10,464	15%	11,892	18%
Total	80,680	100%	75,286	100%	68,910	100%	65,014	100%

Source: NRS population projections

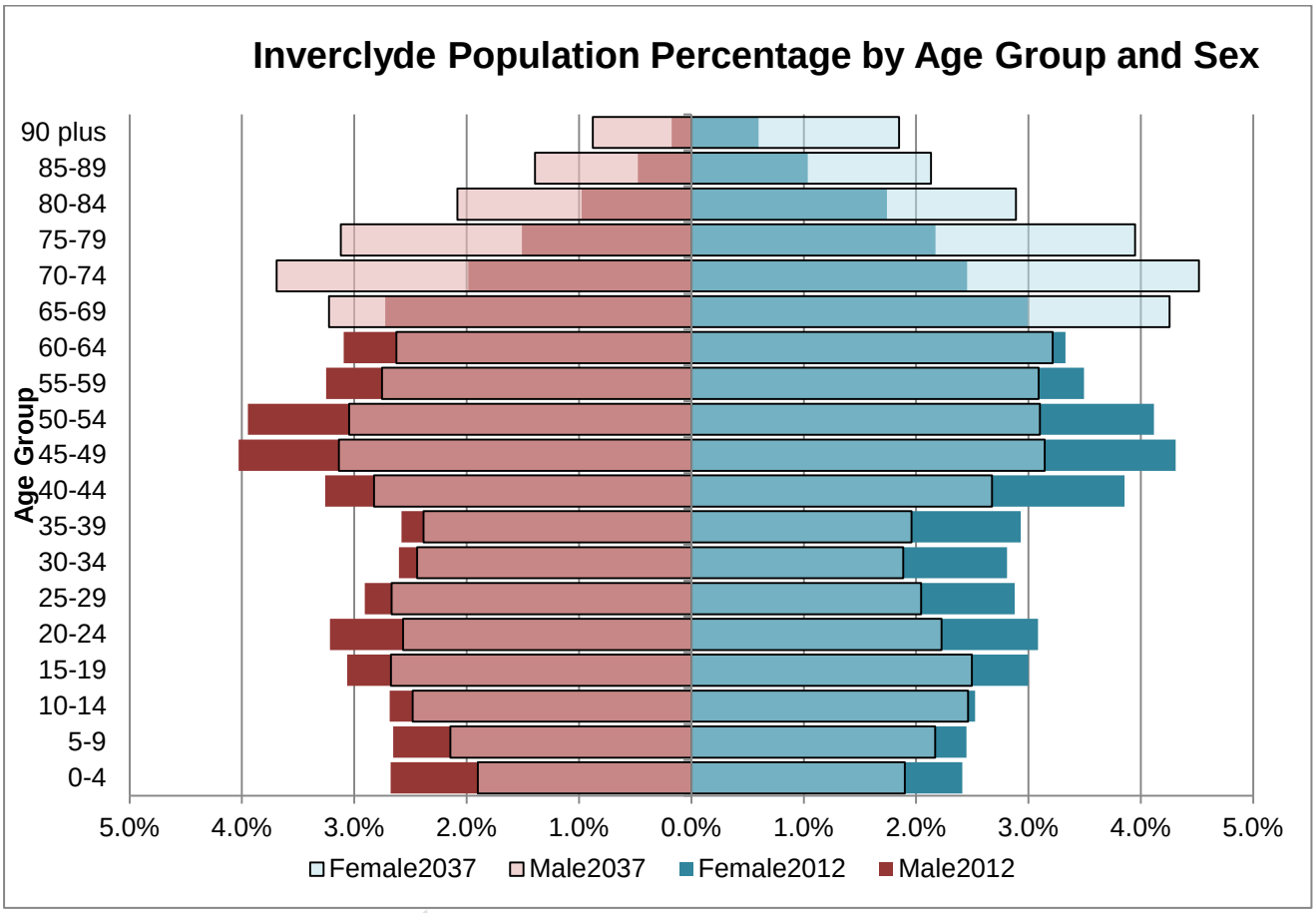
3.3 Our Future Projections

3.3.1 Chart C predicts a reduction in children and young people living in Inverclyde from 17% of the total population in 2012, to 14% in 2037.

3.3.2 Chart D below breaks this down further to show the split by gender and into more age group categories in the shape of a population pyramid. The lighter shaded areas are the projected population figures superimposed on top of the current population figures for each age group. The chart shows that the pyramid is projected to become top heavy, creating an inverted pyramid. There will be more people in older age groups than in younger age groups for

both men and women, meaning that there could be greater demand on support services in the future.

Chart D – Projected Population Age distribution in Inverclyde

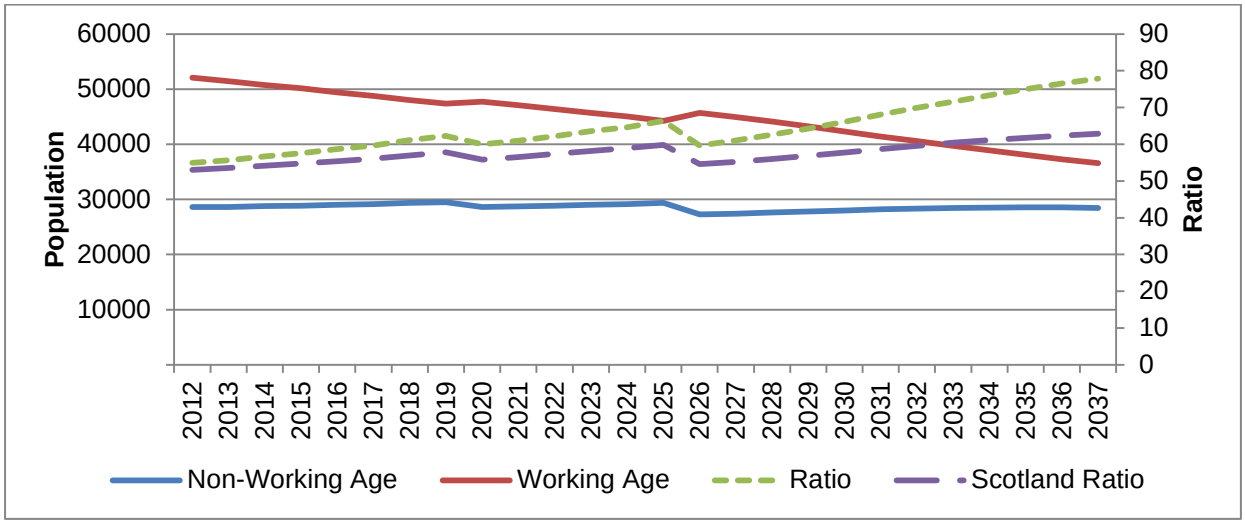


Source: NRS population projections

3.4 Dependency levels

3.4.1 Following on from the age profile of our population, chart E demonstrates that the overall projected fall in Inverclyde's population is as a result of falling numbers of working age-people. As the population ages, the working age population is not being replaced by the generation following. According to the National Records of Scotland (NRS), projections the population in Inverclyde is set to fall by 15,666 between 2012 and 2037 and most of these people will be of working age; by 2037 there will be 15,521 fewer people of working age living in Inverclyde. We need to start to understand what this shift will mean in terms of the availability of unpaid carers and volunteers, who form a vital part of our care economy.

Chart E – Inverclyde Projected Dependency Ratio



Source: NRS population projections

3.4.2 Despite positive self-perceptions of health and wellbeing and overall quality of life in Inverclyde, specific health issues and diseases remain higher than the national average. Some of these differences are present in childhood, whilst others develop in adulthood. Such issues and diseases have an impact on the services provided by Inverclyde HSCP. These include reducing dependency, supporting healthier outcomes and choices, lifestyles, safety, protection and resilience as well as promoting recovery, to live independently for as long as possible. Supporting better outcomes implicitly includes supported self-management, which empowers the individual and eases demand pressures on the wider health and care support systems.

3.5 Long-Term Conditions

3.5.1 If we are to deliver meaningful supported self-management, we need to understand the scale of long-term conditions within Inverclyde. Healthy life expectancy is an estimate of how many years a person might live in a 'healthy' state. Chart F compares life expectancy and healthy life expectancy in Inverclyde and Scotland based on data for the five year period 2009-2013. It shows that both life expectancy and healthy life expectancy is lower in Inverclyde than in Scotland. This demonstrates that the need for care and for supported self-management is likely to be higher per capita in Inverclyde than is the case in other areas.

Chart F: Healthy Life Expectancy in Inverclyde and Scotland 2009-2013

	Inverclyde		Scotland	
Healthy Life Expectancy	**Male**	**Female**	**Male**	**Female**
5-year period 2009-2013	59.6	63.4	63.1	65.3

Source: http://www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/local-authorities

3.6 Learning Disabilities

3.6.1 Inverclyde has a higher than average rate of people who have a learning disability compared to the Scottish average. To achieve their individual outcomes and improve their well-being, considerable levels of health and social care support and resources are required. People with learning disabilities often require support from carers and from agencies throughout their lives. We need to factor this need into our future workforce projetions.

Chart G: Number of adults with learning disabilities known to local authorities per 1,000 population 2010 - 2014

Area	2010	2011	2012	2013	2014
Inverclyde	8.7	8.8	8.7	9.1	9.4
Scotland	6.4	6.0	6.0	5.9	6.0

Source: Learning Disabilities Statistics Scotland, National Records of Scotland

3.7 Physical Disabilities

3.7.1 The majority of people who have a physical disability in Inverclyde are over the age of 50. Chart H below shows that the proportion of those with a physical disability increases as people age. Only 1% of the population aged 16-24 had a physical disability in 2011, compared to 34.4% for those aged 85 and over. As our population gets older, we can expect to see further increases in the prevalence of physical disability, and a workforce that is geared to supporting the associated needs.

Chart H: Number of people in Inverclyde with a physical disability by age and sex

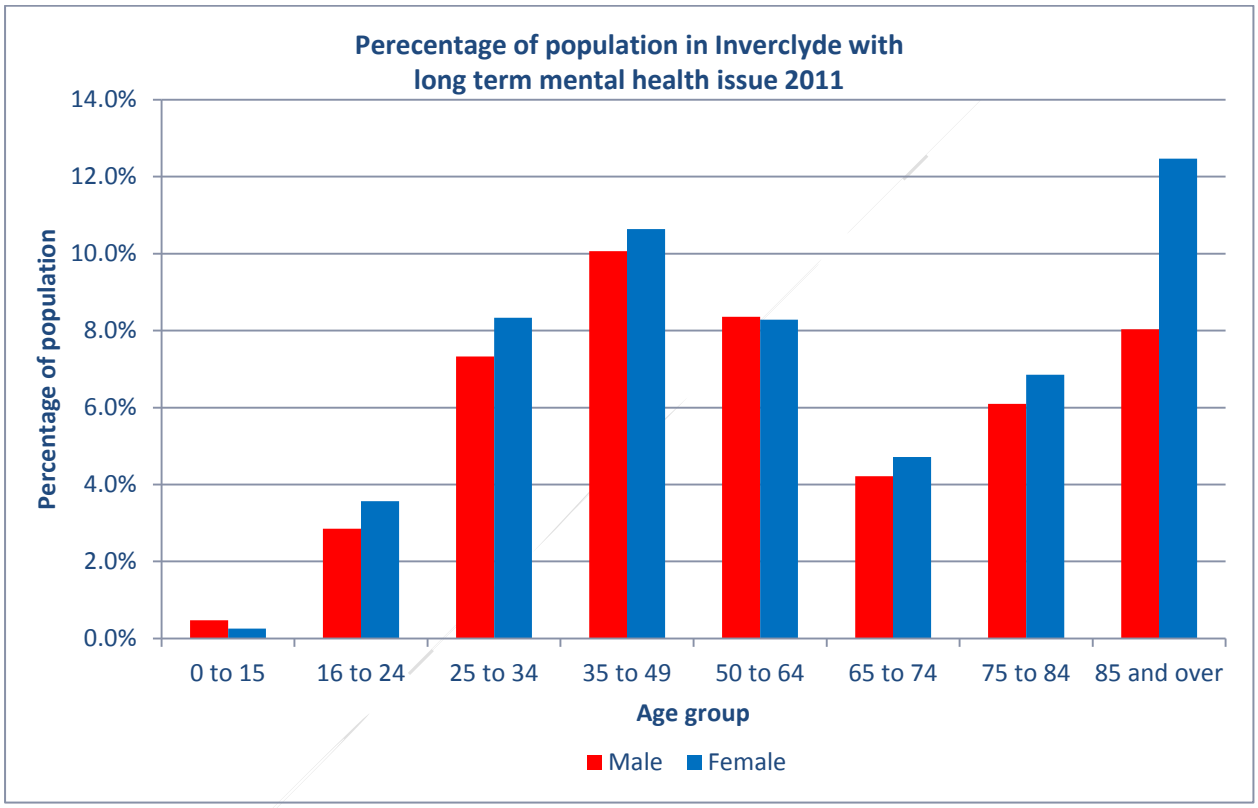
Age	Male	Female	Total	Percentage of total population with physical disability	Percentage of age group with physical disability
0-15	72	71	143	2.2%	1.0%
16-24	75	51	126	2.0%	1.4%
25-34	127	86	213	3.4%	2.3%
35-49	498	404	902	14.2%	10.0%
50-64	982	889	1871	29.4%	11.0%
65-74	637	673	1310	20.6%	16.5%
75-84	451	736	1187	18.7%	23.3%
85+	144	461	605	9.5%	34.4%

Source: 2011 Census

3.8 Mental Health and Well-being

3.8.1 There are a slightly higher percentage of people in Inverclyde with a mental health condition in comparison with the Scottish average. In Inverclyde 6.4% of the total population had a mental health condition recorded in the 2011 census, the Scottish figure was 4.4%. Chart I provides an overview of Inverclyde Long Term Mental Health conditions by age group and sex 2011. Again, there are specific support needs for people with a mental health condition, so we need to shape the future workforce to address this.

Chart I: Percentage of population with long term mental health conditions in Inverclyde by age group and sex 2011



Source: 2011 Census

3.9 Dementia

3.9.1 Dementia presents significant challenges to individuals, their carers and health and social care services across Scotland, so all tiers of support (as detailed in chart B on page 10) need to be co-ordinated and clear about roles and responsibilities if we are to improve the lives of those affected by dementia.

3.9.2 Data from the Quality and Outcomes Framework (QOF) demonstrates that the rate of individuals in Inverclyde with dementia has fallen slightly from 0.9 in 2010/11 to 0.7 in 2014/15. This estimated prevalence is marginally less than

the Scottish figure of 0.8 people per 100 of the total population in Inverclyde. Chart J provides the prevalence rates of dementia in Inverclyde.

Chart J: Rate of Dementia in Inverclyde (per 100 people)

Year	2010/11	2011/12	2012/13	2013/14	2014/15
Rate (per 100 people)	0.9	0.9	0.8	0.8	0.7

Source: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof

3.9.3 Another factor for consideration when assessing the priorities of a future workforce, is the impact of the most common or support-intensive conditions, and their prevalence in Inverclyde. There are 16 GP practices in Inverclyde, and the majority of practices have a higher rate of prevalence for the conditions listed in Chart K below than both NHS Greater Glasgow & Clyde and Scotland.

Chart K: Comparison of the rate of prevalence of key conditions

Condition	Number of Inverclyde practices with higher prevalence rates than NHS GG&C	Number of Inverclyde practices with higher prevalence rates than Scotland
Asthma	13	12
Atrial Fibrillation	11	11
Cancer	11	5
CHD (Coronary Heart Disease)	15	15
CKD (Chronic Kidney Disease)	14	12
COPD (Chronic Obstructive Pulmonary Disease)	11	11
Dementia	11	4
Depression	11	13
Diabetes	14	12
Heart Failure	11	11
Hypertension	15	14
Mental Health	13	14
Osteoporosis[1]	4	4
Peripheral Arterial Disease	14	14
Rheumatoid arthritis	14	13
Stroke & Transient Ischaemic Attack (TIA)	15	13

1. Only 7 practices recorded information on Osteoporosis as part of the QOF.
Source: Quality and Outcomes Framework (QOF) www.isdscotland.org/qof

3.10 Recruitment and Retention

3.10.1 It is evident from research that the recruitment and retention of staff in health and social care sectors has become a challenge. There are real issues in terms of comparatively low rates of pay across which vary by employer.

3.10.2 Our challenges allow us to identify what we need to address, and from there we must identify what should change, and what actions we can take in order to attract people into the health and social care sectors. We need to be thinking about the entire workforce, and how to equip them with the skills to assess for better outcomes. We should empower all of those who need support, by focusing on their abilities and what they can do, rather than any limitations. The data gathered for this plan will enable us to scope the different options and make the best use of our resources to deliver services in the most effective and efficient way.

SECTION 4: WHAT WILL NEED TO CHANGE?

4.1 Service Redesign

4.1.1 As our HSCP has developed, so has our approach to service redesign. We now have full agreement that all service redesign proposals should come to the Strategic Planning Group (SPG) so that they can be understood in the wider context of the delivery of the Strategic Plan. This also means that our People Plan can be overseen in that same context, further bolstering the value placed on all of our people, but especially unpaid carers and volunteers. Service redesign needs to take account of the full range of expertise and inputs that come together to provide care and support.

4.1.2 As we move through the delivery of our Strategic Plan, there will be a need to reconsider how some of our services are organised - including other options that might be more effective at delivering improved outcomes. Our People Plan will be updated as required, depending on decisions made by the IJB about future service redesigns. Such updates will take account of:

- staff roles (including the full range of people covered within this People Plan),
- the necessary skills required;
- the basis from which care is delivered and
- the hours of support required.

4.1.3 During the lifetime of this People Plan, it will have to take account of how these changes will re-shape the workforce. The SPG will need to be mindful to avoid duplication or identify any emerging gaps moving forward, and respond appropriately.

4.1.4 Service redesigns are consulted and negotiated with Inverclyde Council, NHS Greater Glasgow and Clyde, and Trades Unions; however the SPG will have to be kept up to date with developments so as to understand the implications of change.

4.1.5 During redesigns or reconfiguring the focus and skills of our workforce, it is important to retain quality. To ensure that the structure and delivery of our services in the most effective and innovative ways possible, and to ensure that we aim to deliver outcomes (rather than focusing on the systems and processes of how we operate), we will undertake future redesigns based on the five strategic commissioning themes. We will consider what workforce changes are needed, and think about this in the “whole-system” context. This will also support partnership by integrating workers in different sectors.

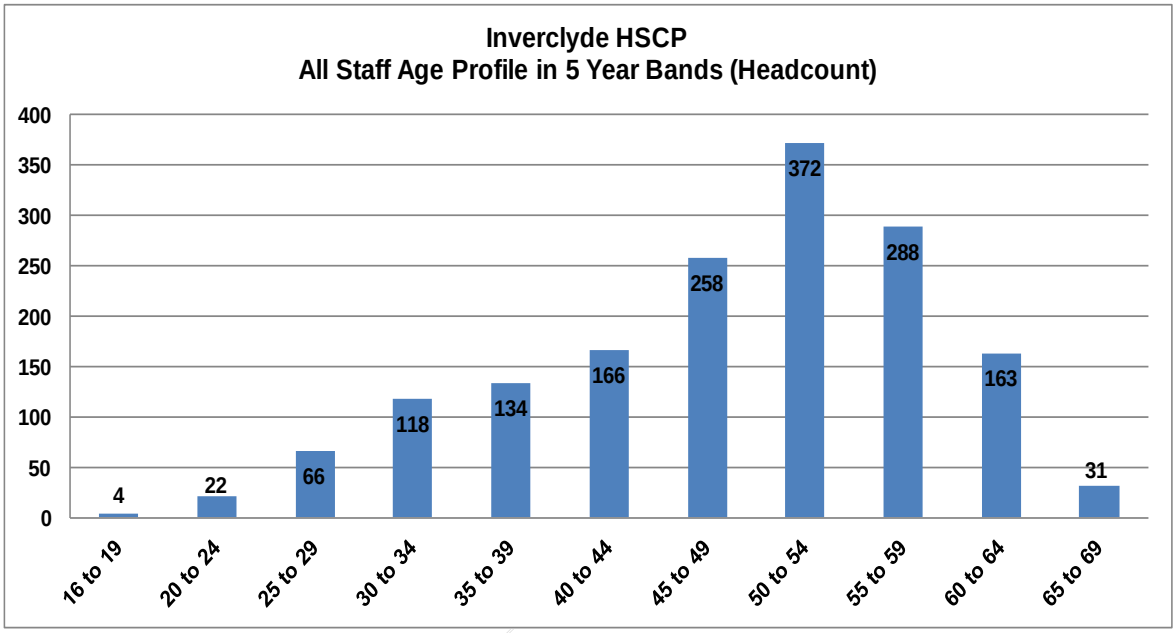
4.2 The Required Workforce

4.2.1 In this section we will consider the skills, numbers and types of staff we will need to deliver, sustain and improve services. We will identify which staff are best placed to do particular tasks and activities, being mindful of the financial constraints on all sectors.

4.3 Aging workforce

4.3.1 The age range within the HSCP paid workforce is 16 to 69 years. We know that there are unpaid workers (carers and volunteers) that full below and above these parameters, but we are not able to put precise numbers against these at his time. The majority of HSCP paid staff fall into the 50 to 54 years, as illustrated in chart L below.

Chart L: HSCP Staff Profiles by Age



4.3.2 As previously indicated by chart C, page 17, there will be a higher proportion of older people by 2037. At the same time it is predicted that there will be a fall in the number of children and young people living in our area.

4.3.3 This is of particular concern when considering our workforce is predominantly made up of local people who fit into the 50 to 69 year age bracket. There may be a reduction in the available younger workforce living locally to fill posts after those in this group are eligible for retirement. As the majority of our health and social care workforce live and work in Inverclyde, this may also impact on our local economy.

4.3.4 From the 2011 census, unpaid carers make up around 10% of our local population. They mostly provide care and support to close friends and relatives.

Information from the 2011 census returns showed that in Inverclyde;

- 8,252 people identified themselves as carers, 10% of the population of Inverclyde at that time.

- Nearly a third of those carers (2,562 people) provided 50 hours or more unpaid care a week.
- 61% of all carers were women.
- 20% of all carers were aged 65 and over, and 23% of male carers were aged 65 and above, and 17% of female carers were aged 65 and above.
- 4,903 carers provide care in a household for someone with a long term health problem or disability.

Chart M shows the number of carers in each age group and their general health.

Carers	Very good or good health	Fair health	Bad or very bad health
All ages	5,985	1,573	677
0 to 24	536	35	5
25 to 49	2,590	430	122
50 to 64	2,063	547	293
65 and over	796	561	257

Source: 2011 Census

4.3.5 The chart above shows that in Inverclyde, sixteen percent of carers aged 65 and above are themselves in poor or very poor health.

4.3.6 Further detail of the needs of carers can be found within the Inverclyde Carer & Young Carer Strategy 2017 -2022.

4.4 Volunteering

4.4.1 As noted earlier, we know of 773 active volunteers in Inverclyde. This figure was derived from a survey undertaken across Inverclyde, to which 27 volunteering organisations responded. Although this identified a high number of volunteers (773), we know from our knowledge of the area that there are many more organisations in Inverclyde that provide volunteering opportunities but who have not submitted a return.

4.5 School Leavers

4.5.1 Inverclyde HSCP will encourage our young people to consider health and social care sector as a career option. We will take a collaborative approach to engaging with our local schools to promote the benefits of health and social career and offer opportunities to gain real life work experience.

4.6 Modern Apprenticeship Scheme (MA)

4.6.1 Inverclyde Council and NHSGGC operate a modern apprenticeship scheme, to which the HSCP is an active participant. There are MAs working in a variety of roles and services. It is our intention to explore over the life-time of this

People Pan to expand the scheme out across the wider health and social care sector. This approach will maximise the opportunity for MAs to consider health and social care as a career path of choice.

SECTION 5: HOW WILL WE EFFECT CHANGE?

5.1 Training Investment and Capacity Building

5.1.1 In coming together to identify and expand on the various dimensions of this People Plan, it became apparent to all of the stakeholders involved that there is a tremendous reservoir of skills, knowledge and experience in the tiers identified as 'Our People'. Even in the present, relatively unco-ordinated shape of that workforce, we can see that there is much to be proud of in the quality of support that is provided to some of our most vulnerable citizens. There is some duplication, which is not always a bad thing because it offers choice. However some of the duplication is wasteful. Perhaps one of the most obvious places this becomes apparent is in training resource. Some professional registration will require specific training, but other training is more generic and is often duplicated. If we could share training across the whole workforce, it would offer greater coverage, more consistency and less wastage. Individually, organisational training is costly.
Key training that could be opened up for shared access:

- Statutory e.g. Health & Safety; Fire Safety
- Mandatory e.g. moving and handling
- Some continuous professional development for registered professions; PDP/Appraisal processes.

5.1.2 There is a need for clarity about what we can and can't deliver in terms of learning and development

- Development of sector wide core competencies
- Shared induction programmes
- Co-production of training plans
- Co-ordination of professional development
- Collaborative training and sharing of expertise
- Development of a sector wide training academy and training passport.

SECTION 6: FUTURE WORKFORCE

6.1 Future Workforce

6.1.1 Figures gathered from Inverclyde Council and NHS Greater Glasgow & Clyde indicate that 97.53 WTE of our workforce will have left employment by 2018. We have acknowledged that social care providers can have difficulty recruiting suitably qualified staff particularly in homecare and nursing.

6.1.2 This Plan also recognises that providers face a recurring cycle of recruitment and training costs due to changes in staffing. The lack of continuity could potentially impact on the service users' experience and expectations.

6.1.3 There is therefore a need to consider ways in which the HSCP and partners manage recruitment and retention of our workforce.

- Age profile data – older workforce and issues about keeping staff healthy; role of modern apprentices in rebalancing age profiles;
- Workforce gender data – we need to understand the implications of imbalance, and take any required action to redress this.

6.1.4 Chart N shows HSCP on the basis of their current age, and this has been used to develop a risk of retirals outline for the HSCP using the following categories

- **Red** – staff whose age, pay band and pension status indicate potential retiral by the end of the calendar year 2018
- **Amber** – anticipated retiral date during 2019 to 2022
- **Green** – anticipated retiral beyond 2022

6.1.5 Chart N below shows a timeline of projected HSCP staff retirals. Note that small numbers of staff have chosen to work beyond their estimated retiral year and, as such, show as years already reached.

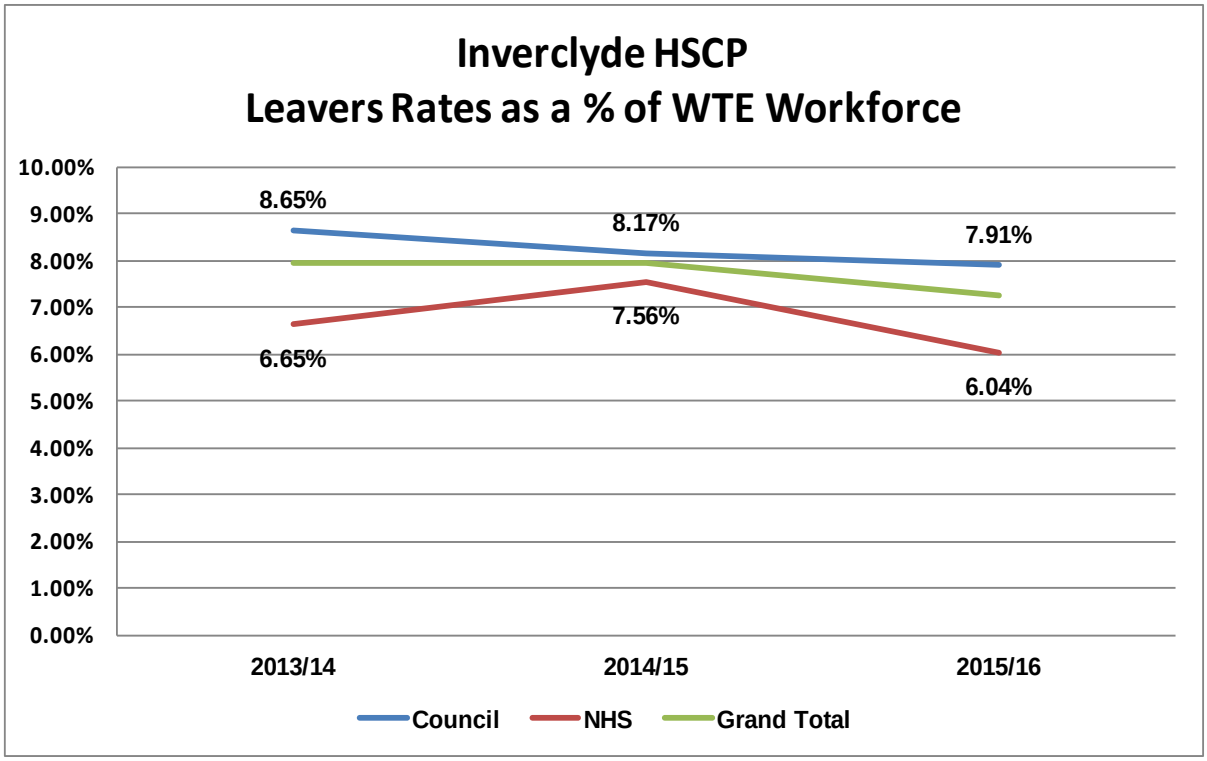


CHART N

6.2 Implementation and Delivery Plan

6.2.1 To bring all of the information we have gathered for our People Plan together, we need to develop a delivery plan. We will continue to work collaboratively with our partners and stakeholders to develop the delivery plan within six months from the date the People Plan is published.

SECTION 7: DEVELOPING AN ACTION PLAN

7.1 Developing an Action Plan

7.1.1 Drawing on the information and data from the foregoing narrative, we need to translate our collective intentions into an action plan that addresses the challenges and begins to shape the overall workforce to deliver the National Wellbeing Outcomes and improved public health.

7.1.2 This people plan has bold ambitions. However, it will be crucial that this is measured in relation to the ever-reducing resources predicted for the foreseeable future. We also acknowledge the gaps in our knowledge, but believe that these gaps are not a reason to delay moving forward (however our progress needs to be mindful of the need to start addressing the gaps in our knowledge).

7.1.3 The themed and tiered approach will be taken to produce an action plan with timescales and outcomes for our people plan.

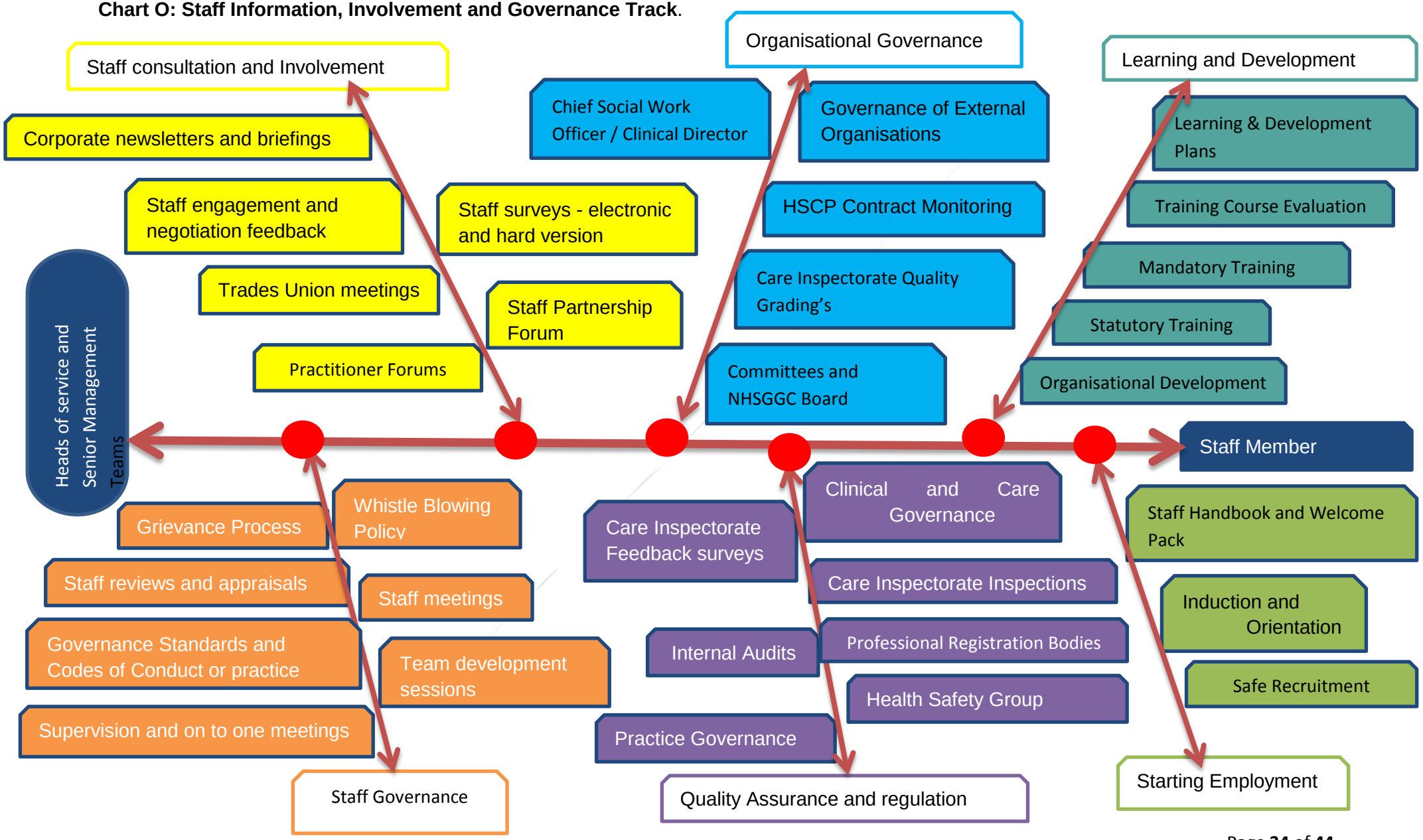
7.2 Monitoring and Reviewing of the People Plan

7.2.1 The monitoring of progress with the actions and intentions set out in the 2017/2020 People Plan will be carried out within the Staff Information, Involvement and Governance Track Framework set out at Chart O below.

7.2.2 The commencement and implementation of service plans, redesigns and the consequent workforce implications are also closely monitored and progress will be reported to local management, the Strategic Planning Group, Staff Partnership Forum and Integration Joint Board, through exception reporting and the annual HSCP performance report as necessary.

7.2.3 The achievement and implementation of specific actions within the 2017/2020 People Plan will be reported in future iterations (on an annual basis but no later than six months following the end of the reporting year that is April to March).

Chart O: Staff Information, Involvement and Governance Track.



Glossary of terms

This section aims to provide clear definitions of some of the terminology used in this Plan.

"Accountability" - we are responsible and answerable for our action or lack of action.

"Acute and Secondary health care"– the health services provided by our local hospital. Generally "acute" relates to urgent or immediately needed care, and "secondary" relates to planned hospital care.

"Adult protection"– the duties and obligations placed on us under The Adult Support and Protection (Scotland) Act 2007 for adults 16 years or over who are unable to safeguard their own well-being, property, rights, interests and are at risk of harm due to being affected by disability, mental disorder, illness or physical or mental infirmity, and are more vulnerable to being harmed than adults who are not so affected.

"Aggregating" – bringing similar numbers or data together to give an average or overall figure.

"Allied Health Professional" - health care practitioners who are not nursing, medicine or pharmacy but provide different services for, or on behalf of, the NHS or HSCP such as Occupational Therapist, Physiotherapist, Speech and Language Therapist or Dietician.

"Asset(s)"– an Individual, group, community, neighbourhood, place, service, agencies or organisation who is considered to be an essential resource, benefit or solution to the successful achievement of an individual's or community outcome.

"CAMHS" – The Child and Adolescent Mental Health Service.

"Capital Expenditure" - the money spent or committed to acquiring or maintaining our assets, such as electronic systems buildings or equipment. It does not include our day-to-day running costs such as staff salaries, insurance, fuel costs etc.

"Care Inspectorate"– the Government's independent registration, regulation, inspection and scrutiny body for registered health and social care services under the Regulation of Care (Scotland) Act 2001 and its amendments.

"Carer"– the unpaid partners, relatives or other people important to the person being cared for who provide physical care and emotional support to enable the cared for person to remain at home and without whom that person would require involvement or increased services and support from paid professional organizations.

"Carers needs" - recognising that carers' lives might be restricted due to their caring role(s), and that they have a right to have their own support and needs taken into consideration, independent of the care needs of their relative or loved ones.

"CHCP"– the former Inverclyde Community Health and Care Partnership.

"CLDT" - The Community Learning Disability Team.

"Commissioner"– the authorised person or budget holder responsible for the delivery, management and purchasing of services.

"Commissioning Priorities" – agreeing the most essential services we have to put in place to meet local needs and fulfil our obligations by law, and agreeing how to provide, purchase or develop these.

"Commissioning" - the process by which the HSCP decides upon and authorises the purchase of services from external or internal providers. This process aims to meet the identified need(s) of service users and/or legal duties and obligations.

"Community Capacity Building"– working with local people to jointly develop and strengthen the skills, abilities, processes and resources needed to improve the lives of our communities.

"Community development"–working with communities to help them to recognise the skills, knowledge and expertise they can bring to public sector planning, and supporting them to develop ways in which they can do this effectively.

"Community engagement" - the process by which the HSCP will communicate and gain feedback from people who use services, localities communities and neighbourhoods.

"Community Planning Partnership"– Each local authority area must have a Community Planning Partnership that includes the Council, NHS, Police, Fire and Rescue Services, the local college, Scottish Enterprise, SEPA, Scottish Natural Heritage, Skills Development Scotland, the regional transport partnership, local community representatives, voluntary organisations, community groups and associations.. All of these have a role to plan for the area to improve outcomes. The Community Planning Partnership must involve local community bodies to enable them to be involved in community planning. In Inverclyde, our Community Planning Partnership is called the Inverclyde Alliance.

"Continence services"–community-based services to individuals who require support or assistance to manage or regain control of their bladder or bowel functions.

"Contingency planning"– the identification of potential or unexpected risk(s), exceptional or unlikely events that might impact on or have catastrophic

consequences; requiring the development of plans to deal with such circumstances.

"Co-production" - the joint reciprocal approach taken by the HSCP, service users and their families, groups, communities, neighbourhoods and partners to achieve change, better outcomes and improvement of health and lives for our population. In co-production, all partners are equal, and agreement is reached by mutual consent.

"Delegated responsibility (authority)" – the duties, obligations or use of powers placed on the HSCP by law.

"Domestic abuse" – the behaviour of a spouse, intimate partner or family member in a domestic setting which involves violence, aggression, psychological, emotional or other control.

"Efficiency saving"– finding less expensive ways to operate, while at the same time improving the service or making it run more efficiently.

"EHRC" - The Equalities and Human Rights Commission

"EQIA" - Equality Impact Assessment ; the requirement of the HSCP to assess the impact of any policy decision , plans or strategies or communication to ensure that it does not discriminate against people who come under the protected characteristics.

"Equalities" – the statutory and legal obligations or duties under the terms of the Equalities and Human Rights Act 2010.

"Equality Duty" - the HSCP's legal obligation under the principals of Public Sector Equality Duty not to directly or indirectly discriminate against the persons who come under the protected characteristics as stated below.

"Financial viability"– ensuring we have the money to provide our services, meet operating costs and commitments, income and to develop our services within the resources we have.

"Geriatric medicine"– medical services specifically provided for older people (over 65 years).

"GIRFEC"– Getting It Right For Every Child; which describes the vision of the Government's National outcomes for Children.

"Governance" - the management arrangements we have in place to ensure our legal commitments, local and national outcomes and services are being delivered by the HSCP or provided on our behalf.

"Health and Social Care Committee" (HSCC) – Inverclyde Council's governance group which oversees the relationship between it and the Integration Joint Board.

"HSCP" - Inverclyde Health and Social Care Partnership.

"IAHF" - Inverclyde Housing Associations Forum.

"Independent Sector" - private businesses which provide health and social care services.

"Inequalities"– inequalities are unfair differences between population groups in Scotland, are not random or chance but are caused by social inequalities out with an individual's control and they're not inevitable.

"Integration Joint Board (IJB)"– our legal governance, scrutiny and decision making group.

"Intelligence"– the gathering of specific information or evidence to inform this strategic plan and its commissioning priorities in relation to the needs of our population.

"Inverclyde Alliance Board" – the formal meeting that brings together the members of the Community Planning Partnership as described above. The Inverclyde Alliance Board is accountable to the Scottish Government for the delivery, performance and review of the agreed outcomes set out in the Inverclyde Single Outcome Agreement.

"Kidney dialysis services" - the community based provision, treatment and support at home for individuals with severe kidney function problems.

"Mainstreaming Equalities" - recognising that the same support or treatment can have different levels of benefits to individuals, depending on their other life circumstances, and taking account of those differences in everything we do.

"Market Facilitation Plan"– a statement of commitment about how we will work with the third, independent and voluntary sector partners and stakeholders to manage the changes needed to shape what services might be available in the future. This will be based on what is needed, what is affordable, and what communities and interest groups tell us they would like.

"Market Position Statement"– a written statement setting out what our commissioning objectives are and what services we need to purchase.

"Mixed Economy of Care" - the provision of the widest range of supports and services provided by many diverse organizations, voluntary, third and private providers and informal support networks to offer the greatest choice to service users, carers, families, communities and neighbourhoods**.**

"Monitoring reports"– reports which describe what providers are delivering, compared to what we have commissioned. Monitoring reports will consider aspects of quantity and/ or quality of service, and provide assurance that public money is being spent in a way that meets identified needs and gives the best possible value.

"National Framework Agreement(s)" - contracts which have been put in place to ensure that service users can expect the same quality of care for the same cost across Scotland from private and third sector social care providers.

"Outcome Focused Assessment" - the way we identify what support might be needed to help service users achieve the outcomes that matter most to them, and what options might be available (or developed) to support those outcomes being achieved.

"Outcome"– goals, wishes, or standards which an individual, group, locality, community or neighbourhood wish to achieve that make a difference and are of value to their lives.

"Out-of-hours" - the services provided out with daytime office hours (8 am - p.m. Monday to Friday). So Out-of-Hours covers evenings and overnight; all of Saturdays and Sundays and bank holidays.

"Outputs"– the information (data) we produce to evidence our service activity.
"Palliative care" means – services provided to anyone regardless of age with a serious illness that cannot be cured, and who requires treatment, support or care at home, in hospital, or care home service.

"Parent organisations" – Inverclyde Council and NHS Greater Glasgow and Clyde Health Board.

"Partner/Stakeholder organisations"– the people, groups, communities, and organisations that have an interest in the work or activity of the HSCP, and/or who have a responsibility to contribute to HSCP planning, and to plan their own work, services and priorities in collaboration with the HSCP.

"People Plan" The document which sets out the current and future workforce demands and needs across Inverclyde who directly or indirectly or contribute to the provision of health and social care.

"Performance Management Framework"– the tools methods we use to help us focus, collect, analyse and understand the levels of service being delivered and whether or not these are having the right effect.

"Performance Reporting Framework"– the reports we prepare for local committees (such as the Integration Joint Board; the Council's Health and Social Care Committee; the NHS Board or the Inverclyde Alliance); Scottish Government and regulatory scrutiny bodies (such as the Care Inspectorate).

"Pharmaceutical services"– the community based medicines services.

"Placements"– there are times when, for a number of reasons, individuals have to leave their usual home either on a temporary or permanent basis. In such cases, a placement is made. This can be to a residential care home; nursing care home; secure care; foster care accommodation, and can be for children,

young people, adults or older people. The placement can be provided by internal or external providers or agencies and is formally commissioned by the HSCP.

"Primary care services"– our community based health care services such as GPs, district nursing, dental, community mental health, and optician and podiatry services.

"Primary Medical Services" the NHS contracting of GP, Dental, Pharmacy and Ophthalmic services as set out in the Primary Medical Services (Scotland) Act 2004 and its amendments.

"Protected Characteristics"– These are the grounds upon which discrimination is unlawful under the Equality Act 2010. The characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

"Prudential borrowing"– the rules set out in our financial Standing Instructions governing the borrowing we can make set against the level of debt and liabilities we incur.

"Psychiatry" - the provision of hospital or community based services for anyone with a medical diagnosis of a mental disorder as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003 and who requires intervention, treatment, advice, guidance and support on a short or longer term basis.

"Quality & Development Service" - supports the day-to-day health and social care services, providing information and analysis needed for good planning, performance management, commissioning, procurement, development and learning.

"Quality grades"– the performance score assessed and awarded by the Care Inspectorate to registered providers of care services.

"Registered Social Landlord (RSL)"– Independent housing associations or organisations registered with the Scottish Housing Regulator under the terms of the Housing (Scotland) Act 2011.

"Rehabilitation medicine" - treatment and support to enable service users to (re)gain or maintain skills to be independent of others or services.

"Renablement Services"–services designed to enable people to (re)gain skills or maintain abilities to live as independently as possible, as part of their recovery following illness or a time in hospital.

"Re-provision" – the change of one service model into another and the work undertaken to make that change happen.

"Reserve funds"– money set aside to meet any unexpected or urgent costs, or to pay for future changes that we plan to put in place.

"Respiratory medicine" –services and treatment for people who have breathing problems.

"Revenue Budget" – the financial forecasting of our income against what we expect to spend.

"Risk and risk management"– the identification of possible future problems, and the management actions that need to be taken to reduce the likelihood of these problems happening.

"Scope"– the range and level of information we need to get a better understanding of a particular issue.

"Scotland Excel"– the national organisation for contracting care services on behalf of Inverclyde HSCP and Council.

"Self-Directed Support (SDS)" – The Social Care (self-directed support) (Scotland) Act 2013. This Act provides the right of a service user (their carer, parent, legal guardian or Power of Attorney) to pick one of four options in how their care or support service is commissioned and when it is delivered.

"Service Redesign"– the process by which we change, alter or structure our services to meet changing need and expectations, and to deliver the outcomes of this Strategic Plan, within the resources at our disposal.

"Service user" – the person who requires treatment, or who needs care or support.

"Set-a-side Budget"– funds which have been allocated for a specific one-off purpose, need or development.

"Social Inclusion" - the right of people and groups to live in, be valued, consulted, involved and contribute to the development of their communities.

"Social Work Scotland" - a professional consultation practice and guidance body set up under the Social Work (Scotland) Act 1968.

"Socio-economic impact" – how a person's status, environment, employment, income impacts on their opportunities to improve their lives.

"Statutory (Public) Sector" – the organisations that are required by law to be in place, and are funded by public money (taxes). Councils and the NHS have always been part of the Public Sector, and HSCPs are now also part of that sector.

"Strategic Children's Services Plan" – The Community Planning Partnership to improve services for children across Inverclyde.

"Strategic Commissioning" - the process by which the HSCP reviews its service-level commissioning and identifies similar opportunities or themes that

emerge across different and quite separate service areas, and then supports providers to deliver more joined-up services in light of this information.

"Strategic Needs Analysis (SNA)"– the information (data) we gather to identify current patterns and levels of service use, and then use this to help us predict future need.

"Strategic Planning Group" - the representatives and partners in the joint production, development and review of this strategic plan.

"Strategy"– how we will plan and what we will do to achieve our goals and outcomes.

"Third Sector" - The voluntary organisations, charitable bodies and providers of health and social care services who are non-profit making.

"Carer and Young Carer Strategy 2017 – 2022" - The Inverclyde HSCP strategy and plans to support carers and young carers.

"Tiers" – The four categories of professional, employed, um-paid individuals or contributors to health and social care services in Inverclyde.

"Whole-system" – relates to the integrated links between the HSCP, IJB, NHSGGC, including Acute Services.

"Whole Time Equivalent" - this relates to the number of jobs, which can be full and part time posts, but calculated on the equivalent number of full time jobs represented by the money used to pay for these jobs.

"Workforce" – The people who are recognised as professional, employed, um-paid or contributors to the delivery or provision of health and social care services who form the basis of the Inverclyde HSCP people plan.

Appendix 1: National outcomes and standards

The 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 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

National Outcomes for Children

The National Outcomes for Children
1. Our Children have the best start in life and are ready to succeed.
2. Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
3. We have improved the life chances for children, young people and families at risk.

The National Outcomes and Standards for Social Work Services in the Criminal Justice System
1. Community Safety and Public Protection.
2. The reduction of re-offending.
3. Social inclusion to support desistance from offending.