AGENDA ITEM NO: 4

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 June 2018**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/30/2018/HW**
Contact Officer:	**Helen Watson Head of Service Strategy & Support Services**	**Contact No:**	**01475 715285**
Subject:	**REVIEW OF STRATEGIC PLAN 2016-19 AND PROPOSED PROCESS FOR DEVELOPMENT OF THE 2019-22 STRATEGIC PLAN**		

1.0 PURPOSE

1.1 The purpose of this report is to present the Review of Inverclyde HSCP's Strategic Plan 2016-19 to the Integration Joint Board for approval, and to outline the proposed process for developing the next Strategic Plan, covering the timeframe from 2019 to 2022.

1.2 The Review has been developed in full collaboration with the members of the Strategic Planning Group, and the members have used the review process to shape a development process for the next Plan.

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that all HSCPs develop Strategic Plans that set out their intentions and priorities. The Plan must be approved by the IJB so that responsibility for services and functions can then be fully delegated from the Council and Health Board to the IJB.

2.2 Our first Strategic Plan was a Statement of Intent setting the vision and direction of travel for the Partnership over a three year cycle of 2016-19, building on a range of plans and strategies that were already in place. In March 2018, the IJB Audit Committee requested that the Plan should be reviewed and that review should be presented to members for consideration.

2.3 This Review highlights progress and challenges, and also allows us to consider if we need to refresh our aspirations as we move forward into our second cycle.

3.0 RECOMMENDATIONS

3.1 That the Integration Joint Board approves the Review of Inverclyde HSCP's Strategic Plan 2016-19.

3.2 That the Integration Joint Board notes the process for developing the Strategic Plan (2019-220.

Louise Long
Corporate Director, (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that all HSCPs develop a Strategic Plan that sets out their intentions and priorities. The Plan must be approved by the IJB so that responsibility for services and functions can then be fully delegated from the Council and Health Board to the IJB.

4.2 Inverclyde HSCP's first Strategic Plan was approved in March 2016 outlining its overarching vision of '*Improving Lives'*. In March 2018, the IJB Audit Committee requested a review of our current Strategic Plan. This has been undertaken by the HSCP's Strategic Planning Group.

4.3 Strong engagement and co-production is evident across Inverclyde and this is reflected in how the review was undertaken.

4.4 A proposal on how to progress the review was discussed at a Strategic Planning Group and agreed. This involved:

- Your Voice - Inverclyde's Community Care Forum - facilitating several focus groups across existing fora
- Questionnaires to all individual members of the Strategic Planning Group
- Small core group of Strategic Planning members meeting to review the feedback

As a result, the format style and content of this review were developed in full collaboration and are reflective of real partnership working.

4.5 It was agreed that the format and content of the review would focus on highlighting examples of challenges and achievements to date and work in progress. The reason being that the second Annual Performance Report (due in June 2018) will report on specific performance measures and indicators.

4.6 Within the Review, each example shows how it correlates to the five Strategic Commissioning Themes which were developed to show *how* Inverclyde HSCP was indeed *'Improving Lives'* for the people of Inverclyde.

4.7 The process for developing the new Strategic Plan (2019-22) will mirror the inclusive approach taken to produce the Review.

5.0 PROPOSALS

5.1 The Key Stages to develop the three year strategic plan are:

- Establish a writers' sub group (July 2018)
- Engagement and information gathering
- 1st draft of plan (December 2018)
- Public consultation
- Final plan

5.2 A writers' sub group will be established to develop the new three years Strategic Plan for the period 2019-2022. The group will consist of Strategic Planning Group members, representatives across the partnership, third and independent sector. The group will be established July 2018.

5.3 The group will agree the approach to develop the strategic plan and will gather information and engage with stakeholders.

5.4 The group will analyse relevant plans from the NHS Board and Inverclyde Council, as well as other key partners.

5.5 The group will produce the first draft by the end of December 2018; this will be presented to the January Integration Joint Board for scrutiny and comment.

5.6 Public consultation will be integral to the development of the Plan, via the engagement networks that underpin the Strategic Planning Group, with wider public consultation commencing early in the new year. The consultation will be across all three Inverclyde Localities.

5.7 A second and final draft will be presented to the Integration Joint Board March 2019 for a final presentation and approval.

6.0 FINANCE

6.1 **Financial Implications**:

One off Costs

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

7.0 IMPLICATIONS

LEGAL

7.1 There are no legal issues within this report.

HUMAN RESOURCES

7.2 There are no human resources issues within this report.

7.3 **EQUALITIES**

There are no specific equality issues contained within this report.

	YES (see attached appendix)
X	NO –

7.4 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

There are no clinical or care governance issues within this report.

8.0 NATIONAL WELLBEING OUTCOMES

8.1 The purpose of the Strategic Plan is to describe how we aim to deliver all of the National Wellbeing Outcomes. The review, in conjunction with the Annual Performance Report therefore supports the delivery of all of the Outcomes.

9.0 CONSULTATION

9.1 Full consultation was undertaken through the Strategic Planning Group.

10.0 BACKGROUND PAPERS

10.1 Inverclyde HSCP's Strategic Plan 2016-19

INVERCLYDE HSCP
Health and Social Care Partnership

Review of Inverclyde Strategic Plan 2016-19 (Draft)

Contents

Introduction by Louise Long - Chief Officer, Inverclyde HSCP

In 2016, Inverclyde Health & Social Care Partnership, as a requirement of the Public Bodies (Joint Working) (Scotland) Act 2014 developed its first three year Strategic Plan (2016-2019).

Our Strategic Plan is a Statement of Intent - setting the vision and direction of travel for the partnership over a three year cycle outlining the services for which Inverclyde HSCP has responsibility and depicting our aspirations for all citizens, both adults and children, across the whole of Inverclyde.

Strong engagement and co-production is evident across Inverclyde partners and this is reflected in how this review was undertaken.

A proposal on how to progress the review was discussed at a recent Strategic Planning Group and agreed. This involved:

- Your Voice - Inverclyde's Community Care Forum - facilitating several focus groups across existing fora
- Questionnaires to all individual members of The Strategic Planning Group
- Small core group of Strategic Planning members meeting to review the feedback

As a result, the format style and content of this review has been developed in full collaboration and reflective of real partnership working.

It is useful to note that each year across the life of our Strategic Plan we are required to report to the Integration Joint Board on our actual performance.

In June 2017, we produced the first Annual Performance Report of Inverclyde HSCP and we will also be developing and publishing our second annual Performance Report to our Integration Joint Board on the 22nd of June 2018. As such a report specifically measures performance and progress against set indicators and outcomes for wellbeing and focuses on dedicated data, for this review we have chosen to highlight some examples of our achievements and work in progress.

This review will allow us to consider if we need to refresh our aspirations in facing challenges as we move forward.

Ultimately the review will assist in the process of developing a second overarching Strategic Plan that is a meaningful and easy to read document for the people of Inverclyde and truly reflects the priorities of our communities.

I trust you will enjoy reading this review which is a snapshot in time. It highlights some of the many positive improvements Inverclyde Health & Social Care Partnership has achieved to date and our commitment to continually reviewing our services to ensure we provide the best possible health & social care for the people of Inverclyde.

Section 1 - Context

Inverclyde HSCP's first Strategic Plan produced in March 2016 outlined the overarching vision of:

'Improving Lives' underpinned by the 4 key values of:

These values are all still relevant however '*Strategic Commissioning'* is the term used for all the activities involved in assessing and forecasting needs, linking investment to *agreed outcomes*, planning the nature, range and quality of future services and working in partnership to put these in place.

With this approach we therefore identified 5 key *'Strategic Themes'* that run through all our planning.

These 5 Strategic Commissioning Themes are:

- Employability and Meaningful Activity
- Re-ablement and support to live independently
- Prevention, early intervention and recovery
- Support for Families and
- Inclusion and Empowerment

This review will highlight examples of how commissioning services with these themes in mind has resulted in positive outcomes and ultimately in '*Improving lives'* for the people of Inverclyde. In addition, underpinning all of the examples highlighted is the alignment to the nine National Wellbeing Outcomes.

Section 2 - Our Achievements

Our People Plan

'*Employability & Meaningful Activity*'

'Inclusion & Empowerment'

The Public Bodies (Joint Working) (Scotland) Act 2014 required that a workforce plan was produced and presented to Integration Joint Boards (IJB), highlighting the structure of the workforce. In Inverclyde we were keen to promote a more inclusive approach, based on our recognition that good health and wellbeing is delivered by a much wider workforce than just those employed or commissioned by the HSCP.

It is for this reason that we agreed on the title of People Plan rather than Workforce Plan. Both the People Plan and the accompanying action/ implementation plan have been developed in a co-produced way with a range of stakeholders and are ambitious in its scope.

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

The People plan considers the workforce in the context of four tiers:

- 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 umbrella of administrative, clerical and support services.

- Tier 3 (b): People who contribute to the provision 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 include 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 resource centres.

Challenges such as our ageing population and depopulation of working-aged people 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.

Each action in The People Plan Action Plan has been set against timescales as follows:

Short Term: 1 Year; Medium Term: 2 Years and Long Term: 3 Years.

A core group with representation from all partners, including the third and Independent sectors, has been established to drive forward the implementation of the action plan with the Strategic Planning Group accountable for monitoring progress.

The full People Plan and People Plan Action Plan can be accessed from the link below.

https://www.inverclyde.gov.uk/assets/attach/7522/Inverclyde%20HSCP%20People%20Plan%202017-2020%20Full%20Version.pdf

Leadership & Accountability

'Inclusion & Empowerment'

The HSCP has deployed a full time Senior Organisational Development Advisor to help support and bring different parts of the health and social care workforce together.

The post-holder also supports senior fora such as the Integration Joint Board (IJB); the Strategic Planning Group; the Staff Partnership Forum and the many intra-professional integrated teams across the range of services. This dedicated support ensures effective implementation of change, development of leadership capacity, multi- agency working and cultural integration.

Examples of development offerings include:

Frontline Leadership Ready to Lead	Staff Awards	Succession Planning
Team Effectiveness	Leadership development - Coaching -Mentoring	Transition & change management
Resilience and Wellbeing at Work	Service Improvement	Staff Engagement

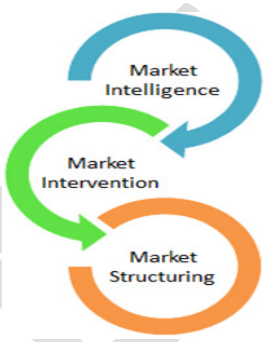
We are also currently participating in the staff engagement tool known as iMatter across our whole workforce of both council and health staff.

In addition a process has been established in Inverclyde whereby all plans and /or reports due for submission to the Integration Joint Board (IJB) are scheduled in advance for consultation and presentation to the Strategic Planning Group for input and amendment.

This ensures the members of the Strategic Planning Group (SPG) are fully engaged and supported in undertaking the requirements of their role and function as laid out in the Terms and Reference (revised February 2018).

Market Facilitation & Commissioning Plan

'Inclusion & Empowerment'



The Public Bodies (Joint Working) (Scotland) Act 2014 also requires that a Market Facilitation Plan is produced to set out the Health and Social Care commissioning priorities and intentions for Inverclyde HSCP.

We are committed to ensuring Inverclyde service users are appropriately supported and that people who need help to stay safe and well are able to exercise choice and control over their support. Inverclyde HSCP currently spends in the region **of £35 million** annually on commissioned health and social care services.

To deliver our commitment we need to ensure that the people who use our services can choose from a number of care and support providers and have a variety of creative support options available to them.

To deliver new models of provision in Inverclyde, we recognise that commissioners and providers alike need to build improved arrangements for working together, to improve quality, increase choice for service users and their carers and deliver a more responsive and efficient commissioning process. By "commissioning" we mean the entire process from assessment; discussing options through to making arrangements for the right supports to be put in place.

This requires structured activities and well planned engagement. Mature and constructive partnership working is critical in ensuring that we create an innovative and flexible approach to service delivery.

Our Market Facilitation & Commissioning Plan represents the beginning of communication to service users and providers to find the best ways to use available resources in the context of complex change and challenges.

It will enable providers of Health and Social Care to have a better understanding of our intentions as a purchaser of services and how we might respond to the personalisation of health and social care.

It will also assist voluntary and community organisations to learn about our responsibilities and contracting activities and thereby help them to build on their knowledge of local needs in order to develop new activities and services.

The Plan will also help service users of Health and Social Care and their families/carers have a greater understanding about the possibilities for change. This may therefore help to lead to greater choice and control. Additionally, it will help individuals become proactive in shaping not only their own support solutions, but those of others in Inverclyde.

The full Market Facilitation & Commissioning Plan can be accessed from the link below

https://www.inverclyde.gov.uk/meetings/documents/10893/04%20Market%20Facilitation.pdf

Children's Services

'Support for Families'

'Inclusion & Empowerment'

'Inverclyde's services for children and young people are leading when it comes to involving young people in their care.'

That is the view in a new inspection report from the Care Inspectorate where involvement of young people received a rare *'excellent'* rating.

The 'excellent' rating is in the category 'participation of children, young people, families and other stakeholders' and is believed to be the first in Scotland

Particular strengths praised include embedding the 'Nurturing Inverclyde' approach across children's services and driving continuous improvement through a culture of collaboration, high aspiration, reflective practice and learning for success.

Inspectors also highlighted work being done to mitigate the adverse consequences of child poverty and how young people and children are involved in every aspect of policy, planning and service development.

The inspection report also highlighted the benefit of Inverclyde investing significantly in prevention and early intervention, especially from pre-birth to starting at school as key strengths which are making a positive difference to the lives of children and young people.

Inspectors focused on the leadership across the partnership. They pointed out the overarching commitment across partners towards repopulation and promoting Inverclyde as a place where families would choose to bring up their children, young people would wish to remain or return to live and newcomers would be made welcome.

The joint inspection focused on the difference that services are making to the lives of children, young people and families in Inverclyde

Specific Examples highlighted include:
Extending the UNICEF Rights Respecting Schools approach to Residential

Children's Houses – St Columba's High School was the first school in Scotland to achieve the UNICEF level one and Level two 'rights respecting schools award' and almost all schools in the area are now involved in this approach.
As corporate parents and with the agreement of UNICEF, partners have successfully adapted and piloted the programme in a residential children's house. Looked after and accommodated young people living in the children's house and care staff report very positively on the difference this has made. This is the first venture of this type and UNICEF have described it as world class.

Becoming data-informed through the development of a Joint Strategic Needs Assessment - Partners recognised the need to carry out a joint strategic needs assessment as a first step towards producing a children's services plan and moving ultimately to joint commissioning.

Outcomes of this work include reducing risks to looked after and accommodated young people associated with going missing from residential placements.

The full Inspection Report can be accessed from the link below

http://www.careinspectorate.com/images/documents/4102/Inverclyde%20services%20for%20children%20and%20young%20people%20joint%20inspection%20report%20Oct%202017.pdf

Inverclyde Delivering Effective Advice and Support

EUROPE & SCOTLAND
European Social Fund
Investing in a Smart, Sustainable and Inclusive Future

I:DEAS

I:DEAS is a Financial Capability Programme relating to Financial Inclusion in Inverclyde. It is funded by the European Social Fund and The Big Lottery Fund for £2.3 million as part of a Scotland wide initiative, which aims to decrease debt and financial concerns in order to improve individuals' and families' social inclusion, and develop their meaningful activity. It commenced in Inverclyde in September 2017 and will run until June 2020.

The service aims to support people who fulfil one of the following:

- be living in a workless household
- be living in a low income household
- be living in a single parent household - (could also be homeless and meet one of the above)

The Eligible Participants (EPs) go through a registration process and have an allocated Mentor who will support them as much or as little as they require dependant on their need.

This is a truly holistic service with regard to finances and inclusion in society.
Our contracted partners are:

CVS	Building Resilience and creating Opportunities – Volunteering
Future Skills	Homes Accessing Affordable Products – Digital Skills
HSCP Advice First	Intensive Debt Advice and Support & Link to Local Agencies
Barnardo's	Family Support – Schools Project, Early Years and access to Family Support
The Wise Group	Mentor Wrap Round Service for each EP and Fuel Poverty Work
Financial Fitness	Income Maximisation for those out of work and in work
Scotcash	Accessing Affordable Loans and Bank Accounts
Community Learning Development	First Step and Moving ON learning Programmes/NQ's

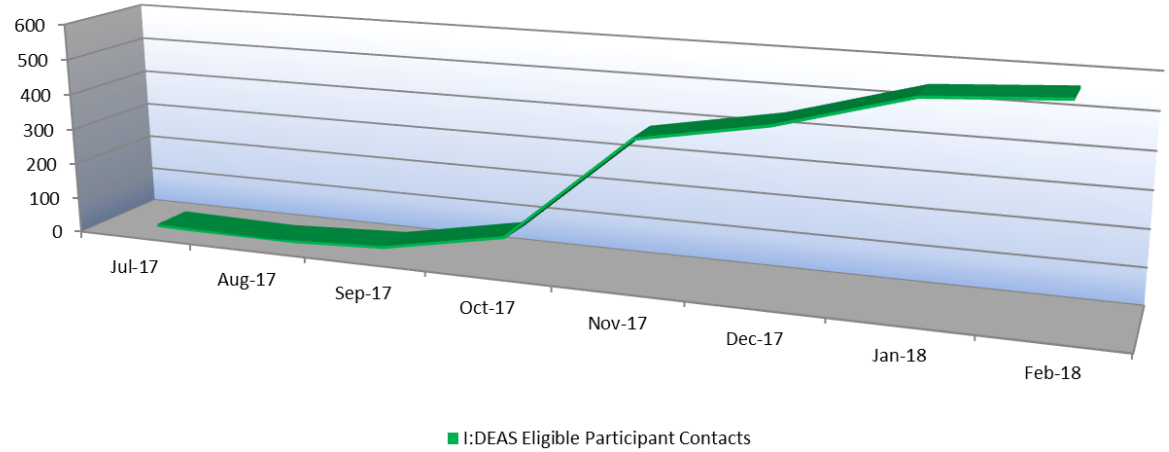
We have dedicated workers in each of these organisations who all work together as a wider team.

Each participant will have an allocated Mentor who will walk hand in hand with them and will provide ranging degrees of support dependant on the individual's needs. The aim is to improve a person's current situation with their finances and ensure they have the skills and capability to be able to continue with positive finances through their lives.

A large part of the service is to ensure that those who are socially excluded due to debt will no longer be, and those who take part will develop skills relating to finances ensuring lifelong learning and behaviour change, creating positive examples and learning for future generations in Inverclyde.

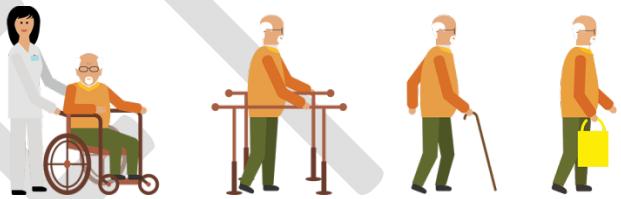
Family support is provided and opportunities for volunteers and peer supporters are available to carry on with the work linking to Inverclyde's Financial Inclusion Strategy.

I:DEAS Eligible Participant Contacts



Reablement Services

'Reablement & Support to Live Independently'



The Reablement team have been enhanced this year by the addition of Social Workers whose main goals are to carry out short term intervention work around discharges from hospital and to support prevention of admission to hospital or care homes.

The team have relaunched under the name of **Home1st**, as the ethos of the service is around facilitating maximum independence and safety for people within their own homes. The team ensures that support in the form of reablement, equipment and care is tailored to an individual's needs to optimise their abilities and also to give support to informal carers where required.

Within the last 12 months using a reablement approach the team have worked in partnership with 934 people to meet the goals that they have around living well at home. The outcomes of the team remain strong with 330 people (35%) they have worked with returning to full independence and requiring no ongoing support from Care at Home Services.

Forty eight percent (453) of the people the team have worked with have required some practical support at home ongoing, however many of these people have regained partial independence with the day to day activities of their lives. Of the initial practical support at the beginning of the programme only 45% was required ongoing due to people regaining abilities.

The service aims to respond to all community requests by giving the optimum support to Inverclyde residents preventing admissions to hospital and to long term care; however the level of complex need amongst referrals has increased.

Although this has created pressures on services it has also been a catalyst for closer working relationships across teams and should be celebrated as innovative work as across Inverclyde HSCP..

Over the last 12 months there has been greater joint working between Home1st with the *in- reach* posts to the hospital, Step Up rehabilitation to prevent admissions, Falls prevention as well as working alongside core Care at Home services Independent Living Services, Assessment and Care Management and District Nursing.

Services working together are providing a flexible, reactive, high quality response provision to the people of Inverclyde.

Inverclyde HSCP's Partnership Discharge Plan

Reablement & Support to Live Independently'

The basis of the Home 1st approach is that people are supported better and achieve improved outcomes when social and health care is provided.

The positive performance relating to discharge process has been a result of good partnership working between Acute (hospital based) and HSCP staff. This work has been underpinned by the Home First – Ten Actions to Transform Discharge Approach. In Inverclyde this has focused on;

- Reducing the number of people identified as having their hospital discharge delayed.
- Aiming to discharge within 72 hours of being fit for discharge
- Ensuring staff are empowered to make changes which improve discharge processes and reduce length of stay
- Ensuring returning home is the first and best option in the majority of discharge situations.

This plan has been re-launched for 2017/18 building on the good work in Inverclyde. The revised plan is also looking to develop;

- Discharging to assess approach: when an individual is medically fit to be discharged they return home where assessment for future needs is completed by the new Assessment and Reablement Team.

- Reviewing the partnership staff involved in discharge to ensure a smooth patient pathway, with early referral for follow-on social care assessment.

- Developing Home1st team, bringing together the reablement inreach team and discharge team to move the emphasis of discharge from hospital to community provision. Discharge planning begins in the community and assessments completed in the service users home.

- Care Home Liaison Nurses involvement in supporting care homes to maintain residents in the community and avoid hospital admission unless it is absolutely necessary.

The Home 1st approach has successfully contributed to a reduction in *long term care* placements, the average length of stay in care homes as well as delayed discharges.

Housing Partnership Group

'Prevention, Early Intervention & Recovery'

Inclusion & Empowerment'

Recognising the importance of good quality and affordable housing for the wellbeing of the local population, Inverclyde HSCP included a Housing Contribution Statement within the Strategic Plan. This was a summary of what housing providers could do to improve outcomes for individuals and families.

Subsequently A Housing Partnership Forum was established to take responsibility for the implementation, monitoring and review of the Housing Contribution Statement by producing and agreeing on a specific plan with detailed activity to achieve desired outcomes.

The Housing Partnership Group (HPG) is chaired by a senior manager from within the HSCP with membership from Inverclyde Council and representatives from each of the local and national (who have a presence in Inverclyde) Registered Social Landlords (RSLs).
The Housing Partnership Group (HPG) reports into the HSCP Strategic Planning Group (SPG) and also feeds into the Strategic Housing Investment Plan (SHIP) and the Local Housing Strategy (LHS) processes. Examples of related activity are to:

- Strengthen existing partnerships to ensure people are pro-actively supported to enable them to maintain their accommodation.
- Increase the suitability of existing housing stock in meeting disabled people's needs through provision of adaptations across tenures.
- Include Health and Social Care Partners in the planning processes for the Affordable Housing Supply Programme.
- Using telehealth/telecare to enable older people to remain independent at home for longer.
- Improving housing outcomes across a range of measures for young people, young people in pregnancy and young parents, including care leavers.
- Exploring models of support and intervention to prevent Multiple Exclusion Homelessness (MEH).

The ultimate aim being to work in partnership to develop housing options for every Inverclyde citizen.

Supported Living

'Reablement & Support to Live Independently'

Inverclyde HSCP has commissioned a Supported Living Service based on our commissioning theme of "*Reablement and Support to Live Independently"* and the six principles contained within the national care standards of:

- Dignity
- Safety
- Choice
- Privacy
- Equality & Diversity and
- Realising Potential.

A key outcome of the Supported Living Service is to promote individualisation and inclusion and to meet the assessed needs of service users with a learning disability, physical disability, sensory impairment, mental illness, addiction or are homeless.

The aim is to establish a framework agreement to support approximately 210 service users. It will have common terms and conditions and standardised funding arrangements.

The value of the contract will be approximately £6.75M per annum. The ten successful providers must provide responsive support dependent on the fluctuating needs of the Service User, and support must be provided 7 days a week, 52 weeks per year.

The model of service includes "Core" and "Enhanced".

The Core Service will cover the majority of the service, which shall be informed by the service user's *Assessment of Need*.

The Enhanced Service shall be purchased in limited circumstances based upon the service user's *Assessment of Need* which are significantly and demonstrably higher and may require more resources than those provided under the Core Service of which the Council shall be the sole judge.

Each *Assessment of Need* will be *Outcome* focused. All Providers will need to demonstrate continuous efforts to work innovatively with service users to promote independence, support social inclusion, increase well -being and reduce unnecessary support where it is unnecessary.

Services under this framework will be person centred and Providers will embrace a culture of change and will be encouraged to offer innovative and alternative ways of supporting service users through assisting in outcome based support planning and increase community alternatives

for those using services. A culture of respecting services user's wishes will be paramount and this framework will embed the culture of co-production in creation of service user support plans.

A key objective of this framework is the effective use and targeting of resources for greatest impact. Resources will be prioritised at those with the greatest need, taking a positive assets based approach in commissioning services, focusing where possible, on what service users can do, rather than what they can't.

Within Mental Health Services, two integrated resource groups have been created to manage more effective use of resources. These groups will improve communication across service areas, increasing cross sector working relationships and improving expected service user outcomes for those using services and for their families.

.

Community Link Workers

'Prevention, Intervention & Recovery'

Inclusion & Empowerment'

Community Link Workers

The Community Link Worker programme is funded by the Scottish Government and delivered in partnership with GP Practices and the Third sector to support people to live well, through strengthening connections between community resources and primary care. In Inverclyde, the project is overseen by the Council for Volunteer Service (CVS).

The Community Link Workers provide a person-centred service that is responsive to the needs and interests of a GP practice population living in an area affected by socio-economic deprivation. They will support them to identify issues that affect their ability to live well.

Taking a person-centred approach, the community link worker holder supports individuals on a 1-1 basis to help them identify personal outcomes and priorities that they would like to address, to overcome any barriers to addressing these and to link them to local and national support services and activities.

The Community Link Workers support the existing GP practice team to become better equipped to match local and national support services to the needs of individuals attending for health care. They will also build relationships and processes between the GP practice and community resources, statutory organisations, other health services and voluntary organisations.

Within Inverclyde we have five full time and two part time workers who are in six surgeries at present. These are the three surgeries in Port Glasgow Health Centre; the surgery at Dubbs Road and in two of the three surgeries in Greenock Health Centre.

Community Connectors

'Inclusion & Empowerment'

'Support for Families'

'Prevention, Early Intervention & Recovery'

The purpose of The Community Connectors Project, funded by Inverclyde HSCP but commissioned and delivered through Your Voice, (Inverclyde Community Forum), is to provide information, support and advice about local activities, facilities, resources and connections for local people, patients, service users and carers. The overall aim is to encourage and support local people to make connections and participate in local activities to support their health and wellbeing, reduce social isolation and life as full an independent live as possible.

The Community Connectors offer *short term assistance* to help identify and access resources and activities which help individuals achieve their personal goals. The project works to achieve 4 outcomes.

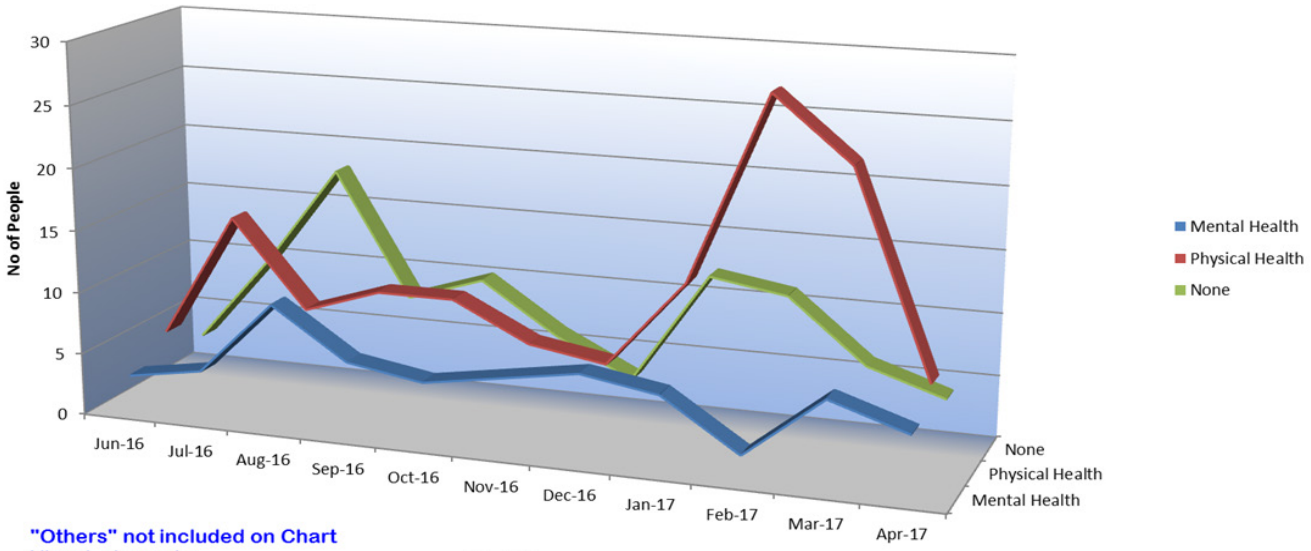
- Local people have increased awareness and access to community activities and resources
- Local people are facilitated to increase their independence and levels of activity through connection to local community resources and activities
- Local people are supported to make links and develop supportive relationships with groups and other individuals
- Local people are more able to live independently, stay in their own homes, avoid unnecessary hospital admission and reduce service demand as a result of being linked to the community.

The Connectors follow a community development approach by sourcing what is available in the community, building on existing assets.

The Community Connector project is a Community Social model of Care '*front door'* facilitating people and communities to come together to achieve positive change using their own knowledge, skills and lived experience of the issues they encounter in their own lives. It is an early intervention 'staying well' service, enabling signposting and maximising independence.

People engaged with Community Connectors Pilot Project June 16 to April 17

Community Connectors were engaged with a total of 320 people during this period



"Others" not included on Chart
Visual - 4 people
Hearing - 2 people
Learning Difficulties - 10 people
Addiction - 20 people

Our 3rd Sector Partners

Council for Voluntary Service Inverclyde (CVS)

CVS Inverclyde
Community Groups Voluntary Organisations Social Enterprises

CVS Inverclyde is the recognised Third Sector Interface (TSI) for Inverclyde with a clear role in developing the third sector, creating connections across sectors, building collaborations and leading the third sector response to local priorities.

The organisation is charitable company limited by guarantee and was formed in 1991 by the coming together of key people within the local third sector at the time. They wanted a way of speaking strategically to public agencies and building a new relationship.

CVS Inverclyde has a seat on all key local partnerships including those within the HSCP such as the Integration Joint Board and the Strategic Planning Group. A series of networks exist to enable the third sector to understand what is happening at these and contribute.

Inverclyde HSCP recognises the value of the third sector and the unique role of CVS Inverclyde in providing advice and guidance in order to develop:

- a volunteering culture across Inverclyde
- an effective and engaged local third sector
- awareness amongst the public of local services and activities
- connections between the public and third sectors
- effective partnerships and collaborations
- new enterprises that can respond to market need
- knowledge of communities and the use of asset based approaches
- strong communities with resilience and reduced inequalities
- the external funding that is brought into Inverclyde
- the voice of communities through the third sector

In recognition of the unique role of CVS Inverclyde, the HSCP currently funds a **Partnership Facilitator** post for the 3rd Sector. The post holder is hosted and line managed within CVS Inverclyde. The purpose of this role aims to support the connections between the HSCP and third sector organisations; enabling greater collaboration; design approaches and more effective / innovative commissioning. The post- holder has a detailed work-plan with key areas of priority identified and agreed with the HSCP. The post- holder has been integral to the development of the Market Facilitation & Commissioning Plan and the People Plan/ Action Plan.

CVS Inverclyde also runs:

Volunteer Inverclyde – a web portal enabling organisations to promote volunteering opportunities and members of the public to access them.

Inverclyde Life – a web portal for the public and professionals to identify valuable activities and services that exist locally – everything from amateur football to statutory services.

Community Link Workers – a team of social prescribers based in six of Inverclyde's GP surgeries

Inverclyde Community Fund – a local funder that distributes grants to local third sector organisations, including on behalf of public bodies like Inverclyde HSCP.

Saltire Awards – a recognition of the contribution made by young volunteers with certificates signed by the First Minister

Trustees Week and Volunteers Week – the local programmes of these national weeks of recognition of the work done on a voluntary basis by trustees and volunteers.

Inverclyde Community Conference and Inverclyde Community Awards – the highlights of the third sector calendar

Your Voice - Inverclyde Community Care Forum

Your Voice (Inverclyde Community Care Forum) is an independent registered charity and Company Limited by Guarantee, set up over 24 years ago.

Its collective Network has built up a reputation of trust and effectiveness over the years and influenced decisions to ensure local services and support meets the needs of local people

Your Voice works with local statutory, voluntary and private providers, as well as national organisations to ensure they listen to the voice of local people. The main areas of work involve:

- Supporting people to speak up and get involved
- Listening to and acting on their views
- Identifying common issues of concern and develop solutions
- Building and developing the skills and knowledge of local people
- Raising awareness of local services and supports
- Connecting people and
- Promoting positive health and well-being

Your Voice and Inverclyde HSCP are committed to ensuring the views of local people who receive services/support, their carers, families and the people of Inverclyde are taken into account when

developing and planning services to ensure that they are responsive to the needs of the people who use them.

A significant development over the last year has been in facilitating public representation on the Integration Joint Board (IJB) and the Strategic Planning Group (SPG). This representation has been drawn from the Health & Social Care Partnership Advisory Group and the associated 11 sub-groups. Inverclyde Advisory Group brings together a network of local people with an interest in health and social care.

The Advisory Group brings issues to the attention of the HSCP Committee and ensures members of the Advisory Network via its sub groups and broader 'Your Voice' network are informed of the nature and outcome of discussions relating to these issues on a regular basis.

Over the past year Your Voice has engaged with a diversity of people and groups to ascertain areas of good practice, identify gaps in services and highlight issues of concern which will evidence need for service developments.

The Independent Sector

Inverclyde HSCP also developed and currently funds a part- time post of Independent sector development worker in an attempt to enhance relationships between the HSCP and the independent sector care providers.

The post requires the appointed worker to facilitate positive communication between Inverclyde HSCP and the Independent Sector raising awareness and understanding of each other's responsibilities.

Examples of the contribution from this post has been inputting to the development of The People Plan and the Market Facilitation & Commissioning Plan. The post- holder is also a core member of the Strategic Planning Group.

A work- plan with priority areas for impact is agreed between the post- holder and the HSCP.

A few examples of the contribution from this post to highlight are:

- **Come On In:**

  A collaborative of care inspectorate, care home residents, family members and staff along with the post- holder have developed a booklet called *Come On In* which has been published and distributed across Scotland. The booklet was funded by the Life Changes Trust. *Come on In* is now being used as a resource to be used with a dementia carers network and is now showcased in The Care Inspectorate website.

- **CAPA: Care… About Physical Activity**

  Working in collaboration with HSCP staff and CVS, a cohort of providers has been developed who will be involved in an 18 month programme designed to support reflection on how to develop and promote increased levels of activity amongst clients in; Care at Home, Sheltered Housing, day-care and respite services. Working with the Care Inspectorate strong networks across providers has been developed. The participants are focused on ensuring they have clarity over what they are hoping to achieve in the activities they develop and that they are rigorous in ensuring they have measurements recorded that note improved levels of activity.

- **National Care Standards**:

  The new standards are introduced in April 2018 and in preparation a methodology has been developed for supporting providers to identify how they are meeting the standards, action they have to follow with staff to develop awareness amongst staff. This work is being progressed with the Care Inspectorate Team Leader at the provider forum. This work is also being discussed in relation to possibly publishing it to distribute beyond Inverclyde.

- **Promoting Excellence:**

  Dementia Friendly Inverclyde continues with regular training sessions on a monthly basis. The learning from the group has also developed networks across providers and local services are supported with environmental assessment to ensure the setting is dementia friendly. The work on environmental assessment has assisted in developing communication across providers who

are now visiting the Dementia Services Dementia Centre at Stirling University to develop their knowledge of the importance of environmental impact on people living with dementia.

The Care Homes have also had access to stress and distress training from psychological services to support them in continuing to work with people who may otherwise have been part of an unscheduled hospital admission as their behaviour became more complex and previously occasioned an admission. The training has been well received and enhanced the ability of staff to support people experiencing stress and distress.

- **Supporting Care Home Managers**

This is a key function of the post assisting with work based issues, ranging from complaints processes, staffing issues, person centred care, Care Inspectorate self-assessment and developing action plans in response to Care Inspectorate feedback.

Section 3 - Work in Progress

To ensure we continue to provide the best possible health & social care to the people of Inverclyde, several service reviews have been or are being undertaken in order to ensure services are indeed fit for purpose. Some examples are as follows:

Carers

The Carers (Scotland) Act 2016 is enacted from 01 April 2018. The aim is to ensure better, more consistent support for carers so that they can continue to care, if they so wish, in better health and to have a life alongside caring. There are statutory duties set out in the Act as follows:

- Carers have the right to be offered or can request an Adult Carer Support Plan (ACSP) or Young Carer Statement (YCS) which sets out their personal outcomes and identified needs.
- A local eligibility criteria must be set which outlines where support is provided to carers based on their identified needs;
- We must establish and maintain a carers information and advice service, including the publication of a short break statement by 31 December 2018;
- Carers and carer representatives must be involved in the planning and evaluation of services including the preparation of the local carer strategy;
- There is a requirement to consider support in the form of a break from caring, and the desirability of breaks from caring provided on a planned basis.
- Health Boards must inform carers, invite their views and take these into account before a cared-for person is discharged from hospital.
- The Scottish Government will publish a Carers' charter to accompany the Act, which sets out the rights of carers in or under the Act.
- Transitional arrangements allow a maximum of one year for all young carers to have a YCS completed and three years to move all adults over to the new ACSP.

We are fortunate in Inverclyde to have longstanding collaborative approaches between services, carers and carer organisations. Inverclyde Carers Centre is already funded by the HSCP to deliver an information and advice service for adult carers both in the community, primary care and the acute hospital setting.

Additional initiatives have been developed to support readiness of the Act: These include:

- Publishing the Inverclyde Carers and Young Carer Strategy 2017 - 2022;
- Inverclyde Carers Centre have delivered an Emotional Support Programme for adult carers;
- Collaborative working to raise awareness of young carers in schools;
- Supporting the transition for young carers to adult carer supports;
- Barnardo's Thrive Project provide group support for young carers to enable them to have a break from their caring role;
- Financial Fitness provide surgeries within Inverclyde Carers Centre to undertake benefits checks and provide information about financial matters or benefits for carers;
- A number of engagement opportunities for carers, supported by Your Voice and Inverclyde Carers Centre have taken place regarding various aspects of the Act including the Carers Charter, development of a local Eligibility Criteria which will inform the content of Adult Carer Support Plans and Young Carer Statements and developing the local Short Break Statement.
- A range of staff learning resources are being developed including working with Inverclyde Carers Centre to deliver Equal Partners in Care training.

This is a strong foundation already in place across Inverclyde HSCP on which to build upon in order to meet the requirements of the Act.

The full Inverclyde Carer & Young Carer Strategy can be accessed from
https://www.inverclyde.gov.uk/health-and-social-care/support-for-carers/inverclyde-carer-young-carer-strategy-2017-2022

Treatment Room Review

'Prevention, Early Intervention & Recovery'

Treatment room services in Inverclyde HSCP are provided across three sites; Greenock Health Centre, Port Glasgow Health Centre and Gourock Health Centre, supported by a cohort of treatment room nursing staff.

The service needed a structured review in terms of its fitness to support future demands and is facing challenges in terms of current demand ;lack of clarity in terms of the scope of the service; and more than 50% of the staff could leave the service in the next 5 years and 75% in the next 10 years.

A steering group of key stakeholders was established to undertake the review. This focussed on how effectively and efficiently the current services were operating, whether all patients in Inverclyde have equitable access to services, review of performance measures in terms of clinical standards and national guidelines and how clear the patient pathway was from referral to front door to treatment.

The recommendations from the review are as follows:

Service Standard

- A service specification that clearly articulates the service profile
- Treatment room service provision in Greenock and Port Glasgow Health Centres to be open 8am-6pm in line with GP practice opening times Monday to Friday.
- Further demand analysis in terms of Gourock re opening hours within the next 6 months
- Develop stand - alone phlebotomy (taking of blood) services in Greenock and Port Glasgow Health Centres.
- Pilot a treatment room service model operated by District Nurses in Kilmacolm in an dual role.
- Implement standard operating procedures across the service to reduce variations in practise.

Appointments

- Implement a scheduled appointment system with 15 minutes appointment time (patients requiring longer appointment will be given a double appointment or longer as required).
- Patients referred for routine interventions will be seen within 2 -5 working days.
- Follow-up appointments will be allocated based on individual patient need.

Workforce Model

- A flexible nursing workforce model developed to reflect needs of the proposed service model matched to 15 minute appointment and peak times of service demand.
- Mix of staff refreshed to ensuring right person, right job to reflect clinical skills required.
- Define the clinical leadership role in terms of operational and clinical capacity requirements.
- Develop leadership capacity of staff.
- Succession plan in light of future potential leavers in the next 5 years.
- Discussions with acute (hospital based) services to support acute staff capacity to cover annual leave for acute clinics.
- Implement the community nursing Learning and Education Framework creating opportunities for training, development, succession planning and development of non - medical prescribers within the team.
- Implement the community nursing Induction programme for new-starts.
- Scope business support requirements at Port Glasgow and Gourock Health centres.
- Explore the need for Advanced Nurse Practitioner role in treatment room services.

Learning Disability Redesign

'Inclusion & Empowerment'

'Employability & Meaningful Activity'

'Support for Families'

Reablement & Support to Live Independently'

This redesign intends to increase the opportunity for carers to be equal partners in the care of adults with a Learning Disability and to have a fulfilling life of their own. In addition the aims and objectives of the redesign support improved transitions so we should see an improvement in the experience of families and carers at key points of change.

The Redesign Programme Objectives are as follows:

- Embed a culture amongst service users, carers and workers of partnership, focused on achieving personal outcomes.
- Ensure that the service is sustainable for the future, delivering more efficient ways of working and contributing to savings and efficiency targets.
- Deliver an **integrated model** of daytime activity services and resource opportunities for local adults with a learning disability, underpinned by the re-ablement model promoting independence, choice and control – and maximising opportunities for real employment wherever possible.
- Deliver a model of supported and independent living, underpinned by the Re-ablement model, which **maximises people's independence** in activities of daily living and in managing their own lives.

A programme of significant engagement and partnership working is evolving and is being led jointly with 3rd sector partners, providers, trades unions and users/carers. Integration Joint Board members are engaged in the process as are the wider relevant elected member group. Timelines are being worked up to ensure that each stage on the process in time bound.

Full reviews of all service users will be undertaken by May 2018. Interim work in Fitzgerald Centre personal care areas will be undertaken by June 2018. The merger of buildings will be by 28th September.

A programme of Learning Disability Redesign Programme Board meetings has been set up, as have a range of sub groups to deliver on each element of the programme.

A series of carer, service user and staff events have on a rolling basis. Ongoing provider and staff engagement with regular communication updates are scheduled.

Allied Health Professional (AHP) Review

'Reablement & Support to Live Independently'

Within Inverclyde Allied Health Professionals (AHPs) are employed directly by the HSCP across Adult and Children's services as well as some AHP services (MSK Physiotherapy, Podiatry) being based and managed by West Dunbartonshire and Renfrewshire respectively

The issues for Inverclyde HSCP in terms of AHP service provision can be summarised as follows:

- Adult services AHPs practice within Health & Community Care, Mental Health, Addiction services but do not work across services despite having core AHP skills transferable to all services whilst retaining their specialist skill base and clinical practice.
- The quality of activity data for adult AHP activity is variable and requires further scrutiny to understand how Inverclyde HSCP deploys AHP resource.
- The balance of AHP resource requires to be reviewed and developed to allow more efficient integration across services rather than a single service approach.
- The Professional Leadership across NHS GG&C is well developed but requires improvement in how it links with Inverclyde HSCP and how Inverclyde HSCP links with the professional structure and Director of Allied Health Professions. At present Inverclyde AHP does not have a recognised AHP Lead.
- A better understanding of AHP services that are based and managed elsewhere is also required.

Allied Health Professionals (AHPs) in health and social care make a significant impact on people's health and quality of life and are key to service development and improvement. AHPs possess a diverse range of specialist skills in rehabilitation, enablement and diagnostics.

AHPs practice within integrated multidisciplinary teams, focusing on personal outcomes for patients and service users and are pivotal to preventative interventions, rehabilitation and enablement and self-management of conditions, reducing the requirement for GP appointments and hospital visits.

Within Health & Social Care Partnerships, Allied Health Professionals need to be appropriately positioned to impact on local planning and influence future developments for integration. Their visibility and accountability for delivery of organisational priorities needs to be strengthened through a new and innovative approach to leadership.

This will support designated AHP leads to have a locus of influence across HSCPs and drive key elements of the nationally agreed AHP outcomes for integration of Health and Social Care

services and support other national policy directives. Within NHSGG&C a number of Health and Social Care partners have a recognised lead Allied Health Professional.

Links to the wider Allied Health Professional Governance structure are presently not as robust as they are intended to be with good links to some professions but lesser so to others and it is paramount that Inverclyde HSCP addresses this inequality by promoting Allied Health Professions governance through a recognised lead AHP role as other professions such as nursing have already established.

It is therefore recommended from this review that a Lead Allied Health Professional Post is considered for Inverclyde HSCP and that this post has an opportunity to exert the appropriate professional influence within the HSCP.

The HSCP also needs to ensure that AHPs are being professionally supported and not being constrained by service specific structures where core competences can be best utilised to ensure mainstreaming of patient/service user care whilst retaining the specialist knowledge base of AHP clinicians.

Improved integration of AHPs across the service will maximise economies of scale whilst maintaining appropriate professional input.

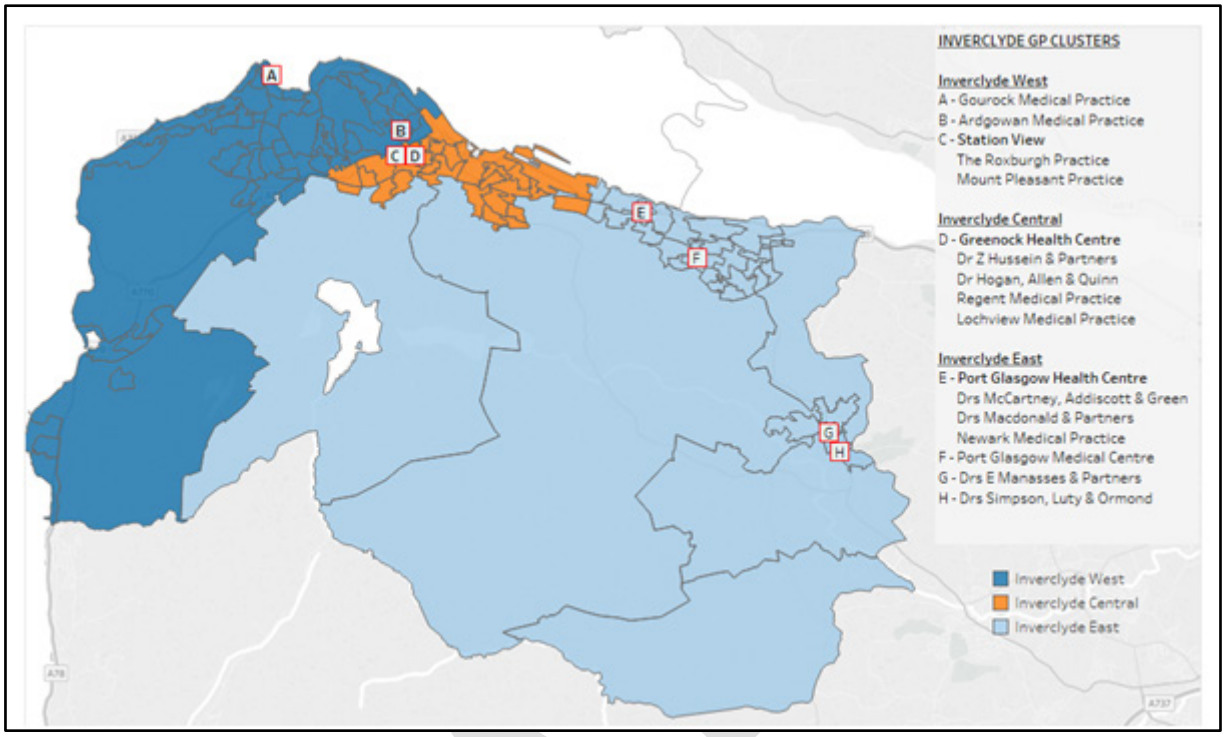
Primary Care Services

'Prevention, Early Intervention & Recovery'

There are fourteen General Practices,(GPs)covering Kilmacolm, Port Glasgow, Greenock, Gourock and their surrounding areas. The fourteen practices cover a population of 81,354 patients. Whilst the overall practice population has been falling since 2010 (down 4.5%) the proprtion of patients on the lists who are over the age of 65 has steadily increased from 17% to 20%.

There have been a number of changes to general practice in Inverclyde in the last few years. Within the fourteen practices there are 68 General Practitioners, with six of these being doctors in training. The overall number of GPs has not varied greatly over the last five years however in line with other areas across Scotland, there are particular challenges recruiting new GPs when vacancies arise.

Inverclyde GP Clusters



GP clusters were introduced in Scotland with the 2016/17 General Medical Services (GMS) agreement between the Scottish GP Committee and the Scottish Government. GP clusters bring together individual practices to collaborate on quality improvement projects for the benefit of patients. Each practice in Inverclyde now has a Practice Quality Lead (PQL) and each cluster a Cluster Quality Lead (CQL).

In Inverclyde there are 3 clusters that align with our planning localities: Inverclyde East, Inverclyde Central, and Inverclyde West. The East cluster is comprised of 6 practices with a total population of 23,608. Central cluster has 4 practices and a total population of 28,509.
West cluster has 4 practices and a total population of 29,237. The clusters in Inverclyde were established early due to the *New Ways of Working* pilot and have been in operation for approximately two years with good evidence of successful working in the clusters.

Clusters communicate regularly through meetings or online tools and also provide feedback on activity and projects to the HSCP at a scheduled quarterly meeting. Quality Improvement work in one cluster has included reviewing and improving identification of Sepsis and using cluster money to support the on-going development of this project. Innovative ways of communicating across a cluster have been supported using Trello, a web based project management app.

The health and socio-economic circumstances of Inverclyde are well documented in our existing Strategic Plan and Health Needs Assessment; however there are some key factors impacting on the delivery of primary care locally such as deprivation; disease prevalence; level of older people and primary care activity.

As a result, Inverclyde HSCP will create a three year Primary Care Improvement Plan (2018-21) that will enable the development of the role of the GP moving forward into the expert medical generalist. The new GP role will be achieved by embedding multi-disciplinary primary care staff to work alongside and support GPs and practice staff to reduce GP practice workload and improve patient care.

Primary Care Improvement and implementing the new GP contract is just one element of developing Health and Care services in Inverclyde HSCP. These include improving access to services and in particular improving digital access and online self-assessment for services. The HSCP is also developing a pilot of “Click to Contact” in partnership with NHS24 which will see local people and professionals able to request a call back from a range of services on the NHS Inform National Service Directory.

We recognise that in order to deliver on the outcomes of the new GP contract, a culture change in how primary care services are used is required. Building on the theme of *Working Better Together*, in 2016 we successfully engaged Pharmacists, Optometrists and Dentists alongside GPs and the wider practice teams to better understand roles and the range of support which could be offered as a first point of contact in primary care. This led to our established culture change campaign Choose the Right Service.

This culture change programme has been widely publicised using a variety of printed and social media and is currently being evaluated.
We will continue this campaign utilising a number of avenues and will link this to our work around unscheduled care.

The relationships built across the wider multi-disciplinary team including health, social care, housing, third sector and others will be the lever with which to address the health inequalities of local populations.

Cluster working is one aspect of this, improving local population health through an emphasis on better intelligence supported by our data analysts.

Agreed quality improvement projects will focus on improving outcomes for individuals and subsequently communities.

Inverclyde Dementia Strategy

'Inclusion and Empowerment'

'Support for Families'

The Community Planning Partnership vision for Inverclyde is Getting It Right for Every Child, Citizen and Community. This means the Inverclyde Alliance works in partnership to create a confident inclusive Inverclyde with safe, sustainable, health, nurtured communities and a thriving prosperous economy, with active citizens who are resilient respected and responsible and able to make a positive contribution to the area.

The Single Outcome Agreement and partnerships are committed to:

- All older people living in Inverclyde have healthy, productive, active and included lives preferably living in their own homes with access to the services they need, when they need them.
- All our communities have good mental health and wellbeing integral to the achievement of all local outcomes for Inverclyde.

As a result, Getting it Right for People with Dementia, their families and carers and working towards a Dementia Friendly Inverclyde has been a key aim of Inverclyde's Dementia Strategy 2013-2016.

The Dementia Strategy Action Plan developed focussed on four key objectives and six key outcomes. These are:

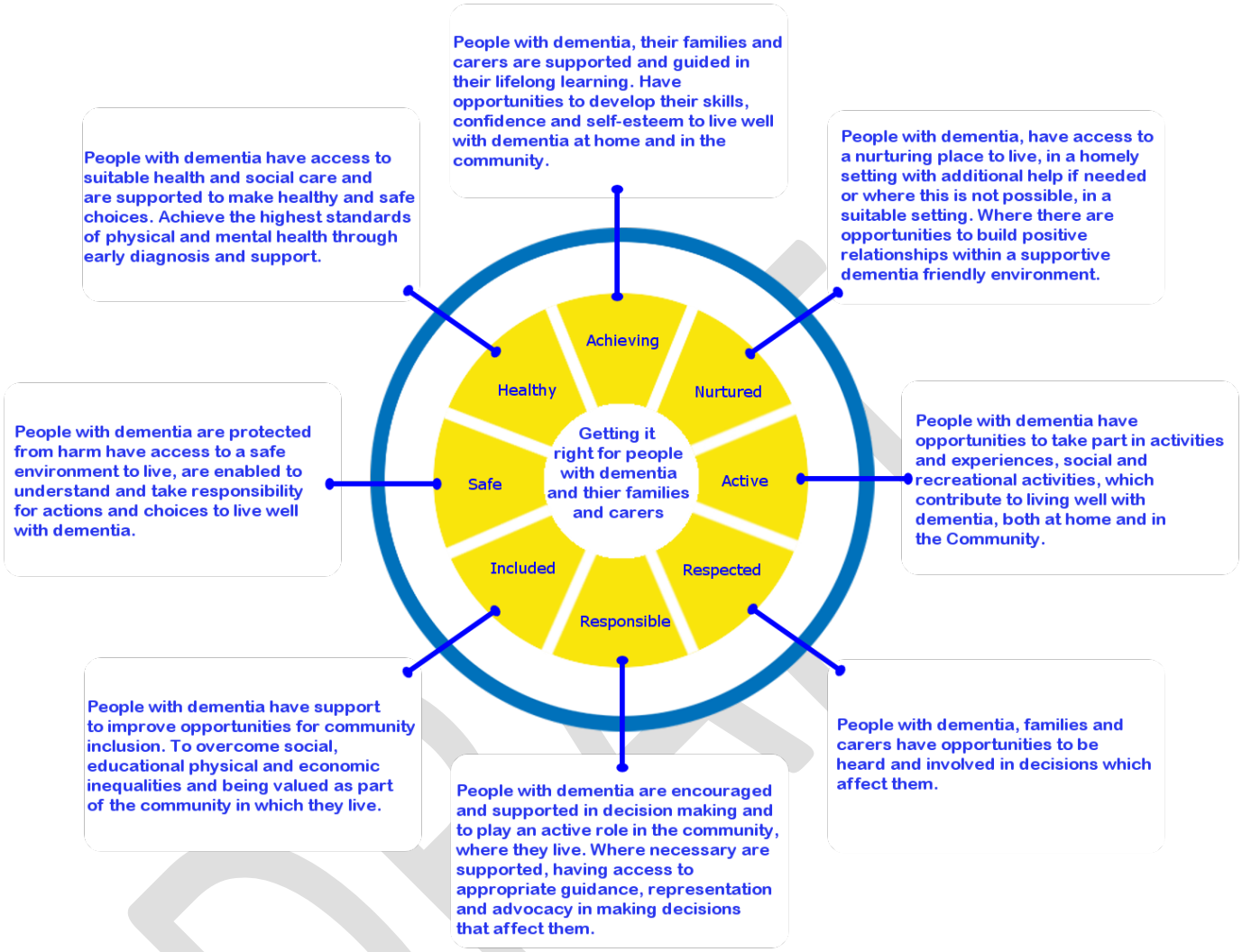
Dementia Strategy Objectives

1. Improve Dementia Awareness and Knowledge
2. Improving Community Inclusion
3. Early Diagnosis and Support
4. Living Well with Dementia

Dementia Strategy Outcomes

- Improve coordination, collaboration and continuity of care across services
- Improve access to services
- Improve flexibility of services
- Improve capacity of services to be responsive
- Increase awareness of dementia in the general public and community
- Increase opportunities for people with dementia, their families and carers to contribute to service planning.

A further mapping exercise was undertaken to highlight relevance to the single outcome wellbeing indicators to ensure linkages at all levels to better reflect the needs of people with dementia, their families and carers. This is fully illustrated in the diagram below:



The Dementia Strategy Action Plan is currently being reviewed and evaluated and the outputs form this exercise this will inform the future direction of travel for the continued implementation of Inverclyde's Dementia Strategy.

Addiction Services Review

'Prevention, Early Intervention & Recovery'

Reablement & Support to Live Independently'

The following key principles will be at the forefront of a new service model:

- To ensure service users receive the right assessment and treatment, at the right time, that is centred on their needs
- To ensure the focus on a recovery pathway in which the service user is fully involved and able to participate in planning their own sustainable recovery.
- To ensure safe, effective; evidence-based and accountable practice, focused on delivering quality outcomes.

The overall aim of the review is to develop a coherent and fully integrated model for Addiction Services in Inverclyde. There are two phases to the review.

Phase 1: To review all aspects of the current model for delivery of services to people with alcohol and drug use problems within the Inverclyde population including the current HSCP service delivery,3rd sector delivery and any other delivery by other relevant partners.

Phase 2 : To develop options for a new model of working with a fully integrated pathway across drug and alcohol services which meets a common set of core professional and practice objectives. This will include focus on future demands and other emerging factors e.g. national policy; resource allocations; ageing population; new and emerging drug trends and also treatments.

The Programme Board has continued to meet and externally commissioned work around service user flow; demand; capacity and workforce development. In addition more detailed analysis of the services has been undertaken by the HSCP's Performance & Information Team.

A draft report of Phase 1 is currently in development.

Inverclyde Community Justice Partnership

Employability and meaningful activity

Inclusion and empowerment

Inverclyde Community Justice Partnership was established on 1st April 2017 to ensure local implementation of this agenda as outlined in the Community Justice (Scotland) Act 2016.

The definition of community justice is:

"The collection of individuals, agencies and services that work together to support, manage and supervise people who have committed offences, from the point of arrest, through prosecution, community disposal or custody and alternatives to these, until they are reintegrated into the community. Local communities and the Third Sector are a vital part of this process which aims to prevent and reduce further offending and the harm that it causes, to promote desistance, social inclusion, and citizenship."

National Strategy for Community Justice, (2016)

The National Strategy for Community Justice was published in November 2016. The local priorities being progressed in Inverclyde Community Justice Partnership are highlighted below. The direction for each of these priorities has evolved directly from people who have lived experience of the criminal justice system, listening to their personal story and forming key messages about what needs to improve.

Some highlights of progress made over the last year include:

Prevention and Early Intervention

Inverclyde led on two regional events titled "An Upstream View in North Strathclyde". This was followed by an Inverclyde collaborative event with the Scottish Criminal Justice Voluntary Sector Forum. Local Third Sector and Community Organisations who attended this event have subsequently led on a bi-monthly Inverclyde Community Justice Breakfast that offers a networking opportunity and a forum to consider new ideas for collaborative practice.

Housing and Homelessness

A joint event was held involving Corporate Parenting and the Community Justice Partnership. This was informed with clear messages and questions posed by a wide variety of people with lived experience. A report was compiled of the event and a working group is currently progressing a "Young People's Charter" targeting young people up to the age of 26 years of age.

Domestic Abuse

A joint report between the Violence against Women Partnership and Community Justice Partnership was submitted to the Inverclyde Alliance focusing on the work being done with perpetrators of domestic abuse by all of the statutory partners involved at different stages. Plotting data to each stage highlighted that with a view of changing the culture around domestic abuse requires an early intervention model. Discussions are on-going with national fora to help us consider a different model.

Women Involved in the Criminal Justice System

Inverclyde was successful in a funding bid for Big Lottery Early Systems Change for Women Involved in the Criminal Justice System. The funding will support a five year project of firstly undertaking research to understand the system with the second phase being implementing changes to the system and tests of change.

Employability

Inverclyde was successful in securing the Scottish Government Employability Innovation and Integration Fund to pilot an “Inverclyde Resilience Project”. This will target employability support to people involved in the criminal justice system who may also have homelessness / housing issues and / or an addiction problem.

Health Improvement

'Prevention, Early Intervention and Recovery'

The Health Improvement Team Review has now been completed and agreed and will allow the HSCP Health Improvement Team to focus more on strategically influencing policy makers and service partners/ providers, rather than providing a direct service delivery model.

In addition there are two separate strands of work which are on-going. These are:

- NHSGGC is undergoing a Smoking Cessation Review which will see a centralised model for non- Glasgow City delivery. This review is currently underway with a planned date for delivery by the end of April 2018.

- Discussions with Children and Families Services and the Oral Health Directorate (OHD) regarding a more coordinated management and delivery model for oral health in Inverclyde, which proposes the current oral health staff are managed through by the OHD.

This model supports targeted work; however, this may necessitate diverse knowledge across many aspects of Health Improvement and Inequalities.

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 will focus heavily on deploying and training volunteers to develop community led responses to palliative care. Compassionate Inverclyde will contribute to the Acute Service Review.

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.

Ardgowan Hospice

Ardgowan Hospice consultations with primary care professionals suggested that there is a perception that hospice care is less likely to be accessed by people from more deprived parts of the community.

To this end, Ardgowan Hospice has established a project called the Inside Out Hospice, which is developing outreach hospice services throughout Inverclyde.

The aim is to provide service users with what they need, where they need it, and when they need it, by transforming day and home support services, making them more accessible and reaching a larger population of potential service users across Inverclyde. A core aim will be to achieve the earliest intervention, to improve the journey of patients with life limiting illnesses.

Service users have expressed interest in day services being made available nearer to their homes, supporting, and improving the life of families, carers, and patients living with life limiting illness, complex, and life changing conditions. Including, Chronic Obstructive Pulmonary Disorder, (COPD) Heart failure, neurological conditions, kidney failure, and other life limiting illnesses.

The Project has already established two Supportive Care Clinics, in Inverclyde with one at Port Glasgow and the other at Greenock Health Centre. A further two are planned; however, in order to benchmark and qualify their planning, a statistical and geographic analysis of Ardgowan's patient referral data for 2017 / 2018 was undertaken.

It is important to set this information in the context of the Palliative Patient referral across the Inverclyde area, and to understand the evidence of local need for each of the hospice's services.

Our objective is to avoid hospital admission for palliative care, as the hospital environment is not usually the best for patients and carers at this difficult time. On that basis we are keen to establish reliable palliative patient referral data across the Inverclyde area. This is equally important to NHSGG&C, Inverclyde HSCP and Ardgowan Hospice.

It is essential therefore that each organisation collaborates to develop the mechanisms, and methodologies necessary to attain the data that can inform our planning models.

A working group has now been established, in partnership with Inverclyde HSCP to reinforce the need to establish reliable palliative patient referral data across the Inverclyde area.

.

Section 4 - Moving Forward Together

Moving Forward Together (MFT) is Greater Glasgow & Clyde's (GG&C) Transformational Change Programme which builds a Vision of an integrated response to the increasing health and social care demands of our population with the ultimate aim of empowering our population and working together to ensure care is designed to meet the needs of our people and is delivered in the right place, at the right time and by the right people.

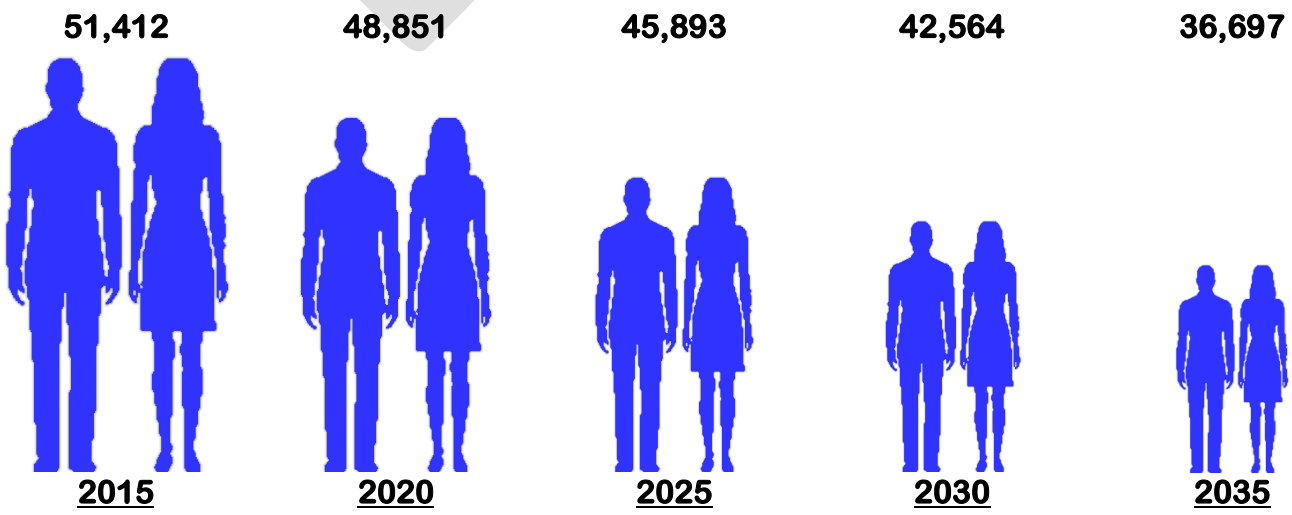
The key objectives of this programme are to:

- Update projections and predictions for the future health and social care needs of our population.
- Implement the clinical case for change as outlined in the National Clinical Strategy for Scotland (2016).
- Review existing national, regional and NHSGGC published strategies and model the impact of delivery on our population.
- Taking the information above to develop new models of care delivery which provide safe, effective and person-centred care which maximises our available resource, provides care in the most efficient and effective way and makes best use of innovation and the opportunities presented by new technology and the digital age.
- Support the subsequent development of delivery plans for these new models of care, which describe the required changes in workplace and the projected benefits realised

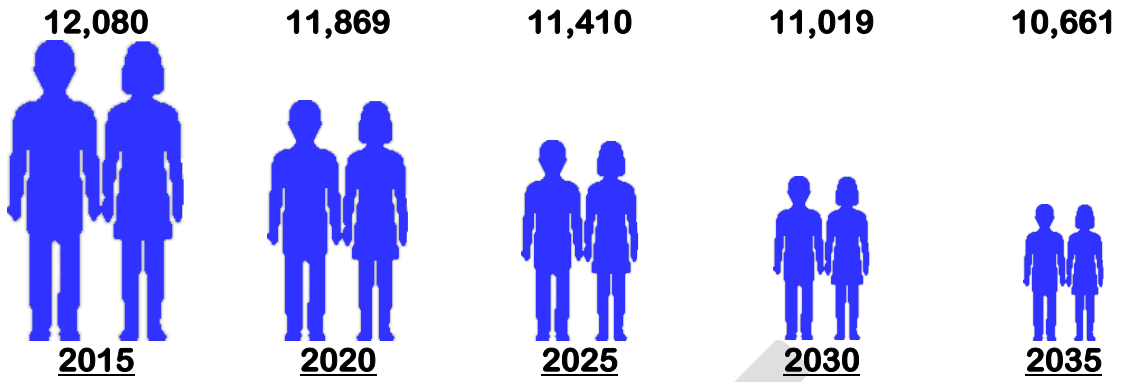
The summary of why this change programme is necessary is described by the following 9 key themes. These are:

1. The health and social care needs of Inverclyde's population are significant and increasing as illustrated below:

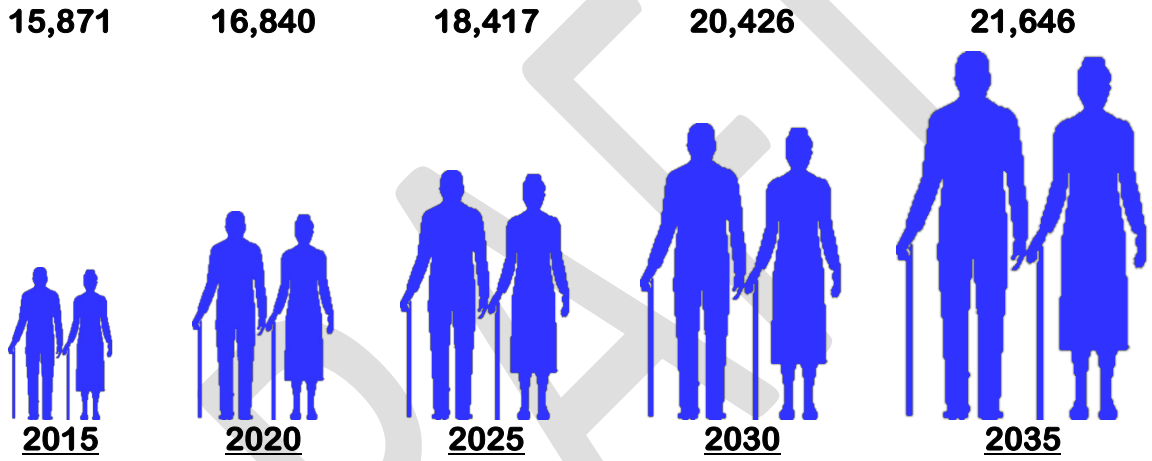
Population Projections (2015 to 2035) – Aged 15-64



Population Projections (2015 to 2035) – Aged 0-14



Population Projections (2015 to 2035) – Aged 65 and over



2. We need to do more to support people to manage their own health and well being and to develop early interventions to prevent crisis.
3. Our services are not always organised in the best way for patients/ service users.
4. We need to do more to make sure that care is always provided in the most appropriate setting by the most appropriate team.
5. There is growing pressure on primary care and community services.
6. We need to provide the highest quality specialist care.
7. Increasing specialisation needs to be balanced with the need for coordinated care which takes an overview of the patient/ service user.
8. Health and social care is changing and we need to keep pace with best practice and standards.
9. We need to support our workforce to meet future challenges

According to the latest official statistics from the National Records of Scotland (NRS) the population of Inverclyde is 79,860 people**.** (This figure varies from the GP population due to patients who reside out-with Inverclyde being registered with an Inverclyde practice).

There are more female than males in every age group except for those aged 0-15. Inverclyde's population is an increasingly elderly population with the percentage of the population in older age groups higher in Inverclyde compared to the rest of Scotland.

Some of the key questions that we are reflecting upon are:

- What are the core elements of our services?
- What co-located services and supports are essential for delivery of those services?
- Given the demographic projections and other factors affecting demand, how do services need to evolve over next 5-10 years?
- Thinking about changes to speciality pathways, at what level do services need to be developed within the community?
- What would the impact of those changes be, and what would be the benefit for service users?
- What would be the impact on the workforce?

However these questions cannot be considered in isolation as the scope of the Moving Forward Together programme includes a range of functions which are delegated to Inverclyde's Integration Joint Board (IJB) in terms of strategic planning, and to the Health and Social Care Partnership (HSCP) for operational delivery.

Therefore this transformational change programme will be taken forward in a planned and sustainable way with full engagement of all stakeholders within Inverclyde HSCP and will align to and link in with our approach to Locality Planning and wider Community Planning within the context of the Inverclyde Alliance Local Outcome Improvement Plan.

The output of these engagement sessions will also be of further value and relevance to Inverclyde HSCP in informing the other key strategic developments over the coming 12-18 months, including development of a Primary Care Strategy, and our new IJB Strategic Plan for 2019-2022.

This Transformational Change Programme will help to align all of Inverclyde HSCP's aspirations as outlined in our first Strategic Plan. Ultimately it will be a key driver in our development as on eof six GGC HSCP in providing a more effective and patient centred system that delivers better outcomes.

Moving Forward Together is also a key description for how *we as an HSCP* will work with all of our partners and stakeholders across Inverclyde to deliver on our priorities and aspirations for the people of Inverclyde.

With all of our stakeholders and partners, Inverclyde HSCP will indeed *Move Forward Together* and continue to strive towards improving the health & wellbeing of all citizens across Inverclyde.

"If everyone is moving forward together, then success takes care of itself"

Henry Ford (1863-1947)

Chief Officer's Closing Remarks.

Working in a complex system inevitably involves effective partnership working and I recognise that Inverclyde Health & Social Care Partnership is not and cannot be the sole provider of health and social care as we move forward into challenging times.

By working together with NHS Greater Glasgow & Clyde Health Board and Inverclyde Council, our HSCP will be able to deliver and achieve better outcomes for the people of Inverclyde.

We also need to see inequalities sensitive practice as more than providing equality of care. We need to stay curious and continually ask the people of Inverclyde what they need.

Our performance measures (as detailed in our Annual Performance Report) tell us that our work across the HSCP is of high quality and does indeed make a difference to people's lives. Nevertheless, we need dedicated time for reflection on our progress and sharing of experiences allows us to consider all perspectives.

I believe that this review shows what we have achieved together so far and highlights why we should celebrate what we have done well.

By recognising progress alongside challenges, we are much more likely to identify the correct next steps.

Louise Long - Chief Officer, Inverclyde HSCP