AGENDA ITEM NO: 5

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/31/2018/HW**
Contact Officer:	**Helen Watson** **Head of Service** **Strategy and Support Services**	**Contact No: 01475 715285**
Subject:	**ANNUAL PERFORMANCE REPORT 2017-2018**	

1.0 PURPOSE

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

1.2 The reporting period is for 1st April 2017 to 31st March 2018.

2.0 SUMMARY

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

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

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

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

3.0 RECOMMENDATIONS

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

Louise Long
Corporate Director, (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

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

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

4.3 Following the format of our first report, our second Annual Performance Report been compiled to be easy to understand, and uses graphics to illustrate performance. It also includes several case studies to help illustrate why the indicators matter to the lives of our citizens.

5.0 IMPLICATIONS

FINANCE

There are no financial implications from this report.

5.1 **Financial Implications**:

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

Annually Recurring Costs/ (Savings)

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

LEGAL

5.2 There are no legal implications from this report

HUMAN RESOURCES

5.3 There are no implications from this report

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

There are no specific equality issues contained within this report.

	YES (see attached appendix)

X	NO –

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

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

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

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

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

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

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

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

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

The performance of the HSCP in relation to inclusion of people with protected characteristics is captured in the report. There are numerous campaigns and innovative ways to get people involved in the development of the HSCP services. These include direct service involvement, the advisory networks, surveys, communications and with policy and planning development. Service user, carers, partners and other stakeholders are represented on our Integration Joint Board, Strategic Planning Group and in our planning forums across all service areas. Feedback is used continuously to improve overall planning and performance and feedback specific to the format of our first Annual Performance Report was been taken into consideration for this second report

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

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

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

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

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

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

5.5 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

There are no clinical or care governance implications

5.6 **NATIONAL WELLBEING OUTCOMES**

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

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

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

Specific examples are provided in section two of the report.

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

Specific examples are provided in section two of the report.

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

Specific examples are provided in section two of the report.

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

Specific examples are provided in section two of the report.

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

Specific examples are provided in section two of the report.

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

Specific examples are provided in section two of the report.

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

Specific examples are provided in section two of the report.

h) **People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.**

Specific examples are provided in section two of the report.

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

Specific examples are provided in section two of the report.

6.0 CONSULTATION

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

7.0 LIST OF BACKGROUND PAPERS

7.1 None

INVERCLYDE HSCP
Health and Social Care Partnership

Inverclyde Health and Social Care Partnership

Annual Performance Report 2017-18

Welcome by Louise Long - Chief Officer Inverclyde HSCP

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

This report will focus predominantly on Inverclyde HSCP's performance for the period to March 2018, specifically measuring our performance and progress against the twenty three National Integration Indicators and the nine National Wellbeing Outcomes.

By publishing an Annual Performance Report each year we can show what we have achieved and the impact we are having on achieving our Vision of ***Improving Lives*** through our four key Values of ensuring:

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

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

We strive to ensure our Health and Social Care Service will continue providing new and exciting opportunities to work together to make a difference to our communities.

With the dedication and commitment of our staff, partners and carers we will continue building on the partnership's strong foundations whilst meeting challenges face on to provide a safe and stable future for everyone.

[redacted]

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

Contents

Context

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

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

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

'Improving Lives' is 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
- Recovery and support to live independently
- Early intervention, prevention and re-ablement
- Support for families
- Inclusion and empowerment

Section 1: Structure of the Report

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

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

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

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

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

5. Health and social care services contribute to reducing health inequalities.

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

7. People using health and social care services are safe from harm.

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9. Resources are used effectively in the provision of health and social care services.

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

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

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

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

Section 2: National Wellbeing Outcomes and the National Integration Indicators

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

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

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

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

The data presented against the National Indicators is the most up-to-date as released by ISD in April 2018.

Where possible we have included data for previous years to allow comparison and progress to be seen.

Section 3: Performance at a Glance:

The 23 National Indicators for 2016/17

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
1*	Percentage of adults able to look after their health very well or quite well	91%	93%	
2*	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	80%	81%	
3*	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	77%	76%	
4*	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79%	74%	
5*	Total % of adults receiving any care or support who rated it as excellent or good	83%	80%	
6*	Percentage of people with positive experience of the care provided by their GP practice	83%	83%	
7*	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	77%	80%	
8*	Total combined percentage of carers who feel supported to continue in their caring role	40%	37%	
9*	Percentage of adults supported at home who agreed they felt safe	84%	83%	
10	Percentage of staff who say they would recommend their workplace as a good place to work	Indicator under development (ISD)		
11	Premature mortality rate per 100,000 persons	505	440	
12	Emergency admission rate (per 100,000 population)	14381	12294	
National Indicator		Inverclyde HSCP	Scottish Average	Comparison

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
13	Emergency bed day rate (per 100,000 population)	159547	125634	
14	Readmission to hospital within 28 days (per 1,000 population)	88	100	
15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%	
16	Falls rate per 1,000 population aged 65+	24	22	
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	90%	84%	
18	Percentage of adults with intensive care needs receiving care at home	63%	61%	
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	263	842	
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	30%	25%	
21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	Indicator under development (ISD)		
22	Percentage of people who are discharged from hospital within 72 hours of being ready	Indicator under development (ISD)		
23	Expenditure on end of life care, cost in last 6 months per death	Indicator under development (ISD)		

The data presented against these National Indicators is the most up-to-date as released by ISD in April 2018. Those marked with an * are taken from the 2017/18 Health and Care Experience Survey (http://www.isdscotland.org/Products-and-Services/Consultancy/Surveys/Health-and-Care-Experience-2017-18/). Details of this can be found in Section 5 on Page 46.

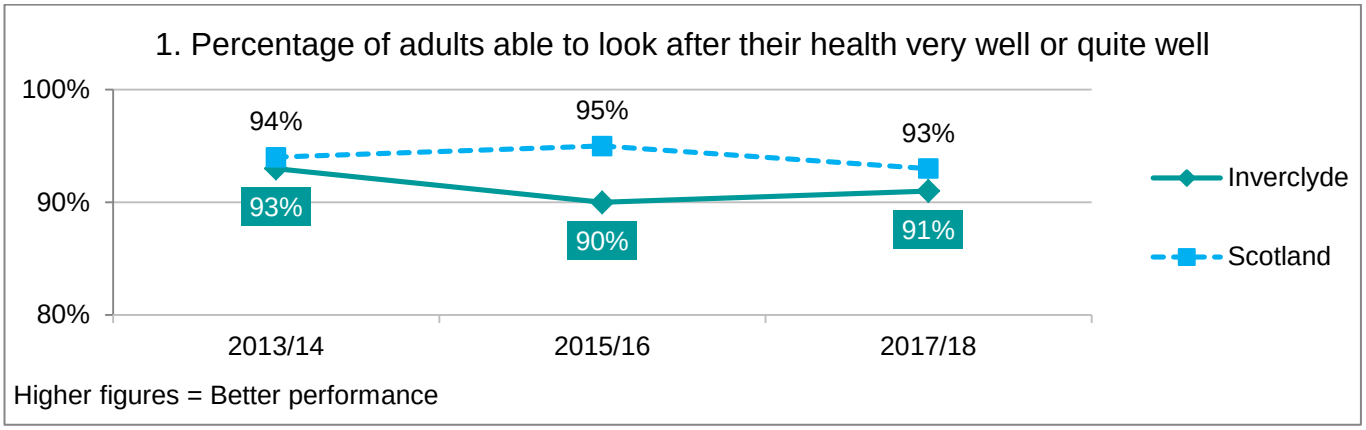
Section 4: The National Health and Wellbeing Indicators:

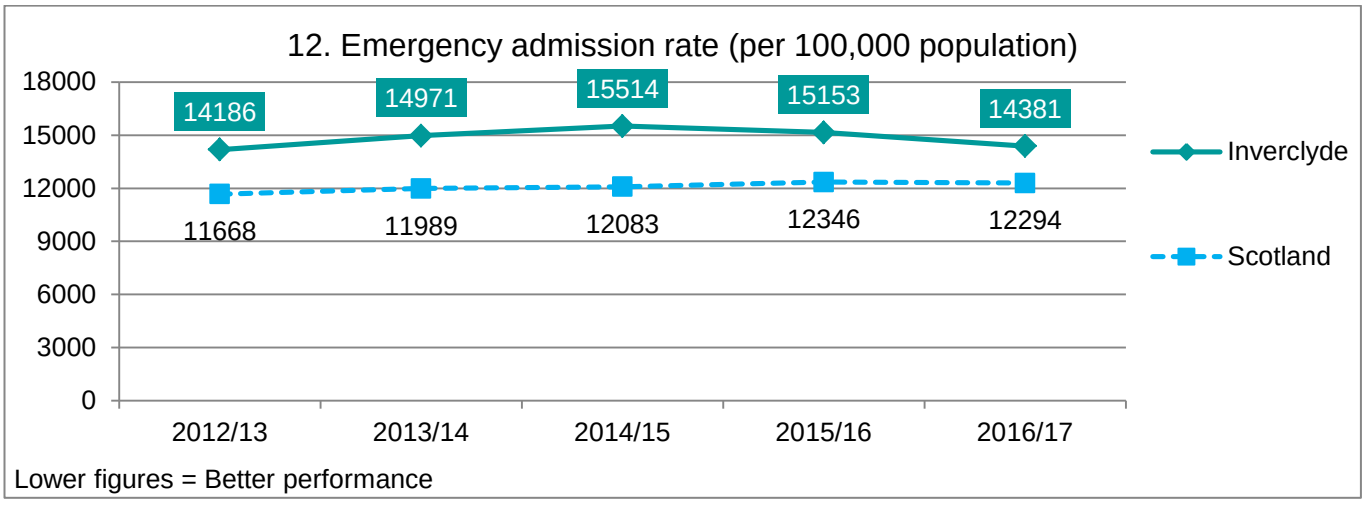
National Wellbeing Outcome 1

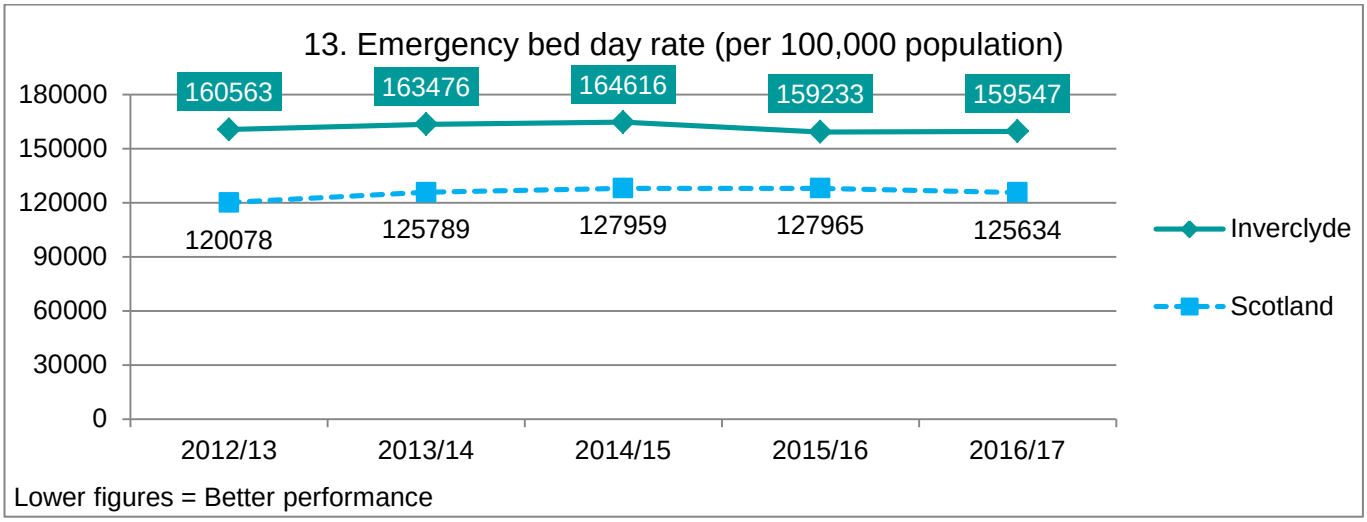
- People are able to look after and improve their own health and wellbeing and live in good health for longer

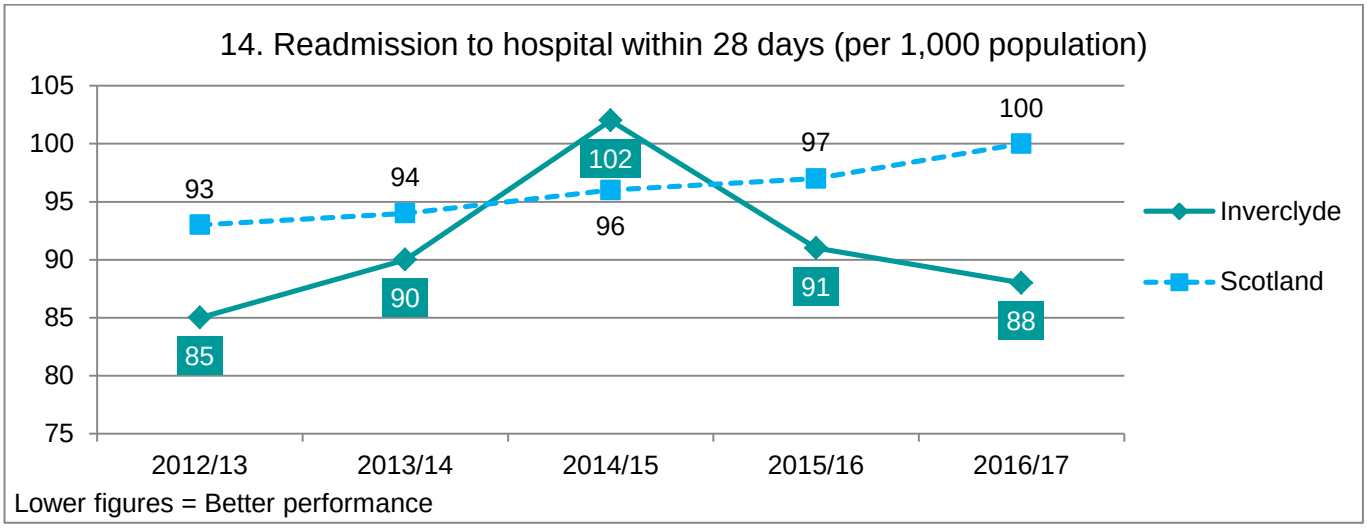
Current performance

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
1	Percentage of adults able to look after their health very well or quite well	91%	93%	
12	Emergency admission rate (per 100,000 population)	14381	12294	
13	Emergency bed day rate (per 100,000 population)	159547	125634	
14	Readmission to hospital within 28 days (per 1,000 population)	88	100	







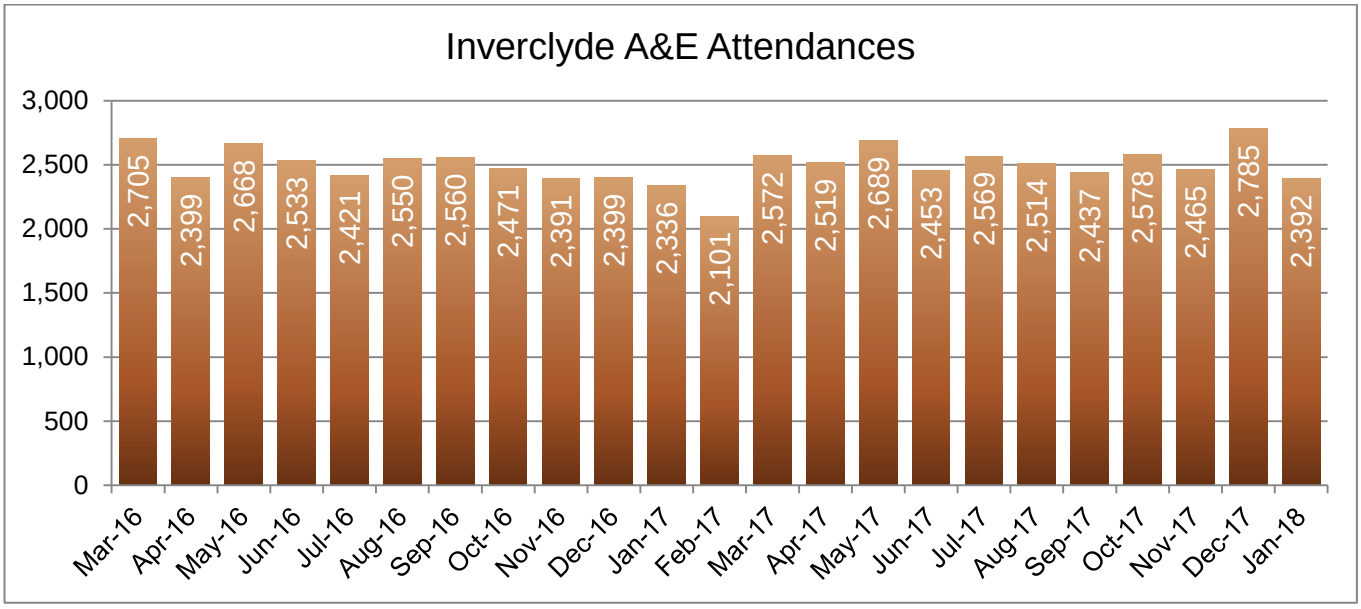


When people need support, it is important that they are seen as early as possible in order that they can begin to take control, look after and improve their own health.

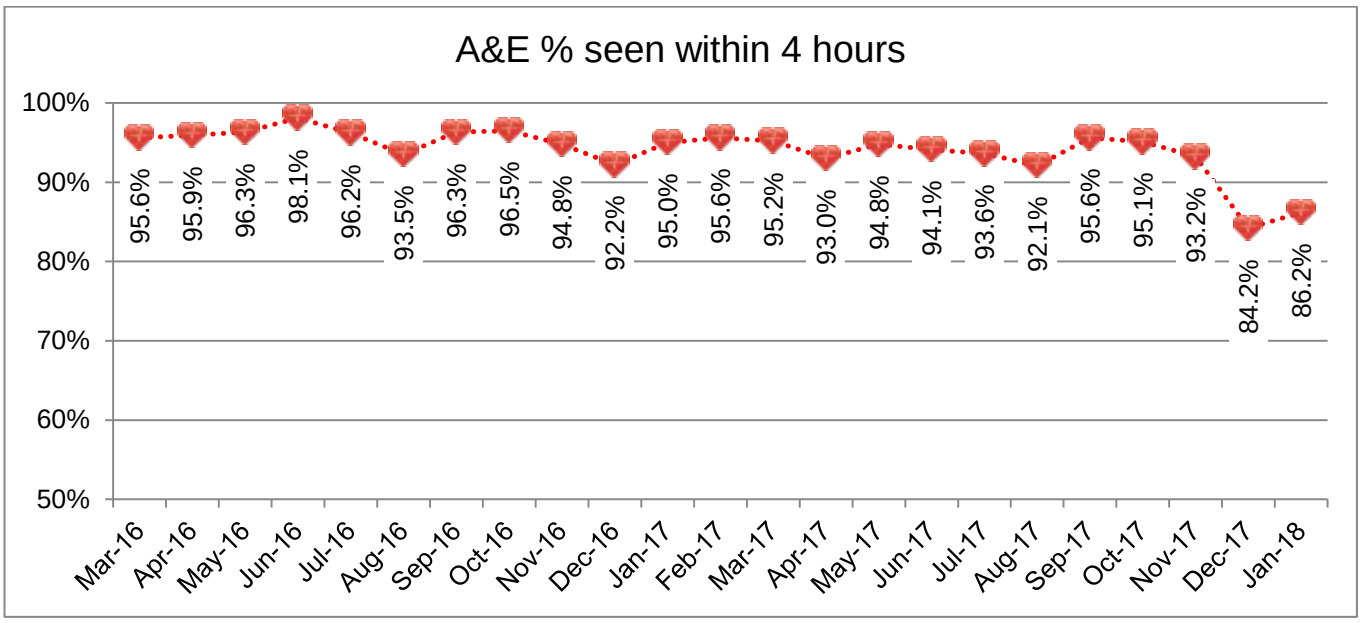
The overall aim of the Choose the right Service initiative is to raise public awareness and direct patients more appropriately to services that are best placed to support their health and social care needs. This means that people are more likely to see the right person, in the right place, and at the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

Accident and Emergency (A&E)

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



With regard to the nationally set 4 hour maximum waiting time target, Inverclyde Royal Hospital Accident & Emergency department consistently saw over 90% of patients within this timeline. Nationally there was a general reduction in meeting this target December 2017 and January 2018.



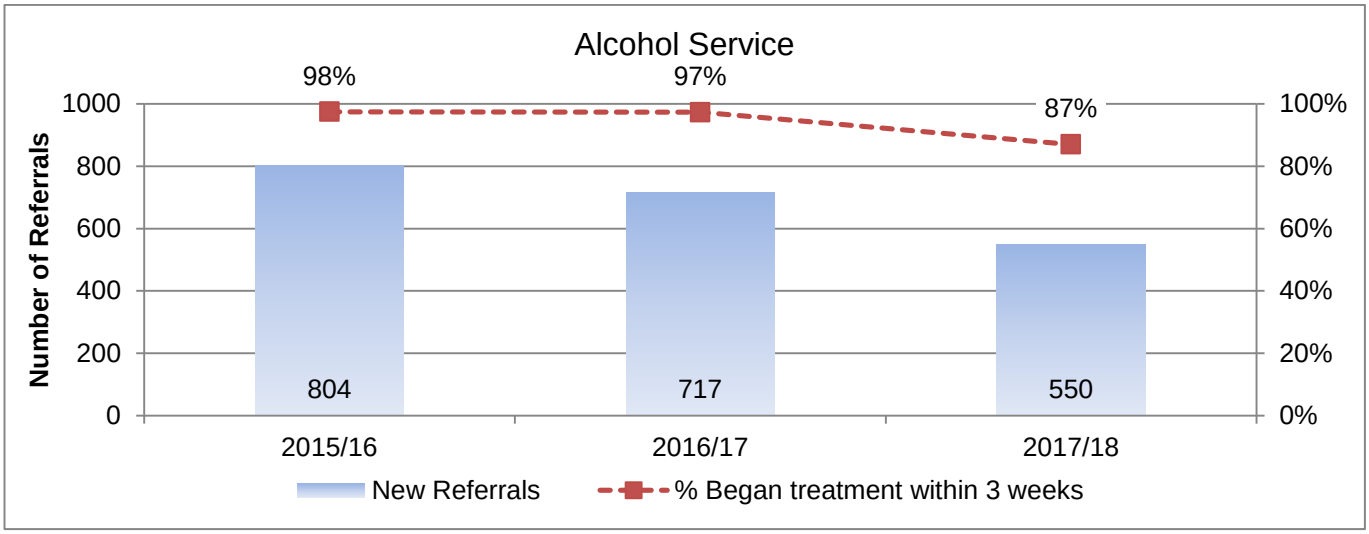
Alcohol and Drug Treatment

A national target has been set that states “90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery”. Seeing people quickly gets them onto a journey of recovery sooner and we hope this will lead to better outcomes.

Addictions - Alcohol

We have consistently outperformed this target in alcohol over the last few years and maintaining this level of performance is challenging. Whilst our performance has dropped to just under the 90% target this year as a whole, our performance in the second half of the year has improved to over 92%.

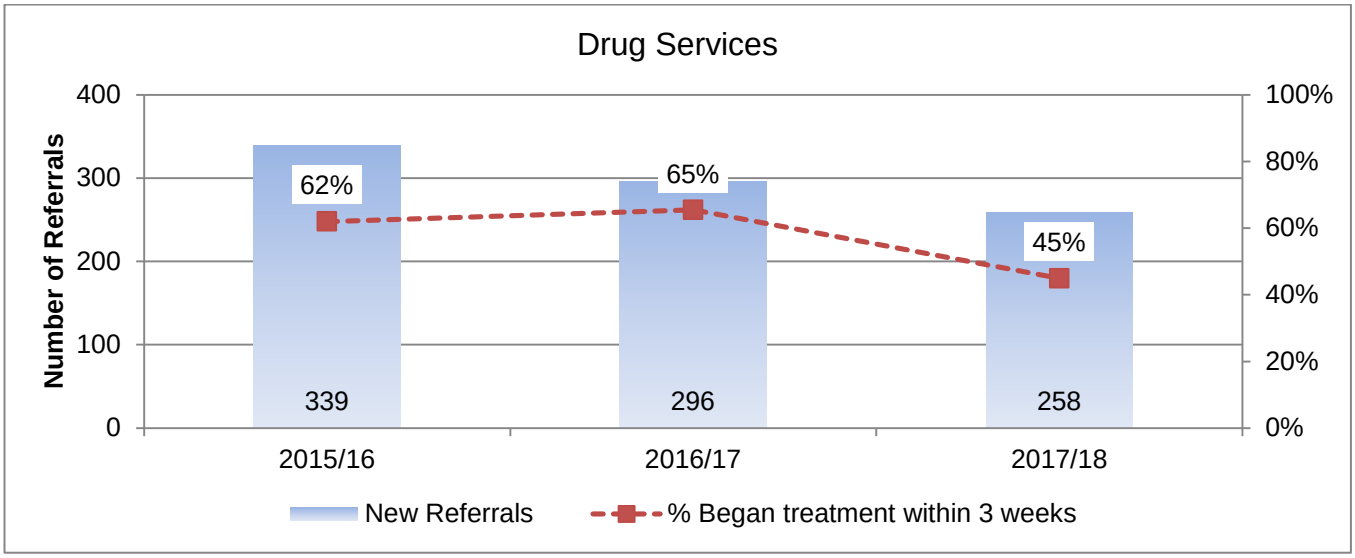
By reviewing the Alcohol Service, we have expanded the range of options available so that we can best serve the needs of the people who use this service. This has resulted in fewer people being referred back into the service once their treatment is concluded.

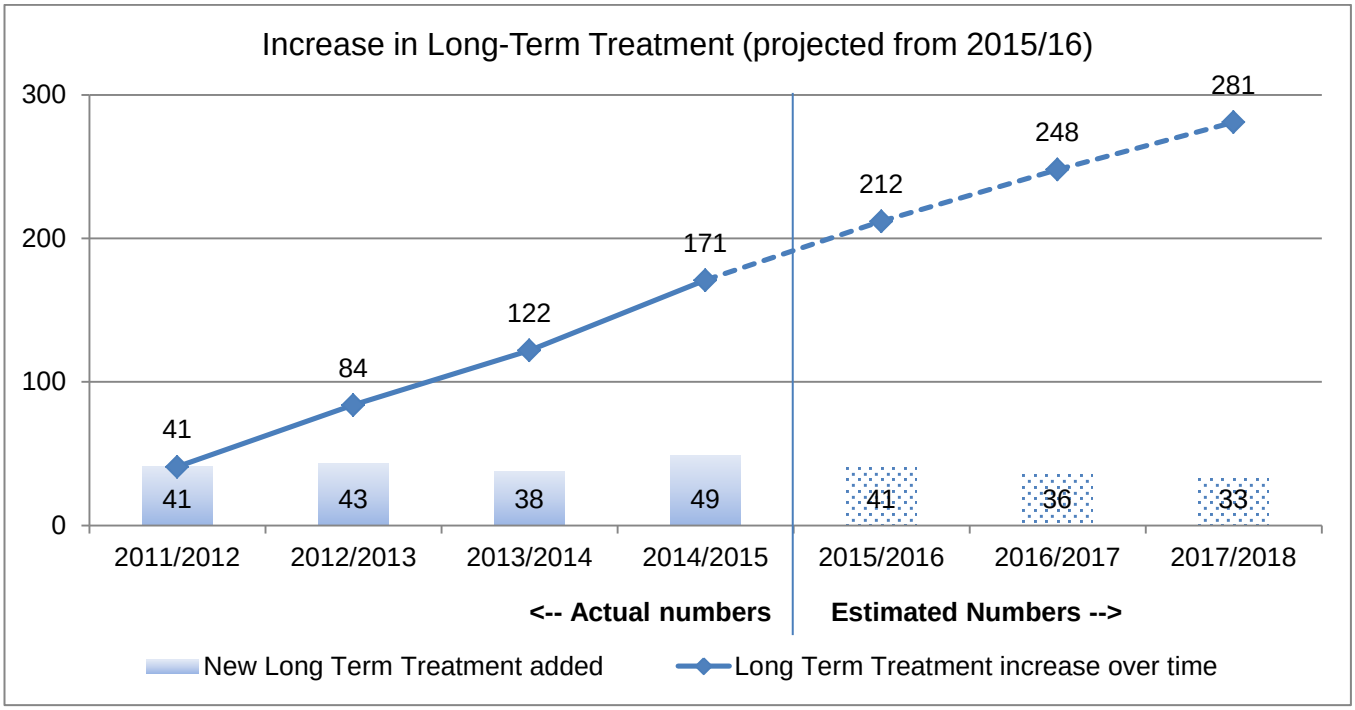


Addictions - Drugs

As can be seen from the graph below, our performance against the 90% target has dropped, from an already low starting point. This is against a backdrop of an increase in the number of people in long term treatment and changes in the substances being misused. Each year approximately 14% of all referrals to the Drugs Service become long term support cases.

It is accepted that for the drugs element of addictions services, there needs to be a much stronger focus on recovery. However over and above that, we are in the process of a significant review that will lead to a full redesign of Addictions Services, so that we can start to deliver lasting improvements in the lives of those people who need our support.





Each year ‘new’ people are added to our case load who will require long-term (greater than 3 years) treatment and support. The graph above shows the number of new people added each year (the blocks) up to 2014/15 and the estimated numbers that will be added from 2015/16. The graph shows the potential challenge and unless we can change this trajectory, this will require significant resource. Our challenge is to support more people to full recovery, and this will be reflected in the Addictions Review as well as our new Strategic Plan due for publication in 2019.

National Wellbeing Outcome 2

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

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	80%	81%	
15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%	
18	Percentage of adults with intensive care needs receiving care at home	63%	61%	
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	263	842	
21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	Indicator under development (ISD)		
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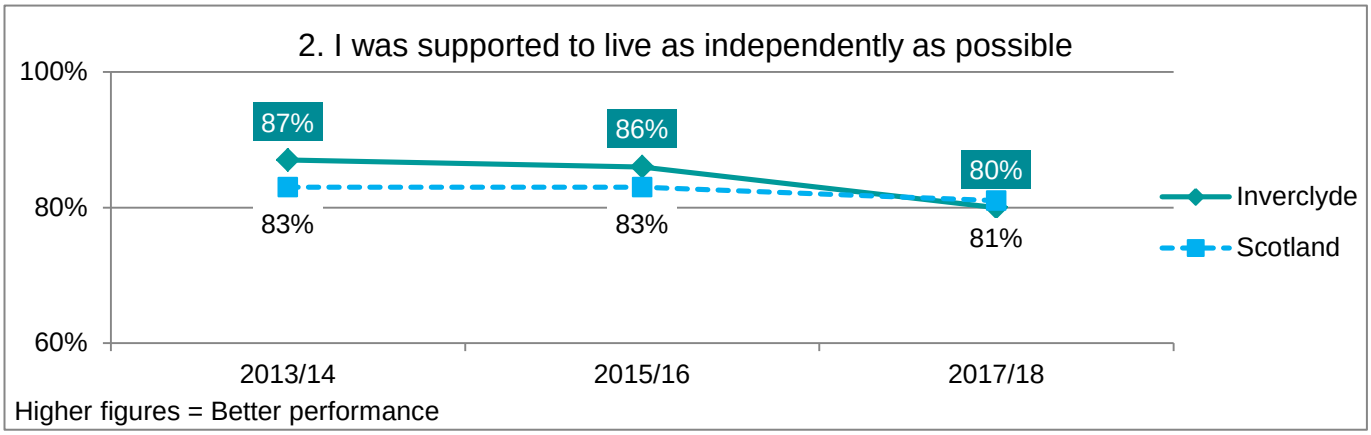
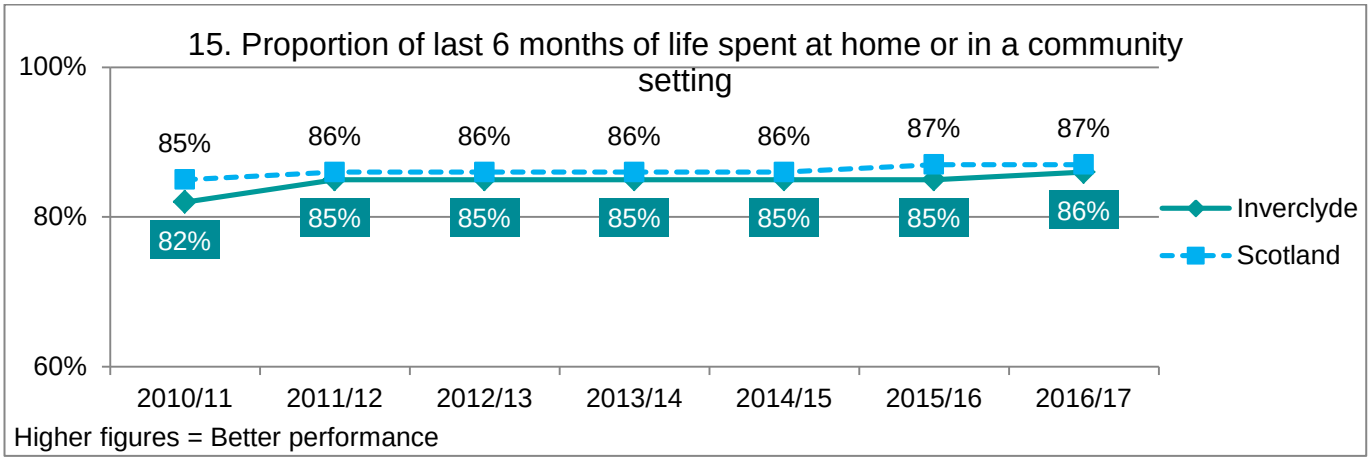
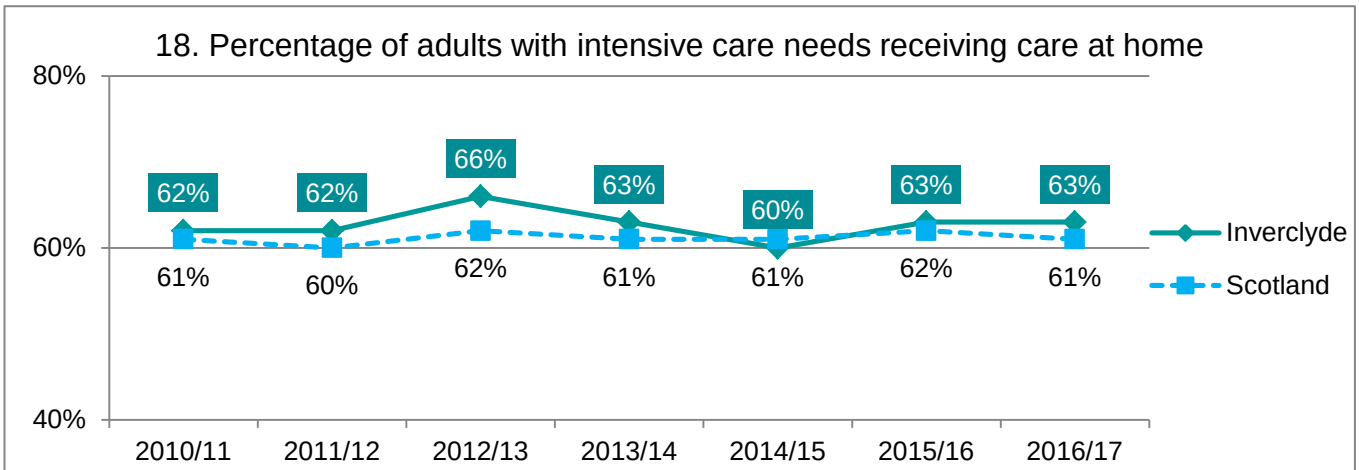


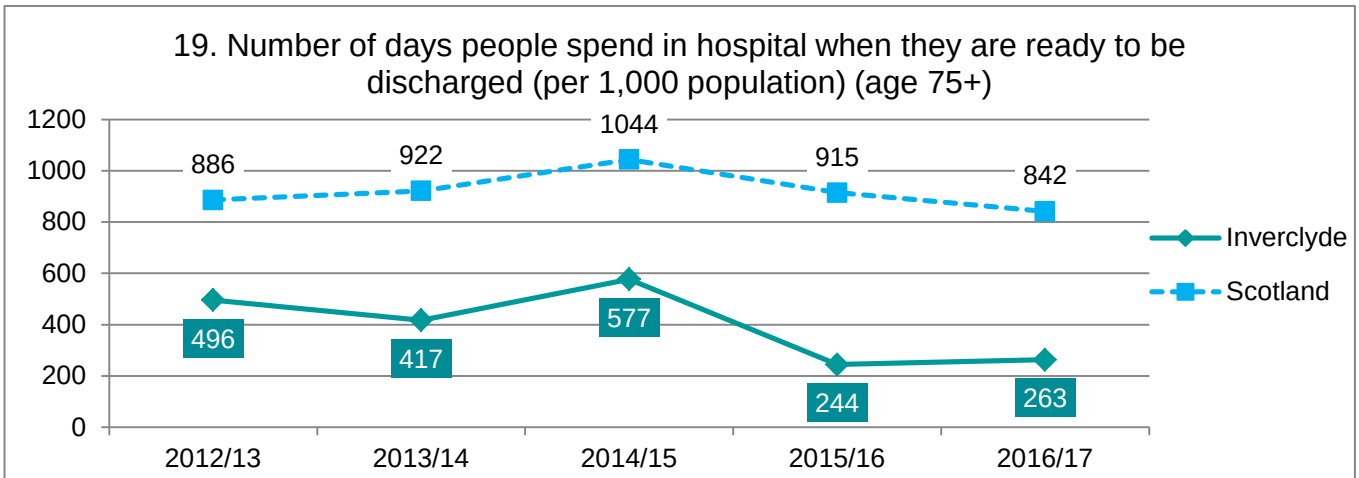
Data for this graph is drawn from the Health and Care Experience Survey. For the first two surveys we were notably higher than the Scottish average, however in the most recent survey there was a reduction nationally and this had more impact locally. We continue to support people to live as independently as possible and hope to see an improvement in the next survey.



Higher figures = Better performance



Higher figures = Better performance



Lower figures = Better performance

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 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.

Care at Home

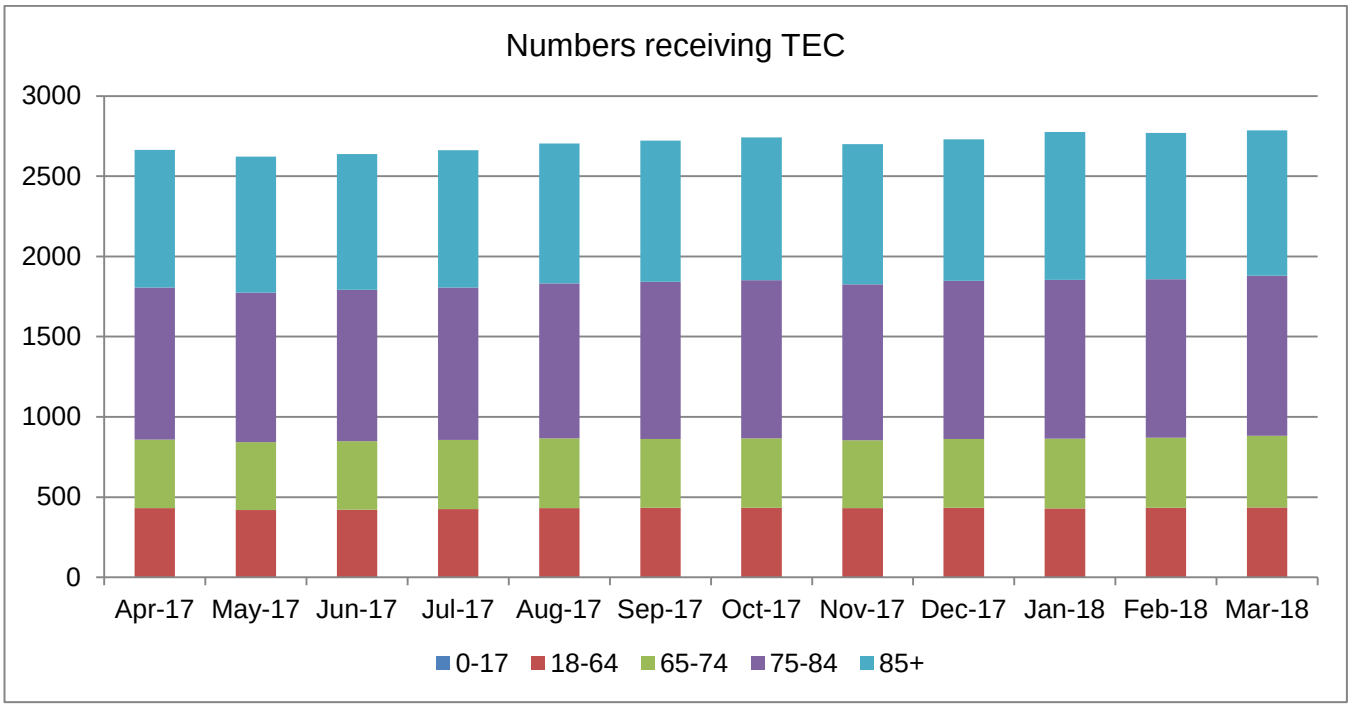
Our Care at Home service provides care and support to those who require assistance to remain independent at home for as long as possible. Investing in this preventative support helps reduce unnecessary admission to hospital and is a key intervention in achieving our aim of "People, including those with 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".

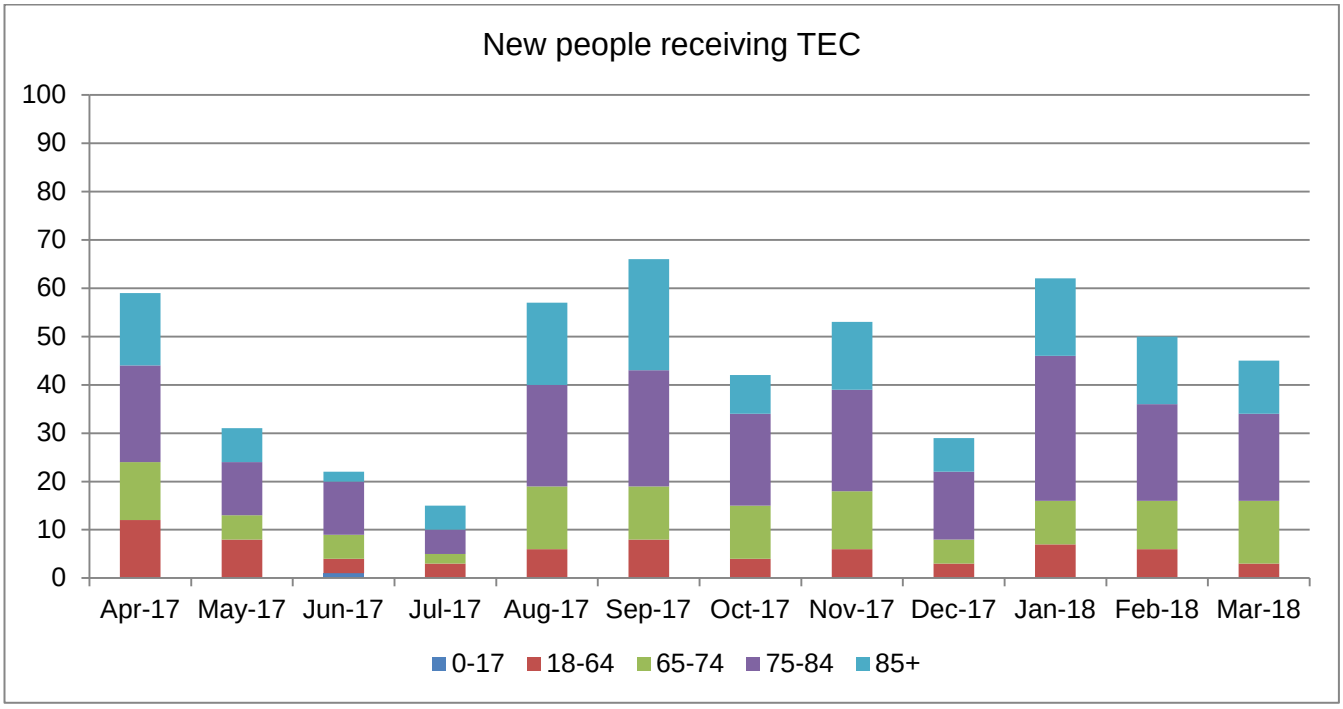
	Average hours of Care at Home provided per week for 65 and over people	Number of people age 65 and over receiving Care at Home
2015/16	7 hours 43 minutes	1,155
2016/17	6 Hours 52 minutes	1,146

By delivering support in a variety of ways including equipment, utilising technology and re-ablement, we can better meet the needs of people to remain independent without relying so much on home visits. The reduction in average weekly hours provided gives a general picture of this.

Using Technology

With our **Technology Enabled Care (TEC)** we support over 2,600 Inverclyde residents with a range of services including community alarms, falls monitors and bed monitors, enabling them to remain in their homes with support that is *'available when they need it'*. As depicted in the graphs although we continue to provide this service across all age groups, this service is a key enabler in supporting our older residents to remain in their own homes with around 84% being aged 65 and over.

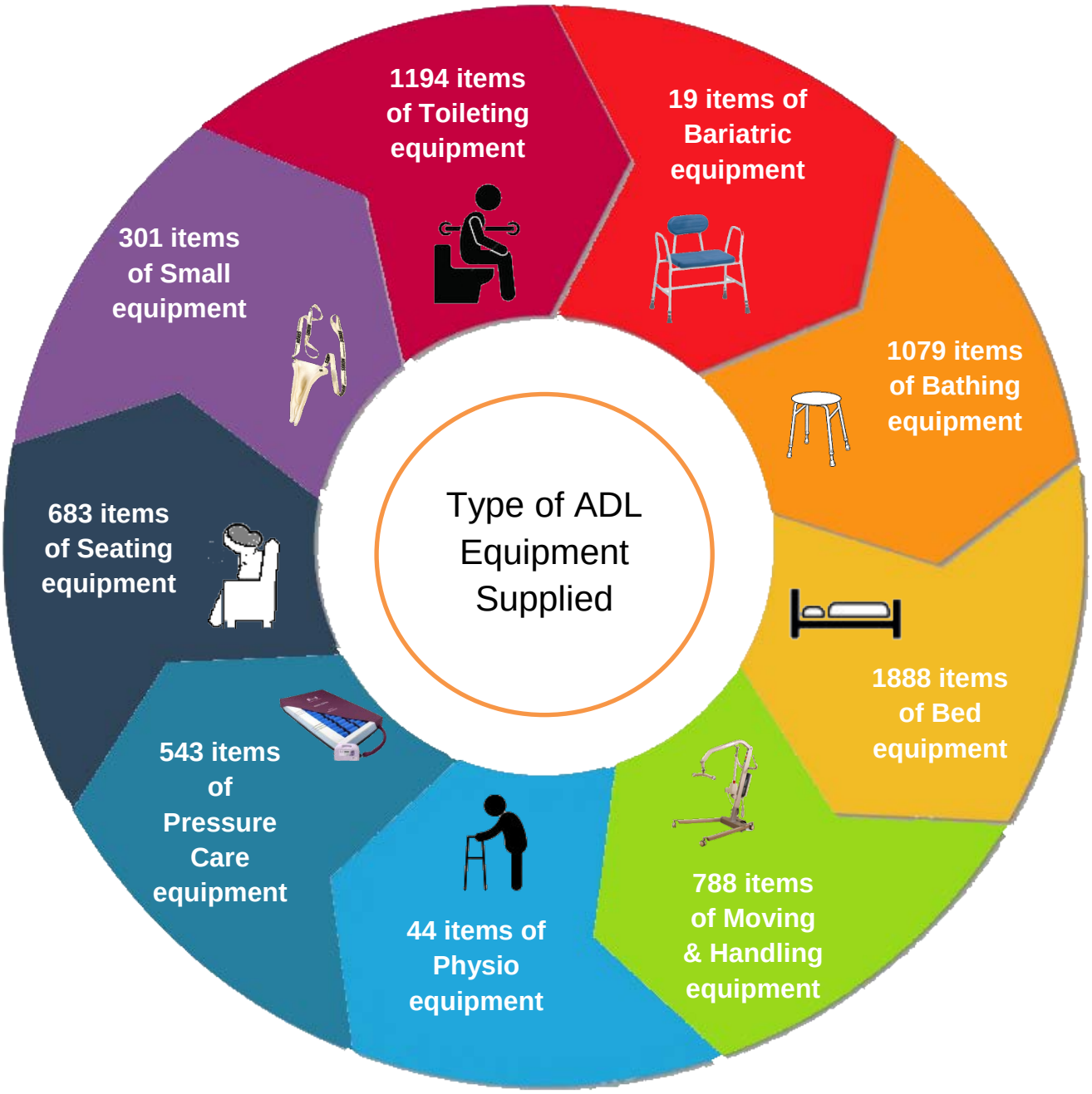




A further key area in supporting residents to remain as independent as possible is **Aids for Daily Living (ADL) equipment.**

In 2017-18, similar to 2016-17, we again provided over 6,000 items of ADL equipment to Inverclyde residents who had a physical need. This equipment ranges from hospital beds with pressure care mattresses and patient hoists, to simple seats for use in a shower. An Occupational Therapist (OT) or District Nurse (DN) carries out an assessment for equipment.

Breakdown of type of equipment supplied to Inverclyde residents in 2017/18.


1194 items of Toileting equipment
19 items of Bariatric equipment
1079 items of Bathing equipment
1888 items of Bed equipment
788 items of Moving & Handling equipment
44 items of Physio equipment
543 items of Pressure Care equipment
683 items of Seating equipment
301 items of Small equipment
Type of ADL Equipment Supplied

Case Study

A is a 12 year old child with a life limiting progressive condition. She lives with her parents, grandparent and younger sibling in unsuitable housing. Due to her condition which requires various aids and adaptations she is restricted to only the living room of her home, in which she has to sleep, eat, manage all her personal care and toileting and partake in recreational activities.

With the assistance of the Occupational Therapy Services, working alongside the local housing providers, together we were able to identify a bungalow style house for the family to move into. Extensive external work was carried out to provide a level access driveway with carport, an electronic door opener to facilitate independent access and an extended patio area to provide wheelchair access to the garden area.

Further internal work was carried out on the property and additional specialist equipment was provided including a full room coverage tracking hoist, a wash dry toilet with tilt in space shower chair and wet-floor covering to name a few.

The family are awaiting the provision of an environmental control system to operate lighting, bed controls and answering machine.

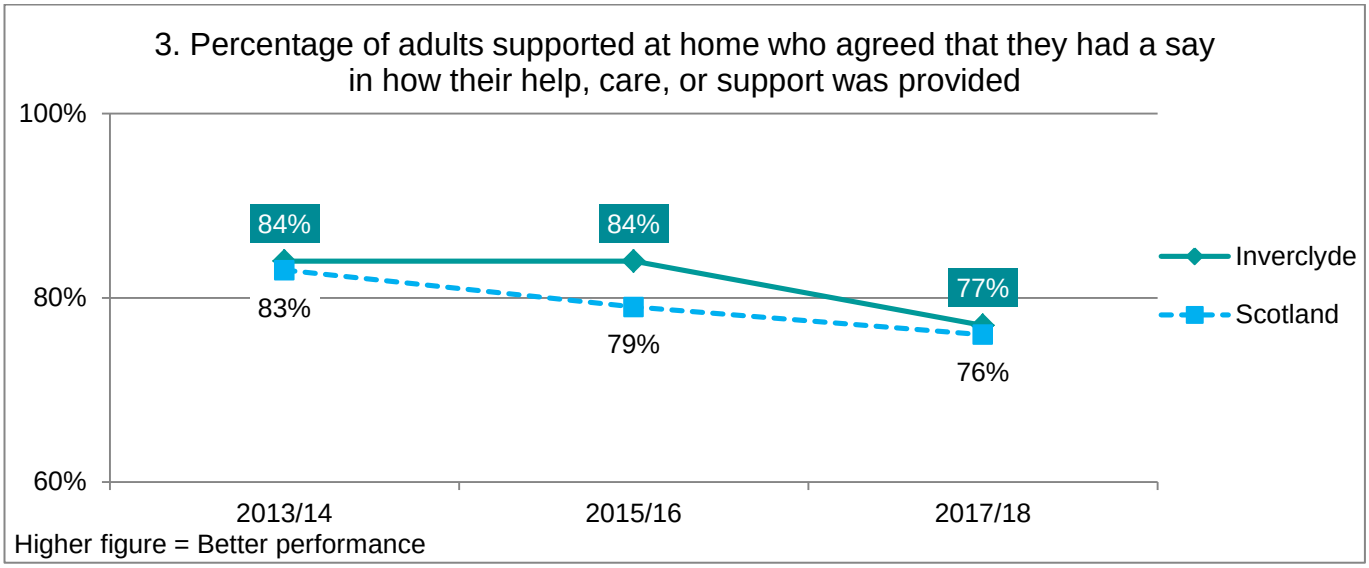
A is now able to transfer easily from room to room within her new home. Her bedroom now allows her the privacy she needs and the direct access into her wet-room allows her to maintain her dignity and a level of independence.

The family report a positive outcome for the entire family and are settling well in their new home.

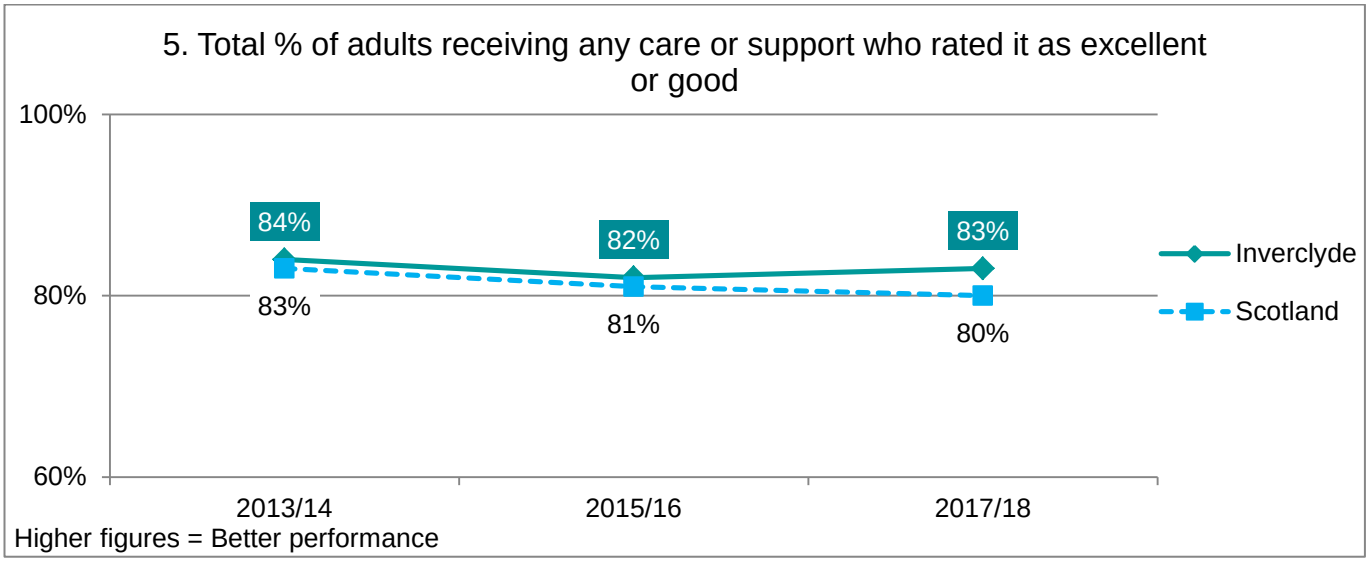
National Wellbeing Outcome 3

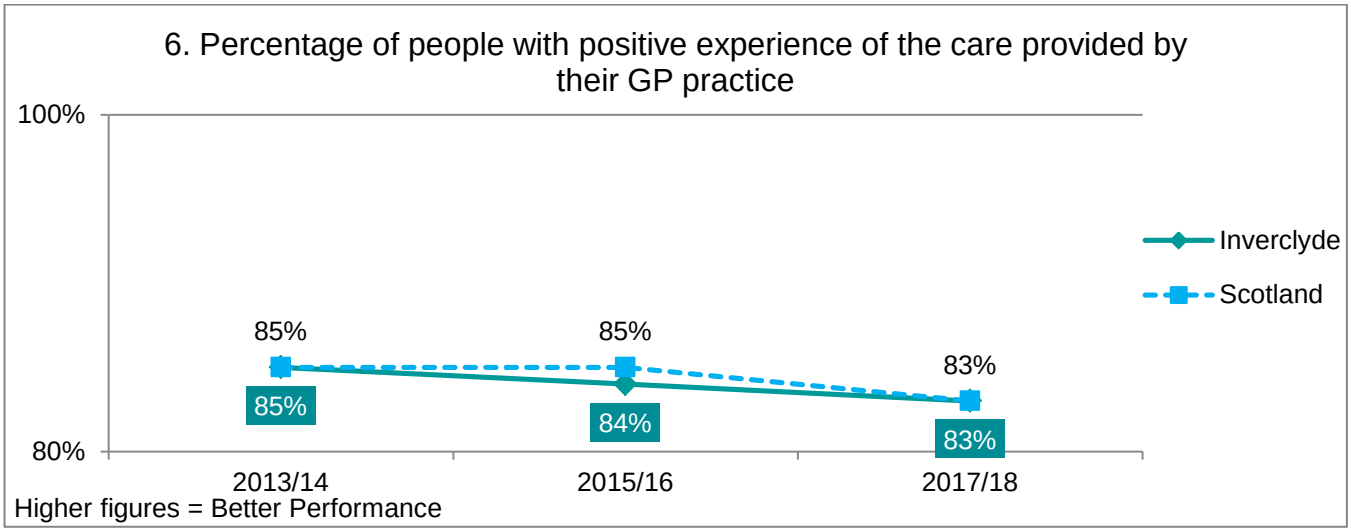
- People who use Health and Social Care services have positive experiences of those services, and have their dignity respected

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	77%	76%	
5	Total % of adults receiving any care or support who rated it as excellent or good	83%	80%	
6	Percentage of people with positive experience of the care provided by their GP practice	83%	83%	



Whilst the HSCP recognise a reduction, services continue to increase consultation and engagement with Service Users and their families on their personal assessed needs and outcomes.





Criminal Justice unpaid work service

In 2016/17 there were 13 unpaid work recipient questionnaires returned to the Service: 10 from individuals and 3 from organisations. Whilst this is down on last year's total (30), we believe this in part reflects the Service's move away from smaller individual projects to larger scale initiatives.

- 100% of respondents were 'very satisfied' with the standard of work carried out.
- 92.3% (12 of 13) of respondents were 'very satisfied' with the attitude and politeness of the workers, with the remaining 7.7% (1) being 'satisfied'.
- 100% of respondents indicated they were 'very likely' to use the service again.

Some comments from organisations who received this Service:

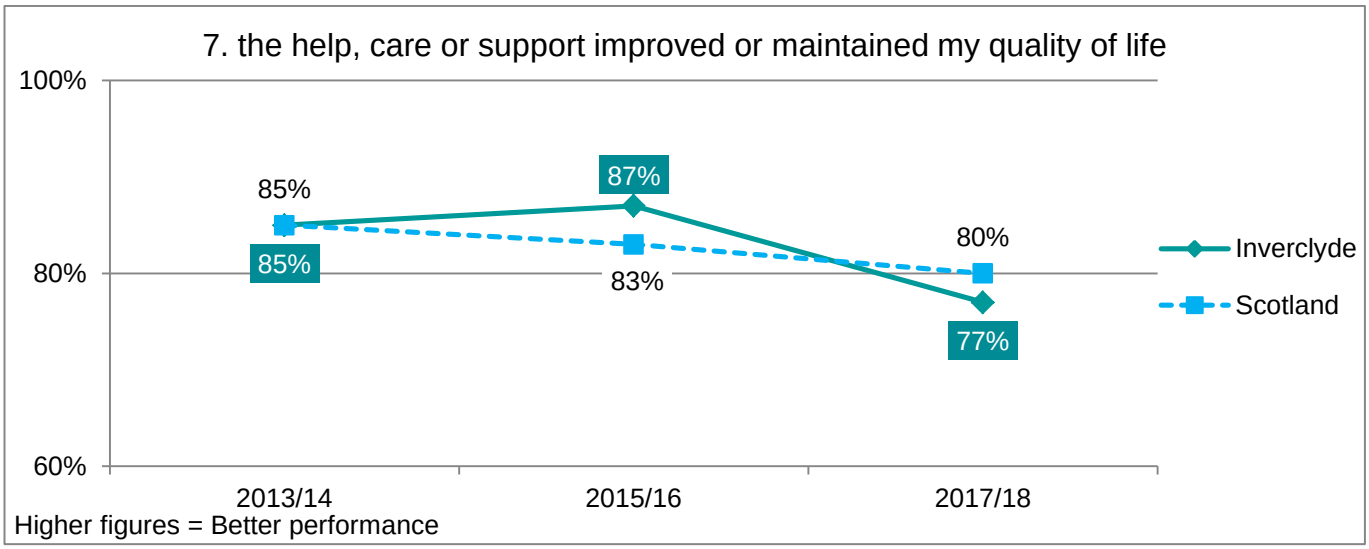
We would like to extend our warmest thanks for all work you did for us in the grounds

Our wonderful premises are now open and your hard work has greatly assisted in allowing us to carry out some great work within our community. As a result of your help, we are now able to provide social activities for 51 children on a weekly basis, support for youth and drop in for parents

National Wellbeing Outcome 4

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

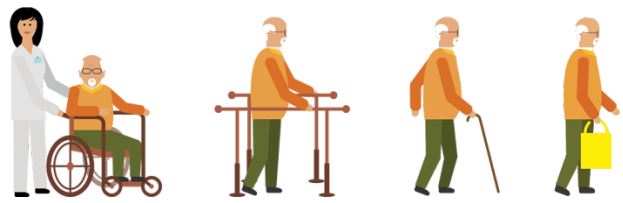
National Indicator		Inverclyde HSCP	Scottish Average	Comparison
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	77%	80%	



Whilst the HSCP recognise a reduction, services continue to increase consultation and engagement with Service Users and their families on their personal assessed needs and outcomes.

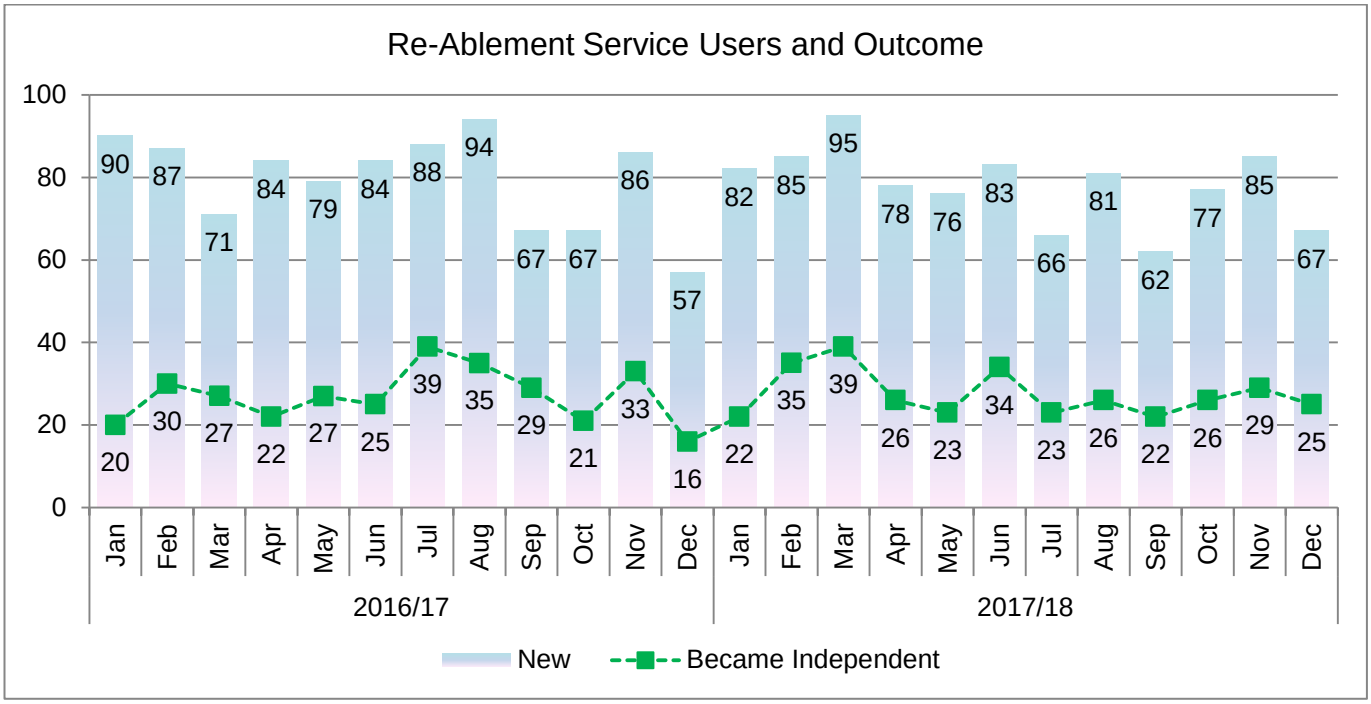
An example of how we are performing against this Wellbeing Outcome and the national indicators is evidenced in Reablement Services.

'Reablement & Support to Live Independently'

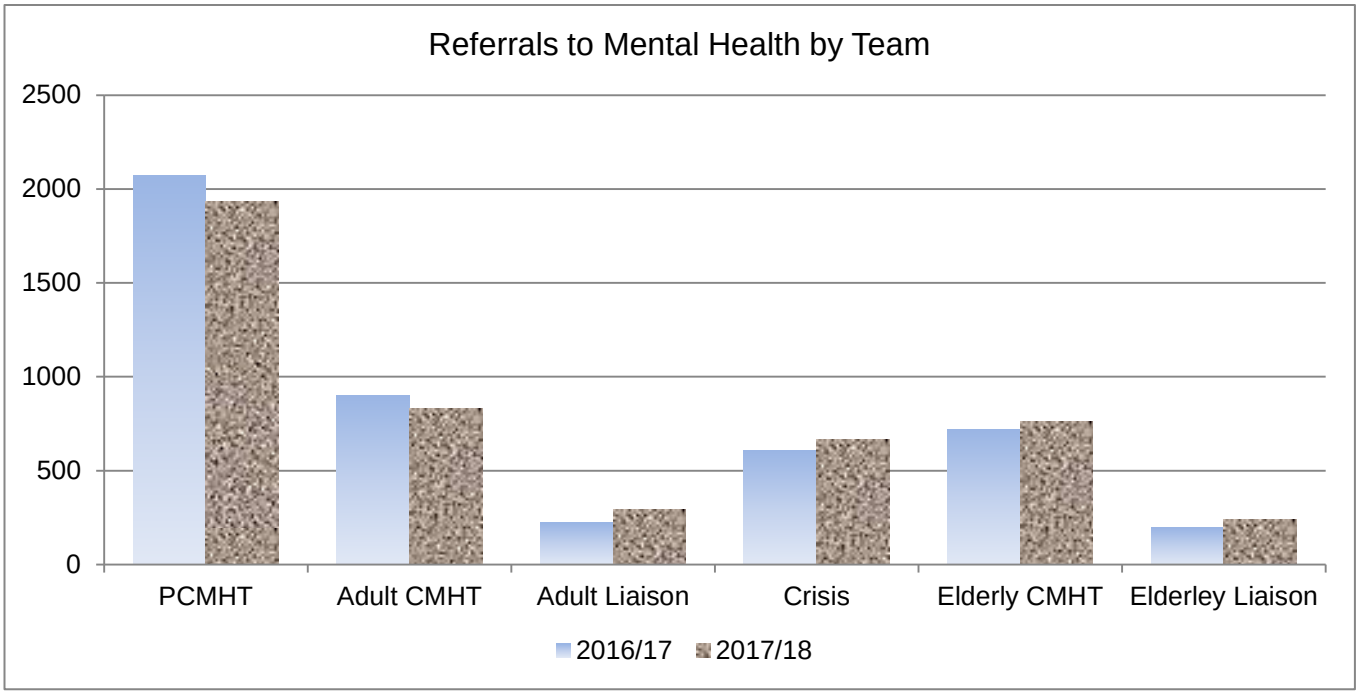


This service provides an initial quick intervention (for up to 6 weeks) to assist people to remain or become independent after being discharged from hospital, overcoming an illness or other notable life incident by using a combination of Occupational Therapy, Physiotherapy, physical disability aids and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

In the year from January to December 2017, 937 new people were referred to the re-ablement service. Of these, 330 (35.2%) became fully independent after receiving the service.



Within our **Mental Health Services** there were a total of 4,727 referrals throughout 2017/18, a slight increase from 4,708 in 2016/17. Every referral involves an assessment to identify the most appropriate intervention to help support each person and improve their overall quality of life. How the referrals were distributed across the various teams is shown in the graph below:



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

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

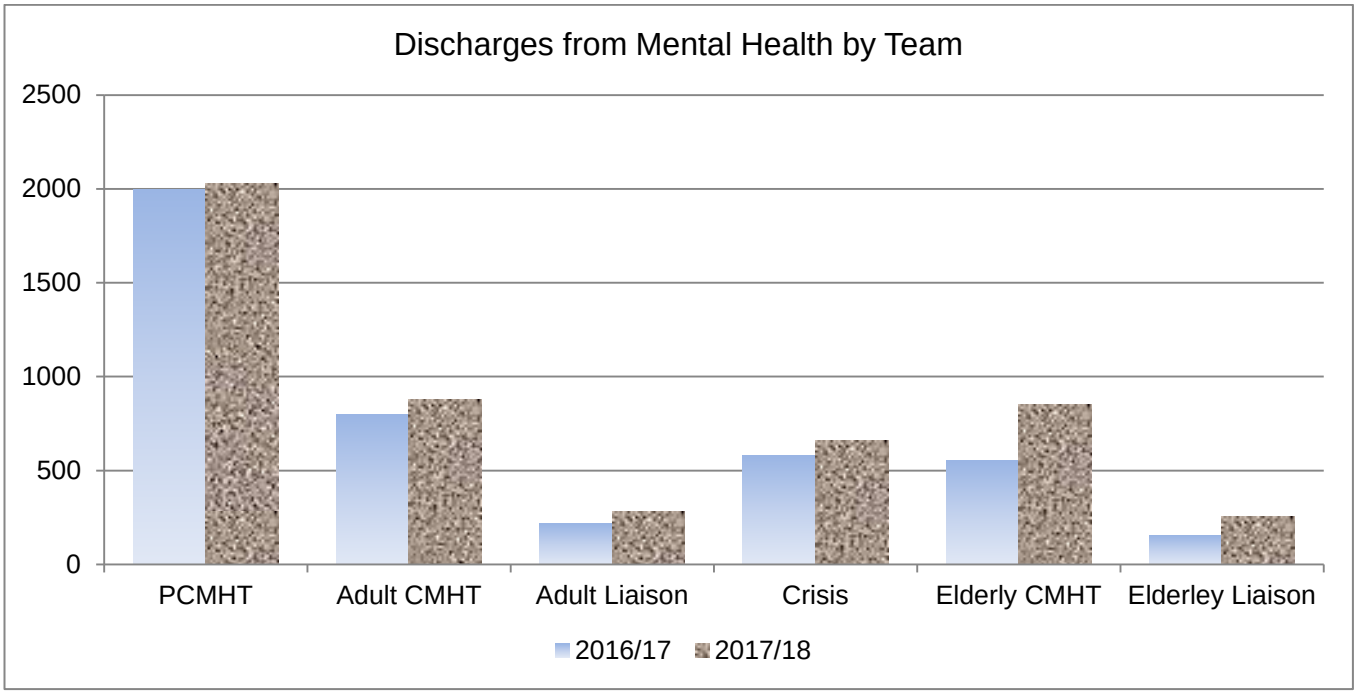
Our **Community Mental Health Team** (CMHT) works in partnership with families and carers, primary care and other agencies to design, implement and oversee comprehensive packages of health and social care, to support people with complex mental health needs. We deliver this support in environments that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

The aims of the Community Mental Health Team are to:

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

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

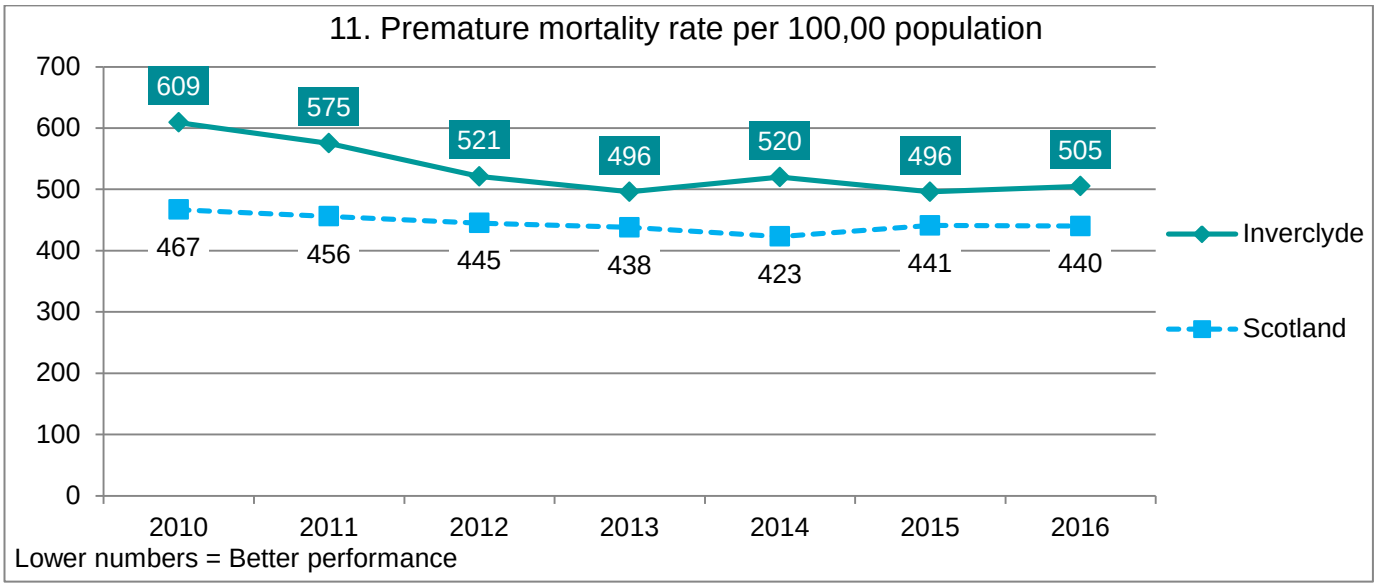
Discharges from our Mental Health Services totalled 4,955 throughout 2017/18 up from 4,303 in 2016/17.



National Wellbeing Outcome 5

- Health and Social Care services contribute to reducing Health Inequalities

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
11	Premature mortality rate per 100,000 persons	505	440	



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

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

In Inverclyde, our approach to **Addressing Inequalities** is multi-faceted, and is led by our Community Planning Partnership – the Inverclyde Alliance – and delivered through its Local Outcome Improvement Plan (LOIP). Central to the LOIP is the need to focus on prevention of health and other inequalities (as described in the Director of Public Health's 2018 Report). The Inverclyde Alliance LOIP has therefore identified 3 areas of multiple deprivation (defined through the Scottish Index of Multiple Deprivation (SIMD) data), to enable a multi-agency focus over the next three years.

Whilst inequalities can manifest in many different ways, the following case study highlights how targeted support can improve lives.

Case Study

The client was referred to HSCP Money Advice by social work. The client had alcohol addiction problems and had been admitted to hospital.

The client was a single woman, living on her own and did not have much family support.

The adviser met the client in her home and although she was challenging to engage with because of her problems, the client agreed eventually to allow the adviser to provide her with assistance.

The adviser made a successful application for Severe Mental Impairment exemption from Council Tax. This not only exempted her from her ongoing liability but cleared previous debts owed to Council Tax.

A further application was also made to her fuel provider's hardship fund, who agreed she was a vulnerable person and due to the current circumstances a grant was awarded which cleared her arrears. A direct debit was also set up to help the client manage her ongoing liabilities.

The client's landlord was a private landlord and whilst in receipt of Housing Costs these did not cover the full rent. The adviser liaised with the landlord to explain the situation. He agreed to reduce the rent costs to the amount paid by DWP. The adviser also arranged for the Housing costs to be paid directly to the landlord so he was guaranteed the rent and the arrears would not increase. We achieved a financial gain of £2,174.

Since engaging with the service the client has begun to accept and take support and is now engaging with various workers including Alcohol Service, Homemaker, Homeless Team and Benefit Advisors. The client now feels better about her financial situation and it is no longer a barrier to her moving on with her life.

Homelessness

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

Figures for the last 4 years show the number of approaches to the service for advice and support (also referred to as 'Housing Options') to prevent homelessness.

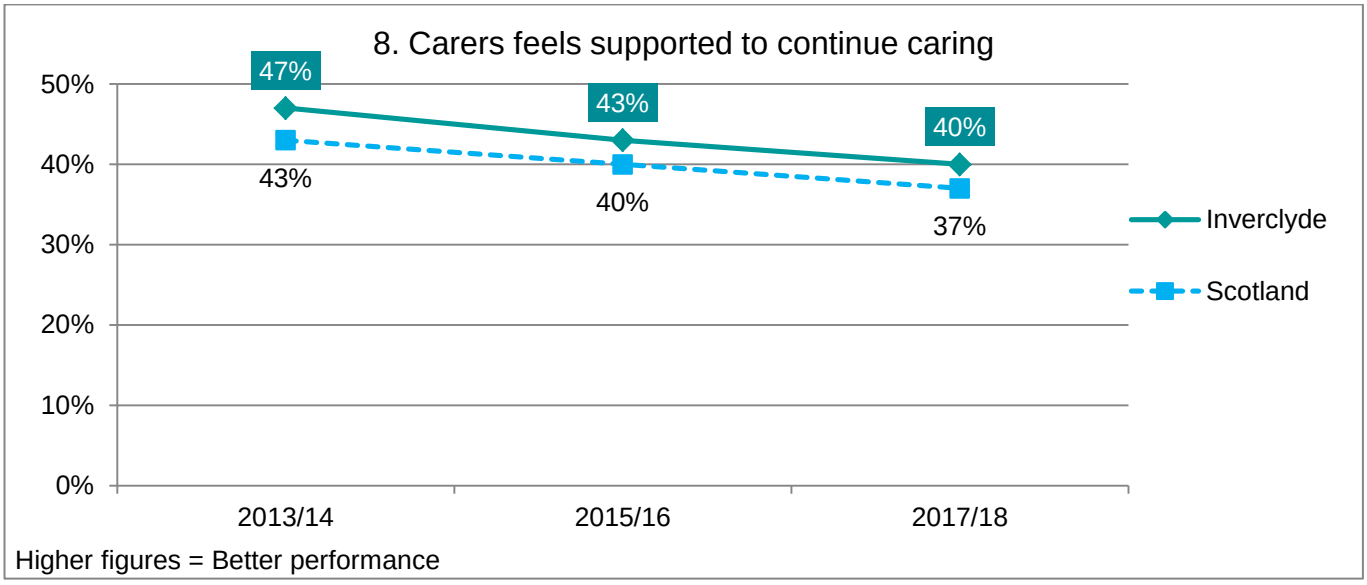
	Number of households approaching the Service	Of all homeless households - number with children	Number of young people (aged 16-19)
2014/15	**1053**	**38**	**116**
2015/16	**924**	**61**	**99**
2016/17	**950**	**83**	**83**
2017/18	**991**	**77**	**70**

Our focus going forward will be to develop interventions to prevent people from becoming homeless in the first instance. We have undertaken a review of our services and the findings from that review will be examined at a stakeholder event in early June 2018. That will help us shape future provision in the wider context of Community Planning, given that homelessness is very often rooted in inequalities across a whole range of factors, including but not limited to health and social care.

National Wellbeing Outcome 6

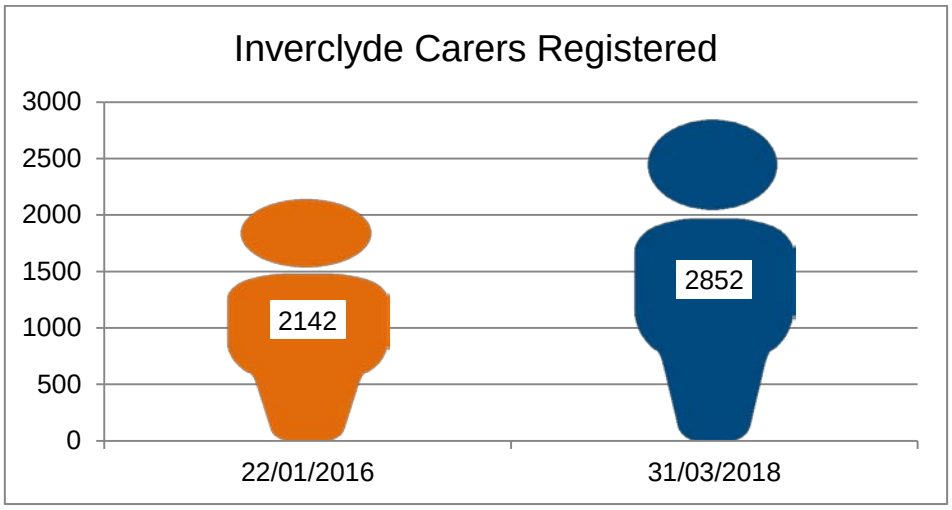
- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being.

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
8	Total combined percentage of carers who feel supported to continue in their caring role	40%	37%	



Inverclyde HSCP is continuing our local interagency approach to support all carers to have a healthy, active and fulfilling life of their own. Inverclyde HSCP is fully committed, working with carers as equal partners, to ensure this is achieved.

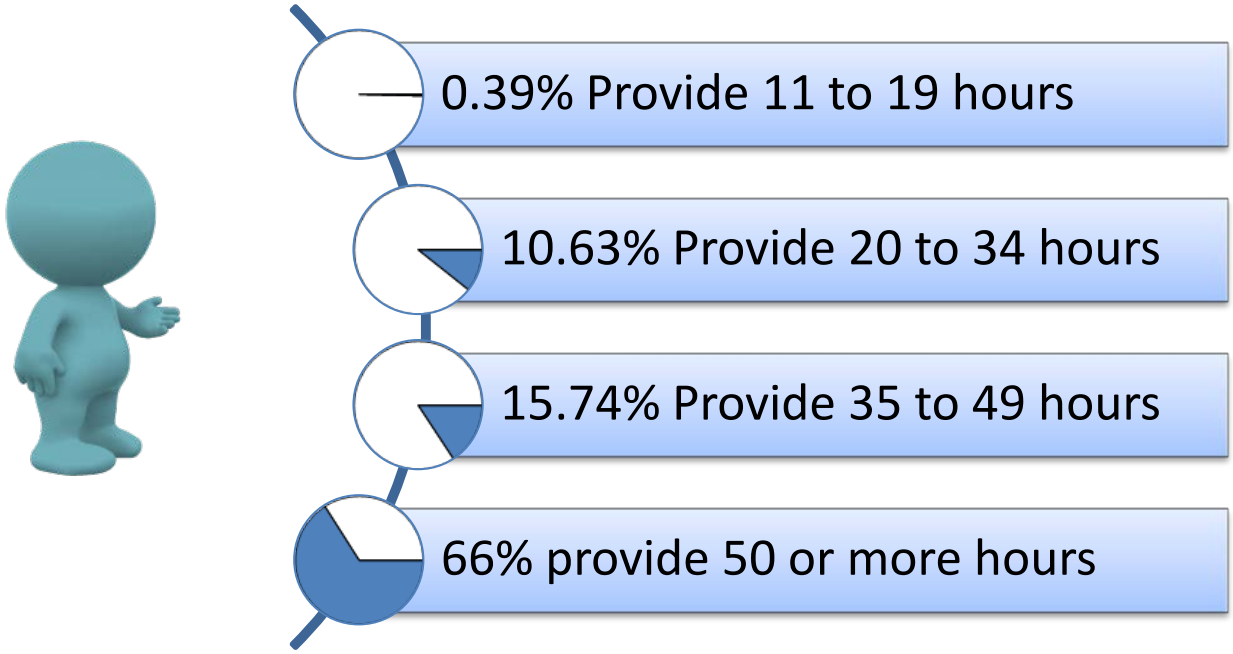
Information held by the Inverclyde Carers' Centre on the number of carers registered (snapshot at the dates indicated):



In the financial year of 2017/2018, 474 new Carers registered with the Carers Centre.

In order to help provide the best support, carers are asked to complete a Self-Assessment questionnaire. As at 31/03/2018, 254 Self-Assessments have been completed.

Of the 254 carers who have completed a Self-Assessment, they indicated how many **hours per week** of care that they provide.



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.

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;
- Collaborative working to raise awareness of young carers in schools;
- 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.

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 and to improve the sense of our carers feeling supported.

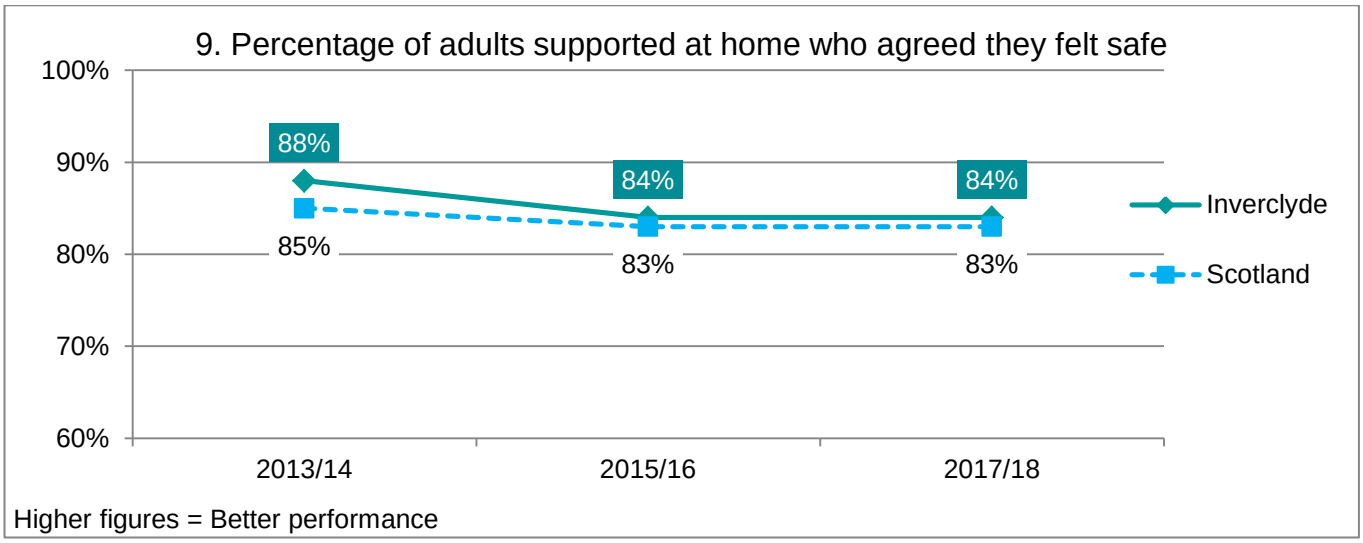
A copy of the Inverclyde Carer & Young Carer Strategy 2017-2022 is available on the Inverclyde Council website:

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

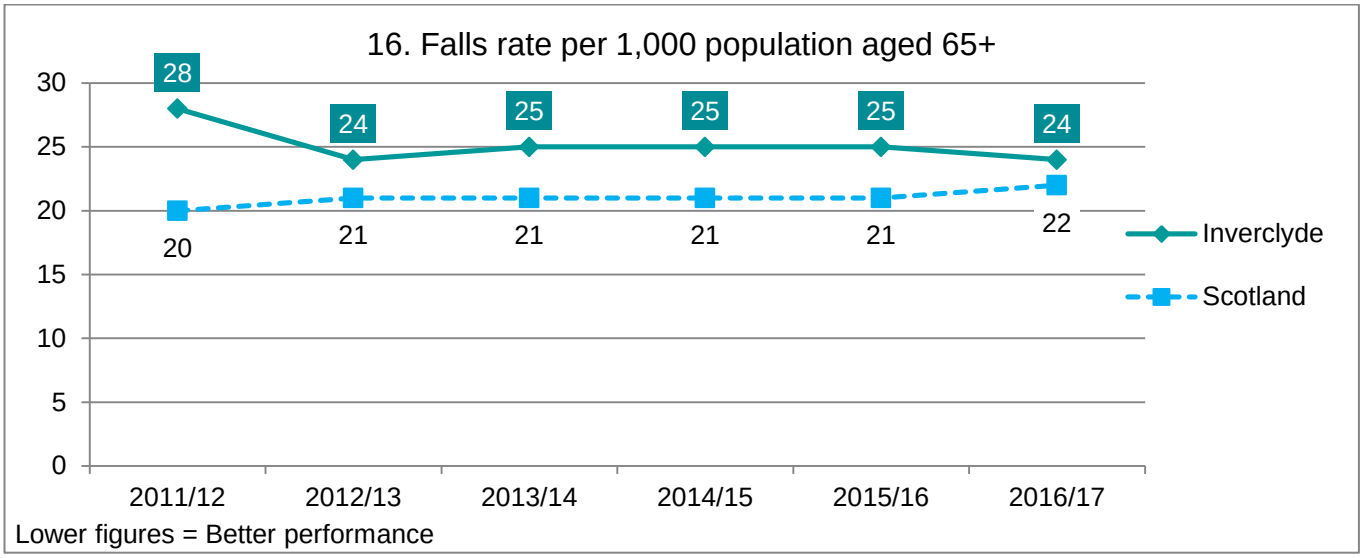
National Wellbeing Outcome 7

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

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
9	Percentage of adults supported at home who agreed they felt safe	84%	83%	
16	Falls rate per 1,000 population aged 65+	24	22	



Whilst the HSCP recognise a reduction, services continue to increase consultation and engagement with Service Users and their families on their personal assessed needs and outcomes.



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

Falls within Inverclyde remain higher than the Scottish levels. 24 falls per 1,000 population in Inverclyde versus 22 falls per 1000 population in Scotland. However, Invercyde HSCP falls are reducing while the Scottish trend is rising.

Falls are often a symptom of other illnesses, not a specific diagnosis, and as such are often picked up as a secondary problem when service users are referred into HSCP services for other reasons. With this fact in mind the falls work has focussed around devising and implementing the falls pathway, Level 1 and 2 screening and promoting the message “Falls prevention is everyone’s responsibility”.

The Level 1 and Level 2 screening has now become embedded practise with Social Work Occupational Therapists (OTs) and Occupational Therapy Assistant’s (OTAs), Community Alarm Team, Rehabilitation and Enablement Service Team (RES), Sensory Impairment Team and Physical Disability Resource Unit (PDRU).

This screening tool has been presented to other Teams within the HSCP and support is continuing to ensure this becomes common practise. Training for staff continues to be delivered across Inverclyde. Inverclyde RES team have piloted an early strength and balance class which is offered to people in the hope of reducing the number of falls.

Work has continued to promote an Ambulance falls pathway as Scottish Ambulance crews convey an average of 600 patients to A&E at Inverclyde each year, which resulted in 393 admissions to hospital last year.

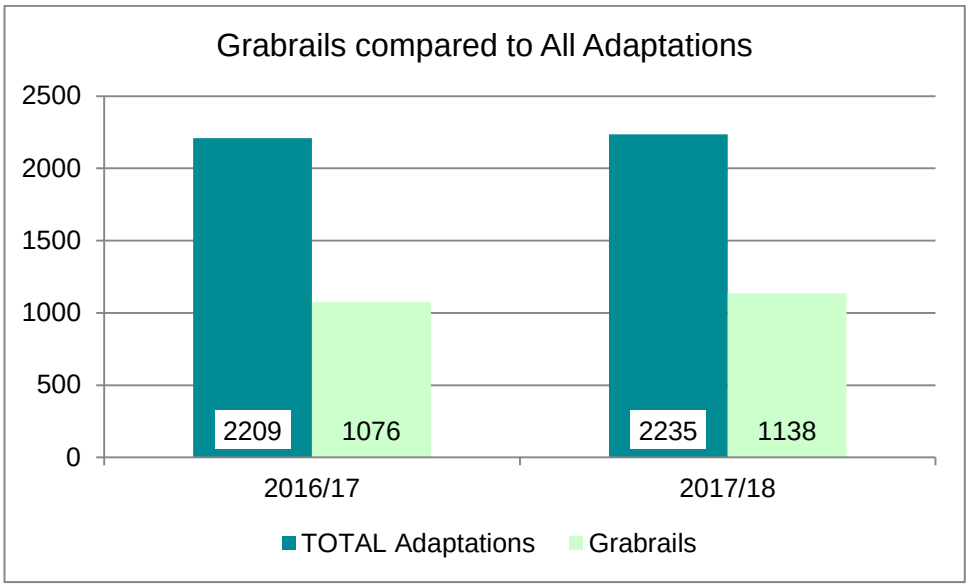
Joint working between the falls physiotherapist and Community Alarm Team has allowed early intervention and potentially reducing the risk of further falls. Since January 2018 all the falls data has been consistently reviewed by the falls physiotherapist to identify those who have not had a recent screening.

We have an action plan which will assist us in continually improving the service and outcomes for those who require this assistance.

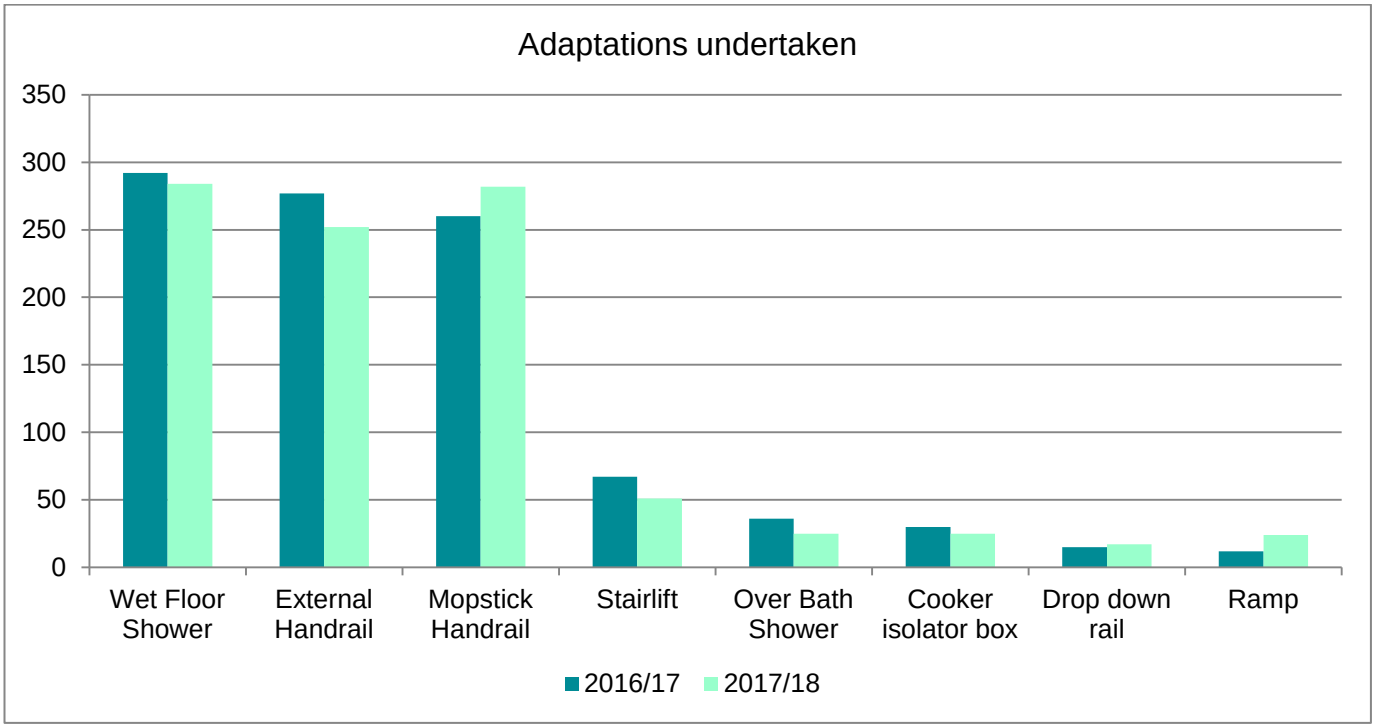
This pathway for falls follows the current evidence of requiring 48 weeks of rehabilitation to optimise changes in strength and balance and reduce future falls. This would be the recommended pathway for all people who have experienced a damaging fall.

A further example of activity aligned to the safety outcome is reflected in the number of housing adaptations we have undertaken.

In 2017/18 we arranged for 2,235 adaptations to assist people to remain independent and safe in their own homes. Of these adaptations just over half (51%) were for grab rails which are a quick and effective solution to help prevent falls and keep people safe whilst living independently as possible.



Excluding grab-rails, the other main types of adaptations carried out are as follows:



Case Study

B is an 89 year old lady referred to Rehabilitation and Enablement Team (RES) by her General Practitioner (GP) with reduced mobility and general frailty. She had a fall in January 2015 sustaining a fractured wrist, was known to have osteoporosis and had commenced treatment just after this.

Her GP felt she had lost her confidence following her fall and that her health was declining. **B** lives alone, has a son she sees occasionally and a niece who assists with shopping. She has carers 2 times daily. In 2012 she had 3 falls.

A falls screening was carried out and changes were made within her home to make it a safer place for **B** to live.

In addition physiotherapy was put in place to help **B** regain confidence with her mobility out-with her home.

B also attended a strength and balance class run by RES team for 12 sessions and showed improvement although she was still a high falls risk. Unfortunately at her review 8 weeks later she had had another fall and again lost some confidence.

She was offered a further 12 weeks of Strength and Balance class which she attended and due to her further improvement and reduced risk allowed her to attend the GG&C Community Falls programme.

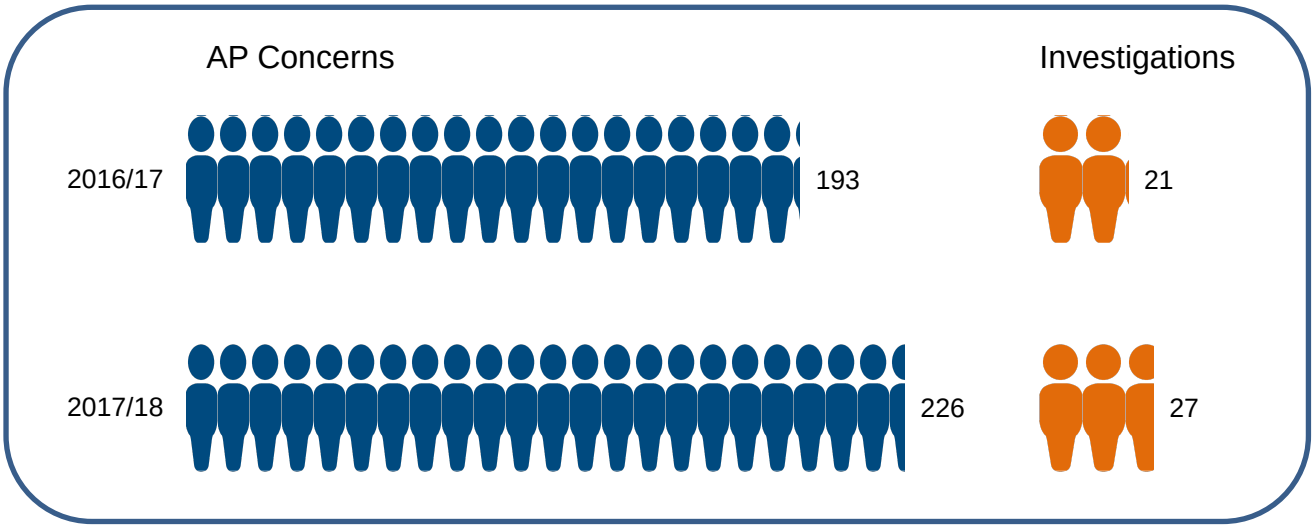
She has had no further falls since the completion of these classes, no admissions to hospital, no further referrals to RES team and her care package has remained the same. She has regained some of her lost confidence and her general health has improved.

Protecting vulnerable adults

Some people with particular vulnerabilities need formalised protection to ensure that they are kept safe from harm.

During 2017/18, 226 Adult Protection concerns were referred to the HSCP (up by 33 from 2016/17).

After an initial review 27 of these concerns - or about 12% - progressed to a full investigation.



In line with the statutory functions of the Adult Protection Committee the on-going priorities are:

- Ensuring the multi-agency workforce has the necessary skills and knowledge. An Adult Support and Protection (ASP) Learning and Development Strategy is being produced to ensure that multi-agency staff have access to appropriate training and learning events that create opportunities to reflect on practice. The content of all training currently being delivered is being audited against the West of Scotland Council Officer Learning and Development Framework. The aim being to identify any gaps and ensure they are addressed by reviewing the content of exiting courses and as required developing new courses to meet these.

- Ensuring the multi-agency workforce has access to relevant procedures, guidance and protocols to meet their responsibilities under the Adult Support and Protection (Scotland) Act 2007. A number of existing procedures, guidance and protocols will be subject to planned review.

- Continued focus on self-evaluation, quality assurance and the impact of activity.

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

Case Study

Mrs A's situation came to light during a Community Care Assessment. She was an older woman with physical disabilities. She was subject to financial/material harm as her money and possessions were being taken by a relative.

There was a police investigation but a criminal case could not be progressed as it was Mrs A's word against her relative. Her memory was at times problematic and the stress of her circumstances was exacerbating this. She was frightened, felt intimidated and even with support did not feel able to take any legal action herself to prevent this relative approaching her.

Concerted efforts by social work to resolve the situation with the relative on a voluntary basis failed. Whilst a lack of evidence for a criminal case, there was sufficient for an application to be made for a 'Banning Order with a power of arrest' which was granted.

Although Mrs A agreed to the order, by the Council making the application this took away some of the stress she was experiencing as she wasn't solely taking action against her relative.

Mrs A felt supported by social work and police.

National Wellbeing Outcome 8

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

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

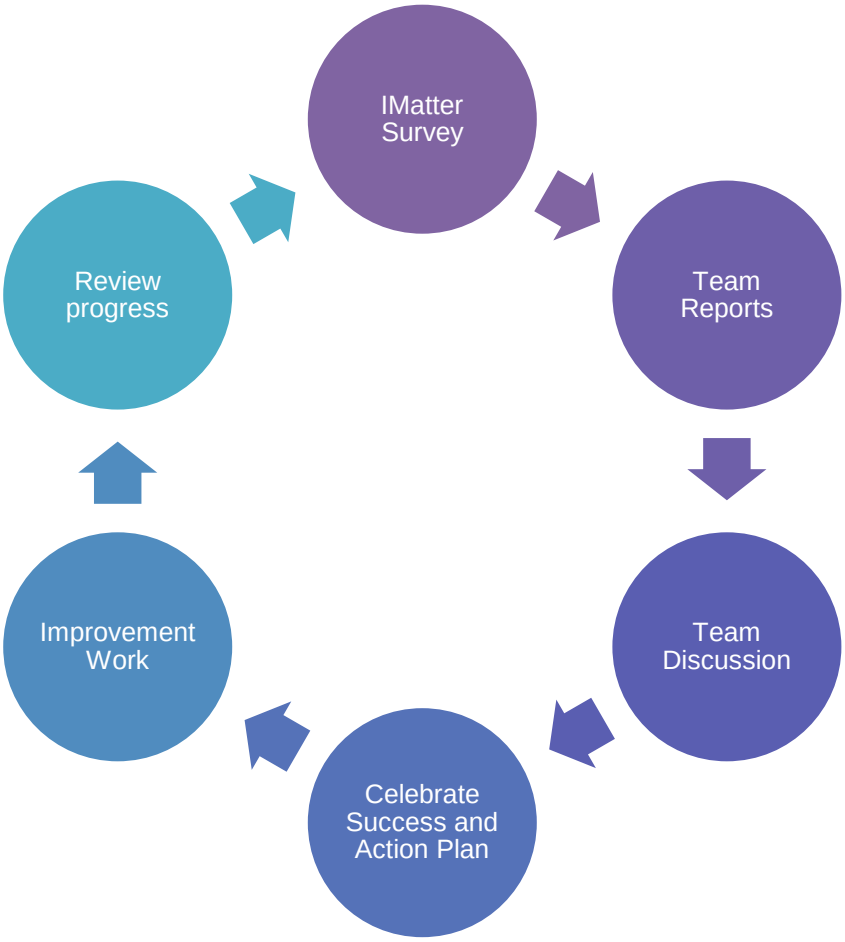
Although the national data is still under development, there are other ways of considering the extent to which our staff experience a sense of job satisfaction.

iMatter

This is the third year that Inverclyde HSCP has taken part in iMatter, an annual national staff engagement survey. The survey is sent out to all employees within the HSCP.

Once the survey is completed this produces a report that each team discusses and jointly agrees what should be celebrated and what areas can be improved upon.

The conversation and action planning is important for supporting improvement.



Why does Staff Engagement Matter?

Research shows that when staff are engaged and involved in their workplace there are many benefits including

- Higher staff morale and motivation
- Increased wellbeing
- Less absenteeism
- Reduced stress
- Better patient or client experience
- Greater efficiency, productivity and effectiveness.

Workforce Planning

Inverclyde HSCP People Plan - A collaborative approach

Inverclyde HSCP's ambitious People Plan has adopted a themed and tiered approach to set out the shape of the overall workforce for the future. This ensures that the right people with the right skills are available to deliver the National Wellbeing Outcomes, improve public health and create new ways of working. The People Plan identifies a four tiered workforce which includes people groups and organisations, carers, families, localities and communities who directly provide or in other ways contribute to the delivery of health and social care. It sets out our key challenges, drivers for change, including service redesign, new ways of working and emerging models of organising future service delivery in line with our five strategic commissioning themes and the ongoing transformation of public services. The People Plan involved a fully collaborative process. It was approved by the Integration Joint Board in June 2017. Implementing the People Plan will take account of all providers, including our unpaid carers.

People Plan action plan

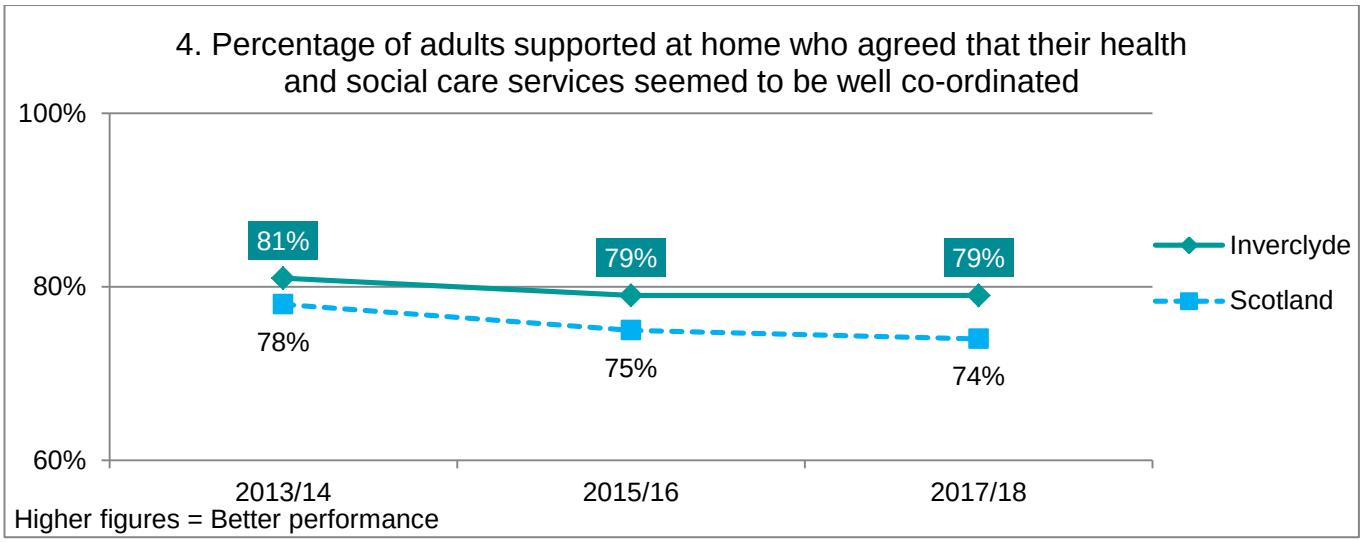
The people plan action plan is designed to fulfil the ambitious aspirations of the Inverclyde People Plan. It is a workforce centred workforce plan, approved by the Integration Joint Board in March 2018. The action plan draws on the information and data from the People Plan narrative and seeks to identify and address the gaps in knowledge and data. It is intended to work as a dynamic, evolving and adaptable plan which takes account of the collective intentions and aspirations of the people plan and addresses the key challenges such as the aging workforce, depopulation of working age people and the ongoing financial constraints. The Strategic Planning Group will monitor the progress of the People Plan Action Plan and will receive regular reports from a representative core group. Regular reports will be made to the Staff Partnership Forum.

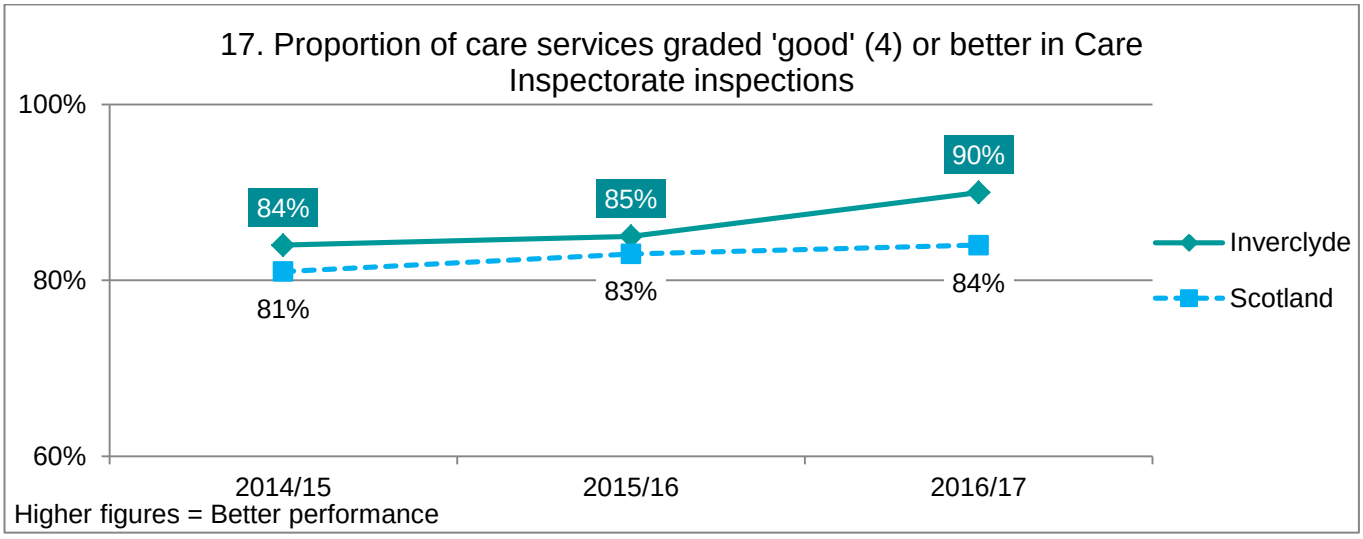
The People Plan Action Plan is aligned to the National Health and Social Care workforce plans Parts 1 and 2 (June 2017 and March 2018 respectively), and it is structured around the 8 workforce planning themes in the Scottish Social Services Council (SSSC) Workforce planning resource which accompanies Part 2.

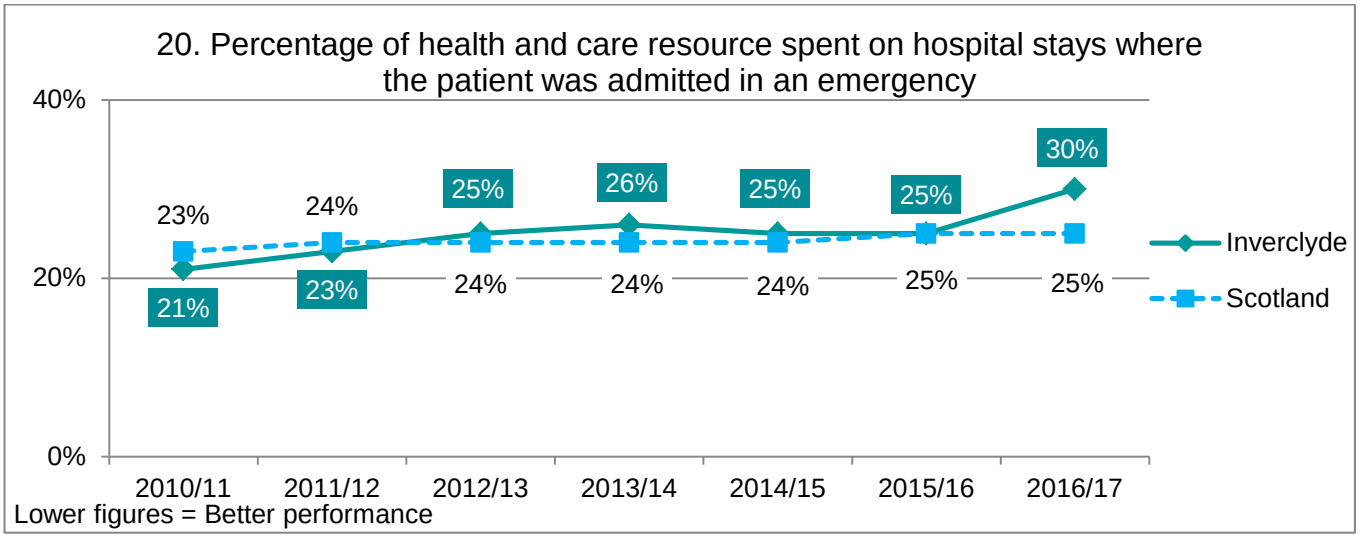
National Wellbeing Outcome 9

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

National Indicator		Inverclyde HSCP	Scottish Average	Comparison
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79%	74%	
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	90%	84%	
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	30%	25%	
23	Expenditure on end of life care, cost in last 6 months per death	Indicator under development (ISD)		



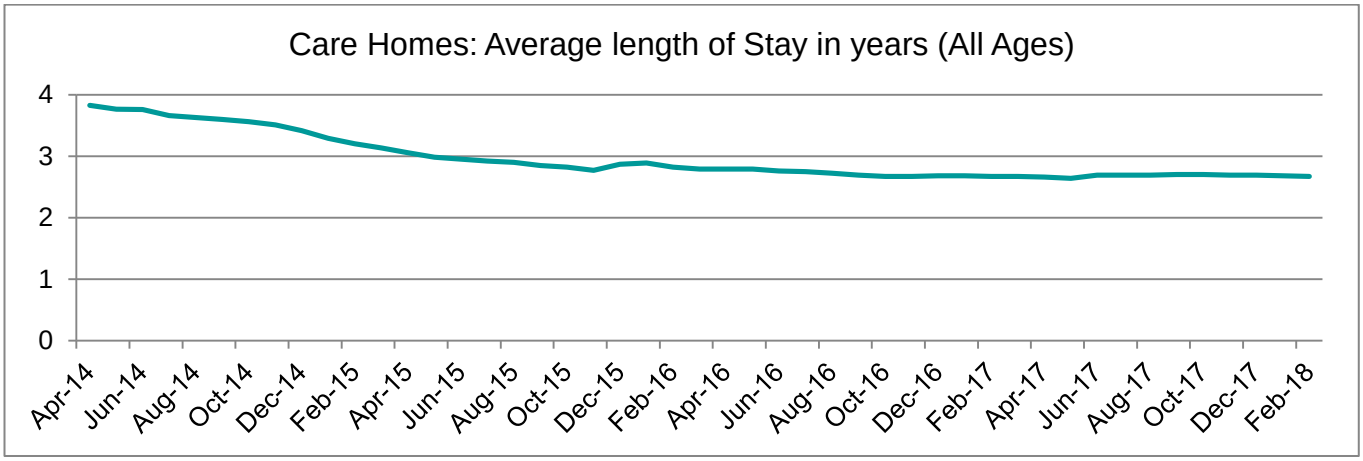


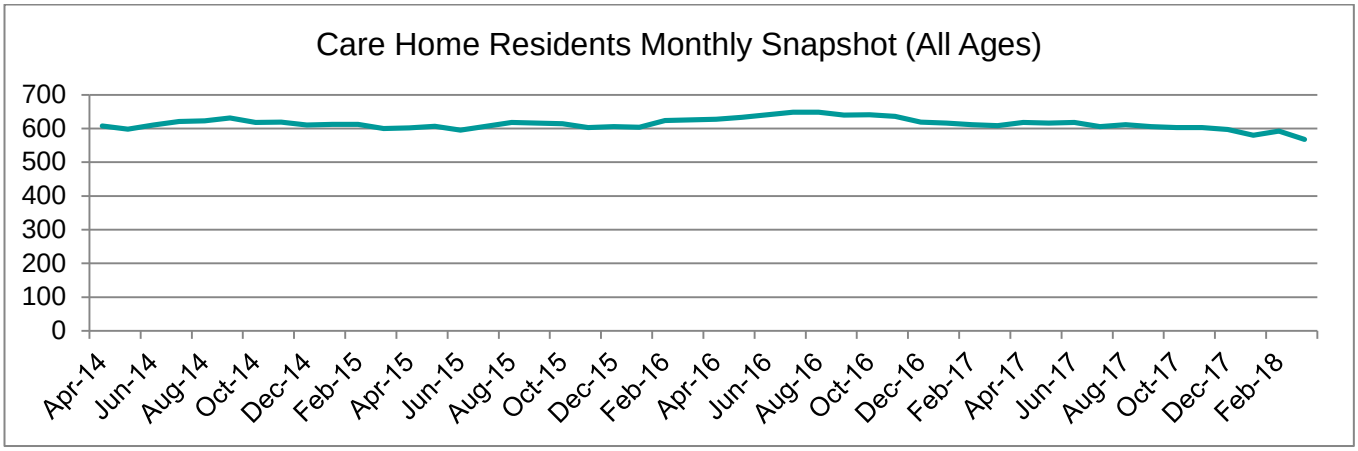


We are concerned about the percentage of spend on unplanned hospital care being higher than the Scottish average, and also that this indicator appears to be showing an increasing trend. Local investigation has identified that hospital care in Inverclyde is not more expensive than in other areas, but rather, the proportion of unplanned hospital admission is much higher here than elsewhere. In response to our high rates of unplanned admission, we launched the "Choose the Right Service" campaign. That programme encourages people to see the appropriate professional at the right time in their illness, rather than waiting until they become seriously ill and need to be admitted to hospital. We are also undertaking a study of the reasons why people attend hospital in an unplanned way. The study aims to identify more appropriate routes into more appropriate services, and builds on clear evidence that if care is provided early in the course of need, less care will be required and the person will generally have a better outcome (cited in, for example, the Christie Commission on the Future Delivery of Public Services, 2011). On that basis, unplanned hospital admissions should be avoided whenever possible.

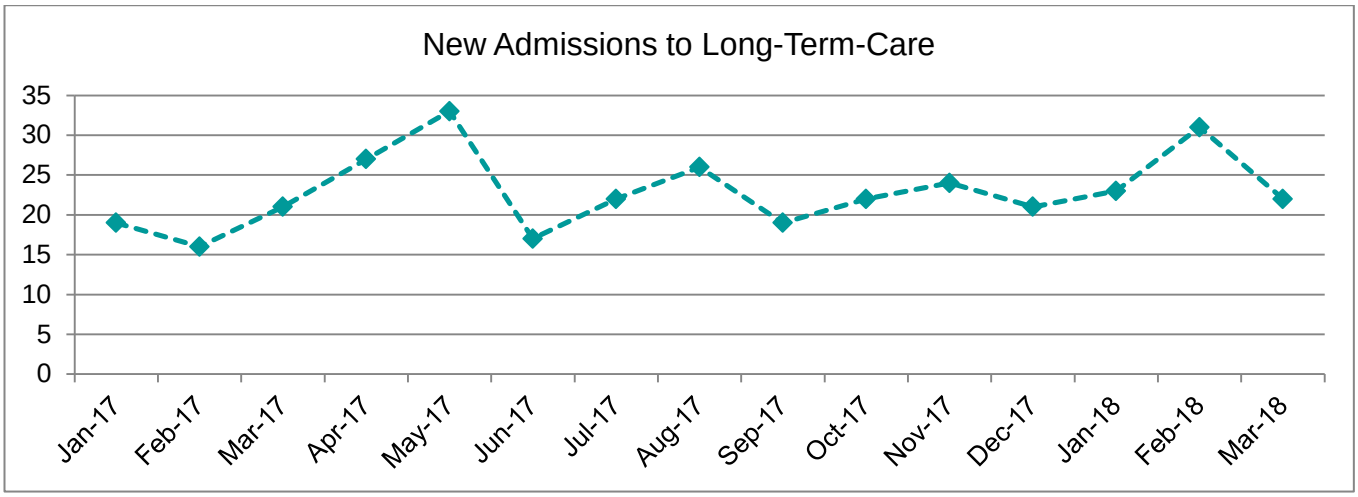
Effective and Efficient use of Resources

In Inverclyde, people tell us that they would wish to retain their independence, in their own homes for as long as possible. However, some people will require an admission to a care home.





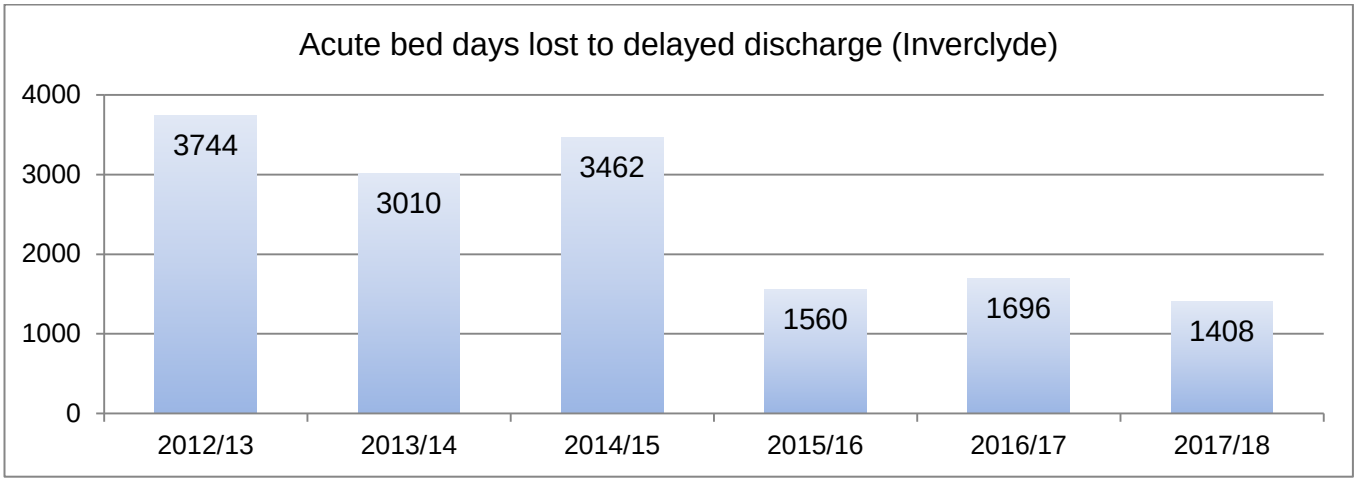
We continue to see on-going and sustained improvements in the average length of stay in care homes reflecting the positive impact of community based services, improved assessment processes and admission to care homes largely being for end of life care. In 2013/14, on average, people who entered a care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



Inverclyde HSCP started the financial year (2017/18) recording a level of bed days lost to delayed discharges that was comparable with other Partnerships in Scotland. The number of bed days lost for all ages for April 2017 beginning of the reporting period was 314 days.

HSCP staff and services have continued to apply the Inverclyde Home1st Plan resulting in a marked reduction in bed days lost month on month, with lows for all ages recorded in November 2017 with 55 days lost, and 33 days lost for those aged 65 and over in October 2017; a significant reduction from 314 days lost in April 2017.

As can be seen from the chart below, the number of bed days lost has reduced for the period from 01/04/2017 to 31/03/2018. The winter months and the high level of winter respiratory illness during February and March 2018 had a minimal impact on the ability to discharge patients in a timely manner. The HSCP still managed to maintain bed days lost relatively low despite the problems faced by staff and service users during this challenging period.



Quality of Care

Ensuring that resources are used effectively and efficiently is not just about getting the best price when commissioning from providers. The quality of what we commission is vitally important, to ensure the best possible outcomes for those receiving the services.

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 shaping and 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, to deliver better outcomes.

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 will therefore help to lead to greater choice and control. Additionally, it will help individuals become proactive in shaping not only their own support and enabling 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

Section 5: Health and Care Experience Survey

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

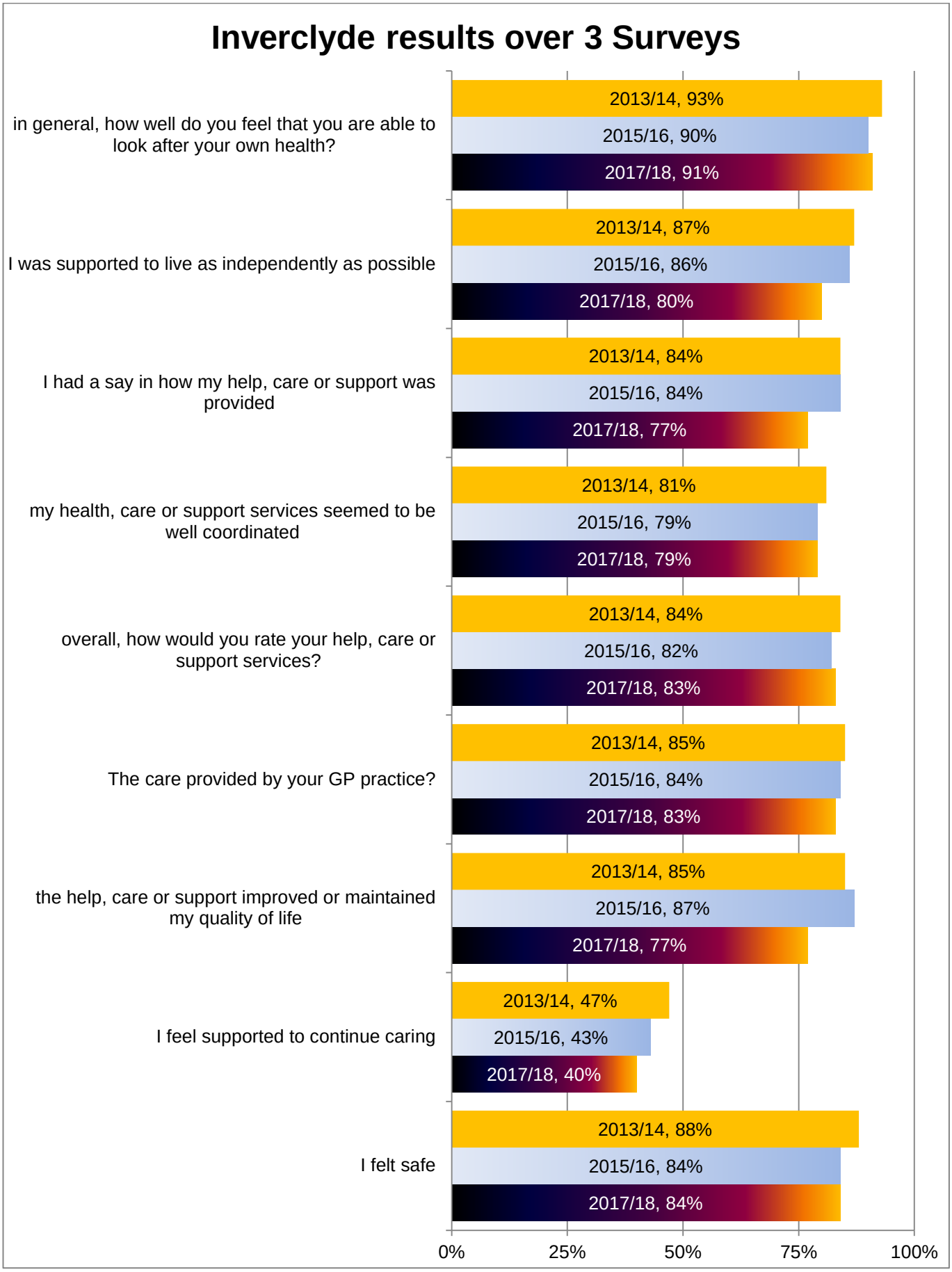
There have been some changes to the way the data from the survey has been 'weighted' so that the results have a better comparison across Scotland. These changes have been applied to the 3 periods presented in this report.

The following table and chart reflect our performance for the last 3 surveys conducted during 2013/14, 2015/16 and 2017/18.

		% Positive 2013/14	% Positive 2015/16	% Positive 2017/18	Comparison to the Scotland average (2017/18)	
1	in general, how well do you feel that you are able to look after your own health?	93%	90%	91%	-2%	
2	I was supported to live as independently as possible	87%	86%	80%	-1%	
3	I had a say in how my help, care or support was provided	84%	84%	77%	1%	
4	my health, care or support services seemed to be well coordinated	81%	79%	79%	5%	
5	overall, how would you rate your help, care or support services?	84%	82%	83%	3%	
6	The care provided by your GP practice?	85%	84%	83%	0%	
7	the help, care or support improved or maintained my quality of life	85%	87%	77%	-3%	
8	I feel supported to continue caring	47%	43%	40%	3%	
9	I felt safe	88%	84%	84%	1%	

In 2017/18 we performed at or better than the Scottish average in 6 of the 9 indicators and in the remaining 3 we were only slightly below the average.

Nationally there has been a downward trend in the results of the survey and we have also experienced this locally.


Inverclyde results over 3 Surveys
in general, how well do you feel that you are able to look after your own health?
2013/14, 93%
2015/16, 90%
2017/18, 91%
I was supported to live as independently as possible
2013/14, 87%
2015/16, 86%
2017/18, 80%
I had a say in how my help, care or support was provided
2013/14, 84%
2015/16, 84%
2017/18, 77%
my health, care or support services seemed to be well coordinated
2013/14, 81%
2015/16, 79%
2017/18, 79%
overall, how would you rate your help, care or support services?
2013/14, 84%
2015/16, 82%
2017/18, 83%
The care provided by your GP practice?
2013/14, 85%
2015/16, 84%
2017/18, 83%
the help, care or support improved or maintained my quality of life
2013/14, 85%
2015/16, 87%
2017/18, 77%
I feel supported to continue caring
2013/14, 47%
2015/16, 43%
2017/18, 40%
I felt safe
2013/14, 88%
2015/16, 84%
2017/18, 84%
0%
25%
50%
75%
100%

Now that the Health and Care Experience Survey is fully established, we will be using the information from it as the basis for some of the discussions with communities as we shape the locality dimensions of our next Strategic Plan (2019-22). The surveys, when viewed over time, help to provide a useful picture of how people perceive the health and care that is available to them. We want to use this information to support meaningful conversations about what people want to see in the future, and where they think there are gaps. We recognise that not all gaps will be able to be addressed by the HSCP, however our work with the Inverclyde Alliance will help us to achieve more comprehensive linkage with our key partners, and influence their strategic direction on behalf of local people.

Section 6: Children's Services and Criminal Justice

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

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

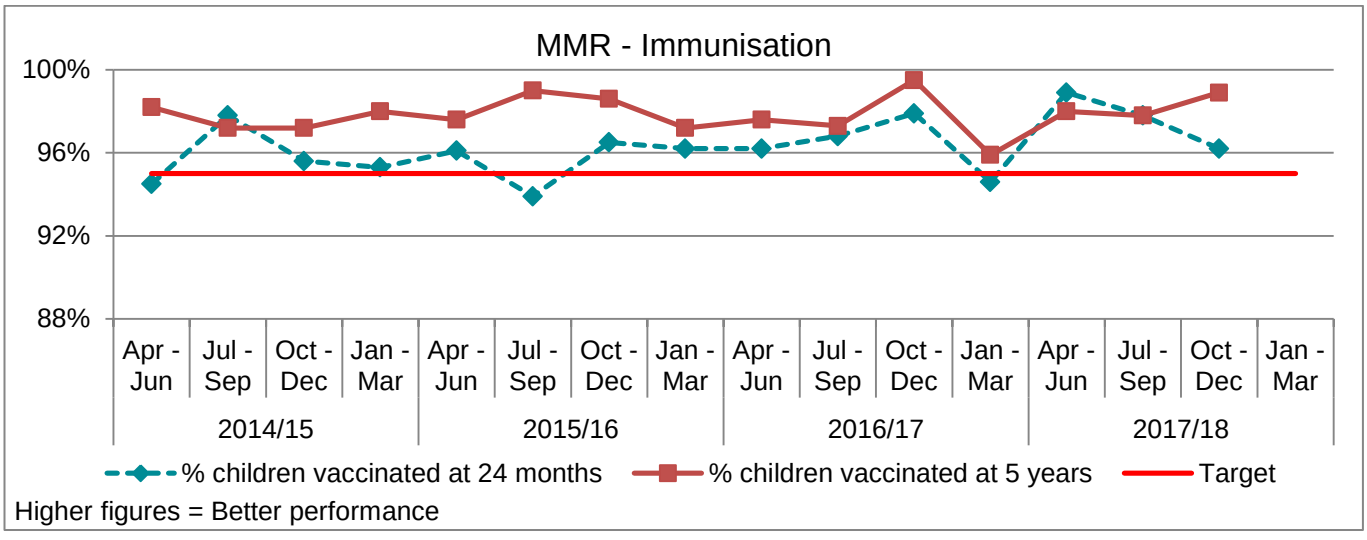
That is the view in a new inspection report from the Care Inspectorate where involvement of young people received a rare *'excellent'* rating.

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

Children in Inverclyde receive the best start in life.

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

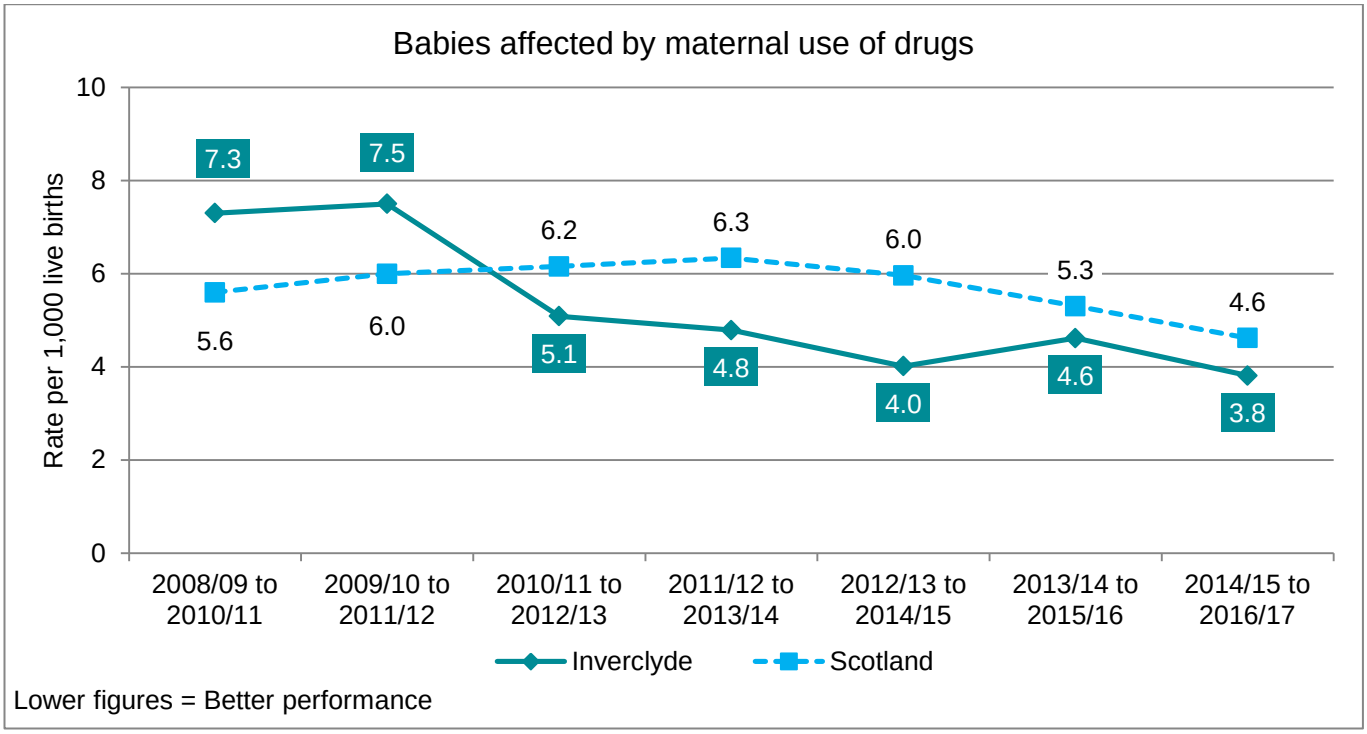
In respect of Measles, Mumps and Rubella immunisations (MMR), at age 5 we are consistently above target. For MMR at 24 months, we have largely exceeded the target of 95%.



Babies affected by maternal use of drugs

The health of a woman is an important factor in pregnancy, as we know from evidence that in general, healthy women have healthy babies. Inevitably, babies will be affected if their mothers are using drugs, and this could lead to poorer outcomes for the child. We work closely with mothers in this category and both rate and absolute numbers have been on a downward trend in Inverclyde since 2008/09.

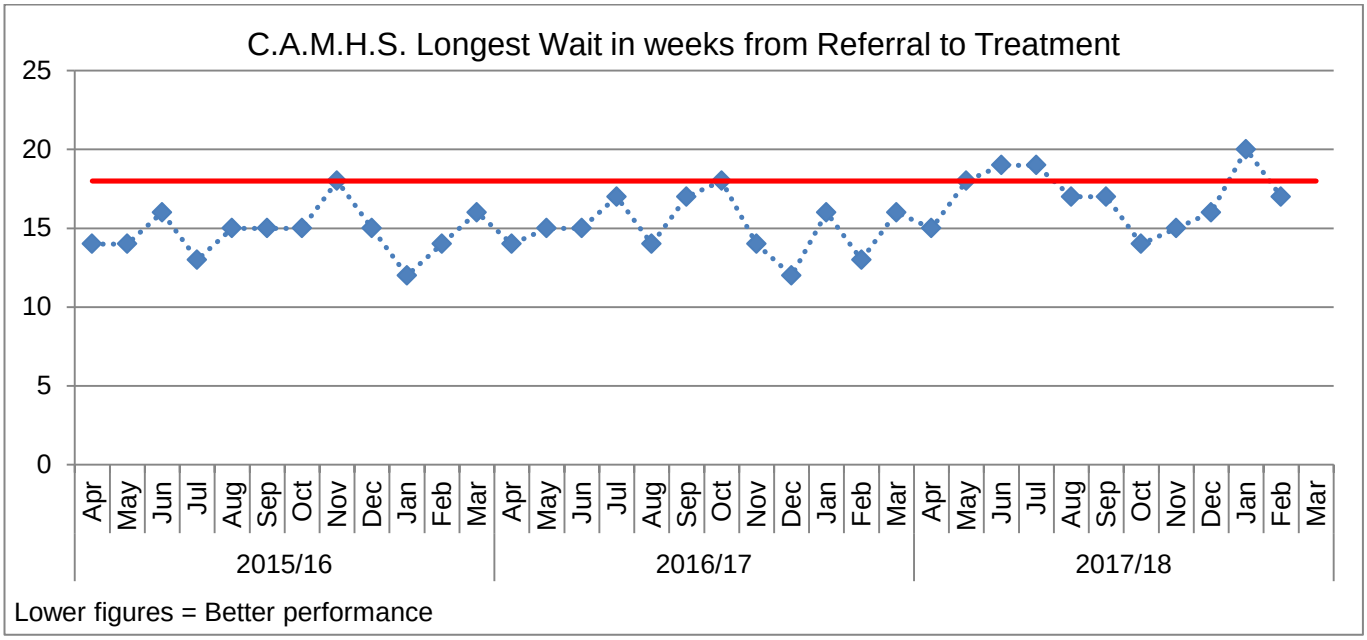
Comparing Inverclyde with Scotland as a whole, Inverclyde now has a considerably lower rate of babies affected by maternal drug misuse than Scotland.



Lower figures = Better performance

Child and Adolescent Mental Health Services (CAMHS)

The target of 90% of young people referred to child and adolescent mental health to have begun their treatment within 18 weeks of referral has regularly been exceeded since the beginning of 2015. However we are currently reviewing this service, recognising that it is a small service with a small staffing complement. This means that if there are gaps in staffing, the service might not be able to deliver to the current levels of performance. To avoid a drop in performance we will aim to anticipate the most effective changes to the operating model.


C.A.M.H.S. Longest Wait in weeks from Referral to Treatment
25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2015/16
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2016/17
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2017/18
Lower figures = Better performance


GETTING IT RIGHT FOR EVERY CHILD, CITIZEN AND COMMUNITY
Included
Safe
Healthy
Achieving
Nurtured
Active
Respected
Responsible
Nurturing Inverclyde

Criminal Justice

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

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

Unpaid Work Requirements provide an opportunity for individuals to pay back to their community through participation in work placements organised by Criminal Justice Social Work Services. This can be particularly challenging for those individuals with little or no work experience and/or poor physical or mental health, but does provide a way for such offenders to start to develop appropriate skills and experience.

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

Some individuals will get more than 1 CPO, but not every CPO includes a requirement for unpaid work.

The graphics below show some Community Payback Order statistics over the last 4 years.

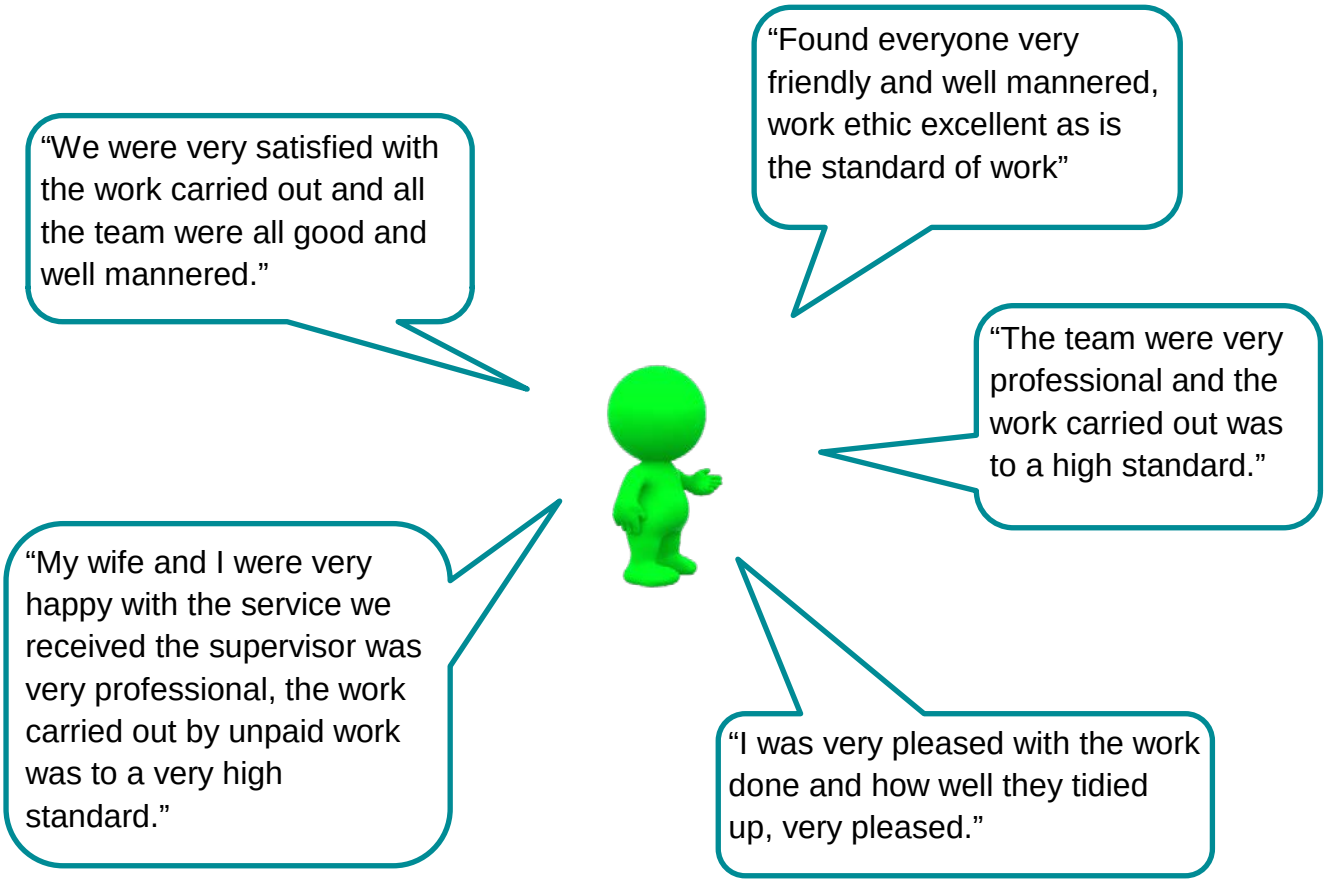
The Unpaid Work Service plans activity for the benefit of individuals, organisations and public areas within Inverclyde. A variety of tasks are undertaken including gardening, painting, joinery and grounds work.

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

Some examples of how much work is ‘paid back’ into the community are shown in the graphics below.

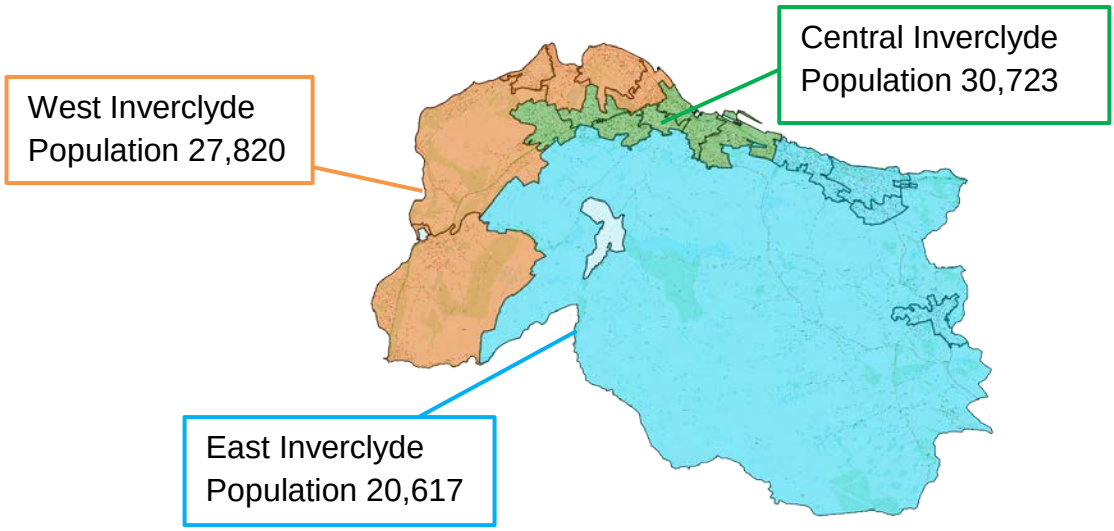
	Number of hours of gardening	Number of hours of painting	Number of hours of ground work	Number of hours of joinery
2015/16	**5,544**	**7,311**		**1,907**
2016/17	**3,804**	**4,161**	**624**	**1,066**
2017/18	**5,478**	**7,125**	**4,803**	**1,235**

Some comments from those who received this Service:



Section 7: Locality Planning

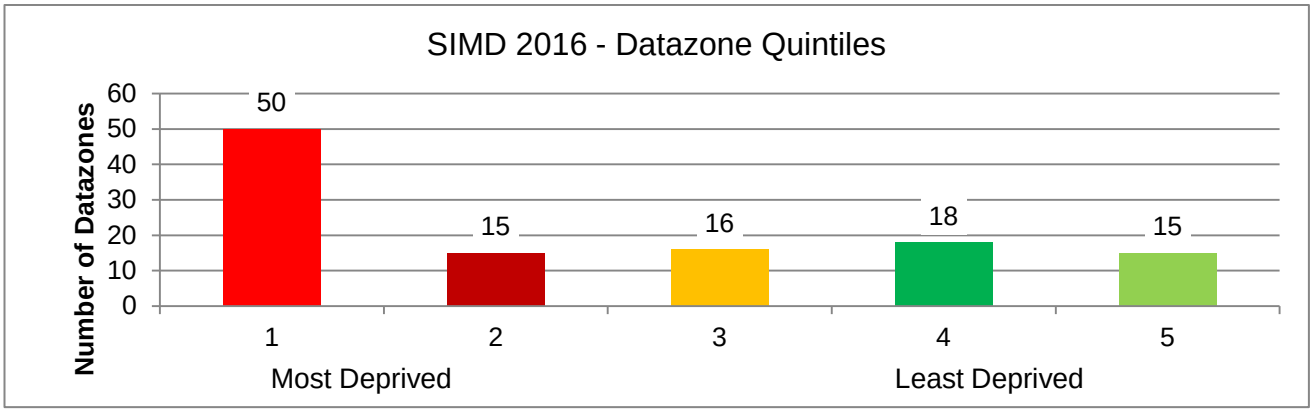
Our locality planning arrangements have been shaped to reflect the strong tradition of partnership working in Inverclyde. The three localities described below cover the entire population of Inverclyde, however we have worked closely with the full range of partners (communities; staff; Council; Voluntary Sector; Commercial Sector; Carers, GP Practices etc.), to ensure that we defined localities that covered the whole population in a way that made sense for those within the localities, while achieving maximum alignment with the Inverclyde Alliance localities.



Population figures have been taken from the National Records for Scotland (NRS) Small Area Population Estimates (SAPE) for Mid-2016. This gives a total population of 79,160.

The HSCP, as a key Community Planning Partner, has aligned its locality planning to the Inverclyde Alliance Local Outcomes Improvement Plan (LOIP). The HSCP is recognised as a key vehicle through which community planning partners can maintain a clear line of sight to the most vulnerable and the most excluded citizens in our community.

The Scottish Index of Multiple Deprivation (SIMD) is a tool for identifying areas of poverty and inequality across Scotland and can help organisations invest in those areas that need it most.



The SIMD identifies concentrations of multiple deprivations across all of Scotland in a consistent way. The SIMD ranks small areas (data zones) from most deprived to least deprived. Inverclyde HSCP has 114 data zones, 50 of which are in the 20% most deprived areas in Scotland. ‘Deprived’ does not just mean ‘poor’ or ‘low income’. It can also mean that people have fewer resources and opportunities. The 2016 SIMD rankings combine 38 indicators across 7 domains, namely: income, employment, education, health, access to services, crime and housing.

With the backdrop of this information we are progressing collaborative working with other agencies and services. For example, Inverclyde HSCP has a long standing, well established relationship with the primary care contractors (GPs) throughout the locality.

General Practice in Inverclyde is made up of fourteen Practices covering Kilmacolm, Port Glasgow, Greenock, Gourock and their surrounding areas. The fourteen practices cover a population of 81,354 patients, including people from outside Inverclyde, for example Argyll and Bute. Whilst the overall practice population has been falling since 2010 (down 4.5%) the number of patients on the lists who are over the age of 65 has steadily increased. In 2010, 17% of the practice lists were aged 65 and above but by 2017 this had increased to 20%.

In recognition of the further integration of health and social care, we are creating a three year Primary Care Improvement Plan 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 (e.g. Advanced Nurse Practitioners, Specialist Paramedics) to work alongside and support GPs and practice staff to reduce GP practice workload and improve patient care.

Some initial results from the pilot for this new approach are noted in the next section.

Section 8: Innovation

Inverclyde has a strong reputation for innovation, based on good relationships between the relevant partners. The HSCP has always regarded its staff as its greatest asset, and the innovations below reflect a positive, 'can–do' attitude that characterises our workforce.

New Ways

In recent years we have been at the forefront of initiatives such as 'New Ways of Working' – an approach to testing the effectiveness of different working practises before fully committing to them. Our New Ways Journey event took place on 1st November 2017 to celebrate the success and learning from New Ways. The point of New Ways is to help our citizens to be able to access the right professional at the right time, rather than always defaulting to the GP. Our work in Inverclyde has informed the new Scottish GP Contract, so sits at the heart of re-shaping health and social care to deliver better outcomes.

Care About Physical Activity (CAPA)

We have also been a test site for the CAPA programme, commissioned by the Scottish Government to build on the skills, knowledge and confidence of social care staff to enable those they care for to increase their levels of physical activity and move more often. The programme runs until October 2018, and we anticipate that it will be able to demonstrate improved outcomes.

The programme includes:

- Working with care homes for older people to embed the use of CAPA
- Working with care at home, housing support and other support services for older people to equip staff to promote physical activity and scope out what specific resources they may require to be developed
- Developing and testing a module on physical activity to embed into health and social care curriculum
- A national event in September 2018 to share good practice widely and to celebrate success.

Technology Enabled Care (TEC)

Inverclyde HSCP is a test site for TEC, which is aiming to develop new ways of working to combine the human expertise of Allied Health Professionals (such as Occupational Therapists and Physiotherapists) with advances in technical and digital equipment. This work is at a very early stage, but will be explored further, and an update will be provided in our next Annual Performance Report.

Service Redesign

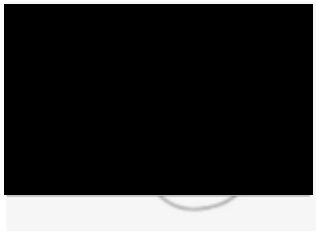
We are currently undertaking some significant redesign work, recognising that in order to secure continuous improvement, we need to regularly check that what we are doing still reflects the best way of working, and best value for public money. Over the next few years we will be implementing the outputs from our redesign work, specifically in Learning Disability Services; Addictions, and Homelessness. The redesign work will be overseen by the Transformation Board, and we will support Providers to adapt to change through the implementation of our Market Facilitation & Commissioning Plan.

Chief Officer's concluding remarks

This is the second HSCP published Annual Performance Report showcasing our progress in delivering the National Wellbeing Outcomes. It has been an exciting year within Inverclyde with the conclusion of the positive joint Children Service inspections and ongoing positive Care Inspectorate inspections across all registered services.

The focus on outcomes has given us an opportunity to think differently about how we deliver services. We are at the beginning of this journey with our Market Facilitation Plan which is a good example of how we intend to work now and in the future. Throughout this report we reinforce the need to focus on outcomes and with this in mind, we have tried to use a format that is easy to read and visibly shows how and where we are indeed making a difference and ultimately improving the lives of the citizens of Inverclyde. The case studies are real life examples of how we are achieving our vision.

It has been a year of significant success however, Inverclyde is ambitious. As we strive for excellence, it is important we continue to learn and improve. We are lucky, our staff and communities in Inverclyde care deeply about health and social care services and we have a responsibility to deliver high quality service that make a difference to people lives.



Louise Long
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Appendix: Glossary of abbreviations

A&E	Accident and Emergency department
ADL	Aids for Daily Living
AP	Adult Protection
ANP	Advanced Nurse Practitioner
ASP	Adult Support and Protection
CAMHS	Child and Adolescent Mental Health Services
COPD	Chronic Obstructive Pulmonary Disease
CMHT	Community Mental Health Team
CPO	Community Payback Orders
DWP	Department of Work and Pensions
EEA	European Economic Area
GG&C	Greater Glasgow and Clyde Health Board
GP	General Practitioner
HSCP	Health and Social Care Partnership
ISD	Information Services Division (NHS)
LOIP	Local Outcomes Improvement Plan
MAPPA	Multi Agency Public Protection Arrangements
MMR	Measles, Mumps and Rubella
MSK	Musculoskeletal
NHS	National Health Service
NODA	No One Dies Alone
NRS	National Records for Scotland
OT	Occupational Therapist
OTA	Occupational Therapist Assistant
PCMHT	Primary Care Mental Health Team
PDRU	Physical Disability Resource Unit
RES	Rehabilitation and Enablement Service
SAPE	Small Area Population Estimates
SIMD	Scottish Index of Multiple Deprivation
SSSC	Scottish Social Services Council
TEC	Technology Enabled Care

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

Arabic

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

Cantonese

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Gaelic

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

Hindi

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

Mandarin

本文件也可应要求，制作成其它语文或特大字体版本，也可制作成录音带。

Polish

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

Punjabi

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

Urdu

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

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