AGENDA ITEM NO: 8

Report To:	**Inverclyde Integration Joint Board**	**Date: 24 June 2019**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/41/2019/HW**
Contact Officer:	**Helen Watson Head of Service Strategy and Support Services**	**Contact No: 01475 715285**
Subject:	**ANNUAL PERFORMANCE REPORT 2018-2019**	

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 1st April 2018 to 31st March 2019.

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 third Annual Performance Report. Members are also requested to acknowledge the improvements achieved during the third year of the Partnership and the further foundations that have been established and continue to drive forward transformational change.

Louise Long
Chief Officer

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 second report and based on positive feedback received, our third 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

5.1

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

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

5.2 There are no legal implications from this report

HUMAN RESOURCES

5.3 There are no HR implications from this report

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

	YES	
X	NO	This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required

5.4.1 The intelligence contained in this report reflects on the performance of the HSCP

against the equality outcomes.

5.4.2 How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance implications arising from this report.

5.6 **NATIONAL WELLBEING OUTCOMES**

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

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
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	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None
Health and social care services contribute to reducing health inequalities.	None
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.	None
People using health and social care services are safe from harm.	None

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.	None
Resources are used effectively in the provision of health and social care services.	None

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 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.

8.0 LIST OF BACKGROUND PAPERS

8.1 Inverclyde HSCP's Annual Performance Report 2017-18.

APPENDIX

INVERCLYDE HSCP
Health and Social Care Partnership

Inverclyde Health and Social Care Partnership

Annual Performance Report 2018-19

Welcome by Louise Long - Chief Officer Inverclyde HSCP

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

It has been an exciting year with much to celebrate. The annual performance report tries to give a picture of some the activity, the performances against local and national targets to give the public an understanding of how we are performing, the areas where we need to improve and areas we are doing well in.

This report will focus predominantly on Inverclyde HSCP's performance for the period to March 2019, specifically measuring our performance and progress against the twenty three National Integration Indicators and the nine National Health and 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 six Big Actions:

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

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

Inverclyde has dedicated and commitment of our staff, communities and partners working together to achieve the best outcomes for the people of Inverclyde.

[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.

The Strategic Plan outlines our ambitions and reflects the many conversations we have with the people across Inverclyde, our professional colleagues, staff, those who use our services including carers and our children and young people across all sectors and services.

We fully support the national ambition of ensuring that people get the right care, at the right time, in the right place and from the right service or professional. We strongly believe that integration will offer many different opportunities to reflect on our achievements and what we can improve on to benefit the local people and communities of Inverclyde.

Inverclyde HSCP is built on our established integration arrangements and our vision, values and 6 Big Actions have been shaped through a wide range of mechanisms of engagement, to reach as many local people, staff and carers as possible. We have also undertaken targeted engagement with the Children and Young People of Inverclyde to ensure that their voices are heard. The vision is:

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

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

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

Big Action 3 - Together we will Protect Our Population

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

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

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

Structure of the Report

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

To support the nine national Wellbeing Outcomes, there are 23 National Integration Indicators against which the performance of all HSCPs in Scotland is 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 and can be found at page 67 of this report.

The 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.

The most recent data available for the National Integration Indicators at the time of producing this report is for the financial year 1st April 2017 to 31st March 2018.

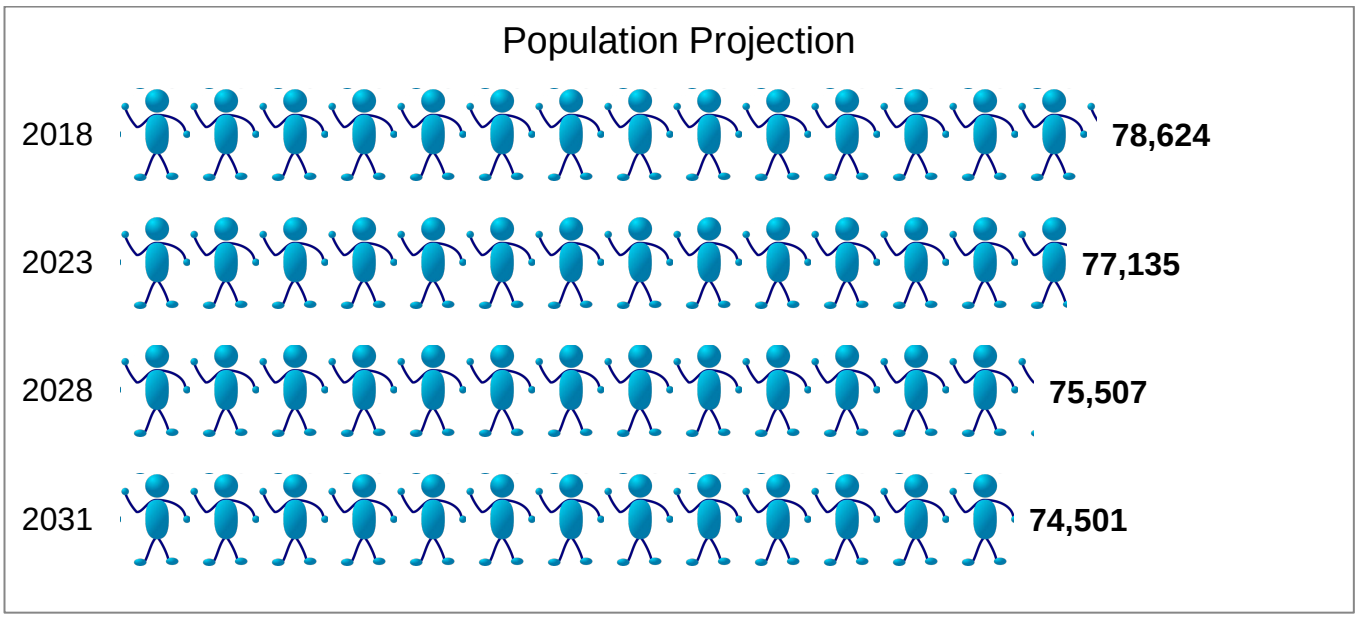
The images for comparing performance in relation to the Scottish average are as follows:

↑ ↓	Performance is equal or better than the Scottish average	Trend is improving (moving in the right direction)
↑ ↓	Performance is close to the Scottish average	Trend is static – no significant change
↑ ↓	Performance is below the Scottish average	Trend is declining (moving in the wrong direction)

The Inverclyde Context

The latest estimated population of Inverclyde was taken from the mid-year population estimates published by the National Records of Scotland (NRS) on 25 April 2019. This gives us a total population of 78,150 as at the end of June 2018.

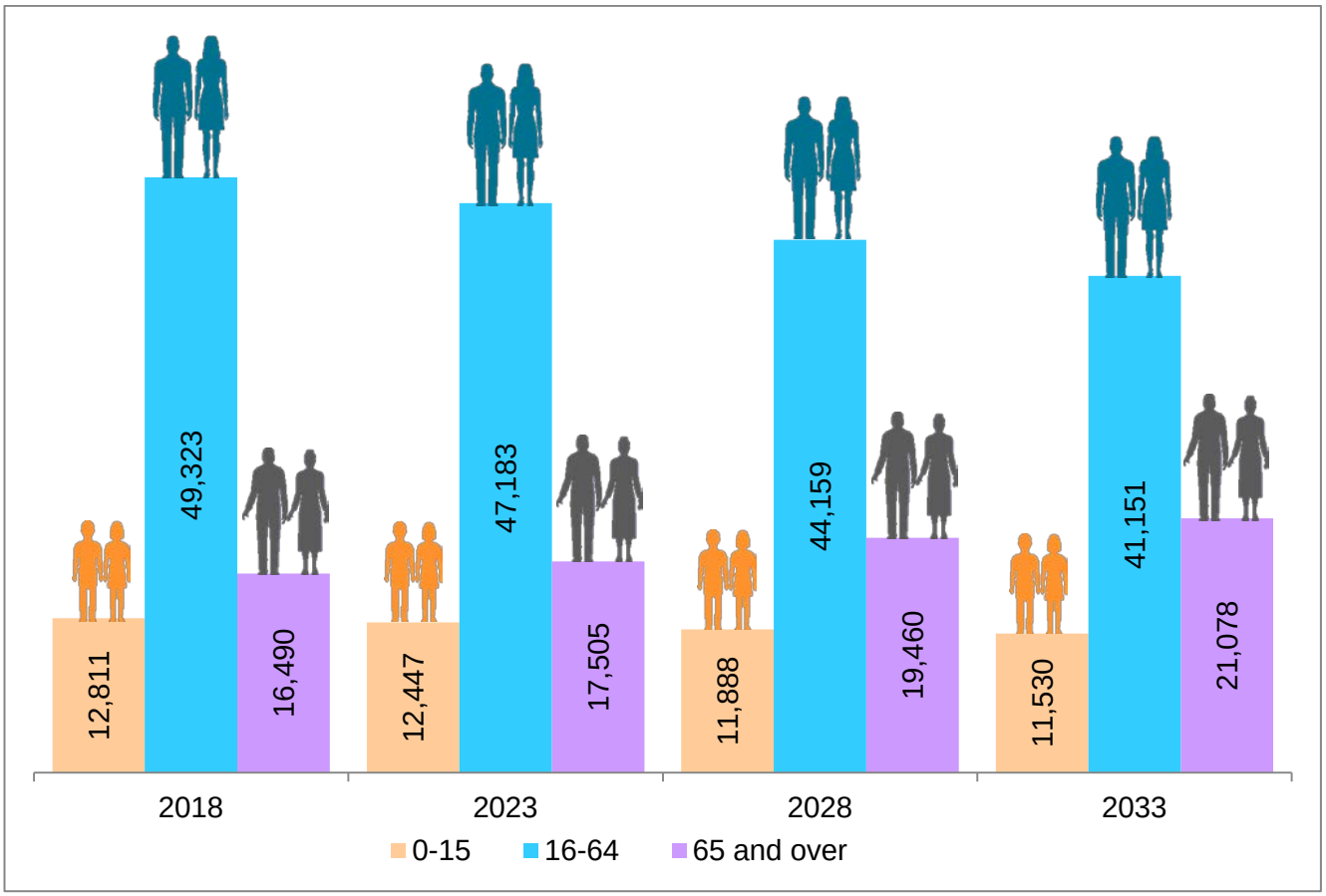
Using the most recent published data available that can be used for population projections (Population Projections for Scottish Areas 2016-based), published by NRS on 28 March 2018, our population is expected to decline as is shown with the graphic below. As these estimates are based upon 2016 population base data the figure for 2018 shown here differs from the mid-year estimates just recently published.



Population projections have limitations. A projection is a calculation showing what happens if particular assumptions are made. These population projections are trend-based and as the process of change is cumulative, the reliability of projections decreases over time. The projected figures do not take into account the work locally to reverse our depopulation.

Our population size is mainly affected in 2 specific areas. From mid-2017 to mid-2018 there were 1,080 deaths in Inverclyde compared to 662 births during this period, resulting in natural change of -418. Outmigration was again higher than in-migration, with an estimated 1,470 people moving into the area and 1,650 leaving, resulting in net migration of -180.

The profile of our population is also changing significantly. As is demonstrated in the graphic below our working age population will reduce whilst the numbers of people over 65 will increase.



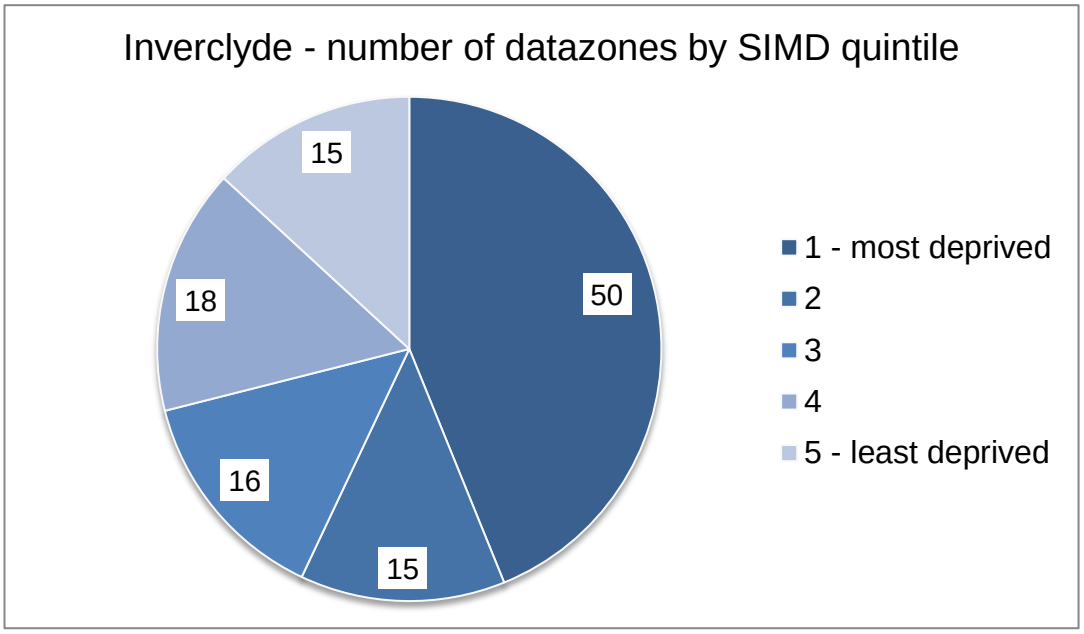
Deprivation

The Scottish Index of Multiple Deprivation (SIMD 2016) is a tool for identifying areas of poverty and inequality across Scotland and can help organisations invest in those areas that need it most.

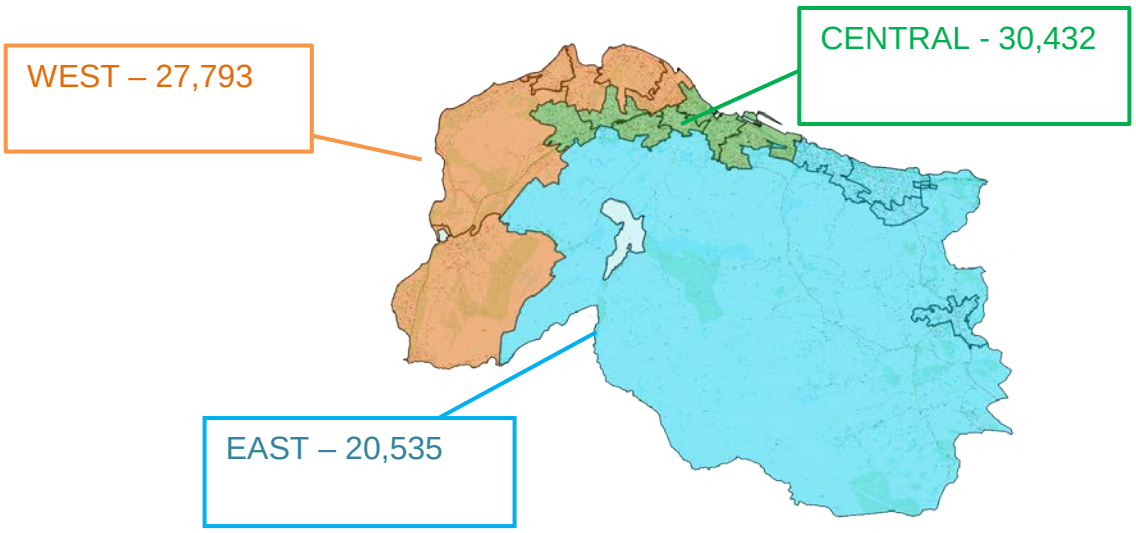
Areas of poverty and inequality across Scotland are measured by a number of different indicators to help organisations such as health boards, local authorities and community groups to identify need in the areas that require it the most. These are routinely published as part of the

Scottish Index of Multiple Deprivation (SIMD).The SIMD ranks small areas called 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 majority of the areas of high deprivation in Inverclyde are in the Central locality, covering Greenock Town Centre.



Locality Planning



In order to obtain the population of the 3 localities we have to use the Small Area Population Estimates (SAPE) published by NRS (National Records for Scotland). The latest available figures for this were published on 23rd August 2018 and are based as at June 2017.

At June 2017 our estimated population was 78,760 which can then be sub-divided into our 3 localities as shown above.

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.

Communication & Engagement

Your Voice - Inverclyde Community Care Forum (ICCF), is commissioned by Inverclyde HSCP to help support involvement, engagement and formal consultation with local communities. Your Voice enables the voice of people who use services, their carers and families to positively and proactively contribute to the planning and provision of health and community care services in Inverclyde. This is only one mechanism to enable people to share their views and contribute to service planning but as Your Voice includes a range of voluntary and community groups, the organisation supports the HSCP by reaching out to a significant number of people.

Your Voice, on behalf of Inverclyde HSCP, organised and facilitated a series of engagement events across Inverclyde. Contributions from these events helped to inform and shape the HSCP Strategic Plan 2019 – 2024. The Strategic Plan lays out the HSCPs intentions and priorities over the next five years, reflecting the complex nature of some of the issues faced.

In addition, based on what people told us, the HSCP will be developing further six Locality Planning Groups (LPGs).

Locality Planning Groups (LPGs)

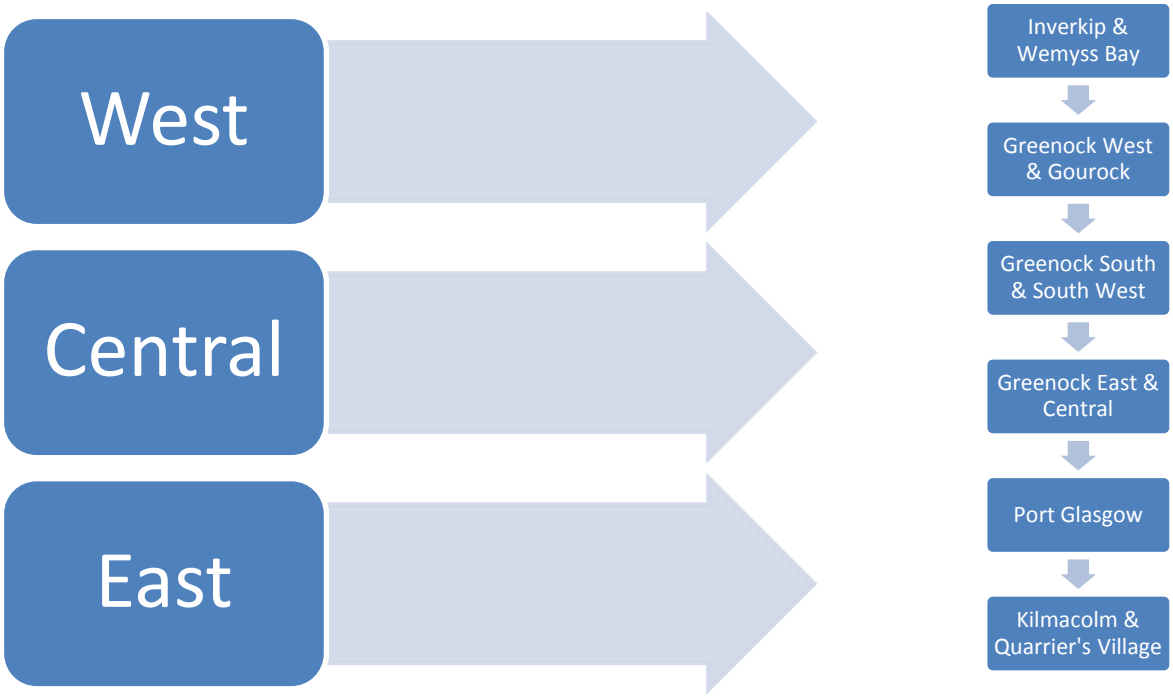
The Public Bodies (Joint Working) (Scotland) Act 2014[1] specified that Health and Social Care Partnerships (HSCPs) set up two or more localities. Localities should be established to enable service planning at local geographies within natural communities[2].

The importance of localities in improving health, and in particular, meeting increasing demand and addressing the widening gap in health inequalities is emphasised in the Marmot Review[3]. The Review proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live and age, and which can lead to health inequalities.

"Effective local delivery requires effective participatory decision making at local levels. This can only happen by empowering individuals and local communities."

The Inverclyde HSCP and Inverclyde Alliance are committed to working better together because we know that's what makes a real difference. The HSCP Strategic Plan 2019 – 2024 states that during the early implementation phase, the current three localities (East, West and Central) will move to six localities in line with Community Planning Partnership (Inverclyde Alliance). To support this, it is proposed to establish six Locality Planning Groups (LPGs) and have these in place by December 2019. The locality change is reflected below.

[1] Public Bodies (Joint Working) (Scotland) Act 2014, Scottish Government
[2] Localities Guidance, Scottish Government, July 2015
[3] "Fair Society, Healthy Lives", Professor Sir Michael Marmot, February 2010



The revised Strategy will standardise our approach to how we communicate and engage with local communities and staff in line with Legislation, and will provide guidance and support for Locality Planning Groups (LPGs) to ensure they have the capacity and capability to work effectively with local people.

Life Expectancy (from birth)

The latest figures available cover the 3 year 'rolling' period from 2014 to 2017. The figures below are the average across Inverclyde and Scotland.

Female		Male
Inverclyde		**Inverclyde**
79.68		**75.16**
Scotland		**Scotland**
81.08		**77.02**

In the longer term, we aim to reduce the differences between Inverclyde and the Scottish average, and also the differences between men and women.

National Health and Wellbeing Outcomes

The Scottish Government set out 9 National Health and Wellbeing Outcomes to be realised through the integration of Health and Social Care.

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

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

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

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

Outcome 5 - Health and social care services contribute to reducing health inequalities

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 wellbeing.

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

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

Outcome 9 - Resources are used effectively and efficiently in the provision of health and social care services

Our Achievements

Recovery

National target 90%

92% of clients referred to alcohol services began recovery treatment within 3 weeks

Advice

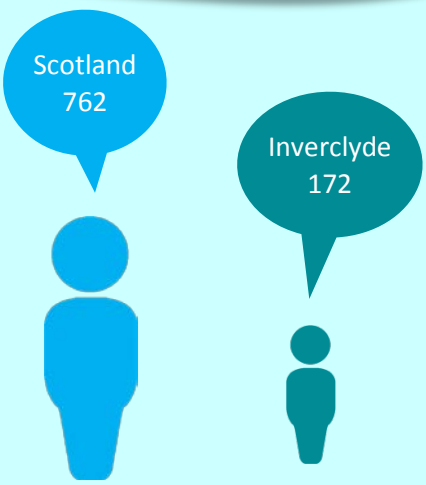
£9,854,340

Working with local people and other organisations we gained significant financial amounts for Inverclyde Residents.

75% of Welfare Rights Appeal Cases with final outcome decision in favour of the client

Discharge from hospital

Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)

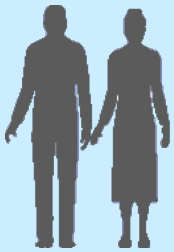


Community

49

49 people benefitted from No One Dies Alone voluntary companion support from 01/12/17

Care



83% of adults receiving care or support rated it as good or excellent

Scottish average 80%

Breast fed babies

More than 1 in 7 babies are exclusively breastfed at 6-8 weeks

Compared to 1 in 9 across other deprived areas

The 23 National Integration Indicators

National Integration Indicator		Time Period	Inverclyde HSCP	Scottish Average	Comparison
1*	Percentage of adults able to look after their health very well or quite well	2017/18	91%	93%	↓
2*	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2017/18	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	2017/18	77%	76%	↑
4*	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	2017/18	79%	74%	↑
5*	Total % of adults receiving any care or support who rated it as excellent or good	2017/18	83%	80%	↑
6*	Percentage of people with positive experience of the care provided by their GP practice	2017/18	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	2017/18	77%	80%	↓
8*	Total combined percentage of carers who feel supported to continue in their caring role *While we are performing better than the Scottish average we are working to improve support to our carers (see page 45)	2017/18	40%	37%	↑
9*	Percentage of adults supported at home who agreed they felt safe	2017/18	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	2017	567	425	↑
12	Emergency admission rate (per 100,000 population)	2017/18	15029	12183	↑

National Integration Indicator		Time Period	Inverclyde HSCP	Scottish Average	Comparison
13	Emergency bed day rate (per 100,000 population)	2017/18	159170	123035	↑
14	Readmission to hospital within 28 days (per 1,000 population)	2017/18	91	102	↓
15	Proportion of last 6 months of life spent at home or in a community setting	2017/18	87%	88%	↓
16	Falls rate per 1,000 population aged 65+	2017/18	25	22	↑
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2017/18	92%	85%	↑
18	Percentage of adults with intensive care needs receiving care at home	2016/17	63%	61%	↑
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	2017/18	172	762	↓
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2017/18	25%	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 Integration Indicators is the most up-to-date as available from ISD in May 2019. Those marked with an * are taken from the 2017/18 biennial 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 on Page 66.

The National Health and Wellbeing Outcomes

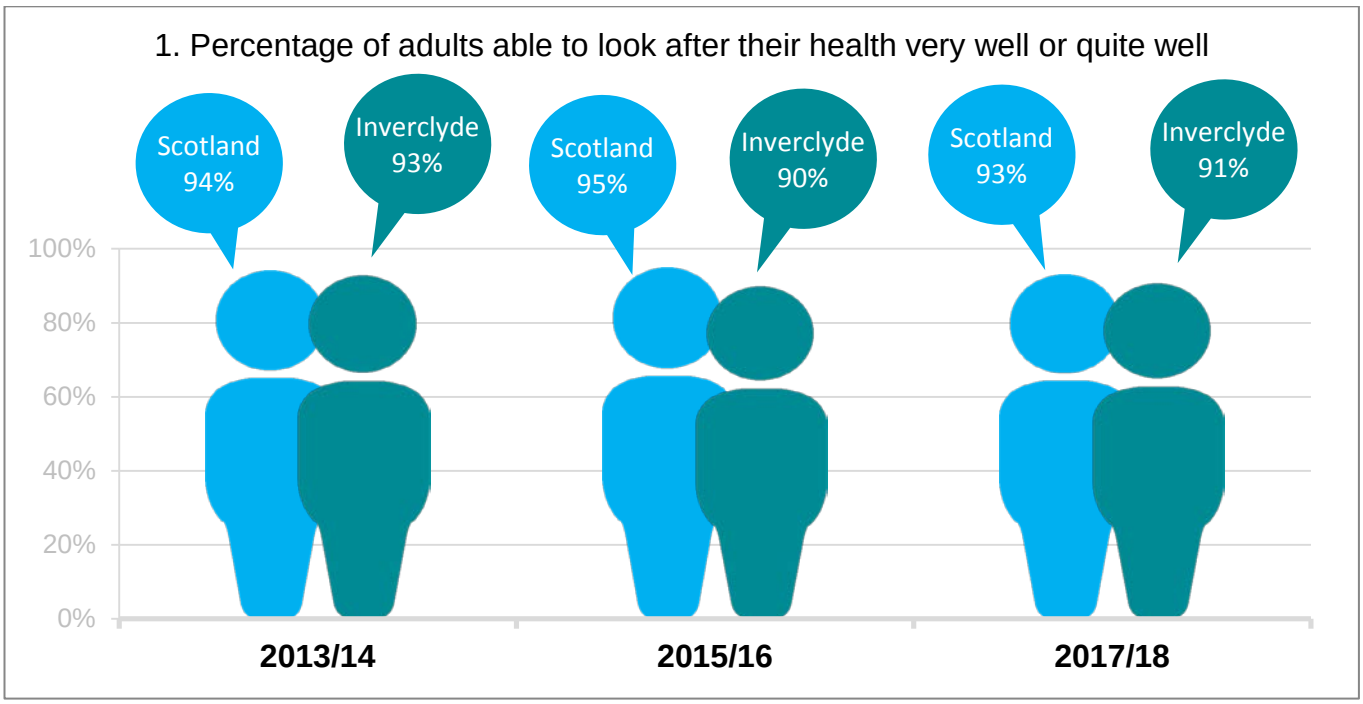
Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer

Maintaining health and wellbeing is better than treating illness. Our aim is to promote good health and to prevent ill health. Where needs are identified we will ensure the appropriate level of planning and support is available to maximise health and wellbeing.

We will support more people to be able to manage their own conditions and their health and wellbeing.

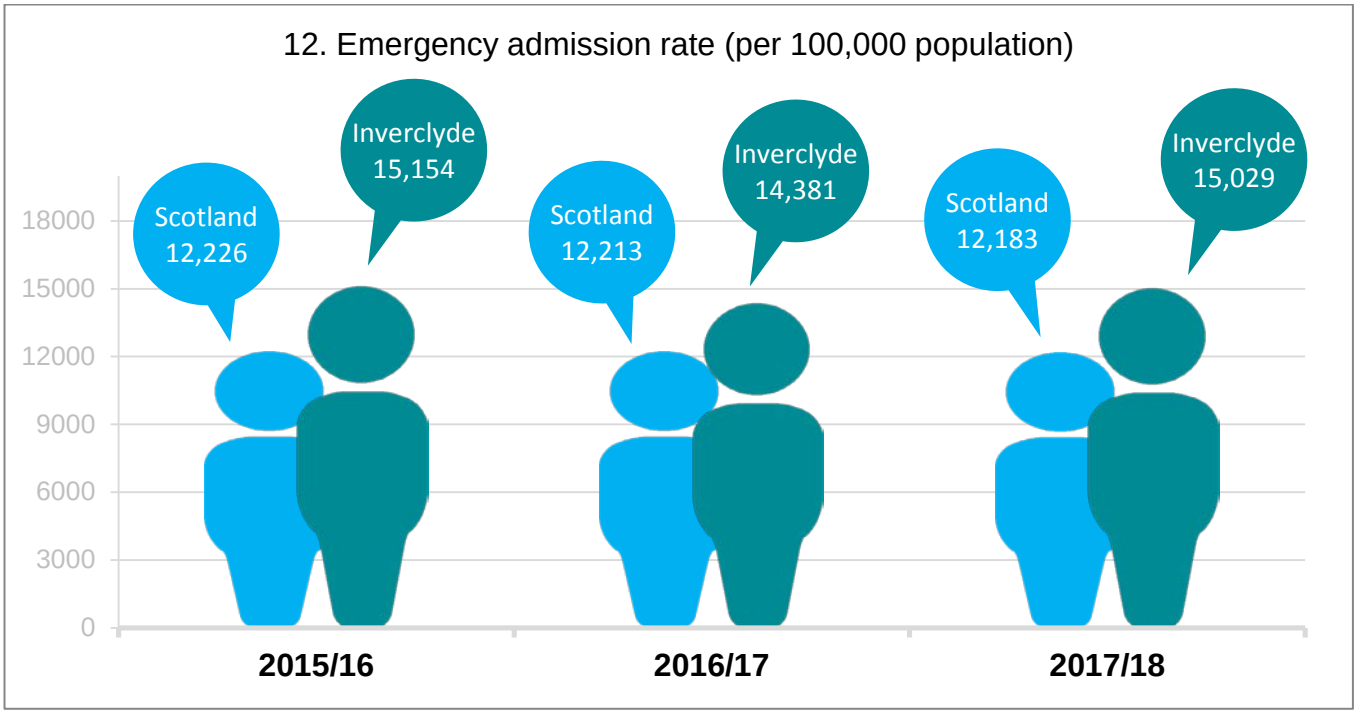
We will support people to lead healthier lives.

Current performance: National Integration Indicators



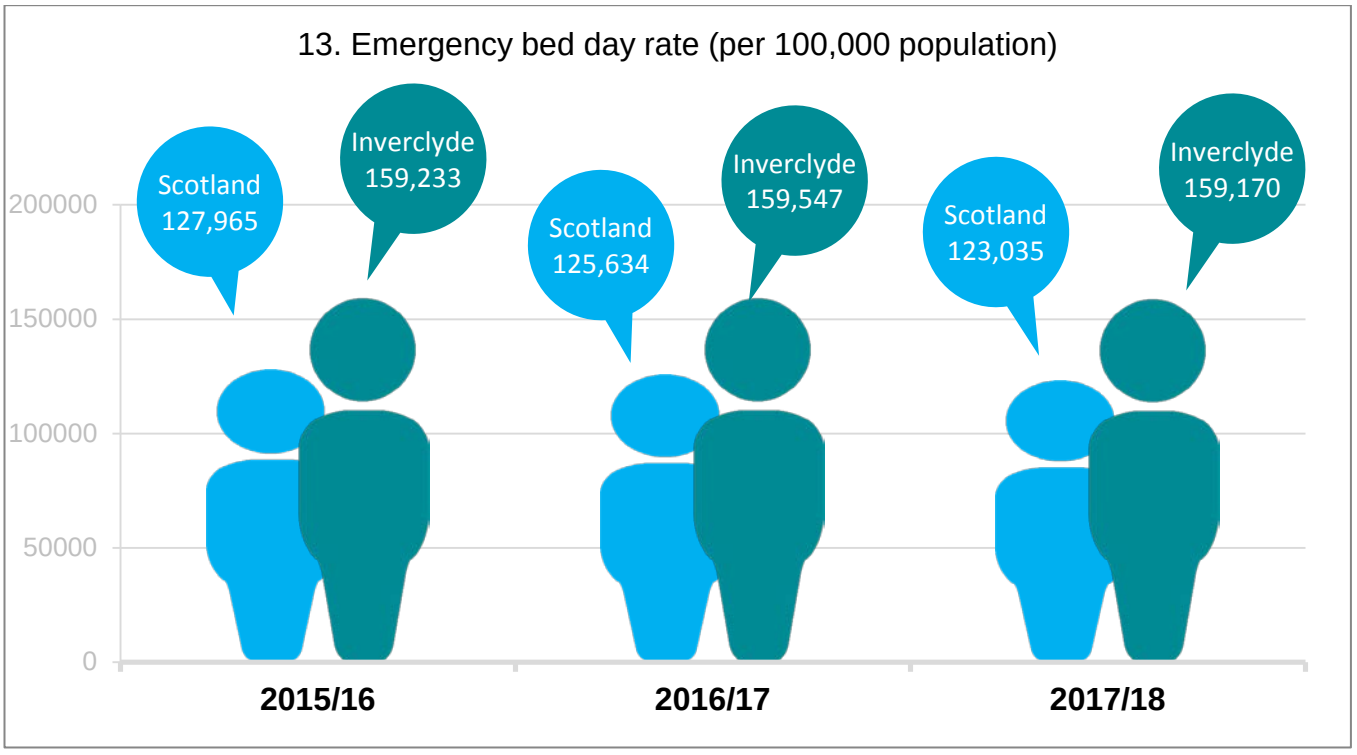
Higher figures = Better performance (data from the biennial Health and Care Experience Survey)

This shows that there is more to be done to support people to look after their health better.



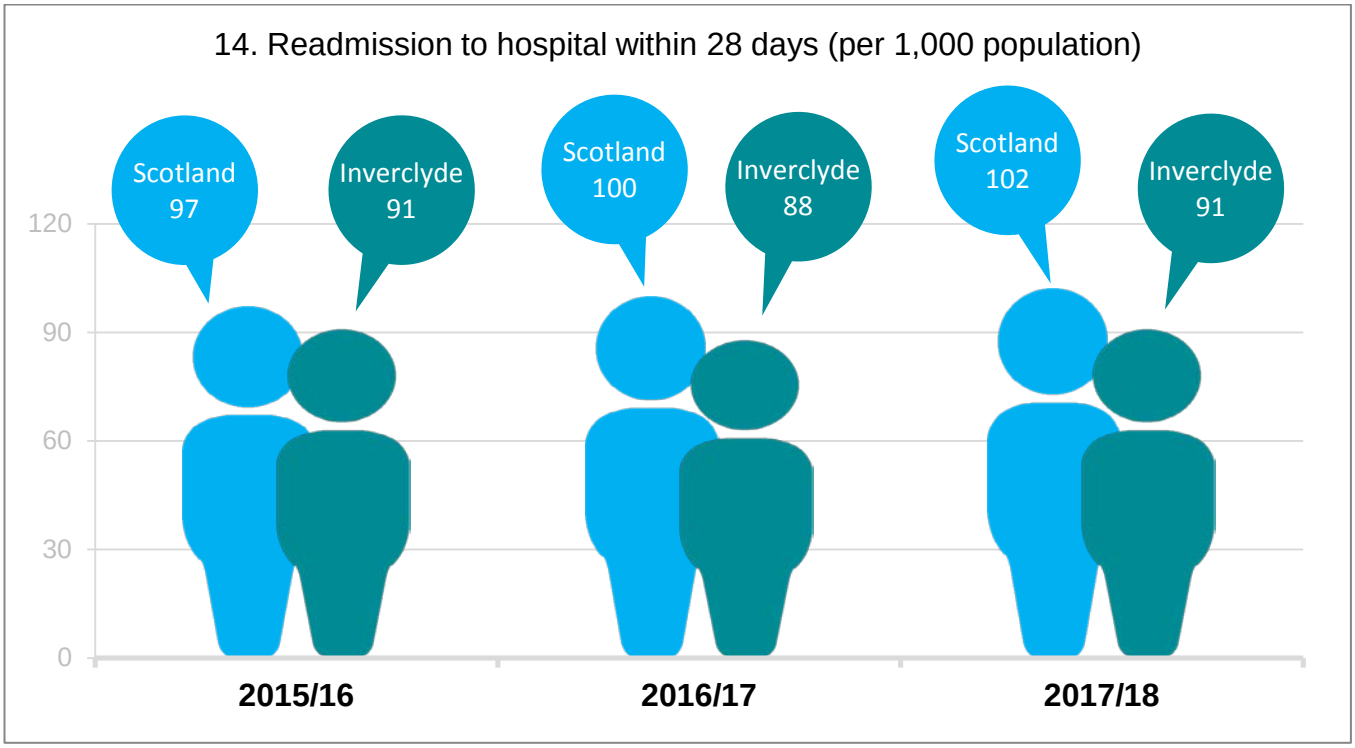
Lower figures = Better performance

When a stay in hospital is needed, it is better to arrange this in a planned way, rather than as a reaction to an emergency or crisis situation.



Lower figures = Better performance

If more hospital care is planned in advance, people can usually get back home more quickly. During the life of our new Strategic Plan we will be working to increase hospital care planning, and so reduce emergency admissions and hospital stays.

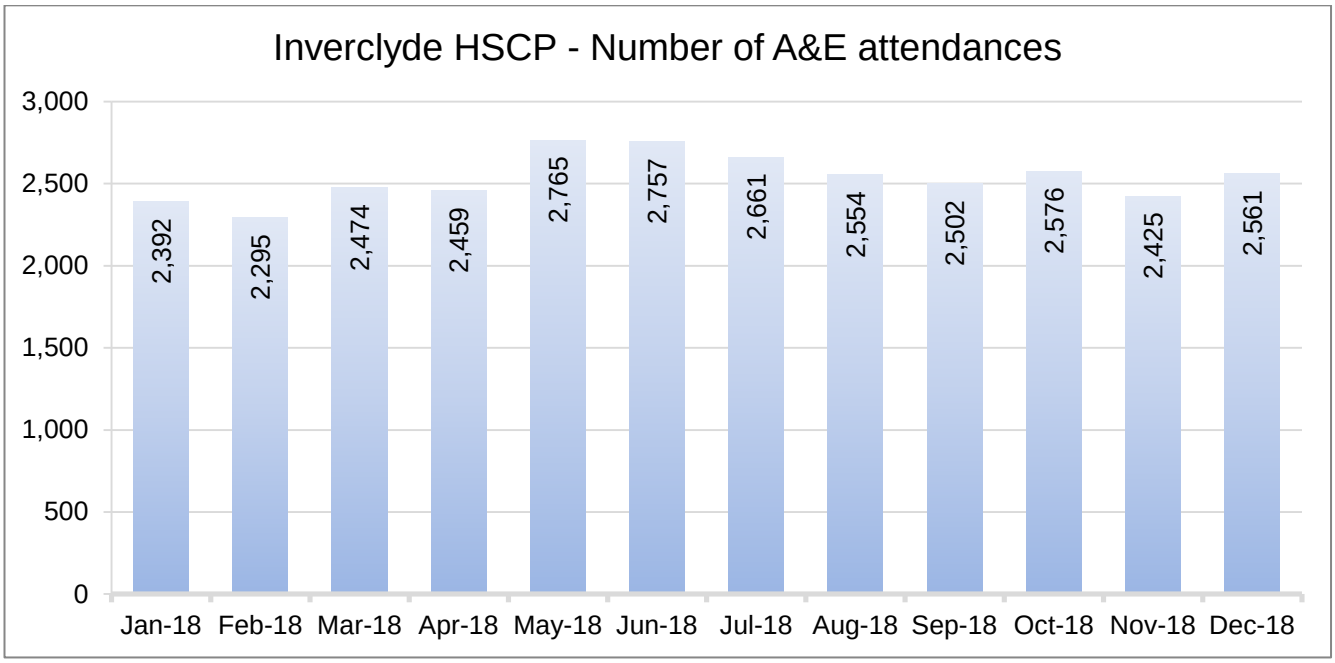


Lower figures = Better performance

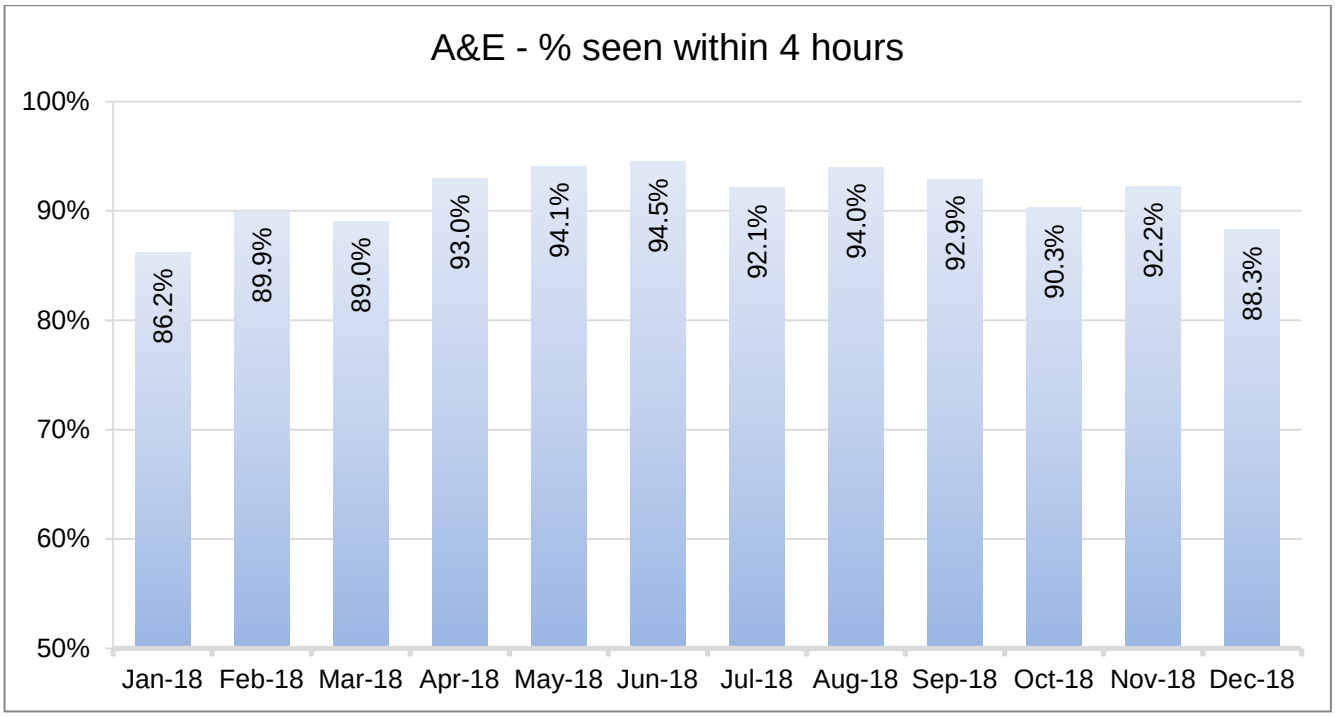
Often when people have to be readmitted to hospital soon after going home, it can be because the discharge took place before the person was fully ready, or because the post-hospital support was not quite right. The graphic above shows that this is notably less likely in Inverclyde.

Current performance: Local Indicators

Accident & Emergency (A&E)



Attendance at A&E continues to remain high for Inverclyde HSCP, with 2018 seeing a slight rise in the number of attends compared with 2017. The total number of attends in 2017 was 30,082, and in 2018 this rose to 30,421 attends (a 1.1% increase). The monthly average number of attends also rose in line with the total number of attends, with the average number of monthly attends in 2017 being 2,507 attends, and in 2018 the monthly average increased to 2,535.
Information derived from A&E attends data suggests that Flow 1 patients (Flow 1 is defined by patients with minor injuries or illness that could otherwise be seen by a GP or other clinicians, or not deemed an emergency) are a major component of the attends reported. The HSCP in partnership with Acute colleagues through our Unscheduled Care Workshops are actively working on reducing the level of Flow 1 patients by expanding "Choose the Right Service" programme to the emergency department and the wider acute setting.
The Partnership is also examining those patients with the highest number of attends to get an understanding of the underlying factors behind their attendances and potential interventions which would provide targeted appropriate support, and enable them to confidently look after their own health where this is relatively straightforward.



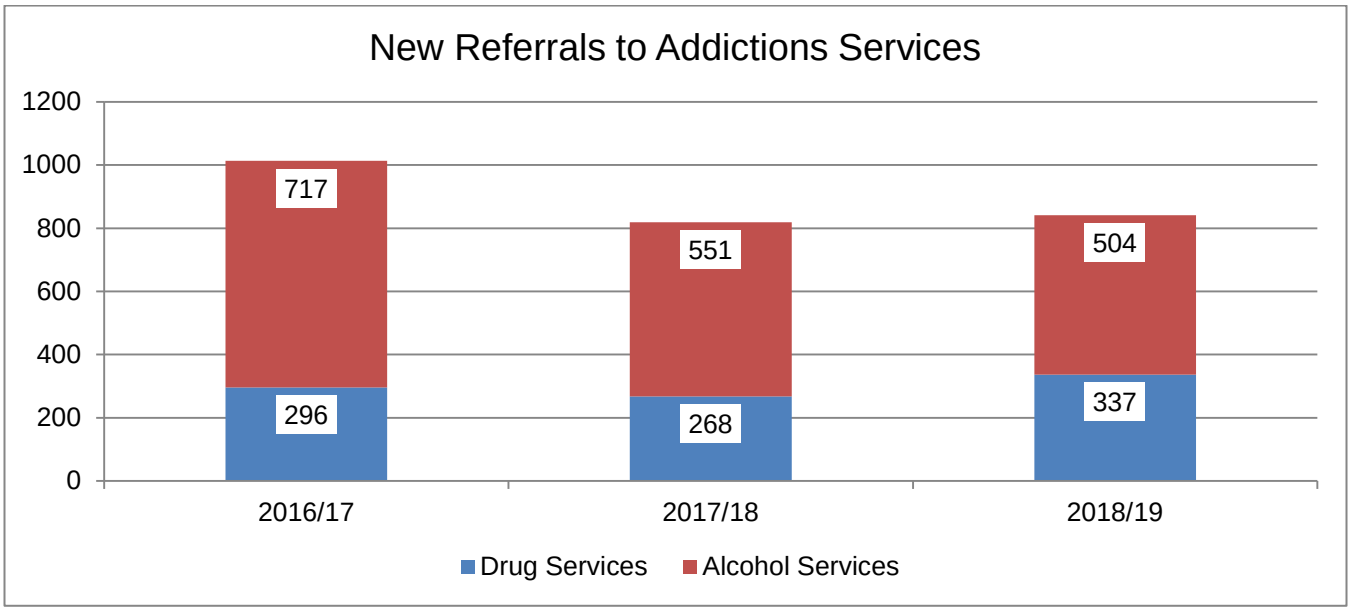
In regards to the A&E 4 Hr hour compliance, it certainly has been a challenging year in meeting the national standards/target for this measure which is set at 95%.
Unfortunately the performance for this measure dropped below 90% on 4 occasions throughout the year. The monthly average in 2017 was 93.5%, this has however dropped to 91.4% in 2018. It is hoped that through the work being done through in our Unscheduled Care Workshops with our acute colleagues to drive down the number of attendances will have a ripple effect on the 4hr compliance target by increasing capacity and therefore reducing the waiting times.

Addictions

A national target has been set by the Scottish Government 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, thus leading to better outcomes.

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.

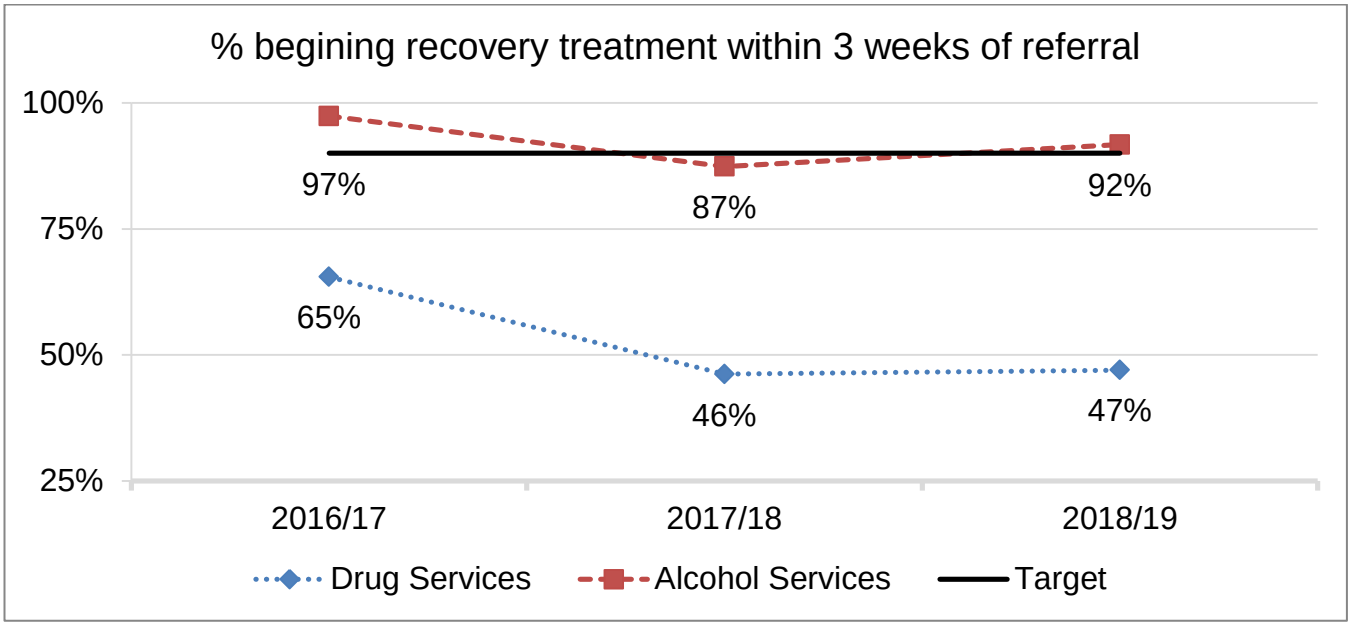
Over the last few years the number of people being referred into the addictions services has gradually declined. In 2018/19 the number rose slightly from the previous year (up 22) however the drug service seen a rise of 69 compared to last year.



Our performance in relation to the target of “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” is shown below.

Alcohol services have, with the exception of last year, consistently outperforming this target and our challenge is to bring performance back up to the high points of 97% plus compliance.

Drug services have been working to improve in this area and we have now begun to reverse the decline of the past couple of years and we expect to see consistent improvements over the next reporting periods.



We are now 2 ½ years into the development of our brand *Choose the Right Service*. The campaign continues to raise public awareness and direct patients more appropriately to services that are best placed to support their health and social care needs. We have developed and engaged in a number of activities to achieve the following outcomes:

- Engaging with our New Scots community to raise awareness and understanding of how to access health and social care services appropriately through drop in sessions at Your Voice with health professionals (oral health, accessing your dentist, eye health and accessing your Optician (May).
- Engaging with our children and young people community to raise awareness and understanding of the campaign through primary school workshops**,** Engagement with new mums/babies though work with Health Visitors.
- Displaying standard messages for self-care and in relation to Choose the Right Service in GP Practices through website development and social media platforms.
- Increase staff awareness of professionals and services that patients and their own family and friends can access alternatively to a GP through ICON, Chief Officer's brief, staff meetings.
- Increase population awareness of professionals and services that they and their own family and friends can access alternatively to a GP by continuing to display of material in HSCP/council/partner premises
- Develop the branding into other service areas; Choose the Right Service for our children and young people currently in design.

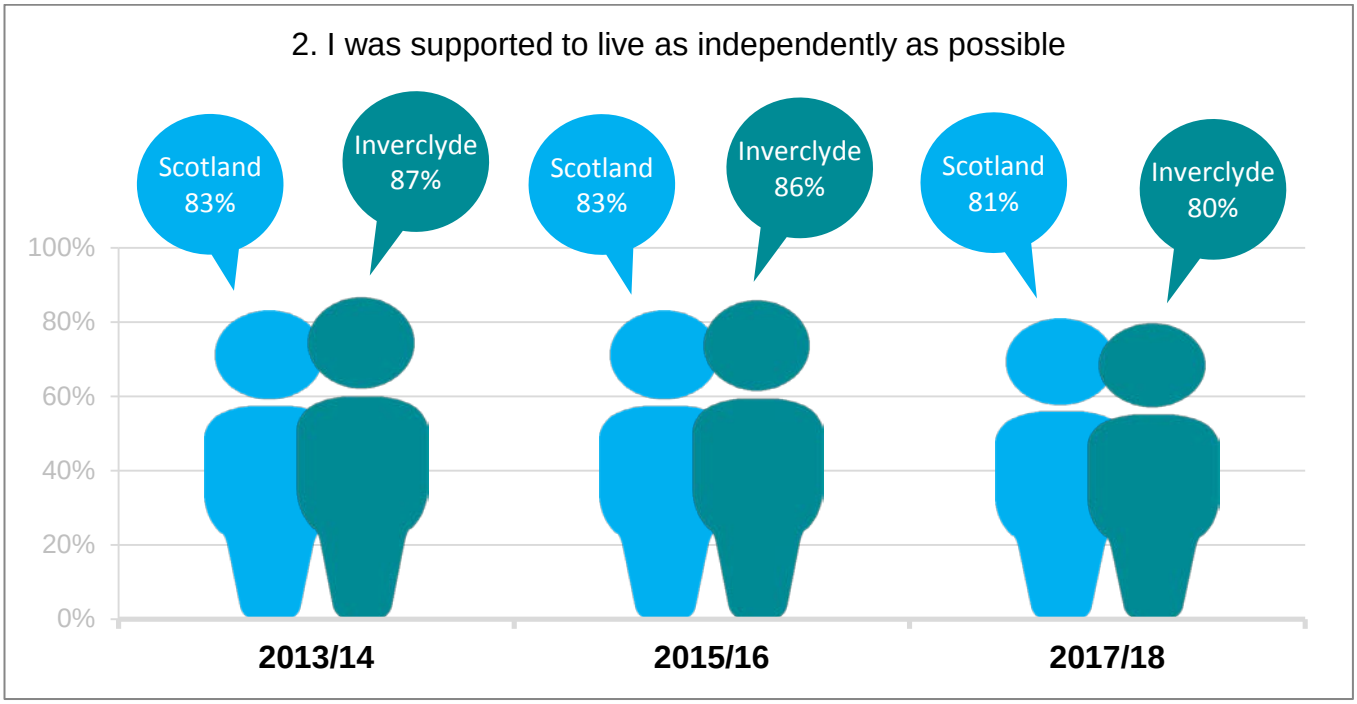
Outcome 2 - People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

People's care needs will be increasingly met in the home and in the community, so the way that services are planned and delivered needs to reflect this shift.

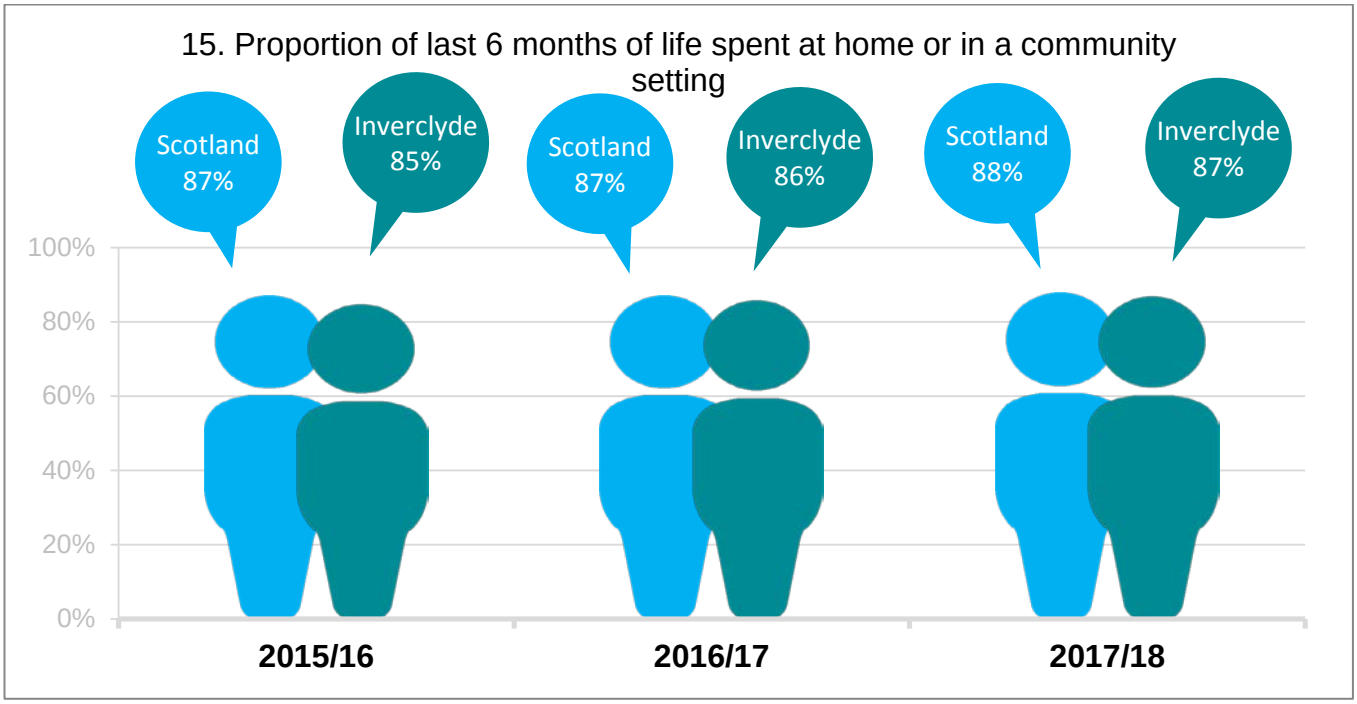
There are a number of ways that we are working towards enabling people to live as independently as possible in a homely setting.

"We believe that staying at home is the first and best option for everyone who wishes to do so"

Current performance: National Integration Indicators

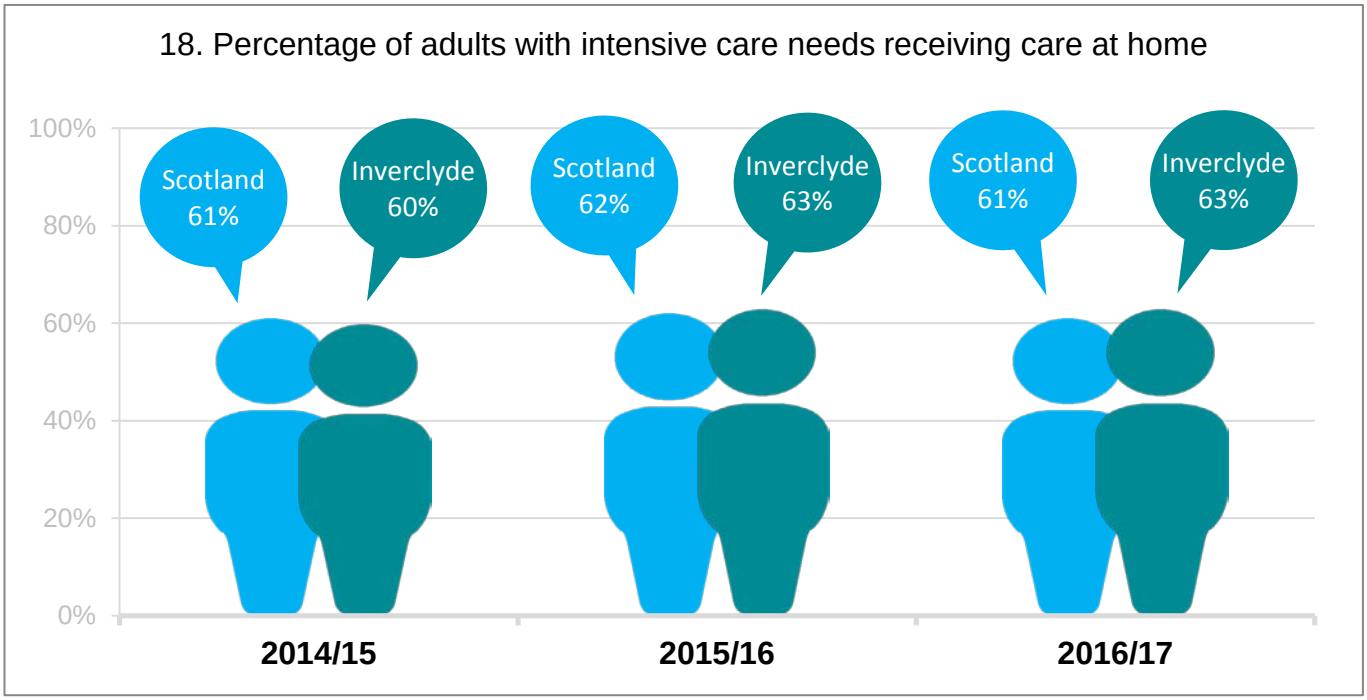


Higher figures = Better performance (data from the biennial Health and Care Experience Survey)



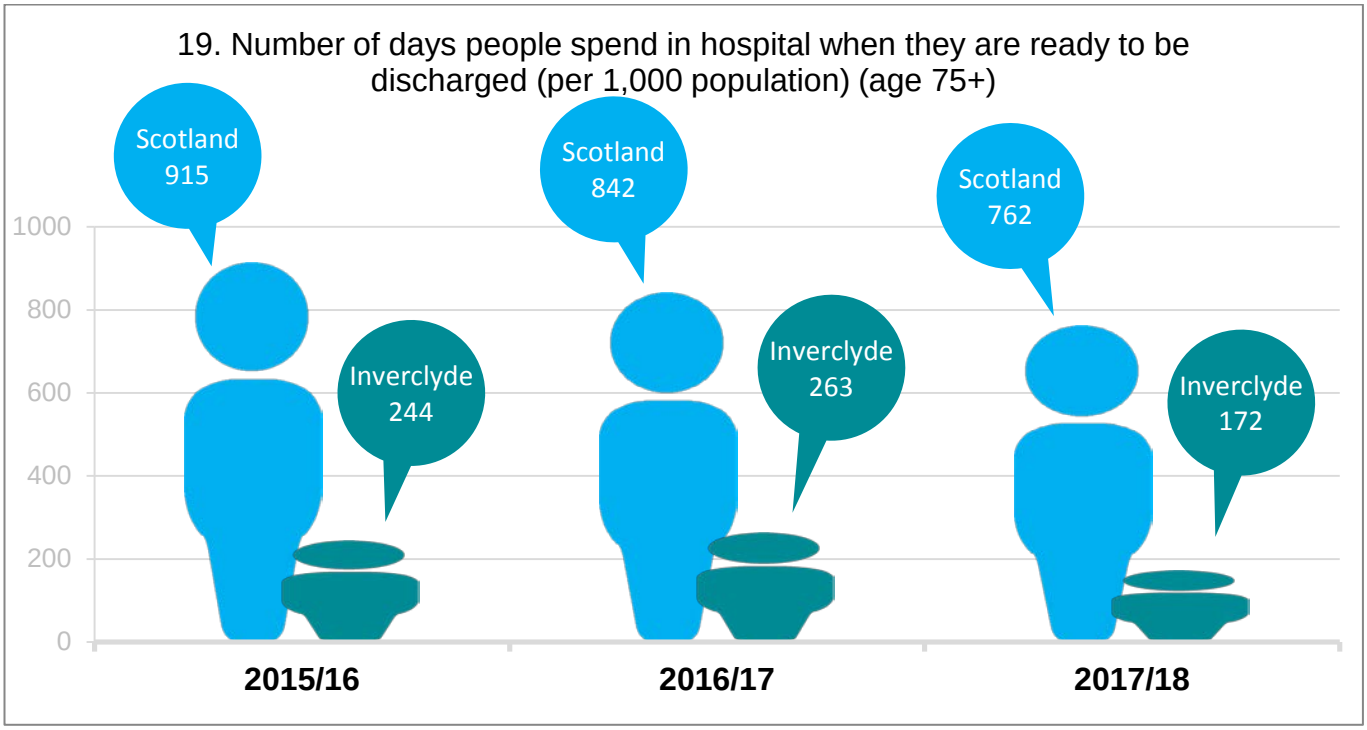
Higher figures = Better performance

Supporting people to be comfortable in their own homes towards the end of their lives often provides a better quality of life right up to the end. This in turn aids the grieving process for families.



Higher figures = Better performance (most recent published data is for 2016/17)

The levels of technological support available nowadays means that people with very complex care needs can often receive care and support in their own home. People tell us that this is what they would prefer, so we work hard to make this option available whenever it is both safe and possible.



Lower figures = Better performance

Inverclyde performance on delayed discharge is the best in Scotland, thanks to well integrated health and care services, and a clear focus on delivering what matters most to people – getting back home safely and with good support.

Current performance: Local Indicators

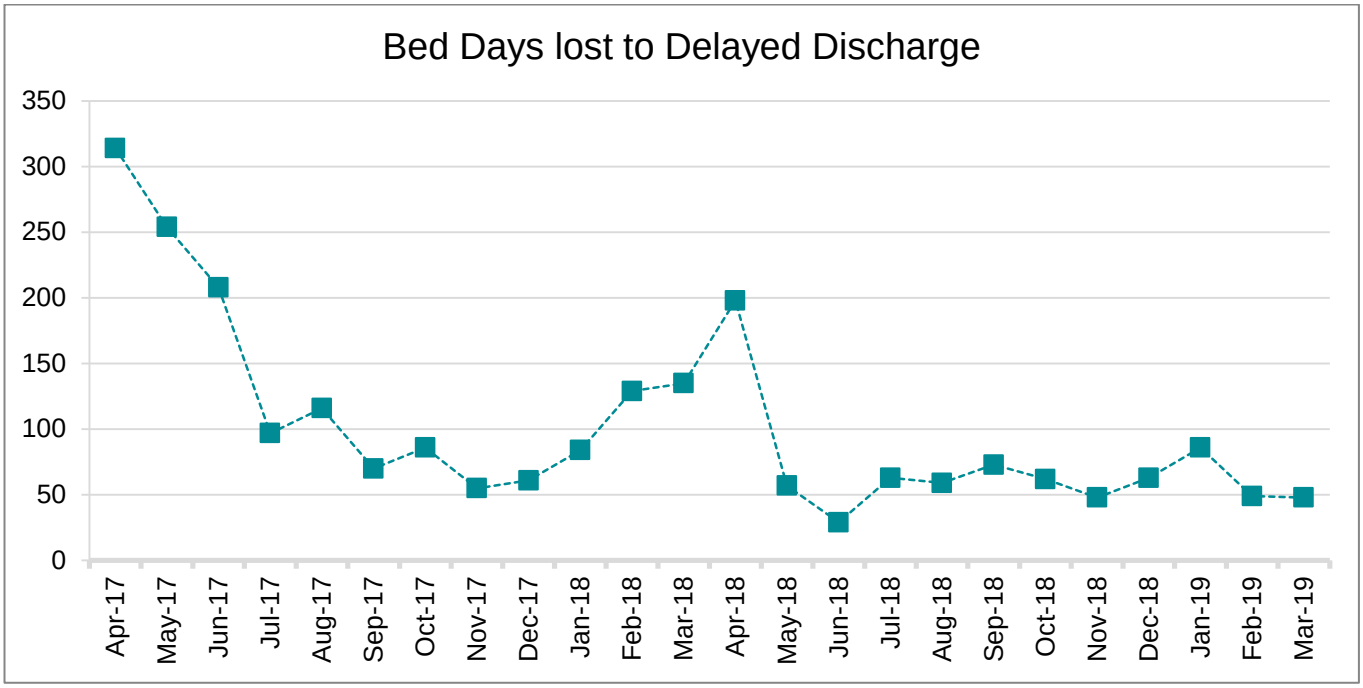
Bed Days Lost to Delayed Discharge

Bed days lost to delayed discharge is an area where Inverclyde has continued to show significant gains in good performance. By continuing to utilise the Home 1st approach, Inverclyde has reduced the number of bed days lost to delayed discharge in 2018/19 by nearly 50% on the previous year. The number of bed days lost in 2017/18 was 1,609, and in 2018/19 this figure was 835 (a 48.11% decrease).

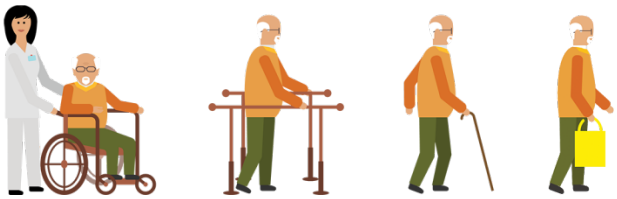
This sharp decrease is also reflected in the average number of bed days lost for both periods with the average for 2017/18 being 134 days lost and the 2018/19 period having an average of 69.6 bed days lost.

Further Analysis shows that in June 2018, the partnership had the lowest number of bed days lost to delayed discharge (29 Bed Days Lost) since the HSCP was established.

The chart below depicts the performance of both fiscal years 2017/18 and 2018/19.



Inverclyde HSCP's Partnership Discharge Plan



"We believe that staying at home is the 1st and best option for everyone who wishes to do so"

The Home1st Reablement Team is part of the HSCP Assessment and Care at Home services. The Home1st Reablement Service is a time limited service which carries out an assessment at home and develops a personal plan, with you, to meet your health and social care needs and outcomes.

Home 1st service aims

To support you with the abilities and confidence that you need to live a full and active life in your home and your community. For you to feel safe at home and live as independently as possible. To listen to what you need and provide you with choices. To provide support for the people who care for you and recognise their needs and rights.

What we do

The team will work with you to help you stay as independent as possible and build on your abilities and confidence. We will help you do more of what matters to you. Our staff will do everything they can to get it right 1st time, and include your family and those who are important to you if you want them involved. For example, we'll work with you on the day-to-day tasks you can do for yourself and what you need assistance with. Together we will agree a plan about what's important to you which we refer to as "working towards your goals". These can be anything from getting washed and dressed, practical help, getting out and about, staying in touch with people or getting involved in hobbies and interests within your community.

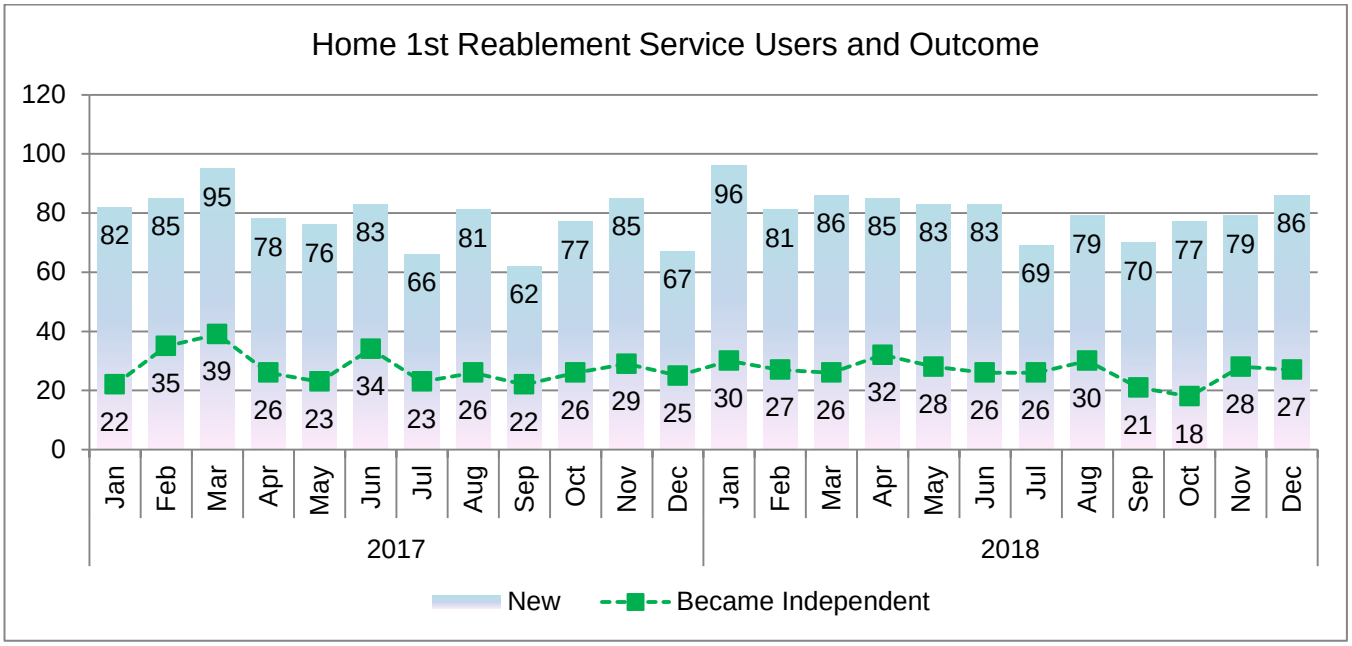
Our team includes:

- Occupational therapy staff
- Home support managers and home
- support Seniors
- Home support workers
- Social workers and social work assistants
- Pharmacy technician

Different team members will be in touch with you throughout the Home 1st period, firstly, someone will visit you at home to start the assessment. The occupational therapy staff are responsible for agreeing goals with you which will be part of your personal support plan. Our assessment staff can also provide equipment to maintain your independence and safety around your home. Our home support staff will work with you and we will talk to you regularly about how things are progressing. Towards the end of the reablement period we will discuss your progress and look at the areas where you can manage on your own and those where you may still need some support. For your on-going needs we will provide information about the self-directed support options available to you which is about having as much choice and control as possible over how your support is planned and provided.

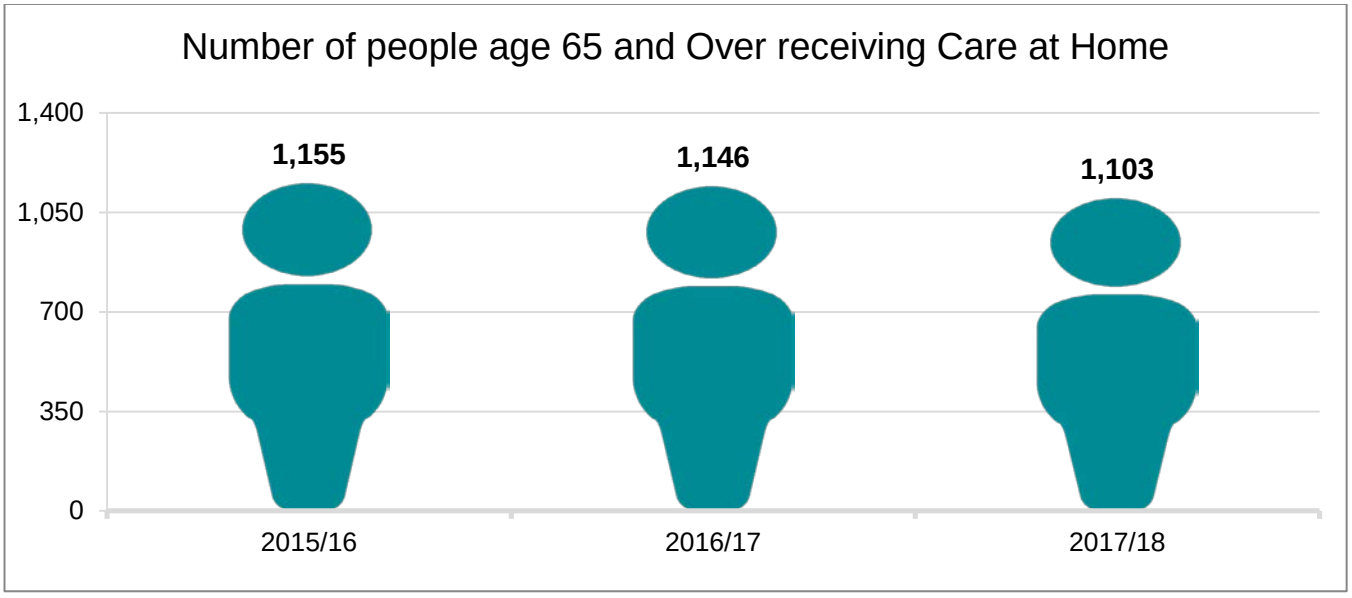
Who can use the service

This service is for people who are returning home from hospital, or when you are going through a period of illness or you are experiencing some kind of change in your life or circumstances. The service is open to anyone who lives in Inverclyde and has given consent for us to be involved. A willingness to work alongside us is important during this time of assessment. Normally we will work with you for six weeks but the time can vary depending on individual circumstances. The service is free during this initial period however, for ongoing service there may be a charge, full details are in the community services charging leaflet.



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”.



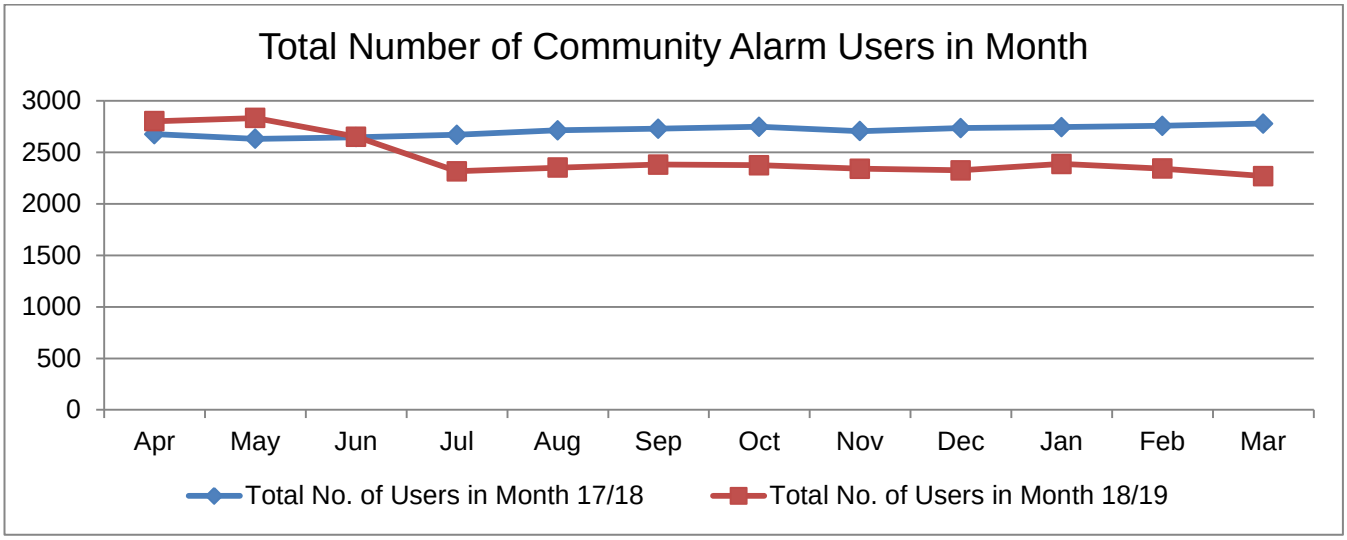
Numbers of people age 65 and over has decreased slightly in the year 2017/18, however, there has been an increase in the complexity of our service users assessed needs.

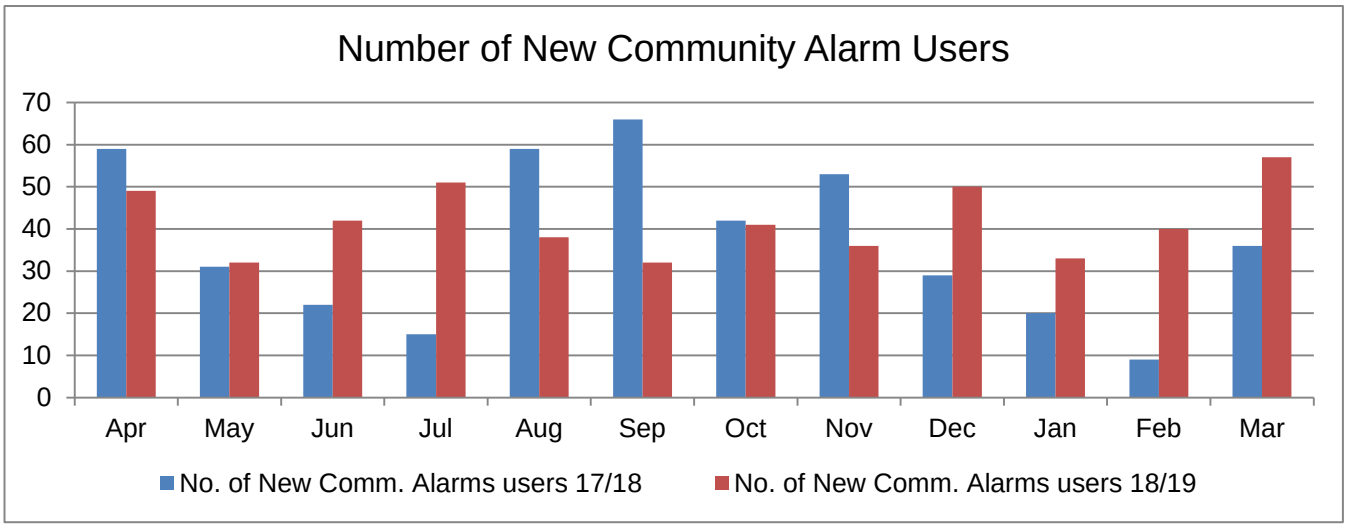
Using Technology

Technology Enabled Care – Community Alarm

2018/19 has seen the introduction of a nominal fee for users who are receipt of the Community Alarm service and as such the HSCP did see a reduction in the number of active clients utilising this service. This fee was introduced in June 2018 and this can be seen as a noticeable drop in the chart below (at the point where 18/19 data intersects with the 17/18 data).

Although the overall numbers receiving Community Alarm service has dropped due to the introduction of the charge, the number of new users in each month has increased slightly (the number of new users in 2017/18 was 441 and in 2018/19 this rose to 501). We are confident that the numbers will settle at a level that shows actual need.





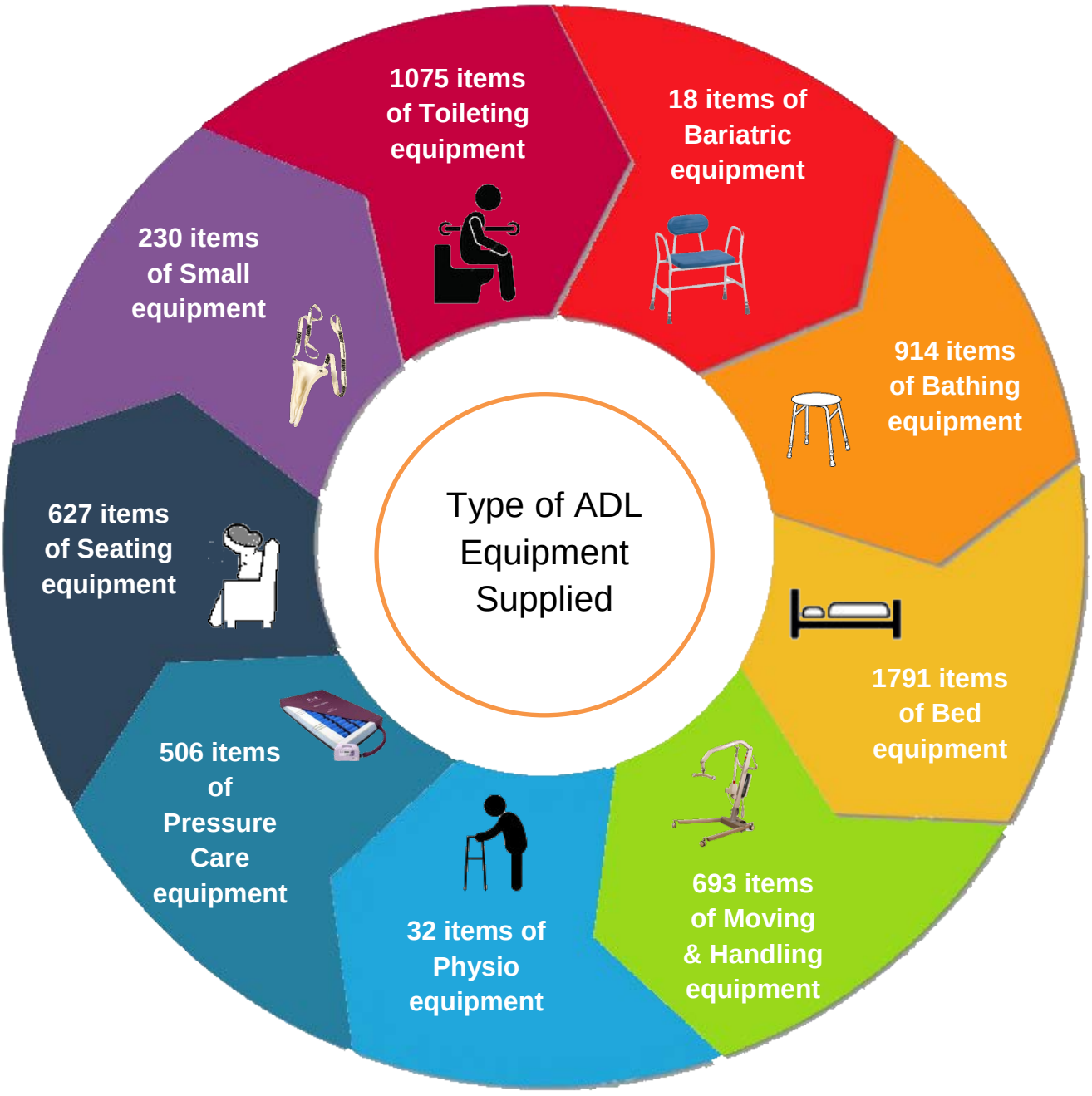
By 2021 we will have a Digital Strategy to Support Technology Enable Care

Aids for Daily Living (ADL) equipment.

In 2018-19, we provided 5,886 unique items of ADL equipment to Inverclyde residents who had a physical need. This is down from the previous year (2017-18) where we provided 6,539 items. 22% of all equipment supplied was to support people being discharged from hospital.

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 2018/19.



Andrew's Story

Andrew is a 98 year old who resides at home alone. Due to being partially sighted and experiencing early stages of cognitive decline everyday tasks were becoming increasing difficult to carry out safely and independently. Following experiencing a fall within the home a referral was made to Occupational Therapy Services.

Occupational Therapy Services responded with priority to carry out an assessment and observed Andrew in undertaking everyday tasks including preparing a meal, mobilising indoors and out of doors, transferring on and off the toilet, in and out of bed and on and off chair. Underpinning the assessment was Andrew's high level of motivation to remain as independent as possible. With risk of falls being the main concern occupational therapy worked alongside wider health services to ensure access to health checks, ophthalmology, sensory impairment services, and physiotherapy.

Andrew's main goal was to retain independence in shopping. The home environment with an extensive number of external stairs was the main factor impeding independent mobility out of doors. Occupational Therapy made provision of external handrails and gave advice on maximising mobility out of doors alongside sensory impairment services to ensure safe mobility and increased confidence. Housing advice was offered however Andrew opted to remain living in his own home whereby he has resided for 70 years.

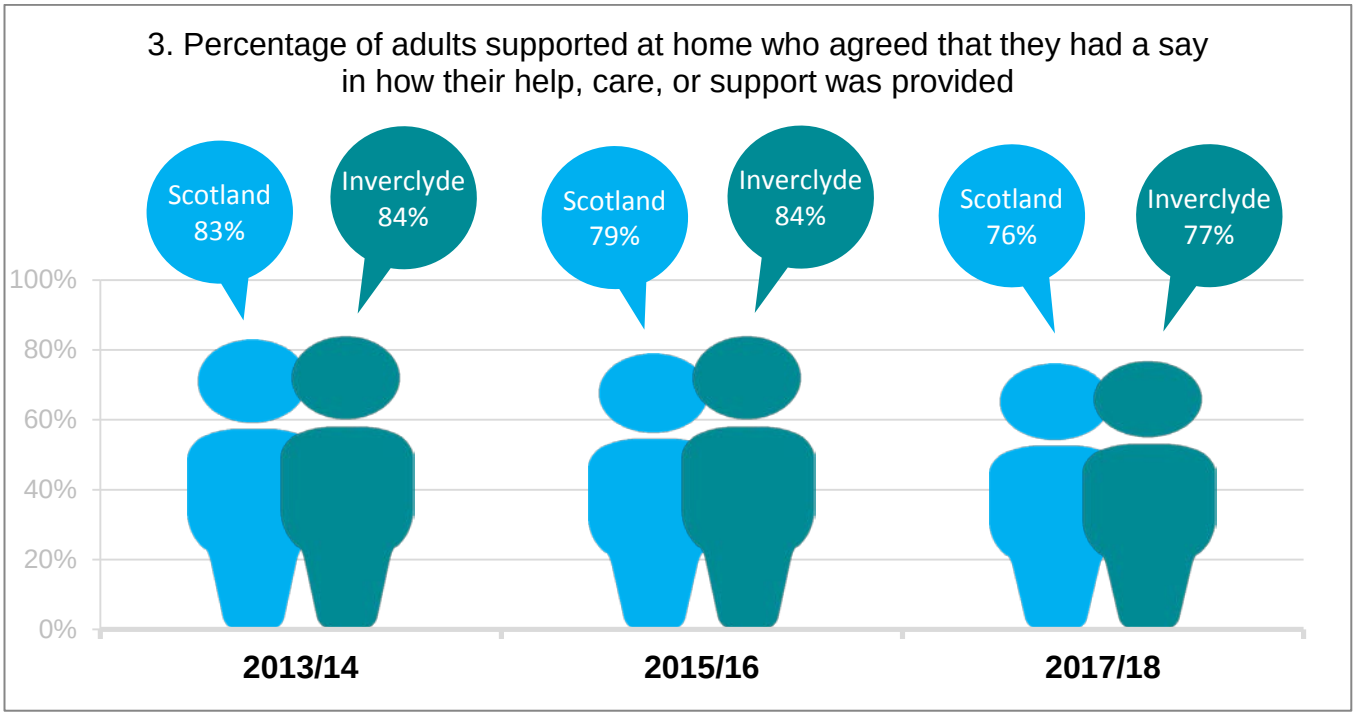
Indoors occupational therapy made recommendation to remove rugs and made provision of a wet floor room to ensure ongoing independence in maintaining personal hygiene. The design of the bathroom was considered ensuring all controls and fittings are dementia friendly to meet ongoing health needs. Overall change in the home was minimised and through working alongside Andrew in kitchen tasks he regained confidence and continues to live as independently as possible with the installation of an alert alarm.

Andrew reports he is appreciative of the help and support he has received from Occupational Therapy Services.

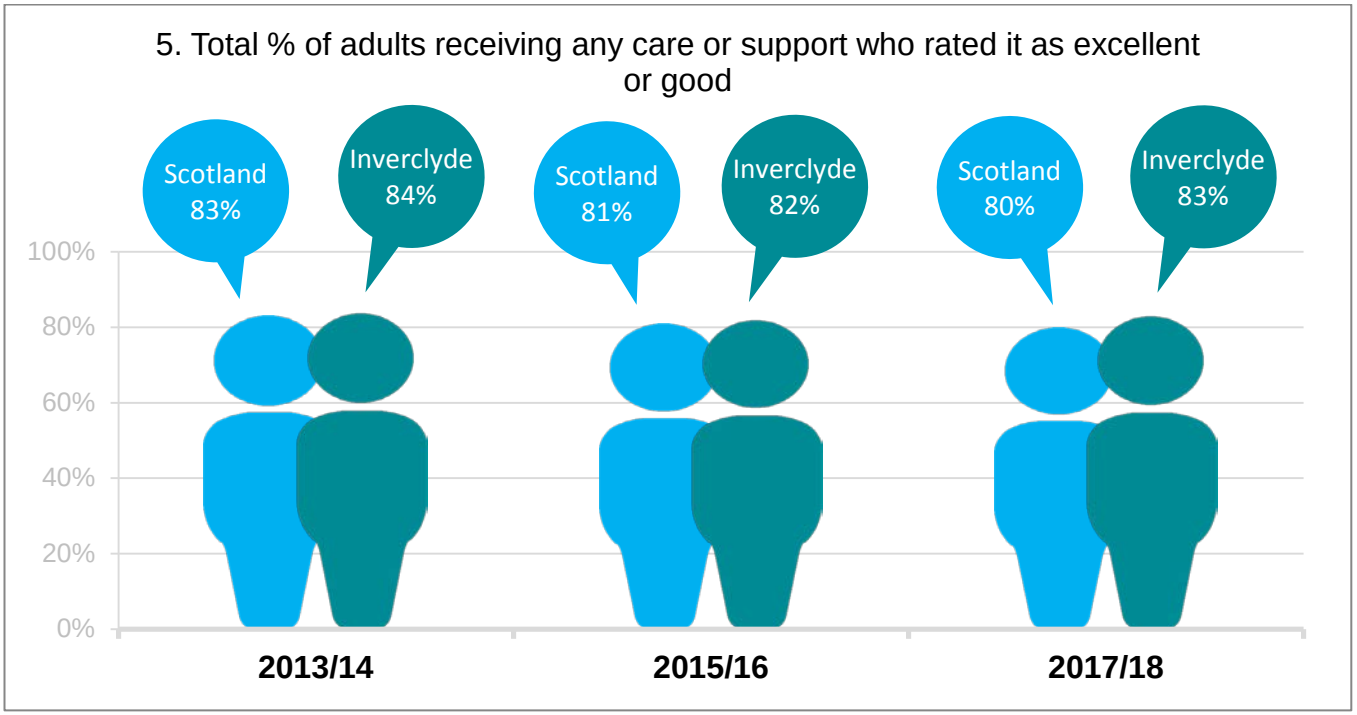
Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected

Improving health and social care outcomes from people who use services and their carers underpins the integration agenda. The Partnership knows that individuals and communities expect services that are of a high quality and are well co-ordinated. A critical part of ensuring that services are person-centred and respecting people's dignity is planning a person health and social care with the person, their family and Carers.

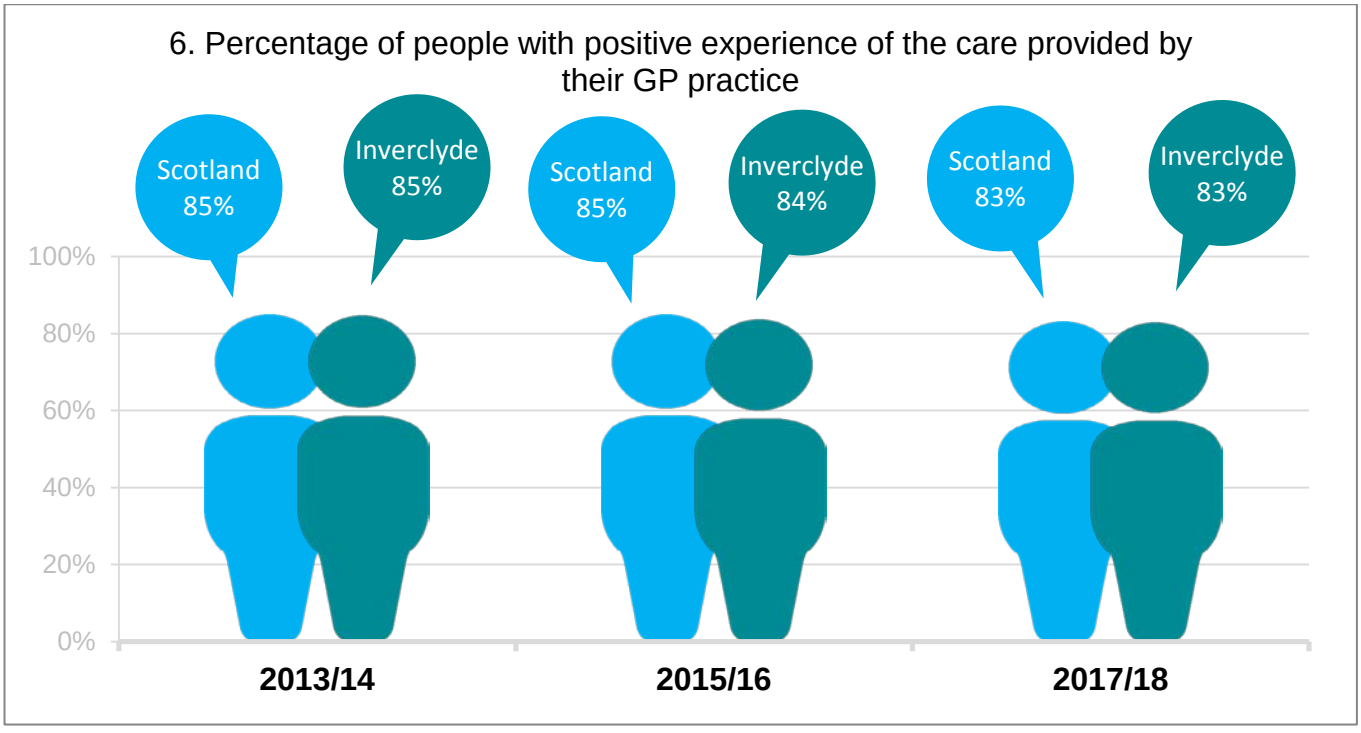
Current performance: National Integration Indicators



Higher figures = Better performance (data from the biennial Health and Care Experience Survey)



Higher figures = Better performance (data from the biennial Health and Care Experience Survey)



Higher figures = Better performance (data from the biennial Health and Care Experience Survey)

Current performance: Local Indicators

Self-Directed Support (SDS)

SDS allows people to choose how their support is provided to them by giving them as much on-going control as they want over the individual budget spent on their support in order to meet their outcomes. Inverclyde HSCP SDS implementation plan works towards ensuring people

who need support will have the confidence to exercise choice over the full range of SDS options.

The SDS Options are:

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

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

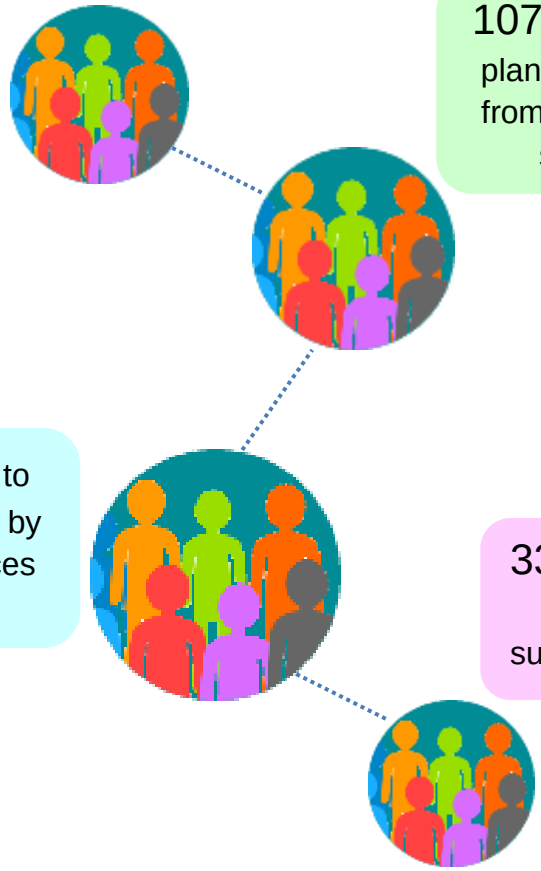
Option Three: The HSCP will arrange support from an appropriate provider after full discussions with the service user. The service user has no responsibility for arranging support and has less choice and control.

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

As at 31st March 2019

53 people have chosen to organise their own support (Option 1)

107 people have chosen to plan their care with support from health and social care services (Option 2)



1679 people have chosen to have their support organised by health and social care services (Option 3)

33 people have chosen a combination of SDS support options (Option 4)

John and Diane's Story

John is an 88 year old man who lives with his wife Diane. Diane has a diagnosis of Dementia and is in the advanced stages. John is the main carer and also has his own health needs. It was important for John that Diane stayed at home and that he could continue to care for her.

Diane's physical and mental health has deteriorated and she required substantial support throughout the day and night with personal care, mobility transfers. She wasn't able to communicate verbally and had difficulty swallowing. All of the above was extremely stressful for John and the family.

After assessment John choose Option 1 after consideration as he wanted to have the most control and flexibility over the support within the budget he was allocated. He choose a provider and a core team supported Diane on a day to day basis. They also supported John in the caring role as well as providing respite for him.

This resulted in a positive outcome as this enabled Diane to remain at home with John and for him to sustain his caring role.

Criminal Justice

From 1st April 2018 we introduced a new Service User Feedback process to better capture the views of those using our service. This involves completing a short form at both the commencement and completion of a community based sentence imposed by the courts.

The forms allow self-assessment of a range of issues including:

- Offending behaviour
- Training and employment
- Housing
- Family life

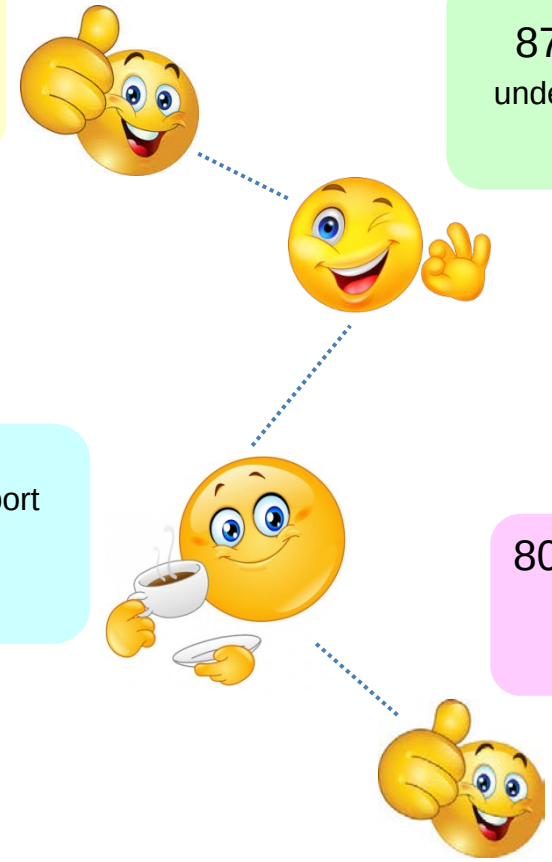
76 'start' and 31 'end' forms were completed by our service users.

Of the 31 'end' forms 24 (or 77%) provided comments on the service and any thoughts on improvements.

Service users who either ‘agreed’ or ‘strongly agreed’ that their time at CJ felt that

90.3% - they were informed and listened to

87.1% - have a better understanding of offending



96.8% - had a good support network

80.6% - the CJ team had a positive impact on behaviour

Market Facilitation and Commissioning Plan

The Public Bodies (Joint Working) (Scotland) Act 2014 requires that a Market Facilitation Plan is produced to set out our Health and Social Care commissioning priorities and intentions for Inverclyde. Our vision is based on “Improving Lives”, and the Market Facilitation and Commissioning Plan represents the communication with service providers, service users, carers and other stakeholders about the future shape of our local Health and Social Care market. By implementing the Plan, we can ensure that we are responsive to the changing needs of Inverclyde service users. This Plan aims to identify what the future demand for care and support might look like and thereby help support and shape the market to meet our future needs.

Full details of the Market Facilitation and Commissioning Plan can be found at:
https://www.inverclyde.gov.uk/meetings/documents/10893/04%20Market%20Facilitation.pdf

Primary Care Improvement Plan

General Practice in Inverclyde is made up of fourteen Practices covering Kilmacolm, Port Glasgow, Greenock, Gourock and their surrounding areas. There have been a number of changes to general practice in Inverclyde in the last few years including a merger and a practice closure. The merger in 2016 resulted in the formation of the largest single practice in the area.

GP clusters were introduced in Scotland with the 2016/17 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 now has a Practice Quality Lead (PQL) and each cluster a Cluster Quality Lead (CQL).

Inverclyde Health and Social Care Partnership created a Primary Care Improvement Plan (PCIP) which was approved by the GP Sub Committee of the Area Medical Committee (AMC) in August 2018.

The main ambitions of the PCIP are:

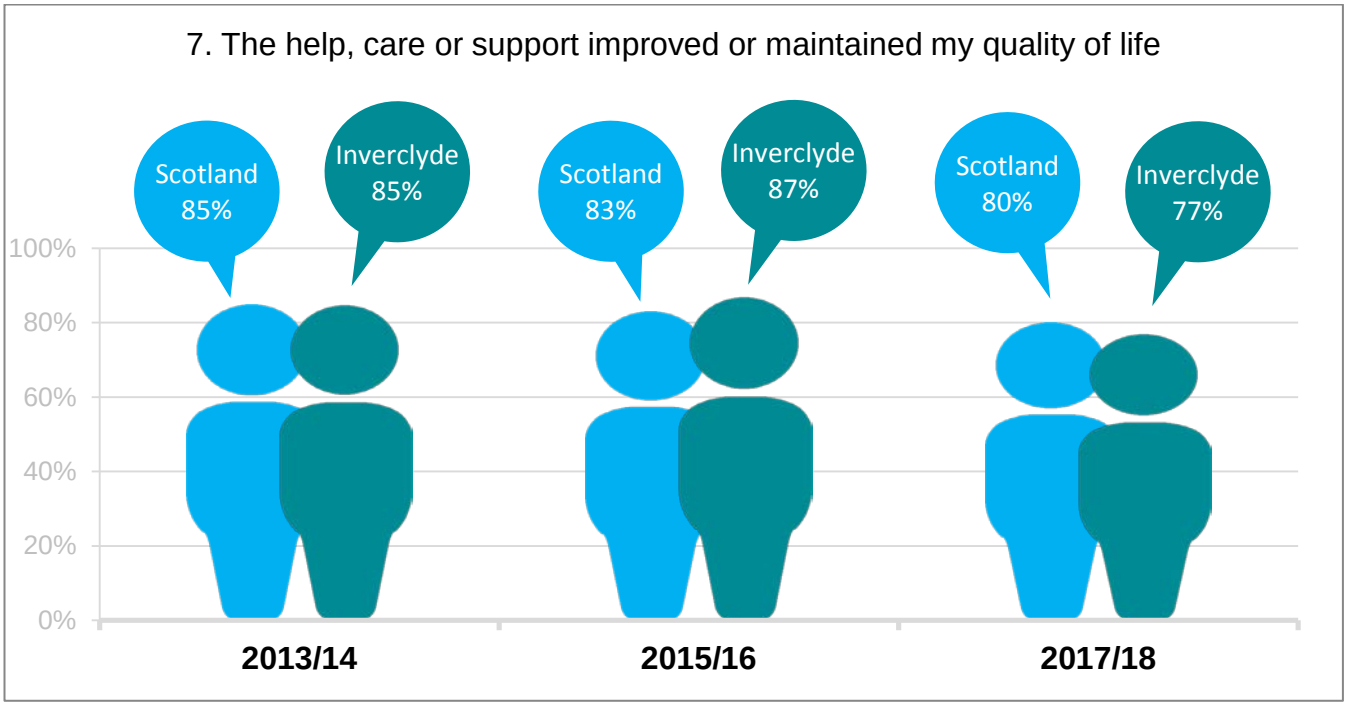
- Support progression of the GP role as expert medical generalist ensuring a refocus of activity is applied within practices, as workload shifts
- Support the delivery of improved patient care by achieving the principles of contact, comprehensiveness, continuity and co-ordination of care.
- Support the re-design of services and embedding of multi-disciplinary primary care teams to create a more manageable GP workload and release GP capacity to improve care for those patients with more complex needs
- Encourage peer led discussions and value driven approach to quality improvement to create better health in our communities and improve access for our patients
- Continue to educate and inform our population of alternative services/professionals to attending a GP through our culture change work and Choose the Right Service campaign

Full details of the Primary Care Improvement Plan can be found at:
https://www.inverclyde.gov.uk/meetings/documents/12219/09%20PCIP%20Update.pdf

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

The focus on this outcome is ensuring that Inverclyde HSCP provides seamless, patient focussed and sustainable services which maintain the quality of life for people who use the services. This means ensuring that treatment, interventions, and services are of the right standard so that they are safe, address people's expectations and outcomes so the people enjoy the best quality of life, whilst they recover or are supported to manage their condition.

Current performance: National Integration Indicators



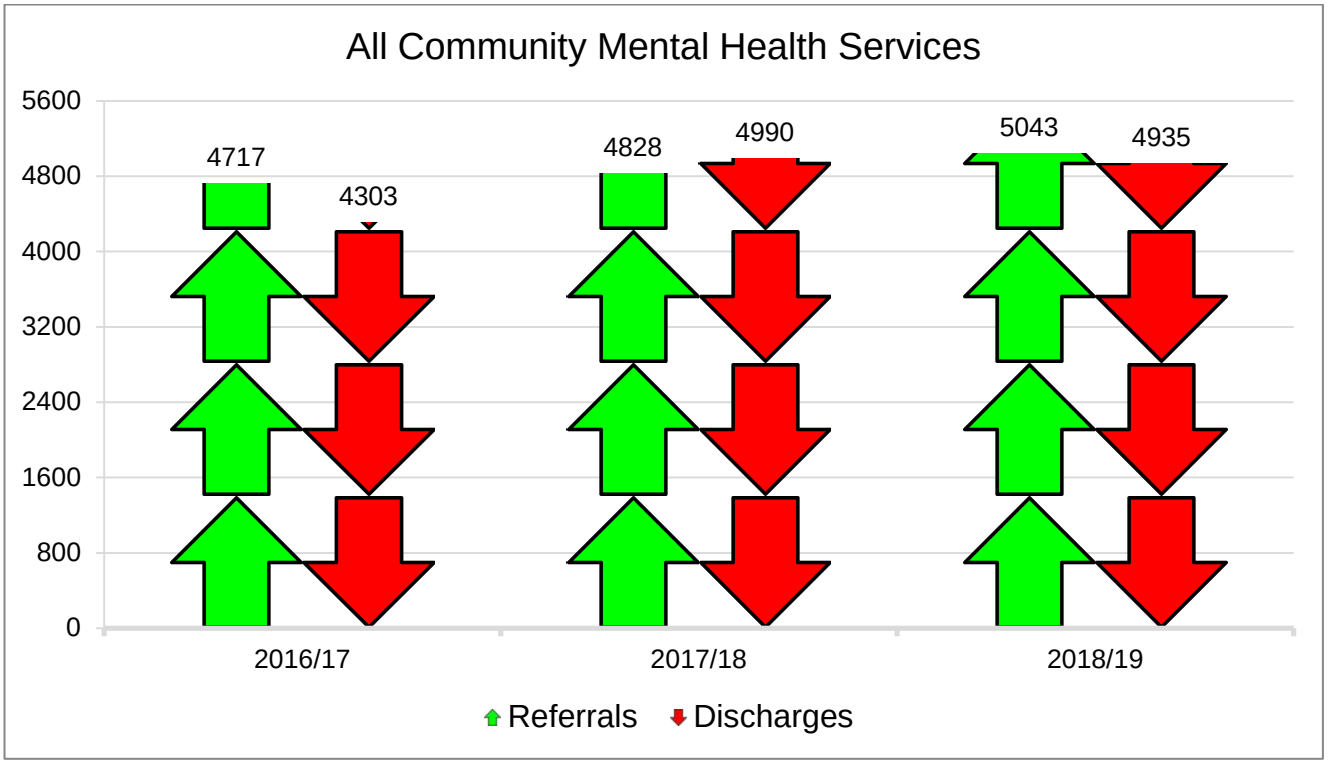
Higher figures = Better performance (data from the biennial Health and Care Experience Survey)

Current performance: Local Indicators

Mental Health

Within our Community Mental Health Services there were a total of 5,043 referrals throughout 2018/19, an increase of 6.9% from 2016/17. This is also matched by an increase in those being discharged from the service with 4,935 in 2018/19 an increase of 14.7% from 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.



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:

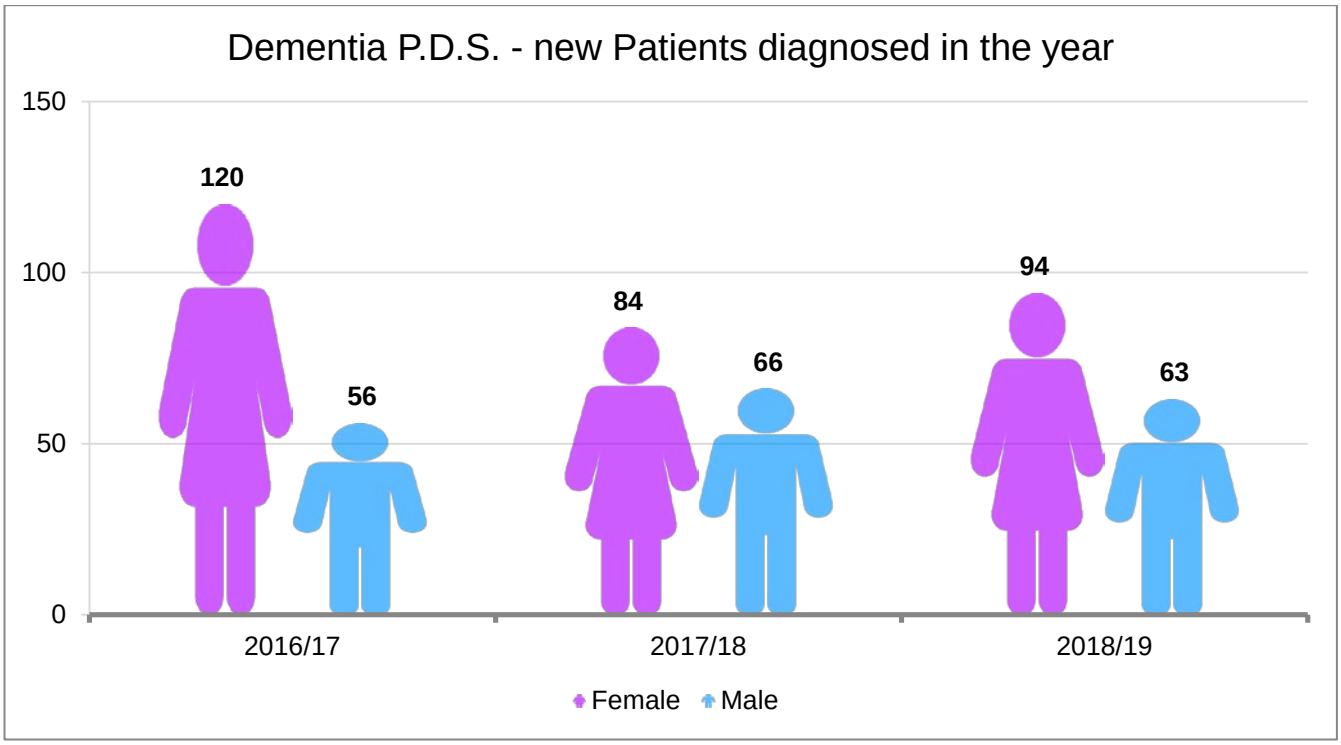
- Reduce the stigma associated with mental illness.
- Work in partnership with service users and carers.
- Provide assessment, diagnosis and treatment, working within relevant Mental Health legislative processes.
- Focus upon improving the mental and physical well-being of service users.

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.

Dementia PDS (Post Diagnostic Support)

Improving Post-diagnostic Support (PDS) is one of the 21 commitments of the national dementia strategy (June 2017). The strategy proposes that: “All people newly diagnosed with dementia will receive appropriate support following diagnosis, with that support being either (a) the current model of post-diagnostic support, or (b) care coordination, based on the 8 Pillars Model of Integrated Community Support. The decision as to be most appropriate option will be based on clinical assessment.”

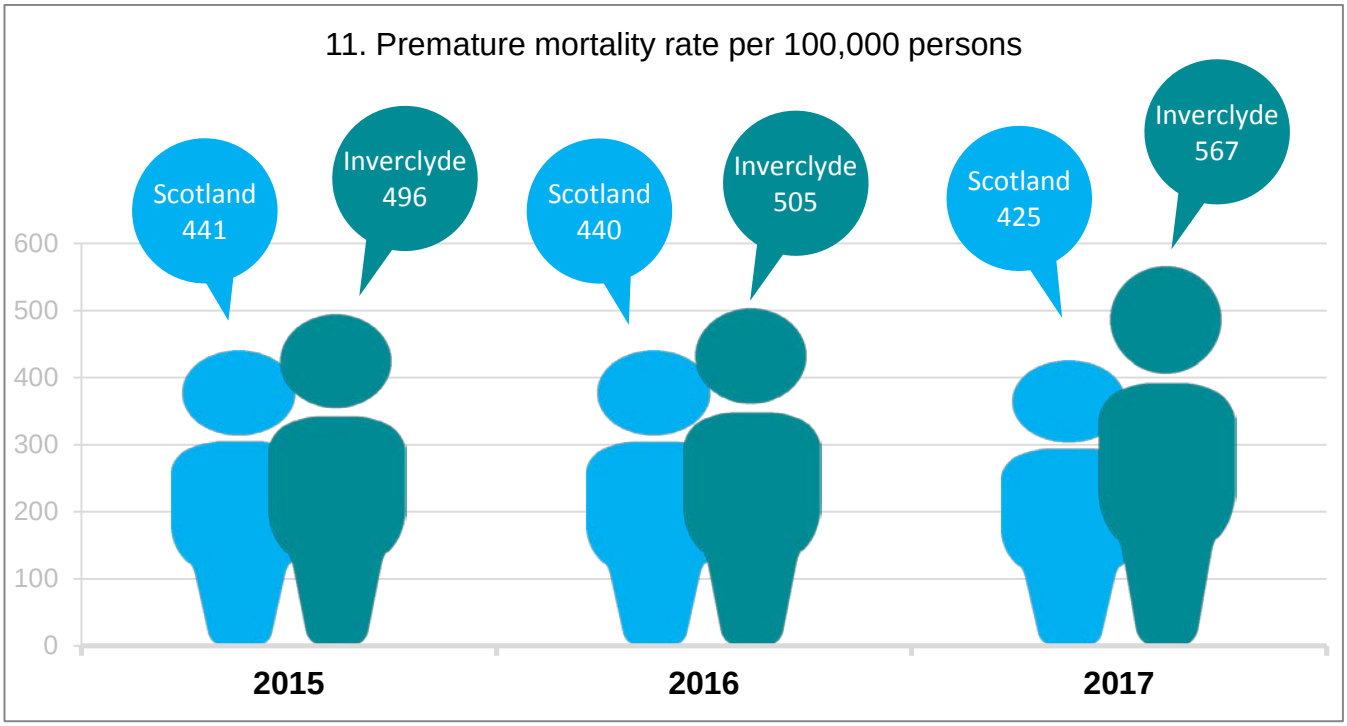
The period of support in each case will be open-ended and flexible. For those who receive post-diagnostic support in an integrated community-based way, this will continue without a time limit. Following the conclusion of the initial programme of work, and if the individual does not move on to the care coordination phase, they will be able to access their named Link Worker again, whether within the year previously stipulated or not. This will allow flexibility for those who might require additional contact or reengagement with the service.



Outcome 5 - Health and social care services contribute to reducing health inequalities

Health inequalities occur as a result of wider inequalities experienced by people in their daily lives. This can arise from the circumstances in which people live and the opportunities available to them. Reducing health inequalities involves action on the broader social issues that can affect a person's health and wellbeing including housing, income and poverty, loneliness and isolation and employment.

Current performance: National Integration Indicators



Lower figures = Better performance (data for this indicator is produced in calendar years with the most recent available figures being for 2017)

This is a complex indicator because the causes of premature mortality are many, and are underpinned by social, health and economic inequalities.

Current performance: Local Indicators

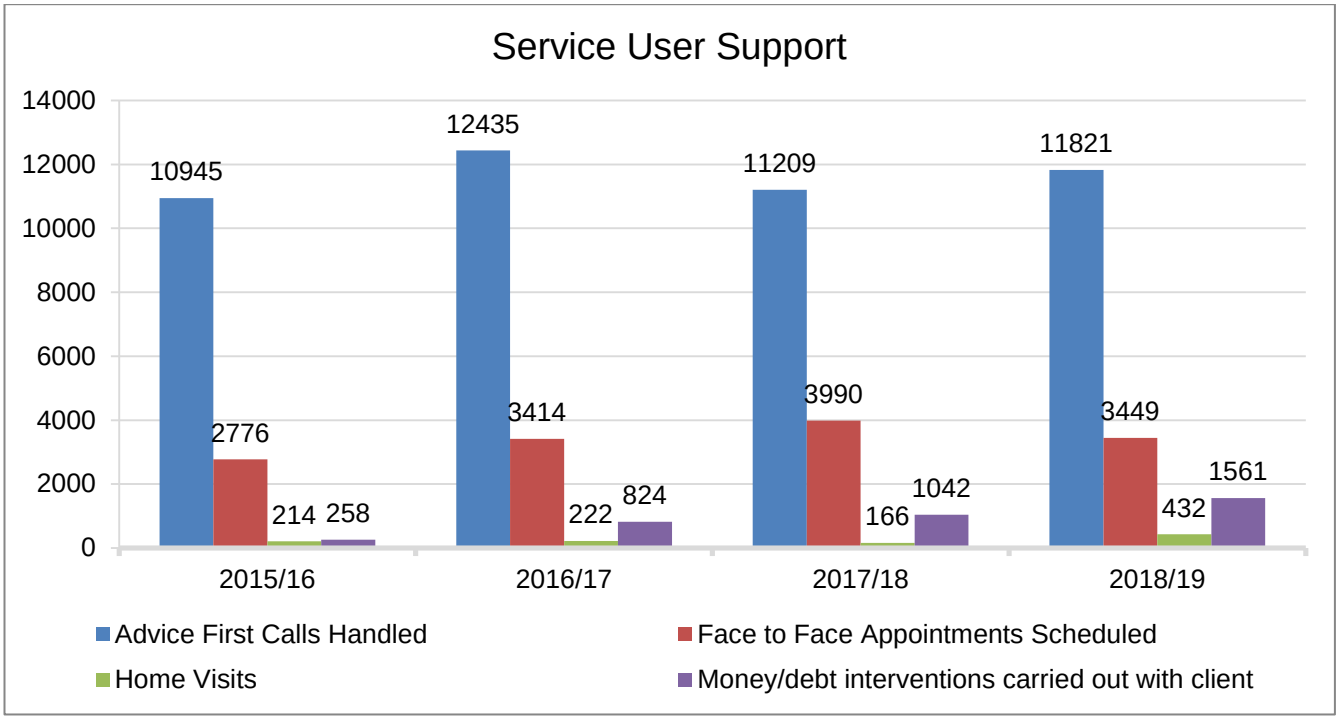
In Inverclyde, our approach to **Addressing Inequalities** is multi-faceted.

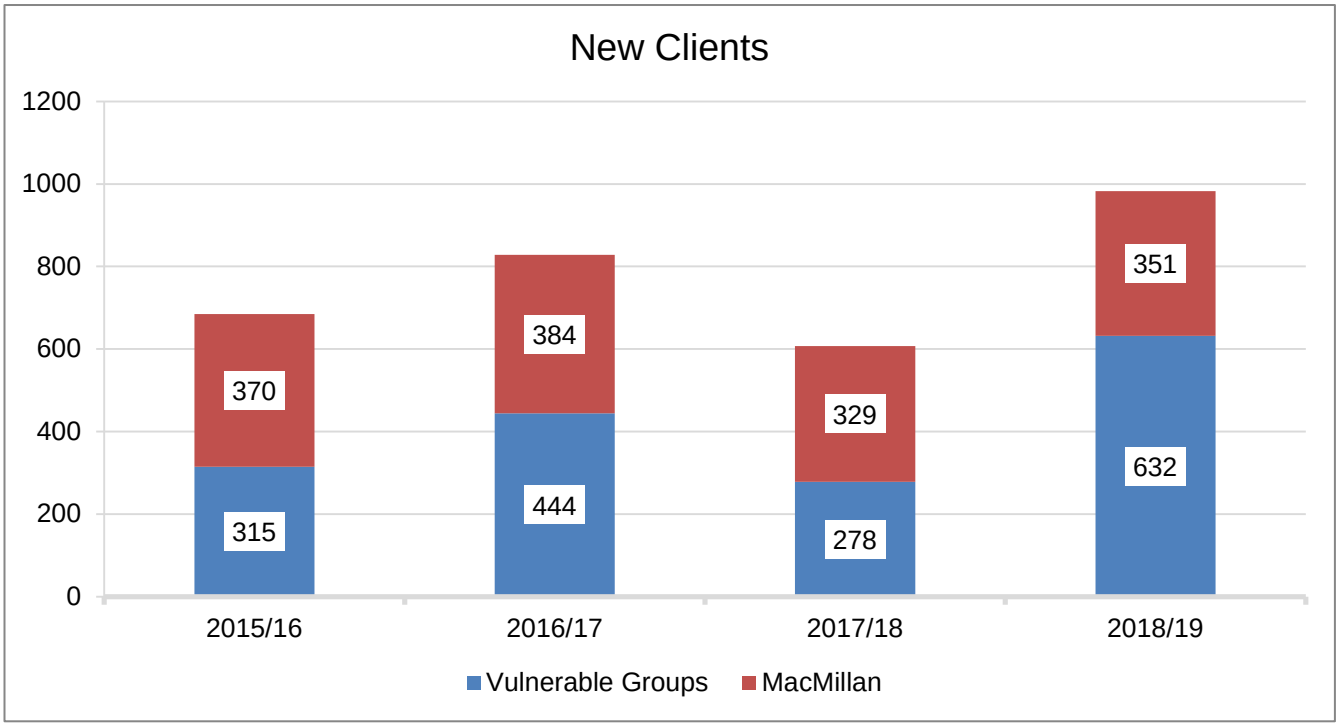
Within this report we have focused on the following areas to demonstrate this:

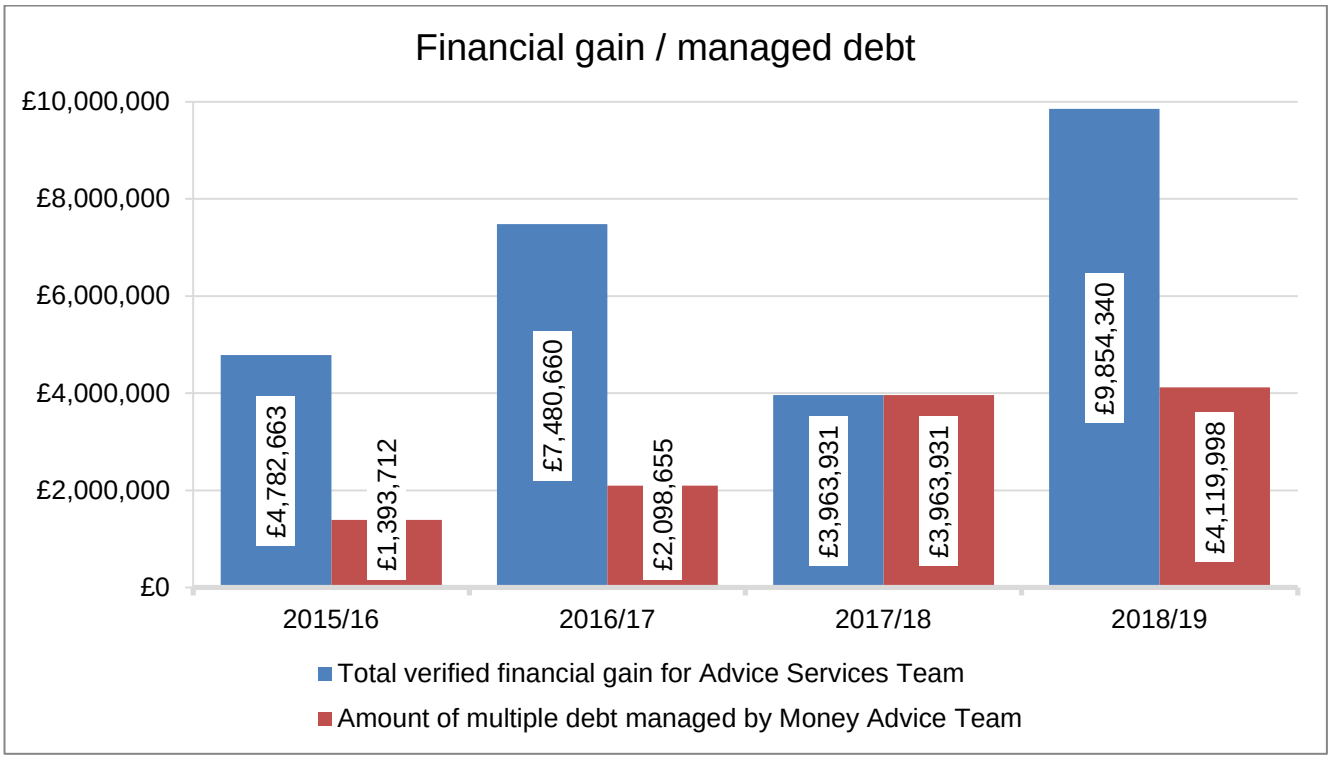
- Financial inequality
- Homelessness

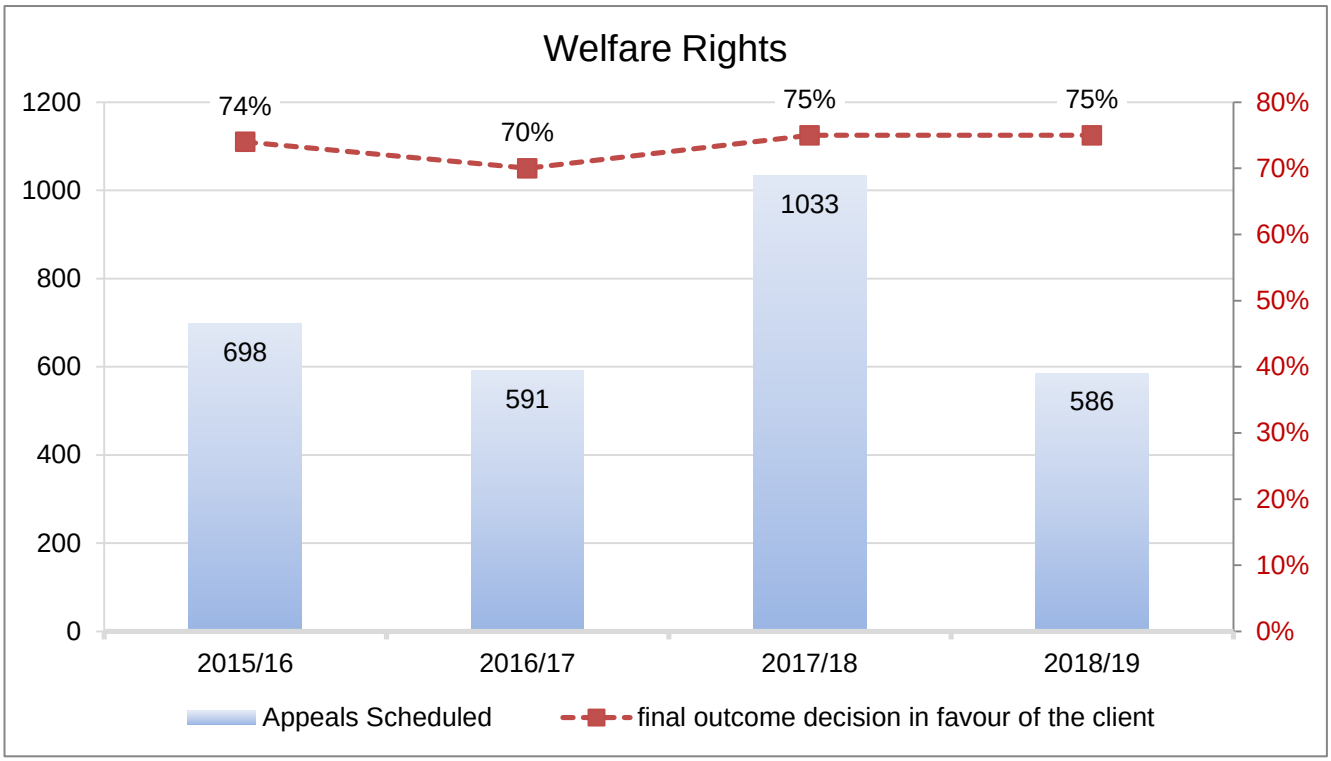
Financial Inequality

Our **Advice Services Team** handles a vast range of enquiries including debt advice, benefits advice, welfare rights appeals and debt resolution. The tables below show activity and outcomes for the past 4 financial years.






Financial gain / managed debt
£10,000,000
£8,000,000
£6,000,000
£4,000,000
£2,000,000
£0
£4,782,663
£1,393,712
£7,480,660
£2,098,655
£3,963,931
£3,963,931
£9,854,340
£4,119,998
2015/16
2016/17
2017/18
2018/19
Total verified financial gain for Advice Services Team
Amount of multiple debt managed by Money Advice Team


Welfare Rights
1200
1000
800
600
400
200
0
80%
70%
60%
50%
40%
30%
20%
10%
0%
74%
70%
75%
75%
698
591
1033
586
2015/16
2016/17
2017/18
2018/19
Appeals Scheduled
final outcome decision in favour of the client

Working with local people and other organisations we gained significant financial amounts for Inverclyde Residents.

*The Macmillan Advisor and the Vulnerable Groups Outreach Worker both migrated on to the Advice Services Caseload Management System during 2017/18 which had an impact on the volume of clients seen and financial gains captured.

A Mother's Story

A Money Advisor was working with a single parent with substantial health issues and under a lot of pressure.

The client admits struggling with budgeting and overcompensates with the children for the lack of things that she had growing up. As a result she struggles to maintain payments towards debts. The client found it difficult to engage with services.

So far the debts written off have totalled over £2000 after the Money Advisor challenged the lenders on affordability and responsible lending.

The client now feels less anxious about her debts. Budgeting support and family support has eased the pressure and the client is very aware of where to go for help should issues arise in the future.

Morag's Story

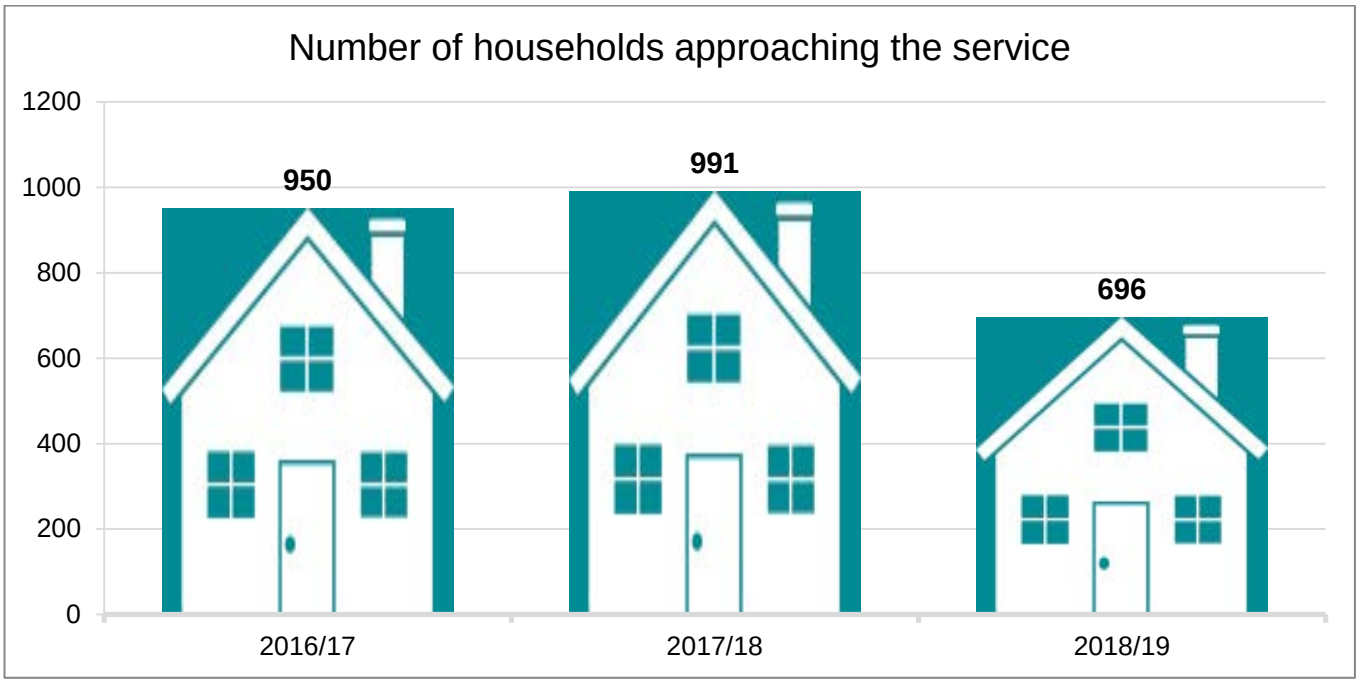
Morag was referred to the Inverclyde Macmillan Benefits Service by the Clinical Nurse Support following a cancer diagnosis. Assistance was made to apply for Personal Independence Payment; contribution based Employment Support Allowance for both Morag and her partner; disability discount to help reduce Council Tax costs and an application was made for road tax exemption. Financial gains confirmed so far are £17,347 per annum.

Morag was also assisted to apply for: a blue badge; bus pass and companion pass; parking bay; and information was provided for Morag and her partner to book a short respite break.

Homelessness

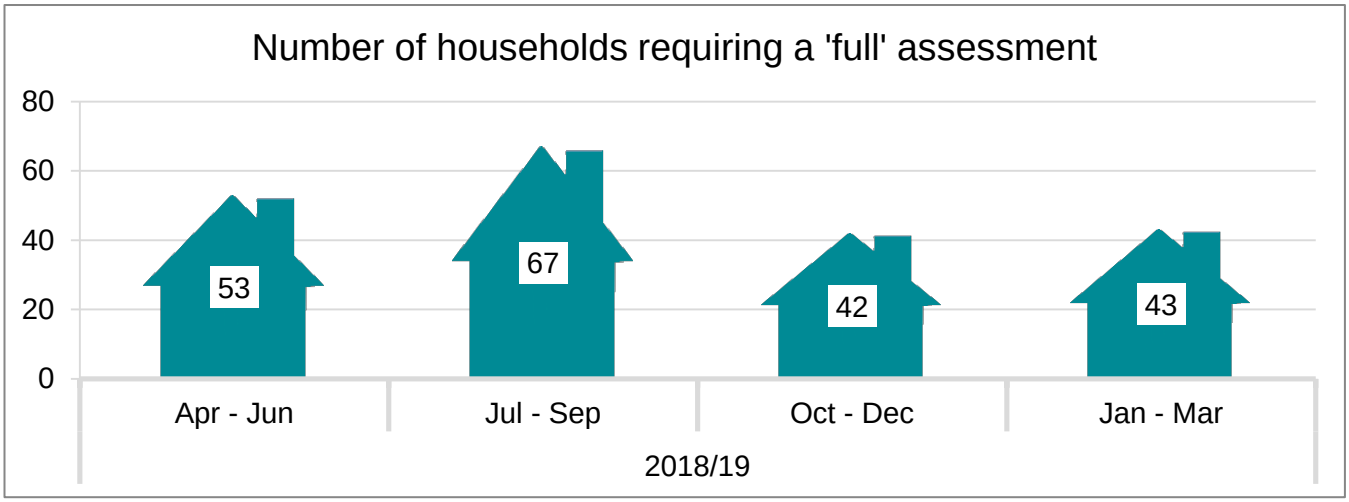
Working towards reducing Health Inequalities, we have also undertaken a range of activities that are designed to resolve homelessness as quickly as possible and, ideally, prevent this altogether.

Figures for the last 3 years show the number of approaches to the service for advice and support (also referred to as 'Housing Options') to prevent homelessness.



By focusing on interventions to prevent people from becoming homeless, we are able to resolve the vast majority of cases (approx. 73%) at this stage.

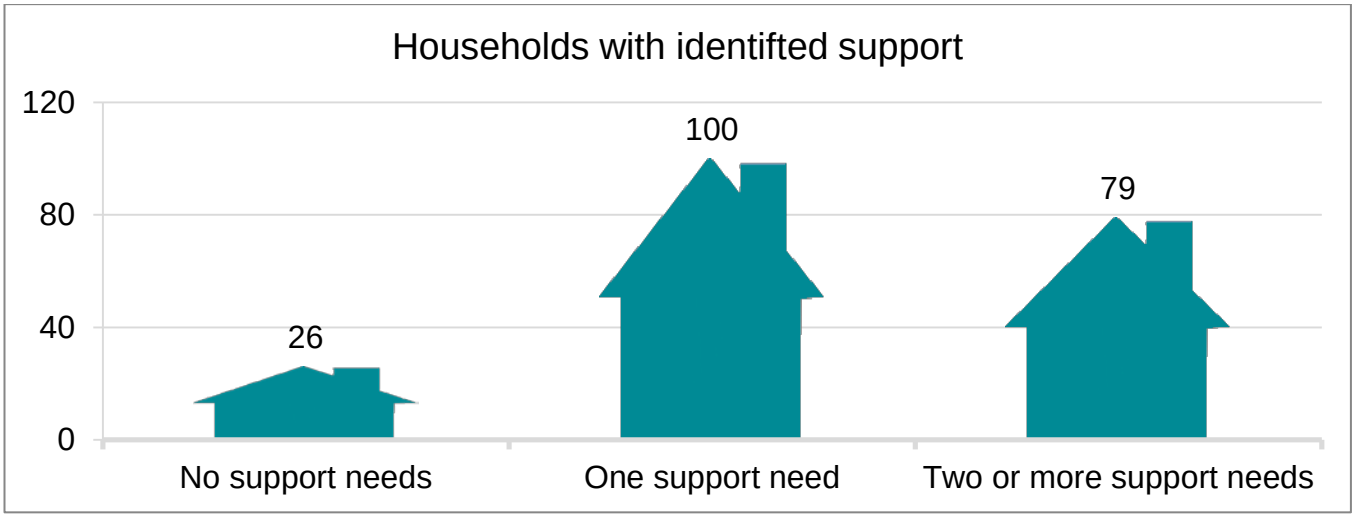
Where it has not been possible to prevent homelessness occurring, the service will carry out a more intense level of support. This involves a fuller assessment of the circumstances and needs of a presenting household and, as necessary, providing temporary accommodation. The chart below shows the number of these assessments that began in 2018/19.



During this assessment a number of areas are covered to identify the required support that can enable resolution of a household's homelessness situation. The areas include:

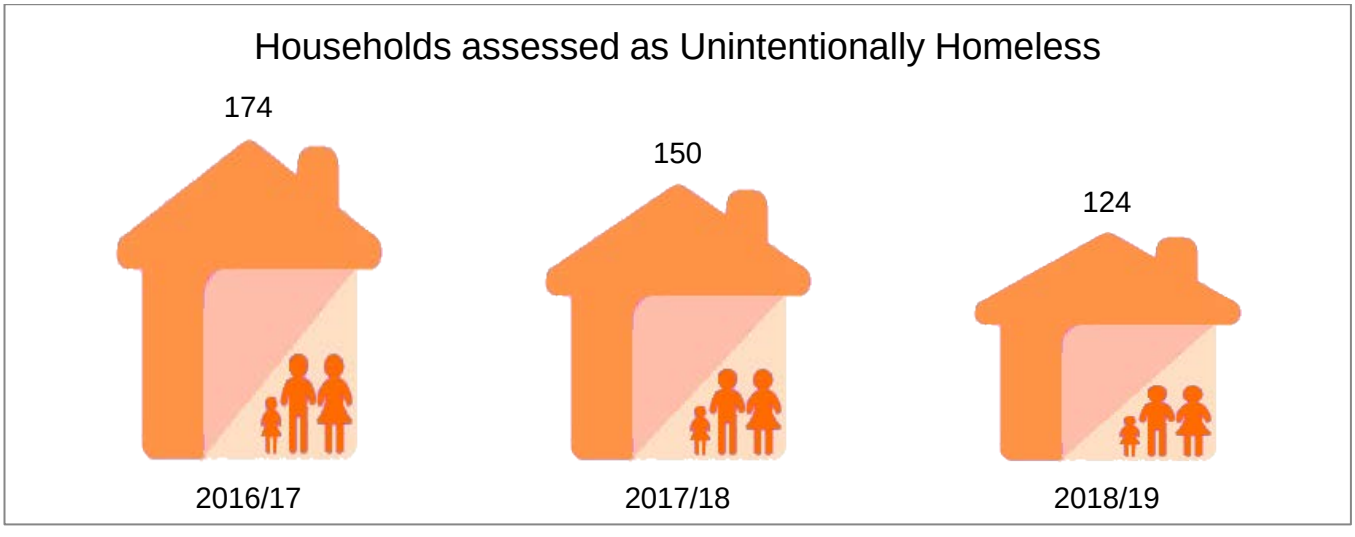
- Mental Health
- Learning Difficulties
- Physical Disability
- Medical Conditions
- Drug or Alcohol dependency
- Housing management / independent living skills

Not every household will require support in these areas, whereas some will require support in multiple areas. The chart below gives an indication of this for 2018/19.



An extract from section 24 of the Housing (Scotland) Act 1987 defines homelessness as follows: '*A person is homeless if he/ she has no accommodation in the UK or elsewhere. A person is also homeless if he/ she has accommodation but cannot reasonably occupy it... A person is intentionally homeless if he/ she deliberately did or failed to do anything which led to the loss of accommodation which it was reasonable for him/ her to continue to occupy."*

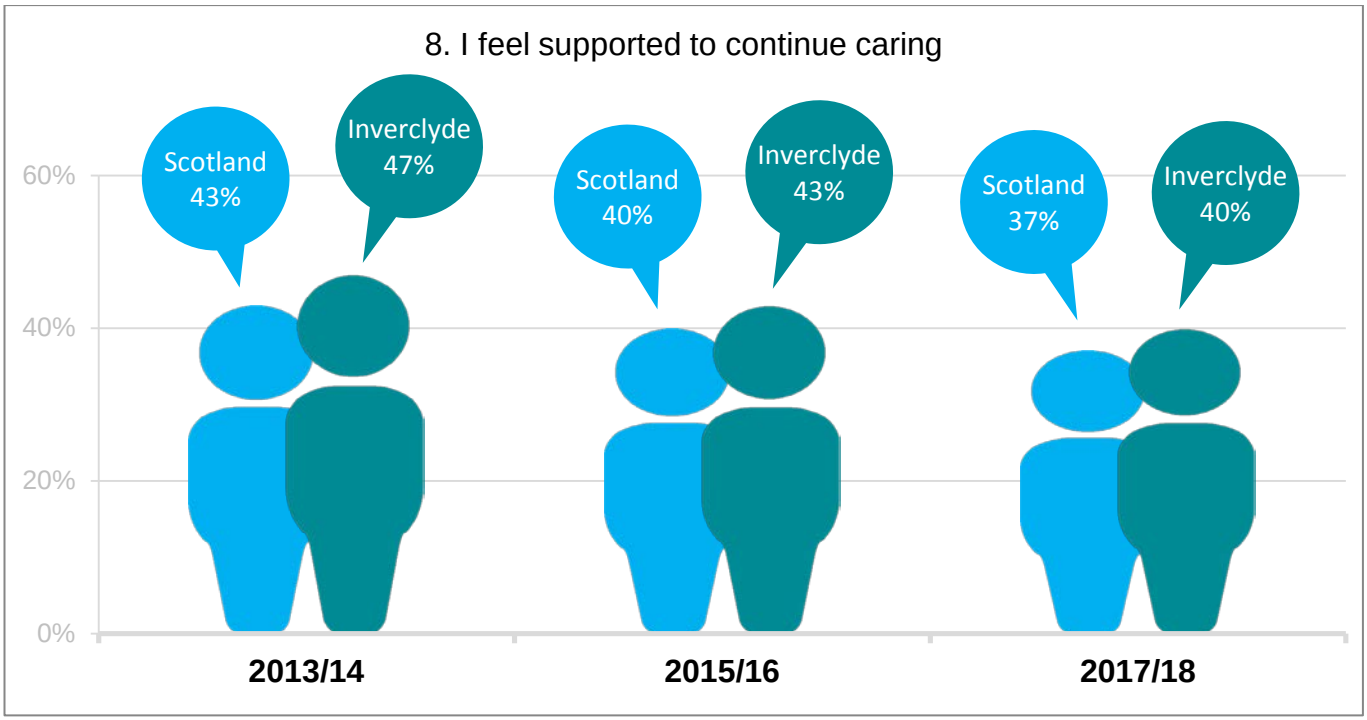
The graph below shows the reduction in the number of households that are assessed in this context as being 'unintentionally homeless' over the last 3 years.



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 wellbeing.

The Carers (Scotland) Act 2016 took effect on 1 April 2018, this is a key piece of legislation to "promote, defend and extend the rights" of Adult and Young Carers across Scotland. It brings a renewed focus to the role of unpaid Carers and challenges statutory, independent and their sector services to provide greater levels of support to help Carers maintain their health and wellbeing.

Current performance: National Integration Indicators



Higher figures = Better performance (data from the biennial Health and Care Experience Survey)

Current performance: Local Indicators

Carers

The Carers (Scotland) Act 2016 commenced from 01 April 2018 and Inverclyde have been working hard with carers and young carers to ensure the successful implementation of the new powers enshrined in the Act. In April 2019, Inverclyde Health and Social Care partnership took the decision to waive all charges for respite and short breaks. We are the first Council to implement this in Scotland and will be of direct benefit to over 250 carers and their families.

The aim of the Act 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 fulfilled life alongside caring. For young carers the intention is to ensure that they are supported to ensure that they have a childhood similar to their non-carer peers.

Inverclyde has:

Worked in collaboration with Inverclyde Carers Centre to ensure the requirements of the Act are implemented locally.

Waived all charges for respite and short breaks. We are the first HSCP to implement this in Scotland and will be of direct benefit to over 250 carers and their families.

Supported Inverclyde Carers Centre to develop Carer Awareness Training to promote the rights of carers across the workforce as we move towards full implementation.

Commissioned Your Voice to develop a range of carer engagement opportunities.

Raised awareness of young carers and issues across education and the wider community, increased capacity of Young Carers support from Barnardo's Thrive Project.

Fund a Carer's Passport Card to support increased identification of carers, linking to a "Carer Friendly Inverclyde" by encouraging local organisations to offer community/commercial discounts for carers. To date over 100 businesses have signed up to the scheme and over 300 carers are in receipt of a card.

Support Financial Fitness to provide an outreach advice service for Carers engaging with Inverclyde Carers Centre.

Support Inverclyde Carers Centre to provide emotional support to carers.

Over 500 carers identified themselves as carers in the past financial year with around 150 Adult Carer Support Plans completed and around 30 Young Carers Statements completed.

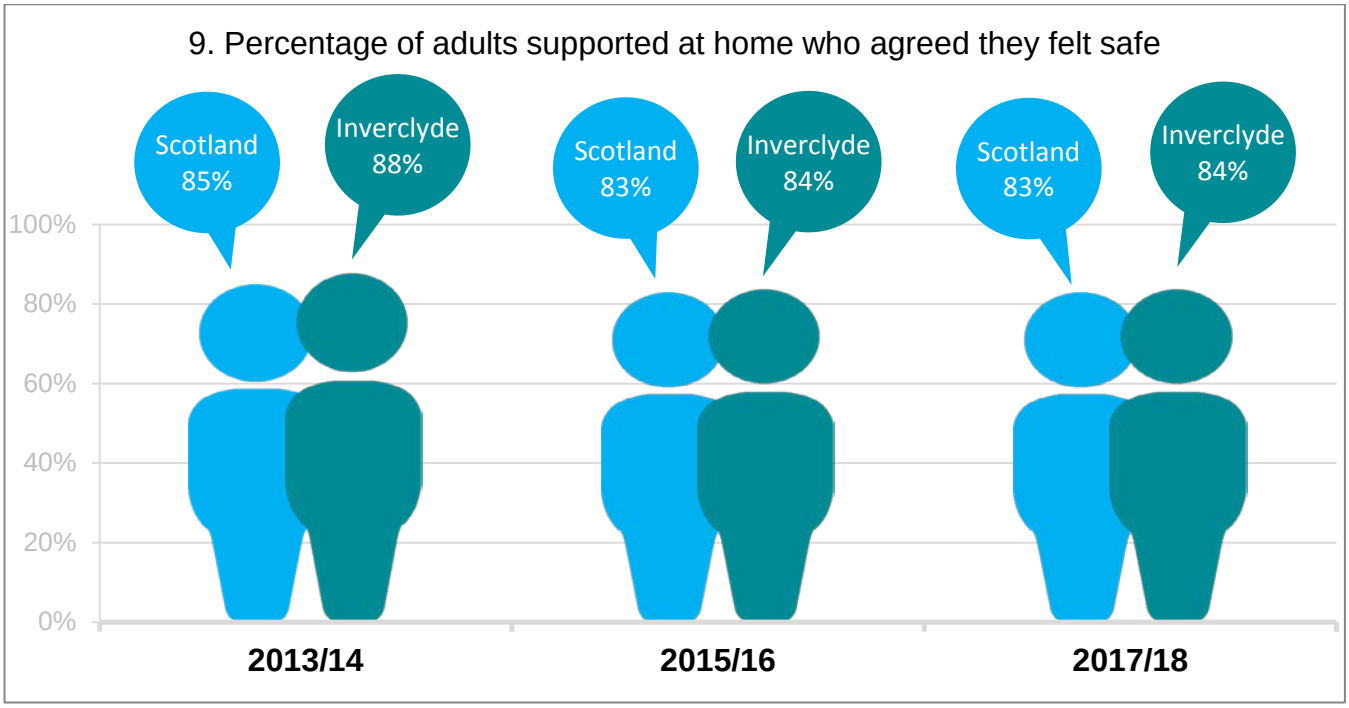
A copy of the Inverclyde Carer & Young Carer Strategy 2017-2022 is available on the Inverclyde Council website:
http://www.inverclyde.gov.uk/health-and-social-care/support-for-carers/inverclyde-carer-young-carer-strategy-2017-2022

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

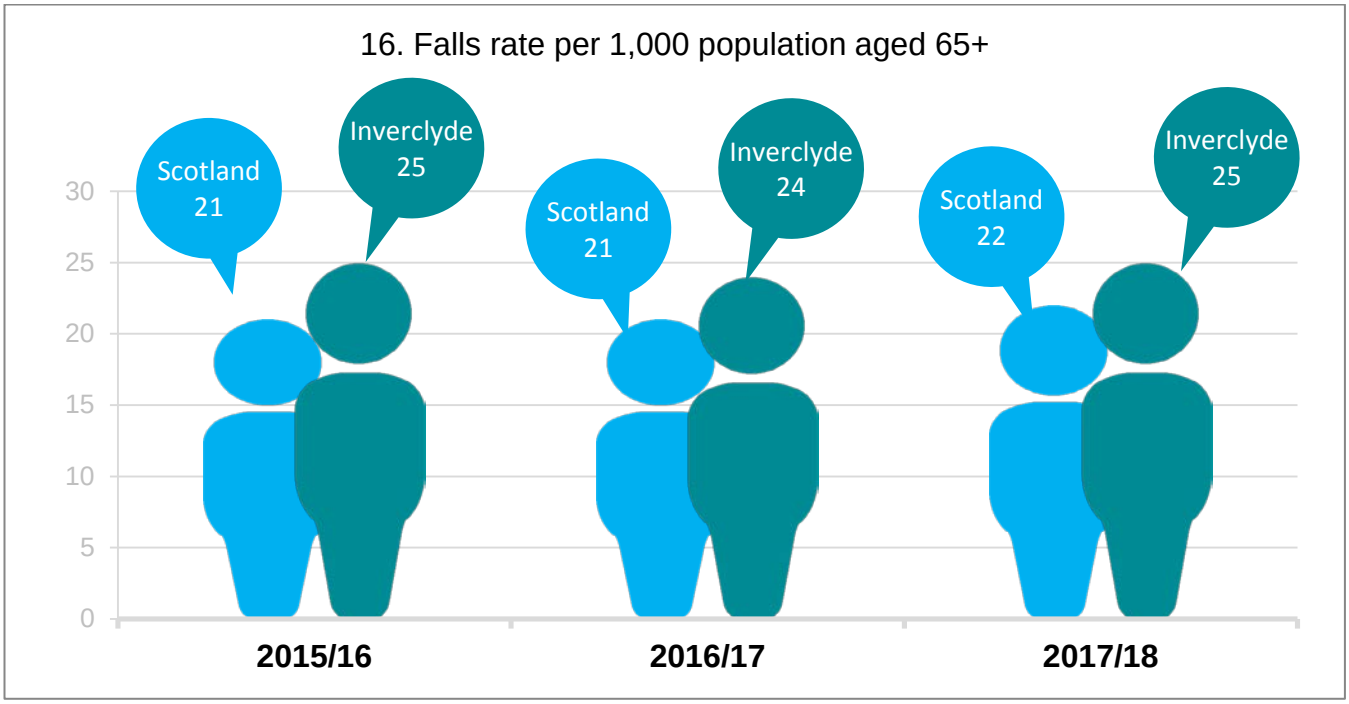
Making sure people are safe from harm is about maintaining safe, high quality care and protecting vulnerable people.

Under the Adult Support and Protection (Scotland) Act 2007, public sector staff have a duty to report concerns relating to adults at risk and the local authority must take action to find out about and where necessary intervene to make sure vulnerable adults are protected.

Current performance: National Integration Indicators



Higher figures = Better performance (data from the biennial Health and Care Experience Survey)



Lower figures = Better performance

Both locally and nationally the number of older people experiencing injury through a fall has remained static over the past 3 years, the Scottish figures range from 21 to 22, Inverclyde 24 to 25.

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.

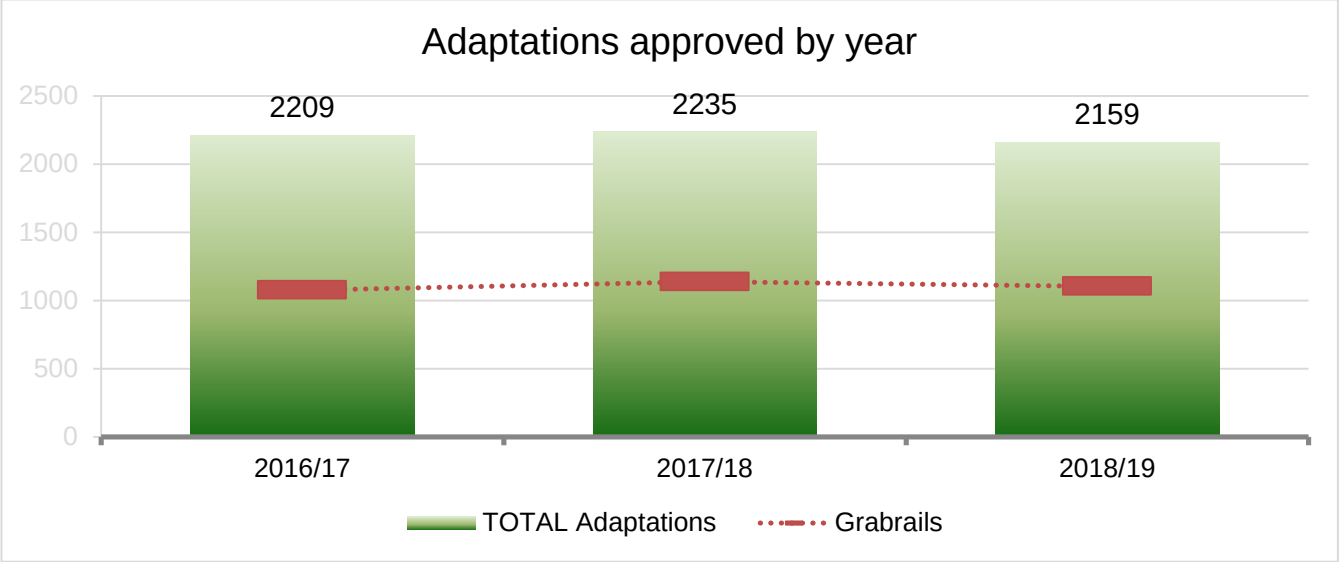
Joint working between the falls physiotherapist and Community Alarm Team should help towards reducing the rate of falls in our older population.

Current performance: Local Indicators

Housing adaptations

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

In 2018/19 we arranged for 2,159 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.



Allan's story

The service received an urgent referral for 77 year old man (Allan) from his GP. The request was for his patient to be seen due to fall and reduced mobility.

Allan was previously independent with walking sticks and driving his own car. Following receipt of referral he was reviewed on the same day by Urgent Community RES Team. He was assessed as unable to transfer or walk unassisted and was issued with equipment which would allow him to continue to weight bear and maximise his potential to be able to return to his usual level of ability.

Specialised community equipment was also issued (wheeled commode chair, high back chair and bed lever) to maintain his function at home and reduce the stress on his wife and support her to take on the new role as his Carer.

The assessor also arranged for him to be seen urgently by other specialist community services.

The Community RES Team worked with Reablement colleagues, shared advice and shared Allan's focussed goals. There was frequent and appropriate communications between all services including Allan's GP and the services worked together to support him to improve both his mobility and function.

He has returned to using walking sticks to mobilise and is in the process of returning to driving.

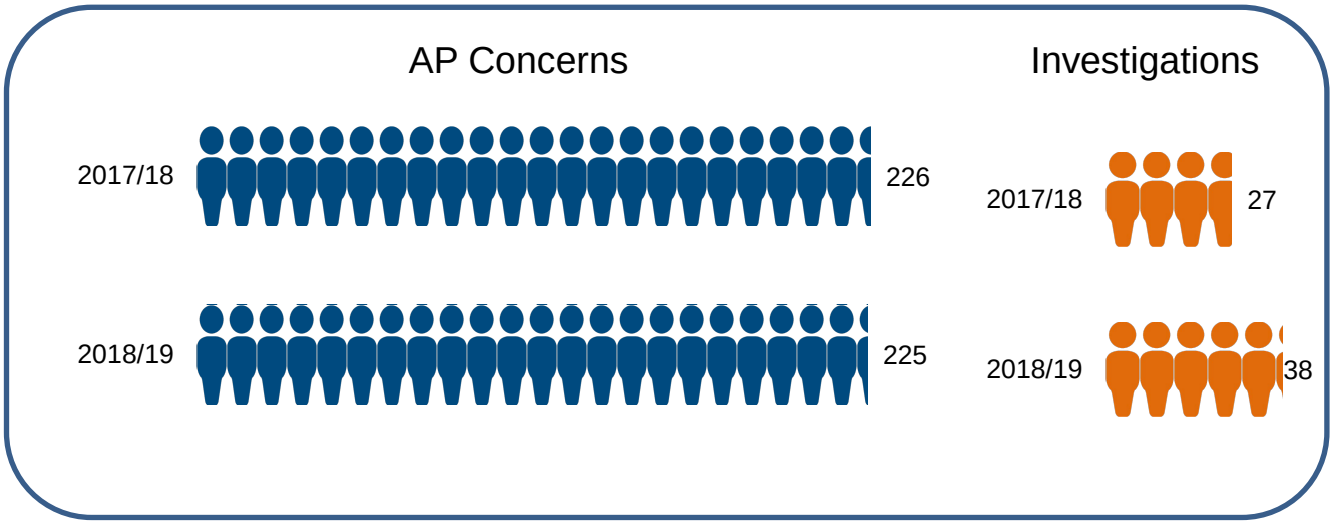
Allan continues to improve with the Community Rehab team and it is hoped that his Reablement Service can stop soon due to his improvements and increased independence.

Protecting vulnerable adults

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

During 2018/19, 225 Adult Protection concerns were referred to the HSCP (no change since 2017/18).

After initial inquiries 38 of these concerns - or about 17% - progressed to a full investigation. Investigations fluctuate from year to year but generally remain within parameters of a 10 to 20% conversion rate from referrals to investigations.



In line with the statutory duties 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 2018/20 has been 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 was audited against the West of Scotland Council Officer Learning and Development Framework. The content of exiting courses have been reviewed and new courses have developed based on identified gaps.

- 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 are subject to planned review.

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

- Review of Communication Strategy to improve public awareness of Adult Support and Protection.

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

Ben's story

Ben's situation came to light following a police referral. He was an older man with cognitive impairment who lived alone. He was subject to financial harm following being targeted by bogus workmen. He was taken to the bank by them in an attempt to withdraw a significant sum from his account for unnecessary and non-existent work to his property.

Social work and health worked together to ensure Ben's wellbeing and finances were safeguarded in the short and longer term whilst the police, trading standards and bank progressed a criminal investigation.

Ben's situation was progressed under auspices of adult support and protection however all appropriate legislation was considered with action under adults with incapacity legislation being utilised to secure his financial position.

Whilst this criminal act was a traumatic experience for Ben and his family, they very much appreciated and felt supported by the coordinated multi-agency response to their situation.

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

An engaged workforce is crucial to the delivery of the HSCP visions and aims. Workforce engagement helps create an environment where the workforce feels involved in decisions, feels valued and is treated with dignity and respect. It is only through an engaged workforce that we can deliver services and supports of the highest standard possible.

Current performance: National Integration Indicators

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.

Current performance: Local Indicators

iMatter

Inverclyde HSCP IMatter has demonstrated a year on year increase in response rates and this year for the first time we exceeded the threshold of 60% return and received a detailed and specific report of the staff experiences of Inverclyde HSCP.

The report demonstrates a 80% average across all questions which suggests that the HSCP staff are well engaged while staff rated Inverclyde HSCP as a good place to work as 7.32 out of 10 on a Likert scale. Our highest and lowest scores are detailed below. It's important to note that only one of twenty nine questions fell outwith the green "strive and celebrate" category.

The Chief Officer along with members of the Senior Management Team created an improvement plan that included:

- A schedule of senior manager service area visits to increase visibility and provide opportunities to meet and speak to staff across the HSCP. The Chief Social Work Officer meets with all new Social Work staff at induction.
- All redesign programmes within the Transformation Board will include staff work streams.

- Creation of 2 “open chairs” for staff members to attend the Staff Partnership Forum is planned.
- Leadership sessions support better conversations and increased feedback within the HSCP.

IMatter helps us focus on what is important to our staff and by focusing on this improvement journey we trust they will know that they matter.

Highest Scores by year		**2017**	**2018**	**2019**
	My direct line manager is sufficiently approachable	90%	91%	90%
	I am clear about my duties and responsibilities	87%	89%	89%
Lowest Scores by year				
	I feel senior managers responsible for the wider organisation are sufficiently visible	67%	68%	70%
	I feel involved in decisions relating to my organisation	61%	62%	65%

Health & Social Care Standards

Health and Social Care Standards (H&SCS) sessions were provided to raise awareness amongst managers and HSCP staff in relation to the Health and Social Care Standards which came into force in April 2018. 104 staff from across the HSCP attended the sessions facilitated by Healthcare Improvement Scotland. The sessions included a presentation of the Standards and time for group discussion and reflection.

The key insights included:

- The standards support Scotland’s journey to integrate health and social care and create shared objectives, a shared language and more joined-up service for the public.
- The Standards will have a far wider impact and will apply to many more people’s experiences of care, including non-registered care and care provided by the NHS and local authority.

- There is a move away from the traditional prescriptive standards to a more holistic model looking at an individual's overall experience and therefore requires a different kind of inspection starting with care homes for older people.
- The Care Inspectorate's expectation is that the H&SCS will be used in planning, commissioning, assessment, and delivering care and support.
- For practitioners, the Standards support a reflective stance and orientate the reader to the patients/service user's experiences and the outcomes that are desired.
- For the Organisation, the Standards orientate leaders to focus on the quality of relationships, how leadership is being evidenced and person centred evidence within the services they manage.

The H&SC Standards provide a real integrated opportunity for the whole of the HSCP workforce to work to shared goals using a common language and shared set of Standards.

Inverclyde HSCP Staff Awards

Our local Staff Awards were held in the Tontine Hotel, Greenock on 5 October 2018 and over 100 colleagues and guests came together to celebrate excellence in Inverclyde HSCP.

Our Inverclyde HSCP Macmillan Welfare Benefit Service won "our service users" category for providing a nationally recognised service, addressing the financial impacts of a diagnosis of cancer. The team also went on to win the overall "Celebrating Excellence Award" for Inverclyde HSCP and were awarded the accolade for making a real difference to people's lives when they need it most.

John Smith our Community Alternatives Resource Manager won the "our people" award for his outstanding contribution in championing recovery and social inclusion in mental health and beyond.

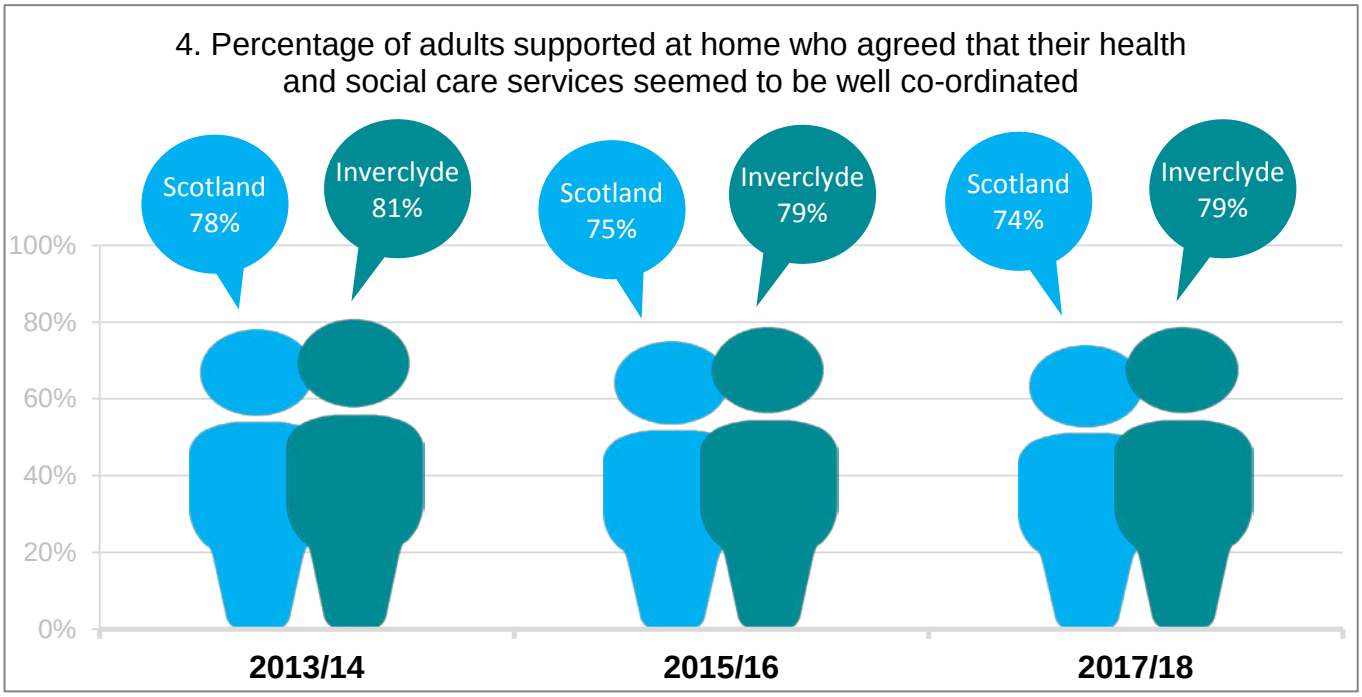
The New Ways project team won the “our culture” award for piloting new ways of working within primary care, introducing new roles and approaches to develop multi-disciplinary teams within GP practices.

The “our leaders” award went to the Health and Community Care Team Leads who inspired and demonstrated innovative leadership and in the development and embedding of the Home 1st Reablement approach. The Home 1st team went on to win the coveted Greater Glasgow and Clyde Chairman’s award for “outstanding excellence”. The strong message of partnership working and the enabling culture inherent in the Home 1st approach is an inspiration.

Outcome 9 - Resources are used effectively and efficiently in the provision of health and social care services

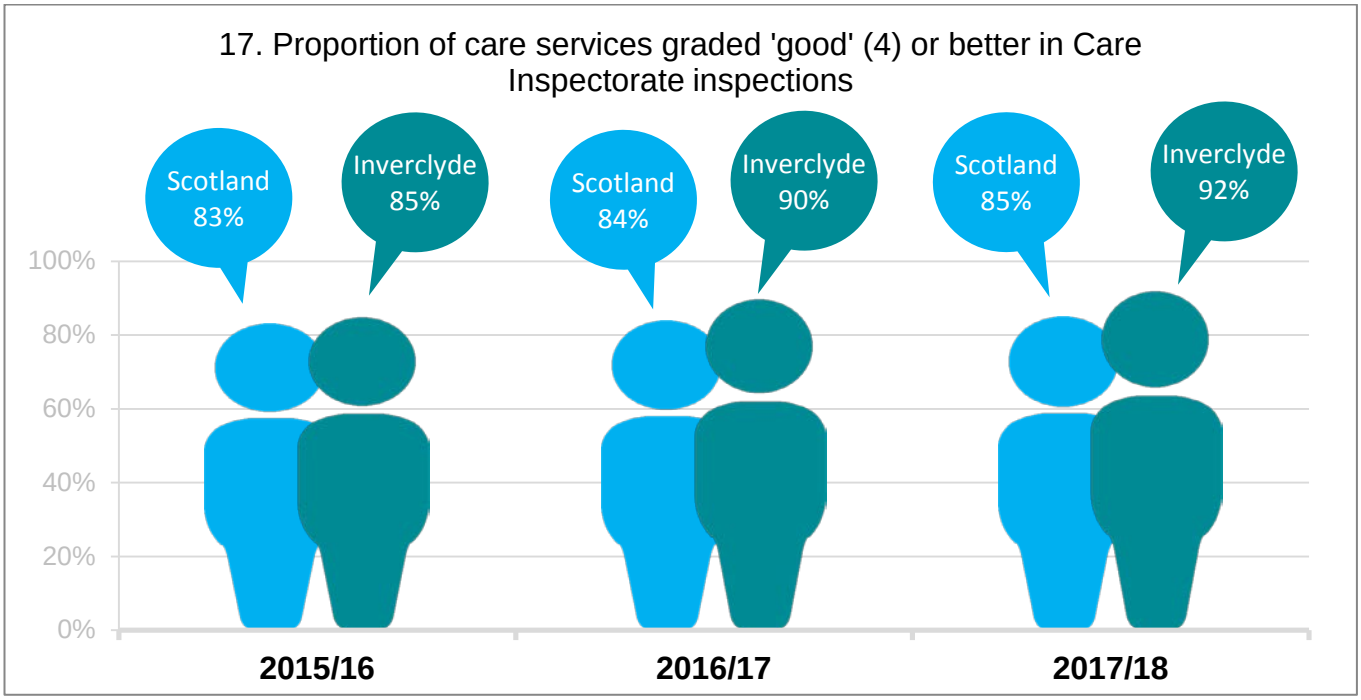
There are various ways that the HSCP is seeking to ensure that resources are used effectively and efficiently. We are improving quality and efficiency by making the best use of technology and trying new ways of working to improve consistency and remove duplication.

Current performance: National Integration Indicators



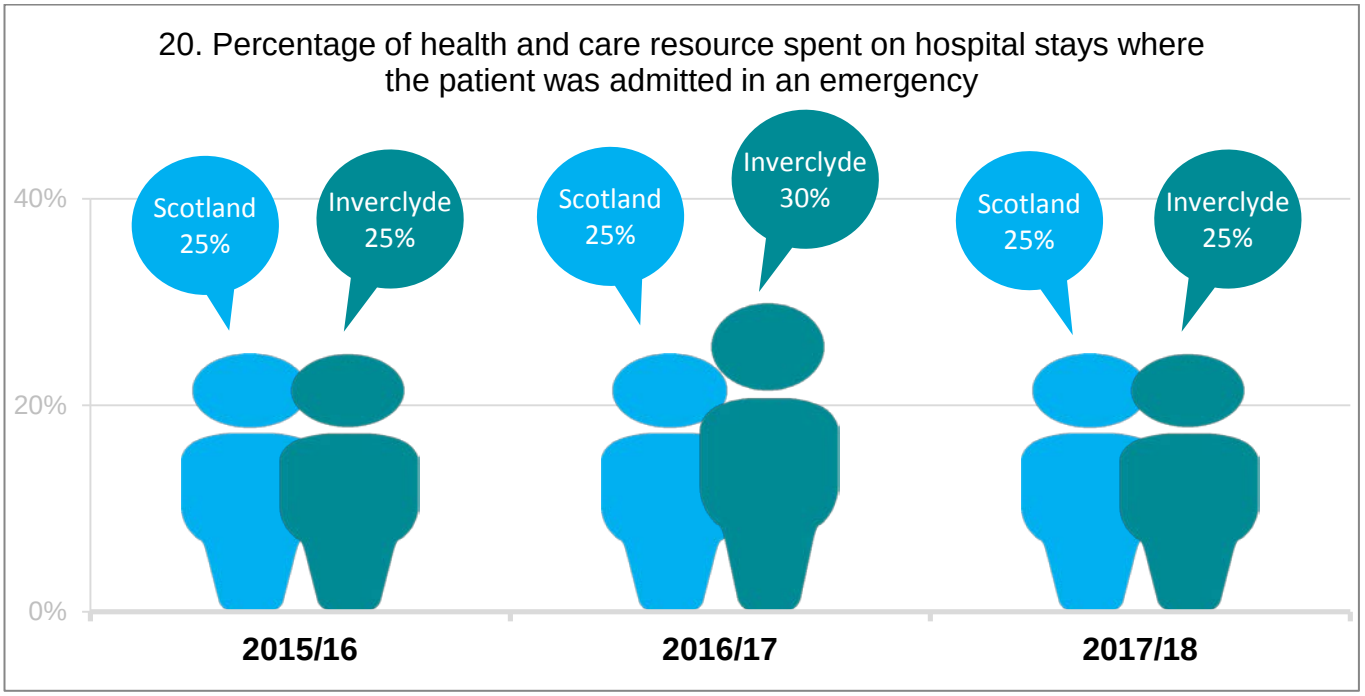
Higher figures = better performance (data from the biennial Health and Care Experience Survey)

We are consistently above average, but continue to try to do better. The six Big Actions in our 2019/24 Strategic Plan have an underlying theme of making the most of integration.



Higher figures = better performance

This reflects the strong partnership working between HSCP officers and our local care provider organisations.



Lower figures = better performance

By reducing this percentage, we hope to release money into community based services. People would rather receive care in their own homes whenever safe and appropriate.

23	Expenditure on end of life care, cost in last 6 months per death	Indicator under development (ISD)

Current performance: Local Indicators

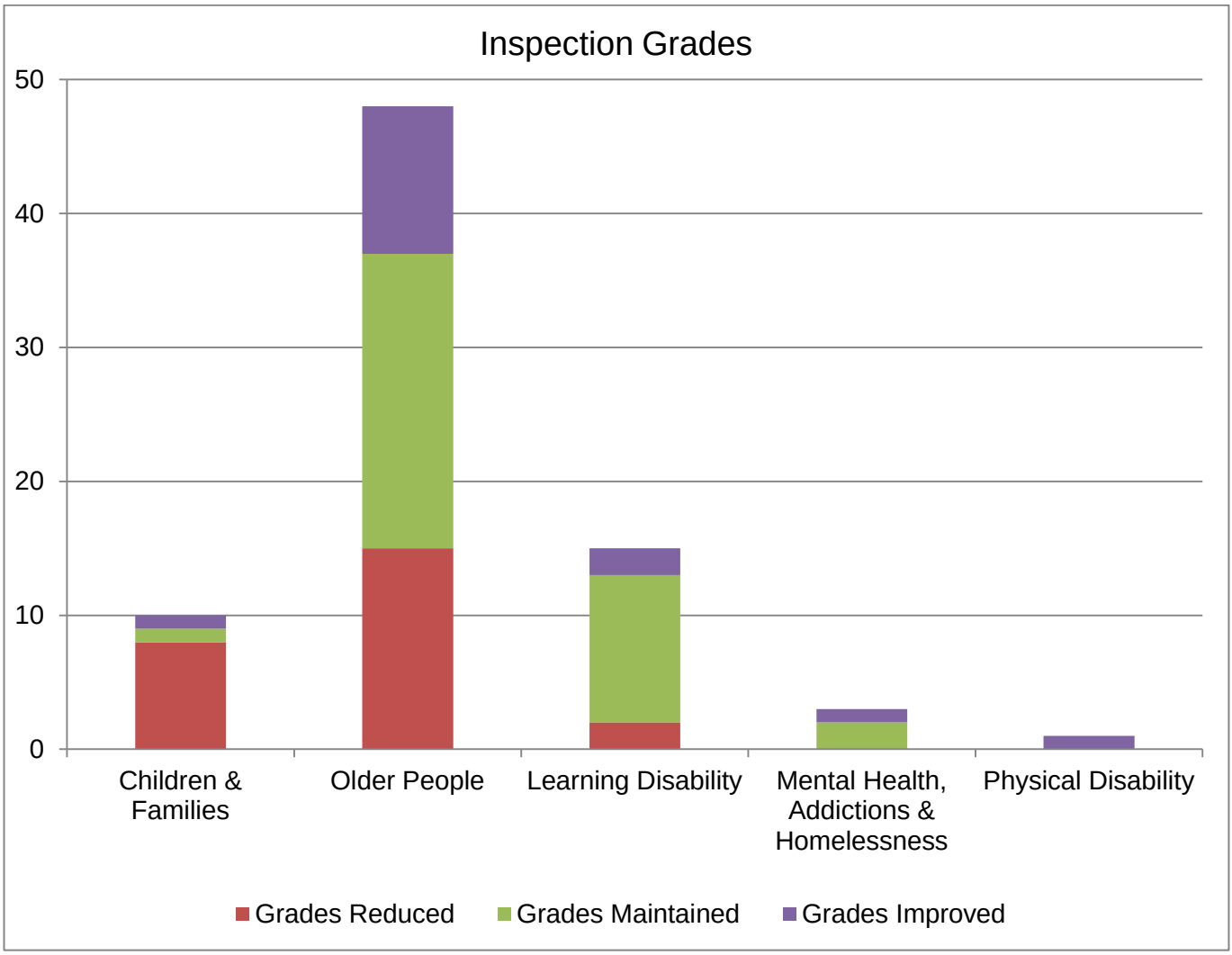
Inverclyde Services Care Inspectorate

Total number of Inspections carried out for providers who receive payment from Inverclyde HSCP was 77.

39 of the services inspected were Inverclyde Area services.
38 of the services inspected were Out of Area placements.

Of the 77 services that were inspected:

- 16 Services improved their grades
- 36 Services grades were maintained
- 25 services grades decreased.



Access 1st

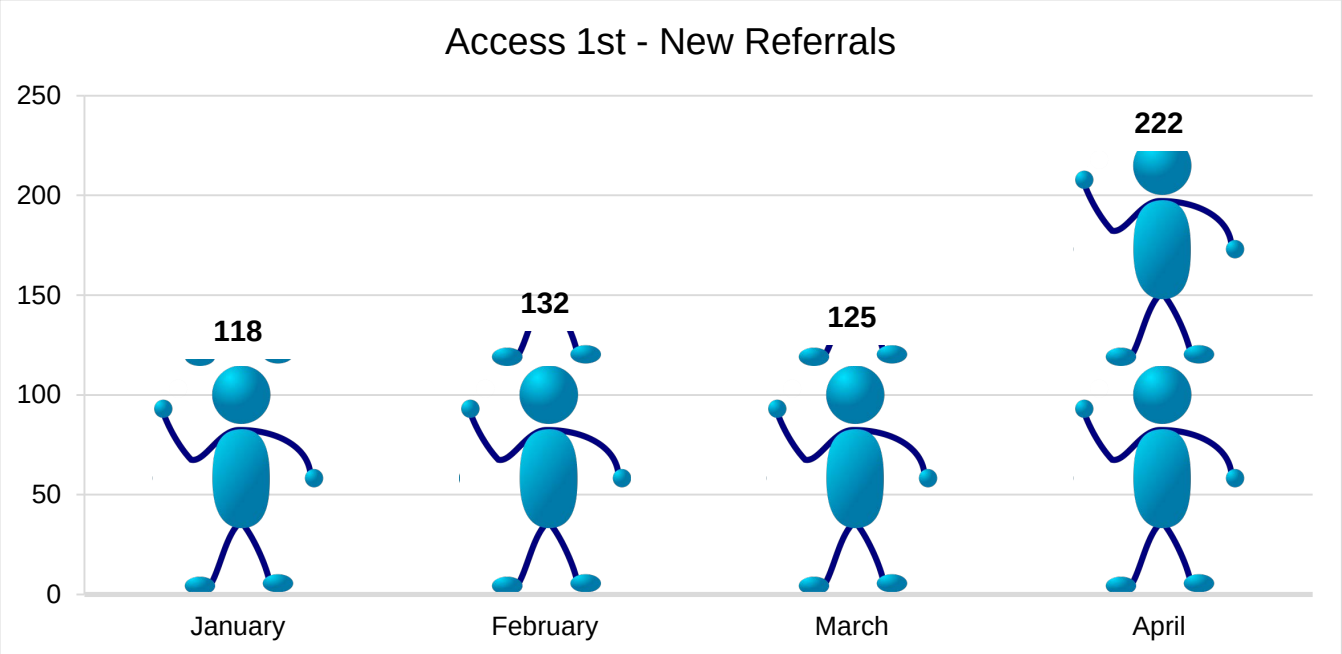
Access 1st is a single point of contact for referrals for adult Health and Social Care Services in Inverclyde. This is in line with our Home 1st approach and fits with the HSCP Big 6 strategic actions.

The approach of Access 1st is to assess the eligibility of need and support people to:

- live a safe, healthy active and satisfying life
- Feel respected and included in their local community
- Feel that they have the same opportunities as others who do not have a long term condition or disability
- Promote equality and dignity
- Support them in their role as a Carer.

Access 1st offers access to a range of supports including:-

- Signposting to relevant community organisations for services available to the whole community including community connectors
- Providing information and advice around health and social care services
- Access to equipment to assist with daily living
- Provide services which can enable individuals to enjoy a full life with a little short term assistance
- Long term support for individuals who require ongoing support due to their health or disability
- Safeguarding adults who may be at risk.



People are able to refer themselves or a family member, friend or carer to Access 1st. We also accept contacts from other professionals and representatives on behalf of their clients or patients.

As part of our overall Assessment and support planning, Access 1st will promote a person's abilities and skills as well as involvement of partner's family's friends and neighbours to meet the assessed needs of the person.

By 2024 we will improve access to HSCP services by moving from 11 access points to 3.

For more information about services we can provide or access on your behalf please contact Access 1st or visit our web page:

https://www.inverclyde.gov.uk/health-and-social-care/adults-older-people/homecare

Compassionate Inverclyde

Compassionate Inverclyde has grown from a small local initiative into something which many of the people involved describe as a social movement.

It comprises many different elements, all connected by a strong overarching story about enabling ordinary people to do ordinary things for ordinary people and guided by the community values of being compassionate, helpful and neighbourly.

Compassionate Inverclyde - the first compassionate community in Scotland was recognised at the COSLA Excellence Awards 2018.

The project is a partnership between Inverclyde Health & Social Care Partnership and Ardgowan Hospice and has brought together hundreds of volunteers supporting and caring for one another at time of crisis and loss.

Community engagement and development has been carried out across all age groups and many organisations within Inverclyde involving schools, churches, workplaces, community centres, hospital, local hospice, youth groups and voluntary organisations.

Strands of Compassionate Inverclyde

Compassionate Inverclyde continues to grow organically and now has many interdependent strands with the overarching movement.

No One Dies Alone (NODA)

One important strand of Compassionate Inverclyde is the No One Dies Alone work stream. Inverclyde Royal Hospital has become the first hospital in Scotland to have No One Dies Alone (NODA) programme. Local people were concerned about many people living and dying on their own. Volunteers provide support to those in their final hours who do not have family or friends available to be with them. Initially developed to support people at end of life in hospital it is now spreading to support end of life care in the community, initially in care homes.

49 People have benefitted from volunteer/No One Dies Alone companion support*

*From inception on 1/12/17 to 15/4/19

High Five Programme

Adapted and delivered to school pupils, college students, youth clubs, prisoners, community groups and a local business. Each five-week programme focuses on five ways to wellbeing and helps people to understand how they can be kind to themselves and to others.

Back Home Boxes

Representing community acts of kindness to support people who live alone as they return home from hospital. The boxes are gifted by a local business and are filled with community donations of essential food items, hand crafted kindness tokens, a get well card made by local school children and a small knitted blanket made by local people and community groups. Volunteers organise collecting contents from local community and distributing the Back Home Boxes within local hospital.

1903 people have received Back Homes Boxes*

*From inception 0n 13/11/17 to 15/4/19

Back Home Visitors

Is a new development based on neighbourliness whereby a volunteer visitor and a young person will visit an older person who lives alone and is socially isolated.

Bereavement Café and Support Hub

The initial drop-in bereavement groups in two community cafes have been superseded by a volunteer led support hub in a local Church. The Hub offers a meeting place for volunteers and a friendly haven for anyone in the community who is experiencing loneliness, loss, crisis or bereavement.

The synergy between each of these community initiatives amplifies their effect, improving the lives of the people of Inverclyde and enhancing the wellbeing of the community. Each day, many people facing bereavement, loneliness, illness and survivorship benefit from community acts of kindness and support that improve their wellbeing irrespective of age, condition or circumstances.

Touching Lives

I wanted to send you a quick email to express my gratitude for the Back Home Box and the kindness of it. I will explain how much it meant.

My brother was recently in Inverclyde Royal Hospital, very unexpectedly – he had collapsed which is frightening enough for anybody but even more so for him. He has had lifelong severe mental health problems and has had struggles with that over the years. He wasn't in that long but got a box given to him on discharge. I can't tell you how much it meant to him, if you had seen and heard his reaction to it you would have been so moved and would have known that what you are doing is amazing.

He leads a very isolated life and has very little contact with anybody, when I went round to visit him he had a beautiful homemade card in pride of place on his unit, what a fabulous idea and also for the children who make them to give too and understand about giving. He was so chuffed with it and he told me he'd even got jam and milk too and listed out the box items. It felt like a Christmas hamper! It's not even totally what is in the box but the very idea that somebody can be so kind to a stranger means the world and in a time of need such a tonic as well as being so useful as he hadn't been able to get the shops.

I will be donating items into the collection boxes you have and hope that it means as much to whoever gets them as it did to both my brother and me. I confess I even felt a bit tearful about it, in a good way! He gave me the heart to hang on my twig tree! So a huge thank you to you and everybody involved and the little girl from a school in Largs who made a beautiful get well card.

You are all stars.

The above feedback demonstrates how one box touches many lives.

Inverclyde Care & Support at Home Grading

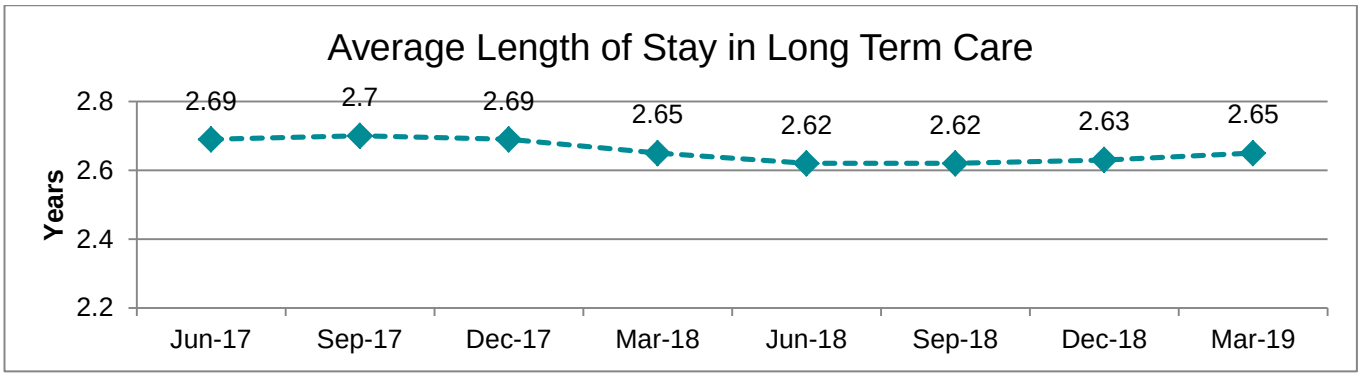
The Care & Support at Home service supports over 1,300 people in their own homes providing a number of different types of support including care at home, technology enabled care – which includes community alarms and other technological assistance - rapid response and respite.

Care & Support at Home's aim is to enable people to live as normal an independent a life as possible in their own homes.

Our annual inspection by the Care Inspectorate in May 2018 graded our Care and Support and Management and Leadership as 'very good'. This has been an extremely positive outcome given the demand for these services.

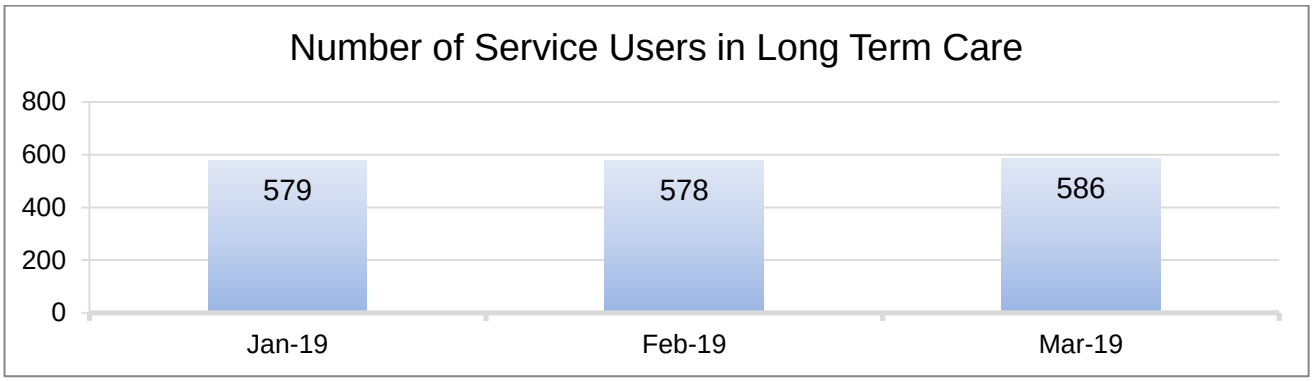
Long Term Care

The Average Length of Stay for those individuals in Long Term Care has remained fairly static. In March 2019, the average Length of Stay was 2.65 years, the measurement for the previous financial year end (March 2018) was also 2.65 years.



Although the Average Length of stay has remained static, we do know that turnover within our care homes has increased, and that clients admitted to long term care in the last few years are staying for shorter lengths of time than they did previously (this indicates that individuals are only being placed in long term care when it is deemed they can no longer live independently in their own homes supported by our other services). This is a stark contrast to some of our clients who were admitted around the turn of the millennium and whose length of stay is around 20 years.

This indicator is now measured quarterly rather than monthly due to the small changes/movements in the data.



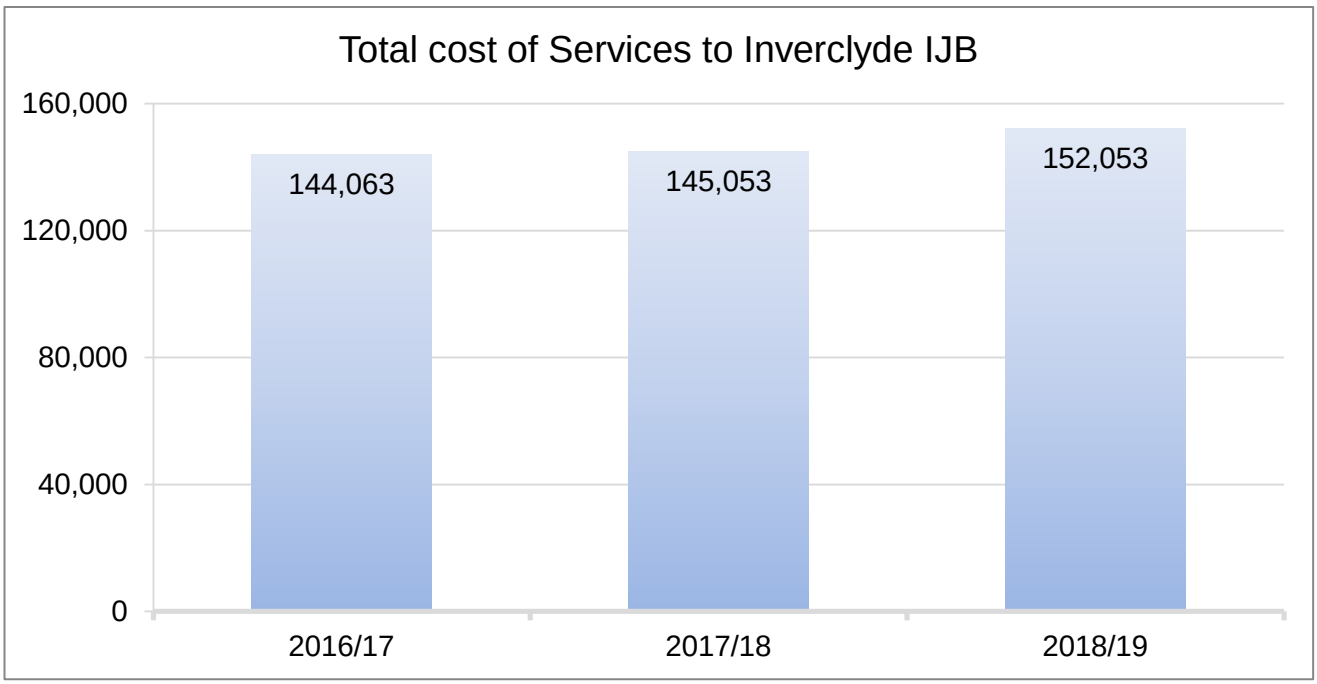
Finance

Inverclyde IJB Financial Summary by Service

	2016/17* £000	2017/18 £000	2018/19 £000
Strategy and Support Services	2,992	2,591	2,416
Older Persons	27,527	26,867	27,020
Learning Disabilities	11,028	10,653	11,898
Mental Health – Communities	5,748	5,804	6,712
Mental Health – In Patients	9,543	9,338	8,729
Children and Families	12,979	12,986	13,738
Physical and Sensory	2,714	2,659	3,117
Addiction / Substance Misuse	3,345	3,389	3,464
Assessment and Care Management / Health and Community Care	6,031	7,772	8,258
Support / Management / Administration	3,520	3,807	4,174
Criminal Justice / Prison Service	55	(38)	26
Homelessness	859	967	791
Family Health Services	21,800	21,766	25,547
Prescribing	18,136	18,817	18,591
Change Fund	1,347	1,236	1,133
Cost of Services directly managed by Inverclyde IJB	**127,624**	**128,614**	**135,614**
Set aside	16,439	16,439	16,439
Total cost of Services to Inverclyde IJB	**144,063**	**145,053**	**152,053**
Taxation and non-specific grant income	(148,023)	(146,889)	(153,538)
Surplus on provision of Services	**3,960**	**1,836**	**1,485**

* The Inverclyde IJB was established from 01/04/2016

The IJB works with all partners to ensure that Best Value is delivered across all services. As part of this process the IJB undertakes a number of service reviews each year to seek opportunities for developing services, delivering service improvement and generating additional efficiencies.



Budgeted Expenditure vs Actual Expenditure per annum

	2016/17* £000	2017/18 £000	2018/19 £000
Projected surplus / (deficit) at period 9	0	(1,426)	(897)
Actual surplus / (deficit)	3,960	1,836	1,485

Explanation of variances

2016/17 - variance due to balances remaining at the yearend on Earmarked Reserves inherited in year from Inverclyde Council

2017/18 - spend on Earmarked Reserves lower than anticipated coupled with a higher than anticipated overall underspend on services, mainly Social Care, as outlined in the Annual Accounts

2018/19 - higher than anticipated underspends on services, mainly Social Care, as outlined in the Annual Accounts

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.

	National Indicator	2016/17	2017/18	Scottish Average (2017/18)	How we compare to our last result	How we compare to the Scottish Average
1	Percentage of adults able to look after their health very well or quite well	90%	91%	93%	↑ 1%	↓ 2%
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	88%	80%	81%	↓ 8%	↓ 1%
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	85%	77%	76%	↓ 8%	↑ 1%
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79%	79%	74%	↔	↑ 5%
5	Total % of adults receiving any care or support who rated it as excellent or good	84%	83%	80%	↓ 1%	↑ 3%
6	Percentage of people with positive experience of the care provided by their GP practice	87%	83%	83%	↓ 4%	↔
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	88%	77%	80%	↓ 11%	↓ 3%
8	Total combined percentage of carers who feel supported to continue in their caring role	46%	40%	37%	↓ 6%	↑ 3%
9	Percentage of adults supported at home who agreed they felt safe	87%	84%	83%	↓ 3%	↑ 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.

Children's Services and Criminal Justice

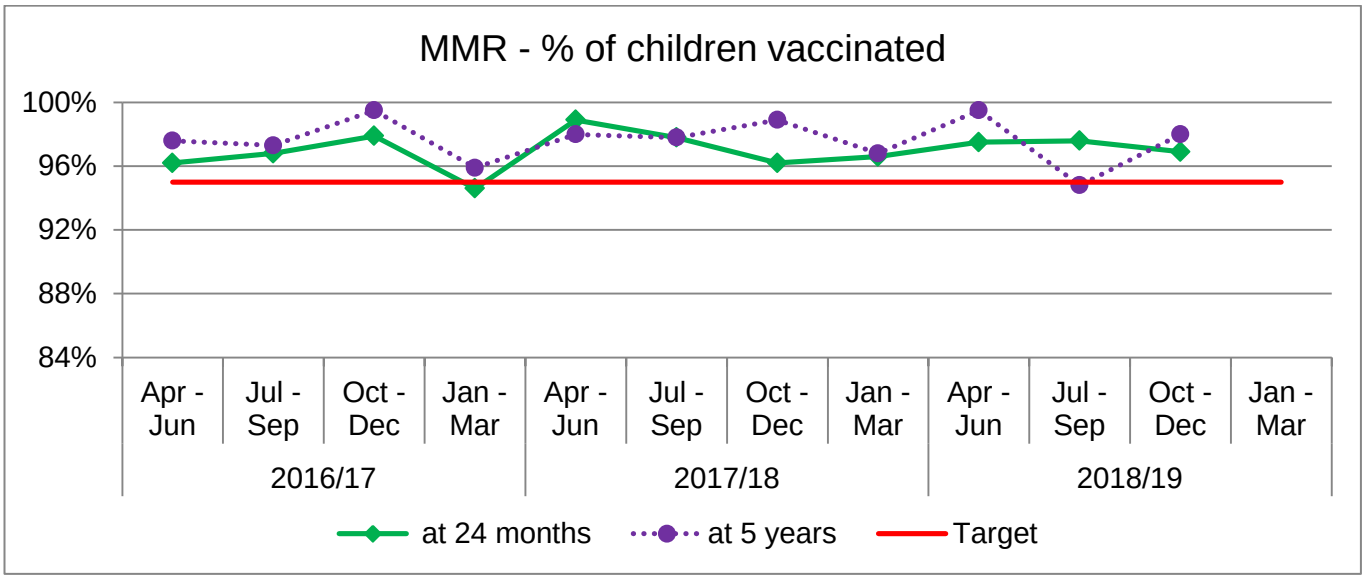
National Outcomes for Children	
10	Our children have the best possible start in life.
11	Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
12	We have improved the life chances for children, young people and families at risk.

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

Children in Inverclyde receive the best start in life

Immunisation levels for common diseases provides a gauge on the health of the child population of the area. Uptake of immunisations also indicated a shared responsibility amongst communities to protect children and prevent the spread of illness.

In respect of Measles, Mumps and Rubella (MMR) immunisations, at both 24 months and 5 years, we have regularly exceeded the target of 95%. The development and introduction of community corporate clinics in Inverclyde has improved immunisation rates across all vaccination domains.

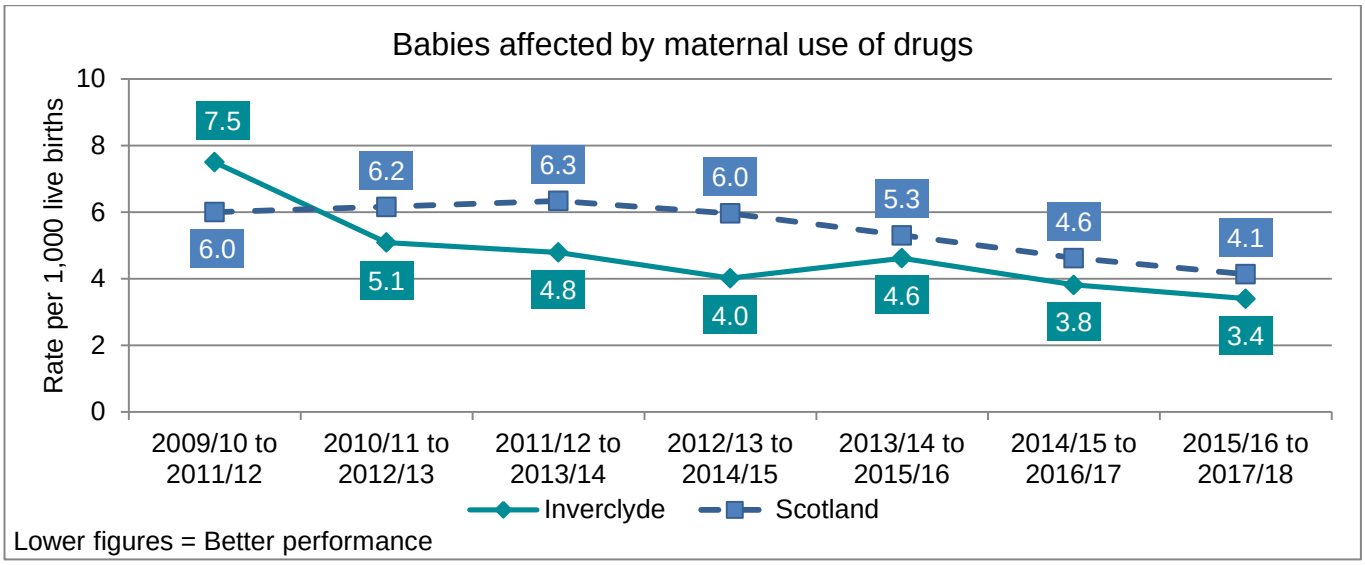


Higher figures = better performance

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 2009/10.

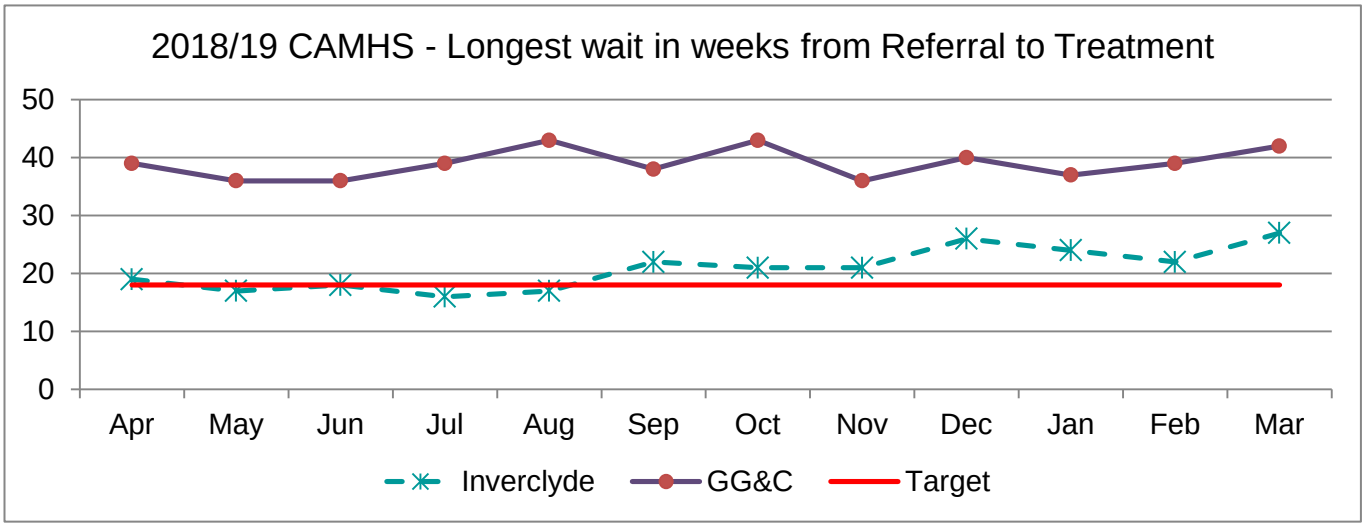
Comparing Inverclyde with Scotland as a whole, Inverclyde now has a considerably lower rate of babies affected by maternal drug misuse than Scotland.



Lower figures = Better performance

Child and Adolescent Mental Health Services (CAMHS)

A GG&C-wide CAMHS Quality Improvement Programme was initiated in April 2018, with one of the early aims being to reduce waiting times for treatment. Inverclyde HSCP has consistently performed better than the GG&C board average and throughout 2018/19 financial year Inverclyde CAMHS met the 90% referral to treatment (RTT) target each month. The longest wait for treatment was 27 weeks, with an average wait of 8-9 weeks. Inverclyde has also performed better than board average in reducing referral rejections for CAMHS.



Lower figures = better performance

A number of local and board wide initiatives are planned or underway to improve service delivery. These are described below.

Quality Improvement Programme

NHSGGC initiated a CAMHS Quality Improvement Programme in April 2018. The improvement plan includes four distinct work streams: 1. Review of overall service provision, leadership and culture; 2. Service Improvements; 3. Training and support; and 4. Supervision and Leadership.

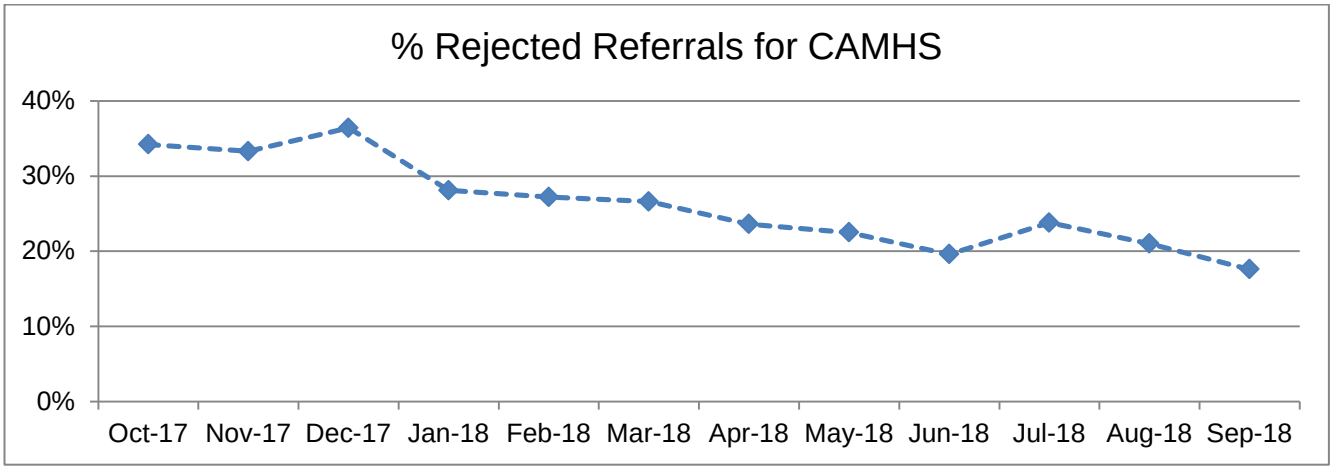
An early action of the programme was seeking to address the dip in percentage of children seen within the 18 weeks RTT target. This included introducing temporary changes to core working hours to include early evenings and weekend work. However, the range of service pressures, and likely future reduction in the RTT target, meant that a more substantial change was required. Consequently, plans were drawn up for a new CAMHS Central Choice Team (implemented from end October 2018) This is being piloted in the Glasgow City area currently and we await evaluation. This is a redesign of the current CAPA model (Choice and Partnership Approach), such that all children who are referred to the service will be seen (aside from inappropriate referrals).

The new Central Choice Team will also focus on being an engaging service, so there has been a change from using opt-in letters to making initial contact with children and families via telephone calls, with letters only used where contact is not possible. Choice appointments will concentrate on exploring what children and families hope to gain from interacting with CAMHS, and where they are referred on for treatment a full booking system will mean both children and families and local teams will know when their next appointment is scheduled. Children and young people not referred for treatment will be offered information on other local services available to them.

Internal audit of rejected referrals and reduction in rejection rate

In August 2017, Glasgow City CAMHS commenced an internal audit of all rejected referrals. Subsequently, the audit was extended to cover all eight Community CAMHS teams in NHSGGC, with data being collected by all teams by January 2018. The audit continued to run up to July 2018, with a pause on reporting internally during February 2018, to accommodate data being collated and submitted to the ISD national audit.

Since October 2017, the NHSGGC Community CAMHS Rejection Rate has varied as shown below.



The above figure is drawn from data submitted to ISD, rather than the internal audit. This demonstrates the impact that the NHSGGC internal audit and associated actions has had, with the rejection rate decreasing from the beginning of 2018, and decreasing substantially most recently. Overall, there is an increase in referrals being accepted across the Board. Currently Inverclyde is sitting < 10% community CAMHS rejection rate.

Early Intervention Project (TiPS)

Other developments in the service include the Early Intervention TIPS Project (Training in Psychological Skills for the Children's Workforce). This is a small team who are piloting a number of interventions including a pilot of 'Let's Introduce Anxiety Management' (LIAM) with Inverclyde school nurses and partner agencies.

Mental Health Access Improvement Collaborative (MHAIC) in Inverclyde

The CAMHS Inverclyde Team successfully applied to participate in the MHAIC. As part of this, the team are working on improving access to neuro-developmental ASD/ ADHD assessments for school age children in the CAMHS pathway. This mainly involves up-skilling core staff to complete the developmental history of children, as well as improving the paperwork for all initial assessments thereby reducing duplication. Findings are positive to date. Next steps will be to transfer the initiative into the Specialist Community Paediatrics school age pathway.

We have also commenced a specialist parenting group programme in CAMHS called Parents in Control (PinC) this initiative is for parents of newly diagnosed children with ADHD and this is evaluating extremely well.

Action Plan within NHSGGC mapped to Audit recommendations

The Audit Scotland report includes a wide range of recommendations for CAMH Services. To review the extent that current and planned service improvements will meet these recommendations. The team are working on the many of the actions currently or they are planned in the near future.

Early help and prevention service for children and young people

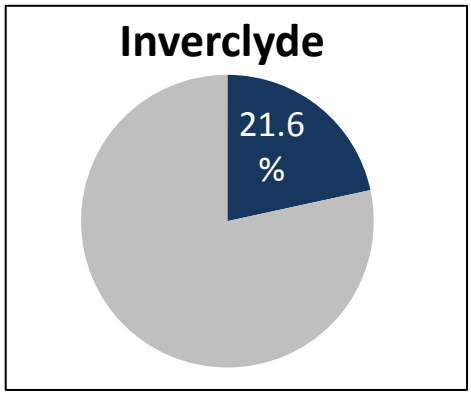
We are also at the exploration and design stage of a tier 2 mental health delivery model. This will be commissioned service across Inverclyde to support the early intervention, prevention and primary care agenda needs and supporting children in their own homes and school communities in the future. This will be a bespoke counselling and mental health intervention that meets the needs of the Inverclyde demographic. It is intended that in 2019 this service development will support the early intervention and avoid escalation of need into Tier 3 Specialist CAMHS provision.

Transitions

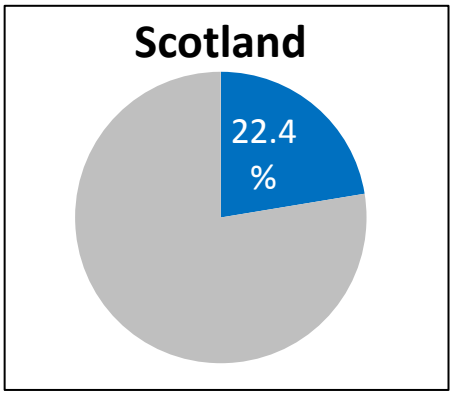
We are also working on improved transitions into Adult services and have on the 1st December adopted the Transition care plans (TCPs). This joint collaborative work will continue to be evaluated to ensure smooth transitions across services within Inverclyde.

Childhood Obesity (at risk of being overweight)

Primary 1 children have their weight measured each year. There is evidence at Scotland level that children are more likely to be at risk of being overweight or obese if they live in more deprived communities (26.1% compared to 17.1% in the least deprived communities in 2017/18). This is even more evident in Inverclyde, with 26.8% of children in more deprived communities being at risk of being overweight or obese, compared to 11.1% in the least deprived areas.



In 2017/18 across Inverclyde, 21.6% of all Primary 1 children were found to be at risk of being overweight or obese. This is slightly below the Scotland level figure of 22.4% of all Primary 1 children.



Infant Breastfeeding Rates

Inverclyde are currently progressing Programme for Government funding to support cultural change to breastfeeding in the community. The focus of this work will also be on increasing overall breastfeeding rates annually with target of 3% by 2022. We also are looking to improve attrition rates at each section of the data points.

We are also involved in an improvement initiative aimed at young mothers and those who reside in the lower SIMD (Scottish Index of Multiple Deprivation) data zones to promote breastfeeding in this group.

The Inverclyde HSCP also supported an Infant Feeding Coordinator post for 2 years. This commenced in December 2018. This focus is on the first 10 days and promoting early handover from midwifery services to Health Visitor with support worker support and coordinator support at this time and thereafter.

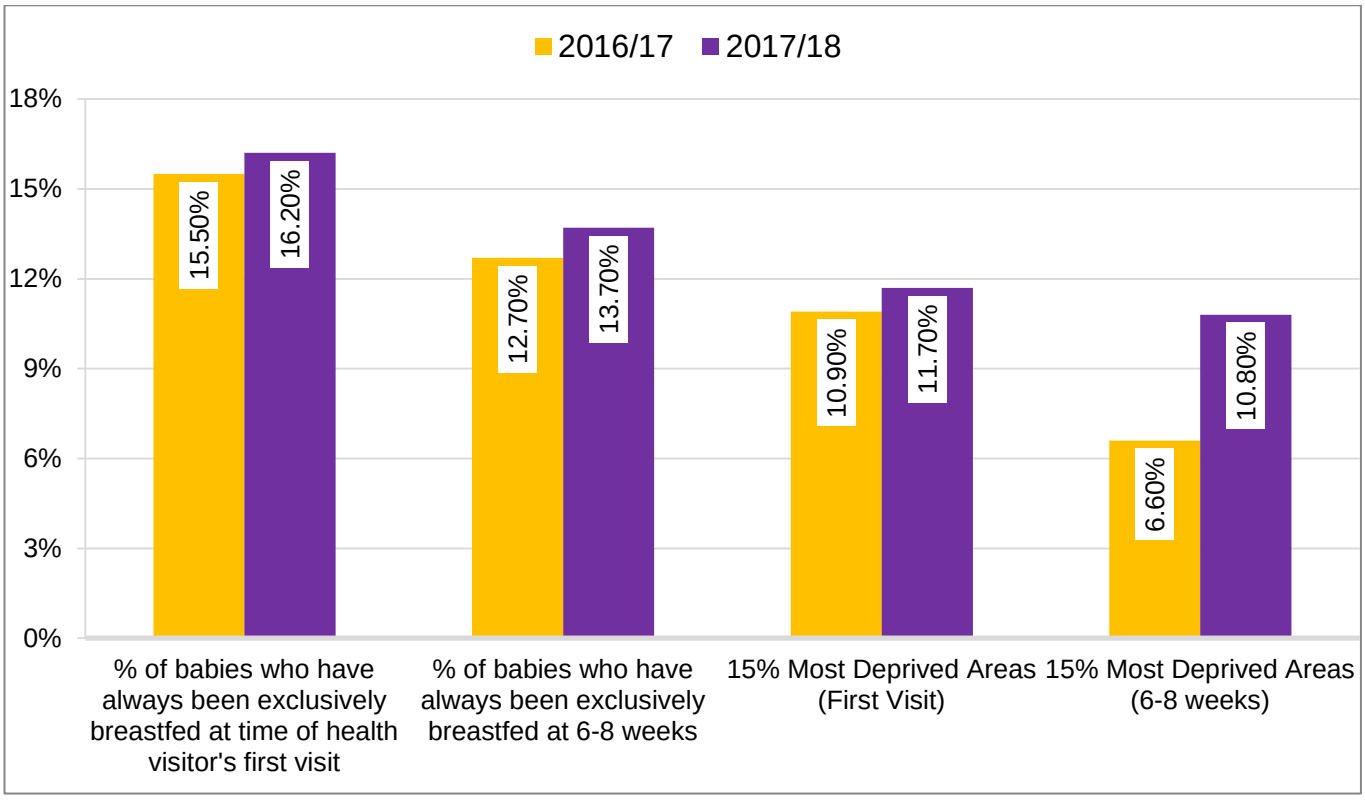
We are also implementing the UNICEF (United Nations Children's Fund) Gold Accreditation Action Plan for revalidation due July 2019.

All of this work will be monitored quarterly via NHSGGC MINF (Maternal Infant Nutritional Framework) group and local re- configured Inverclyde MINF group.

We have also been looking at improved data collection for more accurate performance data and the intention is this dataset will be live in 2019.

By 2024 we will increase the number of Mothers breast feeding

Inverclyde are currently performing above the average for the 15% most deprived areas.



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.

	Community Payback Orders Imposed	Number of people given a CPO	Number of CPOs with Unpaid Work to be carried out	Total number of unpaid work hours imposed
2015/16	**347**	**285**	**266**	**29,309**
2016/17	**308**	**292**	**232**	**28,392**
2017/18	**263**	**238**	**208**	**24,412**
2018/19	**242**	**214**	**181**	**23,360**

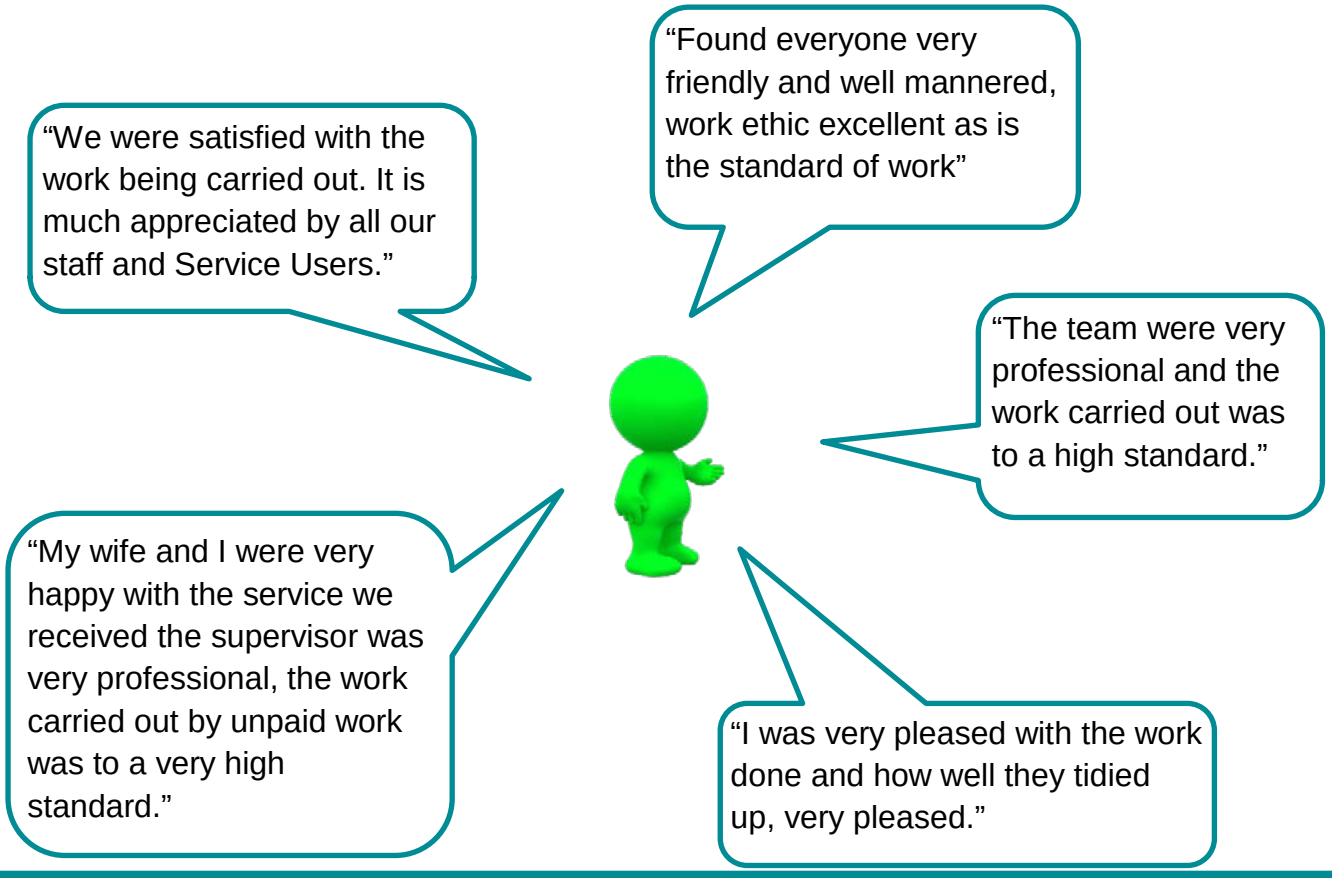
The Unpaid Work Service plans activity for the benefit of individuals, organisations and public areas within Inverclyde. A variety of tasks are undertaken including gardening, painting, joinery and grounds work.

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**
2018/19	**2,726**	**6,012**	**3,835**	**1,281**

Some comments from those who received this Service:



Innovation

INNOVATIVE APPROACH TO OUR NEW STRATEGIC PLAN

Our innovative approach to the new Inverclyde Health and Social Care Strategic Plan engagement listened to nearly 1400 local people including children in order to shape the Strategic direction of the HSCP for the next 5 years. We asked “what are we doing well” against our 6 Big Actions and “what more can we do”. Our people’s responses have helped shape our priorities and vision. Their views have been woven throughout the fabric of our Strategic Plan and demonstrates real co-creation at a Strategic level.

What we did?

Firstly we held community events in our localities and invited people to attend however we realised that in order to support real engagement a different approach was needed. An outreach approach was created and involved going out to existing community groups, schools and housing complexes to talk to people in the heart of their communities.

Different methods were used to engage with children, young people, communities and staff. It is an intergenerational view that created rich discussion and a different type of plan that is easy to understand and creates action to support both young and old. We also engaged with our staff and visited service areas such as Addiction Service, Children Residential facilities and Homecare services to ask staff about their views on our Big Actions, what was working well already and what more we should be doing.

We used a local needs assessment and national information to give information to communities so they could help us shape 6 priorities known as Big Actions. Using the strategic needs assessment for adult and children we broke this down to give specific localities information on the health of people living in their communities. We then took the evidence and drafted action statements with descriptions about what we would do and asked local people and staff to advise how best to explain the actions. They told us what they thought worked well and what words or phrases they didn’t like so we arrived at the 6 Big Actions.

Our vision, values and 6 Big Actions have been shaped through a wide range of mechanisms of engagement in order to reach as many local people, staff and carers as possible. This work included targeted engagement with focus care groups and the children and young people in our schools. We adopted a “you said, we listened” approach that reached out to 1395 local people who kindly shared their thoughts and experiences in order to shape our vision and “Big Actions”.

An ‘outreach’ approach was adopted as part of the engagement and incorporated engagement with 53 focused care groups and listening to 811 individuals.

Our Achievement

What we have achieved by this innovative approach is a plan that has been co-created and is co-owned by the community, the staff and the HSCP. The Plan therefore incorporates people’s views about what’s important to them and professional views. Our “you said, we listened” document demonstrates clearly how we engaged and the impact that engagement has had on the Plan content, our vision statement and how we described our Big Actions.

TEST OF CHANGE - TAILORED CARE SOLUTIONS

In 2018 an application was made to the IHUB (Health Improvement Scotland) for consideration of a 1 year project that looked at a test of change- to tailor and seek opportunities to look at where 1 carer instead of 2 can provide care using special equipment and training. The bid was successful and funding was provided for 1 year costs for an Occupational Therapist to lead the project, training costs to train OT in the techniques and for start-up equipment costs.

The aspirations of the project is to start remodel the Moving and Handling training in Inverclyde, train staff in new techniques, assess all new cases where double up care is required to ensure that any opportunities to tailor and train staff/families/carers to provide support in moving and handling using different techniques and equipment that only require support of one other.

This model of support has been rolled out in parts of England which shows that around 30% of all people who require the support of 2 carers can be supported by 1 carer where different equipment and techniques are used. This approach is not currently the norm in Scotland and there has been a lot of national interest in the pilot.

The work is in its infancy but to date has made a significant difference in how 23 Inverclyde residents have their care provided with very positive feedback from the people involved, their families and carers.

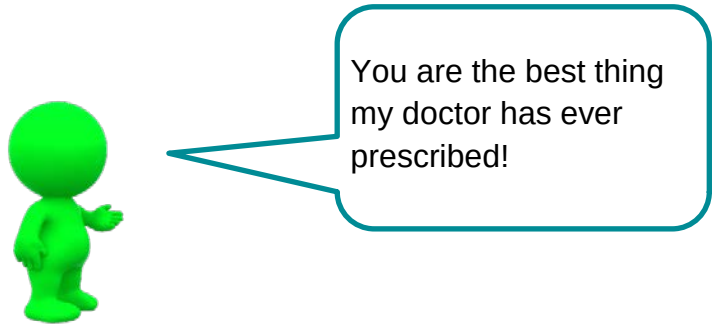
To set up and ensure that care, training and appropriate support is tailored to the individuals care needs takes time and focus, however the outcomes allow for less intrusion in people's lives and homes, more choice as families are often able to be involved.

The assessment, training and set up time and equipment are more costly than our standard approach; however the approach to date has prevented/reduced 291 care hours per week from the people who have been appropriate for this approach.

COMMUNITY LINKS WORKERS

As part of the *New ways of Working* programme, Inverclyde HSCP became an early adopter site for Community Link Workers at the end of 2017. Based within GP practices, the Community Links Workers work with a range of individuals to enable them to identify personal outcomes and priorities for their health and well-being and link them to local and national support services and activities. Working with people who are experiencing complex social and emotional circumstances, this is evidenced in the type of referrals received by the Community Links Workers and also the type of support which they are signposted to. This includes: welfare rights, money and debt advice, advocacy, counselling, victim support and women's aid.

Feedback from GPs is incredibly positive; they have fully embraced the role and are seeing significant benefit from Community Links Workers being able to spend time exploring issues with individuals. The positive impact of this relationship on patients who have mental ill health and also the early intervention for those in distress is recognised and was praised by Clare Haughey, Minister for Mental Health who visited Port Glasgow Health Centre to meet with staff and a service user.



INTRODUCING FLORENCE FOR DIAGNOSING AND MONITORING HYPERTENSION

Inverclyde HSCP were awarded Technology Enabled Care funding in 2018 to test the use of Florence for diagnosing and monitoring Hypertension in general practice. Florence, which was implemented in December 2018, is a simple text messaging service which reduces the need for patients to come into practice and collates data which the clinician can base decisions on. The patient receives a blood pressure monitor to take home and receives text prompts from 'Florence' to take and send in blood pressure readings. Advice and information is texted back in return allowing the patient to better monitor and understand their condition and in some cases to show that the patient does not have high blood pressure.

Two Florence Champions/Trainers in Inverclyde HSCP

Cascaded to 4 GP Practices with more to follow

56 used Florence since December 18 / 35 active patients in April 2019

Average of 4 surgery appointments saved per person

Potential 36 hours (approx.) of staff time saved

Chief Officer's concluding remarks

This is the third HSCP published Annual Performance Report showcasing our progress in delivering the National Health and Wellbeing Outcomes. It has been an exciting year within Inverclyde being recognised through a number of local and national awards as well as the 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 and how we being to address inequalities. The development of the new 5 year strategic plan with communities has been an opportunity to think whole system about how the HSCP and partners work together to address inequalities and improve outcomes for people living in Inverclyde. 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. There is still much to do

Louise Long
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Appendix: Glossary of abbreviations

A&E	Accident and Emergency department
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
ADL	Aids for Daily Living
ASP	Adult Protection
ASP	Adult Support and Protection
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CMHT	Community Mental Health Team
COSLA	Convention of Scotland Local Authorities
CPO	Community Payback Orders
CSWO	Chief Social Work Officer
DN	District Nurse
GG&C	Greater Glasgow and Clyde Health Board
GP	General Practitioner
H&SCS	Health and Social Care Standards
HSCP	Health and Social Care Partnership
I:DEAS	Inverclyde Delivering Effective Advice and Support
ICCF	Inverclyde Community Care Forum
ICON	Inverclyde Council Online
IHUB	Health Improvement Scotland
ISD	Information Services Division (NHS)
LIAM	Let's Introduce Anxiety Management
LOIP	Local Outcomes Improvement Plan
LPGs	Locality Planning Groups
MAPPA	Multi Agency Public Protection Arrangements
MHAIC	Mental Health Access Improvement Collaborative

MINF	Maternal Infant Nutritional Framework
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NODA	No One Dies Alone
NRS	National Records for Scotland
OT	Occupational Therapist
PCMHT	Primary Care Mental Health Team
PDS	Post Diagnostic Support
PinC	Parents in Control
RES	Rehabilitation and Enablement Service
RTT	Referral to Treatment
SAPE	Small Area Population Estimates
SIMD	Scottish Index of Multiple Deprivation
SMT	Senior Management Team
TCPs	Transition Care Plans
TEC	Technology Enabled Care
TiPS	Training in Psychological Skills for the Children's Workforce
UNICEF	United Nations Children's Fund

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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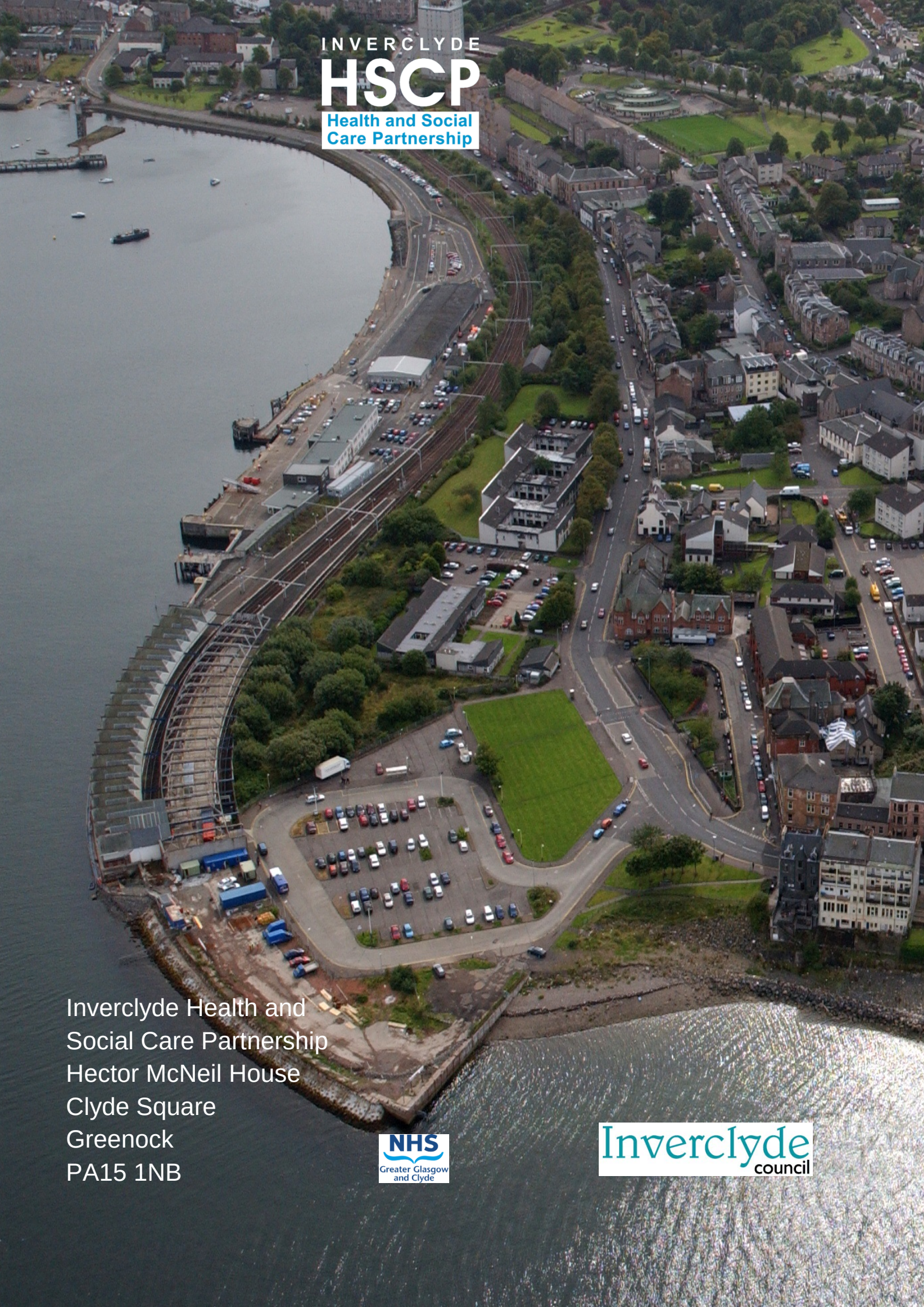

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