AGENDA ITEM NO: 3

Report To:	**Inverclyde Integration Joint Board**	**Date: 21 September 2020**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/66/2020/LA**
Contact Officer	**Lesley Aird Head of Service Strategy and Support Services**	**Contact No: 01475 715285**
Subject:	**ANNUAL PERFORMANCE REPORT 2019-2020**	

1.0 PURPOSE

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

1.2 The reporting period is for 1st April 2019 to 31st March 2020.

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 fourth 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 (IJB), highlighting performance on delivering the nine National Wellbeing Outcomes, as measured against delivery of the 23 National Indicators. This is the fourth Performance Report from Inverclyde HSCP.

4.2 The data for the 23 indicators is provided by Public Health Scotland (PHS) 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 third report and based on positive feedback received, our fourth 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 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.	The report provides intelligence about the quality of provision relating to services for people with physical and/or learning disability; older people; children & young people, people with mental health problems, and people with addictions.
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	The same high standards are expected for services addressing the full range of vulnerabilities without discrimination or stigma
People with protected characteristics feel safe within their communities.	The report demonstrates our performance in keeping service users safe from harm and providing support to enable people to feel safe in their communities and localities.
People with protected characteristics feel included in the planning and developing of services.	There is carer and service user/ public partner representation on our Integration Joint Board (IJB), which oversees and scrutinises the governance reports. Feedback from the IJB is used to continuously improve the governance process and associated reports.
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	The governance report is used by services to inform discussions with people who have protected characteristics, when they are making decisions about what services and supports they would prefer.
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	The current review of Learning Disability Services will be informed by the information coming out of the governance meetings, taking account of the need to ensure that people with a learning disability are protected from gender-based violence
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	Although we do not commission external services specifically for the resettled refugee community, our commissioning does include a requirement for providers to be alert to the protected characteristics of the people for whom we are commissioning. This principle will apply if we are commissioning for this community in the future.

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.	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.
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.
People who use health and social care services have positive experiences of those services, and have their dignity respected.	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.
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.
Health and social care services contribute to reducing health inequalities.	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.
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 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.
People using health and social care services are safe from harm.	Under the Adult Support and Protection (Scotland) Act 2007, 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.
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. It is only through an engaged workforce that we can deliver services and supports of the highest standard possible.
Resources are used effectively in the provision of health and social care services.	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.

6.0 DIRECTIONS

6.1

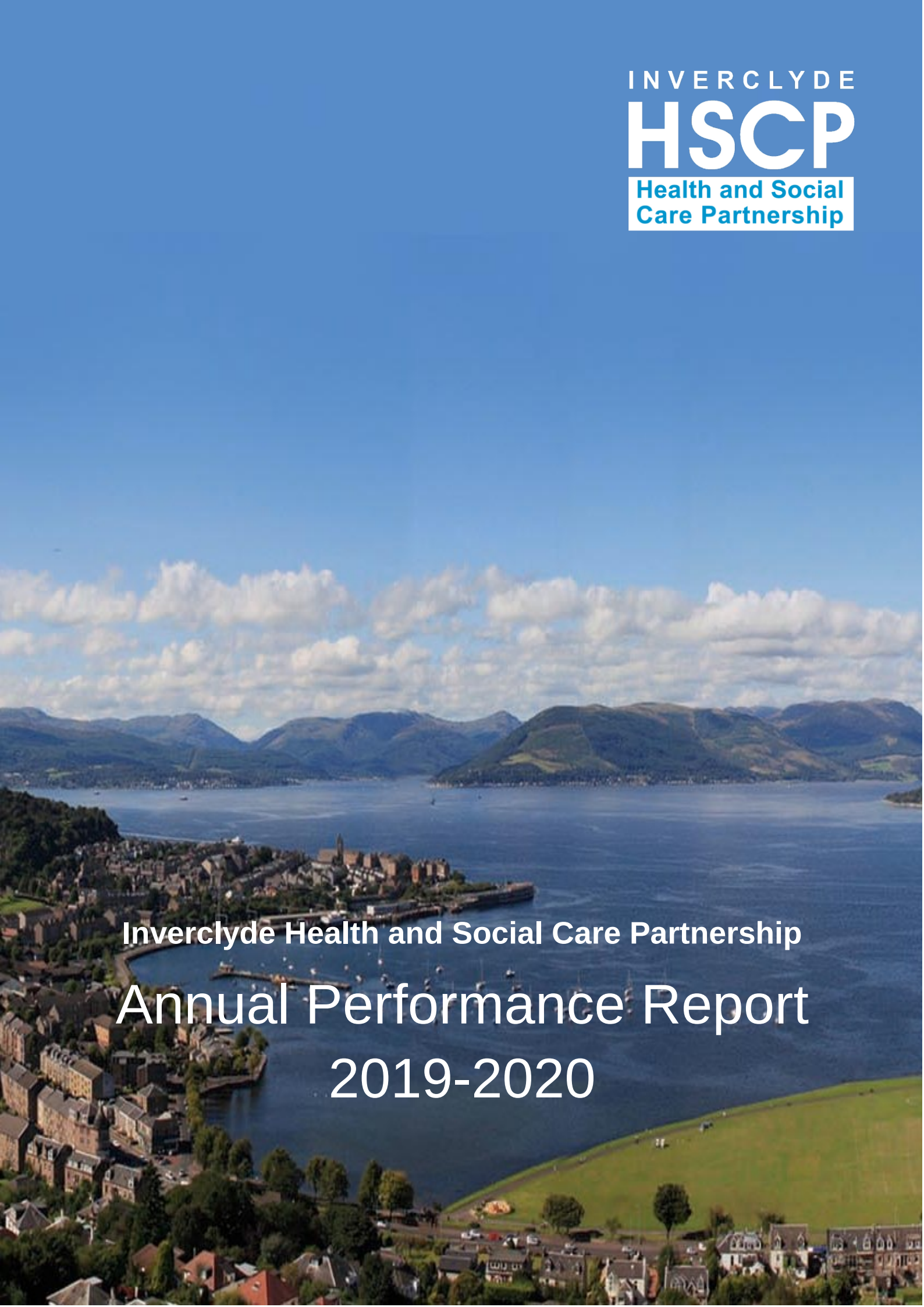
Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

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 2018-19.



INVERCLYDE HSCP
Health and Social Care Partnership

Inverclyde Health and Social Care Partnership

Annual Performance Report 2019-2020

Foreword by Louise Long - Chief Officer Inverclyde HSCP

This is the fourth Annual Performance Report for Inverclyde Health and Social Care Partnership.

The annual report links to the national framework, MSG targets and Inverclyde's IJB Strategic Plan.

The annual report focuses on 2019/20 which is the start of the new IJB Strategic Plan spanning 2019-24.

It has been a challenging year where some progress has been made, there has been significant achievements including a very good Criminal Justice inspection and one of the best performances for delayed discharge in Scotland. The commissioning of social prescribing services, Compassionate Inverclyde and Your Voice network continues to bring the delivery of opportunities for volunteers. Other areas such as Unscheduled Care progress has been slower than expected, however many actions are in place and were beginning to impact. In March the COVID-19 pandemic began to impact on our communities and services. There is no doubt that this will impact on performance for 2020/21.

It is always a privilege and a pleasure to lead the partnership, I am particularly proud of the partnership response to the pandemic. The challenges/demands have seen an unprecedented response from our staff and local citizens to the unprecedented challenge that came from COVID-19, this response has been both innovative and compassionate.

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. 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. Supporting these nine national Wellbeing Outcomes are 23 National Integration Indicators against which the performance of all HSCPs in Scotland is measured, the data for these is provided by Public Health Scotland (PHS) on behalf of the Scottish Government. 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.

- Outcome indicators
    - These indicators are normally reported in the Scottish Health and Care Experience Survey commissioned by the Scottish Government. Data relating to these indicators for 2019/20 was originally due to be published in April 2020 but, due to the COVID-19 pandemic, the publication has been delayed and so the most recent survey results were not available for inclusion within this report.

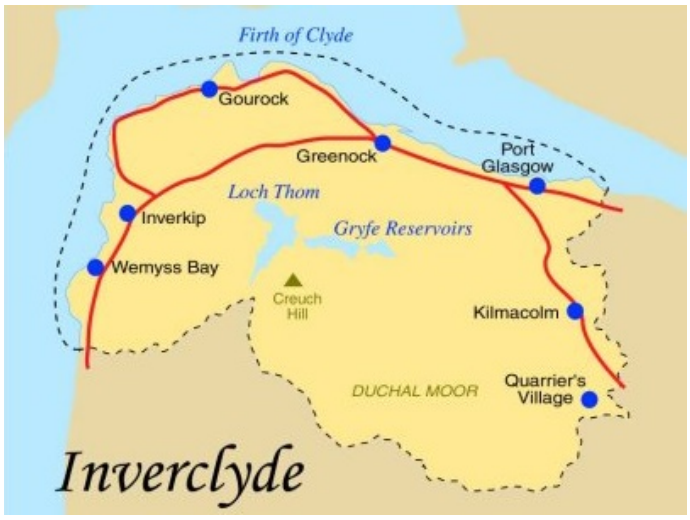
- Data indicators
    - The primary source of data for these indicators are Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. In accordance with recommendations made by Public Health Scotland (PHS) and communicated to all Health and Social Care Partnerships, the most recent reporting period available is calendar year 2019; this ensures that these indicators are based on the most complete and robust data currently available. It is not expected that these numbers will differ greatly to 2019/20 financial year figures, once available, and so should not affect any conclusions that have been drawn.

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.

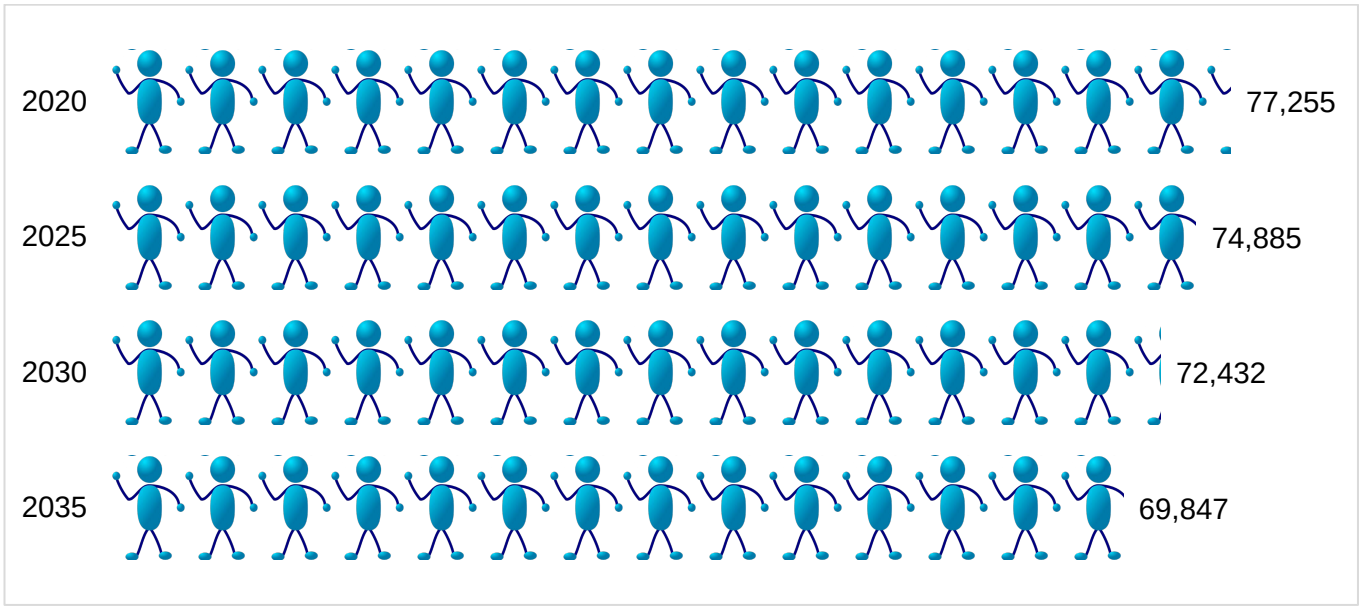
Separate measures specifically relevant for Children's Services and Criminal Justice have been included and can be found at pages 70 and 74 of this report.

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). This gives us a total population of 77,800 (down from 78,150 last year) as at the end of June 2019.



Using the most recent published data available that can be used for population projections (Population Projections for Scottish Areas 2018-based), published by NRS on 24 March 2020, our population is expected to decline as is shown in the graphic below.



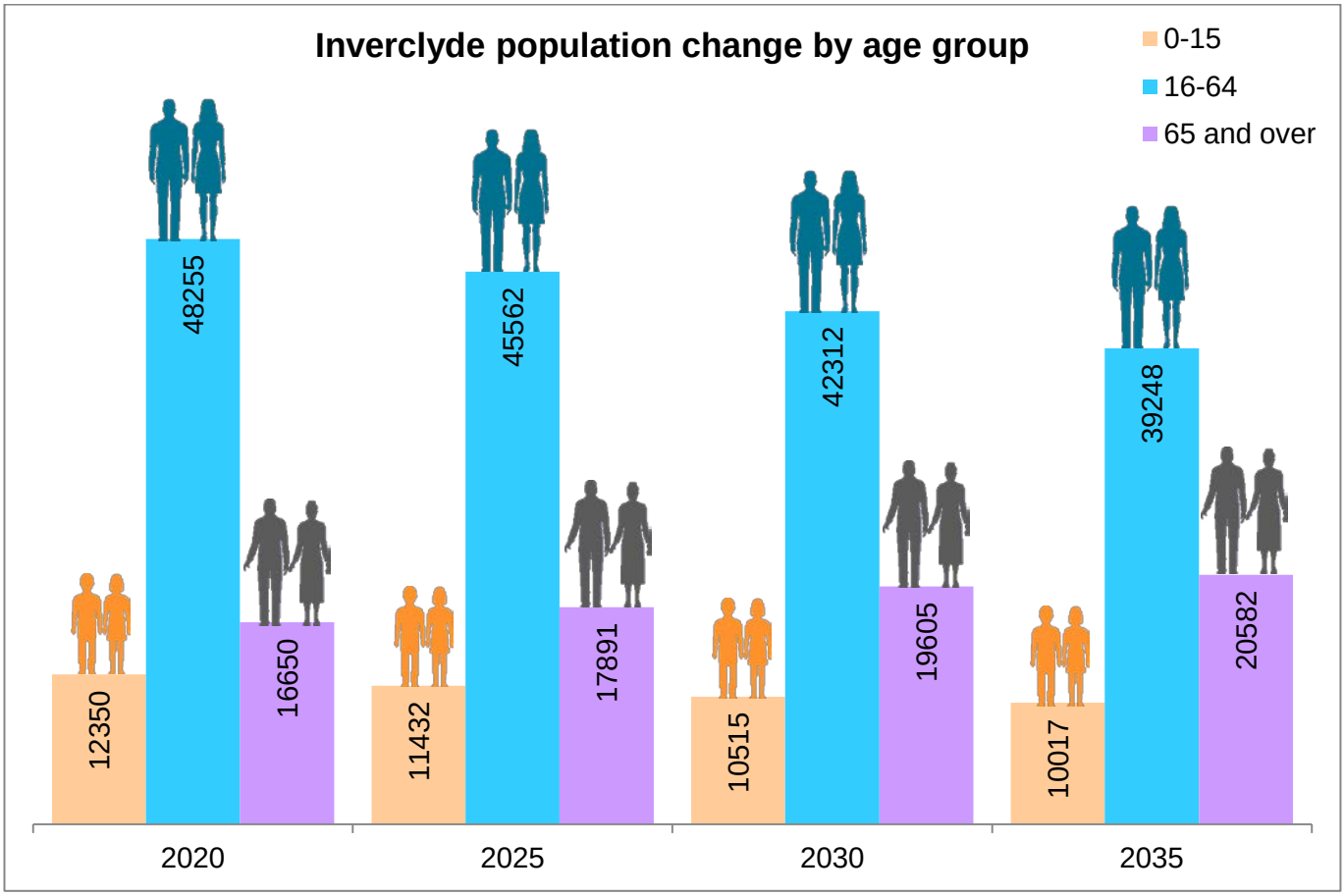
Source: NRS: population projections for Scottish Areas (2018-based)

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 affected in 2 specific areas. From 2018 to 2019 there were 1,010 deaths in Inverclyde compared to 653 births during this period, resulting in natural change of -357.

Outmigration was again higher than in-migration, with an estimated 1,233 people moving into the area and 1,317 leaving, resulting in net migration of -84.

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.



Source: NRS: population projections for Scottish Areas (2018-based)

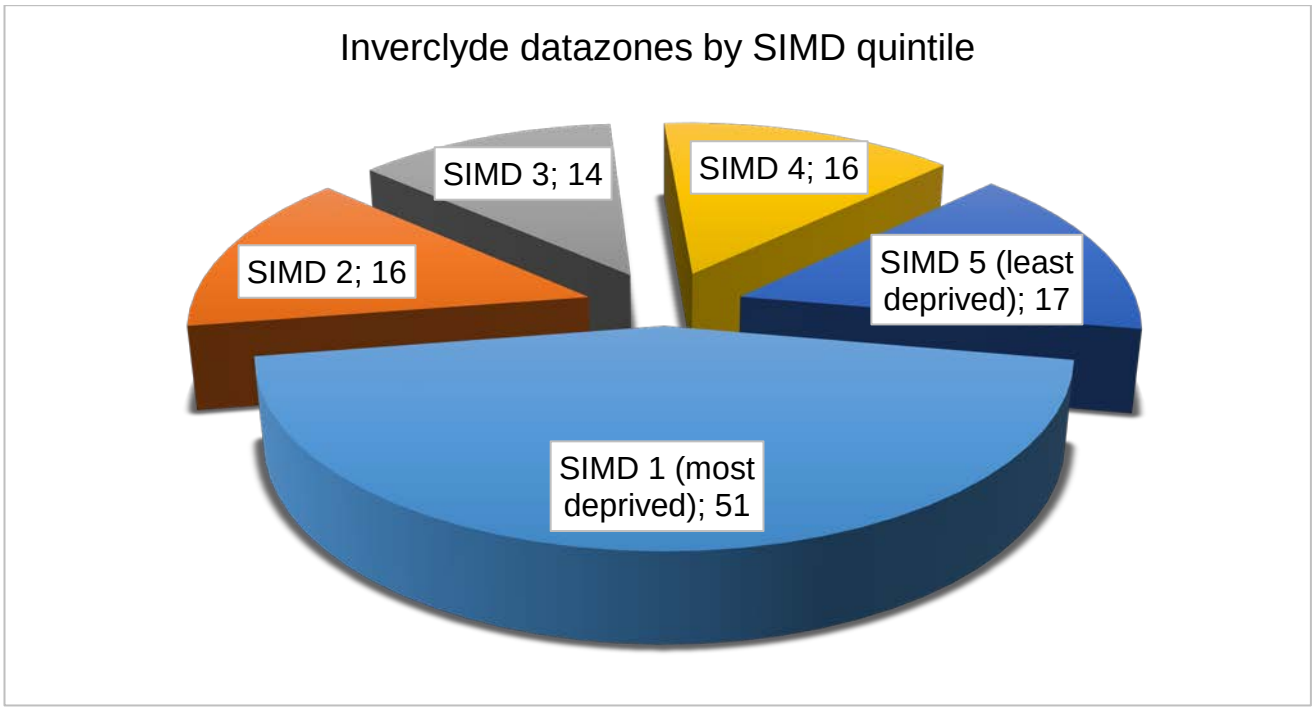
Deprivation

The Scottish Index of Multiple Deprivation (SIMD 2020) 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 (DZ) from most deprived to least deprived.

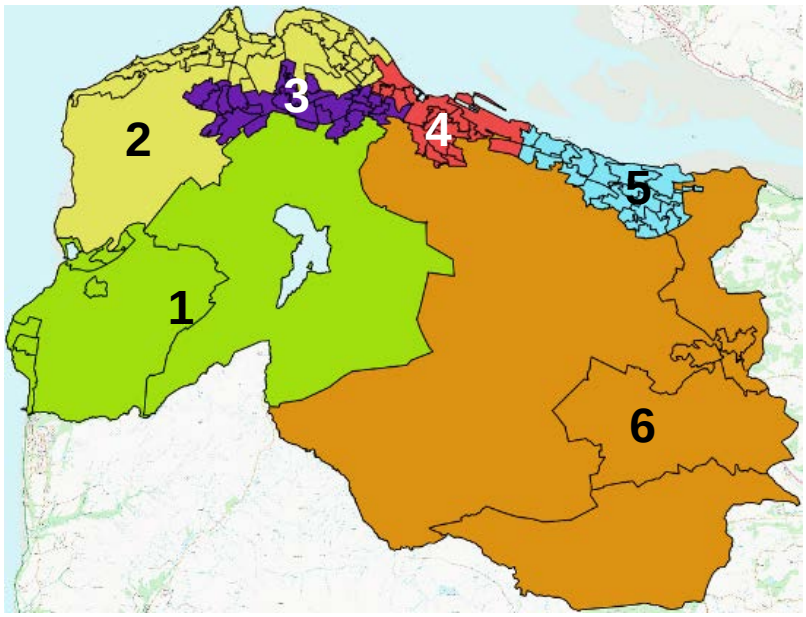
Scotland is split into 6,976 DZ's; Inverclyde has 114 DZ's, 51 of which are in the 20% most deprived areas in Scotland. When looking at the 5% most deprived DZ's in Scotland (a total of 348 DZ's) 21 are in Inverclyde (18.42% of our local area and 6.03% of the National share).

Deprived does not just mean ‘poor’ or ‘low income’. It can also mean that people have fewer resources and opportunities. The highest deprivation areas of in Inverclyde are around Central and East Greenock. Unfortunately this now includes the most deprived area in Scotland.



Source: Scottish Government SIMD 2020

Localities



Our 6 localities are:

1. Inverkip & Wemyss Bay
2. Greenock West & Gourock
3. Greenock South & South West
4. Greenock East & Central
5. Port Glasgow
6. Kilmacolm & Quarrier's Village

Locality Planning Groups (LPGs)

The Inverclyde HSCP and Inverclyde Alliance have been working towards establishing the six new Locality Planning Groups. Arrangements had been put in place to pilot the revised locality planning arrangements in Port Glasgow in January 2020 with Greenock East and Central then Greenock South and South West being established next, however the outbreak of COVID-19 resulted in progress being suspended. This work will recommence once it is safe to so.

Following publication of the Scottish Index of Multiple Deprivation (SIMD) in January 2020, working with local communities in the most deprived areas in Inverclyde is even more important and will be our primary focus as implementation of the HSCP Strategic Plan 2019 – 2024 is progressed.

Communication & Engagement

Once established, the six Locality Planning Groups (LPGs) will be responsible for the development of their respective Locality Action Plans outlining how they will drive forward and deliver transformational change in line with agreed strategic policy and priority areas. Locality Action Plans will set out how community planning partners, including the HSCP, will improve the experience of those who access and use local services, improve outcomes for people living in local communities, ensure services are safe, effective, of high quality, sustainable, provide best value, and address inequalities.

The extent of past engagement and consultation has highlighted that there is real appetite locally to be involved in shaping Inverclyde's future. That is why we are looking to adopt the joint Alliance and HSCP communication, engagement and where necessary formal consultation processes. People want to have their say, and we have a duty to ensure that their voices are able to influence the planning and delivery of services provided by public sector organisations.

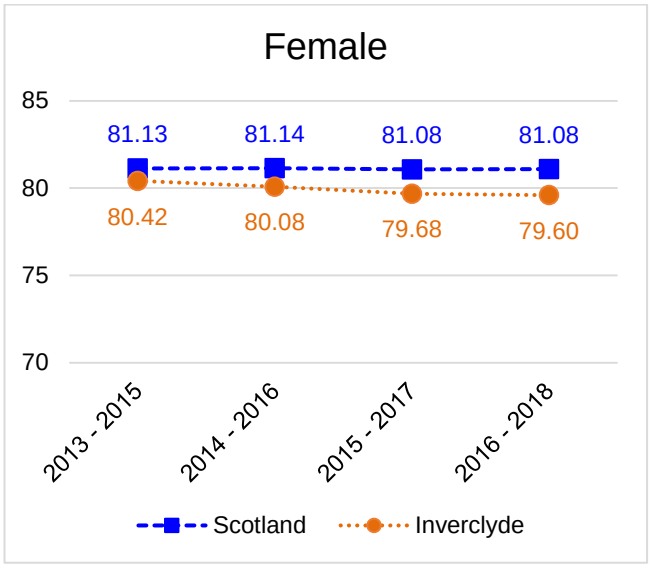
During August / September 2019, the HSCP and Alliance held six community engagement events, one in each locality to "Celebrate the Present, Shape the Future". Over 750 members of the community attended the events, and a significant amount of feedback was shared. A Feedback Report was published which outlined key themes that came out of discussions with people which Locality Planning Groups (LPGs) will be required to take into account, along with other feedback and key priorities when planning services that are fit for the future and improve outcomes for local people.

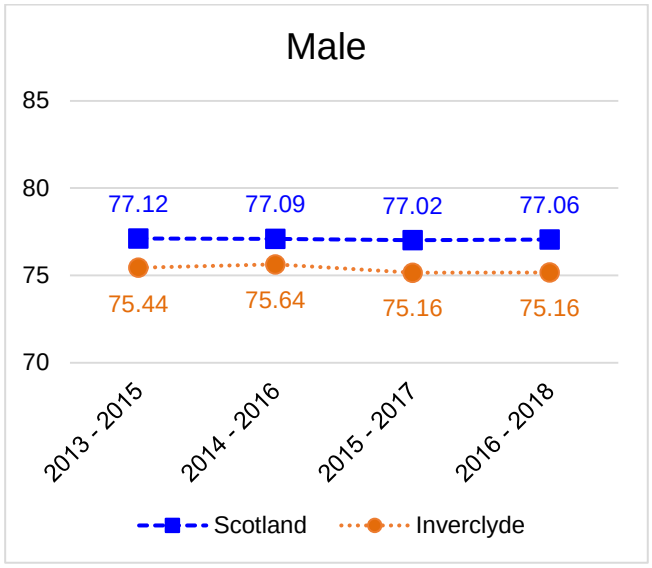
Jointly, we are now aiming to build on all the positive engagement and consultation work carried out, develop continuous dialogue with local communities, and embedding this into our day to day business.

The Communications and Engagement Strategy which outlines some of the key principles and objectives for the HSCP was approved by the HSCP Strategic Planning Group (SPG) in February 2020 and now awaiting approval by the Integration Joint Board (IJB) and Inverclyde Alliance Board. Due to the outbreak of COVID-19 pandemic, progress has been slower than planned.

Life Expectancy (from birth)

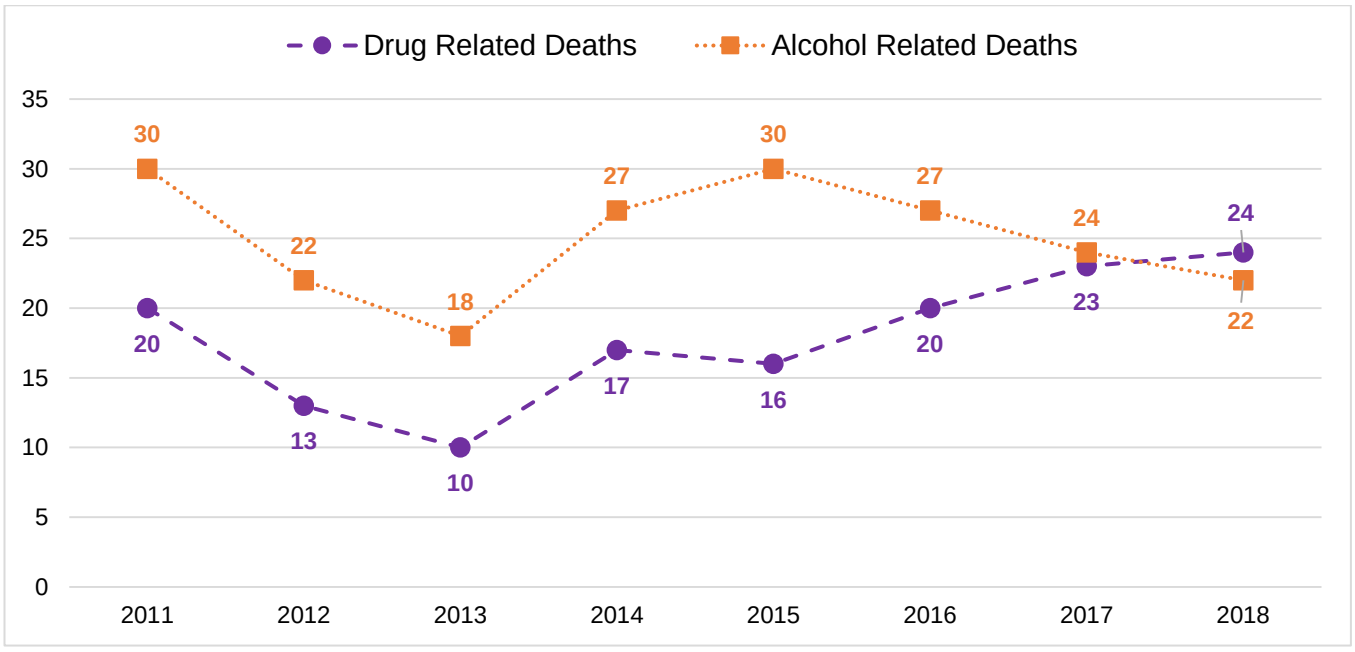
The latest figures available cover the 3 year 'rolling' period from 2016 to 2018 (published by National Records of Scotland in December 2019). The charts below compare the average life expectancy in years across Inverclyde and Scotland.





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

Alcohol and Drug related deaths



Source: NRS deaths by theme data

There is a notable history of high prevalence of alcohol and drug abuse in Inverclyde; reducing this is one of our 'Big Actions'. The changes & improvements we are making now will make an impact on lives in the longer term and show in future reporting; we want to see a sustained improvement to reduce the number of those affected by this.

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%

Over 91% of all people referred to alcohol and drug services began their recovery treatment within 3 weeks

No. of falls when A&E visit required

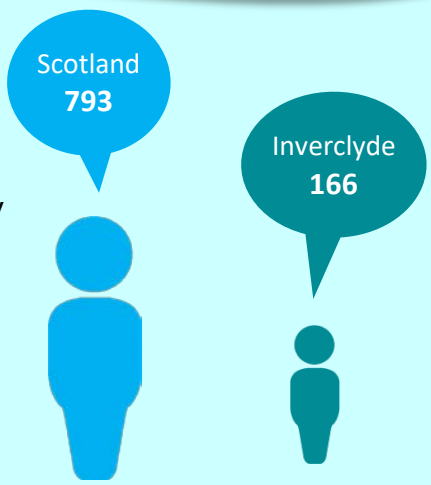
458 less

2,342 in 2018/19

1,884 in 2019/20

Delayed discharge from hospital

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



Criminal Justice Inspection

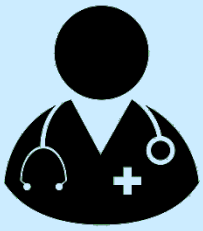
Of the five quality indicator that the Service was assessed against, 3 were noted as 'Very Good' and 2 were 'Good'.

A range of positive outcomes had been achieved for individuals.

Advanced Nurse Practitioner

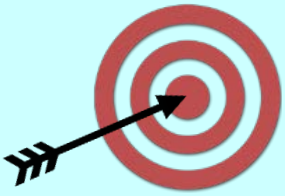
1,167 home visits carried out

Over 680 hours of GP time freed to support more complex patients

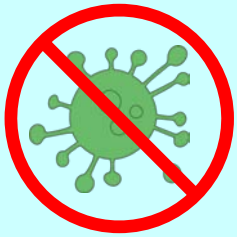


Vaccinations

Over 99% of 5 year old children were vaccinated against Measles Mumps and Rubella (MMR)



Target 95%



The 23 National Integration Indicators

Calendar year 2019 is used here as a proxy for 2019/20 due to the national data for 2019/20 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships. The data for indicator number 18 (Percentage of adults with intensive care needs receiving care at home), unfortunately, was not published in time to be included in this year's report.

Those marked with an * (numbers 1 to 9) are taken from the 2017/18 biennial Health and Care Experience Survey. The 2019/20 survey results will be published later than planned (due to Scottish Government staff redeployment during the COVID-19 pandemic) but we will include them in future performance reports once they are available.

Of the 19 currently reported measures we are at or better than the Scottish average in 10 (green), just below in 6 (amber) and behind in 3 (red).

In 7 measures we have seen an improving trend (green arrow), maintaining our performance in 7 (amber arrows) and reducing performance in 5 (red arrow).

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

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

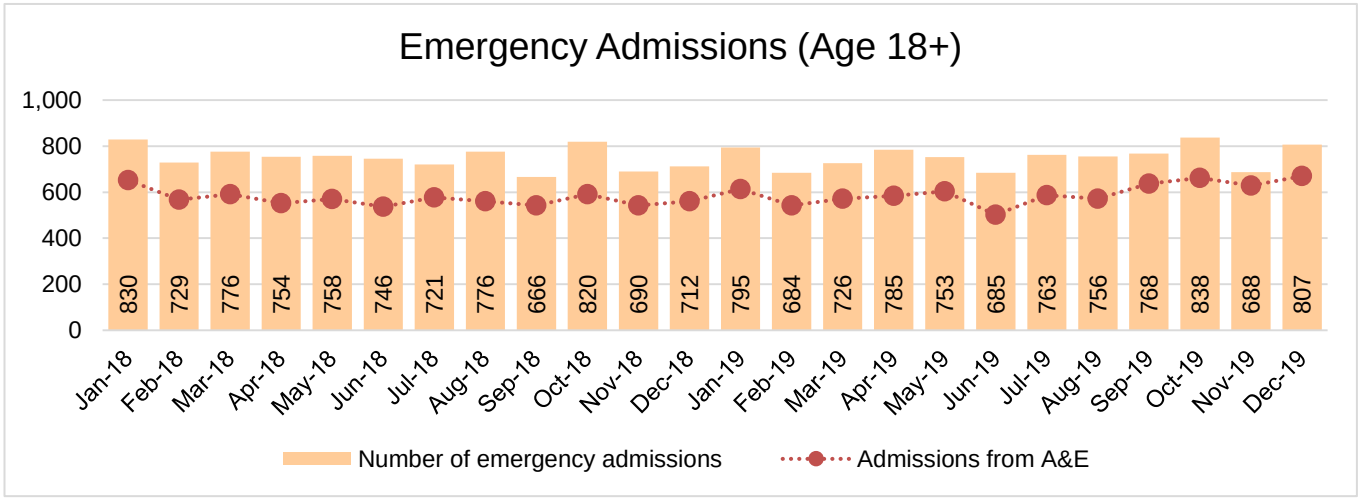
↑ ↓	Trend is improving (moving in the right direction)
→ ←	Trend is static – no significant change
↑ ↓	Trend is declining (moving in the wrong direction)

National Integration Indicator		Time Period	Inverclyde HSCP	Scottish Average	Inverclyde Trend	Scottish Trend
1*	Percentage of adults able to look after their health very well or quite well	2017/18	90.9%	93%	↑	↓
2*	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2017/18	80.4%	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	77.3%	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	78.7%	74%	→ ←	↓
5*	Total % of adults receiving any care or support who rated it as excellent or good	2017/18	83.5%	80%	↑	↓
6*	Percentage of people with positive experience of the care provided by their GP practice	2017/18	83.1%	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	76.6%	80%	↓	↓
8*	Total combined percentage of carers who feel supported to continue in their caring role	2017/18	39.7%	37%	↓	↓
9*	Percentage of adults supported at home who agreed they felt safe	2017/18	84.3%	83%	→ ←	→ ←
11	Premature mortality rate per 100,000 persons	2019	550	426	→ ←	→ ←
12	Emergency admission rate (per 100,000 population)	2019	15063	12602	→ ←	↑
13	Emergency bed day rate (per 100,000 population)	2019	157025	117478	→ ←	↓

National Integration Indicator		Time Period	Inverclyde HSCP	Scottish Average	Inverclyde Trend	Scottish Trend
14	Readmission to hospital within 28 days (per 1,000 population)	2019	92	104	↓	↑
15	Proportion of last 6 months of life spent at home or in a community setting	2019	88.5%	88.6%	↑	↑
16	Falls rate per 1,000 population aged 65+	2019	23.4	22.7	↓	→←
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2019/20	86.6%	81.8%	↑	→←
18	Percentage of adults with intensive care needs receiving care at home	2018	65.9%	62.1%	↑	→←
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	2019/20	166	793	→←	→←
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2019	24.1%	23.2%	→←	→←
The following indicators are still under development by Public Health Scotland (PHS)						
10	Percentage of staff who say they would recommend their workplace as a good place to work					
21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home					
22	Percentage of people who are discharged from hospital within 72 hours of being ready					
23	Expenditure on end of life care, cost in last 6 months per death					

Ministerial Strategic Group (MSG) Indicators

The more that hospital care is planned in advance the better chance that people can usually get back home more quickly. We are working to increase hospital care planning, and so reduce emergency and unscheduled admissions and hospital stays.



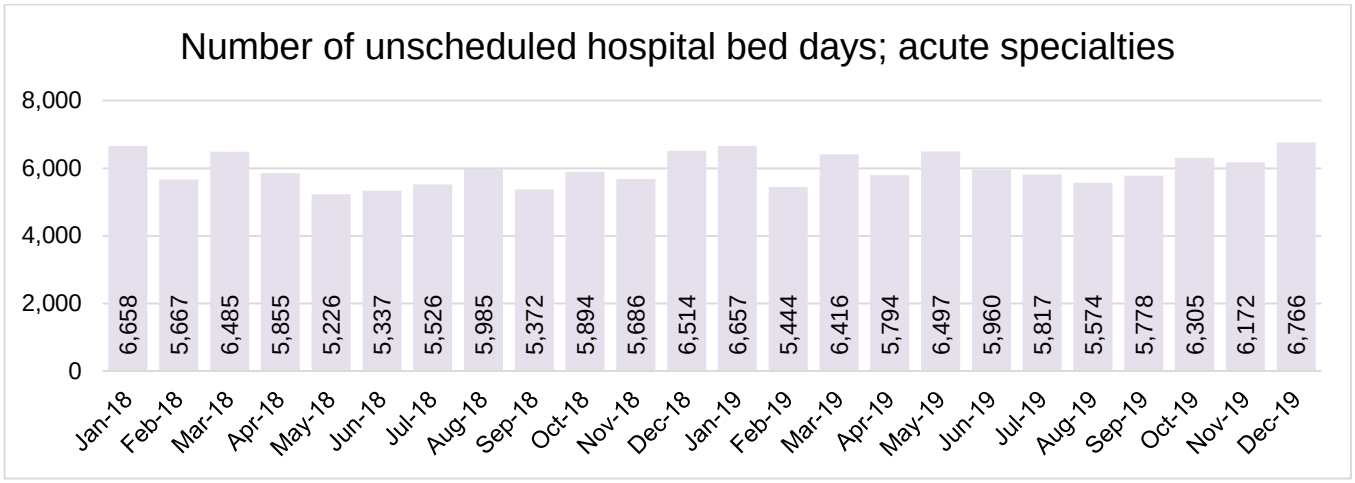
Lower numbers = better performance

The total number of emergency admissions for all ages in the period January 19 to December 19, was 9,048 admissions. This represents a 0.8% increase on the previous calendar year 2018 (previous total was 8,978).

The MSG target for this measure was a 7% reduction on the baseline year of 2015/16 (9,388), but this target is focused on those aged 18 or over, which would mean a projected or expected total of 8,731 attends for 2019. Inverclyde's emergency admissions for 2019 were 317 above the projected MSG target.

The calendar year figure is rarely used, but given the timing of the MSG data releases, and the completeness issue surrounding the data particularly around admissions, calendar years have been used for this report to provide a more timely comparison.

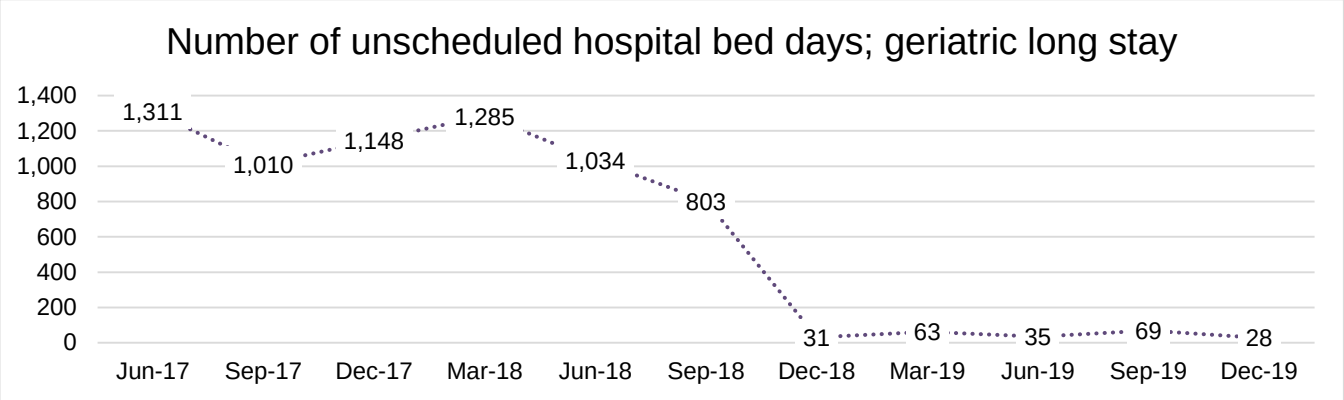
Emergency admissions continue to be challenging for the HSCP.



Lower numbers = better performance

In the calendar year 2019, the number of acute unscheduled bed days saw an increase of 4.3% on the previous calendar year. The total number of bed days in 2019 was 73,180 days. The target for this measure states that a reduction 6% of the baseline year 2015/16 be achieved in 2019/20 (a reduction of 4,301 bed days).

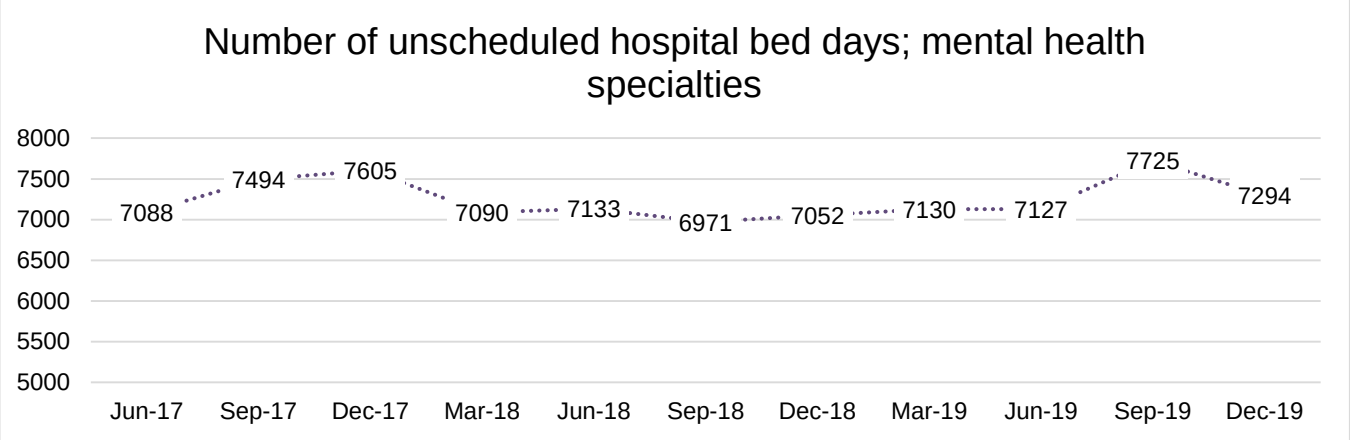
The total number of acute unscheduled bed days in 2015/16 was 73,071. This of course means that Inverclyde has only managed to "tread water" in regards to this performance measure.



Lower numbers = better performance

Unlike the Unscheduled bed days for Acute, the bed days for Geriatric Long Stay is measured on a quarterly basis.

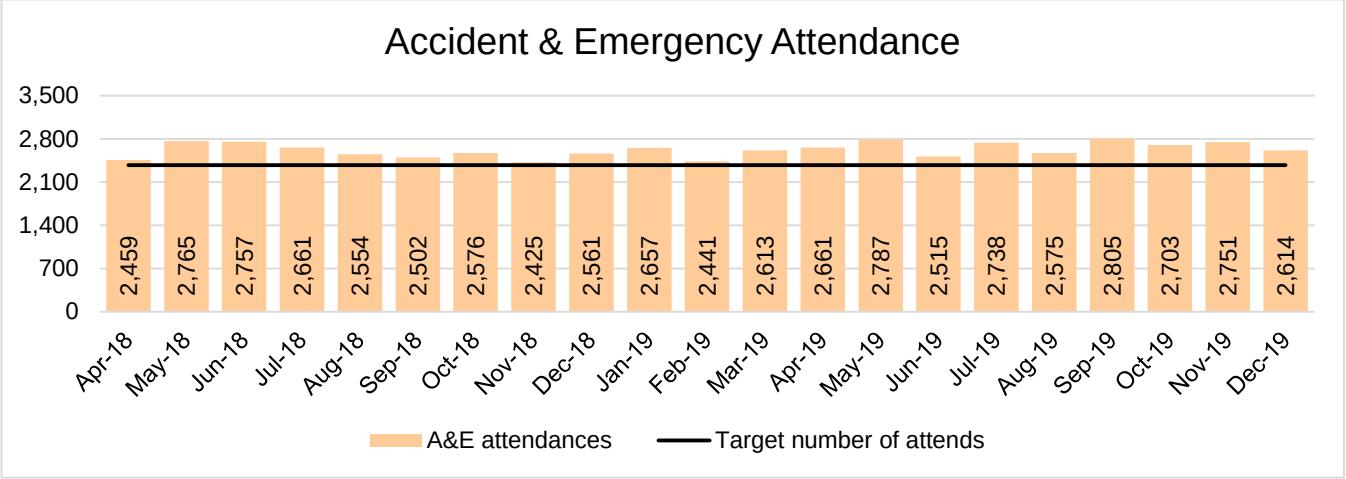
The chart clearly shows a significant drop off in December 2018, going from 803, in September 2018 to only 31 bed days in December 2018. The number of beds days remain below 70 days for the remainder of the reporting period. The delivery of care for these patients transferred from a hospital based to a community based model, where this was appropriate, to better support the individuals.



Lower numbers = better performance

The number of unscheduled beds days for mental health specialities is reported on a quarterly basis, rather than monthly.

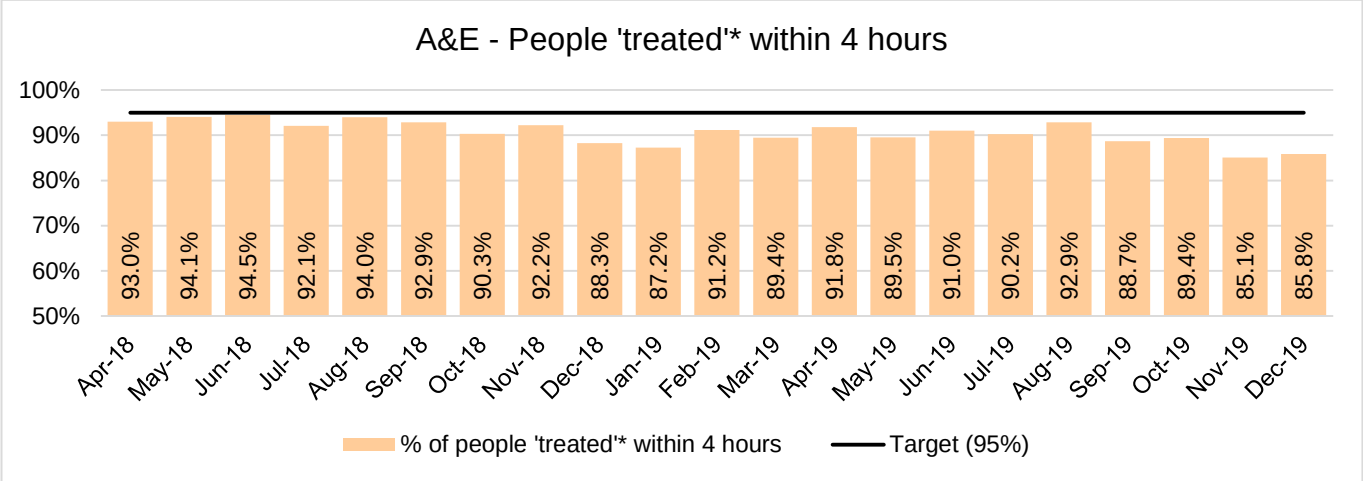
The number of unscheduled bed days for mental health specialities for the calendar year 2018 was 28,246, in 2019 this had risen by 3.65% to 29,267 bed days, an increase of 1030.



Lower numbers = better performance

Inverclyde's target for the number of A&E attends is to achieve a reduction of -3% on the 2015/16 baseline of 29,395 which would translate as a reduction of 882 attends in calendar year 2019. The number of A&E attends for the calendar year 2019 was unfortunately 31,860, which was an increase of the previous calendar year 2018 (30,420) of 1,440 attends. This in turn means that Inverclyde's number of A&E attends for calendar year 2019 is 3,347 over target.

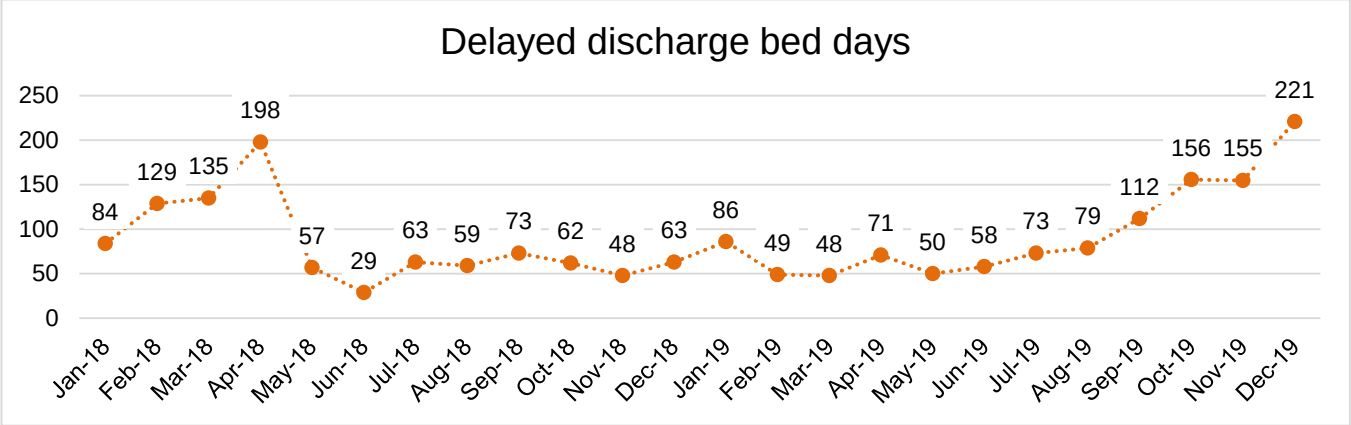
Analysis revealed that a key element of our A&E attend numbers related to Alcohol and Drug service users attending at weekends. To address this the HSCP secured CORRA foundation and IJB funding to move to 7 day a week addictions services to reduce the number of addictions related weekend admissions. Other measures including work around case management of frequent attenders at A&E and In-reach to A&E by Allied Health Professional as part of a wider 7 point plan to address unscheduled care across Inverclyde across all care groups. All of these measures are expected to improve performance in this area in the coming year.



Higher % = better performance

* Treated is measured from time of arrival until time of discharge, admission or transfer

In regards to the 4hr A&E waiting time standard of 95%, this is a national rather than HSCP target, however this indicator has been problematic in recent years, with the MSG data illustrating that the target has not been met in some time. The data suggests that Inverclyde Royal Hospital only managed to get above 90% (still 5% short of the target) 8 times throughout 2018 and, and only 5 times during 2019.



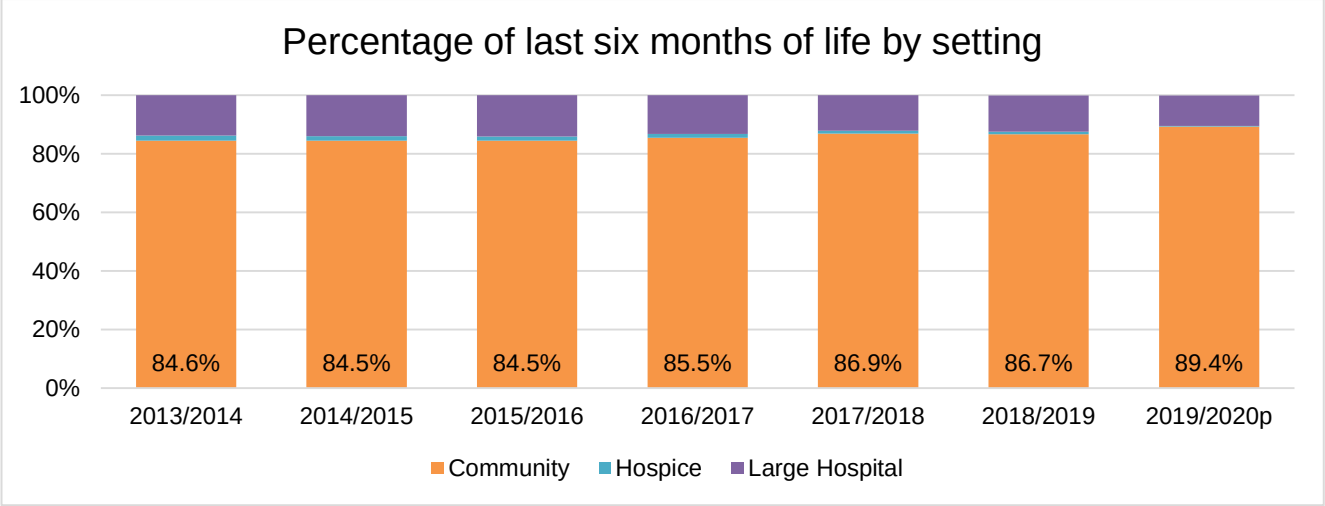
Lower numbers = better performance

Delayed Discharge performance in Inverclyde has been exemplary for a number of years, with the varied measures attributed to Delayed Discharge reducing year on year, specifically “Bed Days Lost” and “Delays at Census”.

The latter months of calendar year 2019 proved challenging for Inverclyde, with number of Bed Days Lost rising from 112 in September 2019 to 221 beds days lost in December 2019. This was due to increased demand for discharge and the need for some complex care packages to be put in place, all of which have been resolved.

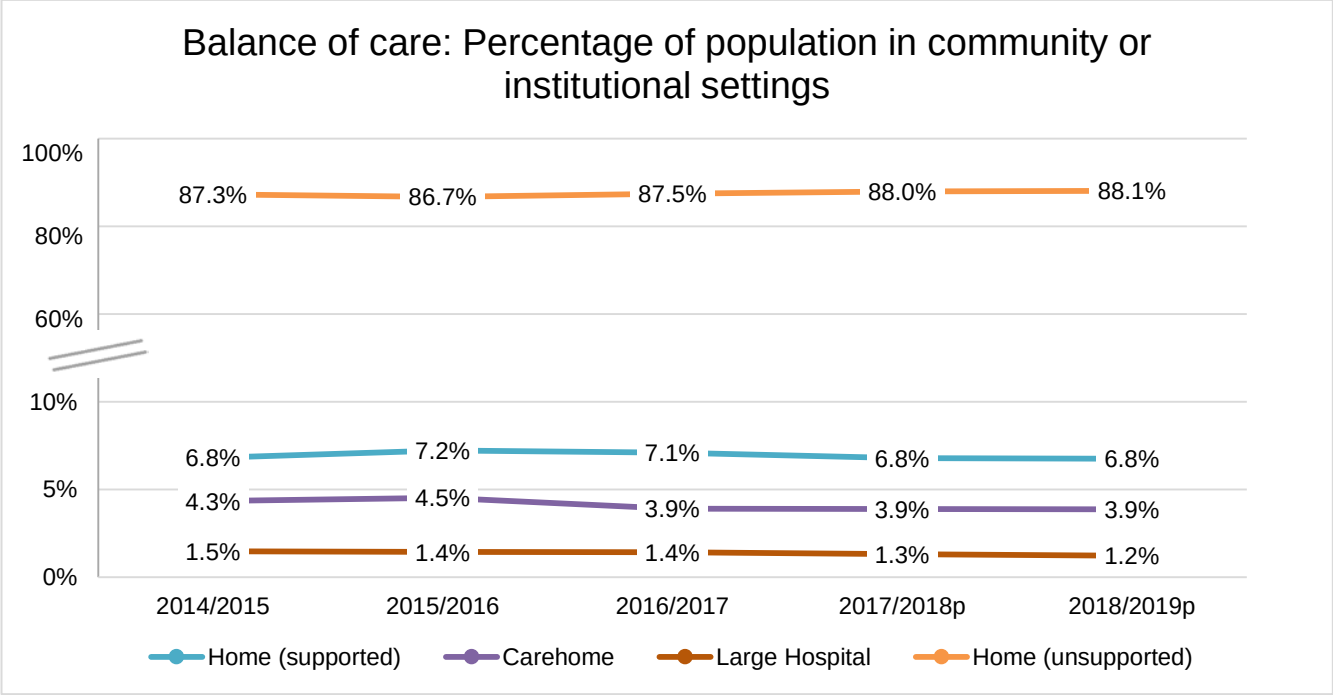
Even with this increase in Bed Days Lost to Delayed Discharge, the HSCP remains on course to meets its obligation to this MSG target.

The MSG target for this measure is a 20% reduction on the baseline year 2015/16 total of 2588. This of course means the target for 2019/20 would be 2070 bed days lost. With Inverclyde’s calendar year total being 1158 bed days lost, the HSCP is still performing very well.



This MSG measure looks to achieve a 2% increase from the 2015/16 baseline figure of 84.5% for those who spend the last six months of life in a community setting. As can been seen on the chart above, Inverclyde HSCP has more than exceeded its expected value (86.5%) in 2019/20 with 89.4% , this was 2.9% over the MSG target.

We fully expect this level of performance to be maintained and ideally where possible, continue to increase in the future.



The purpose of this indicator is to provide a picture of the level of need within the community, with the aim of increasing the percentage of our population who require very little support to live an independent life within their own home, or to provide the proper care to those who require it, again within their own home if possible.

As the chart illustrates, small incremental increases can be seen in the percentage of those at Home (unsupported) since 2015/16 after dropping from the previous year. The percentage of those at home unsupported stands at 88.1%. Those persons who are supported at home has stood at 6.8% for the past 2 years.

For those in care homes, the HSCP would expect this to reduce over the long term, but it has been static for the past 3 years at 3.9%. It should be noted that Inverclyde has an ageing population and it's very possible this level of care home places is required to meet these very challenging circumstances regarding the population as we move forward.

The percentage of those who require acute care in a "Large Hospital" continues to reduce, in line with the aims of the HSCP.

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.

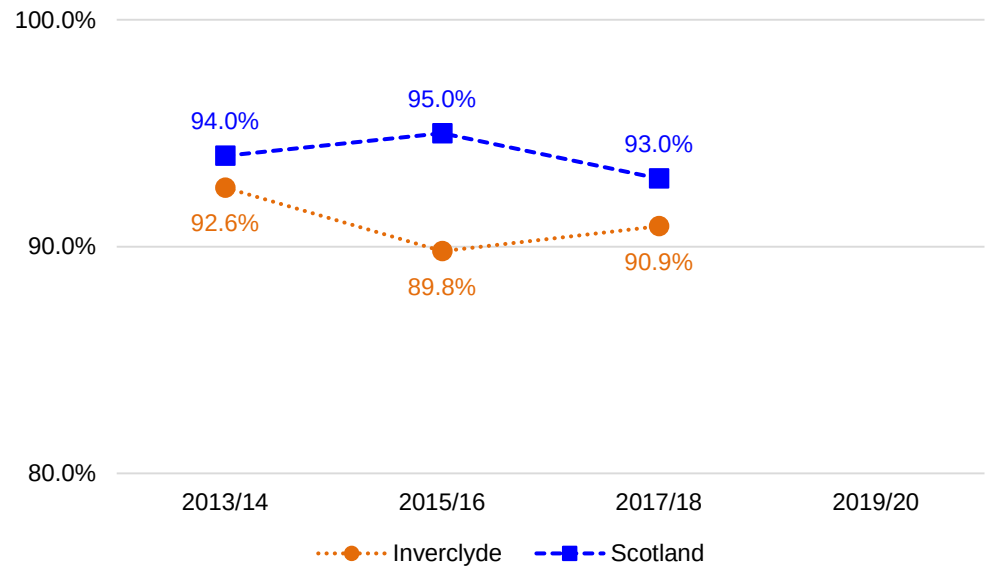
The following big actions from our Strategic Plan directly relate to achieving this outcome for Inverclyde residents.

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

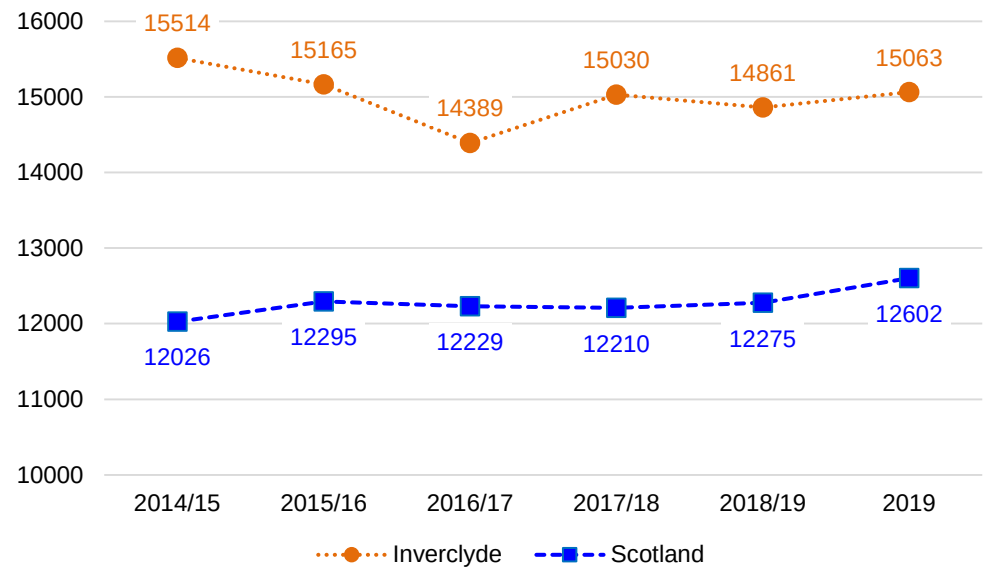
Big Action 5 - Together we will reduce the use of, and harm from alcohol, tobacco and drugs

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

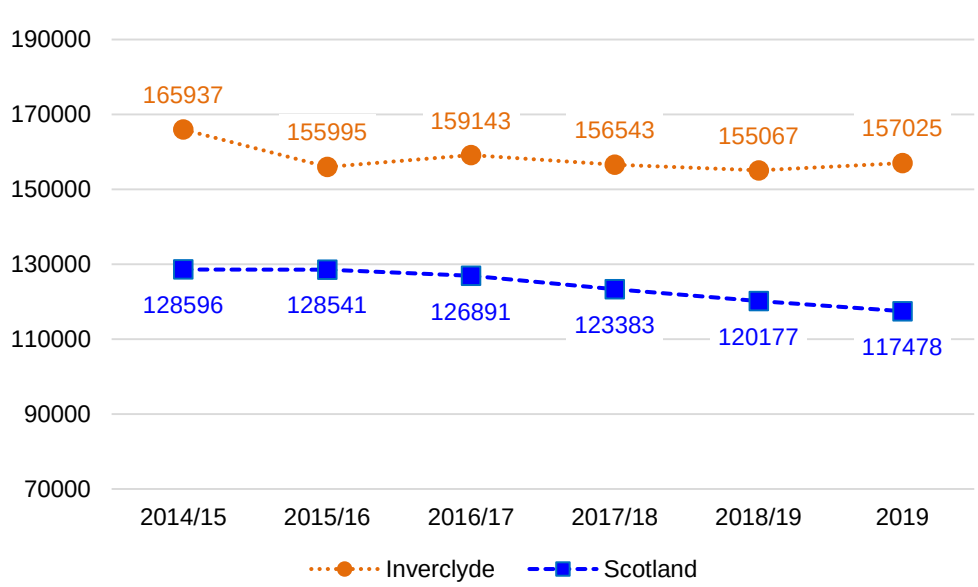
Current performance: National Integration Indicators

1	After a dip we improved in the last reported period and are closer to the Scottish average. Even though locally we achieved over 90%, we are not complacent and want to further support people to look after their health better.	Adults able to look after their health very well or quite well  Higher figures = Better performance

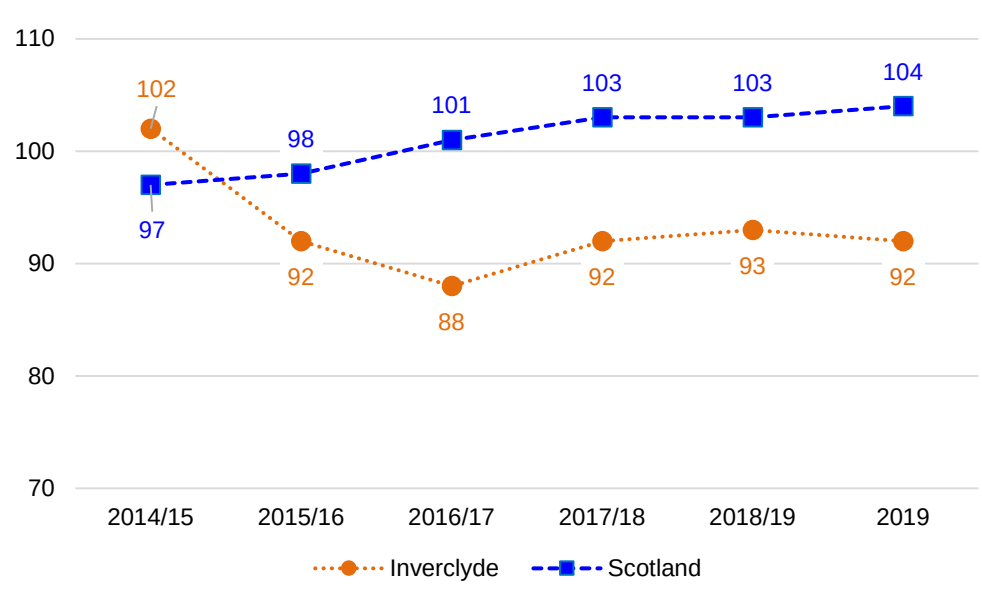
2019/20 survey results will be published later than planned (due to Scottish Government staff redeployment during the COVID-19 pandemic) but we will include them in future performance reports once they are available.

12	We have experienced a slight positive reduction since 2014/15 with the last 3 years being fairly static. Nationally there has been a gradual increase over the same period. A number of measures have been put in place in 2019/20 to reduce this rate further in Inverclyde.	Emergency admission rate (per 100,000 population)  Lower figures = Better performance

Calendar year 2019 is used here as a proxy for 2019/20 due to the national data for 2019/20 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships.

13	After an initial reduction of over 10,000 from 2014/15, local performance has remained static while the national performance has improved. A number of measures have been put in place in 2019/20 to reduce this rate further in Inverclyde.	Emergency bed day rate (per 100,000 population)  Lower figures = Better performance

Calendar year 2019 is used here as a proxy for 2019/20 due to the national data for 2019/20 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships.

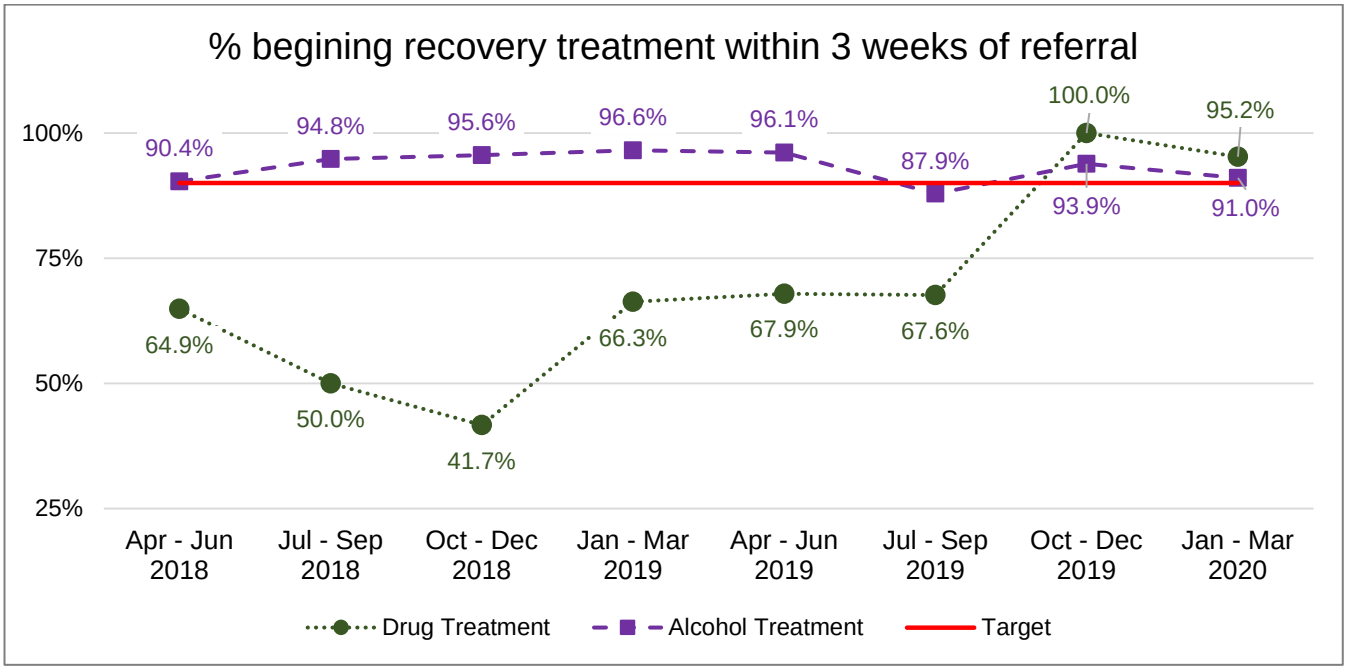
14	Often when people have to be readmitted to hospital soon after going home, it can be because the discharge took place before the person was fully ready, or because the post-hospital support was not quite right. This graphic shows Inverclyde performance has improved and is better than the national picture.	Readmission to hospital within 28 days (per 1,000 population)  Lower figures = Better performance

Calendar year 2019 is used here as a proxy for 2019/20 due to the national data for 2019/20 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships.

Current performance: Local Indicators

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.



Source: SDMD (Scottish Drug Misuse Database)

Inverclyde Alcohol and Drug services redesign has continued during the year with the new service model ensuring those affected by alcohol and drugs are fully supported by an appropriate recovery orientated system of care which includes prevention; care and treatment; and recovery delivered by a range of statutory and 3rd sector partners. The HSCP addictions services have come together into one integrated service across both alcohol and drugs renamed Inverclyde Alcohol and Drug Recovery Service (ADRS). The service is working with other partners to deliver alcohol and drug services and has commissioned appropriate support services to support service users throughout their pathway in recovery.

Through this redesign a review was carried out looking at the different screening and allocation processes within the two teams, with a subsequent redesign into one robust single point of access for ADRS, with updated associated service pathway processes to ensure appropriate and timely access to services. Alongside this an in-depth analysis of waiting times data within the service was carried out, this identified inconsistencies in recording across both services which has been addressed as part of the overall review.

Waiting times have now significantly improved across the entire service in the past year and are now within the 90% target for both drugs and alcohol service users. The next stage will be to amalgamate the drug and alcohol services waiting lists into one for ADRS while still ensuring separate information is maintained for alcohol clients and drug service users.

Choose the right service

Since the development of our *Choose the Right Service* branding in early 2017, we have achieved significant progress in raising awareness and directing patients to services that are best placed to support their health and social care needs

Engaging with our New Scots Community

Translation of materials into Arabic and providing these to New Scots families moving to Inverclyde

Choose the Right Service Flyer is provided in welcome pack to new families

A supply of translated flyers provided to Your Voice as a central point for families to access materials when attending drop in sessions

Illustrative magazine created by “magic torch” to support the New Scots community providing an overview of primary care services and how to access these services. This magazine is available with audio translation to support those that cannot read or write Arabic

Signposting and support has been delivered via Primary Care Service sessions in conjunction with Friday drop in sessions at Your Voice:

Session 1: oral health and visiting the dentist

Session 2: eye health and visiting the optician

Session 3: visiting your doctors surgery

Session 4: minor illness and visiting the pharmacy

Sessions 5 – 7 Health screening for Bowel, Breast and Cervical cancers.

Choose the Right Service for our children and young people.

- This branding and leaflet was launched in August 2019
- Worked with our local schools, nurseries and educational partners to share this resource with the wider community in Inverclyde

Copies of all the leaflets and additional information can be found on our website at https://www.inverclyde.gov.uk/health-and-social-care/health-services-health-improvement-wellbeing/choose-the-right-service

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"

The following big actions from our Strategic Plan directly relate to achieving this outcome for Inverclyde residents.

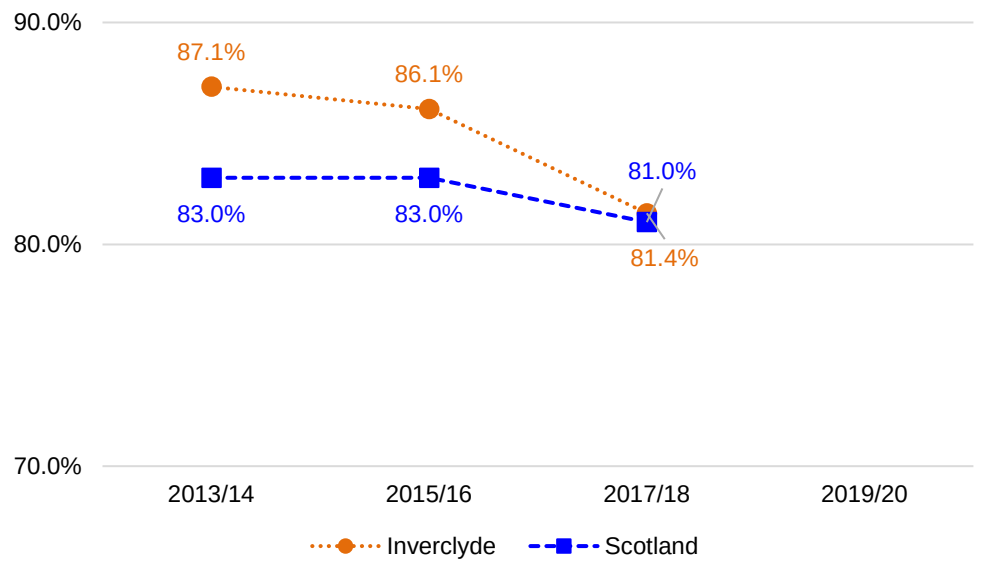
Big Action 1 - Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health

Big Action 3 - Together we will Protect Our Population

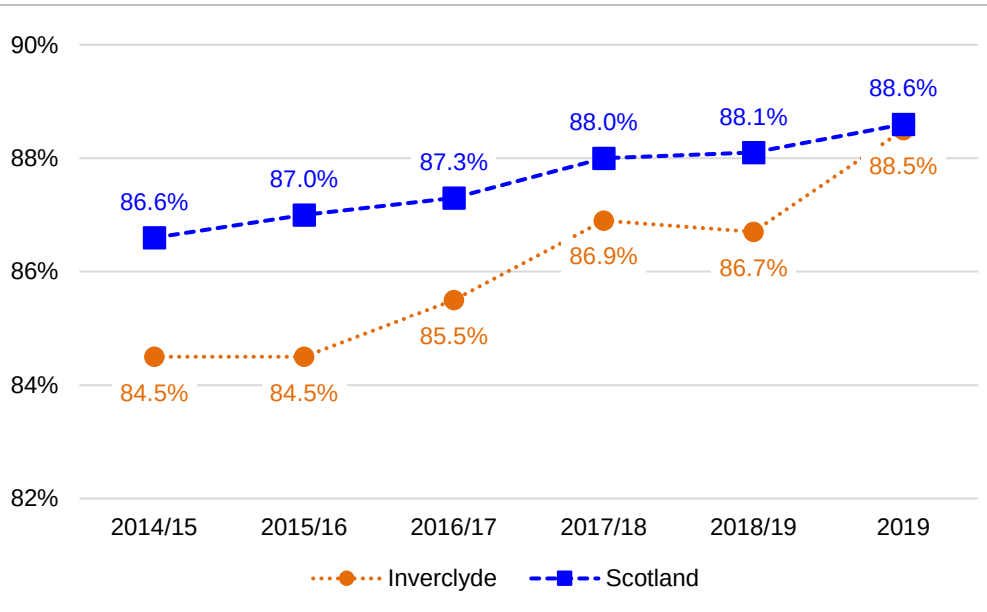
Big Action 4 - We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living

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

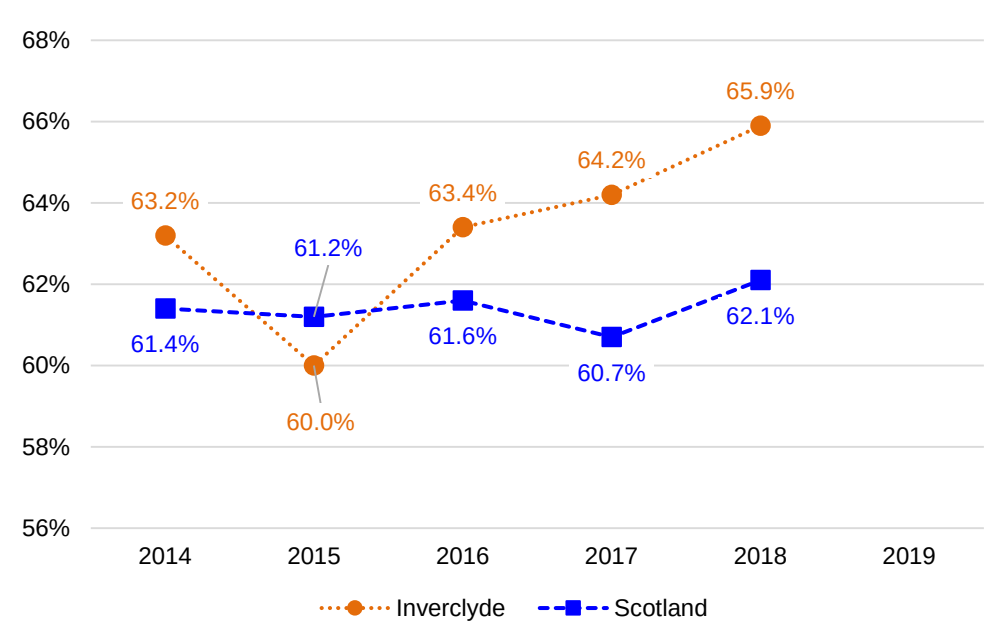
Current performance: National Integration Indicators

2	Supporting people is a key priority and although performance reduced nationally, we experienced a larger drop locally. With our Access 1st and Home 1st approaches we hope to see an improvement in the 2019/20 survey once it's published.	I was supported to live as independently as possible  Higher figures = Better performance

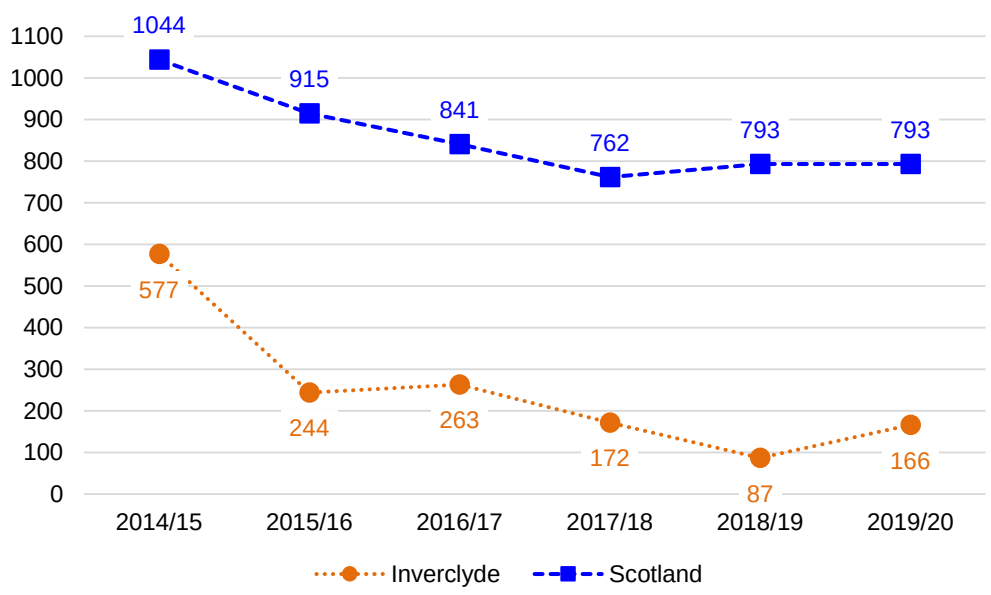
2019/20 survey results will be published later than planned (due to Scottish Government staff redeployment during the COVID-19 pandemic) but we will include them in future performance reports once they are available.

15	Supporting people to be comfortable in their own homes towards the end of their lives often provides a better quality of life. This in turn can aid the grieving process for families. Local performance has improved year-on-year and we are now on par with the Scottish average.	Proportion of last 6 months of life spent at home or in a community setting  Higher figures = Better performance

Calendar year 2019 is used here as a proxy for 2019/20 due to the national data for 2019/20 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships.

18	People tell us that they prefer to be supported to stay at home, so we work hard to make this option available whenever it is both safe and possible. We have seen a sustained improvement in achieving this for more of our residents and we aim to further increase this.	Percentage of adults with intensive care needs receiving care at home  Higher figures = Better performance

The 2019 data for this indicator is not due to be published until September 2020, after publication of this report.

19	Inverclyde performance on delayed discharge is regularly the best in Scotland and significantly better than the Scottish average. We continue to innovate to continue to deliver high performance in this area for our population.	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)  Lower figures = Better performance

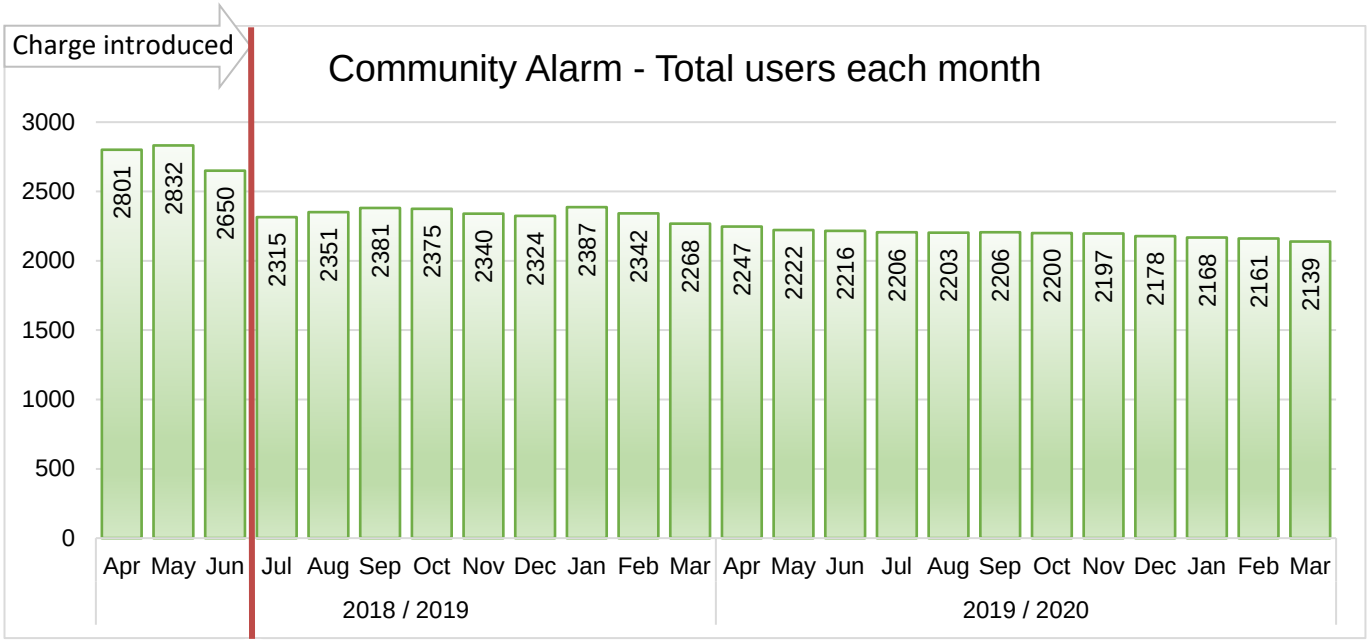
Current performance: Local Indicators

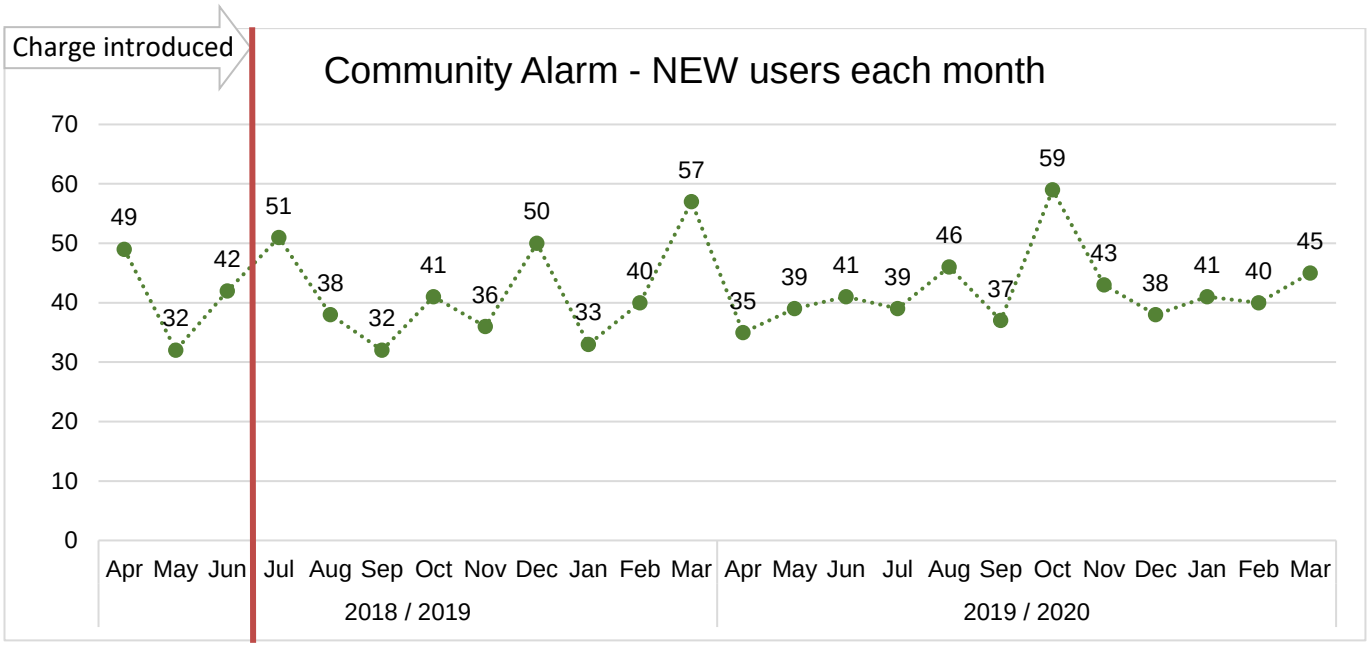
We have developed a Digital Strategy to Support Technology Enable Care

Technology Enabled Care: Community Alarm

The service previously reported a reduction in users following the implementation of a nominal charge in June 2018. In March 2019, the total number of users was 2268. While this figure had reduced to 2139 by March 2020 (a reduction of 129), the number of **new** service users from April 2019-March 2020 has increased to 503 which is slightly higher than the previous 2 years.

We are confident that the level of people being supported with a Community Alarm service represents actual need.

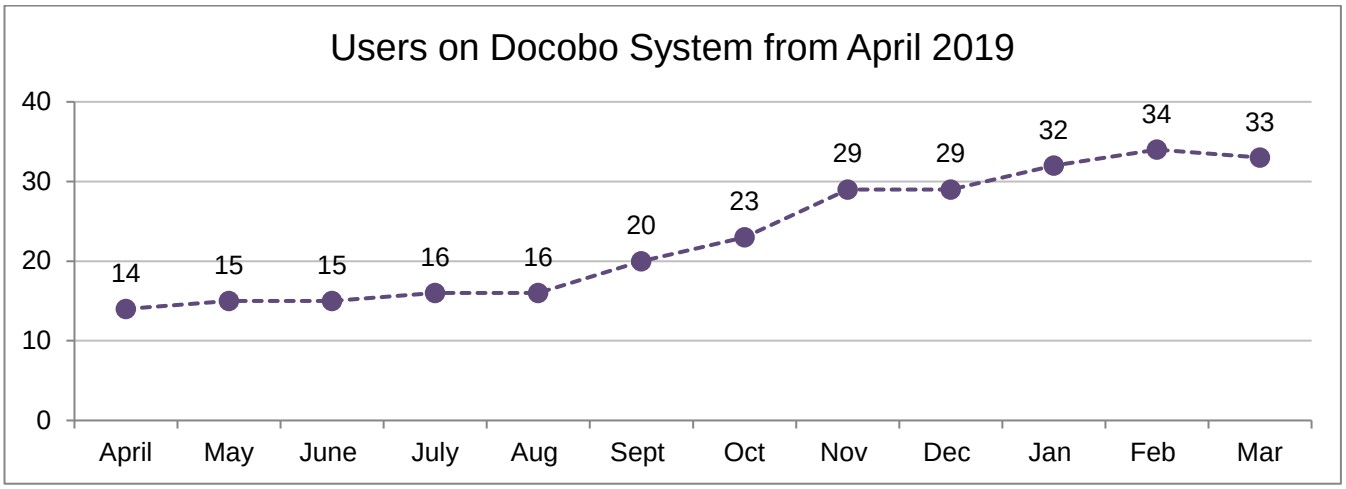




Long Term Conditions – Home and Mobile Health Monitoring

Docobo eHealth Solution

The Service supports people with Chronic Obstructive Pulmonary Disease (COPD) in the community to better self-manage their condition. In April last year, the Service replaced its' home monitoring hubs as the previous equipment had reached the end of its lifespan. There has been an increase in the use of the hubs as the chart below shows. The Service has also introduced the use of an App for those who are confident in using this preferred method of communication which has provided increased capacity to use and recycle the home hubs.



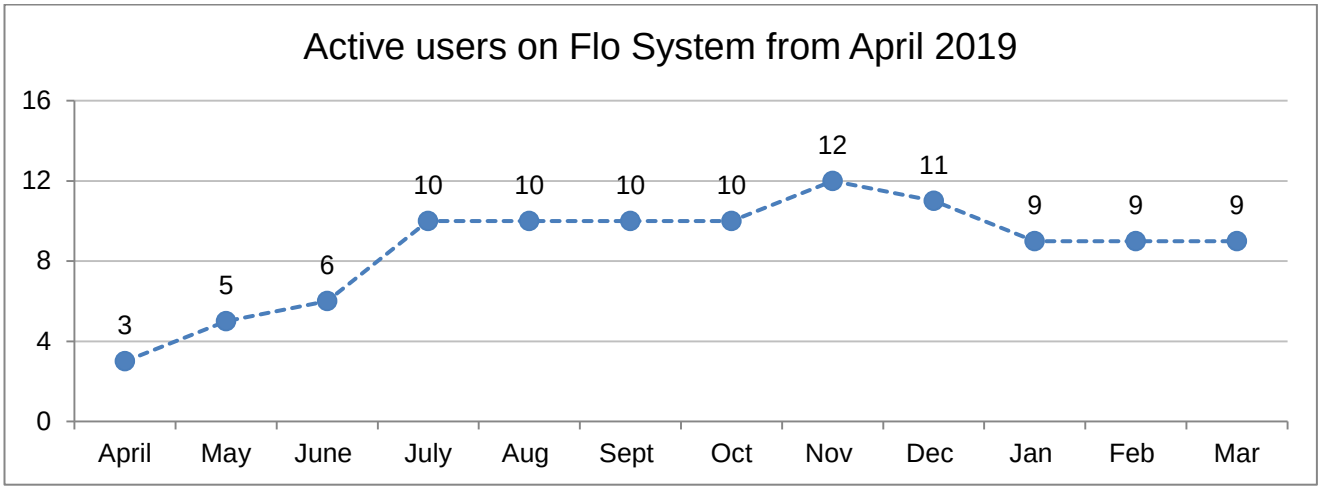
The service provides early intervention and anticipatory medication thus hopefully avoiding potential hospital admissions. Since April 2019, there has been a total of 83 avoided hospital admissions from those using the Docobo remote home health hub.

Florence (FLO)

The Service also supports people in the community using FLO – a phone app which allows users to send their blood glucose readings to their GP practice. This is part of an initiative to improve self-care in diabetes and increase the number of patients self-administering insulin thus reducing the number of home visits required by a District Nurse. Using FLO helps support users in maintaining their independence through self-management of their diabetes and provides early intervention and re-education as required.

The undernoted chart highlights the number of users actively using FLO from April 2019 - March 2020. Two patients have now successfully withdrawn from the service as they are able to self-manage their medication regime.

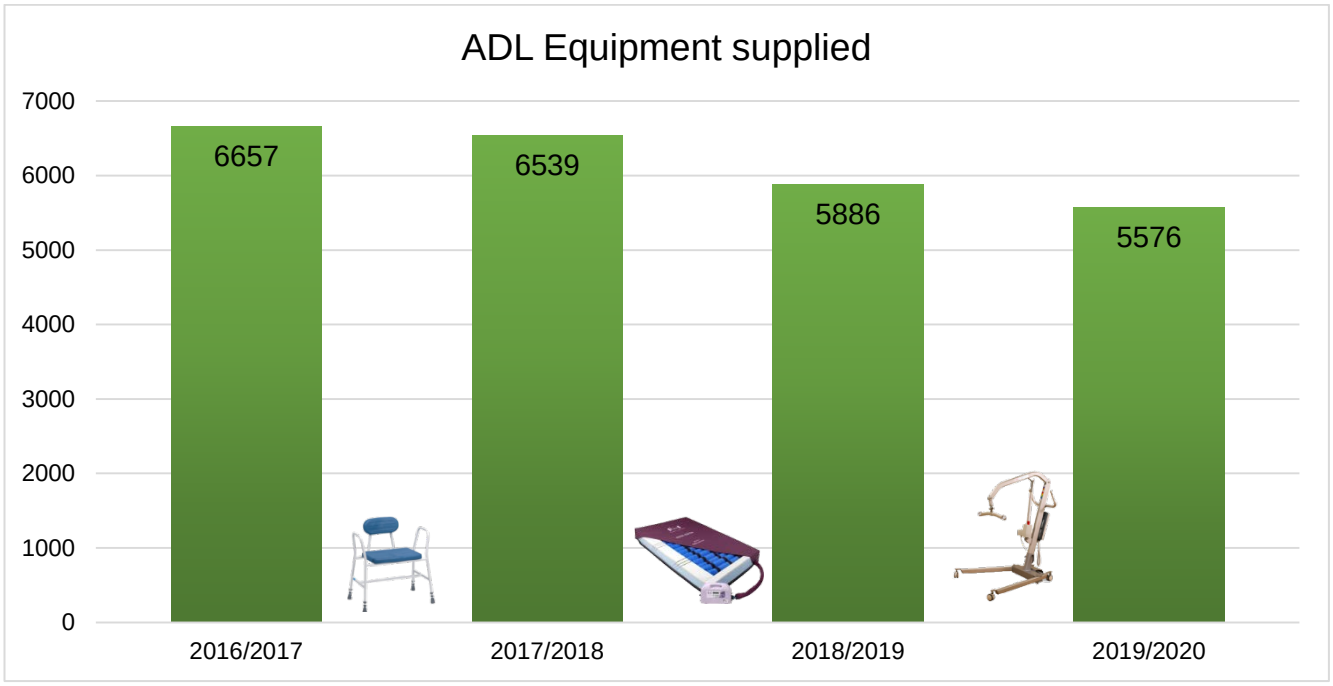
In terms of home visits carried out by District Nurses, this initiative including the use of FLO, has resulted in an overall saving of 1,904 hours over this period.



Aids for Daily Living (ADL) equipment

In 2019 / 2020, we provided 5,576 unique items of ADL equipment to Inverclyde residents who had a physical need. This is down from the previous year (2018/19) where we provided 5,886 items. 22% of all equipment supplied was to support people being discharged from hospital.

The amount of equipment required to support discharge from hospital and for preventing admission (hospital style beds, patient hoists, pressure care mattresses and all associated items) has remained fairly consistent. The reduction in overall numbers is, at least partly, due to our rehabilitation and reablement services helping get people 'back to health' quickly.



This equipment ranges from hospital beds with pressure care mattresses and patient hoists, to simple seats for use in a shower. An Occupational Therapist or District Nurse carries out an assessment for equipment.

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.

The following big actions from our Strategic Plan directly relate to achieving this outcome for Inverclyde residents.

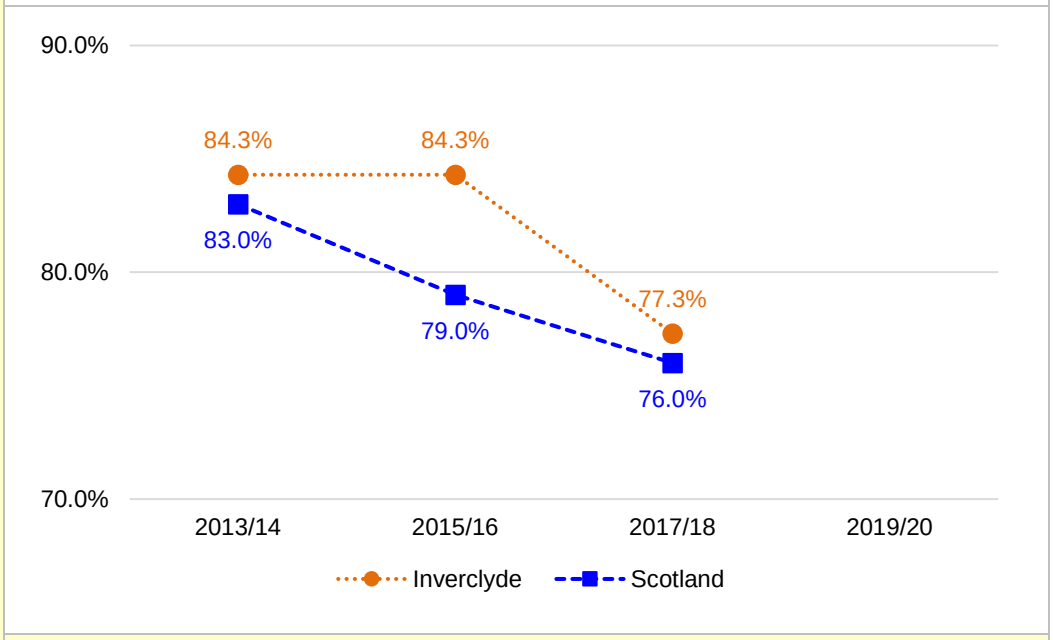
Big Action 2 - A Nurturing Inverclyde will give our Children & Young People the Best Start in Life

Big Action 3 - Together we will Protect Our Population

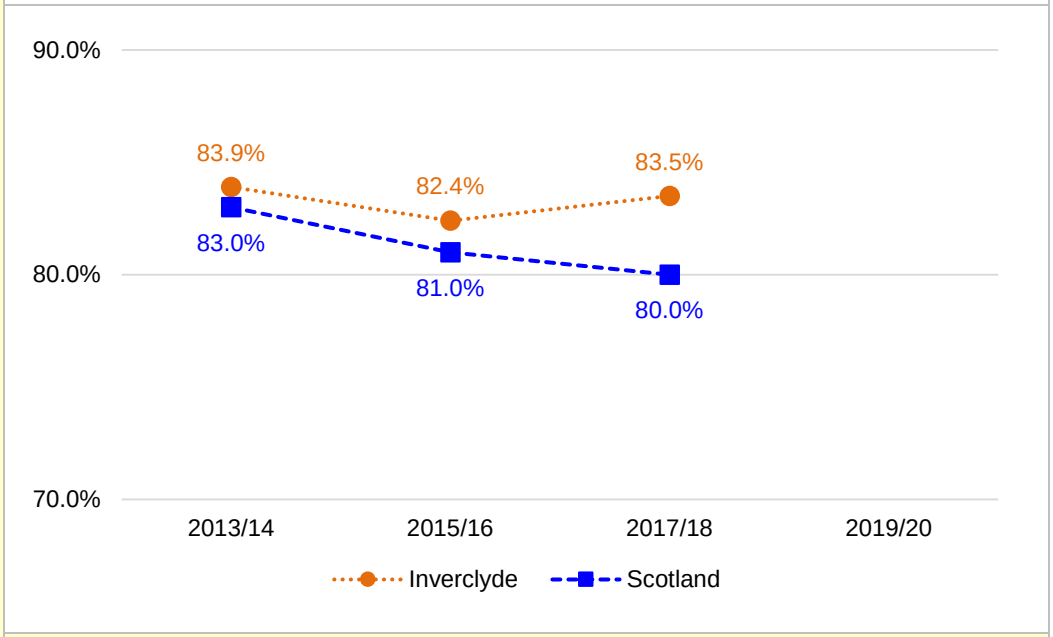
Big Action 4 - We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living

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

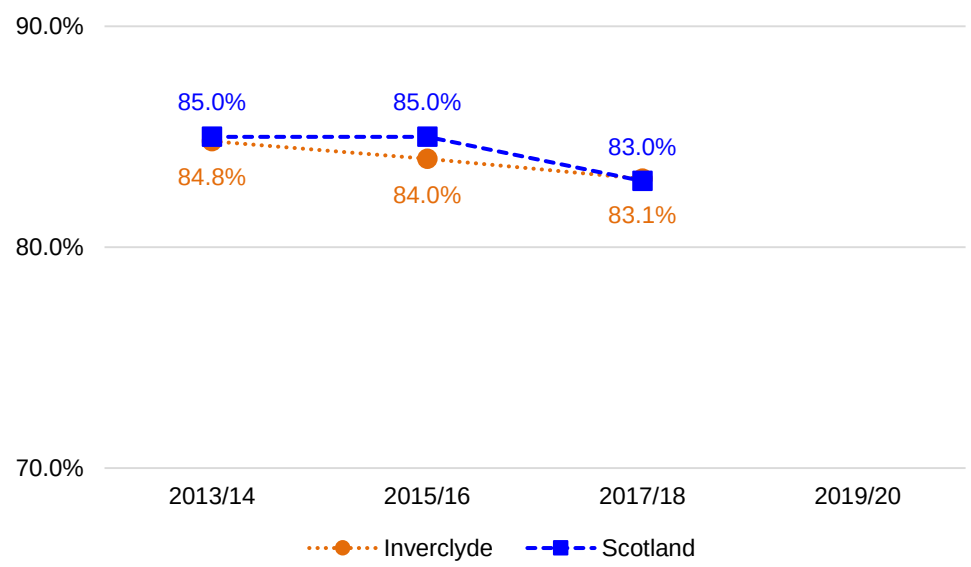
Current performance: National Integration Indicators

3	It's important that those receiving support are included in the planning of this. This helps to better match the care to the needs of each individual. We managed to sustain a high level before seeing a drop in the most recent period; nationally this declined over all periods.	I had a say in how my help, care or support was provided  Higher figures = Better performance

2019/20 survey results will be published later than planned (due to Scottish Government staff redeployment during the COVID-19 pandemic) but we will include them in future performance reports once they are available.

5	Quality of care is essential. In this we have been able to maintain higher rankings than the national average.	Adults receiving any care or support who rated it as excellent or good  Higher figures = Better performance

2019/20 survey results will be published later than planned (due to Scottish Government staff redeployment during the COVID-19 pandemic) but we will include them in future performance reports once they are available.

6	Our GP's continue to provide good levels of support and although performance dipped slightly we are broadly matching the Scottish average.	Percentage of people with positive experience of the care provided by their GP practice  Higher figures = Better performance

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Current performance: Local Indicators

Market Facilitation and Commissioning Plan 2019 to 2024

The Market Facilitation and Commissioning Plan 2019 to 2024 sets out our Health and Social Care commissioning priorities and intentions in line with the overarching Strategic Plan 2019 to 2024.

The Plan was informed by our Strategic Needs Assessment and further shaped by consultation and engagement with our communities. Specific locality data was used to highlight key challenges that affect the population of each locality.

This work helped identify the future demand for care and support to allow us to be better placed to meet the future needs of Inverclyde communities and service users in line with the National Wellbeing Outcomes and our Strategic Plan 6 Big Actions.

Inverclyde HSCP is committed to ensuring Inverclyde service users can choose from a number of care and support providers and have a variety of creative support options available. The Market Facilitation and Commissioning Plan provides an innovative and creative approach to the commissioning of services while being responsive to the changing needs of Inverclyde service users.

Primary Care Improvement Plan

Continued implementation of the Primary Care Improvement Plan (PCIP) during 2019/20 has gone well but has also faced a number of challenges which include:

- the financial constraints of the current funding model slowing down Inverclyde progress
- delays in recruitment
- staff retention issues as other HSCPs begin to recruit to their PCIP teams
- and the start of the COVID-19 pandemic

We now have Community Link Workers (CLW) within every GP practice in Inverclyde. They have received over 1,500 referrals in the past year and received excellent feedback on this programme from the multi-disciplinary teams (MDT) and patients. Money, debt and housing are the main issues affecting those being referred to the CLWs and there are excellent relationships and support from across third sector to support individuals (see case study).

An additional part-time trainee Advanced Nurse Practitioner (ANP) joined the team during 2019 and a total of 1,167 unscheduled home visits were carried out on behalf of GPs. Having an ANP within the team means that the most appropriately skilled professional can visit an acutely ill patient. Each visit undertaken by an ANP saves approximately 35 minutes of GP time which is freed up to concentrate on those patients with the most complex needs. Recruitment of a further 2 posts is planned to expand this excellent programme further.

Workshops were held to explore the data, evidence and issues around additional support required within primary care mental health services. The creation of a Distress Brief Intervention service was agreed to support GPs in offering more appropriate support for those suffering distress. This service is now expected to commence in September 2020.

Patient A's Story – Treating the problem not just the symptoms

Patient A presented to her GP with a variety of concerns including anxiety depression, trouble sleeping and low mood. She advised she was "not coping well" and had some money worries despite having a well-paid job and doing extra hours. She was working around 60hrs every week.

The patient was referred by her GP to the CLW team who spent time getting to know her. Through this they identified a number of additional background issues including: bereavement; relationship breakdown and significant debt problems. The patient was working extra hours to try to cover the debts and was still struggling to keep her head above water. This left her physically and mentally exhausted.

The CLW was able to provide debt advice and put her in touch with a number of agencies that were able to help. She had a number of one to one money advice meetings with one of the debt agencies and a meeting was arranged with her bank which the CLW attended with her. The CLW worked with the patient to look at the triggers around her spending and helped her to reduce household bills to help her overall financial position. During this time she suffered a further family bereavement when her Gran died but despite this was able to keep going with the debt advice and stick to the agreed repayment plan until she was able to clear the outstanding debts.

Instead of simply getting a prescription to treat the anxiety or depression or sleep problems by referring this patient to our CLW team we were able to ensure that the patient could address the underlying problem rather than just treating the symptoms.

The result was a debt plan which is manageable and a major reduction in working hours. Sleeping better and skin cleared up more time for social aspects and money to enjoy simple things. Referral made for counselling to address underlying issues. "I bought myself new clothes today and that's a first in a long time I look and feel good about me"

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.

The following big actions from our Strategic Plan directly relate to achieving this outcome for Inverclyde residents.

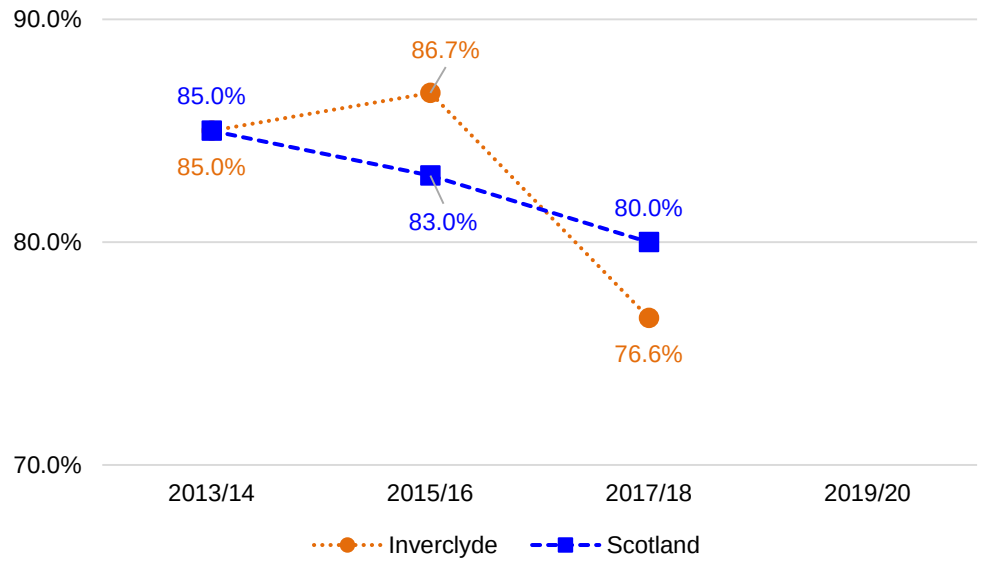
Big Action 1 - Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health

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

Current performance: National Integration Indicators

7	After an improvement our performance then dropped to below the Scottish average. We want to ensure that people receive the right support at the right time and are working to improve this.	The help, care or support improved or maintained my quality of life



Higher figures = Better performance

2019/20 survey results will be published later than planned (due to Scottish Government staff redeployment during the COVID-19 pandemic) but we will include them in future performance reports once they are available.

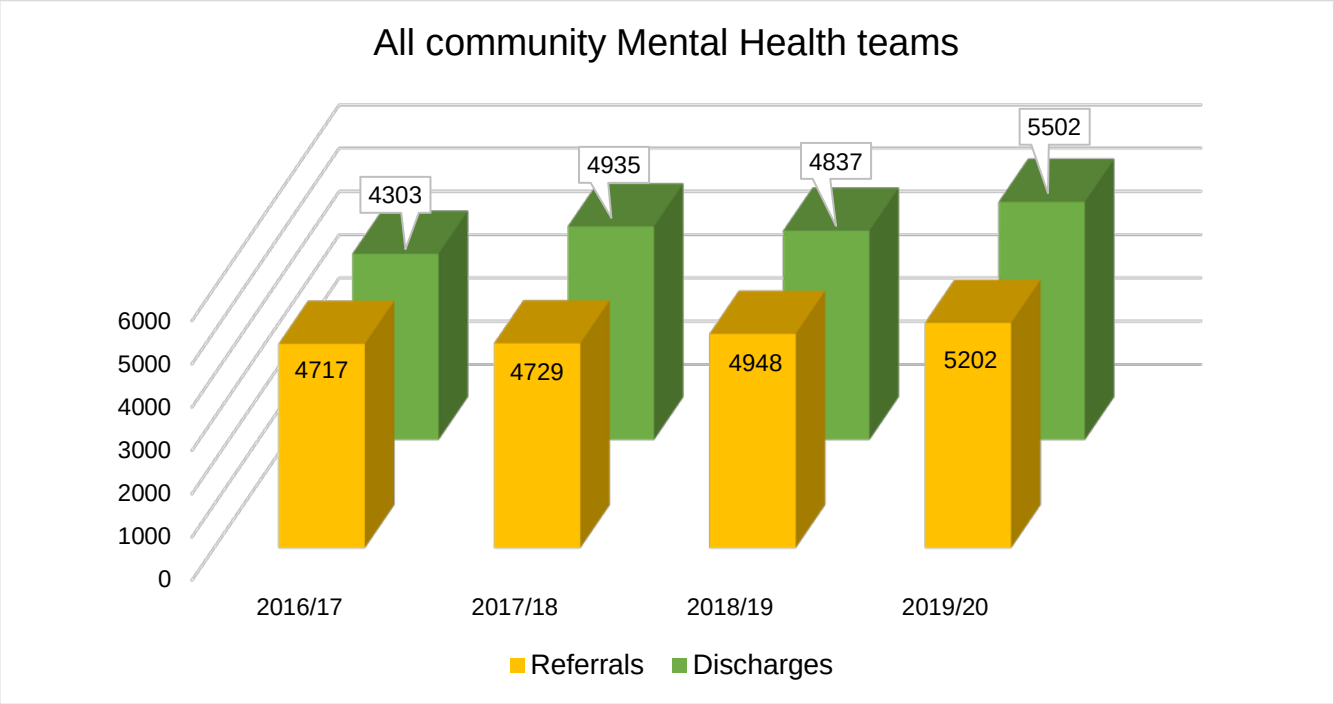
Current performance: Local Indicators

Mental Health

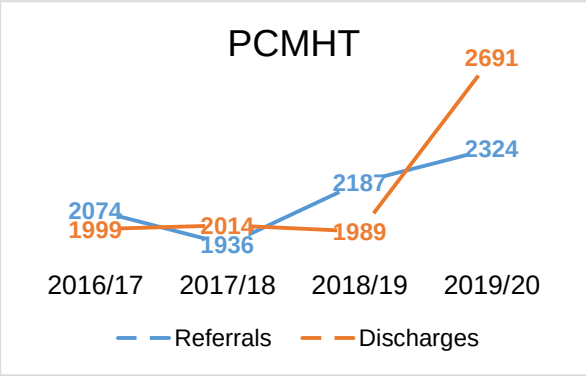
Within our Community Mental Health Services there were a total of 5,202 referrals throughout 2019/20, an increase of 5.1% from the previous year. This continues the year on year upward trend in referrals received. This is also matched by a higher increase in those being discharged from the service with 5,502 discharges in 2019/20 an increase of 13.7% from the previous year. Overall the service is now successfully discharging more clients than are coming into the service.

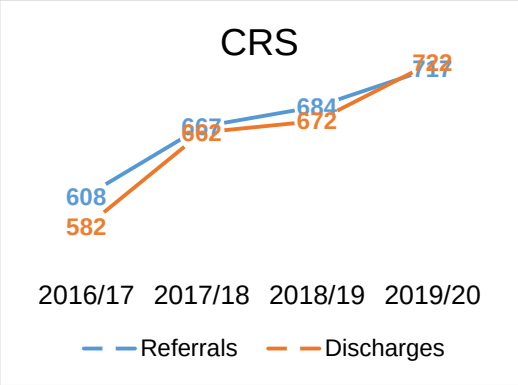
There are a number of reasons for this change including the increasing focus on recovery outcomes in care, increasing number of individuals whose contact is more transient through elements of service such as Primary Care Mental Health Team (PCMHT), Community Response Service (CRS) and Acute Liaison. There is also an awareness of inappropriate referrals being received in respect of some cases of emotional distress which do not require ongoing care through secondary mental health services and are now being redirected more appropriately.

Every referral involves an assessment to identify the most appropriate intervention to help support each person and improve their overall quality of life.



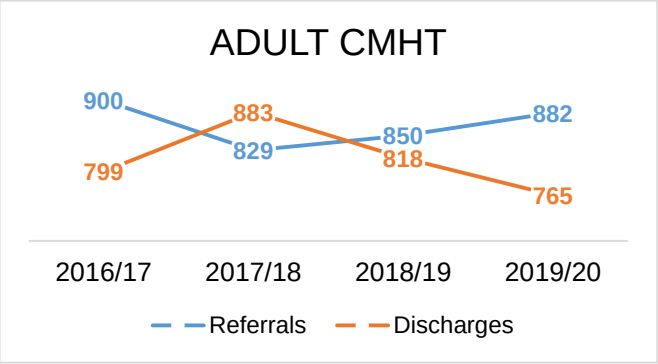
The PCMHT offers a service for those individuals who have mild to moderate mental health problems or issues and offers a schedule of time limited treatment. Referral rates have seen a sustained upward trend. The option for individuals to self-refer has proven to be an effective option and accounts for over 65% of all referrals into the service. The largest users of this service are younger adults aged between 18 and 35 years.

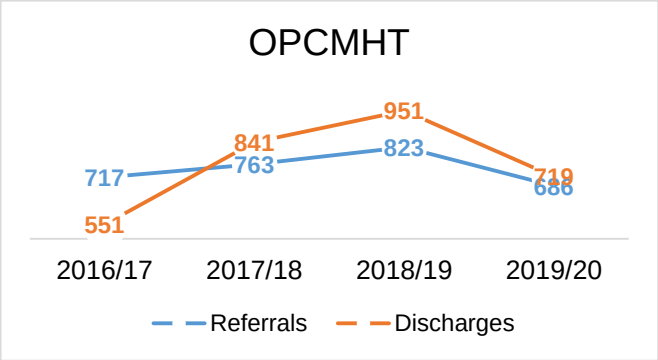




CRS provides urgent assessment and support as an alternative intervention to hospital admission. The increase in referrals alongside competing priorities (e.g. providing timely response to IRH Emergency Department and urgent community requests) has been a challenge for the team due their multi-function role.

The Adult Community Mental Health Team (CMHT) and Older Persons Community Mental Health Team (OPCMHT) provide integrated care working 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. Dementia care is a significant element of OPCMHT work. The services 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 outcomes focused 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.

Appropriate 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.

Inverclyde Dementia Care Co-ordination Programme

Inverclyde HSCP is working collaboratively with Healthcare Improvement Scotland as the Dementia Care Coordination implementation site. The Programme is taking a whole systems and pathway approach from diagnosis to end of life and sets out to develop and evaluate a model of effective and integrated care coordination, for people living with dementia and their carers. The emphasis is on supporting people to stay well at home or in a homely setting for as long as possible.

Priority areas were agreed at the Programme launch event in September 2019 where 92 key stakeholders attended, including people living with dementia and their carers. This informed the action plan which demonstrates the breadth of ambition for our Programme. A Steering Group was established to oversee and inform the whole Programme alongside 2 learning sessions (mini-conferences) for shared learning, progress updates, improvement ideas and action planning.

Our identified priority development areas are:

Summary of progress following the 2 Learning Sessions:

Post Diagnostic Support

- streamlining referral from memory clinic
- establishing weekly PDS waiting list review and allocation
- the role of others in providing PDS e.g. Occupational Therapists and Nursing Staff at Medication Clinic.

Dementia Register and understanding population

- data sub-group was established
- draft Programme measurement plan has been complied
- a baseline report has been drafted providing an overview of what is known about people living with dementia within Inverclyde
- provide a baseline to measure impact of the Programme.

Learning Disability

- Scoping of current LD and Dementia services carried out
- improvement ideas identified.

Additional programme aims

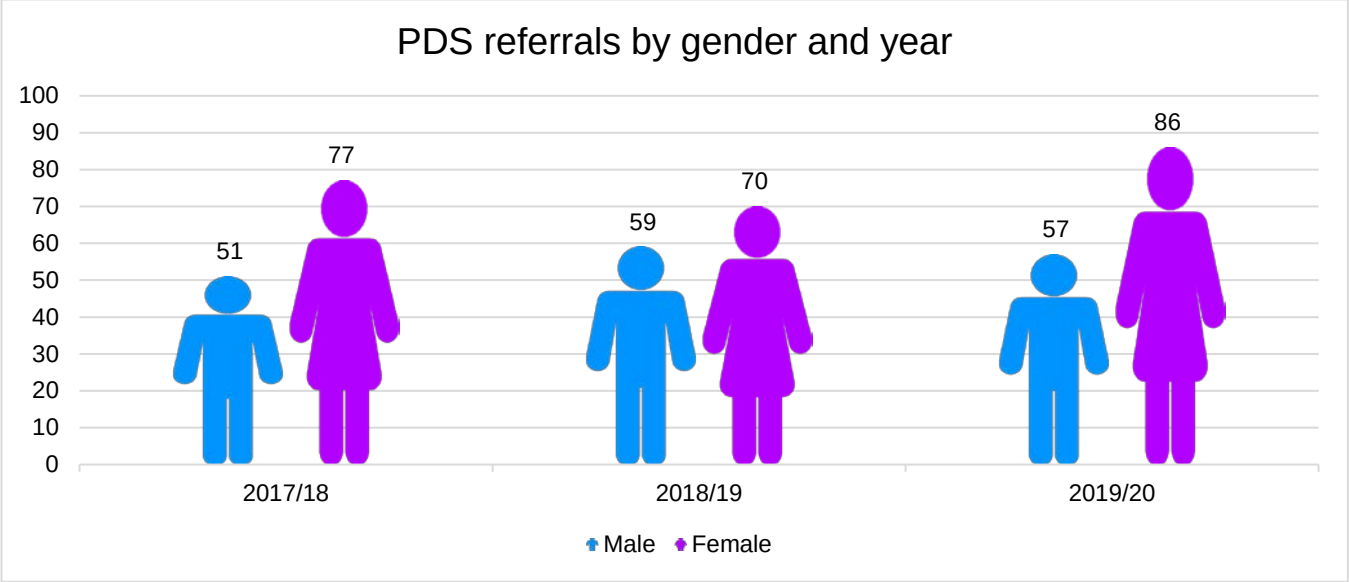
- Use of technology
- Home and Housing
- Allied Health Professionals - priority areas for improvement were identified and informed the Programme action plan.
- Continual engagement with people living with dementia and their carers through the Inverclyde Dementia Reference Group.

The Programme was temporarily suspended in March due to the COVID-19 pandemic and is not expected to recommence before September 2020. However, ongoing support through Post Diagnostic Support (PDS) is being provided to ensure that individuals newly diagnosed with dementia, their families or carers receive timely, quality and effective Support.

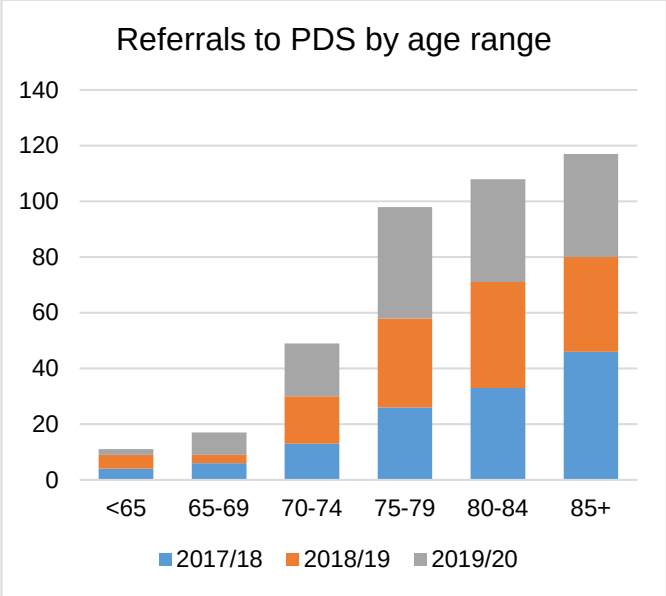
Post Diagnostic Support (PDS)

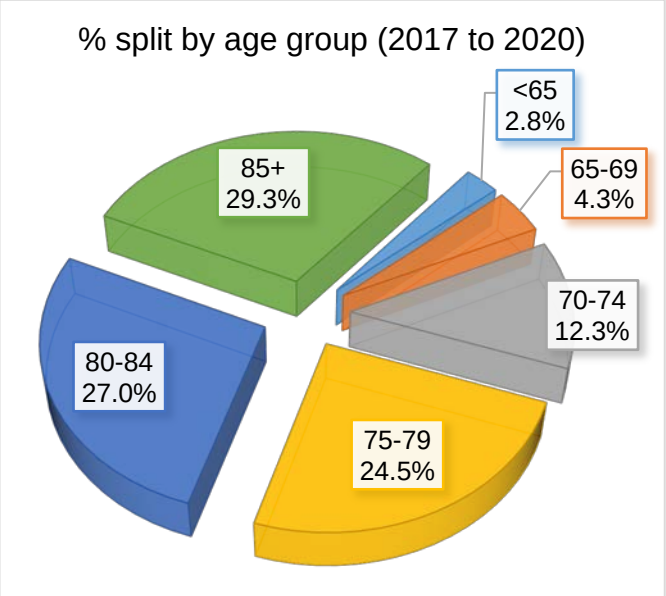
There is a Local Delivery Plan Standard in place that requires *everyone newly diagnosed with dementia will be offered a minimum of one year's PDS, coordinated by an appropriately trained Link Worker or PDS Professional.*

From 1st April 2017 to 31st March 2020, a total of 400 people in Inverclyde received a dementia diagnosis and were referred to PDS services; 167 were male and 233 were female.



Dementia diagnosis and referral to PDS increases with age as can be seen in the charts below.





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.

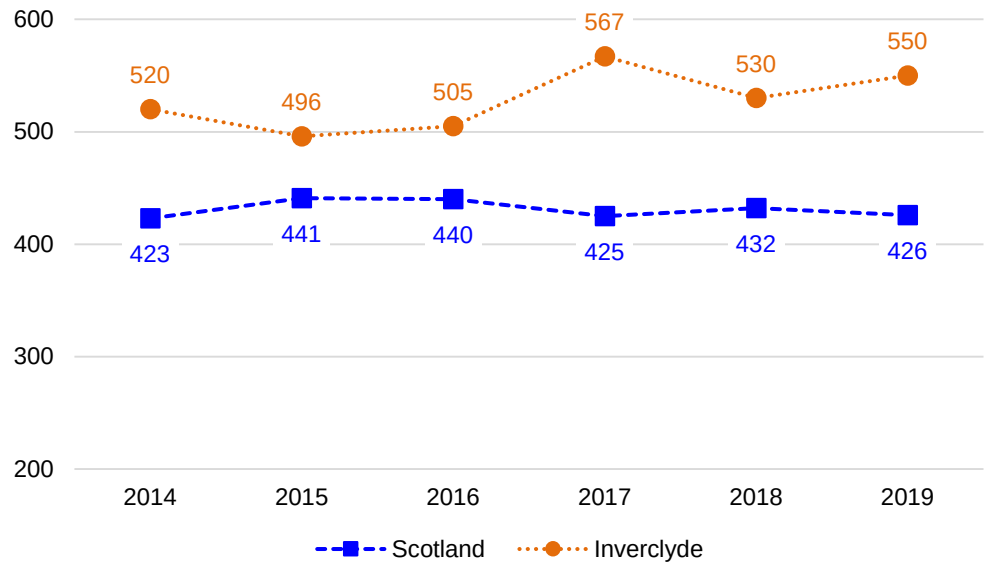
The following big actions from our Strategic Plan directly relate to achieving this outcome for Inverclyde residents.

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

Big Action 3 - Together we will Protect Our Population

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

Current performance: National Integration Indicators

11	This is a complex indicator as the causes of premature mortality are many, underpinned by social, health and economic inequalities. We are working hard to reduce this.	Premature mortality rate per 100,000 persons  Lower figures = Better performance

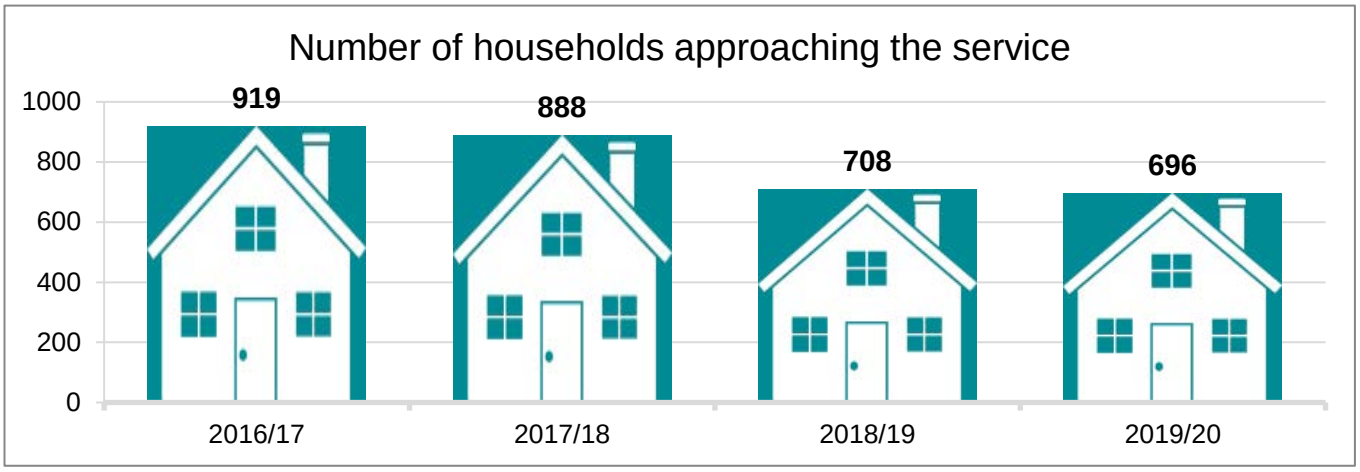
Calendar year 2019 is used here as a proxy for 2019/20 due to the national data for 2019/20 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships.

Current performance: Local Indicators

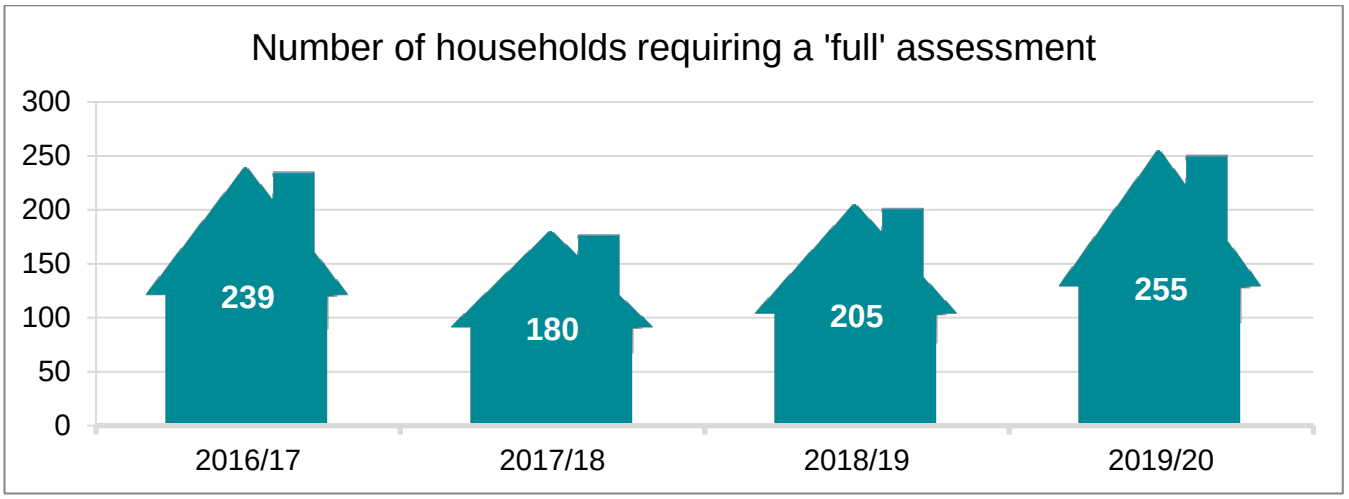
Homelessness

As part of our working to reduce health inequalities, we have undertaken a range of activities that are designed to resolve homelessness as quickly as possible and, as much as possible, prevent this altogether.

The data for 2019/20 presents a changing picture in relation to homelessness and shows the increasing demands in terms of complexity. Whilst overall the number of households presenting to Homelessness services has decreased in 2019/20 which is positive, the numbers requiring full homelessness assessment has increased substantially this year from 205 to 255, with those requiring temporary accommodation increasing considerably this year from 202 to 298.



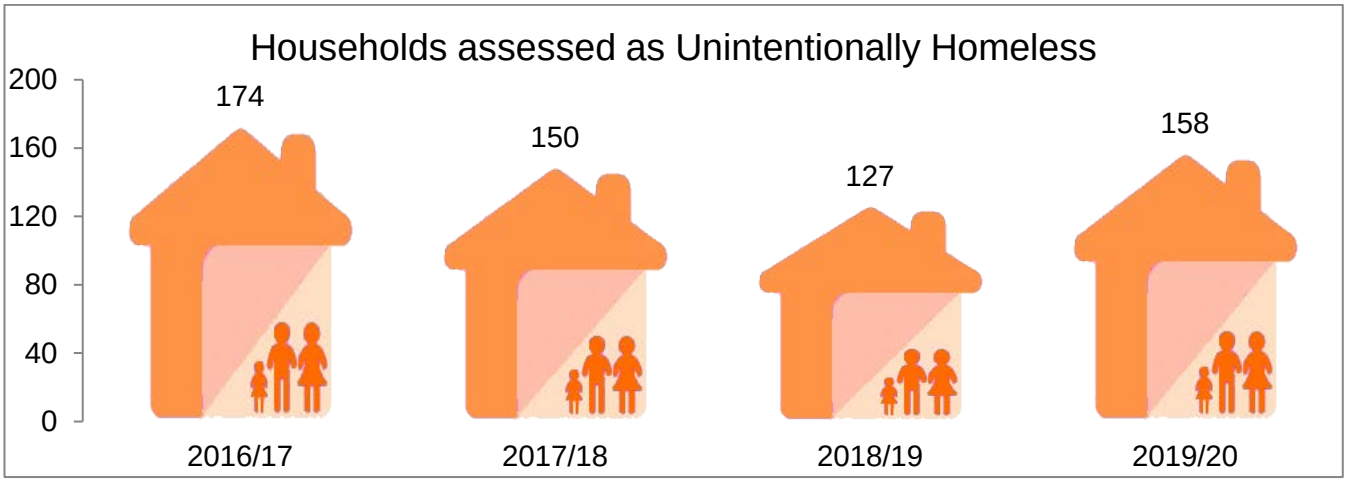
Alongside this is a changing picture of who is requiring support. There has been an increase from 24% to 47% of households presenting as homeless with a drug or alcohol condition.



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 graphic below shows the number of households that are assessed in this context as being 'unintentionally homeless' over the last 4 years. The 24.4% increase in the number of full

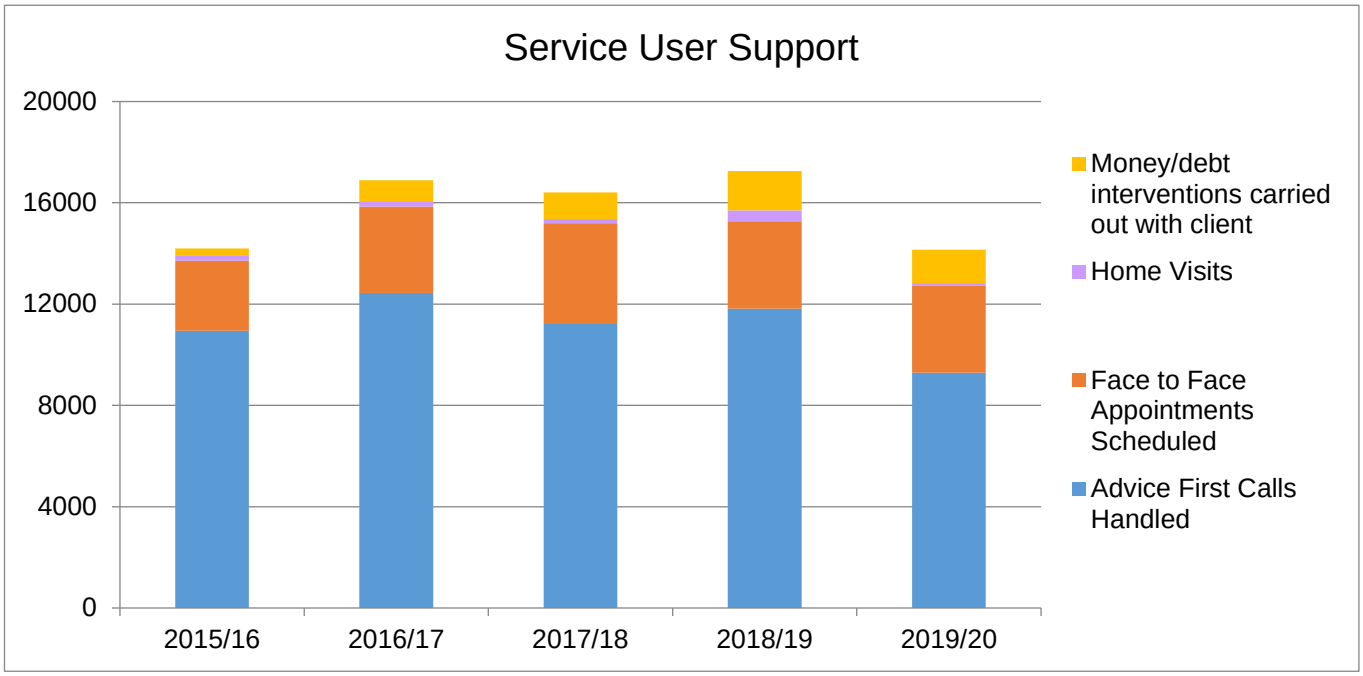
homelessness assessments from 2018/19 to 2019/20 also resulted in a 24.4% increase in the number of 'unintentional' decisions.

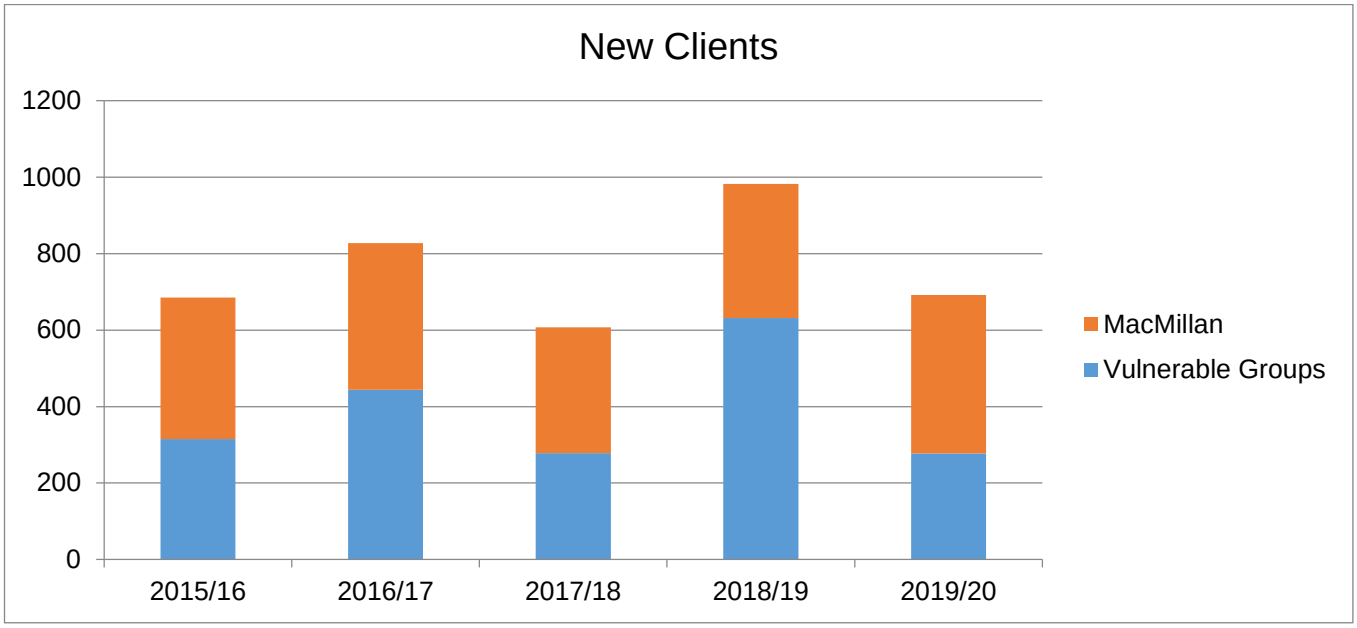


The Rapid Rehousing Transition Plan (RRTP) for Inverclyde was developed in 2019/20 and is the vision for transforming homelessness provision. The RRTP focuses on effective Housing Options to prevent people becoming homeless, and Housing First to support people to move directly into a settled tenancy without the need for temporary accommodation. This is at the forefront of Inverclyde's plans. Cross service working across the HSCP has developed to ensure service users with complex needs are being supported appropriately and in particular using the "Hard Edges" work as an approach, the need to develop intensive support to prevent failed tenancies; cycles of offending and addition is evident and this will be a focus in 2020/21.

Financial Inequality

Our award winning 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 5 financial years.





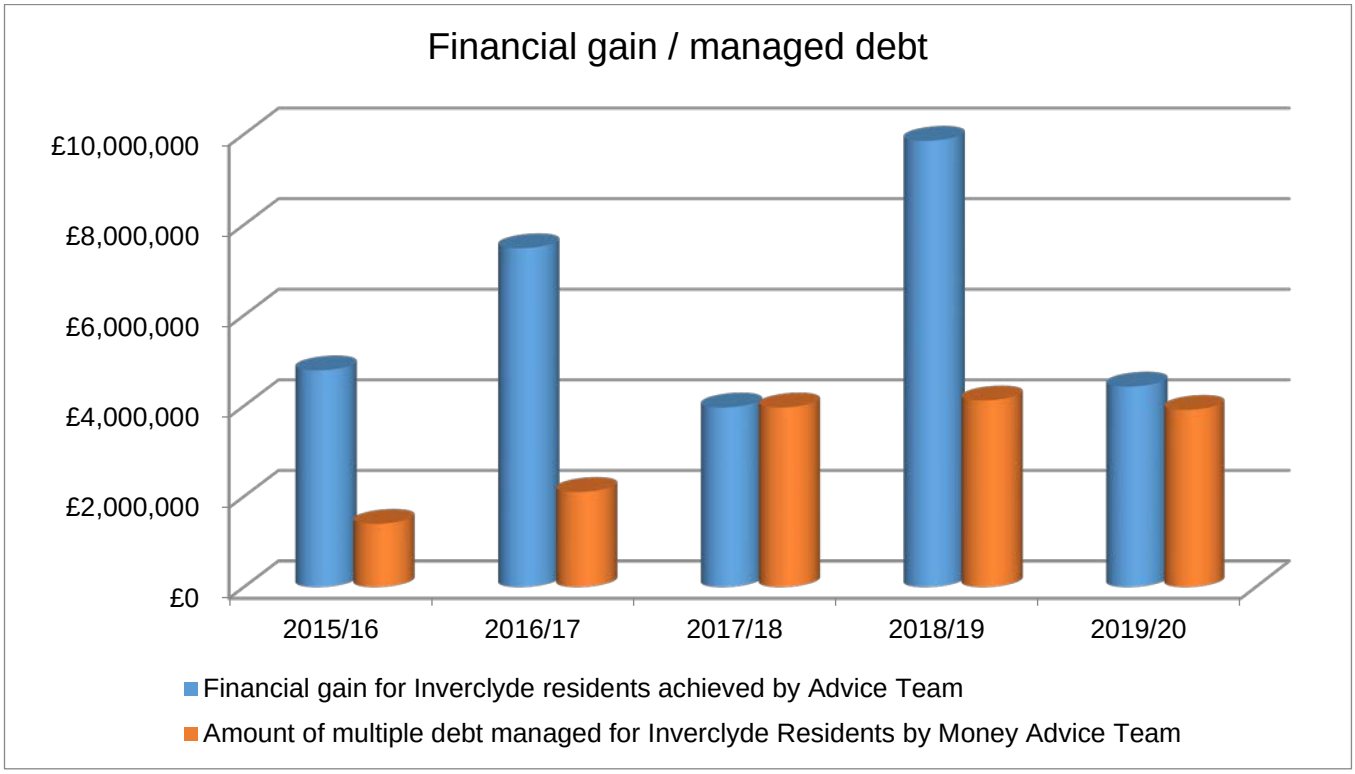
A couple's story

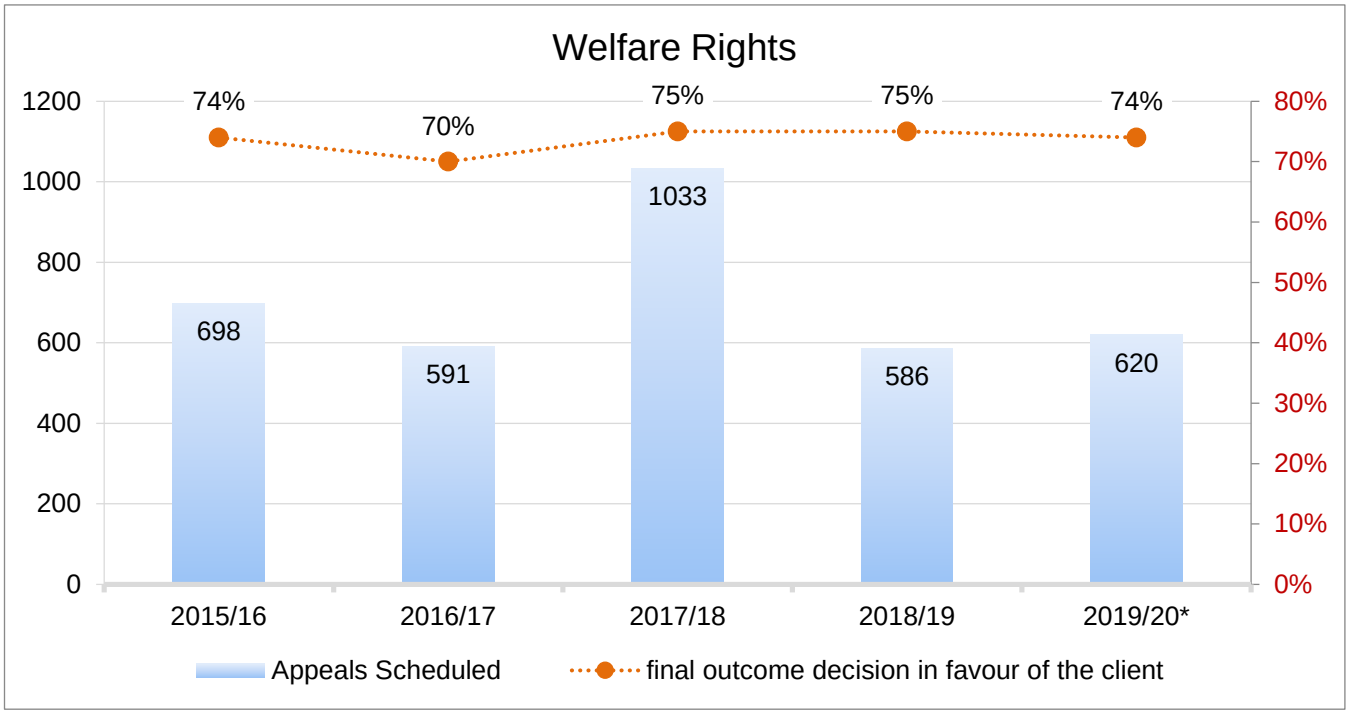
A couple were struck with the devastating double blow of both losing their jobs and one of them being diagnosed with cancer. They approached Inverclyde Macmillan Cancer Support Welfare Rights team for support. They were struggling to make ends meet during a very difficult time.

The couple were successfully supported to make a claim for Universal Credit, Council Tax Reduction and a Macmillan grant for £400 to help buy essential goods.

A referral was made to Macmillan Financial Support for assistance with their mortgage along with referrals to: Inverclyde Advice and Employment Rights Centre for employment law advice, their associated trade unions for help due to their financial situation, the local hospice for transport and hospice support and signposted to the Carers Centre.

The couple are now expecting a baby and a referral was made to Starter Packs who provided the standard/routine starter pack as well as assistance with baby goods.
The total annual financial gains to date amount to £12,477 and the team continue to work with them as their circumstances change and have been providing ongoing support during the COVID-19 pandemic.





*Please note that the 2019/20 Welfare Rights data is an estimate as the Jan-Mar 2020 data is unavailable due to implementation of a new data recording system.

Rachel's story

Rachel had approached our service seeking Welfare Rights representation at an upcoming tribunal relating to her Employment Support Allowance (ESA). She had failed to attend a Work Capability Assessment and her ESA had stopped, subsequently resulting in her Housing Benefit and Council Tax Reduction claims being closed. Rachel was struggling to manage her affairs, she had rent arrears and was too anxious to open the door in case it was the housing officer.

A paper hearing had been conducted in error and a Welfare Rights Officer requested that this was set aside and a new hearing arranged.

After weeks of escalating with various case managers within the Department for Work and Pensions, an Advice Worker advocated on behalf of the Rachel and proved that she had good cause for failing to attend the assessment. Rachel, who was a single parent, had fled domestic violence and was suffering from anxiety and mental health issues.

Rachel had her ESA decision overturned without having the stress of having to attend a tribunal hearing and the Advice Worker worked tirelessly to ensure that she received payment before Christmas, which she did. Her Housing Benefit/Council Tax Reduction was reinstated and backdated offsetting the rent arrears. She was also referred to a free local counselling service for additional support.
The annual amount of financial gains achieved for Rachel amounted to £14,733.

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.

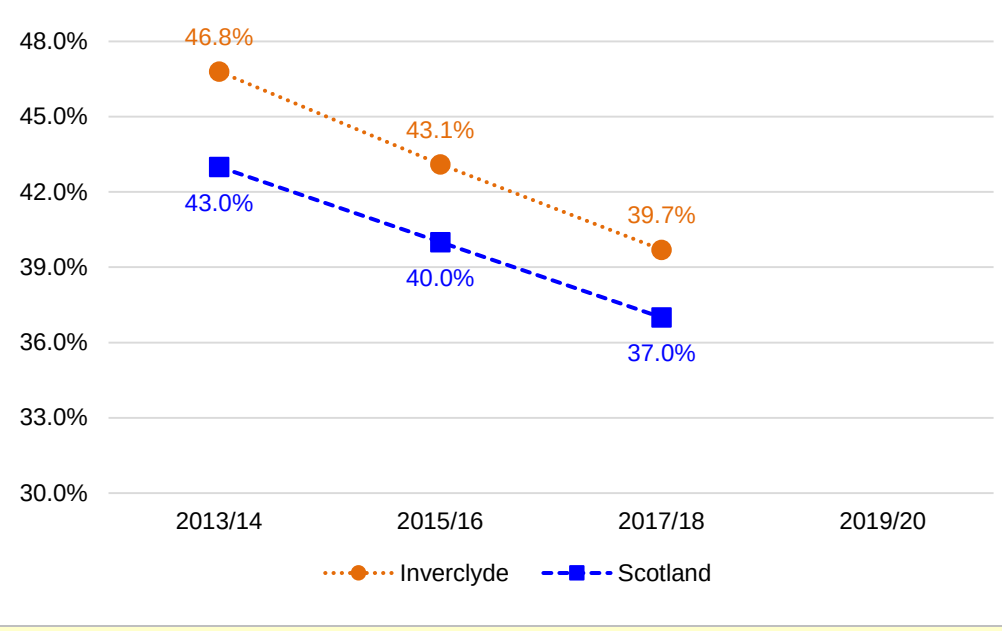
The following big actions from our Strategic Plan directly relate to achieving this outcome for Inverclyde residents.

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

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

Current performance: National Integration Indicators

8	Both locally and nationally there has been a disappointing downward trend. We are focussed on improving the support for carers in partnership with the carers centre and hope to see this trend reversed through initiatives like the Carer Passport.	I feel supported to continue caring  Higher figures = Better performance

2019/20 survey results will be published later than planned (due to Scottish Government staff redeployment during the COVID-19 pandemic) but we will include them in future performance reports once they are available.

Current performance: Local Indicators

Carers

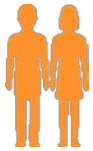
2,725 total registered Carers

584 new Carers identified

2,703 Carers were supported by Inverclyde Carers Centre this year

229 Adult carers support plans were completed

30 young carer's statements have been completed



31 Carers benefitted from Group Holidays

26 Carers benefitted from the Sitter Service

Carer Passports 2019-2020

Since this has been implemented this development has been very successful.

119 Local organisations support are registered Carer passport supporters.

776 Carers now hold a Carer Passport

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.

The following big actions from our Strategic Plan directly relate to achieving this outcome for Inverclyde residents.

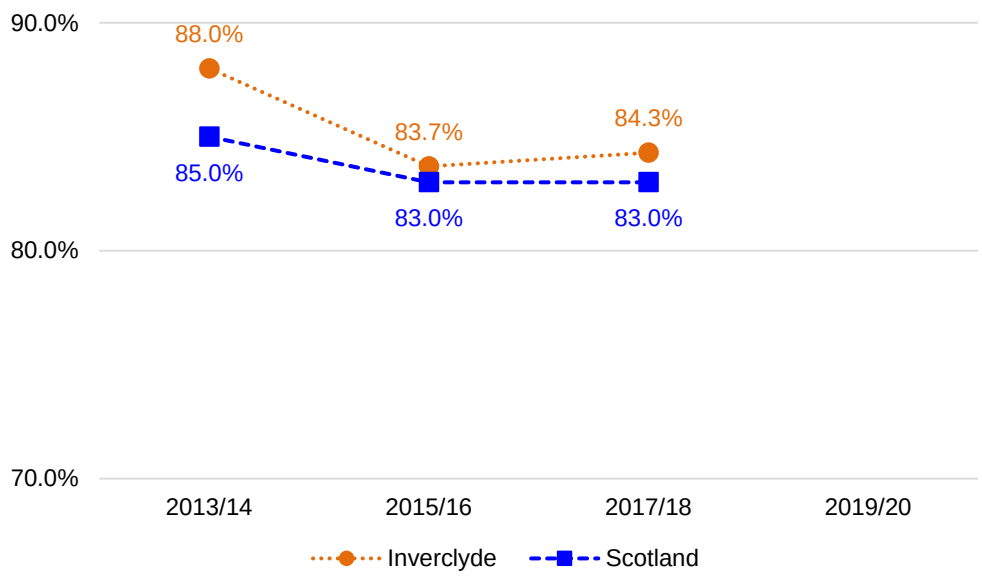
Big Action 3 - Together we will Protect Our Population

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

Current performance: National Integration Indicators

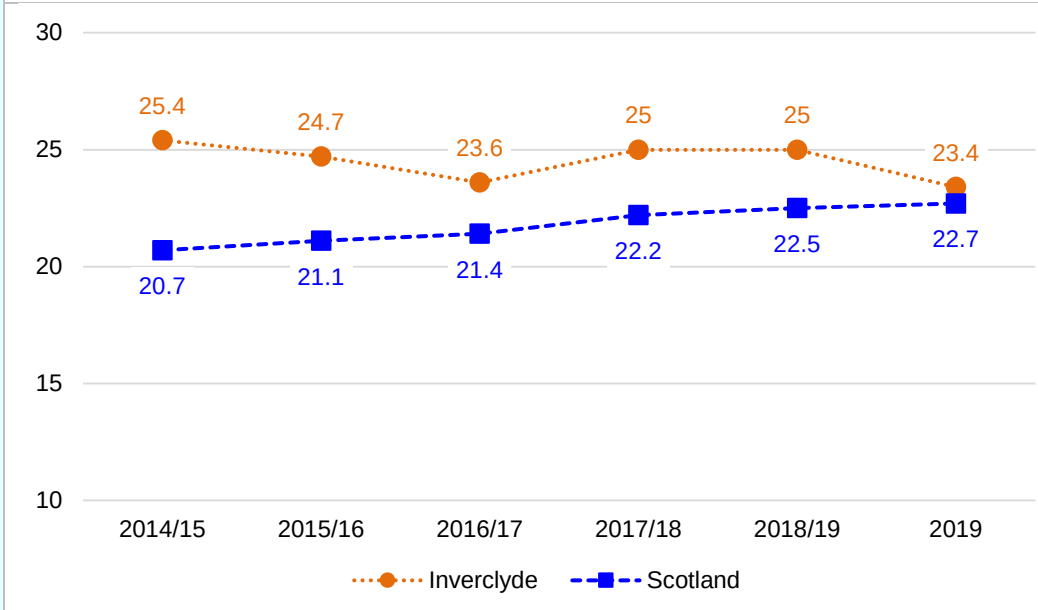
9	It's important that the people who we support feel safe in their own home. This is an essential part of the support. After a reduction both locally & nationally we then improved whilst nationally this remained static.	Adults supported at home who agreed they felt safe



Higher figures = Better performance

2019/20 survey results will be published later than planned (due to Scottish Government staff redeployment during the COVID-19 pandemic) but we will include them in future performance reports once they are available.

16	We have already seen some small improvements in reducing the rate of falls in our older population and anticipate further improvement through our new Falls media campaign and other prevention measures introduced in 2019/20.	Falls rate per 1,000 population aged 65+



Lower figures = Better performance

Calendar year 2019 is used here as a proxy for 2019/20 due to the national data for 2019/20 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships.

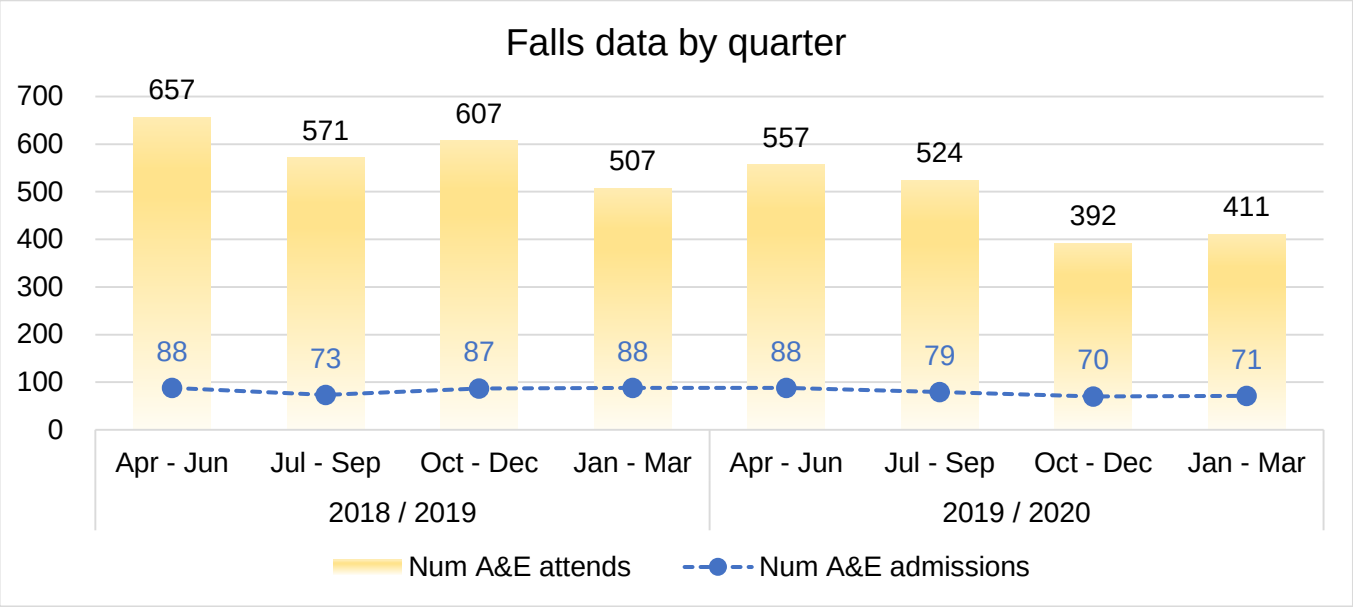
Current performance: Local Indicators

Falls

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.

As part of the falls pathway Inverclyde HSCP Rehabilitation and Enablement Service works closely with Community Alarm Community Response team and the District Nursing, Glasgow Falls Service and Live Active service to support frail older people who experience falls.

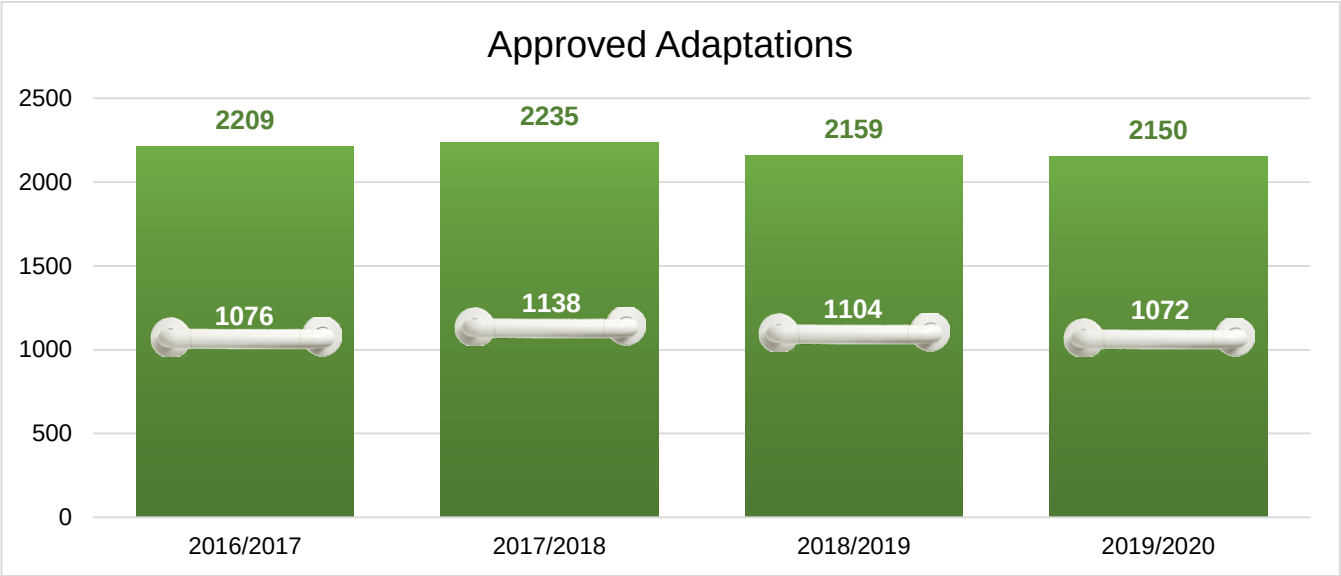
There was a gap for the frailest fallers who didn't meet the criteria to attend the classes that were run by the Glasgow Falls Team, to address this need the Rehabilitation & Enablement Services (RES team) set up Strength and Balance classes hosted at the Larkfield unit.



The pathway from these classes supports people to improve enough to follow through to the Glasgow Falls Teams local classes and then through to Live Active classes.

Our work around urgent response to fallers for rehab, fast track from A&E to community rehab for fallers, support of nursing colleagues, falls awareness work, and the above allows for a mixture of tailored support to meet individual people's needs.

Housing adaptations

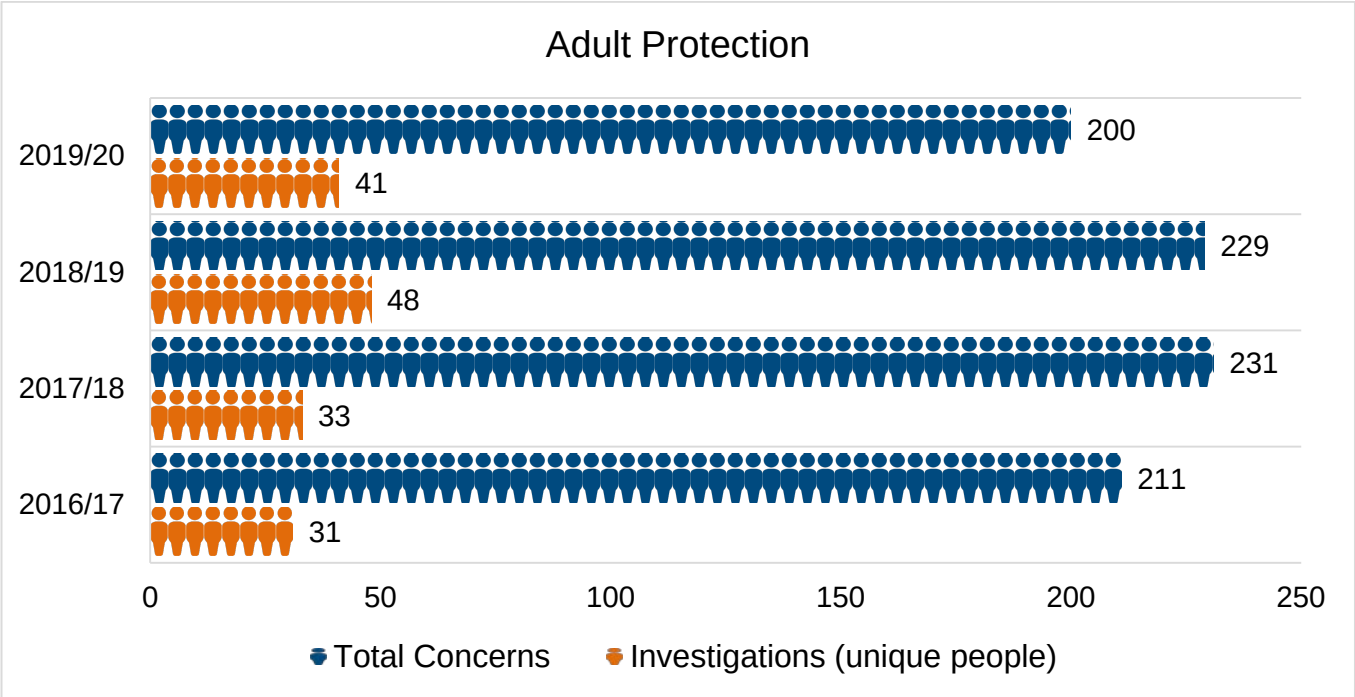


In 2019/20 we arranged for 2,150 adaptations to assist people to remain independent and safe in their own homes. Of all these adaptations, just under half (49.9%) were for grab rails which are a quick and effective solution to help prevent falls and keep people safe whilst living independently as possible.

Protecting vulnerable adults

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

During 2019/20, 200 Adult Protection concerns were referred to the HSCP (a decrease of 29 since 2018/19). After initial inquiries 41 of these concerns - or about 19% - 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 was produced and delivered to ensure that multi-agency staff have access to appropriate training and learning events that create opportunities to reflect on practice. This approach has been very successful as evidenced in the Adult Protection Thematic Inspection Staff Survey Feedback Report. The strategy is currently being reviewed and adapted with the development of a blended learning approach being adopted given challenges arising to delivering training in context of the COVID-19 pandemic.

Ongoing programme of self-evaluation, quality assurance and focus on the impact of adult support and protection activity across operational Adult Services. This includes further development of the Service User and Carer Evaluation to elicit the lived experiences of adults at risk of harm and their unpaid carers to identify strengths and areas for improvement.

Refresh of Communication and Engagement Strategy to improve public awareness of Adult Support and Protection.

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 and aim is to incorporate learning from operating in context of the COVID-19 pandemic.

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

Katie's story

Katie's situation came to light following a referral from the hospital. She was a woman with disabilities who lived alone. A family member was her sole source of support. She was taken to hospital following a fall at home. However on admission her overall physical condition led to concern that she was subject to neglect.

Her situation was progressed under the auspices of adult support and protection. Social work and health staff worked together to establish what had been happening. During this process it was identified that she was being both neglected and financially abused.

A plan was developed with her to protect her wellbeing and finances. Katie now lives in a care setting suitable for her needs and has support with her finances. She continues to see her relative as her relationship with them was important to her but with agreed safeguards in place.

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.

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

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 (PHS)

Current performance: Local Indicators

iMatter is a staff survey tool that helps us focus on what is important to all our staff and by focusing on this improvement journey we trust they will know that they matter. Our 2018/19 report suggested that HSCP staff were well engaged and staff rated Inverclyde HSCP as a good place to work. An improvement plan was created to address some of the areas that scored slightly lower. Due to the COVID-19 pandemic an updated iMatter report is not available.

Leadership Award

Derek Flood
Inverclyde Health & Social Care Partnership

Derek won the Leadership Award at the 2019 Scottish Public Service Awards. This national recognition was for his work in successfully leading and bringing together 3 separate teams under a single vision of improving the lives of our most vulnerable citizens, inspiring confidence and a passion for the possible. The team still carries out the three elements of Social Security advice and information; Welfare Rights representation, and Specialist Money Advice, however this is done in a joined up way that minimises duplication and maximises long-term and sustainable gain for the citizen.

Colin Mair Award for Policy in Practice

Inverclyde HSCP and Ardgowan Hospice fund and support Compassionate Inverclyde, a social movement that is helping to transform attitudes and everyday practices around loneliness, social isolation, death and bereavement across Inverclyde. The ethos is about local people working alongside existing formal services enabling ordinary people to do ordinary things, tapping into our desire to be kind, helpful and neighbourly.

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

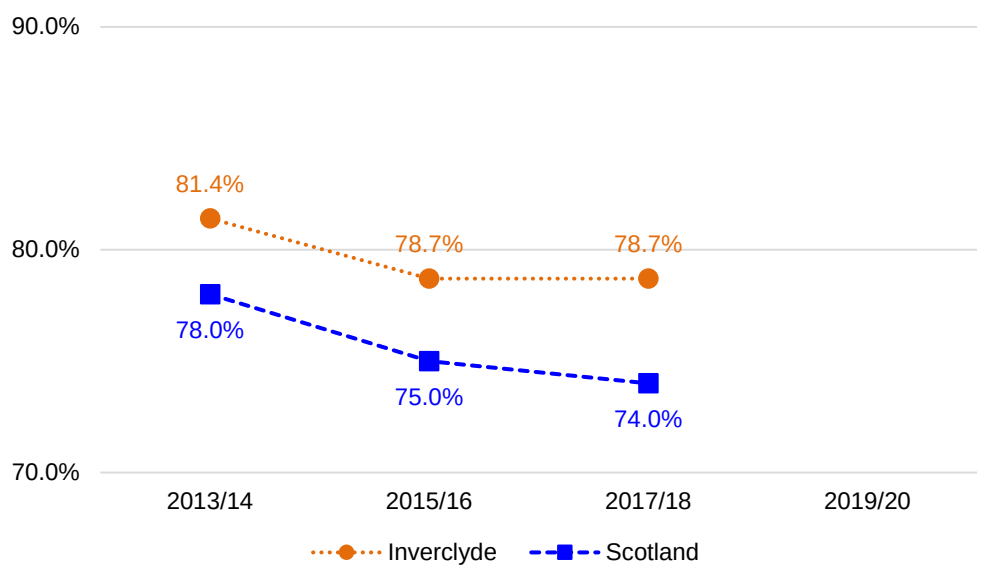
There are various ways that the HSCP is seeking to ensure that resources are used effectively and efficiently. We are improving quality and efficiency by making the best use of technology and trying new ways of working to improve consistency and remove duplication.

The following big actions from our Strategic Plan directly relate to achieving this outcome for Inverclyde residents.

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

Current performance: National Integration Indicators

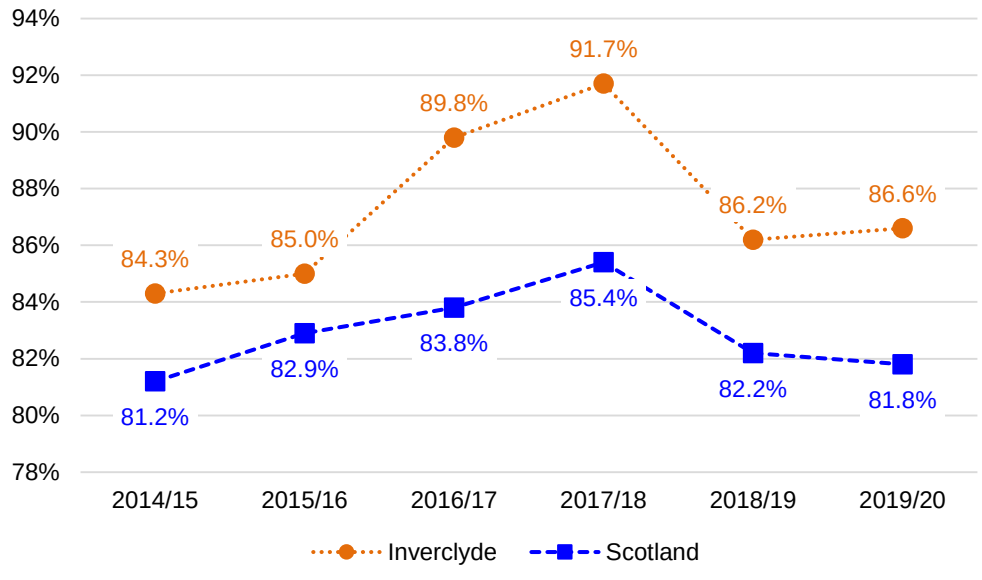
4	We are consistently above the Scottish average, but continue to try to do better. The six Big Actions in our 2019/24 Strategic Plan have an underlying theme of making the most of integration.	My health, care or support services seemed to be well coordinated



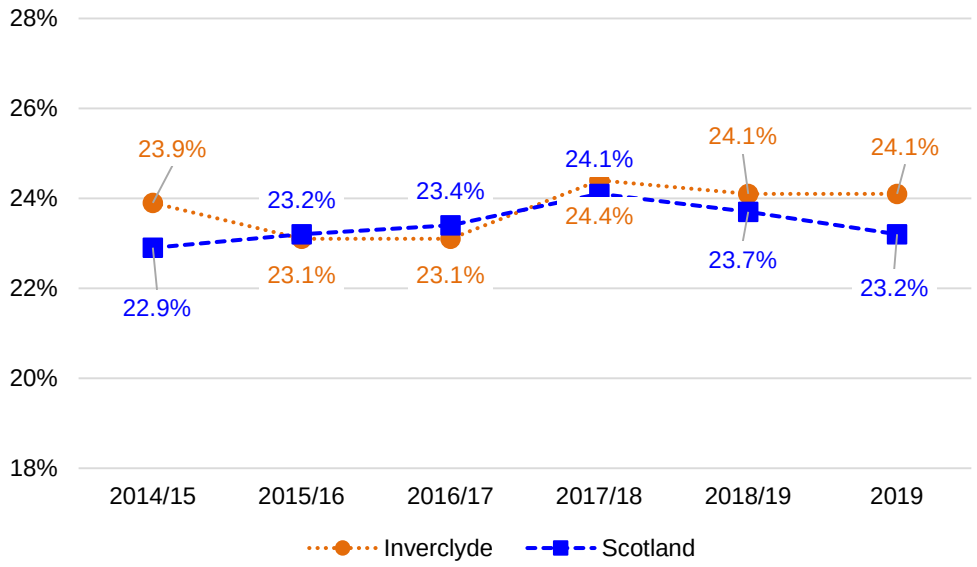
Higher figures = Better performance

2019/20 survey results will be published later than planned (due to Scottish Government staff redeployment during the COVID-19 pandemic) but we will include them in future performance reports once they are available.

17	Even though our performance dropped from a high of 91.7%, we continue to do well and this reflects the strong partnership working between HSCP officers and our local care provider organisations.	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections



Higher figures = Better performance

20	By reducing this percentage, we hope to release money into community based services to support people to receive care in their own homes whenever safe and appropriate. Performance has remained fairly consistent both locally & nationally with only minor changes over the last few years.	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency  Lower figures = Better performance

Calendar year 2019 is used here as a proxy for 2019/20 due to the national data for 2019/20 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships.

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

Current performance: Local Indicators

Inverclyde Services Care Inspectorate

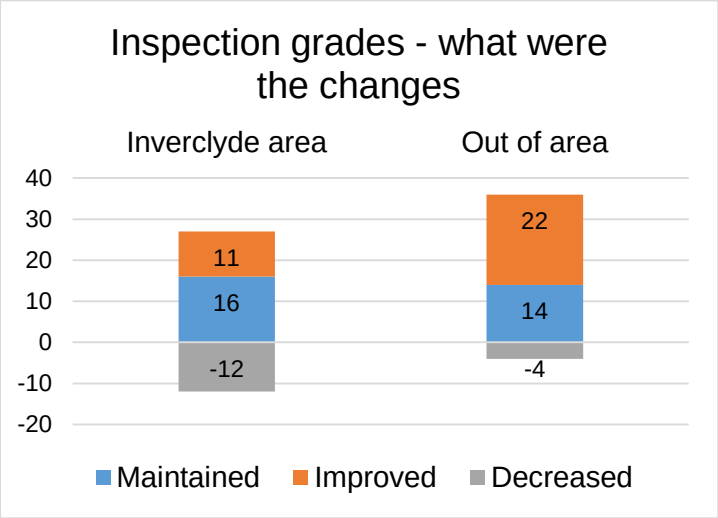
The total number of Inspections carried out for providers who receive payment from Inverclyde HSCP was 79.

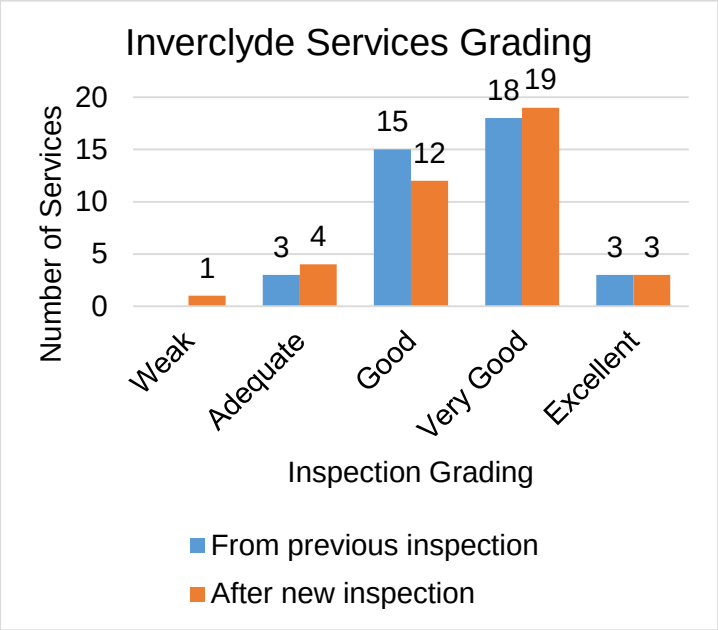
39 of the services inspected were Inverclyde Area services.
40 of the services inspected were Out of Area placements.

Of the 79 services that were inspected:

- 33 services improved their grades
- 30 services grades were maintained
- 16 services grades decreased

From these inspections the Care Inspectorate made 123 recommendations and also 15 requirements.





For the 39 inspections undertaken against Inverclyde services:

11 improved their grades:

3 - from 'Adequate' to 'Good';
6 - from 'Good' to 'Very Good';
2 - from 'Very Good' to 'Excellent'.

16 maintained their grades:

1 - 'Excellent';
11 - 'Very Good';
4 - 'Good'.

12 had their grades decreased:

2 - from 'Excellent' to 'Very Good';
5 - from 'Very Good' to 'Good';
4 - from 'Good' to 'Adequate';
1 - from 'Good' to 'Weak'

These are a sample of the recommendations & requirements made by the Care Inspectorate.

Recommendations

The service should consider how they meet the needs of people who have dementia at mealtimes

The provider should ensure that as required medication protocols are implemented and are easily accessible for all staff

Staff should support residents to be more physically active and occupied in purposeful ways throughout the day

The way people are involved in directing and leading their own care and support should be revisited to embed more of a shared ownership of personal planning

The provider should ensure that they have a policy for Adult Support and Protection as well as Accidents and Incidents which reflects Scottish Legislation

Requirements

The service must comply with the expectations of regulated services to make notifications to the regulator of significant events

The provider must ensure all baths and showers within the home are in working order and available for use

Access 1st

The objective of the Access 1st approach is to provide a single contact point to patients, service users, carers, partners and stakeholders to make new referrals to our adult Health and Social Care Service across Inverclyde.

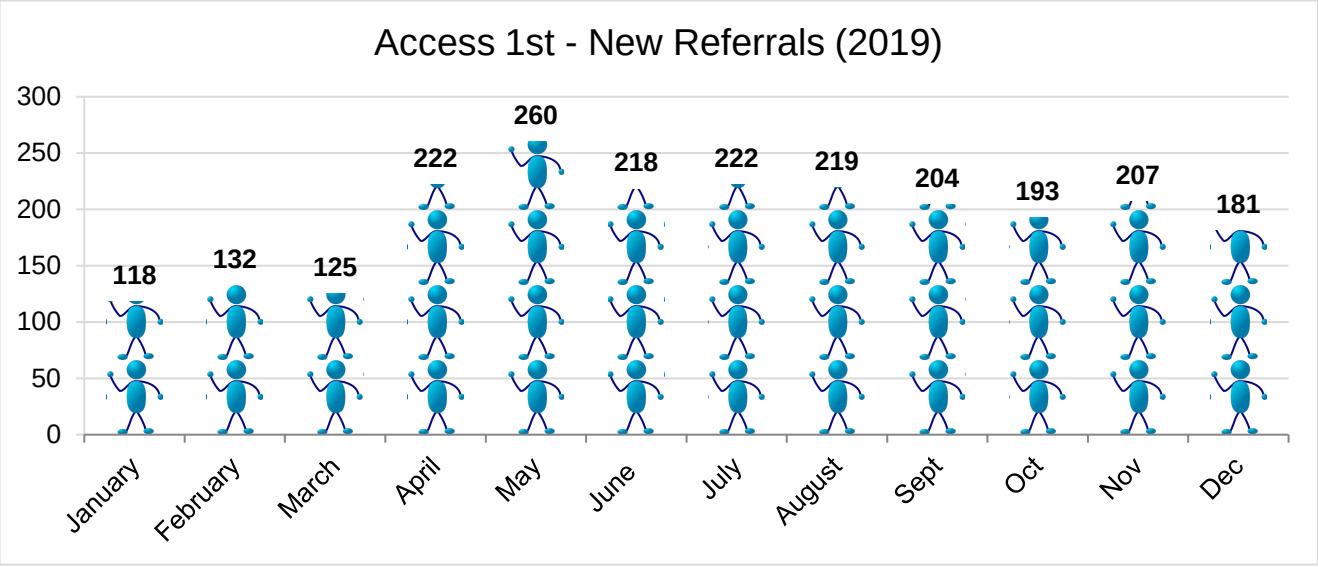
Access 1st will assess the need for support or intervention required based on our eligibility criteria to promote:

- A healthy active and satisfying life
- Wellbeing safety and protection of vulnerable people
- Respect and inclusion in our community
- Independence and the same opportunities as others who do not have a long term health condition or disability
- Equality and dignity
- The rights of carers

Access 1st provides:-

- Signposting to relevant local organisations for services available to the whole community including Inverclyde Carers Centre, Community Connectors, Community Link Workers and advocacy services
- Providing information and advice around health and social care services
- Access to equipment to assist with daily living
- Services which can enable individuals to enjoy a full life with a little short term assistance
- Long term support for individuals who require ongoing services due to their health or disability
- Protection and safeguarding for adults who may be at risk

Referrals can be made by Individuals, family members, friends, carers, members of the public and professionals.



As part of our overall assessment process, 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.

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

Telephone 01475 714646

Email:access1st@inverclyde.gov.uk

We are based at: Greenock Health Centre, 20 Duncan Street Greenock, PA15 4LY

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

Compassionate Inverclyde

Compassionate Inverclyde was approached by Breast Feeding Scotland for advice in becoming a social movement. We were asked to present to a Scotland wide group of professionals leading breast-feeding projects across Scotland and it was identified they wanted to pilot an innovative project in Inverclyde.

The local infant feeding team and Compassionate Inverclyde have been working in partnership to develop an exciting programme of local volunteers "New mum companions" to support new mums just after birth. This support to new mums would allow bonding with the new baby and reduce feelings of isolation and help support new mums who choose to breast feed.

15 new mum companions have been trained however due to COVID-19 this has had to be put on hold. The group are keen to start as soon as possible when it is safe to do so.

Knitted Blanket donation

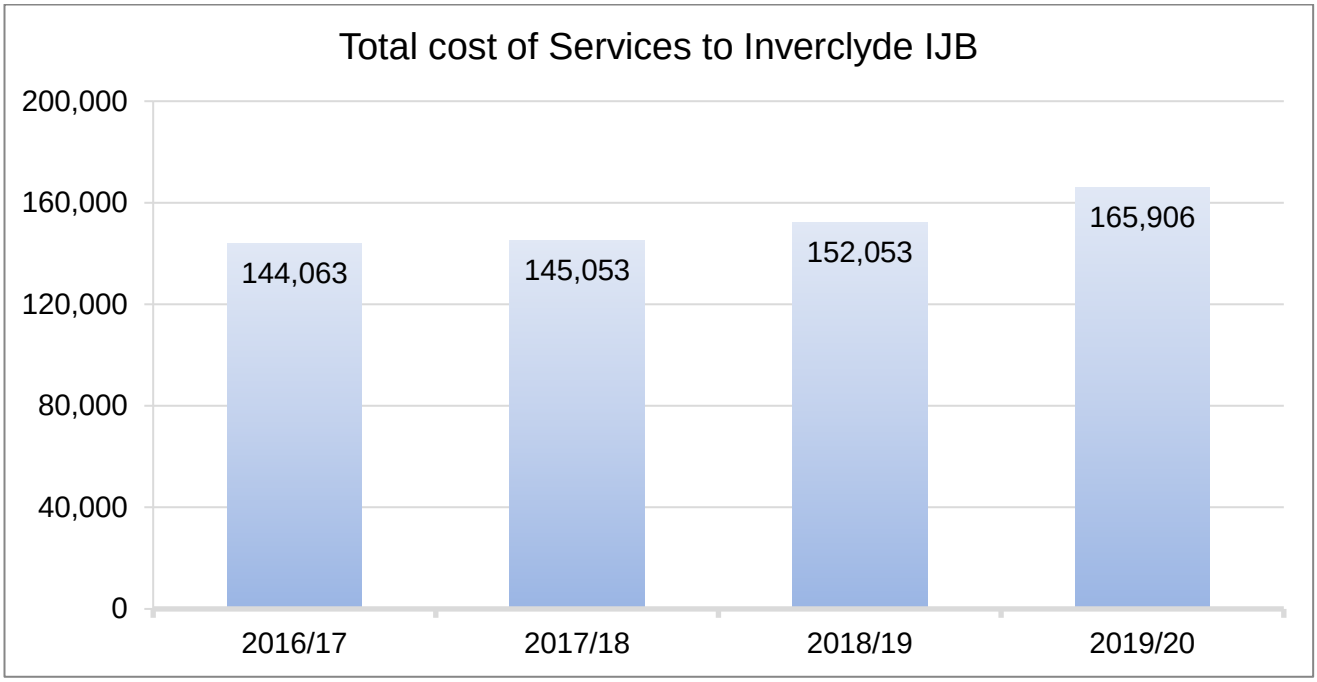
When a male patient was at the end of life and on his own, he was tucked in with a knitted blanket as he was beginning to fail. He looked better and this gave him some dignity and comfort towards the end. He was also given a knitted heart and his daughter received a matching one as she could not be with him at the end. This local initiative is a great example of the kindness and compassion within Inverclyde. The feel good factor for those making and those receiving the donations is incredible.

Finance

Inverclyde IJB Financial Summary by Service

	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Strategy and Support Services	2,992	2,591	2,416	2,111
Older Persons	27,527	26,867	27,020	28,407
Learning Disabilities	11,028	10,653	11,898	12,545
Mental Health – Communities	5,748	5,804	6,712	7,101
Mental Health – In Patients	9,543	9,338	8,729	9,737
Children and Families	12,979	12,986	13,738	14,114
Physical and Sensory	2,714	2,659	3,117	3,203
Addiction / Substance Misuse	3,345	3,389	3,464	3,181
Assessment and Care Management / Health and Community Care	6,031	7,772	8,258	9,981
Support / Management / Administration	3,520	3,807	4,174	4,339
Criminal Justice / Prison Service	55	(38)	26	49
Homelessness	859	967	791	1,043
Family Health Services	21,800	21,766	25,547	27,056
Prescribing	18,136	18,817	18,591	18,359
Change Fund	1,347	1,236	1,133	1,044
Cost of Services directly managed by Inverclyde IJB	**127,624**	**128,614**	**135,614**	**142,270**
Set aside	16,439	16,439	22,632	23,635
Total cost of Services to Inverclyde IJB	**144,063**	**145,053**	**158,246**	**165,905**
Taxation and non-specific grant income	(148,023)	(146,889)	(159,731)	(167,074)
Surplus on provision of Services	**3,960**	**1,836**	**1,485**	**1,169**

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	2019/20 £000
Projected surplus / (deficit) at period 9	0	(1,426)	(897)	(37)
Actual surplus / (deficit)	3,960	1,836	1,485	1,169
Variance in Under/(Over) Spend	**3,960**	**3,262**	**2,382**	**1,206**

Explanation of variances

The 2017/18 and 2018/19 variances were due to a combination of factors, including spend on earmarked reserves being lower than anticipated and a higher than anticipated overall underspend on services, mainly Social Care.

The 2019/20 variance is due to a combination of delayed spend on some earmarked reserve funded projects, delays in filling vacancies and one off additional income received in year.

The Annual Accounts are published each year and these provide additional detail on the financial performance in year and more detailed explanation on in year variances.

The IJB is not currently able to report on Outcome Based spend or overall spend by locality as this information is not held by either partner organisation.

Children's Services

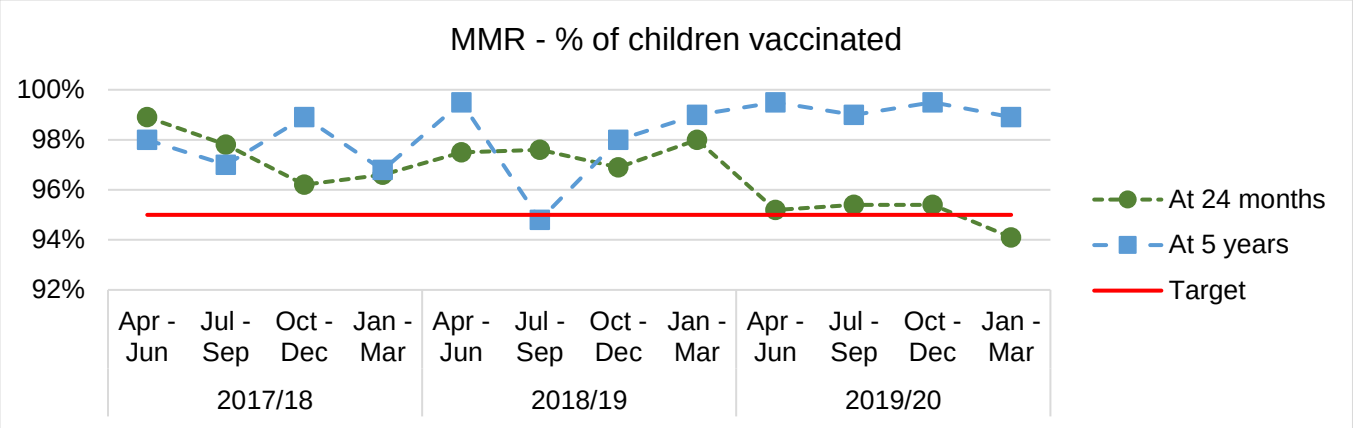
National Outcomes for Children	
10	Our children have the best possible start in life.
11	Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
12	We have improved the life chances for children, young people and families at risk.

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

Immunisations

Immunisation levels for common diseases provide a gauge on the health of the child population of the area. In August 2019, management of pre-5 immunisations was centralised with this becoming a Board-wide service. Immunisations continue to be primarily delivered by the same staff at the same clinics as before, and Health Visitors remain key in advocating and supporting parents to access immunisations. The new arrangement is working well, with all families being offered immunisation appointments within the required timescale.

Statistical information published by Public Health Scotland (PHS), demonstrates that in 2019 Inverclyde as a local authority area consistently outperformed National uptake data at all data points. In respect to Measles, Mumps and Rubella (MMR) immunisations, at both 24 months and 5 years, we continue to exceed the target of 95%.



Higher figures = better performance

Immunisation remains a public health imperative in ensuring overall population health and the upcoming flu season (amidst the ongoing COVID-19 pandemic) is a key focus for the HSCP in general and the Children & Families / Immunisations teams in particular. Supporting parents to attend remains a key focus and improvement area to target; in particular Measles, Mumps and Rubella (MMR) uptake for both 1st and 2nd doses remain improvement targets. In addition, the flu campaign for under 5s is entering a planning phase and a whole system approach will be required to support improved uptake.

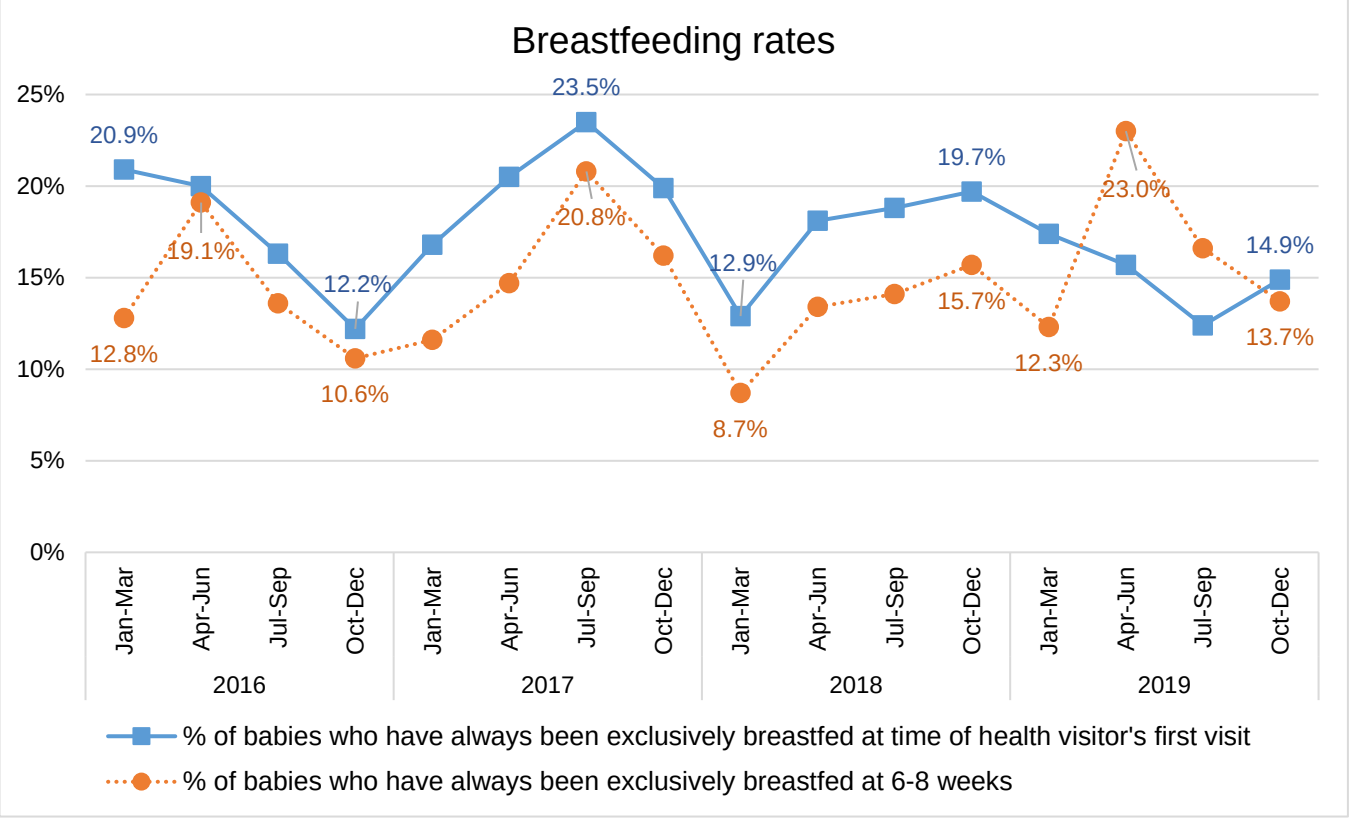
Infant Breastfeeding

Inverclyde continues with the progression of the Programme for Government work stream to support and promote cultural change in relation to breastfeeding in the community. The focus of this work will also be to increase overall breastfeeding rates annually by an extra 3% by 2022. We are also looking to improve how we support women who experience problems breastfeeding and advocate for breastfeeding so that woman feel supported in their communities. Over 50 local businesses have already signed up to Breastfeeding Friendly Scotland and multiple partners across Inverclyde are engaging in collective impact work to see what we can do together to support breastfeeding in Inverclyde.

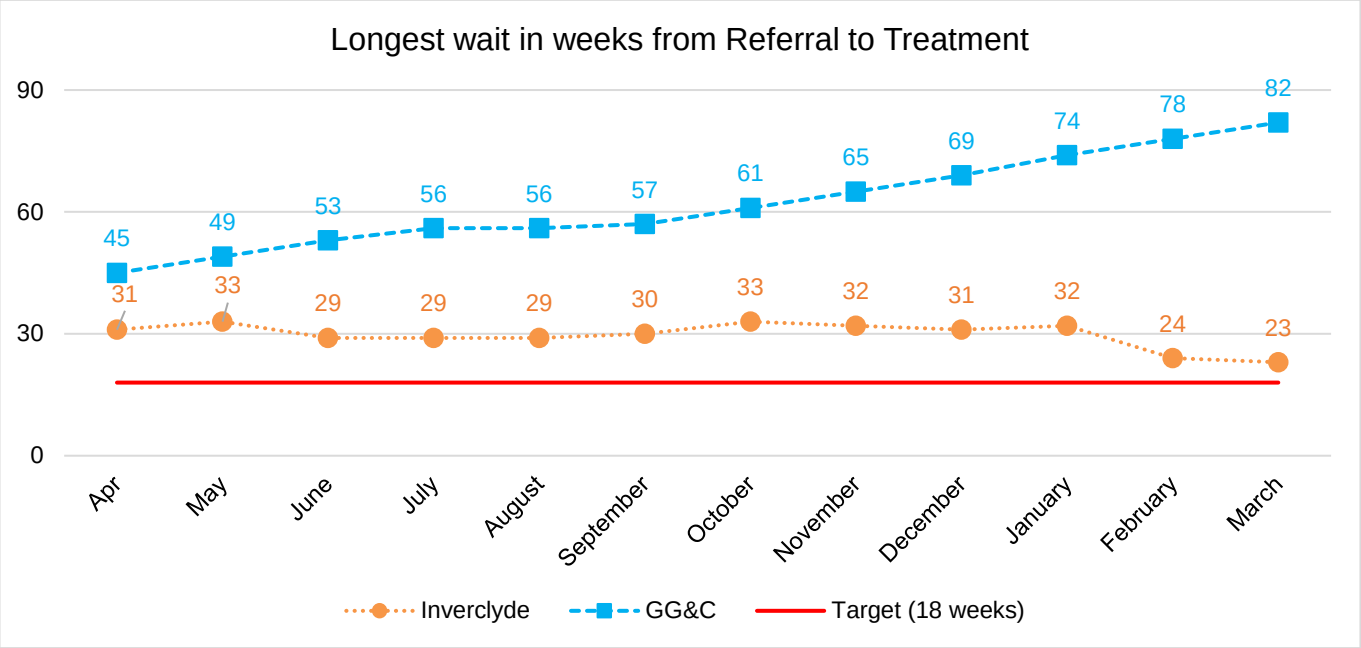
Our Port Glasgow breastfeeding group, supported by local mums, has been successful and although on hold currently, we plan to extend this support to Greenock and Gourock areas as soon as is practicable. We have linked in with Compassionate Inverclyde and 6 helpers have been trained to support Breastfeeding Mums and parents in their local community.

The Inverclyde HSCP continues to support an Infant Feeding Lead and the Programme for Government has funded an Infant Feeding Advisor and a soon to be recruited Health Improvement Specialist to help with engaging the community in the breastfeeding agenda. A number of small projects are underway to support young mums, mums whose infant are accommodated and mums in the early part of their baby's life 2-10 days after delivery to establish and continue breastfeeding.

We continue to maintain the Gold UNICEF Baby Friendly Initiative accreditation and have recently submitted our revalidation report.



Child and Adolescent Mental Health Services (CAMHS)



Lower figures = better performance

CAMHS Inverclyde continues to perform well.

At this stage 92% of young people referred are being seen within the 18 weeks of referral.

The team continue to manage the service despite challenges, including those related to the COVID-19 pandemic. They are adopting;

- A blended approach to access and care with Attend Anywhere and Telephone consultations and face to face assessments as required
- Continued use of eHealth and digital technologies as they become available and approved
- Neurodevelopmental pathway review and consideration for this service in line with Scottish government guidance and plans (anticipated October 2020)
- Tier 2 school counselling service successfully commissioned with 3rd sector and implementation date September 2020
- Adherence to newly launched CAMHS service specification
- Ongoing team developments and supports to meet local needs within the GGC CAMHS waiting list initiative work plan

Revised Universal Pathway (Health Visiting)

The health visiting workforce is now at the Scottish Government end point of 25 Whole Time Equivalent (WTE) Health Visitors in post within Inverclyde. This has facilitated the reduction of caseloads in line with the weighting tool in order to support assessment and planning for children in their early years, and provided greater capacity to support families with additional needs and child protection concerns. The Revised Universal Pathway for pre-5 children is almost at full implementation, hindered only by a delay at NHS Board level in relation to the antenatal contact. All families are now supported with a minimum of 10 face to face home

contacts which provide the opportunity to develop therapeutic relationships and enhance health and wellbeing at an individual and population level.

There are a number of projects that serve to create streamlined pathways between Children's and Specialist Children's Services including a test of a joint speech and language (SLT) assessment process to support early access to SLT following the 27-30 month assessment (Child Health Surveillance) and a new nursery nurse post to work across both service areas designed to support pre-5 children and their parents with neurodevelopmental needs.

School Nursing

In School Nursing, the Scottish Government commitment to increasing the number of Public Health Nurses (SCPHN) for school age children has facilitated an increase in SCPHN from 0.69 to 1.6 WTE with another 1.0 SCPHN due to return to Inverclyde early next year. This is linked to the Transforming Roles agenda (Scottish Government, 2018) which identified a number of key priorities for school nursing and an embedding of multidisciplinary working to support better outcomes for children.

The School Nursing service provide both universal services and targeted provision for school age children and young people. The universal services offered include population screening (Primary 1 and 7 health screening) and vision screening in P7; our data for 2019 demonstrates that vision screening uptake in Inverclyde was the highest amongst other GGC areas at 87.5%.

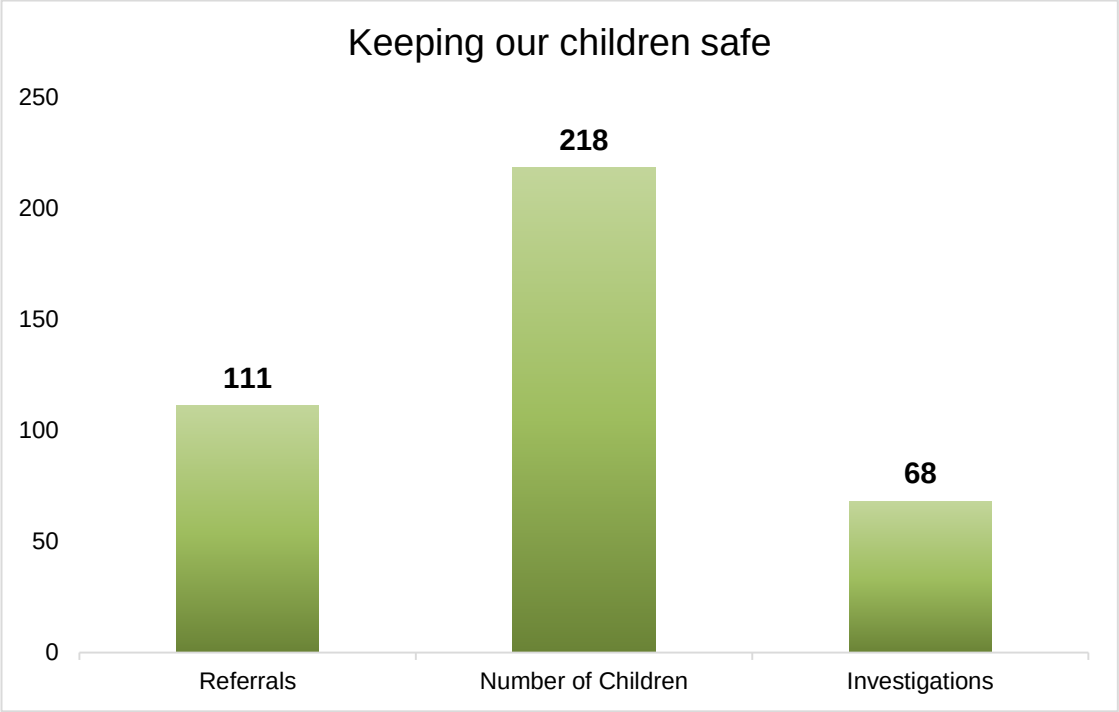
Early support for mental health has been facilitated by Inverclyde's inclusion in the Let's Introduce Anxiety Management pilot (LIAM). LIAM is a training and intervention package developed by NHS Education for Scotland and delivers a Cognitive Behavioural Therapy informed intervention to children and young people aged 8-18 years who are experiencing milder difficulties with anxiety in a one-to-one or group format. Preliminary data from the pilot evaluation was positive and demonstrated a reduction in anxiety symptoms. 8 children have been supported during 2019/20 with a further 11 waiting who should be able to start very soon with an additional school nurse now in place.

As one of the pilot sites, Inverclyde HSCP was identified as a particularly successful example of a multi-agency pilot with stakeholder representatives from School Nursing, Educational Psychology and Barnardo's, as well as support from NHS Service Manager for Children and Families and Head of Inclusion in Education. The strategic and joined-up approach to the delivery of LIAM allowed for multi-agency working which enabled subsequently creative ideas and solutions to be generated. Although the COVID-19 pandemic has impacted on the Partnerships ability to deliver the programme, it is hoped that once practicable, plans to explore small group delivery in addition to 1:1 and also to expand early tests of whole class approaches to build resilience in relation to identification and intervention for anxiety symptoms can be put in place.

Child Protection

The Inverclyde Child Protection Committee is committed to ensuring that our children and young people are offered the highest level of protection within our power, using best practice learning from research and operational experience.

Practice in this area has continued to improve with the Initial Referral Discussion process coordinated by senior social workers now fully embedded. The consistent and effective application of this has resulted in positive improvements in the quality of initial response to child protection concerns.



Between April 2019 and March 2020, 111 Child Protection (CP) referrals were received. As a result of these, 218 children were subject to Initial Referral Discussions (IRDs) between Social Work, Health and Police representatives during this period and this in turn resulted in 68 child protection investigations being undertaken.

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.

There have been significant changes in Criminal Justice Social Work (CJSW) over the last decade including the introduction of Community Payback Orders (CPO). Effective community based sentencing options are essential in achieving the National Outcomes for Justice. In July and August 2019 a team from the Care Inspectorate visited Inverclyde to assess how well the Criminal Justice Social Work Service was implementing and managing Community Payback Orders (CPOs) as well as how effectively the Service was achieving positive outcomes.

The inspection involved reviewing a representative sample of records of 90 people who were or had been subject to a CPO, meeting 40 people subject to CPOs and undertaking focus groups and interviews with key members of staff, partner agencies, stakeholders and senior managers with responsibility for the Criminal Justice Social Work Service.

The inspection report was published in December 2019 and noted numerous key strengths within the Service including:

Leaders demonstrate a strong commitment and vision to improve outcomes for individuals.

There is a well-embedded performance management framework and access to high quality data analysis that shows strong Criminal Justice Social Work Service performance that exceeded national targets, sometimes by a considerable margin.

A range of positive outcomes had been achieved for individuals.

The Service is proactive in responding to the poverty, disadvantage and needs profile of individuals by providing person-centred services that adopt a public health model.

The Service is well integrated into the Health and Social Care Partnership which strengthened governance arrangements and supported quick and easy access to services for individuals including those aimed at addressing mental health and addiction issues.

The Unpaid Work Service was operating effectively and played an important role in improving outcomes for individuals while ensuring payback to communities.

Individuals subject to CPOs experienced positive relationships with staff that were characterised by respect, support and appropriate challenge. Staff were found to be honest, straightforward, trustworthy and reliable.

Of the five quality indicator that the Service was assessed against, 3 were noted as 'Very Good' and 2 were 'Good'.

Quality Indicator	Rating
Improving the life chances and outcomes for people subject to a community payback order	Very Good
Impact on people who have committed offences	Very Good
Assessing and responding to risk and need	Good
Planning and providing effective intervention	Good
Leadership of improvement and change	Very Good

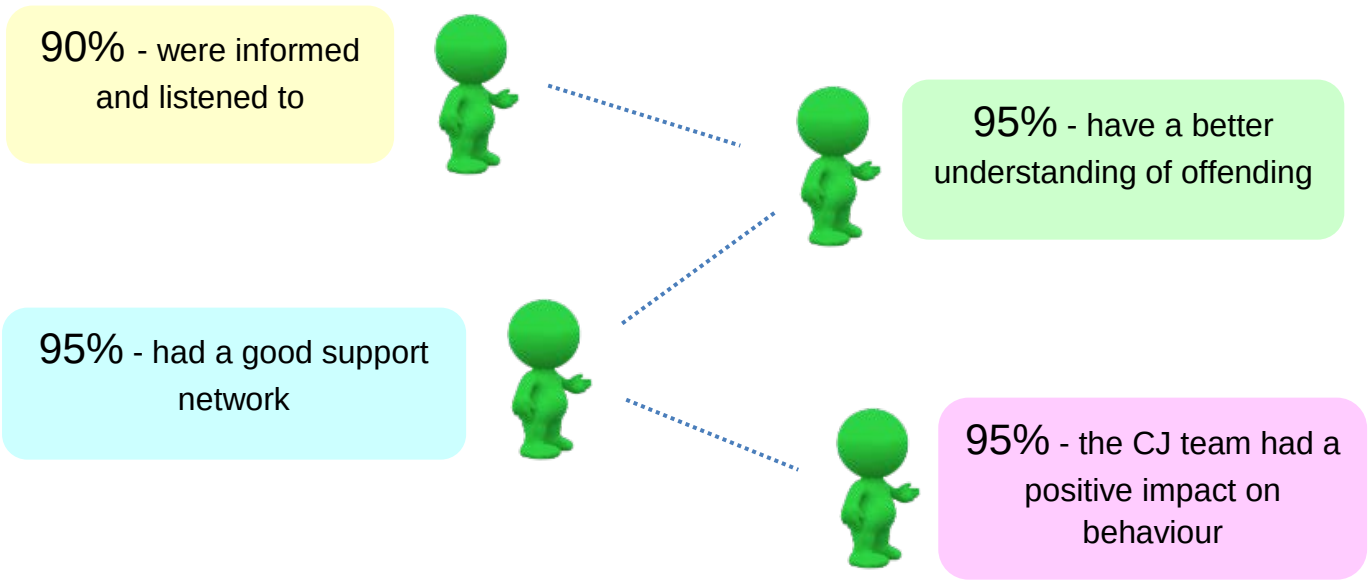
Impact on those who have committed offences

In April 2018 the Service, with support from the HSCP Performance & Information Team, introduced a bespoke Criminal Justice Needs Review tool to capture a range of data both at the commencement and completion of our involvement with individuals in the Criminal Justice system. This includes:

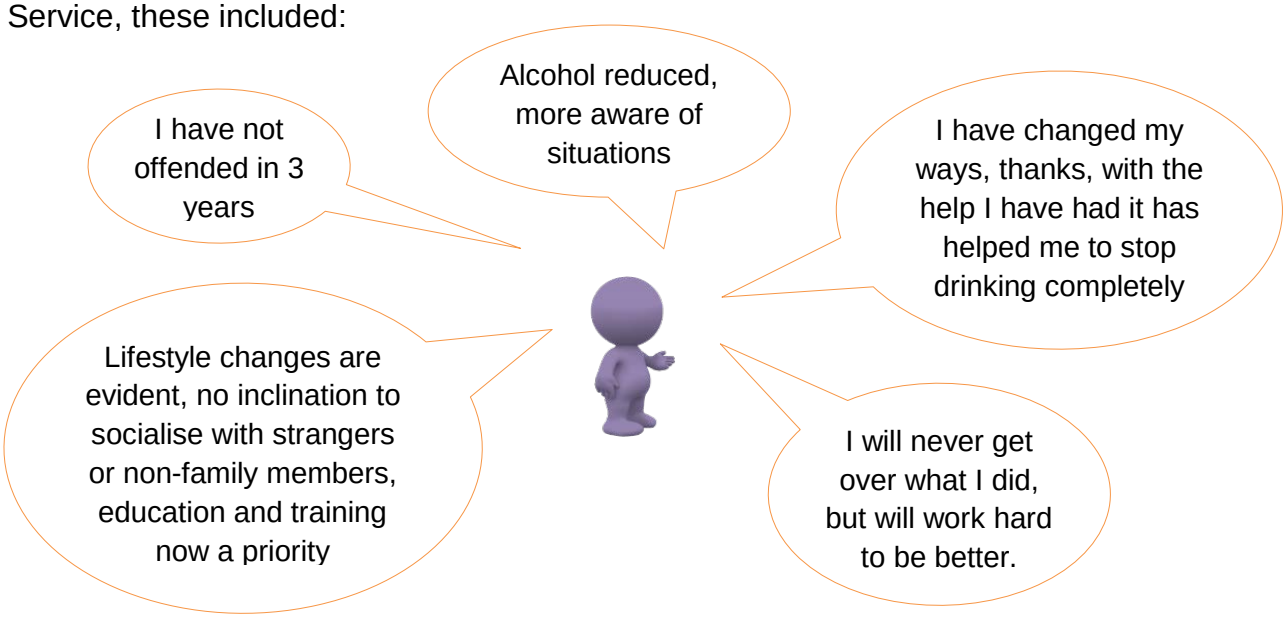
- Self-scoring on nine separate lifestyle areas: health, self-care, emotional well-being, alcohol and drug use, offending behaviour, training and employment, housing, relationships with friends and family life
- Feedback on the Service experience
- Identifying organisations/services the individual has been referred to
- Suggestion box relating to potential Service improvements

To date the Service has collected 94 forms at the commencement of their involvement with Criminal Justice Social Work (stage 1) and 53 on completion (stage 2). Analysis of the 21 forms completed at stage 2 for 2019/2020 evidences:

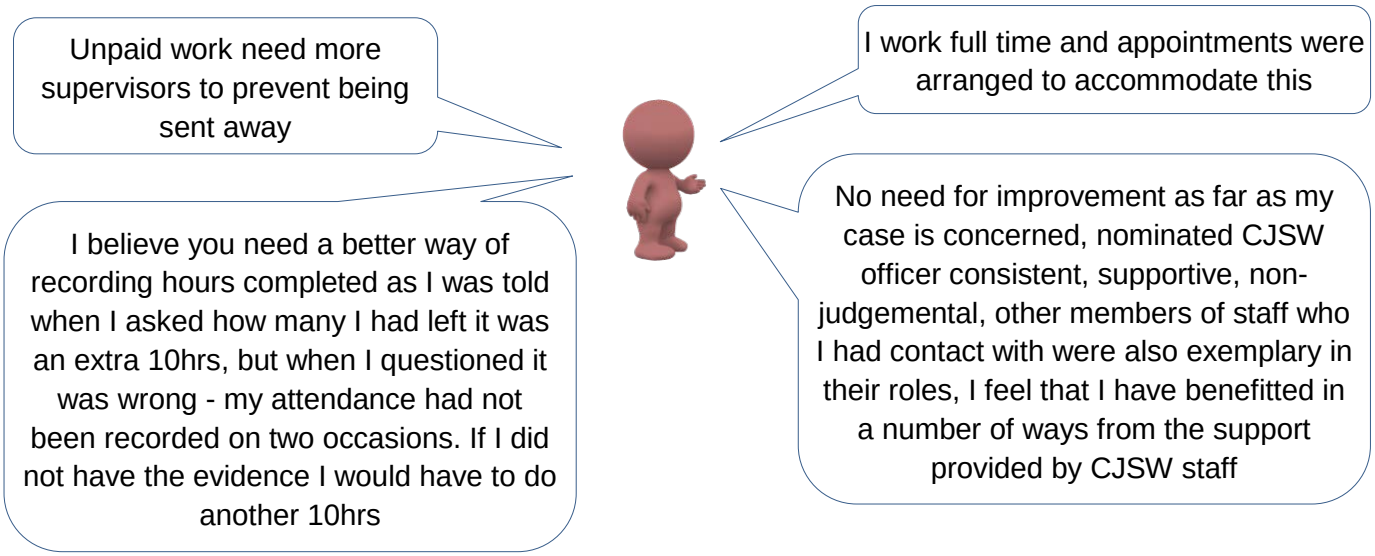
Percentage of individuals who 'agreed' or 'strongly agreed' that they felt:



In addition comments were captured on changes that individuals' had made whilst engaged with the Service, these included:



Comments were also captured on areas the Service could either improve upon or already doing well in. These included:



The Service is committed to achieving positive change in the life circumstances of the individuals it engages with. Our Criminal Justice Needs Review tool is one such mechanism to help capture data on key outcomes. Whilst early analysis on outcomes demonstrates that the Service is achieving its intended outcomes, we also recognise that we still have some way to go to demonstrate year-on-year trend data showing sustainable impact in this area.

The Service is aware that placement availability for those individuals sentenced by the Courts to carry out Unpaid Work in the community can at times be challenging. This has also been reflected in some comments made by individuals too. To help build resilience in this area the Service is working with the Inverclyde Community Justice Partnership to explore the potential for the local third sector to assist with the provision of individual placements. This work will be ongoing throughout 2020/21 and brings with it the possibility of helping individuals reconnect with their community.

Innovation

Up 2 U

The Up2U Creating Healthy Relationships Domestic Abuse and Violence Intervention Programme has commenced within Inverclyde HSCP. Although this has recently been affected by COVID-19 pandemic Social Workers have been working with service users who accept they use abuse and violence in their relationship and want to change.

As part of the Up2U programme we now have in place a Partner Support Assessment. This is for all services users who have been identified as using unhealthy behaviours or are the non-abusive partner. This programme includes motivational interviewing techniques which are used to promote positive engagement with partner support, build on motivation in order to increase the effectiveness in intervention.

As public health guidance allows for sessions to re-commence following COVID-19 the plan is for social workers to begin this assessment with our service users who have been identified through child protection or multi agency plans.

The key for all of the Up2U programmes is the positive working relationship between social worker and service user and their wish to make changes and our support for them to do so. The partner support assessment will only add to the programme already in place.

Adoption Comic Book & Reflection Workbook

The adoption service in partnership with adopted young people, adoptive parents, Your Voice, the Children's Rights Officer and Magic Torch Comics developed a comic book named "Just Ask" to support all adoptive families to explore their children's right to Information and where they can access support safely to do this.

The adoption service worked alongside adopted young people with the support of Your Voice and the Children's Rights Officer to develop an assessment tool and the opportunity for those with lived experience to contribute to the assessment of prospective adopters. The refection workbook includes questions that young people identified as being important areas of exploration for the applicants on their adoption journey and has been fully designed by them with their guidance on how this they would like this resource to be used during the assessment process.

Better Hearings

Inverclyde's Champions Board 'Proud2Care' hosted a local event called Proud2Hear to allow all those who have experience of Children's Hearings to come together to look at ways this could be improved using a variety of perspectives. Proud2Care set the areas for discussion and over 80 people were in attendance including teachers, social workers, panel members, children's reporters, residential staff, advocacy workers and young people etc. The information gathered

has allowed a collaborative approach to the ongoing action plan towards 'Better Hearings' which includes a range of resources and solutions being identified, created and implemented by young people in collaboration with Children's Hearing System, Scottish Children's Reporter Administration and other partner organisations. This includes a jargon buster and "did you know" wall, young person led training for panel members etc. and the full development of a young person friendly action plan that will be accessible to children and young people. Young people themselves are fully involved in developing and helping to action this work.

What You Told Us		How we will achieve this
Keep me at the centre of my hearing and where you can make it as child friendly as possible	Before the Hearing "Prepare Me"	Stop using jargon Give you choices before the hearing
Remember that panel may feel hard for me or others in the room Explain things to me as we go along and help me to understand	During the Hearing "Include Me"	Offer reassurance Give children/young people opportunities to be heard throughout the meeting and discuss these views Use child friendly language
Make sure I have the right support and let me know what is available to help me	After the Hearing "Support Me"	Ensure there is support following the hearing Make suggestions of any services/support that may help

Children's Rights Award

As part of the framework towards Inverclyde's Children's Rights Report 2020 as a response to the duties places under the Children & Young People Act (Scotland) 2014. The Children's Rights Officer in partnership with Your Voice and Inverclyde primary and secondary schools, consulted with over 200 children and young people to develop an award that services and teams can participate in to enhance their knowledge and practice of Children's Rights across the authority. This award has been named the "IROC Award" (Inverclyde Rights of the Child Award). Targeted and voluntary teams/organisations who participated in the award also agree that the evidence provided will be utilised to create a state of children's rights magazine that will fulfil the duties of the act whilst being an exciting and accessible report to showcase the work of services across the authority. Children and young people have been involved in the development of the award from its name, its design, setting the criteria as well as volunteering to be young assessors and eventually being involved in the development of the report (magazine) itself, which will be promoted and shared with young people and relevant services across Inverclyde.

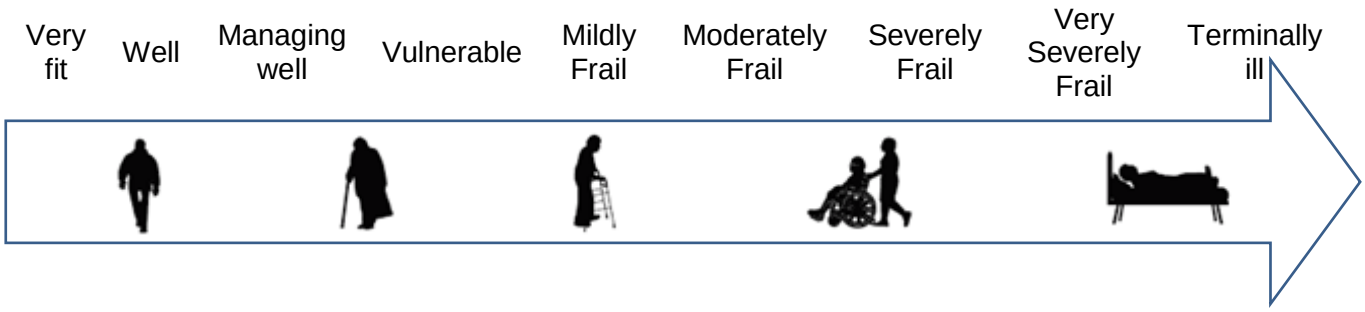
Rockwood Frailty Tool

The Rockwood Frailty assessment tool was rolled out across all community services that are involved with assessment of people over the age of 65. The main strength of the tool is to quantify the level of frailty, within the community, for those who access our services.

This tool is beginning to be used across different areas of our services and Inverclyde HSCP have this tool embedded in both health and social care recording systems.

An initial analysis is being undertaken and it's hoped the tool will offer stronger triaging decisions and identify opportunities for preventative support for people earlier in the care pathway.

There may also be opportunities to expand use of this tool into self-assessment models, Anticipatory Care Planning, falls risks and as a potential model of allocation around Sheltered Housing.



Step up at home

There has been a Step Up Model in Inverclyde for several years. To avoid hospital admission where someone needed enhanced rehabilitation and support but were medically fit they were assessed and where appropriate were admitted short term to local care homes for a period of enhanced rehabilitation and support. This was done in partnership with the Rehabilitation and Enablement Team, Assessment and Care Management and Community Nursing Colleagues and GP's.

This model has proven successful. To build on this and due to the large demand for urgent referrals for rehabilitation, and to support the model of discharge from A&E an enhancement to this model has been developed to support people to remain within their own homes where possible with enhanced care from reablement, and intensive rehabilitation for the community of Inverclyde.

Long Term Conditions Management

Working alongside GP practice colleagues in an in-reach capacity to identify potential patients and facilitate early intervention, work has focused on providing short term, intensive support and education to patients diagnosed with a long term condition (Diabetes, COPD and Hypertension). This has included the use of Home and Mobile Health Monitoring Technology such as Florence (FLO) a text messaging service and Docobo Care Portal - Home Health Monitoring Hubs.

In this area there has been significant collaborative work with the acute diabetes specialist teams in both hospital and community. This involved the consultant physician reviewing patients on the District Nurse caseload via a virtual clinic to optimise treatment plans and include health improvement measures. This approach proved both successful and innovative with primary and secondary teams working jointly. All 32 patients on the caseload have now been reviewed and the number of required visits reduced by 165 each week. It is intended that the consultant physician will continue to review these patients on a regular basis to ensure optimal treatment plans are in place.

This work allows the HSCP to:

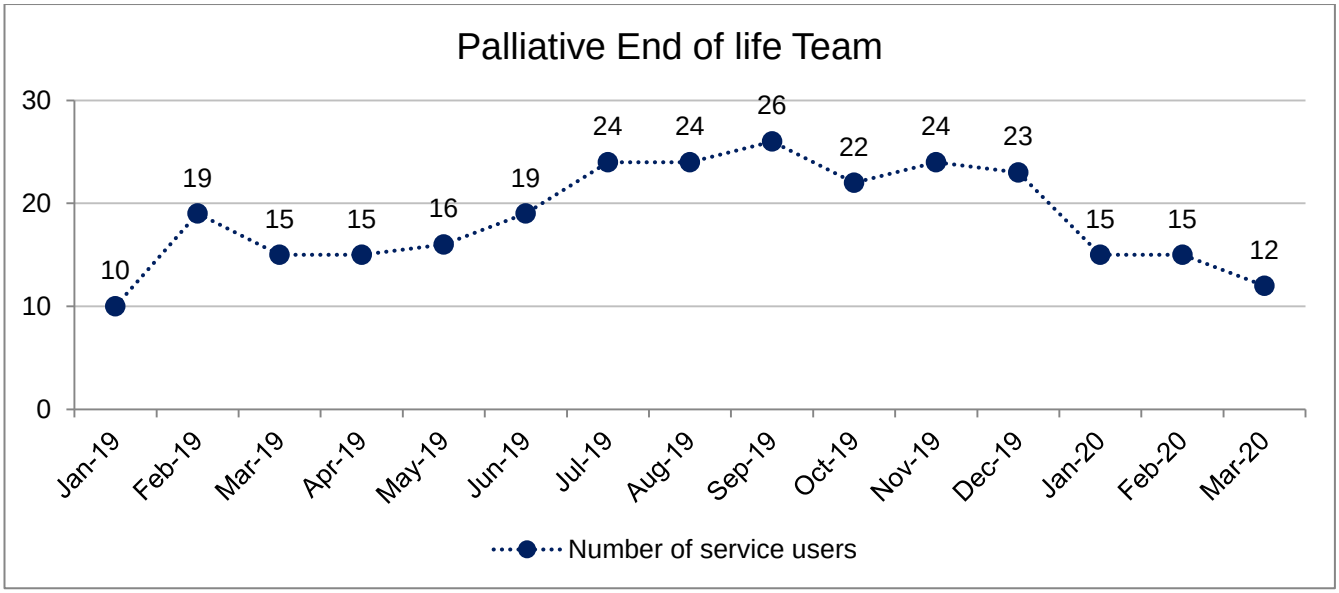
- Continue to support an increase in numbers of patients living with chronic conditions with a focus on self-management leading to improved health and wellbeing
- Use technology to support patients affected by COVID-19 on discharge to help monitor their condition and offer support for a short term period
- Provide additional training and support to GP practices to expand the use of technology like Florence and Docobo allowing patients to be more engaged in interventions and their treatment plans
- Continue collaborative working to ensure appropriate referrals and a decrease in numbers dependant on the District Nursing service
- Continue to review treatment plans of Diabetic patients on the District Nurse caseload
- To pilot support to women who have been diagnosed with gestational diabetes for a temporary period during pregnancy
- Evidence a reduction in GP appointments, hospital admissions and District Nurse visits

- Ensure professionals are able to access robust reporting and analysis of symptom management from the use of technology

Care and Support at home services

Palliative Team

The service introduced a Palliative, End of Life team in Jan 2019. The Palliative Team was created to improve the overall quality of service provided to service users who were in the end stage of life and assist family members/carers at this difficult time. We are working towards these goals by ensuring that shift patterns optimise the continuity of care, providing additional training and supports for staff and gathering feedback from family members.



Response Team

The service introduced a Response team in February 2019, the main objective of this team is to have available resource to respond to any significant change in service user's health / care requirements by increasing the existing care package to meet the urgent change in need. The response team will respond to these increases and ensure a smooth transition of service to the appropriate team. The team is also available to respond to any rapid discharges from hospital and facilitate any weekend discharges during the out of hour's period. This service has been beneficial to the service in having the ability to respond immediately to significant changes without impacting on other teams or resources.

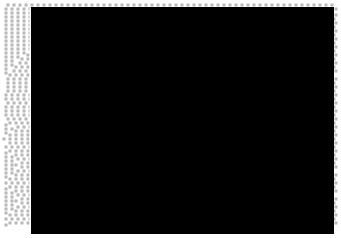
Chief Officer's concluding remarks

This is the fourth HSCP published Annual Performance Report reporting our progress in delivering the National Health and Wellbeing Outcomes.

The HSCP has faced a number of challenges during the year between COVID-19 and our performance in some areas requiring further improvement. In the coming year we will continue to work to address these challenges and improve outcomes across all services. It has also been an exciting year with 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 5 year strategic plan ensures we focus how the HSCP our partners can best work together to address inequalities and improve outcomes for people living in Inverclyde. A strong alliance with the Council led to a joint commitment to 1million anti-poverty fund. 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 challenge, some disappointments and some success however, Inverclyde is ambitious, we always want to do better. As we work to improve and strive for excellence, it is important we continue to learn and develop. The impact of COVID will have a lasting legacy on Inverclyde however we have excellent staff and communities who care deeply about Inverclyde. We have a responsibility to deliver high quality service that make a difference to people lives. In 2019/20 we made significant strides forward however there is still much to do.



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Appendix: Glossary of abbreviations

A&E	Accident and Emergency department
ADL	Aids for Daily Living
ADRS	Alcohol and Drug Recovery Service
ANP	Advanced Nurse Practitioner
ASP	Adult Support and Protection
AWI	Adults With Incapacity
CAMHS	Child and Adolescent Mental Health Services
CJ / CJSW	Criminal Justice Social Work
CLW	Community Link Worker
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CPO	Community Payback Orders
CRS	Community Response Service
DN	District Nurse
DZ	Data Zone
ESA	Employment Support Allowance
FLO	Florence
GGC	Greater Glasgow and Clyde Health Board
GP	General Practitioner
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
LD	Learning Disability
LIAM	Let's Introduce Anxiety Management
LPGs	Locality Planning Groups
MDT	Multi-Disciplinary Team
MMR	Measles, Mumps and Rubella
MSG	Ministerial Strategic Group
NHS	National Health Service
NRS	National Records for Scotland
OPCMHT	Older Persons Community Mental Health Team
OT	Occupational Therapist
PCIP	Primary Care Improvement Plan
PCMHT	Primary Care Mental Health Team
PDS	Post Diagnostic Support
PHS	Public Health Scotland
RRTP	Rapid Rehousing Transition Plan
SCPHN	Specialist Community Public Health Nursing
SIMD	Scottish Index of Multiple Deprivation
SLT	Speech and Language Therapy
SMR	Scottish Morbidity Record
SPG	Strategic Planning Group
TEC	Technology Enabled Care
UNICEF	United Nations International Children's Emergency 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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