
Report To:	Health & Social Care Committee	Date: 27 August 2008
Report By:	Robert Murphy Acting Corporate Director, Social Care	Report No: SW/30/09/YG/BK
Contact Officer:	Barbara Billings Head of Community Care and Strategy	Contact No:
Subject:	Inverclyde Joint Community Care Plan (2009 - 12)	

1.0 PURPOSE

- 1.1 The purpose of this report is to seek approval from Committee for the Inverclyde Joint Community Care Plan (2009 -12).
- 1.2 The report informs Committee of the key priorities for Community Care Services within Inverclyde over the next three years.
- 1.3 A copy of the document is appended.

2.0 SUMMARY

- 2.1 This document builds on and consolidates a number of plans and strategies which have been developed to deliver better integrated Community Care Services and better outcomes for the people who use them.
- 2.2 The plan sets out our broad strategy in providing services to:-
 - Carers
 - Older people
 - People with dementia
 - People who have physical disabilities including sensory impairment.
 - People who have learning disability
 - People who have mental health problems
 - People with addictions
 - People who are homeless
 - People with palliative care needs
- 2.3 This plan has been developed as a result of joint working with our partners in health and the voluntary sector, and after extensive consultation with individual stakeholders and stakeholder organisations.

3.0 RECOMMENDATION

- 3.1 The Committee is asked to accept and approve this report and accompanying Inverclyde Joint Community Care Plan (2009 - 12).

4.0 BACKGROUND

4.1 The Inverclyde Joint Community Care Plan aims to establish the future joint planning objectives in the development of Community Care Services for the people of Inverclyde, for the period 2009 - 2012.

4.2 This document provides a platform for the strategic direction of future services and commissioning which will be developed and delivered jointly in partnership with:-

- Inverclyde Council - Social Work and Strategic Housing Services
- NHS Greater Glasgow and Clyde, Inverclyde Community Health Partnership, Mental Health Partnership, Acute Sector Inverclyde Royal Hospital, Rehabilitation and Assessment Directorate.
- Housing Providers.
- Providers of Care and Support Services in the private and voluntary sector.
- User and carer groups.
- Inverclyde Community Care Forum/Your Voice.

4.3 Planning and commissioning decisions are based on the current and projected needs of individuals and at a community level. Understanding the demand for Community Care Services now and in the future requires that we take into account; current uptake of services, need assessment, availability of resources as well as demographic socio-economic and health indicators. Separate documents that outline the needs of each client group and the current uptake of service provision have been produced to reference this plan. Where appropriate needs assessment information has been reported within each client group section.

5.0 PROPOSALS

5.1 The key aim and strategic objectives for Community Care Services is derived from national and local policy and planning contexts and these are detailed within the document.

5.2 The over arching aim is to:-

“Establish a corporate approach with local partners that sets out achievable arrangements to deliver more integrated and co-ordinated services across health, housing and the independent sector which are responsive and sensitive to meeting the needs of the people of Inverclyde.”

5.3 This key aim will be underpinned by the following principles:-

- Commit to making a positive input to health improvement and ensure equitable access to health, housing and social care in Inverclyde.
- Work together in a spirit of trust, openness, mutual understanding and co-operation.
- Share information, data and statistics in the interests of promoting a common understanding of local needs and aspirations.
- Consult and involve each other in strategic and local planning service reviews

and the development of policy documents and plans.

- Seek to maximise the benefits that can be achieved by partnership working ensuring value for money of any new investments.
- Develop and sustain partnerships with other agencies or bodies where appropriate and involve local communities in service developments.
- Establish joint management and resourcing arrangements, which will be effective for the person who needs services.
- Establish arrangements for evaluation and monitoring of service development to ensure appropriate investment of resources.

5.4 This plan will be implemented and monitored through the joint management and planning arrangements which have been set up to deliver more integrated and better co-ordinated services. Reviews of the plan will be conducted and reported on an annual basis.

6.0 IMPLICATIONS

6.1 Legal:

There are no legal implications from the Inverclyde Joint Community Care Plan (2009-12).

6.2 Finance:

Committee will be alerted to any financial implications for the Council should these arise. Proposals for service redesign outlined within the client sections of the document will be subject to agreement with NHS Greater Glasgow and Clyde.

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

6.3 Personnel:

There are no personnel implications.

6.4 Equalities:

An impact assessment has been carried out. There were no negative impacts.

7.0 CONSULTATION

7.1 There has been extensive consultation with key stakeholders in the development of this plan. Inverclyde Community Care Forum/Your Voice has a pivotal role in providing an ongoing programme of consultation with Community Care service users and carers. Consultation has included large participative events as well as feedback from individual users of services.

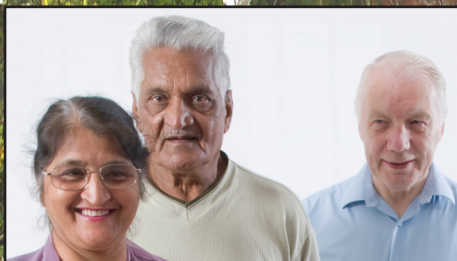
7.2 The Public Partnership Forum, a formal sub group of the Community Health Partnership Committee, is also used to support service user and carer engagement.

7.3 The key messages and the themes resulting from these consultation mechanisms are built into the aspirations and objectives of this plan to be taken forward by the local partnership.

8.0 LIST OF BACKGROUND PAPERS

8.1 Noted within the document.

Inverclyde Joint Community Care Plan 2009 - 2012



Joint Community Care Plan

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Joint Community Care Plan

Community Care

Section 1

Introduction

Inverclyde Joint Community Care Plan aims to establish the future joint planning objectives in the development of Community Care Services for the people of Inverclyde, spanning the period 2009-2012. The plan is produced to set out our broad strategy in providing services to:

- Carers
- Older People
- People with Dementia
- People who have Physical Disabilities including Sensory Impairment
- People who have Learning Disabilities
- People who have Mental Health Problems
- People with Addictions
- People who are Homeless
- People with palliative care needs

Decisions in terms of the planning and commissioning of community care services are laid out within the document and are based on the needs of the local community however more detailed information about the way services are being designed and developed can be obtained from the service specific planning documents.

This document includes a section at the beginning which identifies work in progress as well as any policy or legislation that impacts across community care and that is not specific to a particular service user group. A section has also been included to explain the meaning of acronyms used.

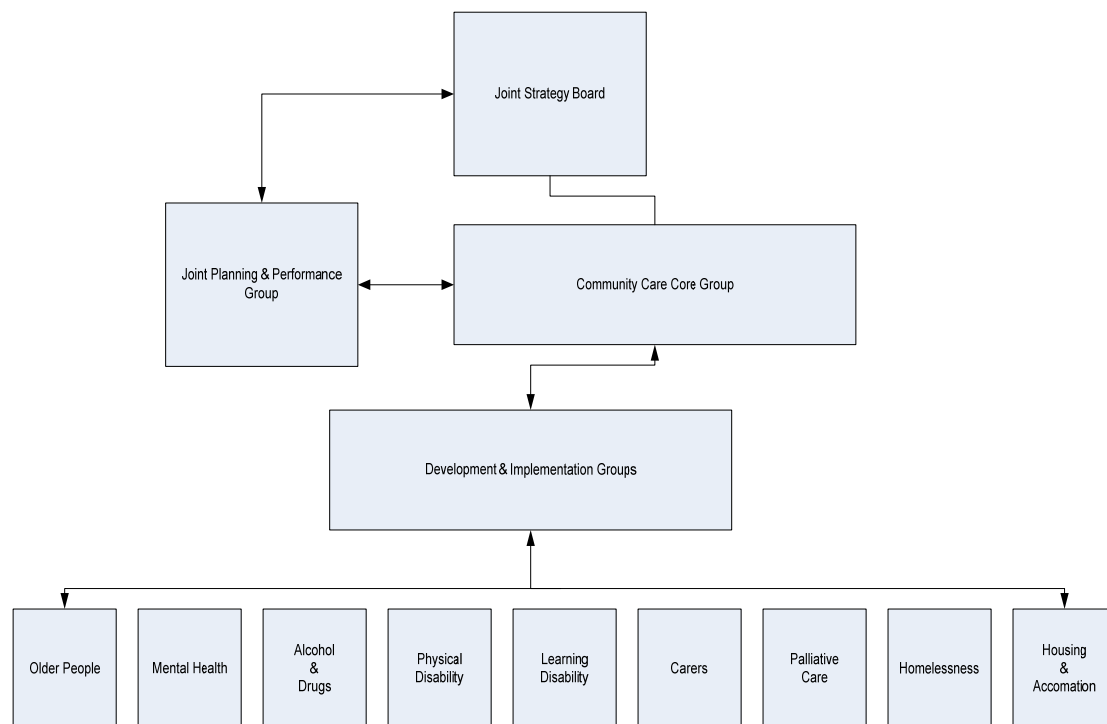
Partners

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Community Care services are planned and provided in partnership with:

- Inverclyde Council - Social Work Services and Strategic Housing Services
- NHS Greater Glasgow and Clyde, Inverclyde Community Health Partnership (CHP), Mental Health Partnership (MHP), Acute Sector Inverclyde Royal Hospital (IRH), Rehabilitation and Assessment Directorate (RAD)
- Housing Providers
- Providers of Care and Support Services in the private and voluntary sector
- User and carer groups
- Inverclyde Community Care Forum/Your Voice

Joint Management Structure



Local Needs

Planning and commissioning decisions are based on the current and projected needs of individuals and at a community level. Understanding the demand for community care services now and in the future requires that we take into account; current uptake of

Joint Community Care Plan

services, needs assessment, knowing what resources are available as well as demographic, socio-economic and health indicators.

Needs and Resources

Separate documents that outline the needs of each client group and the current uptake of service provision have been produced to reference this plan. Where appropriate needs assessment information has been reported within each Community Care client group section.

Shared Vision

We aim to establish a corporate approach with local partners that sets out achievable arrangements to deliver more integrated and co-ordinated services across health, social care, housing and the independent sector which are responsive and sensitive to meeting the needs of the people of Inverclyde.

We will deliver on our shared vision with adherence to the following principles:

- Commit to making a positive impact to health improvement and ensure equitable access to health, housing and social care in Inverclyde.
- Work together in a spirit of trust, openness, mutual understanding and co-operation.
- Share information, data and statistics in the interests of promoting a common understanding of local needs and aspirations (in accordance with a jointly agreed information sharing protocol).
- Consult and involve each other in strategic and local planning, service reviews and the development of policy documents and plans.
- Seek to maximise the benefits that can be achieved by partnership working to ensure value for money of any new investments.
- Develop and sustain partnerships with other agencies or bodies where appropriate and involve local communities in service developments.

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- Establish joint management and resourcing arrangements, which will be effective for the person who needs services.
- Establish arrangements for evaluation and monitoring of service development to ensure appropriate investment of resources.

Ongoing Developments

The aim of providing services is to enable individuals with community care needs to remain as independent as possible and to support people in their own homes. The assessment and care management process is the cornerstone of the provision of community care and is carried out by all adult care services. There are a number of ongoing developments in social care and health that will support frontline staff in achieving these goals.

Single Shared Assessment (SSA) is a process of assessing the needs of people in a way that allows professionals to share information and provide services as quickly as possible. The SSA process has been rolled out to all social work assessment staff and to some health professionals in the community and in hospital based settings. Linked to the progress made with introduction of the SSA, consideration is being given to the implementation of the Indicator of Relative Need (IoRN). This tool is designed to support professionals and managers in decisions about the use of resources and the planning of services, and contributes to delivering Joint Future's wider goals of better and faster access to services for Older People.

We have provided training in accordance with the National Training Framework for Care Management that aims to extend the range of care managers particularly within the NHS and is focussed on improving outcomes for people with complex and frequently changing needs. This should enable people to get faster access to better services by more effective targeting and making more appropriate use of professional services and resources.

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Adult Support and Protection

We have a duty to protect adults in Inverclyde who are at risk of harm and are tasked with implementing the Adult Support and Protection (Scotland) Act 2007. This Act ensure that Inverclyde Council is meeting its' new duties and responsibilities with all partner agencies. This will involve the establishment of an Adult Protection Unit and Inverclyde's Multi Agency Adult Protection Committee. Appropriate links will be established with MAPPA and Child Protection Services given the wider public protection agenda.

It is acknowledged nationally that there is a lack of research and practice experience in the field of adult protection. We will seek to improve knowledge and skills from practice examples to assist in the identification of those at risk and monitoring outcomes of intervention. Awareness raising workshops will continue with staff from all agencies including the voluntary sector and we will continue with multi agency training on new legislation, procedures and practice.

In addition, we will move forward with the implementation of Adult Protection Module on The Social Work Core Business System (SWIFT) system to support frontline activity and measure the impact of the new legislation.

Our key areas for future development are:

- the appointment of key staff for the Adult Protection Unit and an increase in social worker and MHO staff compliment
- the appointment of an Independent Convenor of the Multi Agency Adult Protection Committee,
- formally constitute Inverclyde's Adult Protection Committee
- continue the development and implementation of the Committee's work plan,

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Violence Against Women

The Safer Communities Service of Inverclyde Council is the lead agency in coordinating services around the Violence Against Women Agenda. Priorities are to coordinate, raise awareness and develop services that encourage and improve the reporting of abuse in domestic circumstances and challenge the wider Violence Against Women agenda achieved through ongoing partnership working with local and national agencies. Safer Communities also provide assistance to partner agencies to enable support to be offered to vulnerable people affected by violence and abuse including funding to Inverclyde Women's Aid for provision of the Sexual Abuse Line and to Children 1st for provision of a one to one service for children and young people affected by Domestic and Sexual Abuse.

Inverclyde Women's Aid is the lead support agency in Inverclyde providing support for Women and children affected by Domestic and Sexual Abuse as well as playing a key role in challenging the wider Violence Against Women agenda. The organisation works in partnership with Inverclyde Council Safer Communities Service to raise awareness of these issues, deliver training and offer the best support possible to women and children.

NHS Greater Glasgow and Clyde has prioritized Violence Against Women in its Gender Based Violence Action Plan. Over the next 3 years the NHS has committed to evidence 4 key deliverables.

- Implementation of Routine Enquiry of abuse within priority settings across the NHS
- Dissemination of revised guidance on abuse to staff
- Production of an employee policy on gender-based violence
- Multi-agency collaboration

Consultation

Inverclyde Community Care Forum/Your Voice (ICCF/Your Voice) had a pivotal role in Inverclyde's Joint Community Care management and planning arrangements. The chair of the Forum is a member of the Joint Community Care Board representing community interests.

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The Forum represents a number of local voluntary and community groups who have come together to ensure the voice of users and carers is heard by the agencies that provide services locally. It is crucial that those with an interest in Community Care services are able to participate in the planning and development of services and ICCF/Your Voice has been commissioned to develop a stakeholders network. This network reaches a wide range of users, carers, and organisations in order to keep them informed and gain their views on services and future developments. In addition, ICCF/Your Voice provide an ongoing programme of consultation with community care services users and carers. This service includes e.g. consultation events to encourage large audiences to participate in shaping this plan, support to groups to enable them to put forward their views and concerns, and customer feedback exercises that have helped services become more responsive to the needs of users and carers.

In addition to work carried out by ICCF/Your Voice service providers are also required through Best Value and quality assurance arrangements to put in place customer feedback and outcomes measures in order to ensure continuous improvement in services.

The key messages and themes resulting from these consultation mechanisms e.g. better and more accessible information about services, more flexible respite arrangements, more support to assist people to remain in their own homes and communities are built into the aspirations and objectives of this plan to be taken forward by the local partners.

The Public Partnership Forum, a formal sub group of the CHP Committee made up of patients, carers and member of the public, is also used to support service user and carer engagement. The Chair and Vice Chair of the Public Partnership Forum (PPF) are constituted members of the CHP committee and act as representatives of the local population on that group, feeding directly into the management of local health services and the Health Board. The wider PPF network offer input to consultations and participate in ongoing debate around local health and care services.

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Improving Health and Wellbeing

Improving health and wellbeing is a key objective for Inverclyde Alliance (local community planning partnership) and the relevant partner agencies. The themes of tackling inequality and promoting health and wellbeing are also linked to two of the national outcomes for Community care for Scotland. These are based on improving services, experiences and opportunities for all of the residents of Inverclyde through better services in social care and health, housing and community safety with the intention that the health and wellbeing of local residents is improved.

Health Inequalities

Inverclyde is one of the most deprived areas in Scotland, with long term, complex and multiple inequalities. There is lower life expectancy and higher death rates than the national average with a difference of 11 years in male life expectancy between our most and least affluent communities, and 12 years for women.

Alcohol and drug misuse are significant problems in the area with deaths and hospital admissions for these reasons, more than double the national average. Issues of poverty, unemployment and deprivation combined with the drugs and alcohol culture locally, serve to worsen the health opportunities of the local community and hamper area renewal.

To address some of these inequalities we need to work in partnership to improve access to health care and hospital services, leisure, educational, training and employment opportunities for the most deprived and disadvantaged members of the community. Achieving sustained improvement in the physical and mental health of the people of Inverclyde will pose a challenge for services over the next three years. The area's Single Outcome Agreement, this Joint Community Care Plan and other plans, will seek to address these issues.

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Best Value

The principles of best value underpin the continuous improvement and inspection agenda for local authorities through the implementation of the Public Service Improvement Framework (PSFI) a self-assessment tool for public sector bodies that encourages organisations to review their own activities. The Social Work Inspection Agency's (SWIA's) Performance Inspection Model provides a similar self-assessment tool for Social work Services.

Financial Inclusion

We are committed to working in collaboration with service users and carers to combat the effects of poverty and financial exclusion. Services have been developed that provide income maximisation across all service users groups and is a fundamental tenet to everything that we do.

With specific regard to combating financial exclusion and providing income maximisation, we have dedicated services that offer advice and training to staff in relation to the welfare benefits system and who can provide representation at appeals if necessary. Additionally, we have established a Financial Inclusion Partnership that will address issues of poverty at a strategic level.

Equalities & Diversity

Inverclyde Council's Corporate Equalities Group has been established to facilitate our commitment to ensure equality of opportunity, both as an employer and as a service provider in everything we do. The group involves senior officers from partnership agencies including NHS Greater Glasgow and Clyde (Inverclyde CHP), STUC and the independent sector to achieve our objective in relation to the six equality strands of age, disability, gender, race, sexual orientation, religion or belief.

Ensuring that equalities objectives become central to the duties and responsibilities of every employee, in all the partner agencies, will take time. We will use a broad range of approaches that positively influence the way we work. We will ensure that staff are aware of and equipped to fulfil our commitment to be an equal opportunities employer who;

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- Provides access to employment, training and development for staff at all levels throughout Inverclyde
- Provides staff with information, training and support to help them understand equalities issues
- Enables staff to challenge discriminatory behaviour
- Creates the conditions for a working environment free from discrimination
- Recognises and value peoples differences
- Monitors our employment processes

To this end a range of training opportunities have been rolled out across the partnership in and to other stakeholders and approximately 50 Equalities Champions have been trained in 2008. Additionally, Equality Impact Assessments will be integrated into any service, policy or strategy development in Inverclyde Council, CHP and other partnership organisations.

Housing

Housing is a key component within the partnership's overall aim to support people to live independently in their own homes and to ensure better outcomes for people who receive community care services. Housing cuts across all community care client groups and is addressed within the partnership's planning structure through the Housing and Accommodation Development Group.

Local Housing Strategy

The Inverclyde Local Housing Strategy 2004-2009 (LHS) provides an overview of the local housing system and describes how it needs to develop to meet the need and demand for housing of all tenures. The Strategic Housing Investment Plan (SHIP), updated annually, provides the framework through which housing providers can meet these needs and demands more effectively using available resources. The SHIP establishes the priorities for housing investment in the local authority area, including housing for people with particular needs and funding for social landlords to provide equipment and adaptations in their tenants' homes. The Planning and Housing Service is represented on Joint Community Care planning and other strategic planning structures across the authority to ensure that the housing needs of people with

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community care needs are identified within the Inverclyde LHS and addressed through the SHIP investment programme.

The Scottish Government has issued new guidance on the preparation of Local Housing Strategies and the “new style” LHS will be implemented over the next two years. The new LHS will include housing support as one of its key components and this will be developed in collaboration with the Joint Community Care planning structures and other strategic planning structures across the authority. The introduction of new Strategic Development Plans over the same timescale will provide the opportunity to harmonise the planning and housing systems across local authority areas. Community care and health needs will continue to be represented within this new, streamlined approach to strategic housing planning.

Housing Stock Transfer

The transfer of the local authority housing stock was one of the major outcomes of the LHS and its successful completion in December 2007 is seen as a major step towards increasing housing options and expanding choices for those looking for affordable housing for rent or ownership across the Inverclyde Council area. The stock transfer has provided the development and funding opportunities to take forward a major programme of new house building together with regeneration and area renewal projects throughout Inverclyde.

Older Peoples Housing Demonstrator Project

The Inverclyde Partnership has been successful in securing funding from the Scottish Government’s Joint Improvement Team as part of the Older Peoples Housing Demonstrator Project. This project aims to identify innovative housing, health and social care solutions to achieve better outcomes for older people with care needs living in our communities. This project is being taken forward in partnership with Inverclyde Council, the CHP and River Clyde Homes (the new housing association that was formed as a result of the stock transfer).

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Data Sharing and Integration

The national objective of electronic data sharing is being progressed across Greater Glasgow and Clyde through the Local Data Sharing Partnership (LDSP). The Local Authority and Inverclyde CHP are represented within this arrangement. The aim of the LDSP is to support local partners in the implementation of the electronic sharing of information in order to ensure that all Health and Social Work services respond appropriately and effectively to the needs of service users and their carers. By sharing information in this way it is hoped that agencies can gain a better understanding of the needs of individuals and avoid unnecessary duplication of information gathering and form filling. Inverclyde partnership has developed mechanisms to ensure that it can progress technical infrastructure and systems requirements to take this forward.

Supporting People

In 2007, the Scottish Government and CoSLA agreed a substantial reduction in the number of separate funding streams to local government. The terms of this agreement are set out in a Concordat signed by the Scottish Ministers and CoSLA.

Under the Concordat the ring fence around the Supporting People programme was removed from 1st April 2008, with the Supporting People budget being absorbed into the main local government settlement.

The whole of government is also being moved to an outcome focus approach to performance management, based around delivery of the Scottish Government's five strategic objectives:

Wealthier and fairer – helping to increase wealth and more people to share fairly in that wealth

Smarter – expanding opportunities for people to succeed

Healthier – helping people sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care

Safer and Stronger – helping communities flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life

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Greener – improving Scotland’s natural and built environment, and the sustainable use and enjoyment of it.

Housing support services in Inverclyde will continue to have an important role in helping deliver against many of the national outcomes. These services are crucial in tackling inequalities, and in providing support for the elderly and other vulnerable groups to continue living independent, fulfilling lives.

Given the demographic challenges of an ageing population in Inverclyde, housing support and care packages will become even more important in sustaining increasing numbers of older people and other vulnerable client groups in their own homes in the years ahead.

Inverclyde Social Work Services continues to assess the need for housing support and continue to fund the provision of housing support in line with Scottish Government expectations.

The removal of the ring fence on the Supporting People budget allows more flexible support packages to be developed.

The Inverclyde Partnership recognises although there is no separate national indicator on housing support, these support services have an important role to play in delivering against several of the new national outcomes and indicators.

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Financial Information

The following table provides a breakdown of the gross budget for Social Work Community Care and Homelessness Services for 2008/09. It should be noted that these include all on costs e.g. management and infrastructure. In addition some services for older people with mental health problems are incorporated within the Older People's Budget and Carers Services are included across all care group budgets.

COMMUNITY CARE & HOMELESSNESS - GROSS BUDGET 2008/09		
Care Group	Gross Budget 08/09	Percentage of Total
Addictions	£ 1,422,254	3.23%
Adult Mental Health	£ 3,992,174	9.07%
Older People's Mental Health	£ 995,185	2.26%
Older People	£ 26,188,453	59.49%
Physical Disability	£ 3,153,680	7.16%
Learning Disability	£ 6,510,263	14.79%
Palliative Care	£ 8,397	0.02%
Homelessness	£ 1,752,890	3.98%
TOTAL	£ 44,023,296	100.00%

The following table provides a breakdown of NHS Greater Glasgow and Clyde's budget for Inverclyde 2008/09.

NHS GREATER CLASGOW & CLYDE INVERCLYDE BUDGET 2008/09				
Care Group	Partnership	*Acute	CHP	TOTAL
Older Peoples			£ 127,445	£ 127,445
Physical Disabilities				
Learning Disabilities			£ 529,884	£ 529,884
Mental Health	£ 6,300,162		£ 2,001,611	£ 8,301,773
Geriatric Psychiatry	£ 3,313,121			£ 3,313,121
Addictions	£ 1,180,238			£ 1,180,238
Sub-total	£10,793,521		£ 2,658,940	
TOTAL				£13,452,461

* awaiting updated financial figures from the Acute sector

Joint Community Care Plan

Section 2

Carers

Introduction

There are over 8,000 carers in Inverclyde, which is approximately 10% of the population (2001 Census). Carers include people of all ages, including young carers; people from different backgrounds; ethnic origins and gender. They are involved in looking after someone with a physical or learning disability; mental health issues; HIV/Aids; alcohol or drug dependency; brain injury or terminal illness.

Carers look after family members, partners or friends in need of help because they are ill; frail or have a disability. The care they provide are unpaid. Carers are valued and important partners in the delivery of care, which is acknowledged within Inverclyde Council's Corporate Plan, Inverclyde CHP's Development Plan and through the partnership signing of the Inverclyde Carers' Charter 2007 by NHS Greater Glasgow and Clyde and Inverclyde Council and local carers.

The Joint Carers Strategy 2008-2011 priorities the needs of carers and addresses them through an Action Plan which is monitored and implemented by the Carers Development Group.

Carers Development Group

The Carers Development Group is an inter-agency forum that reports to the Community Care Core Group. It oversees the implementation of the Strategy and has a joint approach to working with and supporting carers. The action plan is implemented through task groups, which involve carers, staff from social work; health and other agencies. The task groups report back on progress to the Development Group. The chair of the Development Group also meets with Inverclyde Carers Council on a yearly basis to discuss the progress of the Joint Carers Strategy and any other relevant issues. In addition, there is an annual review of the Strategy facilitated by ICCF/Your Voice involving carers to review progress on the implementation of the Strategy and any alterations that are required to be made.

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National Policy

National Policy Carers
NHS Health and Community Care Act (1990)
Carers (Recognition and Support) Act (1995)
Children's (Scotland) Act (1995)
Carers National Strategy (1999) (Scotland)
Community Care and Health (Scotland) Act (2002)
Delivering for Health (2005)
Building a Health Service for the Future (2005)
Working Families Act (2006)
The Future of Unpaid Care in Scotland (2006) (Care 21 Report)
Scottish Executive's Response to Care 21 Report (2006)
Changing Lives: 21 st Century Social Work Review (2006)
Better Health Better Care (2007)

Local Policy

Local Policy Carers
Inverclyde Carers Charter
Inverclyde Joint Carers Strategy 2008-2011
Inverclyde Community Health Partnership Development Plan 2008-2010
Single Outcome Agreement (tackling poverty sustaining growth) 2009-2012

Strategic Focus

- Ensure a range of quality short breaks is on offer, which are flexible and reliable.
- Provide information and access to services.
- Promote involvement of carers in individual care planning and in the monitoring, planning and delivery of services.
- Reduce the stress of caring and promote the health of carers.
- Promote training on a variety of issues and facilitate access to employment opportunities for carers and former carers.

Joint Community Care Plan

What have we achieved 2006-2008?

- Established a Short Breaks Bureau (SBB) to act as a one stop shop for accessing information on short breaks.
- Developed community based respite services in a range of settings.
- Secured additional funding for Inverclyde Carers Centre to provide faster access to a range of short breaks including sitting services, group holidays and overnight services.
- Improved information provided for carers through the distribution of 2000 Carer Information Packs, Welfare Rights Information booklets, and web based information, financial inclusion events.
- Increased access to advocacy services.
- Public Events were held during Carers Week and Carers Rights Day.
- Improved training opportunities for carers (e.g. Your Voice, ASSIST).
- Carers are involved in consultation on service redesign, strategies and other issues affecting them.
- The number of carers registered on GP Practice Register is increasing year on year.
- Prevention and Support (PASS) Nurses are actively involved in addressing the health needs of carers.
- Leisure opportunities increased for carers e.g. Leisure Pass Scheme.
- Counselling Service, Alternative Therapies, Stress Management, Healthy Eating classes and Relaxation Techniques are on offer at the Carers Centre.

What are our priorities 2009-2012?

- Establish equity in accessing respite services across client groups and promote alternative forms of respite.
- Improve access to overnight, emergency/crisis respite.
- Promote the use of Telecare (technological support) to enable carers to have a break from their caring role.
- Take full cognisance of the needs of carers in the assessment process.
- Improve the Hospital Discharge experience by ensuring liaison with carers.

Joint Community Care Plan

- Further improve opportunities for carers to have a voice in everything that affects them.
- Improve access to health services for carers, and address carers' health needs.
- Improve employment, training and education opportunities for carers.

Why are these objectives important?

Carers have identified the above priorities as key issues to be addressed in order to allow them to continue in their caring role. Carers are key partners in the delivery of care and as such are entitled to the level of recognition and support, which enables them to care and lead a fulfilling life.

Joint Community Care Plan

Section 3

Older People's Services

Introduction

Demographic projections predict that Inverclyde's population of older people will increase in real terms and as a percentage of the total population over the next ten years. This presents significant challenges in the provision of health, housing and social care, and in supporting older people to remain as independent as possible within their own homes.

Development Group

The Older Persons Development Group is an inter-agency forum chaired by Social Work and reports to the Community Care Core Group. The development group has a collaborative approach to working with and supporting older people to live as independent a life as possible, by coordinating the use of resources, managing pooled budgets and strategic service development.

Older Peoples mental health services are included within the modernising mental health service strategy for Inverclyde. This includes the re-provisioning of services currently based within Ravenscraig Hospital and the development of approaches to care for people with dementia and with functional mental illness.

Joint Community Care Plan

National Policy

National Policy Older People
Better Care For all our Futures
Fair Care for Older People - Care Development Group Report (September 2001)
The Community Care and Health (Scotland) Act 2002
Community Care - Joint Future Scottish Executive (2002)
"Better Government for Older People" All our Futures in Scotland Scottish Executive (2006)
A Strategy for a Scotland With an Ageing Population (2007)
A Delivery Framework for Adult Rehabilitation Services in Scotland – (Co-ordinated, integrated and fit for purpose. Scottish Executive (2007)
"Adding Life to Years" Report of the Expert Group on Healthcare of Older People. Scottish Executive (2002).
Needs Assessment Report: Dementia and Older People in Scotland (2003) Scottish Executive
Equally Well (Scottish Government, 2008)

Local Policy

Local Policy Older People
Inverclyde Hospital Discharge Plan 2007
Inverclyde CHP Development Plan 2008 - 2010

Joint Community Care Plan

Strategic Focus

- Support and enable older people to live independently in their own homes.
- Work jointly with other agencies to achieve better outcomes for older people who need care services in Inverclyde.
- Ensure that we deliver hospital discharge processes which are effective, efficient and sustainable.
- Improve and maintain the health and well being of older people in Inverclyde, preventing inappropriate hospital admission, readmission and protracted lengths of stay.
- Involve service users and carers in the care decisions that affect their lives at both an individual and strategic planning level.
- Work closely with commissioned services to support providers in meeting our current and planned service expectations.

What have we achieved 2006-2008?

- Met our target for reducing the number of people delayed in hospital for six weeks or more in April 2008.
- Secured Fairer Scotland Funding to support development work in early support to people diagnosed with Dementia through Alzheimer's Scotland in Inverclyde.
- Pilot work is underway to extend access for older people to primary care mental Health services based in GP practices.
- Exceeded our target for the provision of intensive home care to people aged 65+.
- Completed an audit of emergency admissions for people aged 75+ and have published the results.
- Consolidated and extended our assistive technology service to support more people at home.
- Updated the review of rapid response services and developed a single point of access.
- Transfer the Community Falls Prevention Programme to the wider programme across NHS Greater Glasgow and Clyde.
- A range of AHP training provided to care homes (e.g. specialist feeding).
- A new model of care provided via 32 very sheltered housing with care flats.
- Additional care home beds commissioned.

Joint Community Care Plan

- Development of a draft protocol for short term loaning of equipment to care homes.
- Roll out of Keep Well to all GP practices including referral to stress management, exercise classes, weight management and smoking cessation.
- Further integration of joint teams.
- Extension of Gerontology services within the Fast Track Assessment service, with dedicated gerontology nurse and geriatrician input.
- Development of a range of pharmacy services have been developed to provide support, interface pharmacy and changes to medication on discharge.
- The Demonstrator for Older People's Housing Support, Health and Social Care project is being piloted locally.
- Services are being shaped to respond to increasing demand for more complex care packages at home, in terms of nursing and home care.
- Development of a range of Telecare services supported by a team of response staff.

What are our priorities 2009- 2012?

- The completion of the older persons service redesign to facilitate closure of Ravenscraig Hospital.
- Commissioning of additional care home capacity for people requiring specific mental health care and support.
- Commissioning of alternative continuing care pathways
- Development of criteria for continuing care facilities for people requiring NHS care.
- Development of a Dementia Care Pathway to ensure people with Dementia have the appropriate support and services available when they require them.
- Provision of primary care mental health services for older people who experience depression and anxiety disorders.
- Support care homes to improve and maintain high standards in care provision.
- Advance the model of intermediate care.
- Continuing to support the delayed discharge agenda.
- Reduction of inappropriate emergency admissions and prevention of multiple admissions.
- Extend the provision of anticipatory care.
- Expand response services linking to community alarm,

Joint Community Care Plan

Telecare and out of hours developments.

- Develop telecare/telehealth technologies.
- Update the audit of hospital admissions from care homes.
- Complete the audit of pharmacy processes on discharge from hospital.
- Develop a process for allocation of housing with care as an alternative to care home admission.

Why are these objectives important?

Collectively these objectives will improve services for older people and provide targeted and faster access to resources when they are most needed. The service objectives ensure the best possible use of joint resources in health, social work and independent sector. Services will be reconfigured in order to support the reduction of continuing care beds and reinforce the criteria for accessing continuing care beds.

Joint Community Care Plan

Section 3

Physical Disability

Introduction

This section considers the needs of people in the local community who have physical or sensory impairments.

A key challenge for the partnership in delivering efficient and effective services for people with a physical disability including sensory impairment is the implementation of the Framework for Adult Rehabilitation in Scotland (Scottish Executive, 2007). This sets out the future strategic direction and makes recommendations for action to support practitioners who deliver rehabilitation services. It proposes that rehabilitation should be more accessible, including direct access, provided locally, with a systematic approach to promoting independence and self-management and that models used should enable seamless transitions between phases of care.

Development Group

The Joint Physical Disability Development Group has responsibility for developing and agreeing priorities for the improvement of services for people with physical disabilities including sensory impairments. The group has membership from Social Work and NHS Greater Glasgow and Clyde (Inverclyde Community Health Partnership and Rehabilitation and Assessment Directorate).

The Group will take forward the implementation of the new framework for adult rehabilitation services to ensure a co-ordinated approach to improving local community physical disability services.

Joint Community Care Plan

National Policy

National Policy
Co-ordinated, integrated and fit for purpose A Delivery Framework for Adult Rehabilitation in Scotland, 2007 (Scottish Executive)
Disability Equality Duty 2006
Review of Independent Living Fund, 2006 (Scottish Executive)
Review of Community and core services in Scotland – consultation 2006
Disability Discrimination Act 2005
Management of Community Care Equipment and Adaptations 2004 (Audit Scotland)
Equipped for Inclusion, 2003 (Scottish Executive)
Community Care and Health (Scotland) Act 2002
Regulation of Care (Scotland) Act 2001
Commissioning Care Services for People with Sensory impairment – an Action Plan, 2000 (Scottish Executive)
Sensing Progress 1998 (Scottish Executive)
The Community Care (Direct Payments) Act 1996
Disability Discrimination Act 1995
Equipment and Adaptations Guidance for Health and Local Authorities (March 2009)
Housing (Scotland) Act 2006

Local Policy

Local Policy
Inverclyde Joint Community Care Statement of Intent Statement 2006/7, including Supporting People Annual Review 2006/07

Joint Community Care Plan

Strategic Focus

- Rehabilitation being at the centre of future health and social care services.
- Shift in focus of services from care to enablement.
- Local, community based delivery of service as much as possible.
- Systematic, continuous care approach to management of older people, people with long term conditions and people with vocational rehabilitation needs.
- Better co-ordination of multi-disciplinary and multi-agency rehabilitation services at strategic and local level.
- Quality transitions between hospital and community and follow up services.
- Strong emphasis on pro-active, preventative care, anticipatory interventions and early intervention thus reducing avoidable admissions to hospital.
- Supporting patient self-management of long-term conditions.

What have we achieved 2006-2008?

- Further developed role of Established Inverclyde Centre for Independent Living (ICIL).
- Reduction in waiting time for clients being registered as blind/partially sighted.
- Increased use of duty times offering a specialist service to visually impaired clients.
- Additional monies were given for equipment provision to increase independence for clients with sensory impairments.
- Development of support group for clients who have Macular Degeneration.
- Established faster and wider access to the Joint Store.
- Increasing access to self assessment for small items of equipment.
- Increased the use of ICIL for health clinics.
- Improved access to information technology.
- Establishment of a Telecare demonstration site located in ICIL.
- Joint working between Occupational Therapy services and Riverclyde Homes linking the housing modernisation programmes with adaptations waiting lists.

Joint Community Care Plan

- Employment of Occupational Therapists by Riverclyde Homes to assist with reduction of assessment waiting lists.
- Widening access to small items of equipment to facilitate hospital discharge.
- Health colleagues are able to access the adaptations budget to ensure adaptations are in place prior to hospital discharge.
- Developing protocols with care homes to provide rehabilitation and through short term loan of equipment to prevent admission to hospital.
- Occupational therapy services located with Riverclyde homes to facilitate robust assessment of need in relation to housing.

What are our priorities 2009-2012?

- Implement the Delivery Framework for Adult Rehabilitation.
- Design services as close to home as possible for people with physical disabilities.
- Development of mobility training for children.
- Development of eye care pathways for adults including Community Optometry Services and the Voluntary Sector.
- Development of Visually Impairment Review Group (multidisciplinary) for children as recommended in Eye care review.
- Promote a care management approach.
- Develop care pathways that ensure seamless service provision.
- Promote the model of self directed care.

Why are these objectives important?

People require services to be delivered as close to home as possible and that resources can be accessed that enable individuals to exercise choice and control over the way in which their condition is managed. We will work in partnership to ensure that the best possible use is made of resources at our disposal to achieve this goal.

Joint Community Care Plan

Section 4

Learning Disability

Introduction

The strategic direction of services for adults with learning disabilities is detailed in the Partnership in Practice Agreement (2007-2010), which has an agreed implementation action plan that will shape services over the next three years.

Development Group

Joint working within learning disabilities is progressed through the Joint Learning Disability Development Group. This has representatives from the Community Care Forum; Health, James Watt College, and Social Work: Children's Integrated Services; Economic and Regeneration Services incorporating the Workforce Plus Initiative.

The remit of this group is to develop and implement the strategic and operational agenda that will enhance joint working and service redesign. The Group reports to the Inverclyde Joint Community Care Core Group and contributes to the NHS Greater Glasgow and Clyde Learning Disability strategic planning group.

National Policy

National Policy
"The Same As You" Scottish Executive (Scottish Executive 2000)
Promoting Health Supporting Inclusion – Nursing Review (2002)
Community Care and Health (Scotland) Act 2002
NHS Scotland's Health Needs Assessment Report – People with learning Disabilities (2004)
Having Your Say? – The Same as You – Report of the Advocacy Sub Group 2006
Partnership in Practice Agreement Guidance – Scottish Executive 2007
Adults with Incapacity (Scotland) Act 2000
Mental Health (Care and Treatment) (Scotland) Act 2003

Joint Community Care Plan

Local Policy

Local Policy
Partnership in Practice Agreement 2007-2010

Strategic Focus

- Working towards ensuring that the particular health needs of adults with learning disabilities are met.
- Developing an inclusive approach to meeting the needs of people with learning disabilities and their carers as outlined within the “Same as You” framework.
- Involve service users and carers in decisions about the services we provide and the choices available.
- Work in partnership to achieve better outcomes for service users.
- Provide support to carers of people with learning disabilities.
- Continue to improve the quality of services provided to people with learning disabilities and their families.

What have we achieved 2006-2008?

- The Merchiston Hospital re-provisioning exercise was completed in August 2007.
- Provided 6 new supported tenancies year on year.
- New service models have been progressed to support independent living.
- Personal Life Planning has been taken forward.
- Research has informed the development of the Health Checks Programme 2007-2010.
- Developments to support the transition from children to adult services have been progressed.
- Community focussed day opportunity services have been expanded.
- The Autistic Spectrum Disorder (ASD) Day Opportunities Pilot Service has now been mainstreamed.
- We have consolidated Local Area Co-ordination.
- Change Fund money has allowed us to progress a range of modernisation and service developments.
- Autism Awareness Training and Total Communication Training has been rolled out.
- Improved local information systems.

Joint Community Care Plan

What are our priorities 2009-2012?

- Develop Clyde wide integrated solutions for forensic, challenging and complex needs.
- Complete the re-configuration of the Community Learning Disability Team.
- Development of a more comprehensive ASD assessment process.
- Meet national targets in relation to health checks for people with learning disabilities.
- Implement within GP practices a named nurse liaison programme, to raise awareness and provide training on specialist health needs.
- Implement an Acute and Primary Care liaison nursing process.
- Improve diet and exercise opportunities for people with learning disabilities.
- Raise awareness of visual and auditory needs by supporting the local optometrists and streamlining the audiology referral processes.
- Develop a strategic approach to delivering services to individuals with a learning disability who misuse drugs and/or alcohol.
- Modernise and improve residential services for people with learning disabilities.
- Focus on the needs of the growing population of older people with learning disabilities.
- Improve access to employment opportunities.
- Continue to develop the “Partnership Matters” approach for personal support for adult learners.

Why are these objectives important?

Learning disability services aim to improve the quality of life of people with learning disabilities and their carers. Our priorities are to support people with learning disabilities to have a fully integrated life in their local community and have choice and access to good quality, flexible services which are based on their assessed need. We will ensure services are socially inclusive and promote equal access to health services.

Joint Community Care Plan

Section 5

Mental Health

Introduction

The Scottish Framework for Mental Health (1999), Delivering for Mental Health (Scottish Executive) 2005 and the National Programme for Improving Mental Health and Well Being in Scotland (*Scottish Executive 2001*) provide the basis for the development of mental health services in Scotland. Mental health services within Inverclyde have been modernised in line with national recommendations and have, through local implementation of the Joint Future Agenda developed models of service provision that are embedded around the provision of integrated, comprehensive mental health services.

Mental health services in Inverclyde are going through a significant process of modernisation and redesign.

This section outlines services currently provided and future developments for services provided to adults with mental health problems. Older people's mental health services are included within the older peoples section of this report.

Development Group

The Mental Health Development Group monitors the progress of policy implementation and of service delivery and redesign. The membership includes representatives of the local authority, health services, independent sector and carers.

National Policy

National Policy
Delivering for Mental Health (Scottish Executive) 2006.
Scottish Framework for Mental Health (1999)
Mental Health (Care and Treatment) Scotland Act 2003
Adults with Incapacity (Scotland) Act 2000
Adult Support and Protection (Scotland) Act 2007

Joint Community Care Plan

Local Policy

Local Policy
Modernising Mental Health Services NHS Greater Glasgow and Clyde July 2007. (Paper approved as basis for public consultation with outcome requiring appropriate board and committee approval).
Inverclyde Joint Community Care Statement of Intent Statement 2006/7, including Supporting People Annual Review 2006/07.
Inverclyde Joint Health Improvement Plan 2006/08

Strategic Focus

- To meet the legislative requirements of the Mental Health (Care and Treatment) (Scotland) Act 2003, Criminal Procedures (Scotland) Act 1995, and Adults with Incapacity (Scotland) Act 2000.
- Ensure that service provision supports social inclusion and enables service users to develop or maintain their skills.
- Develop the recovery model for mental health services.
- Support resource management processes to ensure service is appropriately targeted and unmet needs are identified and addressed.
- Widen engagement with community groups to develop mental health and well being in the community.

What have we achieved 2006-2008?

- Developed new model of care to support the modernisation programme and the closure of Ravenscraig Hospital.
- We have developed community-based services to support inclusion and promote independence.
- Gateways project has been redeveloped to support sustained recovery.
- Access to services has been improved and redesigned to meet the level of need.
- Progress has been made to develop care pathways for people experiencing depression, schizophrenia and dementia.
- There has been continued development of work with ACUMEN service users forum.

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- Service users and carers have been actively involved in service development and evaluation across the range of mental health services.
- Mental health and wellbeing training has been provided to the community to increase capacity to address mental distress-as outlined in Choose Life plan.
- Mental Health Officer Services have been further developed and the service has relocated to more suitable premises.
- We have rolled out training in line with Adults with Incapacity legislation.
- Joint protocols and training on the impact of mental health legislation in terms of Children and Families Services have been implemented.
- Interagency Vulnerable Adult procedures are now in place.
- Inverclyde Anti-Stigma Partnership has been established.

What are our priorities 2009-2012?

- Redesign of Short Stay Psychiatric Unit at IRH and development of intensive care service.
- We will continue to relocate services from Ravenscraig Hospital and progress the hospital closure programme in line with the Modernising Mental Health Services Strategy for Inverclyde.
- Relocate existing community mental health services for adults and older people within fit for purpose accommodation.
- Further develop and extend our dual/multiple diagnosis services.
- Developing a contractual framework with third sector providers and promote a further shift in the balance of care.
- Further develop the primary mental health infrastructure.

Joint Community Care Plan

Why are these objectives important?

These objectives are important in shifting the balance of care from large institutional based provision to more appropriate community or home based settings. Additionally, ensuring that all resources at the disposal of service providers are used in the most efficient and effective manner to secure the best outcomes for service users.

The proposals for mental health service redesign will dovetail with redesign plans for older people and addiction services providing a managed and coordinated move to collocated, fit for purpose office accommodation that is centrally situated.

Joint Community Care Plan

Section 6

Addictions

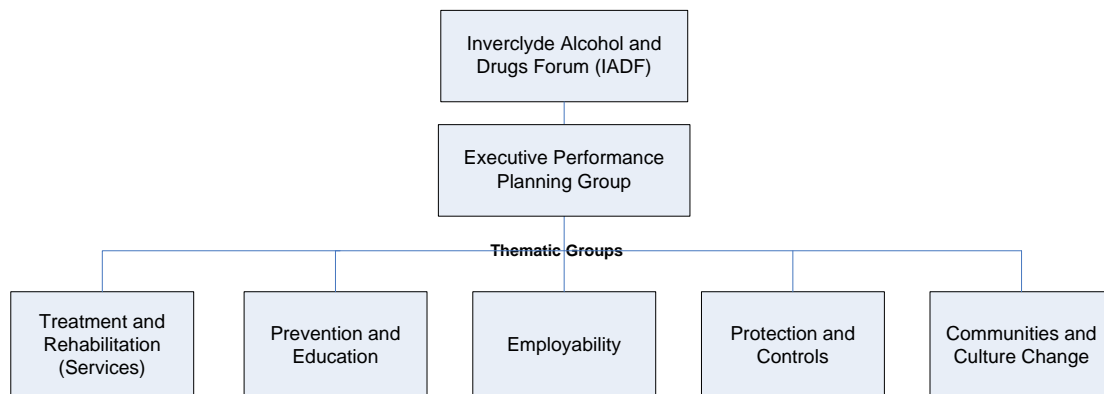
Introduction

Inverclyde Addiction Services have been developed to provide accessible, equitable and inclusive services in order to prevent and reduce the harm associated with drug and alcohol use to the individual, family and wider community, and where appropriate assist individuals in achieving abstinence.

Addictions Services are currently reviewing their strategy and will publish the Inverclyde Addiction Strategy 2009-2012 later this year. The strategy will detail future priorities for the services.

Development Group

The Inverclyde Alcohol and Drugs Forum (IADF) drives the development and delivery of local services. It has a key role to play in responding to the challenges of drug and alcohol misuse and in developing a strategic inter-agency approach to corporate action planning.



There are 5 main thematic sub-groups that form IADF illustrated in the diagram above.

Representatives from community and voluntary agencies are involved in the working groups as well as Health, Police, Education

Joint Community Care Plan

and Social Work Services. IADF provides a vital network for sharing best practice and information. It reports to the Drug Action Team (DAT) and Alcohol Action Team (AAT) which link to the Greater Glasgow and Clyde Action Plan. IADF is currently preparing for the development of the Alcohol and Drug Partnership (ADP) in line with Scottish Government requirements. The primary reporting route will be the Community Planning Structure (SOA). Alcohol is one of Inverclyde's SOA priorities.

National Policy

National Policy
National Plan for Action on Alcohol Problems –Scottish Executive
Getting Our Priorities Right –Scottish Executive.
Mind the Gaps – Meeting the needs of People with Co-occurring Substance Misuse and Mental Health Problems Scottish Executive (2003).
Hidden Harm: Responding to the Needs of Children of Problem Drug Users. Scottish Executive (2003).
The Road to Recovery (2008) Scottish Government – A New Approach to Tackling Scotland's Drug Problems
Changing Scotland's Relationship with Alcohol – A Framework for Action (2009) Scottish Government
Drug and Alcohol Services in Scotland (Audit Scotland 2009)

Local Policy

Local Policy
Greater Glasgow and Clyde Alcohol Action Team Plan for Action on Alcohol Problems (2007)
Inverclyde Joint Health Improvement Plan

Strategic Focus

- To provide equitable, accessible and inclusive services that address the needs of those who experience problems with drugs and/or alcohol.
- Redesigning service delivery to more effectively meet local need.
- Reduce the harm to children affected by substance misusing parents/carers.

Joint Community Care Plan

- Improve and develop prevention services.
- Promote culture change and safer communities in Inverclyde
- Reduce the availability of drugs.
- Reduce crime, nuisance and fear of crime relating to alcohol.

Joint Community Care Plan

What have we achieved 2006-2008?

- We hosted Inverclyde People's Day, an event that will be held annually.
- Extended support to the GP Shared Care Service.
- Established a new Employability Programme.
- New Police Unit "Anti-Social Behaviour Team" formed to target drug dealing and disorder.
- Established joint working protocols between ASIST, youth justice and other agencies.
- Inverclyde Youth Alcohol Advisory Project established.
- Roll out of Alcohol Brief Intervention programme.

What are our priorities 2009-2012?

- Establish Inverclyde Alcohol and Drug Partnership.
- Co-location of service in new build, fit for purpose premises.
- Develop and extend the range of community based services and primary care services.
- Extend community detox services in partnership with Homelessness services.
- Develop joint working protocols between addiction services and other services and agencies.
- Develop and implement recommendations from Getting Our Priorities Right and Hidden Harm across all Addiction Services.
- Extend Acute Alcohol Liaison service.
- Development of joint assessments, joint treatment and support with partner agencies.
- Further extend GP shared care clinic.
- Acute services Hepatitis Nurse Specialist Post.
- Further develop Employability Scheme with "Workforce Plus" Programme.
- Extend Harm Reduction Programme.

Joint Community Care Plan

Why are these objectives important?

There is a particular problem in Inverclyde with drug and alcohol related deaths and hospital admissions. For example Inverclyde has the second highest alcohol related death rate for males and the fourth highest for females. The prevalence of problem drug users in Inverclyde is estimated to be the third highest in Scotland.

Services locally need to achieve the best possible outcomes for services users by making the most efficient and effective use of resources focussing on prevention, harm reduction and abstinence.

Joint Community Care Plan

Section 7

Homelessness

Introduction

Homelessness Services provide accommodation and housing support to meet the needs of people who are homeless or potentially homeless. The partners are working jointly with all housing providers to secure a range of good quality housing options.

Development Group

The Homelessness Strategy Steering Group is a multi agency forum chaired by Social Work Services and reports to the Community Care Core Group. The Group oversees the implementation and monitoring of the Inverclyde Homelessness Strategy and partnership working enables us to address some of the structural issues surrounding homelessness as well as homelessness prevention.

National Policy

National Policy
Housing Scotland Act 1987 Part 2, Homeless Persons, as amended by
Housing (Scotland) Act 2001, and
Homelessness etc (Scotland) Act 2003.
(Scottish Executive) Homeless Task force Recommendations 2002
(Scottish Executive) Ministerial Statement (December 2005)
Implementation of Section 11 of the Homelessness etc (Scotland) Act on 1 April 2009
Strategic Outcome Agreement (SOA) objectives as agreed with Scottish Government.

Joint Community Care Plan

Local Policy

Local Policy
Inverclyde Council Homeless Strategy 2007 – 2009 (being updated to cover period 2009 –2011 in line with the
Inverclyde Local Housing Strategy (LHS)
Strategic Housing Investment Plan (SHIP) 2010-2011
Achieve objectives as set out in local Community Plan.

Strategic Focus

- Ensure no one sleeps rough
- Scope the full extent of homelessness
- Secure sustainable resettlement
- Promote proactive and preventative responses to homelessness
- Reduce the duration of homelessness

What have we achieved 2006-2008?

- Established the Health and Homelessness Action Group
- Streamlined access to Community Nurse, Community Drugs Outreach Worker and Alcohol Home Detox Team.
- Refurbished Inverclyde Centre and improved disabled access
- Established a Private Sector Leasing Scheme
- Participated in Equality & Diversity Training
- Drop-in services provided by Scottish Association for Mental Health
- Improved the standard of temporary accommodation

What are our priorities 2009-2012?

- Establish a generic 'one-to-one' casework system
- Increase availability of temporary accommodation
- Improve access to emergency accommodation
- Significantly improve access to permanent accommodation
- Provide appropriate responses to the needs of people with health needs and disabilities
- Raise awareness of homeless services
- Enhance homeless prevention activity throughout the community

Joint Community Care Plan

- Provide appropriate support to maintain and sustain tenancies.
- Facilitate access to money/debt advice services.
- Establish employment links for homeless clients.
- Address the accommodation and support needs of young people leaving local authority care.
- Assess and address emergency accommodation needs of young people presenting as homeless following family disputes.
- Prevent evictions through robust and early homeless prevention activity.
- Improve discharge from hospital arrangements for people who are homeless or are expecting to return to unsuitable/inappropriate accommodation.

Why are these objectives important?

Through the Homelessness Strategy and activity across the partnership regarding poverty and inequality, we will help to alleviate the problems associated with homelessness. We will take positive action to address the physical and mental wellbeing of our service users.

Joint Community Care Plan

Section 8

Palliative Care

Introduction

“Palliative and end of life care are integral aspects of the care delivered by any health and social care professional to those living with and dying from any advanced, progressive or incurable condition” (Living and Dying Well, Scottish Government, 2008)

There is work underway to extend services to meet the needs of local people who require palliative care. This is prominent within the thinking of the partnership and is currently supported actively across the community care planning arena, including those in the voluntary sector and hospice movement. Best practice examples, already in place in Inverclyde will be built on through the lifetime of this plan as a priority.

Development Group

There is currently no formal group in place locally looking at Palliative Care service development; a group will be established in spring 2009 to audit current service provision and undertake a needs analysis in relation to palliative care, led by Ardgowan Hospice. This group will ensure current good practice is built on and that gaps in service, where these exist, are addressed.

National Policy

National Policy
Living and Dying Well, Scottish Government 2008

Local Policy

Local policy around palliative care will be developed over the lifetime of this plan to build on emergent work across the local partnership, and strengthen our response to national policy and guidance.

Joint Community Care Plan

Strategic Focus

Implement the actions of Living and Dying Well;

- Embed a cohesive and equitable approach to palliative and end of life care for patients and families living with and dying from advanced, progressive or incurable conditions in all care settings

What have we achieved 2006 - 2008?

- Around 80% of GP practices in Inverclyde have signed up to the Gold Standard Framework for Palliative Care.
- Palliative Care information folder provided to all GP practices.
- Joint working and communication, including input to care homes by District Nurses for training and clinical support, is in place.
- Do Not Attempt To Resuscitate Policy is being developed.
- Funding has been increased to enhance the provision of a greater level of respite for patients with malignant and non-malignant conditions.
- Special notes system is in place to enhance sensitive care at end of life.
- Palliative Care pharmacist pilot established.
- Liverpool Care Pathway Coordinator has been appointed jointly with Ardgowan Hospice and Inverclyde CHP.
- Palliative Care Registers have been established in GP practices.

What are our priorities 2009-2012?

- Run pilot for an 'Early Bird' integrated nursing and homecare service between 6am and 8am to achieve a 24/7 service, and deliver more effectively on the health and social care needs of those with palliative, terminal and long term conditions.
- Roll out the Liverpool Care Pathway across Inverclyde.
- Improve compliance with the Gold Standard Framework.
- Implement the Palliative Care Direct Enhanced Service (DES).
- Improve the non-malignant disease pathway.

Joint Community Care Plan

- Develop local pathways for palliative care.
- Link palliative care to the long term conditions agenda.
- Improve training and capacity to deal with palliative care needs in all staff groups, and with carers.

Why are these objectives important?

All services and agencies are committed to maximising dignity and respecting choice for our patients, clients and service users. The palliative care agenda is central to delivering the highest standards of care based on individual needs assessment at a time when sensitivity and responsiveness is needed most, regardless of where or by whom care is provided.

Joint Community Care Plan

Acronym Dictionary	
AAT	Alcohol Action Team
ACUMEN	Argyle and Clyde United in Mental Health
ASD	Autistic Spectrum Disorder
ASIST	Applied Suicide Intervention Skills Training
CHP	Community Health Partnership
DAT	Drug Action Team
DES	Direct Enhanced Service
FIP	Financial Inclusion Partnership
Go for IT	Project to improve the health and fitness of people with learning Disability
HIF	Health Improvement Fund
IADF	Inverclyde Alcohol and Drugs Forum
ICCF	Inverclyde Community Care Forum
ICIL	Inverclyde Centre for Independent Living
IoRN	Indicator of Relative Need
IRH	Inverclyde Royal Hospital
LAC	Local Area Co-ordination
LDSP	Local Data Sharing Partnership
LHS	Local Housing Strategy
MHP	Mental Health Partnership
PASS	Prevention and Support Service
PPF	Public Partnership Forum
PSFI	Public Service Improvement Framework
RAD	Rehabilitation and Assessment Directorate
SHIP	Strategic Housing Investment Plan
SOA	Single Outcome Agreement
SSA	Single Shared Assessment
SbB	Short Breaks Bureau
STUC	Scottish Trades Union Council
SWIA	Social Work Inspection Agency

Joint Community Care Plan

Monitoring

The priorities outlined within this plan will be implemented and monitored through the joint management and planning arrangements, which have been developed to facilitate the delivery of community care services locally.

Annual reviews of this plan will be published in order to ensure that stakeholders and the public are informed of the progress of key action.

Should you have any comments on this document, or on Community Care Services generally please contact:

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