

**Inverclyde Community Health and Care  
Partnership  
Development Plan Update**

**2011-2012**



**Final Draft Pending Committee Approval**

## 1. Introduction

### 1.1 Foreword

In the 21<sup>st</sup> century it is unacceptable that people should experience poorer health outcomes as a result of the social and economic circumstances that they have been born into. Such health inequalities start early in life and persist not only into old age but impact on subsequent generations. We recognise that some of our communities experience disproportionate levels of these poorer outcomes, and are therefore committed to working to find ways to prevent ill-health, protect good health and promote better health; all closely linked to quality of life and the concept of well being.

Scotland's three linked social policies jointly produced by the Scottish Government and COSLA - *Equally Well (2008)*, *Early Years Strategy (2008)* and *Achieving our Potential (2008)*, help us understand the underlying causes of health and social inequalities. The Scottish Government's policy and action plan on mental health *Towards a Mentally Flourishing Scotland 2009-11* is another key document which underpins our approach to addressing health inequalities and thereby securing a platform for improved outcomes in the future.

This update therefore not only reflects on progress on the commitments we made in our substantive plan, but also highlights the actions we will take during 2011/12. Our approach aims to capitalise on our strong Community Planning Partnership, *The Inverclyde Alliance*, and support an inclusive approach to tackling the underlying social and economic determinants of the poorer health outcomes described. As such the Council and Health Board through the Alliance have identified health inequalities as an area for priority action and established an Outcome Delivery Group through the SOA. This will require an interagency multi-faceted approach.

### 1.2 Background

The Inverclyde CHP Development Plan 2010 – 2013 was written in the context of the NHS partnership and was approved at the final CHP Committee on 6<sup>th</sup> October 2010. Since that date the process of formally establishing the Inverclyde Community Health and Care Partnership (CHCP) has been completed. The establishment of the CHCP was endorsed via Greater Glasgow and Clyde NHS Board on 17<sup>th</sup> August 2010 and by the full Inverclyde Council on 26<sup>th</sup> August 2010.

The Development Plan is designed to deliver our key priorities and objectives in relation to the NHS GG&C planning and policy frameworks and those of the Local Authority. Principally, this gives direction for the partnership's health and social work services contribution to strategic objectives in a co-ordinated way, and drives operations to deliver on the agreed outcomes for patients and service users, and to meet performance targets.

The principal objective of the Development Plan is to enable us to deliver high quality health and social care services; to act to improve the health of our population and to address the wider social determinants which cause health and social inequality.

The purpose of the Development Plan Update 2011/12 (hereafter referred to as Update 2011/12) is to; *report on progress and impact against previously identified actions and, using this progress as the new baseline, identify the type and extent of change planned for the coming year*" (NHS GG&C Planning Guidance October 2010).

### **1.3 Audience**

The intended audience of this update is NHS GG&C, Inverclyde Council, the CHCP Senior Management team and as a guide document to Services in creating their own more detailed service work plans. It would be expected that other stakeholders, such as staff, patients, service users and the wider community may refer to this document for links to key policies and updates on progress made.

The Development Plan and yearly updates are reported to NHS GG&C, and to Inverclyde Council, in addition to a business plan for the CHCP. Over time we will be able to streamline these different processes and harmonise reporting requirements of the two parent organisations.

The plans will contain consistent information presented in the required formats, reflecting the need for our staff to have a coherent narrative which they can follow, explicitly setting out the direction of travel for the CHCP and articulating their place within it. In addition, service users and our communities can expect a clear document in place which they can use as a guide to our vision, principles and intended outputs and outcomes. To this end we will reference other key publications in all our statutory plans. It is also our intention to provide a summary for wider use.

### **1.4 Process**

The process of developing the 2011/12 Update has been largely organic, using the December 2010 Organisational Performance Review (OPR) as a key reference point for defining our 2011/12 priorities. This as well as assessing performance against key targets provided a useful body of evidence which has been mapped to outcomes and actions in the 2011/12 Update.

There are a number of important action areas in the Update which reflect the position of the organisation – we are a new team with an organisational culture and climate which needs time to settle. There are obvious opportunities of potential redesign in creating improved services through the CHCP, however we must acknowledge the challenges in bringing together two organisations with differing cultures, groups of staff; a multiplicity of professional backgrounds; an array of service changes and a tough financial landscape.

In the medium term we hope to capitalise on the opportunities, but in the short term we must recognise that this context has had an impact on our ability to plan as creatively and with as much aspiration as would normally be the case. To some extent this limited our delivery against key actions in some areas. This is addressed in the 2011/12 Update, and the tone of the Update is very much one of consolidation.

## 2. Overview of progress made in previous year

### 2.1 Progress During 2010/11

#### CHCP as a whole:

1. Agreement of the Scheme of Establishment and Governance arrangements.
2. Formal establishment of the CHCP.
3. Agreed management structure with subsequent appointments
4. Creation of an integrated CHCP headquarters (Kirn House) and social work practice hub (Dalrymple House)

#### Health and Community Care

1. Consolidation of the Adult Support and Protection Committee, with an Independent Chair.
2. We successfully completed our local COPD telehealth pilot with successful outcomes.
3. Care commission inspection reports indicate high standard across all registered services for people with learning disabilities.

#### Children's Services

1. Child Protection . The HMle inspection of services to protect children has again reflected a very high level of performance within Inverclyde. Services were inspected across 6 themes and were evaluated to be excellent in one and very good in the remaining five.
2. Parenting Strategy: work is progressing positively in this area. A training plan has been developed and is being rolled out across Inverclyde. 39 staff have been involved in training and 20 have been allocated places on the selective seminar. A further 12 places have been allocated on 'teenager' training.
3. Breastfeeding. There has been a 1.6% increase in breastfeeding rates from our last reporting period (July 09 – June 10) taking our performance to 15.5 percent (at October 09 – September 10).

#### Criminal Justice

1. A new format for Social Enquiry Reports for Courts has been implemented.
2. Community Service was awarded the national APSE quality award for excellence in service community engagement and involvement.
3. The SEQ and action plan for high risk offenders together with the programme of the group provided in Inverclyde have been evaluated as among the best in the country.

#### Mental Health, Addictions and Homelessness

1. Agreement of a new, more efficient, service model for Homelessness Services based on case working
2. Opening of new integrated drugs, alcohol, community mental health and learning disabilities centres in the heart of Inverclyde (Greenock town centre)
3. Full implementation of the Primary Care Mental Health Workers service in all GP Practices

#### Planning, Health Improvement and Commissioning

1. Agreement on revised planning cycle to incorporate and streamline the previous processes of both former organisations.

- 2 Establishment of integrated performance reporting across primary healthcare and social work services, with a view to moving towards a joint OPR.
3. Harmonisation of budget processes and reporting formats, to set a working format that can be extrapolated across all CHCP budgets.

We have remained committed to gaining a more sophisticated understanding of the root causes of poor health, low healthy life expectancy and stark health inequalities that exist in Inverclyde. In 2010/11 a number of strands of work were brought to conclusion that link to this key aim.

- Following the Health & Wellbeing Survey, a population study was undertaken in mental health to help us better appreciate the scale of mental illness in our area and the extent to which co-morbidity and multiple disadvantage impacts on our communities.
- We undertook a survey of men who have sex with men who live or work in our area – Identifying feelings of isolation and social exclusion, as well as non use of barrier contraception which will be progressed through the Sexual Health Local Implementation Group (SHLIG).
- We concluded work across health and social care planning services to develop information profiles for each of our client area 'development' groups to inform and assist integrated thinking, decision making and service planning.

We have continued to deliver on our good track record in relation to inequalities and have increased the number of Equalities Impact Assessments that have been delivered. The detail is contained in our EQIA report.

In terms of quantitative performance the table below shows the current status for Inverclyde CHCP in respect of the NHS HEAT target.

#### HEAT Targets and Standards 2011/12

Target/standard	Inverclyde Performance
<b>Health Improvement</b>	
Achieve agreed completion rates for child healthy weight intervention programme over three years ending March 2014.	134 Consent forms returned Cumulative No of completers 9
Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines during 2011/12.	HEAT: 11 Practices opted in (68.8%) 1 Practice never returned (6.25%) 4 Practices didn't opt in (25%) Apr08 – Dec10 963 Target: 1324
Reduce suicide rate between 2002 and 2013 by 20%.	Percentage of staff trained: Dec10: 48% Target: NHS GGC Board target 50%
NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.  <b>Target yet to be set at CHP level.</b>	All SFS Services Dec 2010 – 331 (target: 369) Community Only Sept 2010 – 127 SIMD (Community Only): Jan-Dec2010 180 or 239 successful quits were from the 40% most deprived areas. (75.3%) Target: 60%

Target/standard	Inverclyde Performance
Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2011/12.	Jan11 - 149 Feb11 – 163  Target set at Board level only.
<b>Efficiency</b>	
NHS boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.	This is a GG&C Board Target
NHS boards to deliver a 3% efficiency saving to reinvest in frontline services.	This is a GG&C Board Target
NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.	This is a GG&C Board Target
<b>Access</b>	
From the quarter ending December 2011, 95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.	Board level only: 31 day target: 98.3% (target 89%) 62 day target: 95.9% (target 95%)
Deliver 18 weeks referral to treatment from 31 December 2011.	Data currently recorded separately as outpatient and inpatient / Day Case information
By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.	Sept10 – 94% Target: 86%
Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; and 18 weeks referral to treatment for Psychological Therapies from December 2014.	Dec10: Min Wait: 2 wks Max Wait: 51 wks AVG Wait: 25 wks Target: 0 children waiting more than 52 weeks from referral to treatment.
<b>Treatment</b>	
Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors.	As reported on Corp. Sharepoint (65+ only) Oct09-Sep10: total bed days 25342
To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.	No current data.
Further reduce healthcare associated infections so that by March 2013 NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are	Acute hospital target.

Target/standard	Inverclyde Performance
0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.	
To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14.	Dec10 – 3037 Target: 3242
<b>National Standards</b>	
NHS Boards to achieve a sickness absence rate of 4% from 31 March 2009.	Dec10 – 3.9% Target: 4%
No people will wait more than 6 weeks to be discharged from hospital into a more appropriate care setting.	Mar10 – 0 patients waiting more than 6 wks Target: 0
Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team	Nov10 – GP:94%, Nurse: 66%, GP or Nurse: 94% Local Target only: 98%
To respond to 75% of Category A calls within 8 minutes from April 2009 onwards across mainland Scotland (Scottish Ambulance Service).	SAS target
98% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.	NHSGG&C below target. November 2010. November 2010 figure 94.3%.
No patient will wait longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census).	December 2010 - Reported as no patient waiting longer than 12 weeks.
No patient will wait longer than 9 weeks for inpatient and day case treatment (measured on month end Census).	December 2010 – Reported no patient waiting longer than 9 weeks.
Maintain the number of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources.	Data noting dementia diagnosis (including care home practice) shows an achievement and maintenance of the target up to the report dated March 2010.

### 3. Planning Context

#### 3.1 Single Outcome Agreement (SOA)

At the highest level, Inverclyde CHCP is driven by priorities and actions from the Councils' Single Outcome Agreement in partnership through the Community Planning forum, **The Alliance Board**, and in particular the agreed eight priority outcomes for Inverclyde from these:

1. Inverclyde's population is stable with a good balance of socio-economic groups.
2. Communities are stronger, responsible and more able to identify, articulate and take action on their needs and aspirations to bring about an improvement in the quality of community life.
3. The area's economic regeneration is secured.
4. Economic activity in Inverclyde is increased and skills development enables both those in work and those furthest from the labour market to increase their potential.
5. The health of local people is improved, combating health inequality and promoting healthy lifestyles.
6. A positive culture change will have taken place in Inverclyde in attitudes to alcohol, resulting in fewer associated health problems, social problems and reduced crime rates.
7. All our young people will have the best possible start in life.
8. Inverclyde is a place where people want to live now whilst at the same time safeguarding the environment for future generations.

The CHCP has a role to play across the whole suite of SOA outcomes with importantly leadership from identified CHCP senior managers, as Lead Officers for two of the outcomes: Health Inequalities and Alcohol.

Alcohol is being driven through our Alcohol and Drugs Partnership, with further strategic underpinning through our Alcohol and Drugs Strategy (Inverclyde Alcohol and Drugs Partnership Strategy, 2010) which has been informed by the NHS GG&C Alcohol and Drugs planning framework.

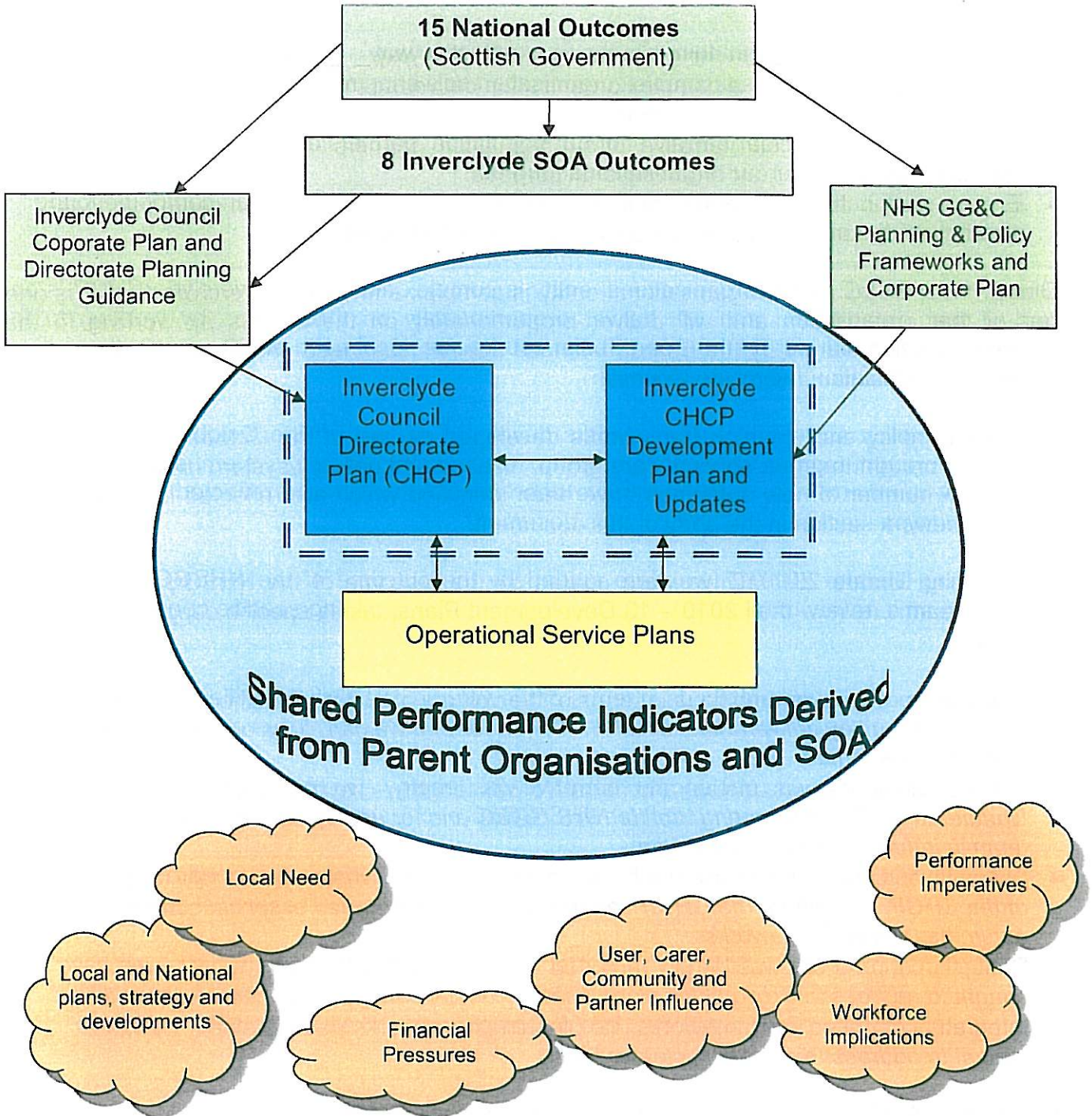
With regard to Health Inequalities it has been identified that Inverclyde is an area of poor health for which we require to develop clear and focussed activity for improvement. We have undertaken work to refine the actions related to the health inequalities outcome to ensure greater measurability of indicators and broader reach across the other SOA Outcome Delivery Groups. We also sought to link the SOA health inequalities outcome action more closely with the NHSGG&C health improvement policy framework.

We are in the process of refining our children and young people's services planning with the SOA outcome around Best Start in Life, the *GIRFEC* principles as key strategic pillars, again taking cognisance of the relevant NHSGG&C planning frameworks (children and young people/maternity).

Figure 2 below shows the CHCP planning architecture and describes in pictorial form where the CHCP Development Plan sits. The diagram is not exhaustive of all our planning and policy events, drivers or products.



Figure 2 Planning Architecture



### 3.3 NHS GG&C Planning/Policy Frameworks

The 2010 – 2013 NHS GG&C Planning Guidance confirmed that effective planning was the means for us to deliver on the Board’s mission statement to “*deliver effective and high quality health services, to act to improve the health of our population and to do everything we can do reduce health inequalities*” and specifically to:

- Address the substantial financial, health improvement and inequalities challenges which we face.
- Ensure that we do the right things in the most effective way.
- Create coherence across a complex organisation delivering millions of individual transactions in a vast range of settings.
- Have a credible and clear narrative for our population, partners and government on how we are intending to deliver our organisational purpose.
- Engage staff in the development of that narrative to ensure that they can contribute to the direction of the organisation and the services in which they work.

Clearly NHS GG&C as an organisational entity is complex and vast – Inverclyde CHCP is one part of that organisation and will deliver proportionately on these aims by working to the strategic direction set out by the Board, balanced against local need and the aspirations of our co-parent organisation Inverclyde Council.

The twelve policy and planning frameworks developed as part of the October 2010 Planning Guidance, brought together service, care group, disease and delivery system issues have been revised. A number of new outcomes have been identified which are reflected in the tables at each Framework section in the body of this document.

In producing Update 2011/12 we were guided by the outcome of the NHSGG&C Corporate Planning team's review of all 2010 – 13 Development Plans, taking specific cognisance of the following:

- Plans were often over ambitious in terms of the volume of activity identified – *we will streamline out key deliverables for 2011/12 in order that we can focus on output and improved outcomes*
- Intended audience was unclear and narrative was lengthy – *we have clearly stated that Update 2011/12 is a reporting tool for NHS GG&C and for use by our senior management team in informing local prioritisation.*
- Essential actions were not universally taken into account – *where appropriate to the context of the CHCP, and where the CHCP can deliver we have included essential actions as set out in the revised frameworks*
- Reflection of progress was largely recorded as actions rather than as impact – *we have sought to address this by making clear what the actual change we expect to see will be.*
- Integration of the policy frameworks into planning frameworks was variable – *we have sought to address this, making clearer links*

### **3.4 Inverclyde Council Directorate Planning Guidance 2010/11**

Inverclyde CHCP is subject, as an operating directorate of Inverclyde Council, to the Council's corporate planning guidance and is required to produce a yearly Directorate Plan in a consistent format with the other Council Corporate Directorates. In common with the NHS planning guidance the Directorate Plan is required to clearly identify strategic objectives for the year and set out the programme of actions required to deliver the set objectives. The directorate plan is intended to:

- Assist accountability to Elected Members.
- Articulate a sense of direction.
- Determine and clarify priorities to be delivered.
- Align planning to resource management.
- Secure political approval and support for programmes and actions.
- Assist in managing and improving service delivery.

The CHCP is governed, in addition to the strategic aims of the NHS GG&C Board, by the Council's corporate vision in terms of how we operate, behave and interact with the public:

- We will be confident and ambitious.
- We will be respectful, caring and trustworthy.
- We will be open, honest and accountable.
- We will listen, engage and respond.
- We will be a supportive and caring employer.
- We will strive for excellence in all we do.

The CHCP is central to the delivery of the 'Healthy and Caring Communities' strategic outcome of Inverclyde Council (one of the Council's 5 key outcomes).

### **3.5 CHCP Key Priorities**

As part of the early development of the new enhanced partnership the CHCP requires to establish a culture, structure and profile which assimilate with the Health Board and Council. A period of settling in is required for the CHCP against a backdrop of capitalising on the positive momentum created by the establishment of the CHCP.

At this stage the CHCP focus is on operational and logistical pressures to ensure that the delivery of frontline services is maintained at a time of change for staff. Work has begun with Heads of Service and Service Managers to determine the actions to be taken to bring about effective change. The 'Embedding the CHCP – Action Plan' (December 2010) has been devised following a number of development sessions involving the SMT and Extended Management Group between October 2010 and January 2011.

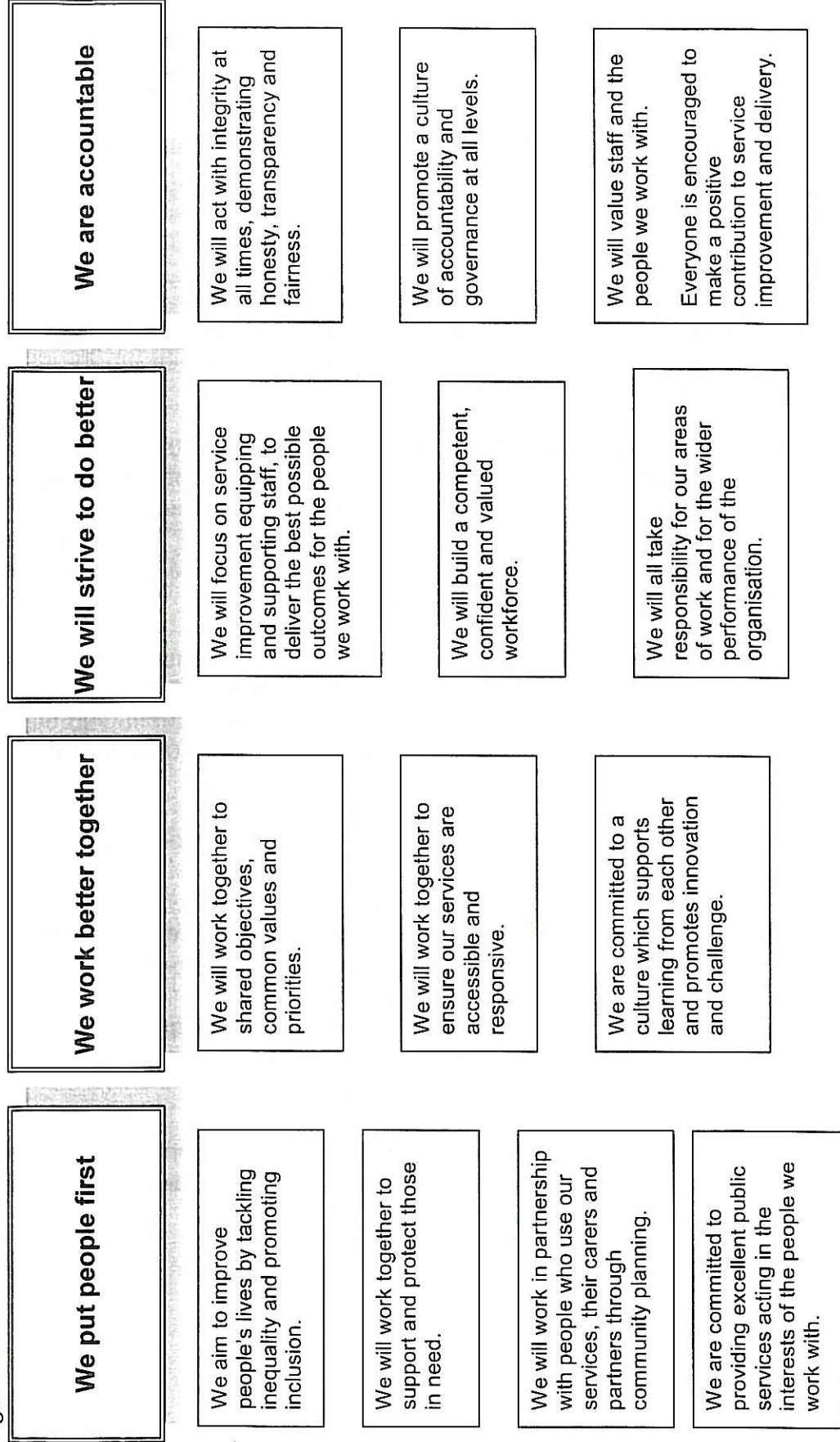
We have develop the mission statement of the CHCP, and we are communicating the key principles for operation with staff and our communities. This work is gaining momentum and will inform our actions and direction as we move forward – in essence it is about bringing together the Social Work principles and the NHS GG&C Transformational Themes (shown in figure 3 below).

The CHP Development Plan 2010 – 2013 reflected the following specific priorities which remain relevant to us as a CHCP:

- Reduce health inequalities
- Improve performance
- Understand our customers/patients
- Manage the impact of demographic change
- Manage our finance
- Influence key stakeholders and partners
- Plan how we develop as a new organisation
- Plan how the SMT develops as a team
- Improve information systems
- Engage with staff

Our core objectives and principles are consistent and provide a firm foundation for the agreed set of values for the CHCP – figure 4 below shows the principles and values developed for the CHCP.

Figure 4



### 3.6 The economic climate and impact on our planning context

Given the economic climate and its associated cost pressures for the public sector it seems prudent to focus on consolidating good practice; focusing on improving quality through efficiency, and reducing waste rather than looking to develop new cost-hungry initiatives. We must achieve our savings targets across the CHCP, which will comprise our share of NHS savings for the Board, as well as our share of Social Work savings for Inverclyde Council.

However we must also take account of, and respond to, particular key local factors. The Inverclyde job market is particularly dependent on the public sector, and the private sector has relatively few good quality jobs with career pathways or even regular contracted hours. The James Watt College published its Inverclyde Skills Survey (2010) indicating that around 65% of local companies had either paid off employees or had stopped recruiting. Alongside this, Inverclyde residents have a higher than average reliance on benefits as outlined below.

Headline	Inverclyde	Scotland
JSA Claimant Count	5%	3.8%
Incapacity Benefit	13%	9%
Economic Inactivity	23.9%	20.4%
Unemployment Rate	9%	6.6%
Employment Rate	71%	73.9%
% of population in 15% most deprived datazones	36%	15%

Source: Employability Case Study 2: Inverclyde Council Integrated Employability Programme

With job losses in both sectors, and an already high reliance on benefits, families are experiencing additional pressures that can impact on both physical and mental health. This could be further compounded by the welfare reform programme that will see reduction in income for many of our poorest families, and ultimately lead to an increase in demand for Primary Care and community health and social care services.

## 4. Effective Organisation

### 4.1 Organisational Development Approach to Embedding the CHCP

To become an effective organisation and continue our progress toward the integration of health and social work in a manner which best reflects the aspirations of the CHCP, the Board and Council the following key priorities were identified:

- Develop a vision and set of values for the CHCP. The senior management team and extended management group developed these initially, and they have been refined through consultation with staff and services. The final version will be launched and shared with staff and stakeholders.
- Open and transparent communication has been a key priority with communication processes being reviewed. The team brief system has been widened to ensure it encompasses all staff working for the CHCP. The newsletter will be used to help all staff understand the role and function of different service areas and access to council and health board communication systems will be utilised.
- Four staff engagement events were held to promote ownership and to engage staff to in the development of the CHCP. Staff were encouraged to participate and to offer their opinions on how the CHCP will manage change across all service areas. This included options to deliver better outcomes for the people of Inverclyde as well as developing a better understanding of each other's roles functions.

- Opportunities have been taken to work with the newly established CHCP committee to develop their understanding of the CHCP as well as their role and responsibilities.
- Development sessions have been held within the newly integrated service areas to further develop the necessary infrastructure to support the CHCP.

To continue to progress the establishment of the CHCP and to secure ownership throughout the organisation we will seek to bring added value in how we do things, rather than just a change in established systems, processes and structures from the predecessor organisations

The key to achieving these changes is to secure ownership throughout the organisation and by being able to identify what is necessary to make it succeed. Every part of the organisation influences, directly or indirectly, every other part and as such we must take a whole system approach by anticipating the impact that change in one area will have on another.

## **5. Finance and Workforce**

### **5.1 Financial Year 2010/11**

The CHCP revenue budget is £110.5m with a projected underspend of £0.3m being 0.25% of the total budget. The Capital budget is £0.9m and will be spent in full.

### **5.2 Financial Year 2011/12**

The indicative revenue budget for the CHCP for 2011/12 is £108.1m inclusive of savings targets of £2.1 million to be achieved through a number of initiatives whilst minimising the impact on front line services.

- The Inverclyde Council Social Work budget is £48.2 including a savings target of £1.7m being 3.6% of the net total budget.
- The NHSGG&C budget is £59.8m including a savings target of £0.4m being 0.6% of the net total budget, however excluding Family Health Services, Prescribing and Resource Transfer the saving to be made from the remaining budget represents a 3% target.
- The establishment of the CHCP has resulted in Management Structure and Accommodation savings of £0.4m.
- In 2011/12 additional resources of £1.2 million will come from the Government's Change Fund initiative, on a non recurring basis, to facilitate the reshaping of services for older people.
- The confirmed Capital Funding for 2011/12 is £1.4m for existing Social Work projects with minimal funding anticipated from NHSGG&C.

All of these factors, in conjunction with economic and demographic pressures, will provide significant challenges during financial year 2011/12.

### **5.3 Workforce Issues**

The CHCP is fully committed to working with its staff to developing a workforce within Inverclyde which can effectively deliver high quality services to the population it serves. Bringing two separately governed workforce sectors together will be challenging, however the interface between workforce and finance enables both costs and savings opportunities to be addressed.

A main area for development will be the establishment of a Service level Agreement between health and Council HR to provide a more integrated approach to HR for all staff located within the CHCP.

Staff review and appraisal will be maintained through existing organisational systems i.e. KSF for health and the Staff Appraisal System for Council staff. The latter will be implemented in April 2011.

#### **5.4 Attendance Management**

The CHCP continues to focus on improving attendance management and further training for NHS managers and team leaders has been carried out as well as updates on the use of the standard Attendance Management Toolkit. Training includes a focus on the Work Life Balance Policy and the 2010 Staff Survey indicated that Inverclyde performed well in this with a 30% increase in the number of staff responding positively to the question on flexibility at work.

Training will also be implemented to meet the challenges across service areas relating to the integration of staff and will include managers from both host organisations. This will facilitate fuller understanding of the differing conditions of service and absence management targets. It is anticipated that this later issue will become a single target for the CHCP.

Monthly absence reports are provided to the SMT and to all managers for action and discussion with staff generally to keep a high profile for attendance management, and with individuals where attendance targets have been met. In December 2010 absence levels, for health staff, fell to a very healthy 3.92%, meeting the 4% HEAT standard, and placing the CHCP in the best performing position for that month across Partnerships. In January 2011, sickness absence levels rose to 5.13%. Whilst disappointing, analysis indicated that this was due entirely to short-term sickness absence linked to seasonal illnesses.

Absence for social work staff is recorded on a quarterly basis – the latest data for the quarter ended 31 December 2010 indicated that sickness absence levels were at 7.12%. The Inverclyde Council target level for sickness absence is 5%. This level of absence is higher than previous quarters, and again is attributed to seasonal sickness.

Actions will include continuing training as required, working with managers to promote effective practice and exploring the potential for innovative ways to support staff back to work from long-term sickness absence. Work has also commenced on developing guidance for managers which covers both the NHS GGC and Inverclyde Council attendance management policies and processes, and exploring the opportunities for shared paperwork.

#### **5.5 KSF and Appraisals**

During the course of the year significant progress was made towards ensuring that all NHS-employed staff were engaged in the KSF review cycle including annual reviews and personal development plans (PDPs), and ensuring that all staff had access to computers. This was monitored quarterly with reports going to SMT and being circulated to managers. Problems were identified where staff had lost details of user names and passwords and support was provided to remedy this. During March 2011 over 60% of reviews have been completed on the eKSF system and work is continuing to achieve as close to the 80% HEAT target as possible.

Particularly good progress was identified within District Nursing resulting in this being written up as an example of good practice. This was presented at the GGC KSF Leads Conference in December 2010 and has since been added to the national KSF web-site for all staff to access across the UK.

Our plans for 2011 are to ensure KSF and the Council's Appraisal system are effectively embedded within the CHCP. This will include continued monitoring, a focus on all staff – regardless of their employing body - taking ownership of their own PDPs and progressing these with their manager's support, and training for social care managers in the KSF system which is planned for May 2011.

Inverclyde Council is currently rolling out a competency-based approach to staff appraisals. This will apply to social care staff within the CHCP, with CHCP managers and team leaders already covered by the scheme since June 2010. All remaining staff will be covered by the scheme from April 2011. The appraisal arrangements include an annual performance appraisal and the development of personal

development plans or performance improvement plans. As the scheme is in its infancy, progress will be monitored.

There are many similarities in the above approaches and work will be carried out to determine the scope for joining up some processes.

## **5.6 Partnership Working**

During 2011 with the establishment of the CHCP, a new Staff Partnership Forum was very quickly put in place and its constitution, remit, a communication plan and membership agreed reflecting the integration of health and social care services and staff within the CHCP. The SPF has an agreed work plan with a number of work streams identified to address workforce issues including support of change and redesign, joint workforce planning, joint staff training and development and performance management. The largest work stream is the development of joint protocols covering terms and conditions, practical working arrangements, health and safety and where/if appropriate, joint policies.

The SPF is co-chaired by the CHCP Director and a Unison staff representative.

## **5.7 Staff Governance**

The NHS Staff Governance Standard has been discussed at SPF and it was agreed that this would be adopted across the CHCP, applying to Inverclyde Council as well as NHS staff. A Staff Governance Action Plan was agreed for 2010-11 and this will be monitored early in 2011-12. The results of the 2010 NHS Staff Survey were also reported to SPF with an analysis reflecting the local responses. Inverclyde staff were amongst the highest responders with almost 85% of staff participating. Indeed Inverclyde also featured in 17 of the highest performing clusters with some very positive results. Although this reflected NHS staff views only, SPF will address this when reviewing the results of the Staff Governance monitoring exercise in order to agree the 2011-12 Joint Staff Governance Action Plan.

## **5.8 Change and Redesign**

Inverclyde has taken forward a significant amount of redesign over the last year with changes in Mental Health, Addictions and Children and Families services as well as the development of integrated working across the CHCP. A review of administrative services has commenced with any proposed changes being implemented in 2011-12. In addition the CHCP is participating in the system-wide redesigns of community based AHP services and both the CAMHS and Paediatric frameworks. The establishment of the Rehabilitation and Enablement service has also moved towards implementation in May 2011. Change Fund monies will also be available to consider the redesign of services for older people, and a local Steering Group is being established to take this forward.

## **5.9 Workforce Planning**

Discussions about workforce planning within the context of the CHCP have commenced and will be progressed during 2011-12 reflecting both health and social care staff and services.

## **5.10 Staff Development**

This remains a priority. There has been significant development activity during the course of the year with NHS staff responses in the 2010 NHS Staff Survey showing positive results in the 'appropriately trained' section with appearances in the highest performing clusters on 5 occasions. Discussions with Inverclyde Council have been initiated to identify ways to take staff development forward cost-effectively, minimising any duplication in delivery. During 2011-12 a CHCP Development Group is planned to oversee staff development as well as OD initiatives to support the CHCP development and a positive and empowering culture.

## **5.11 Healthy Working Lives**

Inverclyde Council currently holds the Gold award, whilst Inverclyde CHP (as was) achieved the Bronze award in 2010. However it was agreed that the newly formed CHCP would work towards the Silver award with the support of the wider Council so that the CHCP can learn from the experiences of working through Silver and Gold programmes. Taking this approach, we believe that the HWL programme will not only support the health and wellbeing of all CHCP staff, including their mental wellbeing, but will hopefully aid team building across integrated services. The HWL group is a sub-group of APF and recently launched their programme for Silver.



#### 4. Planning Frameworks

- 1.1 **Acute Services:** During 2010/11, we have made considerable progress in improving communication and information flows between Acute Services and Primary Care. Key areas of work have included the development of an improved system for notification of deaths which is currently being piloted with one of our GP practices; working with Acute Services to ensure that our plans to reshape care for older people include the development of anticipatory care; and detailed analysis of alcohol-related presentations to A & E with a view to streamlining referral pathways to specialist alcohol services.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
2010/11 Services provided meet national access targets	We will work with colleagues in the Acute Sector to support the delivery of the 18 week RTT	We participate the 18 week RTT both in terms of awareness raising within community, and via several of the working groups.	Improve the management of GP to hospital referrals through better use of technology resulting in quicker and safer referral processes for patients.	HEAT re SCT refs
2010/11 Improved management of GP to hospital referrals through better use of technology resulting in a quicker and safer referral process for patients.	By the end of year 1, electronic referrals from GPs will have been increased in respect of Inverclyde Patients	GP referrals to secondary care are increasingly managed via SCI gateway. Clinical performance as at December 2010 is 90.85%. We are working with colleagues in other divisions to ensure data relating to this measure are accurate. There has been disparity between locally recorded and centrally reported data which we are pursuing.		
2011/12 Improved access and engagement with services.				
2011/12 Modernise services				
2010/11 Acute Services provided based on systematic review of demand on services	By the end of year 1 we will have developed routine access to acute sector management information to help us understand demand and usage patterns so that we can identify what will have the biggest impact on improving the primary/secondary care interface for our patients and for the NHS system as a whole. In particular, we will have achieved a much better understanding about how actions in primary care affect	The year one action is not yet complete but is being progressed on a system-wide basis as part of the remit of the Corporate Strategic Information Group.	Once system wide routine information has been agreed, 2011/12 will use the outputs of that work to identify the key relationships and interdependencies, and the key demand areas.	4. Key demand areas identified 5. Streamlining opportunities identified
2011/12 Improve secondary care interface with Primary Care and other parties.			<b>OPR Action – Delayed Discharges, continually review progress and processes to improve</b>	6. Maintenance of the Delayed Discharges standard of 0 delays over 6 weeks.

<p>2010/11 Efficient and economic services</p> <p>2011/12 Improve resource utilisation.</p>	<p>secondary care and vice versa.</p> <p>Develop a comprehensive approach to demand management with CHCRs</p> <p>By the end of year 1 we will have developed routine access to acute sector management information electronically where possible, to help us understand demand and usage patterns.</p>	<p>Work is being done with our local Acute/Primary Care Interface Group. We will be bringing management information into the next meeting of this group, based on directorate activity focussing on RAD, A&amp;E and medical specialities.</p>	<p>We will use interface intelligence to streamline patients, transitions between acute, primary and community health and social care services.</p>	<ul style="list-style-type: none"> <li>• Key demand areas identified</li> <li>• Patient pathways mapped</li> <li>• Local improvement targets for LOS developed</li> </ul>
<p>2010/11 There are agreed benchmarking, efficiency and effectiveness measures for Acute Services which demonstrate productivity and value for money</p> <p>2011/12 Improve resource utilisation.</p>	<p>Length of stay reduced by improving patient flows and improving discharge planning.</p> <p>DNA rate reduced.</p> <p>By the end of year 1 we will have actively contributed to the wider NHSGGC system's work to develop a means of monitoring effective implementation of the Hospital Discharge Protocol.</p> <p>By the end of year 1 we will have defined and reinforced the primary care role in encouraging attendance.</p>	<p>In relation to hospital discharge, work is underway regarding communication of deaths in hospital to primary care and vice versa. We are piloting this with one practice with a view to rolling out.</p> <p>Attention is being paid to inaccurately completed discharge paperwork. It has been decided these inaccuracies will be handled as an incident to facilitate improvement.</p> <p>We have undertaken work to begin scoping the level of DNAs in AHP services. We have been raising awareness of DNAs through our PPF – particularly in relation to information giving about the 18 week RTT.</p>	<p>Beyond year 1 we will undertake an in-depth analysis of the relationships between DNAs in primary and secondary care.</p> <p>We will complete the notification of Death pilot commenced in year 1.</p> <p>We will establish a process of having discussion of incidents related to hospital discharge and maximise learning.</p>	<ul style="list-style-type: none"> <li>• Pilot evaluation complete. We will establish systems to report DNAs across a range of key services</li> <li>• DNA reports established.</li> <li>• Incident reports and improvement plan process in place.</li> </ul>
<p>2010/11 There is whole system consideration of resources and how they shift as the balance of care changes.</p> <p>2011/12 Shift the Balance of Care.</p>	<p>Work with partners to consider how we shift the balance of care including the resource implications.</p> <p>By the end of year 1 we will have scoped the longer term implications of our changing</p>	<p>We have progressed work around the shifting the balance of care programme, and are utilising the change fund with a focus on re-aligned and anticipatory care as part of reshaping care for older people.</p>	<p>We will develop a commissioning strategy to support the redesign of services for older people.</p>	<p>Commissioning strategy agreed in place, and associated action plan developed.</p>

<p>demography, and considered potentially feasible options where services and their resources might be transferred from secondary care to primary care.</p>	<p>2010/11 Reduced admissions to Acute Hospitals and reduced bed days.</p> <p>2011/12 Shift the Balance of Care.</p> <p>Improve Health</p> <p>Improve secondary care interface with primary care and other parties.</p>	<p>Reduced rates of admission and bed days for patients with a primary diagnosis of COPD, Asthma, Diabetes or Heart Disease.</p> <p>By the end of year 1, Fast Track input to multi-disciplinary diabetes consultant clinic will be fully developed.</p> <p>Care pathways between primary and secondary care are planned and designed in partnership with agreed feedback arrangements about utilisation and appropriateness.</p> <p>By the end of year 1 we will have developed routine access to acute sector management information.</p> <p>Appropriate multi-agency arrangements in place to support vulnerable children, adults and their families/carers.</p> <p>By the end of year 1 we will have established Inverclyde CHCP</p>	<p>Discharge rated per 100,000 population as at Oct 09 – Sept 10</p> <p>COPD – 571.0 (increase)</p> <p>Asthma – 158.3 (decrease)</p> <p>Diabetes – 192.0 (increase)</p> <p>CHD - 1133.3 (increase)</p> <p>This action is complete.</p> <p>This workstream is being progressed on a system-wide basis as part of the remit of the Corporate Strategic Information Group.</p> <p>Inverclyde CHCP has been operational since 1<sup>st</sup> October 2010 and headquarters were established housing the new management team on 5<sup>th</sup> January 2011.</p> <p>This workstream is being progressed on a system-wide basis as part of the remit of the Corporate Strategic Information Group.</p>	<p>Develop a process to ensure that anticipatory care plans are developed and implemented as soon as possible.</p> <p>In 2011/12 we will further develop this service making use of telehealth to facilitate the treatment of diabetic foot ulceration.</p> <p>Work with secondary care to help them to provide the full range of secondary care service required by primary care in the time line and model required.</p> <p>Continue to build on the good foundations for the CHCP and work to increase the partnerships' reach into secondary care and with community/voluntary sector</p> <p>Consolidate our local arrangements for adult support and protection.</p> <p>We will maximise involvement of key local fora to develop anticipatory care and the older people's commissioning strategy.</p>	<p>Local LOS target</p> <p>Improved community services through reshaping care for older people.</p> <p>Number of new anticipatory care plans agreed.</p> <p>Fast track service referral rates endorsed service expansion.</p> <p>Key demand areas identified</p> <p>Patient pathways mapped.</p> <ul style="list-style-type: none"> <li>Regular CHCP Committee meetings.</li> <li>Adult support and protection steering group and Committee established.</li> <li>Number of new anticipatory care plans agreed.</li> </ul>
<p>2010/11 Integrated Health and Social care and Support for People in need and at risk.</p> <p>2011/12 Improved secondary care interface with primary care and other parties.</p>	<p>2010/11 Patients treated in the right place by the right person.</p>	<p>2010/11 Integrated Health and Social care and Support for People in need and at risk.</p> <p>2011/12 Improved secondary care interface with primary care and other parties.</p>	<p>2010/11 Integrated Health and Social care and Support for People in need and at risk.</p> <p>2011/12 Improved secondary care interface with primary care and other parties.</p>	<p>2010/11 Integrated Health and Social care and Support for People in need and at risk.</p> <p>2011/12 Improved secondary care interface with primary care and other parties.</p>	<p>2010/11 Integrated Health and Social care and Support for People in need and at risk.</p> <p>2011/12 Improved secondary care interface with primary care and other parties.</p>

<p>2011/12 Modernise services</p>	<p>CH(C)Ps including:</p> <ul style="list-style-type: none"> <li>- managing demand;</li> <li>- population health;</li> <li>- quality of care;</li> <li>- levers and incentives for change;</li> </ul> <p>using evidence and effective models and lessons from other systems.</p> <p>By the end of year 1 we will have developed routine access to acute sector management information.</p>	<p>We have moved forward positively with improved local communication between planning and secondary care via our GP - Consultant forum and acute/CHCP interface group. This has been supported by our Clinical Improvement Group.</p> <p>Awareness raised through acute/CHCP liaison group; clinical improvement group; GP forum and PEG.</p>	<p>Commissioning strategy agreed and in place, and associated action plan developed.</p>
<p>2010/11 Where patients require referral or intervention from secondary care there are clear routes and agreed criteria with primary care.</p> <p>2011/12 Improved secondary care interface with primary care and other parties.</p>	<p>Develop effective information flows and relationships between primary and secondary care including joint agreement on thresholds for access and referral; clinical engagement on redesign and RTT.</p> <p>By the end of year 1 we will have developed routine access to acute sector management information and local communication pathways to ensure that GP reps on care pathway groups can feed back to the whole of primary care.</p> <p>By the end of year 1 we will have contributed to a system-wide process to improve:</p> <ul style="list-style-type: none"> <li>- the communication of discharge information</li> <li>- medicine management across the transfer of care between primary and secondary care</li> <li>- access to investigations</li> </ul> <p>a process to ensure more effective dialogue between acute and primary care clinicians, in particular in relation to the</p>	<p>Engagement achieved via GP forum, clinical governance group and PEG.</p>	<p>Determine responsibilities shared between primary and secondary care.</p> <p>Develop criteria for community health and social care services.</p>
<p>2010/11 There are agreed, effective and timely information flows between primary and secondary care in the most appropriate format.</p> <p>2011/12 Improved secondary care interface with primary care and other parties.</p>	<p>Our Acute/Primary Care interface group continue to meet. We are aware of and await the outcome of the electronic discharge pilot at RAH.</p>		<ul style="list-style-type: none"> <li>• Key responsibilities identify and improvement actions agreed.</li> <li>• Criteria developed for high demand services.</li> </ul>

<p>2010/11 The mutual interdependence between primary and secondary care is recognised and planned for.</p> <p>2011/12 Improved secondary care interface with primary care and other parties.</p> <p>Improved health.</p>	<p>redesign of patient pathways</p> <p>Ensure short term delivery of specific improvements to acute and primary care interface specifically.</p> <p>CH(C)Ps to develop stronger response within primary care on issues placing significant demand on secondary care, e.g., emergency activity, alcohol.</p> <p>By the end of year 1 we will have developed routine access to acute sector management information that will enable us to form a stronger response to acute sector pressures, through having a clearer understanding of what these pressures are, and what actions taken by primary care might help reduce these pressures.</p>	<p>We have undertaken significant work in relation to alcohol related presentation and admissions, making use of SPARRA data. There has been active consultation with GP/Consultant Forum on this work.</p> <p>Routine access to acute sector information is improving via our acute sector interface group.</p> <p>The CHCP actively responds to pressures as and when they arise (e.g. winter pressures)</p>	<p>We will strengthen the establishment of routine referral to alcohol services to repeat presenters at A&amp;E related to alcohol. We will support opportunities for further use of SPARRA</p> <p>In 2011/12 we will secure an agreed way forward for accessing acute sector information (e.g. in relation to unscheduled and routine referrals)</p>	<p>Improved actions developed and agreed as a result of the SPARRA work implementation.</p> <p>Regular reports in place and utilised effectively.</p>
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**Financial Update**

There do not appear to be any financial implications with regards to Enhanced Services or Quality and Outcomes Framework in Inverclyde CHCP.

**Workforce Implications**

The shrinking population of Inverclyde has meant that 2 smaller practices have amalgamated with larger ones over recent years. This ongoing trend may mean further amalgamations or non-replacement of leaving or retiring GP Principals. However this may be offset by the increasing health demands of an ageing population. Should this happen there may be a small impact on practice ancillary staff numbers.

1.2 **Adult Mental Health:** The Primary Care Mental Health Workers are now in post with support to all Inverclyde GP Practices, and we have undertaken a Population Complexity Analysis to help us understand how and where demand for mental health services emerges.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
<p>2010/11 Delivery of care on a timely basis in the right settings, and which focuses on recovery.</p> <p>2011/12 Delivery of effective treatment care and support.</p> <p>2011/12 Efficient and effective deployment of resources to sustain the capacity of service to respond during a period of reducing budgets.</p>	<p>By the end of year 1 we will have Completed the 2010/11 actions of the Ravenscraig Retraction Plan (full closure to be achieved by end of financial year 2012/13).</p> <ul style="list-style-type: none"> <li>- Achieved benchmark bed numbers for adult mental health.</li> <li>- Transferred the IPCU beds from Dykebar to Inverclyde.</li> <li>- Move mental health, addictions into new premises.</li> </ul> <p>By the end of year 1 we will have Completed the 2010/11 actions of the Ravenscraig Retraction Plan (full closure to be achieved by October 2012).</p>	<p>Primary Care Mental Health Workers (PCHMW) are in place in all our GP Practices.</p> <p>We have fully integrated our Older People's Mental Health Service into our Community Mental Health Team (where there is now no upper age limit).</p> <p>We are progressing well with the development of our extended response service, with implementation plan due for completion as planned on 01.04.11 with implementation by 31.03.12.</p> <p>We are working closely with staff-side colleagues in respect of changing working practices etc.</p> <p>Good progress is being made – in the case of our inpatient redesign, benchmarking work has been done with the intended outcome on course to be realised with the introduction of our Partnerships Beds implementation. Ravenscraig Hospital will fully close, as planned in the 4<sup>th</sup> Quarter of 2012.</p>	<p>Specifics –</p> <ul style="list-style-type: none"> <li>• Kempock – secure a partner provider and begin reprovision process.</li> <li>• Extended response service and extended hours of all elements of the extended response service for mental health will be established.</li> </ul>	<ul style="list-style-type: none"> <li>• Kempock action plan on track</li> <li>• All elements of the extended response service in place.</li> <li>• Improved access demonstrated through service activity data</li> </ul>

<p>Develop proposals for sustainable service delivery of service models</p> <ul style="list-style-type: none"> <li>- Undertake preparatory work in respect of the determination of pathways and measurement criteria for ensuring timely access to psychological therapies in advance of the introduction of the HEAT Target in 2011</li> <li>- Review of PCMH models, data audit and patient pathway modelling</li> <li>- Harmonisation of resources/materials</li> </ul> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- A system in place to report waiting and activity across all tiers.</li> <li>- A system in place to compare activity in SIMD regarding antidepressants.</li> <li>- A process in place for the use of appropriate QOF data for GP activity in relation to diagnosis and referral to PCMH-T.</li> </ul> <p>A process in place to monitor referrals into employability and financial inclusion services.</p> <p>We will Continue to strengthen the community mental health services through shifting the balance of care and redesign from hospital based services to community based services</p>	<p>The Local Action Plan for the framework for a Psychologically Minded NHS is developed for primary care.</p> <p>Data collection system in development.</p> <p>Data being collated on paper based system</p> <p>Working group set up to review and analysis activity and impact.</p> <p>The design of the integrated Out of Hours service with inpatient services in development.</p>	<p>Complete, development implement system during 2011/12.</p> <p>Development of the caseload complexity benchmark for CMHT.</p> <p>Collected sign posting data.</p> <p>Complete the design and draw up implementation. Put in place training.</p>	
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<p>2010/11 Efficient and effective deployment of resources to sustain the capacity of services to respond during a period of reducing budgets.</p>	<p>Clyde CHPs ensure achievement of benchmark levels of bed use consistent with Clyde Strategy</p> <p>By the end of year 1 we will have benchmarked inpatient bed numbers as per the Modernising Clyde Mental Health Services and benchmark activity levels against Greater Glasgow.</p> <p>CHCPs ensure rebalancing of local NHS and social care infrastructure to optimise its effectiveness.</p> <p>By the end of year 1 we will have reviewed our local mental health services and developed plans for reconfiguration.</p> <p>Review of community services to ensure deployment of resource inputs are focussed and targeted efficiently and effectively to maximise health outcomes for patients.</p> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>• Completed an analysis of population complexity in relation to people with mental health needs, and to inform service priorities</li> <li>• Improved access times to services</li> <li>• Implemented PCMH service to all GP Practices</li> <li>• Audited the PCMH service implementation.</li> </ul>	<p>Operating at benchmark bed levels for adult mental health in SSPU &amp; IPCU</p>	<p>Implement the relocation of IPCU, SSPU, adult mental health day hospital and Milan Suite in December 2011 to IRH.</p>	<p>Progress reports submitted to CHCP Committee</p> <p>Antidepressant prescribing rates and referrals to PCMHs</p> <p>Report and findings shared across Heads of Mental Health; CHCP; ADP; Alliance Board.</p> <p>ABI target data</p>
<p>Mental health service redesign proposals completed in respect of adult and older people's mental health services</p>	<p>Complete the ADDD patient review conducted by GPs to ensure ongoing good practice.</p>	<p>Population Complexity analysis complete.</p>	<p>Fully implement redesign proposals and report to CHCP Committee.</p> <p><b>OPR Action</b> – assess the impact on antidepressant prescribing rates of GP direct access to Primary Care Mental Health Service</p> <p><b>OPR Action</b> – report on findings and share practice around review of 200 psychosis patients</p> <p><b>OPR Action</b> - Bring ABI activity back on track towards achievement of the target set</p>	<p>Antidepressant prescribing rates and referrals to PCMHs</p> <p>Report and findings shared across Heads of Mental Health; CHCP; ADP; Alliance Board.</p> <p>ABI target data</p>
<p>Completed.</p> <p>Arrangements set up.</p>	<p>Completed.</p> <p>Arrangements set up.</p>	<p>Completed.</p> <p>Arrangements set up.</p>	<p>Completed.</p> <p>Arrangements set up.</p>	<p>Completed.</p> <p>Arrangements set up.</p>



		<ul style="list-style-type: none"> <li>Monitored referrals to PCMHIT from GPs.</li> <li>Implemented ABI training mental health team</li> </ul>	<p>Arrangements set up.</p> <p>Training programmes agreed.</p>	<p>Training implemented and monitoring roll out specification for specialist services.</p> <p>Implement action plans and monitor progress against key actions.</p>	
<p>2010/11 Improving the quality of life for those who have a mental health problem</p> <p>2011/12 Improve the mental health and wellbeing of the population addressing health inequalities.</p>	<p>Development and implementation of local Mental Health Improvement action plans consistent with the forthcoming Mental Health Improvement Framework</p> <p>By the end of year 1 we will have developed as part of Inverclyde CHCP development, local actions consistent with Mental Health Improvement Framework</p>	<p>Development of cross-cutting Commission / Care pathways arrangements for mental health; addictions and homelessness for specialist services with interface arrangements for primary care and acute.</p> <p>A local event is planned for 15.03.11 to further develop the implementation of Towards a Flourishing Inverclyde.</p> <p>Roll out training to all social work staff and care groups.</p> <p>50% of NHS employed staff achieved by April 2011.</p> <p>As part of the establishment process for the CHCP, we have extended the current choose life post to develop a wider remit for mental health improvement.</p> <p>Framework for CHCP agreed.</p> <p>We have progressed work to look in a structured way at performance data related to mental health.</p>	<p>Development of cross-cutting Commission / Care pathways arrangements for mental health; addictions and homelessness for specialist services with interface arrangements for primary care and acute.</p> <p>A local event is planned for 15.03.11 to further develop the implementation of Towards a Flourishing Inverclyde.</p>	<p>Complete and implement Psychological Therapies Action Plan.</p> <p><b>OPR Action</b> – conclude review of antidepressant prescribing and act on findings.</p>	<p>Action plan in place. Progress made.</p>
<p>2010/11 Improved promotion of mental health and well-being through wider Partnership working.</p>	<p>Continued implementation of planned programme of training to ensure that key frontline staff in mental health and substance misuse services, are trained in using suicide assessment/suicide prevention training programmes.</p> <p>By the end of year 1 at least 50% of appropriate staff will be trained in using suicide assessment/ suicide prevention training programmes.</p>	<p>Roll out training to all social work staff and care groups.</p> <p>50% of NHS employed staff achieved by April 2011.</p> <p>As part of the establishment process for the CHCP, we have extended the current choose life post to develop a wider remit for mental health improvement.</p> <p>Framework for CHCP agreed.</p> <p>We have progressed work to look in a structured way at performance data related to mental health.</p>	<p>Achieve 21 day access targets for specialised drug and alcohol services</p> <p>50% of appropriate staff will be trained in using suicide ass. Etc.</p>	<p>Targets achieved</p> <ul style="list-style-type: none"> <li>The target achieved locally is 52% and there is to be further maintenance standard still to be developed by SG, which is due to be published by end of March 2011.</li> <li>Targets achieved.</li> </ul>	
<p>2010/11 Strengthened approaches to prevention of mental illness</p>	<p>Implement the Inverclyde Psychologically Minded NHS Action Plan</p> <p>By the end of year 1:</p> <ul style="list-style-type: none"> <li>Waiting times for psychological therapy services will be</li> </ul>	<p>Framework for CHCP agreed.</p> <p>We have progressed work to look in a structured way at performance data related to mental health.</p>	<p>Complete and implement Psychological Therapies Action Plan.</p> <p><b>OPR Action</b> – conclude review of antidepressant prescribing and act on findings.</p>	<p>Compliance with national targets HEAT and development of local plans to implement the psychological therapies waiting list target.</p> <p>Former HEAT target reports on</p>	

	<p>reduced.</p> <ul style="list-style-type: none"> <li>- We will have a system in place to produce routine reports that describe local antidepressant and antipsychotics prescribing patterns.</li> <li>- We will have taken measures to actively foster a more psychologically minded CHCP, both within and beyond specialist mental health provision, through the development and implementation of a local Psychological Therapies action plan.</li> </ul>	<p>Psychology waiting data will form part of a routine mental health performance report being put in place. Additional capacity in psychology has been brought in and will have an impact of psychology waiting times, as well as a new approach to discharge reviews and referral management being implemented.</p> <p>IT practices and processes to be secured. Ensure data accuracy.</p> <p>Key role for Primary Care Mental Health Workers.</p>	<p>Development of the PCMH-T team to contribute to individual and group psychological therapies.</p>	<p>Antidepressant Prescribing</p> <p>Local action plans developed and implemented consistent with the framework.</p>
<p>2010/11 Strengthened approaches to prevention of mental illness.</p>	<p>Contribute to the implementation of Towards a Mentally Flourishing Scotland by taking a population health approach to improving mental wellbeing</p>	<p>Further develop the local Suicide Prevention Action Plan through Choose Life Inverclyde and associated funding to partnership projects and initiatives/</p>	<ul style="list-style-type: none"> <li>• Implement action plans and monitor progress against key actions.</li> <li>• Support the Choose Life Inverclyde Core Implementation Group overseeing the local suicide prevention action plan.</li> <li>• Devise and implement appropriate performance management/ measurements for intended outcomes for well-being improvement outcomes.</li> <li>• Contribute and respond to the national developments pertaining to mental health</li> </ul>	<ul style="list-style-type: none"> <li>• Progress reports, including outputs data</li> <li>• Number of people trained in suicide prevention workshops</li> </ul>

	<p>Review and develop care pathways for people with dementia to include early diagnosis.</p> <p>By the end of year 1:</p> <ul style="list-style-type: none"> <li>- We will have reviewed care pathways for people with dementia to include early diagnosis.</li> </ul> <p>We will have undertaken a training needs analysis within the first 6 months of establishment of the CHCP, to include the impact on services of release of staff.</p>	<p>Strengthen opportunities for day activities (work, leisure, training, education, volunteering) for people with enduring mental health problems by working with Condition Management Programme to develop care pathways</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Reviewed referral and care pathways with the Condition Management Programme.</li> </ul>	<p>Review of care pathways for Dementia complete. Evaluation of post diagnosis support project completed and informed development of future model for OPMH Dementia Care</p>	<p>improvement in taking a local population approach to improving mental wellbeing.</p>	<p>Number of people with dementia etc. accessing support, including CHCP financial inclusion service</p>
		<p>We are reviewing all the activities of a local commissioned provider and assessing the needs of all the individuals using the service with a view to redesigning more appropriately to meet needs.</p> <p>In older people's service we are reviewing our day hospital facilities with a view to redesigning.</p> <p>The condition management programme has been disbanded as part of the wider cost savings work, however we are working with the community planning partnership to develop routes into employability for people with enduring mental health problems.</p>	<p>Commission the most appropriate local service.</p> <p>We will undertake a review of adult mental health day hospital and plan a redesign.</p> <p>Establish a model for future provision of specialist mental health day services in partnership with wider older peoples services, and third sector providers.</p>	<p>Establish the early intervention and support service for people with dementia and their carers.</p> <p>The action links to our Reshaping Care for Older People change delivery plan.</p>		<p>New service model commissioned.</p> <p>Review complete.</p> <p>Model established.</p> <p>Clear path into employability services established.</p>
			<p>By the end of year 2 we will have established routes into</p>			

	<p>- Reviewed the mental health day services provision - ongoing (older people and adults).</p>	<p>This action has been carried forward to year 2.</p>	<p>employability. Establish model for future provision of specialist mental health day services in partnership with wider older peoples services, and the third sector.</p>	<p>Review complete and new mode identified.</p>
<p><b>Financial Update</b> Undertaking a major skill mix review of both community and inpatient services with a view to creating a single mental health service system that will offer more continuity of services and more effective use of investment.</p> <p>Implementation of the Inpatient review proposals and exploration of further related options for achieving cost effective delivery of inpatient services. Our top priority remains to close Ravenscraig Hospital by March 2013 and replace with high quality local services.</p>				
<p><b>Workforce Implications</b> Retaining skill mix Secondment opportunities.</p>				

1.3 **Alcohol and Drugs:** Specialist Alcohol Workers are now co-located in the new, purpose-built premises at Wellpark, and Specialist Drug Workers are co-located in the remodelled premises at Cathcart Street, enabling us to provide more accessible and coherent services to some of our most vulnerable populations. The services have clearer vision and direction due to the completion and ratification of the new Inverclyde Alcohol & Drugs Strategy which was formally agreed in October 2010.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
<p>2010/11 Deliver care in the right settings</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Identified opportunities for further integration and co-location of teams and services.</li> </ul> <ul style="list-style-type: none"> <li>- Reviewed the FSF funding situation and developed an action plan to respond to any changes.</li> <li>- Made ABI training available to non specialist addiction staff.</li> </ul>	<p>We have successfully co-located Specialist Alcohol Teams in our purpose built Wellpark Centre. Similarly, Cathcart Centre has been completely remodelled to house our new integrated Community Drugs Team, in the heart of Greenock town centre. Services users have further benefited from the development of single points of access and a drive to increase the management of methadone provision by GPs supported by community pharmacists.</p> <p>We have reviewed all our FSF funded workstreams and will seek continuation of relevant strands via the new/launch of funding available.</p> <p>We are undertaking addictions awareness work in schools via our FSF Funded Youth Alcohol Team. Our Health Improvement and Inequalities team have been working closely with the FSF funded Alcohol Culture Change team.</p> <p>We have 11 out of 16 practices</p>	<p>Further development and embedding of the integrated service model and care pathway.</p> <p>Commission services in respect of formerly FSF funded programmes via new tendering/commissioning arrangements.</p> <p>Rolling out ABI training across all specialist services (mental health, learning disabilities, homelessness and drug services) alongside non-specialist addictions staff.</p> <p>Work closely with GPs to support and encourage them to see the benefit of ABI's</p>	<p>Number of FAST screenings</p> <p>Number of ABI's delivered</p> <p>FSF tender KPIs.</p>

<p>2010/11 Deliver better care through early intervention</p>	<p>Local Alcohol and Drug Strategies incorporate 12 core elements of the NHSGGC Prevention and Education (health improvement) model.</p>	<p>participating in the ABI LES – we continue to work with practices to increase the number of ABIs undertaken but respect local practice to target ABIs at the right people. In the case of non-HEAT ABIs we have recording issues which we are working to address – poor recording is masking a growing practice of undertaking ABIs.</p>	<p>The new Inverclyde Alcohol and Drugs Strategy was signed off by the Alcohol and Drugs Partnership in October 2010. The Strategy includes the core elements of the Prevention and Education model and discussions are ongoing as to how this work will be taken forward in Inverclyde with support from the Board's Mental Health Partnership.</p>	<p>Further implementation of the framework. Needs assessment completed. User friendly version in place.</p>
<p>2010/11 Focus on the most vulnerable people</p>	<p>Substance misuse services address unmet need and barriers to access through a range of targeted services.</p> <p>By the end of year 1:</p> <ul style="list-style-type: none"> <li>- 75% of new referrals to specialist drug and alcohol services will have been seen within 21 days of the referral being made.</li> <li>- We will have developed a local implementation and training plan to deliver sensitive inquiry training in GBV for specialist addictions staff.</li> </ul>	<p>At Sept 2010 94% of new referrals to specialist drug and alcohol services were seen within 21 days</p> <p>This action has not been progressed in the addictions services in year 1, we have prioritised Health Visiting</p>	<p>During year 2 we will continue to implement the prevention and education framework, based on the completion of a needs assessment.</p> <p>Launch the user friendly version of the ADP Strategy in April 2011..</p> <p>By March 2013, 90% of new referrals to specialist drug and alcohol services will have been seen within 21 days of the referral being made</p> <p>We will work to maintain this positive performance.</p> <p>We will build GBV awareness raising training into induction for new staff and through PDP's for existing staff.</p>	<ul style="list-style-type: none"> <li>• Proportion of new referrals seen within 21 days of referral.</li> <li>• % age of specialist addictions staff trained in sensitive GBV inquiry.</li> </ul>
<p>2010/11 Focus on the most vulnerable people</p>	<p>Participate in the ADSM/SMA High Risk Offenders follow-up of</p>	<p>We have completed a supported self evaluation with SMA on high</p>	<p>If year 1 action completed it should inform year 2 action.</p>	

<p>2010/11 Focus on the most vulnerable people</p>	<p>the thematic inspection</p> <p>By the end of year 1 we will have undertaken a case file audit and completed the supported self-evaluation tool in partnership with SWIA</p>	<p>risk offenders and this has been peer reviewed by East Renfrewshire CJSW. This included undertaking a file audit with SWIA inspector. An improvement plan has been developed and will be discussed at a further session with SWIA in February 2011. This will then be implemented and reviewed on an annual basis. An annual audit of high risk offenders case files will also be undertaken, including Prison Based and Community Criminal Justice files.</p>	<p>During 2011/12 we will implement the actions from the MAPPA Business Plan.</p>	<p>Key indicators from MAPPA</p>
<p>2010/11 Prevent ill health</p>	<p>Agree arrangements that will enable all MAPPA agencies to measure and audit performance</p> <p>By the end of year 1 we will have developed a MAPPA Business Plan.</p>	<p>The first NSCJA MAPPA Business Plan was agreed in September 2010 which ensures all aspects of the Scottish MAPPA guidance are being progressed. This includes initiating a Quality Assurance sub-group where the focus will be on developing a quality assurance framework, agreeing performance management information and providing regular reports of these to the NSCJA MAPPA Strategic Oversight Group.</p> <p>Our Alcohol and Drugs Strategy has been produced and signed off by the ADP Executive Group</p>	<p>Implement the local implementation plan.</p> <p>Launch public version.</p>	<ul style="list-style-type: none"> <li>• Number of staff trained.</li> <li>• Number of ABI's undertaken.</li> </ul> <p>Public version of ADP Strategy in place.</p>
<p>2010/11 Improve Access</p>	<p>Local Alcohol and Drug Strategies developed and implemented as per a local action plan.</p> <p>By the end of year 1 the ADP will have developed a local Implementation Plan, including detailed proposals of the number of CHCP staff who will be trained in Alcohol Brief Intervention.</p> <p>Clear care pathways in place (and audited) between community-based services and specialist/acute services.</p>	<p>Care pathways around how people are admitted to secondary care are being developed, in line with the development of service</p>	<p>We will develop systems to monitor access of Inverlyde patients to specialist bed as well as community based services, and</p>	<ul style="list-style-type: none"> <li>• Systems developed</li> <li>• Numbers of patients accessing services as a population to</li> </ul>

	By the end of year 1 we will have contributed to the system wide work to produce a consistent methodology across all CH(C)Ps.	specifications for drugs and alcohol service improvements. Dedicated beds are in place for alcohol on the Gartnavel site with admission via the Inverclyde-based consultant for Inverclyde patients. Service specifications have been subject to EQIA and are almost complete. We are building in routine plans for auditing the use of the specialist beds and movement of patients between primary and secondary care.	movement between the two. We will finalise the care pathways for interface between community and acute specialist services.	referrals and specialist service caseloads.
2010/11 Improve services	Substance misuse services operate with an integrated multi-disciplinary workforce model	Workforce integration has begun as a result of physical co-location of teams.	Further development and embedding of the integrated service model and care pathway.	Multi-disciplinary workforce model in place. Integrated service model and care pathways in place.
2010/11 Strengthen initiatives aimed at promoting cultural change and attitudes to alcohol.	By the end of year 1, the ADP will have scoped options for change.	Executive Group of the ADP is now the ODG for alcohol as part of our SOA sub-structure, with a key focus on addressing culture issue and awareness raising.	We will implement the contractual and deliver arrangements of new FSF funded work in 2011/12  We will strengthen our relationship with the local licensing forum to bring to their attention ADP priorities in relation to the health implications of alcohol misuse.  No further action in 2011/12	Key measures referenced within Fairer Scotland contractual arrangements.
2010/11 Finalise re-provision of Wellpark Centre for Alcohol Services and refurbishment of Cathcart House for Community Drug Team and the Integrated Learning Disability Team.	By the end of year 1, the re-provision programme will have been completed.	We have completed the build, refurbishment programme and co-location of relevant staff teams.		
<b>Financial Update</b>				
We have confirmed investment in 2011/12 to progress the ADP priorities.				
<b>Workforce Implications</b>				
We still have work to be done in developing the specialist nurse lead role in addictions, but now have a largely settled team.				



1.4 **Cancer:** Work with our SOA partners has secured agreement for the development of the new Greenock bus station as a smoke-free area. We are also progressing well with the implementation of Liverpool Care Pathway, and we will be continuing our emphasis with local communities on the importance of taking up screening opportunities, particularly in relation to breast, bowel and cervical cancer screening.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
<p>2010/11 The incidence of cancer among the population is reduced through primary prevention, including:</p> <ul style="list-style-type: none"> <li>- Improved public awareness of cancer risk</li> <li>- Improved population lifestyles, i.e. improved diet, increased exercise, reduced alcohol intake and smoking</li> </ul> <p>2011/12 Cancer health inequalities between deprived and non-deprived population are identified and reduced.</p>	<p>By the end of year 1 we will:</p> <ul style="list-style-type: none"> <li>- Be able to evidence that we have locally promoted national cancer awareness programmes</li> <li>- Be able to evidence that we have continued to prioritise smoke free services, and made efforts to identify funding to increase our current capacity from 1.7WTE to 2.5WTE</li> <li>- Increased uptake rates for HPV, bowel, breast and cervical cancer screening.</li> <li>- Be able to evidence that we have worked with Inverclyde Alliance to promote a smoke-free culture</li> </ul> <p>By the end of year 1 we will:</p> <ul style="list-style-type: none"> <li>- Have contributed to a reduction in the numbers of people at risk from cancer by reducing the numbers of people who smoke.</li> </ul> <p>Have provided support to families who are living with the consequences of a confirmed diagnosis.</p>	<p>Promotional materials widely distributed amongst CHCP staff, PPF and Local Voluntary Organisations.</p> <p>Our efforts to increase smoking cessation have been less successful than we would have wished, but we are working with the Board to develop more detailed intelligence on the efficacy of different approaches currently on offer.</p> <p>We have made good progress through our SOA Health Inequalities Outcome Delivery Plan in respect of achieving agreement for developing the new Greenock bus station as a smoke free area. The latest ScotPHO profile data reports Inverclyde smoking has reduced to 25%.</p>	<p><b>OPR Action</b> – await provision of more detailed demographic data re bowel cancer screening from the Board and analyse to ensure efficient coverage of target group</p> <p><b>OPR Action</b> – await more current data on breast screening to ensure an inequalities sensitive approach to update/ local promotion</p> <p>Move forward plans via the HIODG re a Smoke Free Greenock Bus Station.</p> <p>We will work with Macmillan, Marie Curie Cancer Care and the British Heart Foundation Cancer to sustain their financial support work with a view to rolling out this model in respect of people with chronic heart failure, and other long term conditions.</p>	<p>Bowel, breast and cervical cancer screening uptake rates. HEAT H6 Smoking HPV uptake rates and 3 cancer screening rates</p> <p>HEAT H6 Smoking</p> <p>Referrals to Welfare Rights and Financial Fitness.</p>

<p>2010/11 Patients with cancer have equity of access and improved access to services in the right place at the right time:</p> <p>2011/12 Patients with cancer experience high quality service which are safe, effective and efficient.</p>	<p>Continue to develop electronic systems to support service delivery/local and regional services: SCI Gateway to improve vetting of referrals, e.g. eTriage, eTertiary referrals and inter-hospital referrals.</p> <p>By the end of year 1 we will have worked with the NHSGGC Board to develop robust information-sharing with primary care from all of the specialities involved.</p>	<p>Work has been undertaken on an individual patient basis to ensure good robust communication between tertiary, secondary and primary care.</p>	<p>We will continue with the year 1 actions in this area.</p>	<ul style="list-style-type: none"> <li>• Available datasets</li> <li>• Identification of data groups</li> <li>• Streamlining of patient data duplications</li> </ul>
<p>2010/11 Patients with cancer have equity of access and improved access to services in the right place at the right time:</p>	<p>Develop relationships with voluntary and charitable organisations, e.g. Cancer Charities, support Groups, Cancer Coalition to support patients at home and preventing unnecessary hospital admission/readmission</p> <p>Deliver cancer access and waiting times targets</p> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Worked with Independent Contractors to identify the intelligence that should be shared from specialist services to primary care to help prevent unnecessary hospital admission/readmission.</li> </ul> <p>Improved patient information through ensuring availability in various formats.</p>	<p>The Council is currently reviewing how it engages with the third sector, and this workstream will need to be consistent with the Council's agreed approach (once agreement achieved). This workstream has therefore been deferred pending completion of the Council's review.</p> <p>This work needs to build on the system-wide review of intelligence, so has been deferred until that review has been completed.</p>	<p>Support the Inverclyde Council review of working with third sector organisations.</p> <p>In 2011/12 we will work with independent contractors to build on the outcome of the system-wide review of intelligence re specialist services and primary care in relation to cancer.</p>	<p>Review completed</p> <ul style="list-style-type: none"> <li>• Anticipatory care plans developed</li> <li>• Delayed Discharge standard maintained.</li> </ul>
<p>2010/11 Patients with cancer have improved access to palliative care at the right time and in the right</p>	<p>Deliver generalist and specialist palliative care when and where required, including</p>	<p>Local work to implement the Liverpool Care Pathway is progressing well with buy in across</p>	<p>By March 2012 we will have implemented the first year's actions of the Inverclyde Palliative</p>	<p>Actions completed from Inverclyde Palliative Care Action Plan</p>

<p>setting, and that meet or surpass the national standards:</p>	<ul style="list-style-type: none"> <li>- Establish diagnosing 'dying' and communicate this appropriately</li> <li>- Deliver better end of life care through Liverpool Care in all care settings and roll out through established NHSGGC plan</li> <li>- Address Symptom relief in all care settings:</li> <li>- GGC symptom relief algorithms when approved to be rolled out to all care settings and equitable care provided across patient pathways specifically including OOH</li> <li>- Improve access to psychological, social, emotional and spiritual needs across all care settings with partners in providing palliative care</li> <li>- Ensure 24 hour support through Community nursing, Home care and other services such as equipment to support people as near to home for as long as possible</li> <li>- Support all staff through appropriate training to support patients who are dying and their carers through communication and competency in providing good quality care including pain management in all care settings</li> </ul>	<p>GP practices and the majority of local care homes.</p> <p>Inverlyde Palliative Care Planning and Implementation Group is well established and functioning well. All aspects of this action are being addressed through the Inverlyde Palliative Care Action Plan.</p> <p>Redesign of Ardgowan Day Hospice services will allow for improved access to non-clinical interventions re palliative care (e.g. spiritual and psychological care). In addition Ardgowan Hospice is now plugged in to our community based services pathway for referral of clients to services such as Money Matters and Live Active. The Lead Consultant from Ardgowan Hospice has taken up our invitation to participate in the local GP/Consultant Forum.</p> <p>CPD input from Macmillan for independent contractors is being planned for early 2011.</p>	<p>Care Action Plan, encompassing all of the relevant actions identified through the cancer framework.</p> <p>Encompass all elements of cancer framework outcome 4 actions). (Reflects the content and intended direction of the palliative and end of life care direction statement.)</p> <p>Our local Lead GP for the LCP will undertake a joint session with GP/Consultant Forum on the LCP and DNACPR issues</p>
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**Financial Update**

Risks to sustaining the welfare rights and financial inclusion support for people with terminal cancer and their carers, due to Macmillan funding ending.

**Workforce Implications**

Staff currently delivering welfare rights and financial inclusion may have to be redeployed

1.5 **Children and Young People and Maternity Services:** Following the Child Protection Inspection we have now developed and agreed a Child Protection Medical Protocol. SNIPS continues to function well and has achieved national recognition, and UNICEF Baby Friendly Accreditation stage 2 has been achieved.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
<p>2010/11 We will Improve the lives of the most vulnerable children.</p> <p>2011/12 Service planning will be improved through the development and use of better information and intelligence.</p>	<p>By the end of year 1 we will have: Worked with the Children's SOA Outcome Delivery Group to try to identify resources to enable the 'Healthier, Wealthier Children' Action Plan work to continue beyond 2011 to alleviate child poverty.</p>	<p>Due to major Council re-organisation the lead for the children's SOA ODG has been vacant for some months. This role has now been filled by the Corporate Director for Education, and work will be progressed during 2011/12.</p>	<p>We will review our Children's Services Planning arrangements to better reflect the new planning context and more closely reflect the SOA</p> <ul style="list-style-type: none"> <li>• Progress the Healthier Wealthier Children's agenda.</li> <li>• Identify CPP opportunities to reduce child poverty.</li> <li>• Work with drugs and alcohol and mental health services to develop closer links and shared understanding re identification of the needs of vulnerable children and families.</li> <li>• Improve IT access and systems to promote reports and record keeping in line with Board-wide work and local actions.</li> <li>• Improve access and provision for travelling families.</li> <li>• Implement the Healthy Child programme and develop ante natal provision for teenage parents.</li> <li>• Staff engagement re Board wide audit of work of Health Visitors.</li> </ul>	<p>Integrated Children and Young People Services Plan in place, a relevant strategic planning forum operational.</p> <p>Improve multi professional service working re vulnerable children and families.</p> <p>CHFT establish effective links with Health and Homeless action groups.</p> <p>Briefing sessions and audit have taken place.</p>

	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Further improved our performance in relation to Child Protection.</li> <li>- Responded to areas of improvement identified by HMI Inspection and significant case reviews.</li> <li>- Worked with Maternity Services to develop means of ensuring that information sharing across the ante natal and post natal periods enables identification of potentially vulnerable women and children.</li> </ul>	<p>Areas for improvement identified by HMIe report in 2005 have been addressed e.g. Child Protection medical protocol is agreed. Further work is to be carried out in training of GPs.</p> <p>SNIPS continues to function well and has achieved national recognition. In 2010/11 254 women have been referred to SNIPS.</p>	<ul style="list-style-type: none"> <li>• Workforce planning re Health Visiting service, particularly in relation to identifying capacity for parenting agenda and the additional 30 month universal contact will be completed</li> <li>• We will complete our local parts of the Review of School Nurse Service.</li> <li>• We will organise Team development days to promote integration of children's services and development of integrated work plan for children's services.</li> <li>• We will begin Peer professional shadowing.</li> <li>• Further development of IAF Framework to incorporate Pre-Birth assessments, Social Background Reports and Young Carers Assessments.</li> </ul>	<p>Workforce planning completed</p> <p>Review complete in line with Boe d.</p> <p>Workplan is in place.</p> <p>Increased knowledge across professionals.</p> <p>Number of IAFs completed</p> <p>Re-established local planning links with maternity services and local within SOA planning structure.</p> <p>Development days have taken place by August 2011.</p>
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<p>2011/12</p> <p>Service design is targeted at vulnerable women and their families to reduce the health inequalities gap between deprived and non deprived populations.</p> <p>There are improvements in the health of women, children and young people and the promotion of parental confidence.</p> <p>Women, children and families have equitable access to services.</p>	<p>Implementation of HALL4.</p> <p>Increase breastfeeding at 6 weeks.</p> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- an action plan in response to HMIE Integrated Inspection of Children's Services, and established quarterly/ annual reporting on LAAC. We will implement measures from the Quality Improvement Framework and output from the Participation Strategy.</li> </ul> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Worked more closely with the fostering and adoption team to develop a plan to address health needs of children in kinship arrangements or looked after at home.</li> <li>- Scoped the detail and potential costs of establishing community supports to enable children currently in residential care outwith Inverclyde to be returned to their local community.</li> <li>- A revised financial framework established.</li> </ul>	<p>Fully implemented, all families have allocated HPI codes.</p> <ul style="list-style-type: none"> <li>• UNICEF Baby Friendly accreditation stage 2 achieved.</li> <li>• Peer support workers in place.</li> </ul> <p>An action plan has been developed and implemented</p>	<p>include CAMHS.</p> <ul style="list-style-type: none"> <li>• Introduction and development of practitioner forum across children's services.</li> </ul> <p><b>OPR Action</b> – review MMR 24 month uptake rates to identify the reasons for the recent downturn in performance which has previously been consistent</p> <p>Achieve UNICEF Baby Friendly accreditation stage 3.</p> <p>Implement GG&amp;C Children and Family Community Nursing standards Core Audit Schedule.</p> <p>Subsequent HMIE inspection has been conducted. An updated improvement plan will be produced based on inspection findings.</p> <p>Continue to consolidate LAAC nurse role.</p>	<p>Forums are up and running.</p> <p>MMR 24 month rates</p> <p>Stage 3 achieved</p> <p>Audits will be completed, results tracked for improvements over time. Each CFHT will produce an improvement plan with respect to each cycle of audit.</p> <p>Revised action plan in place</p> <p>Number of nurse-led assessments have increased provision to foster care households.</p> <p>Increase the number of Level 4 carers who can take children and young people with significant additional needs (target for 2011 is 1 new Level 4 carer)</p>
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<p>Implementation of the Adoption and Children (Scotland) Act 2007.</p>	<ul style="list-style-type: none"> <li>- Established a revised approval process for kinship care.</li> <li>- Increased the number of foster care placements.</li> <li>- Increased the number of respite foster care placements.</li> <li>- Implemented national regulation and guidance in respect of new legislation.</li> </ul> <p>By the end of year 1 we will have completed the implementation of the Integrated Assessment Framework (IAF) and have worked with the wider system to develop an electronic solution for Inverclyde.</p>	<p>This has not been progressed in 2010/11 and will be covered. This has been delivered. There were 30 foster places available in 2010, and are 36 available for 2011.</p> <p>We now have 5 respite carers approved. We are working on revising policy, practice and procedures to ensure they are compliant with the new Regulations and Guidance that are associated with the legislation.</p>	<p>Establishment of an approved kinship cares panel and ensure effective representation (including nursing).</p> <p>We will develop Family Ties, kinship support group and aim to get kinship carers more involved in the running of the group</p> <p>New policy and procedures in place</p> <p><b>OPR Action</b> - Conclude work to agree an electronic solution for sharing IAFs</p> <p>We will scope the potential for an IT system in place in assessing children's needs to reduce duplication of assessment</p> <p>Consolidate practice around new legislation. Deliver and implement adoption and permanency procedures in line with above.</p>	<p>New approval process in place.</p> <p>Family Ties developed Increase the number of Inverclyde Foster Carers so that there is a choice of placement when a child becomes looked after in foster care (target for 2011/12 is 3 carers)</p> <p>Numbers of Electronic IAFs completed</p> <p>Adoption activity fully compliant with revised legislation.</p>
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<p>2010/11 We will improve the lives of the most vulnerable children.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Fully established our children and family teams.</li> <li>- Developed an interim plan to shift the focus of child and family teams to 0-19 age range provision.</li> </ul>	<p>Child and Family Health teams are fully established.</p> <p>An interim plan has been developed and is being discussed.</p>	<p>We await the outcome of NHS GC&amp;C review of School Nursing remit.</p> <p>Clinical supervision established</p> <p>Await results of evaluation by GCU include clinical supervision within core audit framework.</p>	<p>3 teams fully established. Currently developing health improvement, parenting (Triple P) and baby massage and geographical delivery models via teams.</p>
<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Developed a local implementation and training plan to deliver sensitive routine inquiry in GBV for Health Visitors.</li> <li>- Reviewed our CCN model in light of the Board redesign.</li> <li>- Developed a model of practice for children with ASN in mainstream school.</li> </ul>	<p>The roll out of this training was delayed due to other processes linked to Triple P training.</p> <p>This has been developed centrally based on local submission of numbers to be trained. We have identified Health Visitors as our key local group to be trained. Managers who will be supporting staff who will be undertaking routine enquiry have participated in briefing sessions.</p> <p>Redesign ongoing and Inverclyde participating in development meetings and consultation. Nurse in place now to develop SNS to mainstream schools link established between school service, Skylark and CCN team.</p> <p>Phase 1 – Planning for replacement Redholm granted. Building on schedule.</p> <p>Community engagement re design and planning concluded successfully.</p>	<p>Training will be delivered by central Violence Against Women Team. (see health improvement section)</p> <p>Continue to engage in the Board redesign plans and identify resource implications for redesign care pathways within acute.</p> <p>Explore a revised working model for the SN in mainstream schools in partnership with community paed and education services.</p> <p>We will open the replacement for the Redholm Children's Unit in March 2014.</p>	<p>Training delivered</p> <p>Board redesign complete and local actions implemented.</p> <p>Revised working model agreed.</p> <p>New unit open and operational.</p>	



<p>To 2010/11 the care of children and young people is planned and delivered through a collective approach across NHS GGC.</p> <p>2010/11 Children and families will have improved access to services that are equitable and appropriate</p>	<p>engagement.</p> <ul style="list-style-type: none"> <li>- Complete tender process.</li> <li>- Construction underway</li> </ul> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Reviewed Speech and Language Therapy and implemented a triage system to achieve an 8 week referral to triage and 10 week triage to assessment / treatment. Stage 1 pre-referral will increase to 10% by April 2011</li> <li>- Identified gaps in service provision for children with chronic /complex needs.</li> <li>- Mapped care pathways for children with complexity through work with the acute sector and partner agencies through MCN work.</li> <li>- Scoped future redesign options to ensure sustainability of services in the context of changing demography and a reducing population of children and young people. While balancing this with an increase in work with vulnerable young people, child protection and increases in number of children with additional needs.</li> <li>- Progressed smarter working between acute and community services by participating in the operational discharge planning group.</li> </ul>	<p>SLT review is ongoing within GGC. Care aims approach implemented.</p> <p>8 week RTT achieved 18 week RTT achieved All staff trained in care aims.</p> <p>We identified that our main gap is that there is limited respite care available for under 5s</p> <p>Communication with Yorkhill re children admitted to RHSC Shared care with RHSC could improve services for patients.</p> <p>Care pathways implemented for children with specialist health needs - SPRUN - Sleep Scotland</p>	<p>Continue to work towards the 10% KPI target for stage 1/ pre-referrals, recognising that this is a challenge as we are currently at 5%</p> <p>Implement skill mix in SLT as opportunity presents.</p> <p>Monitor impact of RAM allocated.</p> <p>Quantify extent of gaps in provision and impact.</p> <p>Streamline paedics service and identify referral route pathways between acute and school nursing.</p> <p>Support robust information sharing by working within national guidelines and with clinical networks to meet national standards for conditions/ treatment.</p> <p>Work with managed clinical networks to ensure equity of service and improved information in fields:</p> <ul style="list-style-type: none"> <li>- exceptional healthcare needs</li> <li>- Rheumatology</li> <li>- Gastroenterology</li> <li>- Epilepsy</li> <li>- Renal/ Urology</li> </ul>	<p>KPI target 10% achieved.</p> <p>Skill mix of 3:1 achieved.</p> <p>Effect on waiting times and stage 1/ pre-referral work</p> <p>Gaps identified.</p> <p>Streamlined process achieved.</p> <p>More children with complex conditions managed at home/ in shared-care arrangements</p>
				<p>Annual review of SPARRA data</p>

		<p>SPARRA data analysed to provide anticipatory care and reduce hospital admissions. Continue to work with this group. Referral pathways developed working with RHSC to ensure appropriate use of allergy skin testing and pathway developed as one stop shop.</p> <p>Support staff through appropriate training and development to be completed in primarily good quality care.</p>	<p>SPARRA data to be reviewed annually by clinical implementation group. Requires closer working with acute services and GPs.</p>	
<p>2010/11 There is a focus on early intervention in the lives of children and young people.</p> <p>2011/12 – There is a focus on early intervention in the lives of women, children and young people.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Developed a Whole Population Parenting Strategy for Inverclyde and established a programme for implementing the Triple P Programme if funding is available</li> <li>- Improved the quality and currency of information relating to breastfeeding rates through work with the NHSGGC Board.</li> <li>- Costed and developed a local breastfeeding peer support network</li> <li>- Scoped OHAT redesign options with a view to ensuring implementation of the Childhood Oral Health Strategy</li> </ul>	<p>We have secured FSF funding to ensure that Triple P will be an integral part of a parenting strategy which is delivered at levels appropriate to client need (including Mellow Parenting, NCH work) with a parenting assessment in advance.</p> <p>We have taken steps to improve the quality of local data gathering including locally reviewing infant feeding history forms before sending in for collation and having a closer relationship with information services re data. We have seen resultant improvements in the quality of managing information re the Breastfeeding target.</p> <p>Our local network of breastfeeding peer support workers is in place – initial feedback is good.</p> <p>Capacity to support breastfeeding has been affected by reduced staffing.</p>	<p><b>OPR Action</b> – have in place a detailed action/implementation plan for the roll out of our whole population parenting strategy.</p> <p>Have in place a detailed action/implementation plan to ensure co-ordination of parenting pathways within strategy.</p> <p>Scope the proportion of children and families staff that require to be trained.</p> <p>Sub group of the SOA 7 to establish parents strategy as part of GIRFEC development.</p> <p>Continue to develop breastfeeding peer support network and implement recommendations of the GG&amp;C breastfeeding review. Renew impact of reduction and develop alternative responses.. In 2011/12 we will achieve</p>	<p>Strategy action plan in place.</p> <p>Number of staff trained in Triple P Number of Health Visitors trained to primary care level 3.</p> <p>Breastfeeding rates – overall, SI D</p> <p>UNICEF Stage 3 accreditation achieved.</p>

		<p>Our local Oral Health Strategy has just been out to consultation and comments are being considered and will inform future redesign.</p> <p>The aim of the Oral Health Programme is to improve oral health in our pre-school children. 'The Oral Health Action Team', train all the staff within the establishment to the National Tooth-brushing guidelines. The programme is then monitored every term and the resources are delivered. The OHAT give additional input when required to staff, children and parents. In addition to this, the OHAT have developed a play box in relation to oral health and nutrition. This can be used for structural play to encourage and learn about good oral health behaviour and nutrition.</p> <p>To develop an understanding of the importance of good oral health behaviour, healthy eating and nutrition.</p> <ul style="list-style-type: none"> <li>- Demonstrate confidence when visiting the dentist and create a friendly atmosphere.</li> <li>- Obtain the importance of tooth-brushing twice per day with fluoride toothpaste to prevent gum disease.</li> <li>- Raise awareness of breastfeeding and nutrition.</li> <li>- Encourage sugary snacks/drinks to meal times to prevent tooth</li> </ul>	<p>UNICEF stage 3 accreditation.</p> <p>Implement the final recommendations of the Local Oral Health Strategy.</p> <ul style="list-style-type: none"> <li>- Developed opportunities to support children and young people to be active with opportunities and encouragement to participate in play and recreation, including sport, in collaboration with Community Planning Partners.</li> <li>- A system in place to provide expert advice to partners to ensure that the health improvement opportunities of diversionary activities are maximised, and that those young people most vulnerable</li> </ul>	<p>PIs taken from strategy actions.</p>
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<p>We will improve the health of children and young people.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Supported the Community Safety Partnership to develop its plan to reduce knife crime injuries to young people.</li> <li>- Identified information delivery preferences of young people in relation to sexual health education, in collaboration with Sandyford and our local SHLIG.</li> <li>- Maintained and improved our high rates of childhood immunisation uptake by disseminating NICE guidance throughout integrated teams.</li> <li>- Work with Board on developing and implementing injury prevention strategy.</li> <li>- Gathered information on uptake and completion of hepatitis immunisation in babies.</li> </ul>	<p>decay.</p> <ul style="list-style-type: none"> <li>- Define an understanding of healthy snack options.</li> </ul>	<ul style="list-style-type: none"> <li>- to experiencing health inequalities are fully engaged</li> <li>- Ensured the implementation of the ACES programme and have worked towards securing recurring funding beyond 2011.</li> <li>- Be able to evidence that we have worked with education colleagues in Inverclyde Council to contribute to the implementation of the Curriculum for Excellence from August 2010, with a strong focus on the health improvement outcomes</li> </ul>	
	<p>We provided additional support to the Joint Action Group through 0.2 the Health Visitor.</p> <p>The local SHLIG was suspended pending major Council restructuring. It has now been re-instated and this action will be carried forward.</p> <p>NICE guidance disseminated.</p> <p>We understand that the NHS Board has begun an outline strategy and we await wider engagement to contribute to this.</p> <p>The Data for hepatitis immunisations in babies is only</p>		<p>Once the JAG final recommendations are approved we will consider their delivery plan and the fit with GIRFEC.</p> <p>Complete this action through the reinvigorated SHLIG.</p> <p>Maintain positive immunisation rates.</p> <p>Identify local actions in line with strategy recommendations.</p> <p>Explore mechanism for local performance monitoring. Continue to implement the process to</p>	<p>PI – from the community safety, JAG action plan.</p> <p>Principle for Young Persons' Sexual Health information developed.</p> <p>Immunisation rates</p> <p>Local action plan in place.</p>

	<ul style="list-style-type: none"> <li>- Developed opportunities to support children and young people to be active with opportunities and encouragement to participate in play and recreation, including sport, in collaboration with Community Planning Partners.</li> <li>- A system in place to provide expert advice to partners to ensure that the health improvement opportunities of diversionary activities are maximised, and that those young people most vulnerable to experiencing health inequalities are fully engaged</li> <li>- Ensured the implementation of the ACES programme and have worked towards securing recurring funding beyond 2011.</li> </ul>	<p>provided at Board- wide.</p> <p>A first draft of our active living strategy has been produced. The strategy includes specific outcomes related to early years, children and parents and young people. Education is a key partner in both the development and future implementation of this strategy.</p> <p>Youth Health Forum/Youth Council campaign to 'Unlock Fitness in Inverclyde'</p> <p>Dedicated time of HIP-Y to work with CLD and Partners. 'Health Zone' at 'Youth in the Park' event.</p> <p>HIP-Y attendance at / input to More Choices More Chances Providers meetings.</p> <p>HIS-Y attendance at / input to More Choices More Chances Partnership meetings.</p> <p>Youth Health Forum/Youth Council engagement with young people.</p> <p>HI staff working with partners to signpost and refer young people to appropriate services on a 1:1 basis.</p> <p>As at January 2011 47 families have engaged with the ACES service (of those 23 male and 24 female).</p> <p>Again at January 2011 7 were awaiting programmes to start. The most common source of referrals for these families was GP practices and School Nurses.</p>	<p>maximise uptake.</p> <p><b>OPR Action</b> – Increase referrals to ACES programme via staff having a proactive role in identifying eligible families, and benefiting from the learning of the Renfrewshire CHP experience.</p> <p>Roll out of ACES Schools delivery model and development of community service for children/families with additional support needs.</p>	<p>HEAT H3 – Child Healthy Weight</p>
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	<ul style="list-style-type: none"> <li>- Be able to evidence that we have worked with education colleagues in Inverclyde Council to contribute to the implementation of the Curriculum for Excellence from August 2010, with a strong focus on the health improvement outcomes</li> </ul>	<p>Health Improvement representation at Health &amp; Wellbeing Steering Group meetings.</p> <p>Curriculum for Excellence Partners Template being used by HHI Team to map HI sessions / programmes to Curriculum for Excellence (cfe).</p> <p>Revised Consequences Programme, new Sexual Health &amp; Relationships Education curriculum resource and Inverclyde Young Person's Alcohol Project mapped to CfE health &amp; wellbeing experiences and outcomes.</p>	<p>Embed the SHRE curriculum and Positive Mental Attitudes curriculum throughout the secondary sector.</p> <p>Staff Trained</p> <p>Sessions delivered.</p>	<p>Every secondary school using the curriculum.</p> <p>Staff Trained</p> <p>Sessions delivered.</p>
<p>2010/11 Service users can access CAMHS services at a place and time they need it.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Worked to identify resources to improve CAMHS services.</li> <li>- Developed an out of hours on call CAMH psychiatry service.</li> <li>- Scoped potential CAMH redesign options.</li> <li>- To evaluate PCMHW for children</li> <li>- CAMHS</li> </ul>	<p>CAMHS redesign progressing CAPA model is in place</p> <p>An on call system has been implemented for OOH and 1 year RTT has been met.</p> <p>Robust evaluation and identification of implementation of recommendation.</p>	<p>Continue to progress CAMHS redesign, continuing to reduce waiting times in line with board targets.</p> <p>Identify funding for sustainable for sustainable post and review governance around this.</p> <p>Review implementation of CAPA and embed as model of referral and LT management.</p> <p>Review structure and integration of specialist children's services in line with redesign models.</p> <p>Progress implementation/ increase in age range to CAMHS service following addressing issues and worries around resources.</p>	<p>CAMHS HEAT target.</p> <p>Structure in place which reflects Board-wide model but addresses local position/ arrangements.</p>

<p>2010/11 We will improve the quality of the services we deliver.</p>	<p>Develop support for Young Carers.</p> <p>By the end of year 1 we will have worked to identify who our young carers are, and scope their support needs.</p>	<p>There is an active support group for young carers and dedicated Social Work support.</p>	<p>Establish integrated multi-agency provision for this group, and ensure the interests of young carers are considered at our Carers Development Group.</p>	<p>Integrated group work provided.</p> <p>Young Carers explicitly referenced in Local Carers Strategy.</p>
<p>2010/11 Our service planning reflects demand, evidence base and views of service users and their carers.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Fully implemented the IAF which considers the views of children and carers.</li> <li>Children and families involved in the redesign of services.</li> </ul>	<p>Evaluation has been completed and reflects good progress. Very positively completed by HMIE inspectorate.</p>	<p>Update with outcomes from evaluation of IAF pilot.</p> <p>Implement the Participation Strategy and View Point.</p>	<p>Outcomes updated</p> <p>Participation Strategy and View Point implemented</p>
<p>2010/11 Remove barriers to learning and improve the outcomes for our most vulnerable children and young people through effective integrated children's services</p>	<p>Year on Year improvement on SOA Attainment Levels.</p> <p>We will have actions in place to improve SOA attainment levels.</p> <p>Implementation of the "We Can and Must Do Better" Strategy.</p>	<p>Specialist LAAC teaching team in place.</p> <p>Rolling programme of training</p>	<p>Funding secured to have further term of letter box initiative and chatter books.</p>	<p>Number of children receiving additional teaching support.</p> <p>Minimum 50 children inclusive of LAAC and children looked after at home.</p>
<p>2010/11 Ensure the redesign of Youth Justice and Youth Support Services are fully implemented and delivering an effective service.</p>	<p>Undertake an evaluation of these services.</p> <p>We will implement the redesign of Youth Justice and Youth Support Services.</p>	<p>The redesign of community youth support and intensive support services has reconfigured staffing positions, worker roles and responsibilities in line with local service priorities. The redesign is in keeping with national policy drivers.</p>	<p>Planned relocation of staff from the Mearns Centre to the refurbished St. Lawrence's Primary School.</p> <p>Review Youth Justice Co-ordinator arrangements for Inverclyde.</p> <p>Develop intensive support and monitoring service within Inverclyde.</p>	<p>Relocation complete.</p> <p>Review complete and staff in place.</p> <p>New service model.</p>
<p>2010/11 Deliver safe and high quality services</p>	<p>By the end of year 1 will have continued to build strong relationships between midwifery and primary care staff.</p>	<p>Several development sessions have taken place with Midwives, Health Visitors and Social Workers. Joint chairing of Infant Feeding Strategy Group is in place between maternity and children's services.</p>	<p>OPR Action – continue to work collaboratively with the Inverclyde CMU to increase breastfeeding rates</p> <p>We will take steps to ensure that</p>	<p>HEAT target - Breastfeeding rate</p>

<p>2010/11 Improved quality of life of women and babies through early interventions and screening programmes to support better health outcomes</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Increased breastfeeding rates</li> <li>- Improved low birth weight rates</li> <li>- Reduced infant mortality rates</li> <li>- Developed a volunteer breastfeeding peer support network, if funding can be secured.</li> <li>- Increased uptake of smoking cessation services amongst pregnant women.</li> </ul>	<p>A local peer support network has been started. 5 peer supporters were recruited in October 2010.</p>	<p>children and young people with cancer have equality of access to services and receive care in the right place at the right time.</p> <p>Proctor's model supervision embedded for health staff.</p> <p>Robust induction process in place for CFHT.</p> <p>IT capacity and systems reviewed.</p> <p>Safe system of transfer of West of Scotland Family Health Record between Health Visitor and school nurse service (local arrangements for 2011 await guidance GGN&amp;C thereafter).</p>	<p>Model used universally in Children and Families service.</p>
<p>2010/11 Service design is targeted at vulnerable women and their families to reduce the health inequalities gap between deprived</p>		<p>Number of midwives included in SNIPS reduced from 2 to 1. Acute midwifery service pressures</p>	<p>OPR Action – we will focus smoking cessation work on women smoking in pregnancy and in deprived areas.</p> <p>We have a renewed focus on early years and health life expectancy determines in our SOA Health Inequalities outcome delivery group. We will progress these actions through that forum.</p>	<ul style="list-style-type: none"> <li>• Smoking in pregnancy rates/ SIVD smoking rates</li> <li>• Peer Support network number – Supporters, Supported Women</li> <li>• Low Birth Weight stats improved.</li> <li>• Infant mortality rates improved</li> </ul>
			<p>OPR Action – ensure that there is an engagement process in place with acute regarding vacancies in SNIPS that will have a direct</p>	



and non-deprived population			have resulted in a 1 WTE reduction in the SNIPS establishment but we continue to put in place comprehensive child protection plans for all vulnerable women who are pregnant.	impact on community services -  * There are currently no vacancies as post has been deleted	
2010/11 Patients have equity of access to maternity services and care at a place and time when they need it	By the end of year 1 we will have supported the acute sector to implement the Hub and Spoke maternity services model.	Marketing Group has been established, chaired by our Head of Children's Services and an action plan will be developed.		Complement the actions emerging from the action plan.	Indicators from the action plan.
2010/11 Maternity treatments and care are provided through integrated care pathways	By the end of year 1 we will have: <ul style="list-style-type: none"> <li>- Actively promoted healthier lifestyle choices for pregnant women and their families.</li> <li>- Worked closely with midwifery colleagues to make health education an integral part of care and handover to community health visiting services.</li> <li>- Worked with Community Planning Partners to promote a change in culture within Inverclyde that supports breastfeeding and improved nutrition during pregnancy, and reinforces the importance of smoking cessation and alcohol abstinence during pregnancy.</li> </ul>	Smoking in pregnancy/ cessation rates (whichever we have)  Priority areas of breastfeeding and smoking agreed.  Agreed through SOA  Due to major Council re-organisation the lead for the Children's SOA Outcome Delivery Group has been vacant for some months. This role has now been filled by the Corporate Director for education and work will be progressed on these agreed actions during 2011/2012.	We will work with colleagues in Acute Health Improvement Team to support the role out of the smoking in pregnancy service within IRH.  Ensure development of seamless referral pathways to community smoke free services.  Progress these actions through our SOA Children's Outcome Delivery Group. Supported by the SOA Health Inequalities Outcome Delivery Group.  Review care pathways in light of refreshing maternity strategy.		

Financial Update

We will be exploring funding opportunities to assist in the delivery of some of our strategic objectives. The financial framework around LAAC Children, Adoptive and Kinship Care especially should continue to be monitored as a key risk. The impact of service redesign across Children's Services will require to be monitored and managed both in terms of finance and workforce planning.



Updated Framework

1.6 **Updated Outcomes - Long Term Conditions, Disability and Older People:** This Revised action table reflects Board-wide work to consolidate three of the previous actions tables due to the degree of overlap. The tables following this one provide a review of achievements against our original year one actions, and future updates to the plan will follow the consolidated model

Outcome 2011/12	Action 2011/12	Change/Progress/ Performance Indicator
<p>People are supported to live independently and safely as possible in their communities for as long as possible.</p> <p>People get access to the right level of care and support when they need it.</p> <p>We involve people in assessment, planning and delivery of services.</p>	<p>Implement the Inverclyde CHCP Reshaping Care for Older People plan and our Rehabilitation Plan to deliver on the following actions:</p> <ul style="list-style-type: none"> <li>- Develop clear strategies to support self management.</li> <li>- Implementation of tiered models of service which ranges from universal services through to specialist and/or intensive care for those with complex needs; priority to maintain people at the lowest level as long as possible.</li> <li>- Review of model and approach to day services.</li> <li>- Develop plans to use telecare and telehealth in supporting people safely in home, where there is evidence of effectiveness.</li> <li>- Explore models (e.g., local area coordination) to help people access leisure activities and social opportunities.</li> <li>- Support care homes to maintain people's links with their local community.</li> <li>- Inverclyde reshaping care for older peoples change plan measures.</li> <li>- Develop plans for personalisation of care; more flexible services designed around the needs of the person, not the professionals.</li> <li>- Train and equip community based staff to undertake personal outcomes assessment and planning.</li> <li>- Support people with a recent diagnosis to plan for future support.</li> </ul>	<ul style="list-style-type: none"> <li>- Number of people self directing their care and support.</li> <li>- Number of carers receiving an assessment.</li> <li>- Number of short breaks for carers.</li> <li>- T6: Long Term Conditions bed days per 100,000 population for COPD; Asthma; Diabetes and CHD.</li> <li>- T4: Balance of care for older people with complex care needs (10 hours+ home care).</li> <li>- E7: Electronic management of referrals.</li> <li>- T12: Emergency bed days for patient aged 65 year+.</li> <li>- T6: Long Term Conditions bed days per 100,000 population for COPD; Asthma; Diabetes and CHD.</li> <li>- T9.1: Number of patients registered with dementia.</li> <li>- Number of patients on Liverpool Pathway.</li> <li>- Number of staff trained in assessment and care management.</li> <li>- E4.2: Non-routine inpatients ALOS.</li> </ul>

<p>A systematic and integrated multi-agency approach to care is in place, which optimises outcomes for individuals.</p>	<ul style="list-style-type: none"> <li>- Develop clear pathways of care across primary / acute; health/social care – for dementia, key long term conditions. Develop effective information flows and relationships between secondary and primary care.</li> <li>- Structured engagement and joint working between independent contractors, community staff and CH(C)P management.</li> <li>- Influence local housing strategies to ensure housing development reflects individual and population needs of disabled people.</li> <li>- Further development of integrated equipment services.</li> </ul>
<p>We have services which are focused on effective assessment, early intervention and maximising opportunities for recovery and enablement.</p>	<ul style="list-style-type: none"> <li>- Implement the shared assessment Framework and care management guidance.</li> <li>- Adopt and implement an outcomes-focused approach to assessment, care planning and review for community care, such as Talking Points: Personal Outcomes Approach.</li> <li>- Move forward with anticipatory care models of service.</li> <li>- Further development of use of SPARRA and other methods of risk stratification and intervention to enable people to remain at home.</li> <li>- deliver community rehabilitation and enablement service redesign;</li> <li>- case and care management;</li> <li>- Develop comprehensive range of early intervention services.</li> <li>- Offer re-enablement as part of home care services.</li> </ul>
<p>Carers are recognised as a key partner in the planning and delivery of services, and services are provided to support them in their caring role.</p>	<ul style="list-style-type: none"> <li>- Improve access to high quality information for Carers. --</li> <li>- Develop plan following end of CIS funding.</li> <li>- Review provision of respite and determine the shape, direction and level of short break provision.</li> </ul>
<p>People are able to die with dignity in a place of their own choosing.</p>	<p>Deliver better end of life care through Liverpool Care Pathway in all care settings.</p>

<p>Staff are trained to ensure that they have the right knowledge, skills and approach.</p>	<ul style="list-style-type: none"> <li>- Review skill mix, competency development and training, specific service redesign (e.g., AHPs).</li> <li>- Develop the skills and knowledge of non-specialist workforce.</li> <li>- Review inpatient bed usage for older people's services.</li> </ul>	
<p>Our services provide value for money and are efficient and effective.</p>		
<p>We understand and respond to inequalities in access and outcome.</p>	<ul style="list-style-type: none"> <li>- Allocate resources in line with patient and population needs.</li> <li>- Develop approaches to inequalities sensitive practice, to identify and address complex health and social circumstances recognising the inequalities experienced by particular groups and also how these can be compounded by other factors such as age, disability, gender, race, age, sexual orientation and socio-economic status.</li> <li>- Support implementation of the NHSGCC Communication and Language Plan.</li> <li>- Develop EQIA throughout all services.</li> </ul>	

1.7 **Disability:** We have audited the use of IORN and completed the process of agreeing standards and process for eligibility criteria, and we now receive routine AHP activity data to help us manage access to support.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
<p><b>Disability</b></p> <p>People are supported to live as independently as possible in their communities for as long as possible</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- A local plan to shift the balance of care into communities, which includes developing and extending housing with care options such as telecare.</li> <li>- Further developed access to our Joint Equipment Store and related services</li> </ul>	<p>We have an outline SBC plan which is now being used to implement reshaping care for Older People. A key strand of that work will be to develop anticipatory care in respect of disability.</p> <p>There are well established processes and protocols in place with the Joint Equipment Store (JES), further strengthened with CHOP inception. A JES Management Group meets on a 6 weekly basis to address operational issues.</p>	<p>Implement year 1 of our reshaping care for older people change plan.</p> <p>Streamline systems and processes to create an integrated service for the joint store.</p>	<ul style="list-style-type: none"> <li>- Local evidence of integrated multidisciplinary workforce mode</li> <li>- Increased equipment issues, introduction of self assessment.</li> <li>- Plan being implemented.</li> </ul> <p>Delivery of equipment provided by JES will be handled by the CHOP</p> <p>Improved access to equipment via CHOP dedicated transport.</p>
<p>We involve people in the assessment, planning and delivery of services.</p>			<ul style="list-style-type: none"> <li>- Develop robust and sustainable processes for disabled people to be part of all services PFPJ activity.</li> <li>- Review of advocacy services.</li> </ul>	<ul style="list-style-type: none"> <li>- Evidence of service user involvement in planning and redesign.</li> <li>- Evidence of use of advocates to support patients – CHOP framework for public involvement in place.</li> </ul>
<p>We have the right information to support effective service planning and delivery, and this is shared across agencies.</p>			<ul style="list-style-type: none"> <li>- Reinstate local disability planning group to support delivery of local elements of Board wide plan.</li> <li>- Improve data quality for disability to better inform future service planning.</li> <li>- Establish effective shared performance management framework that informs service plans.</li> </ul>	<ul style="list-style-type: none"> <li>- Coherent Planning and Performance Framework.</li> <li>- Local action plans developed and monitored.</li> </ul>

Carers are recognised as a key partner in the planning and delivery of services, and services are provided to support them in their caring role	By the end of year 1 we will be able to evidence that: - We have undertaken a review of local respite provision in conjunction with acute and social work.	This action has not been completed in year 1 and has been carried forward to year 2.	In 2011/12 we will review respite provision and scope the options for a more streamlined approach.	Review completed. Model Agreed.
People get access to the right level of care and support when they need it.			Work with the RAD to improve the outreach service within Inverclyde.	- Bed occupancy/waiting times for admission/ use of different forms of respite. - IORN used comprehensively
Assessment processes are effective in identifying the needs of individuals and the service responses required	- Implement the shared assessment framework and care management guidance	We have audited the use of IORN and complete the process of agreeing standards and process for eligibility criteria. We have begun the service redesign of the information and assessment team making links to the Council's new contact centre and using voluntary organisations more effectively.	Roll out further training for front line staff to improve consistency of IORN scanning.	- Eligibility criteria applied universally. Redesign complete SLA developed and in place.
Staff, service users and carers have a shared understanding of services available with greater focus on early intervention and local provision of services	- Reviewed and developed Advocacy and Information resources		Complete redesign and deliver SLA with financial fitness.	
A systematic and integrated multi-agency approach to care is in place, which optimises outcomes for individuals.			Improve transition arrangements from children with a disability to adult services and adult to older people services, via the introduction of clear and consistent criteria.	Clear transition arrangements are in place, based on assessed need.
We have services which are focused on effective assessment, early intervention and maximising opportunities for recovery and enablement.			Further progress and work to facilitate job opportunities with local services to deliver vocational rehab opportunities.  We will continue to roll out employability and health awareness training across the CHCP to support staff to	- Employment outcomes for people with a disability. - Progress against action plan/KPIs.  There are more job opportunities for local people with a disability.

<p>Services will be better organised to meet people's needs and will demonstrate a rehabilitative approach to meeting people's holistic needs</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Improved the quality of care for younger disabled people who are currently looked after in care homes.</li> <li>- Co-located health and social work learning disability teams in refurbished fit for purpose premises at Cathcart Street.</li> <li>- Transitional health passports will be developed for young people transferring from Lilybank and Glenburn Schools.</li> </ul>	<p>We have undertaken focus group work with our local care home for young people with a physical disability.</p> <p>This has been delivered.</p> <p>Passports have been developed and continue to be used to support transition.</p>	<p>Understand their role in the employability pipeline.</p>	<p>We will continue to explore opportunities for other forms of care provision for young people with as physical disability.</p> <p>Continue this action.</p>	<p>Transition is easier and more seamless.</p>
<p>People get access to the right level of care and support when they need it</p>	<p>Deliver community rehabilitation and enablement service redesign</p> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Improved quality and currency of service access data.</li> </ul> <p>Better end of life care through having implemented the Liverpool Care Pathway in all GP practices and local care homes</p>	<p>We are currently engaged in the process to transfer rehab services to the community.</p> <p>We now receive routine activity data which better support performance management.</p> <p>The LCP is fully implemented as a model of practice across community and care home settings in Inverclyde.</p>	<p>Complete the reprovion and seek appointments for integration.</p>	<p>Integrated community rehab team in place.</p> <p>Waiting times reduced.</p> <p>Increase use of LCP in all settings.</p>	
<p>People are encouraged to determine their own support needs</p>	<p>By the end of year 1 we will be able to evidence that:</p> <ul style="list-style-type: none"> <li>- More disabled people are empowered to manage their own care through personalisation.</li> <li>- We are achieving better transitions of care from acute to community settings.</li> </ul>	<p>Scottish Personal Assistance Employers Network (SPEAN) Personal Self Directed Payments training has been delivered to facilitate more people being able to direct their own care.</p> <p>Our local Physical Disability Group is being reconvened and refocused</p>	<p>Establish clearer organisational arrangements and responsibilities for budgets and deliver related to personalisation.</p> <p>All allocated Social Work cases will be reviewed to ensure income and</p>	<p>Better use of available resources and improved outcomes for individuals.</p> <p>Reviews undertaken.</p>	



<p>People are supported to stay as healthy as possible</p>	<p>- We have clear links between disability services and financial inclusion and employability services.</p>	<p>to address identified gaps and improve transition arrangements between acute and community care.</p>	<p>benefits are being maximised appropriately.</p> <p>Establish clearer and stronger links between Inverclyde Centre for Independent Living and local financial inclusion resource.</p>	<p>Links established and operation:</p>	
<p>People are supported to stay as healthy as possible</p>	<p>By the end of year 1 we will have reviewed our local self management approach and identified any gaps in provision.</p>	<p>This work will be advanced as we develop a CHCP approach to supported self management through GP forum; PEG; Clinical governance and community pharmacy.</p>	<p>Progress this agenda in year 2.</p>	<p>Systems to support self management are in place.</p>	
<p>We will ensure that we are meeting our new duties and responsibilities with partner agencies of the Adult Support and Protection (Scotland) Act 2007.</p>	<p>By the end of year 1 we will have developed an agreed workplan and established four multi-agency sub-groups to progress the identified workstreams.</p>	<p>A work plan has been developed incorporating all five work streams in Adult Protection and progress of these will be reported on a regular basis to the Adult Protection Committee. With regard to Quality Assurance, this includes developing a quality assurance framework, implementing this and reporting on audits and performance. In addition to Quality assurance sub groups exists for Training, Communication and Engagement, and Procedures.</p> <p>We have undertaken analysis on the number of adult protection investigations and the outcome to inform systems all processes.</p>	<p>To use the outcome of Adult Protection investigation reviews to improve systems and progress and identify training needs.</p>	<p>A comprehensive training plan is in place.</p> <p>Input from multi agency staff groups is clearer.</p>	
<p><b>Long Term Conditions</b></p> <p>People are supported to live independently and safely as possible in their communities for as long as possible.</p>				<p>- Use the Community Pharmacy Chronic Medication Service to support people to be more involved in managing their own medicines, whether in the community or in hospital.</p> <p>- Use patient involvement groups</p>	<p>- Proportion of COPD admission: followed up by Early Supported Discharge Service.</p> <p>- Increase the number of integrated LTC care plans.</p> <p>- Number of people self directing their care and support.</p>

<p>Staff are trained to ensure that they have the right knowledge, skills and approach.</p>			<p>attached to MCNs to inform work on identifying and addressing barriers to patients accessing services.</p> <ul style="list-style-type: none"> <li>- MCNs ensure their patient involvement groups inform work on identifying and addressing barriers to patients accessing services and promote that within CH(C)Ps.</li> <li>- Disseminate the document Supporting people with LTCs to Self Manage: Essential guide to multiagency knowledge and skills and support the development of education and resources which enable healthcare workers to develop the awareness, knowledge, skills and values which support self management.</li> <li>- Provide a means for people with LTCs to support each other by easily accessing, contributing to and sharing local information.</li> </ul>	<ul style="list-style-type: none"> <li>- Number of carers receiving an assessment</li> <li>- Number of short breaks for carers.</li> <li>- T6: Long Term Conditions bed days per 100,000 population for COPD, Asthma, Diabetes and C D.</li> <li>- E7: Electronic management of referrals</li> <li>- E4.2: Non-routine inpatients ALOS.</li> </ul>
			<ul style="list-style-type: none"> <li>- Identify Core Competencies required for each LTC tier of care together with Identification of individual training needs and delivery of appropriate training.</li> <li>- Review core competencies for staff delivering Self Management and contextualise them in relation to inequality by linking to NES.</li> <li>- Promote the Equality website <a href="http://www.equality.scot.nhs.uk">www.equality.scot.nhs.uk</a> and E-learning modules to staff.</li> <li>- Ensure a workforce culture and values in place which reflects and is aligned with the LTC model.</li> <li>- Staff are trained in agreed care</li> </ul>	

<p>People get access to the right level of care and support when they need it. A systematic and integrated multi-agency approach to care is in place, which optimises outcomes for individuals. We have services which are focused on effective assessment, early intervention and maximising opportunities for recovery and enablement.</p>			<p>management systems, processes and protocols and ensure that each CH(C)P has a documented MDT process for identifying patients appropriate for care management.</p>	
			<ul style="list-style-type: none"> <li>- Establish a system of early identification of needs and response to problems or deteriorations and identify those at risk of moving up to level 3 to allow an anticipatory approach to disease management. Local systems in place should continue but further development will be driven by an organisation wide direction.</li> <li>- Provide systematic primary care and specialist healthcare services for people in care homes, including the use of advanced/ anticipatory care plans to guide decisions around end of life care.</li> <li>- Consider how key working or local area coordination approaches could be delivered with and for people with LTCs.</li> <li>- Develop integrated proactive pathways of care for common LTCs. Ensure, where appropriate, that key interface with Local Authority housing and social care is developed by each MCN.</li> <li>- Ensure services are in place to allow rapid response to the call for help.</li> </ul>	<ul style="list-style-type: none"> <li>- Develop explicit signposting to</li> </ul>

<p>We involve people in assessment, planning and delivery of services.</p>			<p>the appropriate intervention and clinician.  - Publish appropriate protocols and guidelines, including referral guidelines.  - Ensure that people with LTCs, carers and the voluntary sector are enabled to participate in the planning, delivery and evaluation of services, through MCNs, drawing on experience from the 'Hearty Voices' and similar programmes.</p>	
<p>Patients have an improved experience of care and are empowered to be full partners in their care.</p>	<p>By the end of year 1 we will have developed a pathway with the Community Pharmacy Chronic Medication Service to ensure that people are supported to be more involved in managing their own medicines.</p>	<p>Community Pharmacists are registering 50 patients per pharmacy by 31<sup>st</sup> December 2010 in line with national advice. Information and support has been given to the Community Pharmacists by Community Pharmacy Development Team and our local Prescribing Support Team. Awareness raising has taken place at Inverclyde GP Forum and practice managers' meetings and via the 'Inverclyde Prescriber Bulletin'.   Explore the potential to progress polypharmacy and older people's pharmacy reviews via the change fund.</p>	<p>We will progress the roll out of the chronic medication service in conjunction with PPSU and pharmacy colleagues.</p>	<p>Chronic medication service is fully implemented.</p>
	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Scoped anticipatory care models, informed by initiatives</li> </ul>	<p>Local SPARRA work has shown that most of the high risk patients are not presenting with LTCs (bias</p>		<p>Polypharmacy and older people's pharmacy reviews are in place and contribute to reduced hospital admissions.</p>

	<p>such as Keepwell, SPARRA and the Board's LTC Strategy.</p> <ul style="list-style-type: none"> <li>- Worked to promote engagement of independent contractors in the introduction of Wave 4 Keep Well</li> </ul> <p>Undertaken an analysis of what work is required to link funding streams to maximum benefit (e.g. telecare linked to SPARRA)</p>	<p>towards alcohol issues).</p> <p>Our pilot of the use of telehealth in COPD provide very positive and effective learning for using the approach in other consultation groups.</p> <p>Keep Well Wave 4 is implemented into our 6 participating practices.</p>	<p>Build on the COPD telehealth pilot to expand the approaches to diabetes care linked to acute and the Scottish Centre for Telehealth.</p> <p>We will progress the transition phase for Keep Well in 2011/12 towards mainstream in 2012/13</p>	<p>H8 – Targeted cardiovascular health checking.</p>
<p>A systematic and integrated multi-agency approach to care is in place, which optimises outcomes for individuals.</p>			<p>Progress the following actions when relevant IT links and protocols have been established between community pharmacy Scotland community pharmacies.</p> <ul style="list-style-type: none"> <li>- Ensure Community Pharmacists, while delivering medicines adherence support to patients, are aware of and can act upon agreed signs/symptoms of deterioration requiring onward referral.</li> <li>- Enable electronic referral of high risk patients with complex medicine related needs to Community Pharmacies for repeated adherence support by the community pharmacist.</li> <li>- Encourage Community Pharmacists to take the opportunity to refer patients onto other social care services as required, particularly in areas of deprivation.</li> </ul>	
<p>Individuals have a clearer understanding about their</p>	<ul style="list-style-type: none"> <li>- Where possible, support people on long term benefits</li> </ul>	<p>A workshop has been arranged for late April 2011 to begin the process</p>	<p>We will re-establish the Inverlyde Financial Inclusion Strategy Group</p>	<p>Group operational strategy complete.</p>

<p>condition and their role in managing it which improves patient's capacity to look after themselves.</p>	<p>back to work, to maximise the health benefits attributed to being in work, working collaboratively with Inverclyde Council and Trade Unions. Work with all stakeholders to develop a shared and targeted approach to improving social and economic circumstances that have a health impact.</p> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Delivered a structured programme of education for people with type 2 diabetes through the DESMOND self management education package.</li> <li>- Developed guidelines that enable staff to directly refer people into employability pathways.</li> </ul>	<p>required to move this action along. We have continued to progress the employability agreed through our SOA employability outcome delivery group.</p> <p>DESMOND has been successfully introduced in year 1.</p> <p>Processes for direct referral are in place.</p>	<p>to develop a financial inclusion strategy for Inverclyde that reflects multi agency involvement.</p> <p>Continue with the implementation of supported self care for people with type 2 diabetes</p> <p>Implement policy and guidelines and direct referral.</p>	<p>LTC admission rates</p> <p>Policy and guidelines in place.</p>
<p>Staff are trained to ensure that they have the right knowledge, skills and approach to LTCs care.</p>	<p>By the end of year 1 we will be able to demonstrate that front-line staff understand their roles in prevention, identification and management of Long Term Conditions.</p>		<p>In year 2 we will move from the planning stage to implementing the single point of access to specifically focus on rehabilitation for partners within LTC.</p>	<p>Single point of access in place and improved response/ allocation time based on assessment need.</p>
<p>A systematic and integrated multi-agency approach to LTC care is in place across CH(C)Ps.</p> <p>Reduction in hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes and CHD.</p>	<ul style="list-style-type: none"> <li>- Agree and implement plans to roll out proactive integrated care management through the CH(C)P areas.</li> <li>- Establish a system of early identification of needs and response to problems or deteriorations and identify those at risk of moving up to level 3 to allow an anticipatory approach to disease</li> </ul>	<p>These actions have not been progressed in year 1 and will be picked up in year 2.</p>		

	<ul style="list-style-type: none"> <li>- management.</li> <li>- Agreed systematic primary care and specialist healthcare services for people in care homes, including the use of advanced / anticipatory care plans to guide decisions around end of life care.</li> <li>- Evaluate use telehealth and telecare supports, with an emphasis on helping people to self manage their conditions at home.</li> </ul>	<p>Anticipatory Care Planning has started to be rolled out in Primary Care and in care homes</p> <p>We have continued to explore opportunities for the use of telehealth and telecare.</p>	<p>Complete initial roll out of ACT in primary care and care homes</p> <p>Expand out as and when finance is available, and in line with our Reshaping Care for Older People change plan.</p>	<p>ACP initial roll out complete</p> <p>Telehealth/Telecare expanded locally.</p>
<p><b>Older People</b></p>				
<p>People remain active in later life, continue to have meaningful things to do and are part of their local communities.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Explored models of access to leisure activities such as Live Active and Vitality for older people.</li> <li>- Worked with partners to develop options to reduce isolation and strengthen support for older people.</li> <li>- Focused on preventing depression and anxiety and promoting positive mental health by extending PCMH-N to older people.</li> <li>- Achieve the national CoSLA Contractual Performance Targets.</li> </ul>	<p>Live Active and Vitality are in place and on offer for older people</p> <p>These actions have not been progressed in year 1 and will be picked up in year 2.</p> <p>We achieved our CoSLA Contractual Performance Targets in Year 1</p>	<p>The following actions will be progressed via the implementation of our Reshaping Care for Older People Change Plan in 2011/12</p> <ul style="list-style-type: none"> <li>- Work across planning partners to improve information, advice and support to older people including active ageing and volunteering.</li> <li>- Establish ongoing engagement with older people and their carers</li> <li>- Work to maintain or improve access performance and develop primary care capacity.</li> <li>- Work across partners to reduce isolation and strengthen support for older people.</li> <li>- Focus on preventing depression and anxiety and promoting positive mental health.</li> <li>- Maintain performance</li> </ul>	<p>Implement Change Plan actions</p> <p>H1 Home Care Return Respite Return Other contractual returns</p>
<p>People with care and support needs have a say in finding solutions personalised to their needs and aspirations</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Established a community rehabilitation and enablement service with close links to day</li> </ul>	<p>Our rehabilitation services redesign paper is complete and implementation opportunities are being considered. A single point of</p>	<p>- Monitor implications for existing services of local authority plans for personalisation</p>	

<p>People live as independently and safely as possible.</p>	<p>hospitals, social care services and the acute hospital.</p> <ul style="list-style-type: none"> <li>- A training plan to equip community based staff to undertake personal outcomes assessment and planning, including case management and SSA training.</li> <li>- Improved systems to identify carers and give them information and support in their caring role</li> <li>- Worked across partners to develop options for a broader range of care and support options to meet people's needs through developing our local SBC plan.</li> <li>- Ensured that rehabilitation and re-ablement is available in a range of settings.</li> </ul>	<p>access is proposed with strong links to local gerontology services. We will also seek, wherever possible, to bring in rehabilitation and enablement services and support earlier in the care pathway.</p> <p>Limited plan complete and will inform detailed action plan</p>	<p>- Confirm the level and quality of nutritional advice and support is appropriate.</p>	
<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Influenced the Strategic Housing Investment Plan (SHIP) and Local Housing Strategy to promote telecare being inbuilt in any housing provision plans</li> <li>- Strengthened the community older people's mental health services through shifting the balance of care by implementing the procurement to replace the hospital based continuing care services to community based services in partnership beds on the Kerpock site</li> <li>- Worked in partnership with</li> </ul>	<p>Ward 4 remodelling is complete. 10 beds are in place for organic illness and 10 for functional illness. Initial feedback is good from both staff and patients/carers.</p> <p>Our OPMHS is fully integrated into the CMT. The review of the Argyll Unit is nearing completion with the findings to be implemented by 01.04.11 to create a fully functioning assessment unit.</p> <p>We have offered advice and influenced the local Housing and Accommodation Sub Group in developing the new Local Housing</p>	<p>- Implement policies and procedures to support and protect adults at risk of harm in line with Adult Protection legislation.</p> <ul style="list-style-type: none"> <li>- Confirm access to falls prevention services are clear and effective.</li> <li>- Maximise financial inclusion for older people with access to money and benefits advice</li> <li>- Analyse local pharmaceutical care for older people</li> <li>- Review availability, adequacy and effectiveness of local crisis response services</li> </ul>	<p>- HEAT T8: to increase the level older people with complex care needs receiving care at home.</p>	



<p>People with dementia and their carers receive the treatment, care support following diagnosis that enables them to live as well as possible regardless of setting.</p>	<p>Inverclyde Council to ensure adults at risk of harm under the terms of the Adult Support and Protection Act have received protection and appropriate support</p> <ul style="list-style-type: none"> <li>- Fully scoped Adult Protection training costs.</li> <li>- Complete the review of OPMHS Community and Day Activities.</li> <li>- Remodel the hospital based older person assessment facilities by remodelling Ward 4 to support functions and organically ill patients.</li> <li>- We will have processes in place to support appropriate allocation of Housing for Older People</li> </ul>	<p>Strategy and the Strategic Housing Investment Plan. We are also actively participating in local discussions around sheltered housing provision.</p>	
	<p>We have completed the review of care pathways for people with dementia.</p> <p>We have developed a future model of care for older people's mental health services including for people with dementia, and dementia information following diagnosis.</p> <p>We have successfully developed CPN liaison with care homes.</p>	<p>In linking this with our Reshaping Care for Older People plan and the national Dementia Strategy we will implement the following:</p> <ul style="list-style-type: none"> <li>- Improving staff skills and knowledge in health and social care settings.</li> <li>- Ensure people in all care settings have access to treatment and support that is appropriate. Develop liaison arrangements to support prescribing and medicines management.</li> <li>- Further develop care pathways for dementia across whole system of care provision.</li> <li>- Health improvement activity and information.</li> </ul>	

<p>People are able to die with dignity in a place of their own choosing.</p>	<p>By the end of year 1 we will have implemented the year 1 actions from the Inverclyde Palliative Care Action plan</p> <p>Developed CPN Liaison with care home sector</p>	<p>Implementation of the Inverclyde Palliative Care Action plan is on track and we expect to progress to implementation of year 2 actions during 2011/12.</p> <p>To develop mental health liaison service for older people including into care homes and other care settings.</p>	<ul style="list-style-type: none"> <li>- Establish early intervention and support service for people with dementia and their carers.</li> <li>Expand on work already undertaken (e.g. into other care settings such as general hospital).</li> <li>- Putting in place recognised tools or triggers for palliative and end of life care needs.</li> <li>- Assessment and review of patients with palliative care and end of life care needs using recognised tools.</li> <li>- Work to ensure that timely, holistic and effective care planning takes place at appropriate stages of the patient journey.</li> <li>- Roll out GG &amp; C symptom relief algorithms to all care settings and care equitable provided across patient pathways specifically including OOH</li> <li>- Ensuring that people recorded on palliative care registers have multi-disciplinary support and a named professional to co-ordinate care.</li> <li>- Facilitating anticipatory prescribing to enhance patient care and aid the prevention of unnecessary crises and unscheduled hospital admissions.</li> <li>- Collaborative work to produce information on palliative and end of life care support available.</li> <li>- Implementation of consistent Do Not Attempt Resuscitation and associated documentation across care settings.</li> </ul>	
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<p>The health and care system of GGC optimises outcomes for older people, use of resources and continues to be sustainable in face of mounting pressures.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Contributed to the NHS Greater Glasgow &amp; Clyde Board strategy reflecting 'Reshaping Services for Older People.</li> <li>- Developed a local joint SBC plan that takes account of projected increases in our older</li> </ul>	<p>We have developed an initial change fund plan for Inverclyde, which will form the basis for our more detailed plan.</p>	<p>OFRR Action – have in place our Older People's Strategy by the end of 2010/11, including a local action plan to reshape care for older people.</p> <ul style="list-style-type: none"> <li>- Complete the review of homecare services and</li> </ul>	<p>- Roll out pilots on Supportive and palliative Action Register (SPAR) work (nursing care homes and developments in residential care and continuing care bed settings) as appropriate</p> <ul style="list-style-type: none"> <li>- Work to ensure consistent access to 24 hour community nursing and home care services to support care plans indicating a wish to be cared for at home.</li> <li>- Rapid access to appropriate equipment required for the care of those wishing to die at home.</li> <li>- Act on working group recommendations on minimum standards for the content of patient and carer information on palliative and end of care.</li> <li>- Responding to review of quality mechanisms, eg, National Care Standards, to take account of palliative and end of life care.</li> <li>- Putting in place processes such as electronic Palliative Care Summary (ePCS) for transfer of information to appropriate professional across sectors.</li> <li>- Work taking forward NES education and good practice programme.</li> </ul>	<p>Reshaping Care for Older People Change Plan in place</p> <p>Review complete.</p>
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	<p>population. Undertaken a review of homecare services.</p>		<p>implement recommendations - Implement the Home Care Scheduling Module in SWIFT following the initial pilot programme  OPR Action – write up and share how we are using SPARRA data, and the outcome being achieved</p>	<p>Scheduling module in place.  Report in place</p>
<p>Financial Update</p> <p>The change fund allocation will be deployed to progress number of initiatives within the development plan. Other targets that are not linked to the change fund will be delivered within existing resources.</p>				
<p>Workforce Implications</p> <p>The ongoing AHP redesign work streams and opportunities presented by CHOP integrated working arrangements will provide workforce capacity to progress targets.</p>				

1.8 **Primary Care:** We have undertaken a detailed analysis of SPARRA data in relation to alcohol-related repeat admissions and have begun work to clarify routes into specialist alcohol services. We have also completed a local mental illness complexity strategy which has delivered useful intelligence on deprivation and multiple mobility.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
<p>2010/11 Patients can access primary care at the place and time they need it, including out of hours.</p>	<p>Agree robust systems to test and measure the access available for patients across primary care, including variation and gaps in access, particularly in relation to specific groups who may experience difficulties in accessing services due to disability, race or gender.</p> <p>Gain a full understanding of barriers to access. There is a lack of a clear measure of access</p>	<p>Health literacy work showing use of AIP and equalities scheme to practices/contractors – offers of support to practices from CHOP office.</p> <p>We will continue to support and maintain the 48-hour access monitoring system, which measures</p>	<p>We will progress the health literacy agenda in relation to health improvement (e.g. teenage smoking and newly diagnosed type 1 diabetes)</p> <p>Maintain our good levels of performance re 48 hour access, focussing on improving wherever</p>	<p>HEAT 8 – Smoking  Improved cognition of the health message  48 hour access stats.</p>

<p>2010/11 Primary care provides a range of service to meet patient needs in different settings and with appropriate entry arrangements.</p> <p>2010/11 Ensure that patients have information and access to alternative services to ensure that primary care is used appropriately.</p>	<p>which looks at ability to register within a local area, appointment arrangements, and any differential access for different groups such as communication or literacy issues.</p>	<p>appointment availability with appropriate member of the GP Practice team to maintain a minimum performance of 95% and aim to improve 48 hour access from May 2010 baseline of 95% to 98% by May 2011.</p> <p>Submission date. May 2010 95% achieved 48hr access (baseline). Nov 2010 94% 48hr access achieved; (current).</p>	<p>possible.</p> <p>Continued support from Project Managers to Practices to achieve access improvements.</p> <p>Addressing relatively poor performance through QOF visits, with specific focus on one particular outline. 5 of 16 undertaken this for and raised at GP forum.</p> <p>OPR – Address our relative poor performance in GP advance booking and devise and action plan to respond across practices</p>	<p>Advance booking stats/ GP satisfaction surveys</p> <p>QDA results.</p> <p>Quality Improvement Visits.</p>
<p>2010/11 Primary care provides a range of service to meet patient needs in different settings and with appropriate entry arrangements.</p> <p>2010/11 Ensure that patients have information and access to alternative services to ensure that primary care is used appropriately.</p>	<p>Review potential for directories of services at locality level as a means of improving referral and access by patients.</p> <ul style="list-style-type: none"> <li>- Review local information and local alternative services.</li> <li>- Maximise partnership working with local voluntary, partner agencies and primary care providers by exploring issues and current barriers to accessing services</li> <li>- Including entry arrangements and current knowledge of services.</li> </ul> <p>Utilise existing networks and engagement forums to determine the most effective method for communicating and informing</p>	<p>A good example of a local directory of service completed in 2010/11 is CARE (COPD, Awareness &amp; Respiratory Education) group engages health, voluntary representatives in care for COPD locally and improve services. This group addresses issues and provides education to support Clinicians in the management of COPD and Respiratory conditions. Palliative care services directory launched in Nov 10. Directory in place via Keepwell Wave 2/4 re community based external service providers.</p> <p>Keep well – external service provider, info leaflet to PPF, voluntary organisations and community groups regarding</p>	<p>We will continue to use existing forums and referrals to deliver on a shift in the balance of care (eg link to reshaping care for older people).</p>	

	<p>patients of services provided and accessible.</p> <p>To improve communication and information sharing, by the end of year 1, we will have developed a directory of services or enhanced existing directories to inform and increase both patients and referrers knowledge of services available at local level.</p>	<p>services available from your GP.</p> <p>Opportunities to engage with 3<sup>rd</sup> sector service have been expanded via community based services pathway.</p>		
<p>2010/11 Primary care services seek and are responsive to patient views.</p>	<p>Test different models of patient engagement, building on existing PPF structures, QOF and GP Survey results to determine the most effective means of generating robust information:</p> <ul style="list-style-type: none"> <li>- at practice level;</li> <li>- in planning;</li> <li>- in individual consultations;</li> <li>- with specific communities of interest.</li> </ul> <p>By the end of year 1 we will have scoped our existing engagement mechanisms and undertaken an evaluation of local best practice.</p>	<p>We have opened dialogue with GP practices regarding the use of patient fora and have participated in two such groups to gauge level of usefulness.</p>	<p>Intention to agree a shared approach and exploit learning from both Health and Social Work through an agreed tool for gathering and analysing user experience/ feedback.</p> <p>Beyond year 1 we will examine learning from other parts of the system with a view to developing a consistent and effective process for routine patient engagement, and use this to inform our local plans, annual engagement and communication as part of our planned local review.</p> <p>Revisit audits of engagement undertaken and use these to inform our new local plan as above, including the potential for use of GP practice patient fora.</p>	<ul style="list-style-type: none"> <li>• Tell us your story model to obtain patient experience feedback.</li> <li>• Revised integrated arrangements for PFP/Engagement</li> </ul> <p>CHCP action plan in place for PFP/engagement, including practices (CHCP public involvement framework).</p> <p>Inclusive model of patient involvement in place as part of CHCP public involvement framework.</p>
<p>2010/11 Primary care services understand and respond to the inequalities which affect patients in accessing primary care and onward referral to secondary care.</p>	<p>Develop and pilot models of clinical practice, and practice organisation, which identify and address complex health and social circumstances, including:</p>	<p>Work re SPARRA/ Alcohol and practices</p> <p>Pathway development regarding alcohol related incident follow up.</p>		

	<ul style="list-style-type: none"> <li>- develop descriptors of effective practice;</li> <li>- clarify the link between inequalities and individual patient characteristics;</li> <li>- work with small teams to develop and implement the model;</li> <li>- models of professional leadership and behaviour change;</li> <li>- clear pathways into employability and financial inclusion support in the community;</li> <li>- collection of appropriate data;</li> <li>- different experience and needs of specific communities due to, e.g. disability, race, gender.</li> </ul>	<p>Development of clinical improvement steering group.</p> <p>Referral pathway via keep well. Other models include area wide</p> <p>PLT session (4 per year). ~ 2 In-house, 2 CHOP wide.</p> <p>CPD elements for contractors via existing forums including dental, pharmacy, GP, Optometry.</p> <p>Symptom reporting re LD (diagram booklet)</p> <p>We have developed local policies for working with Homeless people and travellers (especially in relation to cancer screening).</p> <p>Child Smile will be incorporated in GDP contract. At present 10/11 GD practices deliver Child Smile Service.</p> <p>Prison Work is in development – our clinical director and Head of Mental Health, Addictions and Homelessness are on the programme board, to ensure robust</p>	<p>We will hold an education session on effective PLT to be delivered by our local NES advisor to support managers in organising in-house PLT sessions. Timescale June 2011.</p> <p>Continue to develop models of education for contractors to meet CHOP priorities (ie. Adult Protection, Child Protection).</p>	
<p>2010/11 Primary Care services are comprehensive in their coverage and provide continuity of care where needed.</p>	<p>Build on the child smile programme to increase the numbers of children with a dentist, to support prevention and early intervention.</p> <p>By the end of year 1, we will have explored different methods/models of working including geographical to improve the delivery and quality of care (i.e. Nursing Homes and</p>		<p>We will continue to explore more efficient modes of primary care (eg in community)</p> <p>Deemed not to be feasible to move</p>	

<p>2010/11 Primary care services are resourced to meet the demands they face and to meet the needs of patients.</p>	<p>prison Service).</p> <p>We will also have explored potential opportunities to work collaboratively (e.g. minor surgery).</p> <p>By the end of year 1, we will have a robust plan to increase the number of GPs participating in the Childsmile programme.</p>	<p>clinical and cost-effective handover. There will be liaison with the Head of Criminal Justice services.</p> <p>Nursing Homes-Collaboration in visiting homes but no real appetite to develop a model.</p> <p>Was explored in detail – issues with secondary care interface and suspected impact on training cases being lost.</p>	<p>forward – lack of support from GP group.</p>	
<p>2010/11 Primary care services are resourced to meet the demands they face and to meet the needs of patients.</p>	<p>CH(C)P planning should take full account of the impact on primary care demand and type of service required due to demographics and patterns of illness, specifically:</p> <ul style="list-style-type: none"> <li>- long term conditions;</li> <li>- mental health, including depression;</li> <li>- alcohol;</li> <li>- ageing population.</li> </ul> <p>By the end of year 1 we will have developed routine intelligence that allows us to map access to primary care, and utilisation of existing capacity. In particular, we will focus on LTCs; mental health, including depression; alcohol, and our ageing population.</p> <p>We will also have:</p> <ul style="list-style-type: none"> <li>- Gained a clearer understanding of the variation in the types of services available across the different practices.</li> <li>- Ensured access to an</li> </ul>	<p>Maintain local focus on services to suit the needs of the population to ensure that delivery of care is in the most appropriate setting.</p> <p>Closer working monies enabled a focus on: implementation of LCP and Review of 0.75% of population on long term anti depressants.</p> <p>Access to primary care data continues and proves a challenge.</p> <p>We have completed a local mental illness complexity strategy which has delivered useful intelligence on deprivation and multiple mobility.</p> <p>No concerns on annual level of variation amongst practices.</p> <p>There remains a gap in mental</p>	<p>We will use SPARRA mental health data in 2011/12 to inform local planning and determine actions required</p>	<p>Review of SPARRA mental health data completed</p>



	<p>appropriate range of services out of hours. Developed clearer intelligence about how Inverclyde's population use Primary Care services.</p> <p>Maintain a local focus on services to suit the needs of the population to ensure that the delivery of care is in the most appropriate setting. (primary vs secondary care).</p> <p>By the end of year 1 we will have identified areas of work that could be considered for future enhanced services/programmes including opportunities for use of interventions (telecare and outreach) to maintain patients with long term conditions, elderly care, complex or mental health issues) in the community.</p>	<p>health. Crisis service being developed in MH, CAMHS, Psychological services now in place. Issues regarding access to primary care data.</p> <p>Near patient testing, coming out of QOF previously secondary care</p> <p>Sign 121 – re dermatology</p> <p>Annual assessments await OGI.</p> <p>Links to above. Also linked into Scottish Centre for telehealth re diabetics.</p>	<p>Await outcome of OGI and move forward appropriate.</p>	
<p>2010/11 Premises for primary care services are planned and resourced to reflect service requirements.</p>	<p>CHCP accommodation strategies to include clear plans for independent contractor premises including consideration of the potential for joint working and effective use of premises within localities across the 4 independent contractors groups. This should include:</p> <ul style="list-style-type: none"> <li>- plans to address accessibility issues including DDA compliance;</li> </ul> <p>By the end of year 1 we will have developed a local accommodation strategy that maximises the opportunities that will emerge as our CHCP becomes established.</p>	<p>One of our practices will move into accommodation in the new Kilmacolm community centre in Summer 2011</p> <p>We have completed:</p> <ul style="list-style-type: none"> <li>• vacating Elizabeth Martin clinic</li> <li>• Outline of capital scheme for expansion of Gourrock health Centre (subject to funding)</li> <li>• Move of Nicol Street centre to Dalrymple House and Mearns centre.</li> <li>• Move of Strone Office to Dalrymple House; and</li> <li>• Establishment of CHCP HQ to Kim House with relocation of staff from Roxburgh House,</li> </ul>	<p>Formal accommodation strategy to be developed however a number of tentative proposals are underway/ being developed:-</p>	<p>Accommodation strategy in place:</p>

<p>2010/11 Primary care has a clear place at the centre of NHSGGC planning, decision making, resource allocation, communication and public engagement.</p>	<p>Develop a model of locality groups which create structured engagement and joint working between independent contractors, community staff and CHCP management. These will:</p> <ul style="list-style-type: none"> <li>- enable shared decision making on service delivery and use of resources;</li> <li>- provide an opportunity for independent contractors and frontline community staff to bring about change;</li> <li>- strengthen and encourage innovation and development including the testing of new ideas;</li> <li>- focus on effective primary care team working, including exploring different models of attachment and alignment;</li> <li>- be structured around natural communities and local circumstances within individual CH(C)P areas;</li> <li>- contribute to strengthening engagement with patients;</li> <li>- provide a primary care perspective to inform the CH(C)P interface with secondary care;</li> <li>- support independent contractors to work together including professional</li> </ul>	<p>Dalympole House, Belville Street and selected staff from Greenock Health centre.</p> <ul style="list-style-type: none"> <li>• Move MH partnership from Cathcart Street and Ravensraig to crown House</li> </ul> <p>Considered by PEG and GP forum and there is no appetite for a sub-Inverclyde locality model.</p> <p>Actively encourage via PEG, GP Forum and Clinical improvement steering group.</p> <p>As per plans stated above re engagement.</p> <p>Acute sector interface group GP/Consultant Forum.</p> <p>Education sub group has been established in line with CPD advisor being put in place. Development</p>	<p>We do not intend to progress with subdividing Inverclyde into smaller locality units.</p>
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<p>2010/11 The independence of primary care practices is balanced with cooperation where that is in the interests of patients.</p>	<p>development.</p> <ul style="list-style-type: none"> <li>- By the end of year 1, we will also have reviewed existing PEG arrangements to further improve and enhance this forum.</li> </ul>	<p>programme being developed.</p> <p>Reviewed in light of move to CHCP and invited renewed SW engagement. PEG development sessions held and PEG starting to revitalise.</p>	
<p>Develop further models of community service provision which are based around the practice structure. To achieve this we will need to:</p> <ul style="list-style-type: none"> <li>- explore opportunities for working with groups or 'clusters' of practices;</li> <li>- consider the implications for small or single handed practices to ensure they benefit from changing arrangements.</li> </ul> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Explored opportunities for working with groups or 'clusters' of practices.</li> <li>- Scoped Spend to Save options in response to financial pressures.</li> <li>- Further progressed joint working with the OHD in order to develop and implement an appropriate model of dental care centre thereby improving local access to specialist dental services.</li> <li>- Finalised plans for our Community Dental Service Redesign, and implemented</li> </ul>	<p>Thinking about working on a cluster/ collaborative model we have explored a proposal to do single CHCP minor surgery service. This has not developed beyond feasibility study due to a lack of appetite amongst practices, the cost of providing a 'shared' service would exceed costs of providing services in the current model.</p> <p>GP practices have robust contingency plans established. This involves 'buddy arrangements'.</p> <p>Re Spend and Save options, in the area of COPD telehealth, the evaluation showed that the £50k expenditure avoided opportunity costs of £450k. This would be borne out if took a higher number of patients in the programme based on economies of scale on the costs, based on the recommendations of the COPD telehealth pilot which we are pursuing.</p> <p>Rational prescribing schemes invest in pharmacists to improve clinical and cost effectiveness of</p>	<p><b>OPR Action</b> – Ensure a solution is found to the issues related to dental chairs at Greenock Health Centre/IRH</p> <p>We will continue to scope opportunities to scale up spend to save opportunities i.e. have undertaken Challenge remains the release of costs avoided.</p> <p>Continue and ensure focus adhered to re reduced costs.</p>	

<p>Primary care has effective leadership and is innovative.</p>	<p>these in collaboration with the OHD</p> <ul style="list-style-type: none"> <li>- Further developed our work on prescribing, which is both clinically and cost effective via local prescribing management activity focussed on rational/formulary prescribing, management of depression and promoting the elimination of wasted medication (including patient involvement)</li> </ul>	<p>prescribing. A 1.6% overspend in our prescribing budget in March 2010 (from 6.35% in August 2009) and been reduced to 0.7% expected in March 2011 (currently 2.3% in August 2010).</p> <p>Further discussions have taken place with regards to the IRH dental centre proposal. The detail of the proposal is being reconsidered. Locally we will await the outcome of this review and contribute where possible.</p> <p>Rational prescribing scheme:</p> <ul style="list-style-type: none"> <li>- Promotion of elimination of wasted medicine</li> <li>- Methotrexate audit to ensure patient safety and find position as a CHCP.</li> </ul> <p>Means of rationalising GP response to Nursing Homes had been discussed but reverted to improved advice and guidance to Nursing Homes.</p>	<p>Ongoing</p> <p>1<sup>st</sup> done/ 2<sup>nd</sup> cycle to take place and action plan to be prepared.</p> <p>Action plan being prepared to focus on lessons learned and link to outcomes agreed in GP re Mental Health.</p> <p>We will improve review advice and guidance to nursing care homes</p>	
<p>Primary care has effective leadership and is innovative.</p>	<p>Identify and promote good practice within a model of professional leadership.</p> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Implemented Keep Well Wave 4, with the six practices identified.</li> </ul>	<p>This has been achieved</p> <ul style="list-style-type: none"> <li>- Developed a system for monitoring Keep well 4 referrals into community based Health Improvement services.</li> </ul> <p>A referral tracking database is in place to replace the Keepwell</p>	<p>We will work to take forward the agreed model for the extension of Keepwell when this is established.</p>	

	<p>2010/11 The primary care workforce is appropriately trained and professionally developed.</p>	<p>Ensure protected learning time is used effectively to delivery primary care priorities, across all contractor groups.</p> <p>Establish effective development programmes for key staff groups including practice managers and practice nurses.</p> <p>Develop a model of locality groups, which create structured engagement and joint working between independent contractors, community staff and CHCP management. These will:</p> <ul style="list-style-type: none"> <li>- Enable shared decision making on service delivery and use of resources;</li> <li>- Provide an opportunity for independent contractors and frontline community staff to bring about change;</li> <li>- Strengthen and encourage innovation and development including the testing of new ideas;</li> <li>- Focus on effective primary care team working, including exploring different models of attachment and alignment;</li> <li>- Be structured around natural communities and local circumstances within individual CH(C)P areas;</li> <li>- Contribute to strengthening</li> </ul>	
tracking tool which has not proven fruitful in Inverclyde	<p>Review of PLT and CPD arrangements and develop programmes of future priorities.</p> <p>Establishment of a rolling 6 monthly CPD programme for contractors.</p> <p>Appointment of NES associate CPD advisor.</p>		
		<p>PLT programmes tailored to needs of a group with rolling programme available for topics including Child Protection and Adult Protection.</p>	

	<p>engagement with patients;</p> <ul style="list-style-type: none"> <li>- Provide a primary care perspective to inform the CH(C)P interface with secondary care;</li> <li>- Support independent contractors to work together including professional development.</li> </ul> <p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Reviewed PLT and developed a programme of future priorities.</li> <li>- Contributed to the Board-wide review to reconfigure the AHP workforce in line with skill-mix recommendations.</li> <li>- By the end of year 1 we will have reviewed our existing engagement structures between independent contractors, community staff and CHCP management and have a model in place that:</li> <li>- Enables shared decision making.</li> <li>- Provides opportunities for independent contractors and frontline community staff to bring about change.</li> <li>- Strengthens and encourages innovation.</li> <li>- Focus on effective primary care team working.</li> <li>- Is structured around natural communities and local circumstances.</li> <li>- Contributes to strengthening engagement with patients.</li> <li>- Provides a primary care</li> </ul>	<p>GP forum/GP Consultant forum Director and CD have a programme of practice visits in place for 2011/12</p>	<p>Undertake practice visits.</p>	
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	perspective to inform the CHCP interface with secondary care. - Supports independent contractors to work together including professional development.			
2010/11 There is a robust and clear plan to ensure the future workforce for primary care.	Reach collective agreement with the LMC (and other contractor representative bodies) to collect comprehensive workforce information to support effective workforce planning arrangements.  By the end of year 1 we will have contributed to the Board-wide programme to reach collective agreement with the LMC to collect workforce information.	Contribute to the Board wide programme to reach collective agreement with LMC workforce information. Implement any agreed actions.	Awaiting direction from Lead Director (David Leese)	
2010/11 Effective and agreed partnerships are in place between primary care, Local Authority and other services.	Implement an agreed model of NHS provision of Prison Health Services in line with Scottish Government Health Department Policy  Engage with carers in line with the Carers Charter and improved access to primary care and community health services	Various board wide workstreams are progressing against a national timeframe. Key national decisions need to be moved forward in order for project to come to a conclusion.  As at November 2010 there were 1112 carers registered with GP practices.  Improved links between practices and the Carers Centre with support from PASS are positive aspects of our work to improve primary and community care and respond to the needs of carers	By the middle of year 2 we will have developed proposals for a model of NHS provision of Prison Health Services as part of a Board wide plan.	
2010/11 Primary care services have clear and consistent approaches to engage patients and the public and respond to their views.	By the end of year 1 we will have improved our intelligence about the profile of our unpaid carer population.			

<p>2010/11 Primary care can access the full range of supporting secondary services if requires in the timeline and model required.</p>	<p>Explore changes to processes and systems needed to ensure that there is clear joint ownership of service challenges across acute services and CHCPs including:</p> <ul style="list-style-type: none"> <li>- managing demand;</li> <li>- population health;</li> <li>- quality of care;</li> <li>- levers and incentives for change;</li> <li>- using evidence of effective models and lessons from other systems.</li> </ul> <p>Develop effective information flows and relationships between secondary and primary care including:</p> <ul style="list-style-type: none"> <li>- clear and systematic opportunities for direct clinical contact (including GPs, dentists, optometrists);</li> <li>- clinical engagement on redesign and RTT;</li> <li>- joint agreement on thresholds for access and referral;</li> <li>- use test sites, starting with the Renfrewshire CHC)/RAH interface, to identify system changes required to support engagement on day to day activity and pathway redesign.</li> </ul> <p>Ensure short term delivery of specific improvements to the acute/primary care interface, specifically:</p> <ul style="list-style-type: none"> <li>- discharge information;</li> <li>- medicines management and hospital prescribing;</li> <li>- access to investigations;</li> </ul>	<p>Establishment of joint group with acute challenges and utilise existing forums on improving discharge planning, e.g. prescriptions, clinical data, co-ordination and partnership working.</p> <p>Establishment of Clinical Improvement Steering Group.</p> <p>SPARRA - use of data to determine if those patients are at risk and if admissions are receiving optimal care in the community.</p>	<p>Continue to develop models of work and improvements via the clinical improvement steering group and GP/ consultant forum to ensure that issues are addressed appropriately.</p>
<p>Our Acute/Primary Care interface group continues to meet. We are aware of and await the outcome of the electronic discharge pilot at RAH.</p>	<p>Take any relevant action as a result of the pilot.</p>		



<p>2010/11 Gaps and challenges to services are fully considered in reviewing and changing the distribution of resources.</p>	<ul style="list-style-type: none"> <li>- improving access/streamlined patient pathways.</li> </ul> <p>Communicate change effectively through regular reporting on progress with actions on interface and redesign.</p> <p>We will also have delivered specific improvements to the acute/primary care interface in relation to:</p> <ul style="list-style-type: none"> <li>- discharge information;</li> <li>- medicines management and hospital prescribing;</li> <li>- access to investigations;</li> <li>- improving access/streamlined patient pathways</li> </ul> <p>Beyond year 1 we will identify the key primary/acute care interface demand areas and map the patient pathways with a view to identifying opportunities for streamlining</p>	<p>We are engaged in an MRI Knee pilot designed to speed up the patient pathway.</p> <p>Medication waste campaign was to be delivered by local prescribing support team.</p> <p>We have progressed this action via our work on SPARRA data and alcohol, putting in place routine referral and sign posting from A&amp;E to specialist alcohol services.</p>	<p>Identify areas of work via SPARRA data to develop future enhanced service/ programmes including opportunities for use of interventions/ telecare and outreach to maintain patients with long term conditions, elderly care, complex or mental health issues within the community.</p>	<p>SPARRA data analysis to focus on alcohol presentation, A&amp;E and support in the community.</p> <p>Closer working monies utilised in a variety of ways to deliver local objectives.</p> <p>Implementation of CCP</p> <p>Review of patients on long terms depressants.</p>
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<p>2010/11 Care pathways between primary and secondary services are planned and designed in partnership including the resources required and there are agreed feedback arrangements about utilisation and appropriateness.</p> <p>The mutual independence between primary care and other services is recognised and planned for.</p>	<p>Implement agreed approach (by Acute/CHC/P Directors Group) to ensure short term delivery of specific improvements to the Acute/Primary Care interface, specifically:-</p> <ul style="list-style-type: none"> <li>- Discharge information</li> <li>- Medicines management and hospital prescribing</li> <li>- Access to investigations</li> <li>- CHCP to develop stronger response within primary care on issues placing significant demand on secondary care e.g. alcohol (Y1 and Y2)</li> </ul>	<p>Developed a process for improving links between secondary/primary care to implement more effective ways of communicating medication changes to patients and GPs and Pharmacist.</p> <p>Development of clinical improvement steering group and GP/Consultant forum to direct areas of joint work.</p>	<p>Ongoing engagement with contractor forums to identify areas of improvement in service, delivery process and pathways.</p>
<p>By the end of year 1, we will have</p> <ul style="list-style-type: none"> <li>- Established mechanisms to improve information flows and relationships across primary and secondary care, including discharge planning e.g. prescriptions, communication, co-ordination and partnership working.</li> <li>- Explored opportunities for improving systems/data required for follow up.</li> <li>- Formal procedures for ensuring communication breakdown is followed through and improved upon.</li> </ul>	<p>Work undertaken regarding SCI referral which has yielded improvements in our SCI referrals rates.</p>	<p>We will take this forward as part of new outputs.</p> <p>We have progressed work to secure improved communication of notification of death paperwork etc.</p>	<p>We will follow up these actions specifically in relation to the change fund work.</p>

**Financial Update**

The financial implications are small and should have little impact locally. The financing of the change of practice premises in Kilmacolin is likely to be made by Practitioner Services.

**Workforce Implications**

The development of Primary Care Services as outlined above should be met from the present workforce.

1.9 **Sexual Health:** In the last year we have developed a 2 day CPD programme for school teachers and have delivered 5 sets of courses for staff. We also commissioned a bespoke sexual health citizen's panel through the council, as well as an on-line ga men's health needs assessment.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
<p>Deliver efficient and economic services</p>	<p>By the end of year 1 we will have a fully agreed local sexual health action plan that includes:</p> <ul style="list-style-type: none"> <li>- A response and set of actions around the key findings of the recent Inverclyde Gay Men's Health Survey, in particular, the finding that a high proportion of the respondents regularly engage in unprotected sex;</li> <li>- A commitment to work with Sandyford and Greenock Prison to address specific sexual health needs at the prison (male and female prisoners have different but identified unmet sexual health needs).</li> <li>- A process to monitor STI testing and incidence rates</li> <li>- A commitment to work with local partners in the Violence Against Women Multi Agency Partnership (VAMWAP) and Community Safety Partnership to raise awareness about sexual abuse from a partner in relationships</li> <li>- A structured timetable to work with communities of all ages to raise awareness about the role of alcohol in increasing sexual</li> </ul>	<p>Timelines slipped due to the temporary suspension of the SHLIG due to major Council and CHCP reorganisations. However, the group has now re-convened and will meet on the 30<sup>th</sup> November 2010.</p> <p>This work will be subsumed into the Board-wide negotiations around Prison Health Services.</p> <p>STI testing rates data will be available from Sandyford in the annual data report due in May 2011. The most recent information indicates that between January and June 2010, Inverclyde sexual health services were accessed by 1,568 people (1,190 female and 378 male), with the majority being between 16-24 years old. 55% were from the most deprived SIMD quintile indicating that inequalities targeting is effective.</p> <p>Information pamphlets have been developed and will be distribute as</p>	<p>Implement the recommendations of the GMHNS as per chosen direction of the SHLIG and in line with agreed priorities, evidence of need and affordability. (Indicators derived from the recommendations approved at November SHLIG)</p> <p><b>OPR Action</b> – resolve accommodation issues for Sandyford Inverclyde.</p>	<p>We are working with the estates department to secure agreement to upgrade the Sandyford Hub premises which will also resolve reported accommodation issues</p> <p>Programme delivered and evaluated.</p>

	risk taking behaviour.	<p>part of the Safer Streets campaign in December 2010. The pamphlets will also be adapted for Board-wide use and distribution, and Inverclyde versions will be distributed to all CHCP staff in the new year.</p> <p>Our Youth Sexual Health Worker is taking this forward through the 'Girl Power' programme.</p> <p>These data are published on an annual basis and will be available from Sandyford in the annual data report due in May 2011.</p> <p>The C-card review is now complete and recommendations will be incorporated into our local action plan.</p>		
Deliver care in the right setting	By the end of year 1 we will have developed a process to monitor levels of LARC provision and HIV testing in primary care.			
Deliver better care through early intervention	By the end of year 1 we will have a fully agreed local sexual health action plan that includes a programme for condom provision in line with recommendations that emerge from the recent review undertaken by Sandyford.			
Focus on the most vulnerable people	<p>Analyse barriers to access to services and implement improvements to access to Primary Care to address socio-economic issues for:</p> <ul style="list-style-type: none"> <li>- LGBT people</li> <li>- African people with or at risk of HIV</li> <li>- Looked after and accommodated Children</li> </ul> <p>By the end of year 1 we will have undertaken an EQIA in respect of our local sexual health action plan to ensure that it is equalities sensitive across all populations.</p>	EQIA will be undertaken early in 2011.	Complete EQIA process and achieve quality assurance sign off by 31 <sup>st</sup> March 2011.	Signed off EQIA and report on action to be taken.

<p>2010/11 Prevent sexual ill health</p> <p>2011/12 Promote sexual wellbeing and prevent sexual ill-health.</p>	<ul style="list-style-type: none"> <li>- Deliver linked programmes and services aimed at reducing teenage pregnancies in 13 to 15 year olds</li> <li>- Provide high quality consistent sexual health and relationships education in schools and for young people both in and not in school.</li> <li>- Provide interventions to improve communication between parents and children on sexual health and relationships</li> <li>- Increase vaccination rates for HPV and Hep A, B and C</li> <li>- All CHCPs should have plans to improve sexual health visible in the work of their Health Improvement Team (Sexual Health). CHCPs need to agree with the</li> </ul>	<p>Teenage pregnancy data are published on an annual basis and will be available from Sandyford in the annual data report due in May 2011.</p> <p>In the last year we have developed a 2 day CPD programme for schools teachers and have delivered 5 sets of courses for staff following an externally commissioned review of SHRE in Inverdyde Schools.</p> <p>We commissioned a bespoke sexual health citizen's panel through the council which indicated that there are some communications issues that need to be addressed. The SHLIG has set up a short-term working group to take this forward, including exploring possibility of bolstering parental communications through the use of e-mail.</p> <p>Vaccination data are published on an annual basis and will be available from Sandyford in the annual data report due in May 2011.</p> <p>Incorporated into team workplan.</p>	<p>2011/12 Action</p> <p>Deliver accessible free condoms at local level for young adults and specific target populations, including people living with HIV, MSM and sub-Saharan Africans.</p>	<p>Condom distribution data reports</p>
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	<p>specialist team the balance of roles and responsibilities for delivering key programmes of work including SHRE training for teachers.</p> <ul style="list-style-type: none"> <li>- Ensure performance measures are in place for all sexual health improvement programmes and services and reported to the planning groups .</li> </ul>	<p>Local plan under development as described earlier.</p>		
	<p>By the end of year 1 we will have a fully agreed local sexual health action plan that includes a commitment to work with Sandyford, Community Planning Partners, and with Primary Care Independent Contractors to</p> <ul style="list-style-type: none"> <li>- reduce STI rates amongst young people;</li> <li>- reduce the number of pregnancies in 13-15 year olds</li> <li>- raise awareness of the implications of sex under the age of 16, and its association with alcohol; regret; non-use of contraception/barrier protection, lack of school based SHRE and lack of communication with parents on SHR4</li> </ul>	<p>Routine data reports have now been agreed and should be delivered by Sandyford from early 2011.</p> <p>Most of the other data are published on an annual basis and will be available from Sandyford in the annual data report due in May 2011.</p> <p>Issues raised by that report will be taken forward through the revised SHLIG action plan.</p>		

**Financial Update**

The work around improving sexual health has been mainstreamed into our overall health improvement activity, so is funded through recurring money.

**Workforce Implications**

We have one health improvement practitioner who focuses solely on sexual health, but this worker is also a member of the core health improvement team, ensuring clear linkages across team workstreams.

1.10 **Unplanned Care:** We have put a rolling CPD calendar in place for contractor multi disciplinary teams to help develop approaches to unplanned care. Input from each contractor forum provides an opportunity to direct and create a shared learning approach to professional development. One initiative to emerge from this is the introduction of phone triage for MSK Physio and phone consultations in some practices.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
<p>Unplanned Care has a clear place at the centre of NHSGGC planning, decision making, resource allocation, communication and public engagement.</p>	<p>By the end of year 1 we will have developed a structure which will support engagement and joint working between primary and secondary care, and independent contractors and which will allow for:</p> <ul style="list-style-type: none"> <li>- Shared decision making on service delivery and use of resources.</li> <li>- Strengthened innovation and development including the testing of new ideas.</li> <li>- Strengthened engagement with patients, carers and communities.</li> <li>- Supporting independent contractors to work together including professional development.</li> <li>- Effective communication/information sharing across partners.</li> </ul>	<p>This is being taken forward through our GP/Consultant Forum and Primary/Secondary Interface Group</p> <p>Addressed via our Clinical Improvement Steering Group – examples include MRI Knee pathway work /Dementia Registers/Bright Ideas Fund re LD symptom charts and the Minor surgery proposal</p> <p>Evidenced via work on COPD and through PPF/ IRH forum</p> <p>There is a rolling CPD calendar for contractor multi disciplinary teams supported by NES in terms of quality assurance for delivery of courses. Input from each contractor forum provides opportunity to direct and create a shared learning approach to professional development.</p> <p>Development evident through SPARRA work at CHOP level e.g. Checking with social work and health visitors re paediatric admissions/risk and A&amp;E data with addictions services.</p>	<p>We will participate in the pilot which commences 1<sup>st</sup> April 2011-02-16</p> <p>As per action in Primary Care section.</p> <p>Agreed a pathway for those patients at risk of alcohol related attendances at A&amp;E to access screening and prompt referral to alcohol services.</p>	<p>More appropriate referrals to Orthopaedics. Reduction in Orthopaedic waiting times.</p> <p>Pathway in place.</p>

<p>Unplanned care services seek and are responsive to patient views</p>	<p>By the end of year 1 we will have developed a structure which will support engagement and joint working between primary and secondary care, and independent contractors and which will allow for:</p> <ul style="list-style-type: none"> <li>- Strengthened engagement with patients, carers and communities.</li> <li>- A better understanding of the interface between the use of GP services and A &amp; E.</li> <li>- Actively encouraging appropriate access to unscheduled care services in both primary and secondary care.</li> </ul>	<p>Refer back to responses and actions in acute framework</p> <p>We have seen local improvements since the introduction of phone triage for MSK Physio and phone consultations in some practices.</p>	<p>We will continue to pursue our work in relation to SPARRA, to highlight the characteristics of the GP / A&amp;E interface. And understanding variability.</p> <p>We will use evidence from SPARRA to try and influence changes to patterns of behaviours of patients based on the evidence.</p>	<p>Referral rates and attendance rates at A&amp;E</p> <p>Reduced A&amp;E presentations linked to alcohol in line with the agreed management protocol</p>
<p>Premises for unplanned care services are planned and resourced to reflect service requirements.</p>	<p>By the end of year 1 we will have explored the potential for service enhancement afforded by the possible co-location of out of hours primary &amp; secondary care services, and will have developed local proposals.</p>	<p>This action has not been progressed and will be picked up with OOH in year 2 pending OOH initiation.</p>	<p>We will progress this action in year 2</p>	
<p><b>Financial Update</b></p>				
<p>There are no immediate financial implications resulting from the above, although routine referral to alcohol services from A&amp;E may have an impact in the longer term</p>				
<p><b>Workforce Implications</b></p>				
<p>There are no workforce implications resulting from the above.</p>				



## 2. Policy Frameworks

### 2.1 **Employability, Financial Inclusion and Responding to the Recession:** Bronze Healthy Working Lives Award achieved and we are working towards Silver, and the implementation post for Healthier, Wealthier Children has now been appointed.

Outcome	Action Identified for 2010/11	Change/Progress/ Performance Indicator	Action 2011/12	Change/ Progress/ Performance Indicator
Our patients have been given the opportunity to maximise their employability aspirations.	<p>By the end of year 1 we will have implemented work to:</p> <ul style="list-style-type: none"> <li>- raise awareness with staff groups on the benefits of work and work related involvement for service users.</li> <li>- create a culture of aspirations towards employability within the CHCP and across Community Planning. Continue to work with CPP partners through SOA processes.</li> <li>- Develop with condition management care pathway.</li> </ul>	<p>Training delivered to 58 NHS staff.</p> <p>We have worked with the Inverclyde Alliance to develop specifications for employability services in Inverclyde, following up from FSF.</p> <p>Completed prior to dissolution of the service. Secure/ staff resource from NHS GG&amp;C displaced staffing pool to boost awareness raising about health benefits to employment.</p>	<p>Continue to roll out employability and health training to all staff, including the Community Development Trust as our training partners and as the one stop shop for referrals.</p> <p>Continue to support the local employment engagement unit with a health secondee one day per week.</p> <p>OPR Action – report to May 2011</p> <p>OPR on re-commissioning process and tendering for employability pathways</p>	<p>Number of sessions delivered.</p> <p>Number of staff trained.</p> <p>Number of small to medium sized employers engaged in the employability and health agenda.</p> <p>Health secondee in place.</p> <p>Report to OPR (May 2011)</p>
<p>We have improved the health of our staff and actioned the requirements of Healthy Working Lives.</p> <p>2011/12</p> <p>We have increased (NHS GGC) staff retention for people who are at risk of losing their job as a result of social circumstances or illness.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Achieved the Healthy Working Lives Bronze Award.</li> <li>- Raised awareness amongst Independent Contractors about the benefits of registering to work towards the Healthy Working Lives award.</li> <li>- Raised awareness amongst local employers to register and work towards the Healthy Working Lives Award.</li> </ul>	<p>We have achieved Bronze status for Healthy Working Lives and are working towards our Silver award.</p> <p>It has been agreed that the CHCP progresses the work initiated by the CHCP in terms of achieving the Silver Award. Inverclyde Council has already achieved Gold status and will work with the CHCP Healthy Working Lives Group to provide valuable support.</p>	<p>We will strive to achieve the Healthy Working Lives Silver Award in 2011/12.</p>	<p>HML Silver Award.</p>

<p>2011/12 we have provided staff with support to deal with financial issues which might impact on their work situation.</p>		<p>We continue to support practices in relation to Healthy Working Lives. As yet no practices are working towards their own awards.</p> <p>Healthy working lives guidance has been used to shape Inverclyde nutrition policy. A draft is currently available with a final publication due in 2011. Aim to promote local businesses which display the HML award and have healthy catering in place for members of staff and the general public.</p>	<p>Engage through the FSF appraisal group in awarding contacts and monitoring to SOA Programme Board.</p>	<p>(1 year) KPIs in FSF specifications.</p>
<p>2010/11 We have maximised the organisation's contribution to economic regeneration to reduce poverty and income inequality.</p> <p>2011/12</p> <p>We have supported people claiming unemployment and disability benefits into NHS jobs.</p> <p>We ensure that the NHS investigates the impact of child poverty.</p>	<p>By the end of year 1 we will:</p> <ul style="list-style-type: none"> <li>- Have worked with NHSGGC Board to develop systems that allow us to commission services from the 3rd sector and do so on a rolling or three year contract in order to develop sustainability in the sector.</li> <li>- Implement the 'Healthier Wealthier Children' implementation plan</li> </ul>	<p>The Council is currently reviewing how it engages with the third sector, and this workstream will need to be consistent with the Council's agreed approach (once agreement achieved). This workstream has therefore been deferred pending completion of the Council's review.</p> <p>Implementation post now appointed and related Income Maximisation Worker based on social work services will start in December 2010. We will have the plan implemented by the end of the funded project in January 2012.</p> <p>Staff in post and delivering on local implementation plan for HMC.</p> <p>We have engaged in the future jobs fund scheme in 2010/11.</p>	<p>Continue to deliver for lifetime of project – look to develop sustainability in main stream services for this agenda.</p> <p>We will undertake any relevant actions from the DWP workplan when produced.</p>	<p>Referrals to income maximisation services and outcome of these referrals.</p>
<p>We have alleviated the financial consequences of illness for patients and the impact of financial</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- A plan in place to assess the</li> </ul>	<p>The Inverclyde Financial Inclusion Strategy is being developed to take</p>	<p>We will work to develop a seamless referral pathway with</p>	<p>Pathway developed and implementation commenced</p>

<p>concerns on recovery.</p>	<p>financial inclusion needs of patients and ensure the majority of our staff know where and how to refer patients for financial inclusion advice. -Engaged with financial inclusion advice providers to scope pathways to support.</p>	<p>account of the move to CHCP. This will include mapping of local financial inclusion data underway. A local study is being undertaken to determine the impact of the spending review, both structurally and in terms of the impact on local people. The local SOA Employability Outcome Delivery Group has undertaken a dedicated session on the links between employability and health on 24<sup>th</sup> November, from which an action plan will be developed.</p> <p>MacMillan welfare rights workers providing financial inclusion information and support to vulnerable groups.</p>	<p>mainstream and 3<sup>rd</sup> sector for service users requiring financial inclusion information and support.</p> <p>We will progress discussions with other partners regarding externally this service to LTCs.</p>	<p>Increase welfare rights information to people with LTCs.</p>
<p>2011/12</p> <p>We have reduced the impact of poverty on early years and on those in greatest need.</p> <p>We have taken a horizon scanning approach to the recession so that we can respond to changes in demand on service and alleviate the consequences on health in the longer term.</p>			<p>Complete local analysis of the future impact of welfare reform.</p>	<p>Complete analysis and response plan agreed.</p>

2.2 **Health Improvement:** Through our SOA processes we have secured agreement to install smoke-free signage in Inverclyde's play parks, and we have secured the Smokefree status of the new Greenock bus station.

Outcome	Action Identified for 2010/11	Change/Progress/ Performance Indicator	Action 2011/12	Change/ Progress/ Performance Indicato
We reduce the prevalence of smoking in the population.	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Delivered our Smokefree targets in relation to overall population; SIMD; pregnant women and young people.</li> <li>- Communicated the routes of access to Smokefree services with all CHCP staff groups.</li> </ul>	<p>At October 09 – Sept 10 Smoking in pregnancy was 21.3% in Inverclyde (28.4% in the most deprived quintile). This represents an improvement from the previous data.</p> <p>At Sept 2010 there was a 38% quit rate in all Smoke Free services, 54% in Community Smoke Free Services</p> <p>Initiated pilot of smoke free play parks in 4 areas across Inverclyde. These parks will be monitored to determine effectiveness of initiative with possible expansion to new/ refurbished play areas.</p>	<p>We will reinvigorate the Youth Tobacco service in CHCP Health Improvement Team.</p> <p>We will move to a targeted approach to education on smoking for LAAC and MCMC Group.</p> <p>We will continue to deliver community smoke free services within context of reduced staffing.</p> <p>We will continue to develop the smoke free pathway with pharmacy services.</p> <p><b>OPR Action</b> – Increase the numbers of people taking up smoking cessation opportunities, working with GPs to increase referrals to smoking cessation and a reductions in direct prescribing of NRT</p> <p>We will progress this model to other play parks beyond the current number.</p>	<p>HEAT H6</p> <p>Smoke Free Services uptake numbers</p>
We reduce the initiation and uptake of smoking in young people.	<p>By the end of year 1 we will have delivered the Smokefree schools programme and have this workstream incorporated into our rolling Health Improvement Team workplan.</p>	<p>We have fully implemented Smoke Free Schools and the ongoing review of this programme is incorporated in our HI team work plan. All of our children's residential</p>	<p>We will continue with this action and develop sustainability via capacity building with school staff.</p>	<p>Smoke free play park signs in place.</p> <p>School staff trained in approach.</p> <p>Number of sessions delivered</p>

			units are smoke free. There is a group working on smoke free placements for LAAC children and young people. This is a joint project between Health and Social Work and is working towards publishing a draft policy which will go out for consultation in April/ May 2011.		Complete draft policy and agree for use	Policy in place
We have local tobacco control plans linked to national policy and local priorities (and plans are in place for each entity).	By the end of year 1 we will have implemented the first year's actions from our local tobacco plan.		We continue to face challenges in engaging partners in this agenda.		We will want to secure but in of partners to deliver a tobacco action plan.	Tobacco action plan in place
We provide an evidence-based treatment pathway for adults in all areas of the Board's responsibility	By the end of year 1 we will have developed a local plan in conjunction with partner agencies to improve healthy eating and physical activity levels among adults.		-Active living strategy to be published in 2011. -HIA results of HIA of Gourrock Highland Games as rationale for development of smoke free events policy.		We will work with alliance partners to generate a focus on tackling adult obesity, through FSF and engaging alliance partners and the 3 <sup>rd</sup> sector locally.	Measures from FSF tender.
We provide services and support for positive mental health targeting life stages and settings - Children and young people, older adults, communities and workplace.	By the end of year 1 we will have incorporated tier zero mental health improvement initiatives into our Health Improvement Team workplan.		Work is being undertaken to scope out the interfaces between mental health/primary care and the wider mental health improvement agenda. Local work on implementing the Psychologically Minded NHS framework will augment work to address this action.  Ongoing.  MH now firmly embedded in CHOP HI team.  Develop TAMFS and actions  MH improvement lead identified.			
We address the harmful effects of alcohol at individual behavioural level. We have a comprehensive	By the end of year 1 we will have finalised and begun implementing our ABI training plan.		We have 11 out of 16 practices participating in the ABI LES – we continue to work with practices to		<b>OPR Action</b> - Report the results of whole system approach to drinking sensibly and the work of our Youth	Report shared across the sy: an

<p>drugs and alcohol prevention and education strategy.</p>		<p>increase the number of ABIs undertaken but respect local practice to target ABIs at the right people. In the case of non-HEAT ABIs we have recording issues which we are working to address – poor recording is masking a growing practice of undertaking ABIs. See children's services section</p>	<p>Alcohol team/ Culture Change Team</p>	
<p>We have a comprehensive programme of services for the improvement of infant nutrition. We achieve the SG HEAT target for exclusive breastfeeding at 6-8 weeks by 2011.</p>	<p>By the end of year 1 we will have trained all appropriate staff in Baby Friendly Policies and received UNICEF friendly accreditation Stage 3.</p>			
<p>We reduce the prevalence of childhood emotional and behavioural problems and improve parental confidence &amp; well - being through evidence based population parenting programmes.</p>	<p>By the end of year 1 we will have developed a local parenting plan aimed at reducing the prevalence of childhood emotional and behavioural problems and improving parental confidence and wellbeing.</p>	<p>See children's services section</p>	<p>We will work with Alliance partners to secure future funding to enable us to roll out the Triple P programme further.</p>	<p>Indicators dependent on securing funding, but if so, should align with FSF monitoring data.</p>
<p>We achieve an improvement the oral health of young children in NHSGGC. 2011/12 – We ensure that the NHS investigates the impact of child poverty.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Increased the number of GDPs participating in the Childsmile programme</li> <li>- Increased the number of children participating in the Childsmile programme</li> <li>- Begun a programme of targeted fluoride brushing.</li> </ul>	<p>All but one of our GDPs (n) is participating in the Childsmile programme. We have supported the coordination and administration elements, and consent element of this work in conjunction with the OHD.</p>	<p>Work with OHD to increase numbers of participating GDPs to 100%. Continue to support OHD.</p>	<p>Number of participating GDPs. New HEAT fluoride target.</p>
<p>2011/12 We ensure that the provision of overweight and obesity is given prominent recognition as a priority for NSH Greater Glasgow and Clyde and Local Authority partner organisations.</p>			<p>We will develop and implement the Inverclyde active living strategy and Inverclyde nutrition policy. Youth Sexual Health worker.</p>	<p>Policy/ Strategies developed and implemented.</p>

2.3 **Quality – Creating a Person-Centred and Mutual NHS:** Work has already begun to synergise our engagement mechanisms with local communities across all of the CHCP services. During the past year of change, we have also managed to fully deliver our EQIA programme, demonstrating the degree of priority placed on this workstream.

Outcome	Action Identified for 2010/11	Change/Progress/ Performance Indicator	Action 2011/12	Change/ Progress/ Performance Indicator
2010/11 We understand and take account of patient experience in the planning and delivery of services.	By the end of year 1 we will be able to demonstrate that we are: <ul style="list-style-type: none"> <li>- Working to understand the patient experience and ensure that it informs the way we deliver services.</li> <li>- Involving patients and the public in the planning and delivery of services.</li> </ul>	As we move forward with CHCP implementation we will synergise both formal (PPF) and informal mechanisms for gathering user/carer feedback. It is our intention to agree a shared approach and exploit the learning from both health and social work through an agreed integrated framework and tool for gathering and analysing user experience/feedback, working collaboratively with the local voluntary sector provider (Your Voice).	Implement the use of VOICE (visioning outcomes in community engagement) and the SHC participation Toolkit across the CHCP.	VOICE plans in place for engagement activity. Training on Participation SHC Toolkit delivered.
2011/12 We involve and engage the public fully in decision making and service change. All public involvement activity has increased engagement with groups and individuals who experience discrimination associated with disability, race, gender, sexual orientation, age, social class/ socio-economic status and religion/ belief.			Develop and implement mechanisms for gathering of patient/user/carer experience data. Create and implement CHCP Public Involvement Framework. Re-organise our PPF structures to better reflect local needs.	Patience experience reports available for service improvement. Revised Public Involvement arrangements and redesigned PPF.
2011/12 We are accountable to population of NHS Greater Glasgow and Clyde.				
2010/11 We understand the impact of inequality and discrimination on patient experience and access.	By the end of year 1 we will have: <ul style="list-style-type: none"> <li>- Delivered our EQIA programme.</li> <li>- Supported staff in developing a consistent approach to understanding communication issues such as comprehension and literacy and language barriers, and reflective practice that helps us to understand the</li> </ul>	We have delivered our EQIA programme in relation to commitments from our last OPR, with 12 quality assured EQIAs having been undertaken to date. We continue to work with the CIT to develop a more focussed means of checking EQIA progress. We will work to further embed EQIA across all services as part of CHCP	Support an increase in local capacity to independently undertake EQIAs via Lead Reviewer. Training and maximising use of our Equalities Champions. CHCP arrangements planned for 01.04.10 did not actually come into effect until 01.10.10; therefore this	EQIA delivered. Local Reviewer trained Audit complete. Action plan agreed.
2011/12 We have a co-ordinated approach across the organisation to public involvement, person centred care, safety and effectiveness with clear				

<p>accountability and measurable impact on patient outcomes.</p> <p>2010/11 Care and services are provided in partnership with people, treating individuals with dignity, empathy and respect, based on their strengths, needs, experiences and preferences.</p> <p>2011/12 – We are responsive to age, gender, sexual orientation, disability, race, faith/ spirituality, socio-economic status or geographic location.</p>	<p>patient experience.</p>	<p>implementation – with the intention to complete 9 pending EQIAs and begin work on two new EQIAs so far identified. A meeting has been scheduled for late November to look at how we integrate the CHP and Social Work Services approaches to the equalities agenda to produce a CHCP policy and approach.</p>	<p>workstream has been deferred to year 2.</p> <p>Complete Inverclyde Council Corporate Equalities Group baseline audit of EQA's and implement relevant actions from new Equalities Act.</p>	
	<p>By the end of year 1 we will be able to demonstrate that we are regularly seeking out the views of those who use our services, and centrally collating these views to develop a learning and good practice database.</p>	<p>We have successfully implemented our Tell Us Your Story model of progress: compiling user experience – information is gathered and fed back to our communications group for use/learning at service level.</p> <p>The national GP survey results highlights some issues to be taken forward, however the survey itself did not provide sufficient local granularity.</p> <p>After early development work this was put on hold due to CHCP implementation</p>	<p>Build on the Tell Us Your Story Scheme and ensure user experience data is available for service redesign.</p>	<p>Patient/Carer/User experience regularly reviewed in service air used to inform redesign.</p>
<p>2010/11 The care we provide is safe and effective - we minimise errors and harm to patients, and care is evidence based.</p>	<p>By the end of year 1 we will have agreed a process for self assessment of quality in our teams based on the 'How Good is Our School' model..</p>		<p>We will resurrect original work and bring this action to completion, linked closely to existing arrangements for Clinical Governance and Quality Assurance.</p>	<p>Self Assessment/ Quality Assurance work progressed</p>



2.4 **Sustainability:** We have used the first year of our plan to embed the principles of sustainability across the CHCP, and will be fully engaged in the implementation of the NHSGGC Sustainability Action Plan once it emerges.

Outcome	Action Identified for 2010/11	Change/Progress/ Performance Indicator	Action 2011/12	Change/ Progress/ Performance Indicator
We have comprehensive travel plans in place which support patients, visitors and staff to access services and increase opportunities for active travel.	By the end of year 1 we will have agreed local actions to promote active travel.	This action was delivered in year 1 and has been carried forward to year 2.	Publication of active living strategy in 2011. Continue to link with partners to support active commuting and journey share schemes.  We will work to implement the actions coming out of the Sustainability PIG, and incorporate relevant actions in our local Active Living Strategy (e.g. in relation to active travel particularly).	Active Living Strategy published and includes active transport.
Our procurement activities minimise environmental impact and maximise health, social and economic benefits	By the end of year 1 we will have contributed to a revised Board procurement policy that supports sustainability.	The Board has incorporated this workstream into the responsibilities of the sustainability PIG.	We will work with the procurement departments of both parent organisations to help achieve a policy the CHCP can work to on sustainable, economic and responsible procurement.	CHCP has clear guidance regarding procurement.
Our workforce is highly aware of sustainability and is supported to act in a sustainable way. We set a leading example of workplace practices including diversity, inclusion and workplace health.	By the end of year 1 we will have ensured local dissemination of NHSGGC energy awareness and sustainability communications and materials.	This action was delivered in year 1 and has been carried forward to year 2.	We will work to implement the actions coming out of the Sustainability PIG.	
2011/12  We understand the current environmental, social and economic impact of our plans and actions and work in partnership to			Actions will be developed from the outputs of the sustainability PIG.	

<p>make sure this impact is positive.</p>			<p>Actions will be developed from the outputs of the sustainability PIG.</p>	
<p>2011/12 Our plans for new buildings minimise negative environmental impact and are driven by sustainable, energy efficient design.</p>			<p>Actions will be developed from the outputs of the sustainability PIG.</p>	
<p>2011/12 Our community engagement activity leads to reduced health inequalities and improved social, economic and environmental impact.</p>			<p>Actions will be developed from the outputs of the sustainability PIG.</p>	

2.5 Tackling Inequality: Inequality of outcomes remains a stubborn challenge in Inverclyde, however the 2010 ScotPHO Health & Wellbeing Profiles indicate that over the past two years we have narrowed the inequalities gap between ourselves and other local authority areas in some key areas, such as smoking prevalence, early deaths from CHD and early deaths from some avoidable cancers.

Outcome	Action Identified for 2010/11	Change/Progress/ Performance Indicator	Action 2011/12	Change/ Progress/ Performance Indicator
<p><b>Goal 1:</b> All planning processes explicitly use disaggregated data</p>	<p>Given that disaggregated equalities groups data is not currently routinely available for any of our services, our year 1 action will be to work with the wider NHSGGC system to develop means by which to capture this intelligence.</p> <p>Data shortfalls have been identified in all of our planning and policy sections indicating the need for a structured, system-wide approach.</p>	<p>We have begun work to revise the equalities category on our SMIFT (Social Work Client Management Information) system to bring them up to date for reporting purposes.</p> <p>We have engaged on a Board-wide basis through the Strategic Information Group to improve data quality, currency and inclusiveness.</p>	<p>Show evidence of use of disaggregated data to meet the needs of inequality groups.</p>	<p>Evidence use of data.</p>
<p><b>Goal 2:</b> Each part of NHSGGC demonstrates that equality groups are part of all public and patient involvement activity</p>	<p>We have attempted to establish a baseline of equality group involvement in PPF activity; however the reality is that most participants are disinclined to divulge their equalities group status. We therefore need to work with the wider system to develop alternative means to ascertaining the equalities group status of our PPF participants so that we can then begin to develop plans to increase equality group engagement, both in PPF and via other approaches.</p>	<p>We encourage our PPF members to think beyond their own specific care group or equalities group interests, preferring to promote an ethos of improving overall population health and equality of access based on patient needs. This approach does not lend itself well to being separated out into the various planning and policy sections.</p> <p>Our community engagement activity continues to be planned with equality's groups in mind. PPF and other groups are supported to think beyond their own immediate</p>	<p>We will introduce the use of VOICE to ensure seldom heard groups are specifically considered in engagement planning.</p> <p>We will support the continued involvement of minority and seldom heard groups via our CHCP Public Involvement Framework to be delivered in 2011/12.</p> <p>We will review process for engaging with travelling people via the HHAG and discuss new</p>	<p>VOICE planning in place.</p> <p>CHCP Public Involvement Framework in place.</p> <p>Process reviewed PST practice implemented.</p>

		<p>constitutions.</p> <p>Inverclyde Health Visitors and School Nurses working procedures to improve access for travelling families. Work has been undertaken through Health and Homelessness Action Group to establish agreed processes for engaging with travelling people. An agreed protocol has been developed for engaging travelling families in health screening and we are working to implement best practice from West Dunbartonshire CHCP.</p>	<p>approaches as we explore best practice.</p>	
<p><b>Goal 3:</b> Each part of NHSGGC can demonstrate how health improvement framework priorities are tailored to meet needs of equality groups</p>	<p>By the end of year 1 our Health Improvement Team workplan will clearly reflect targeting to socio-economic groups that have poorer health outcomes. Our local sexual health workplan will have particular emphasis on gay men and offenders.</p> <p>By the end of year 1 our local Clinical Governance group will have developed risk management systems that prevent unlawful discrimination.</p>	<p>Health improvement activity in relation to HEAT targets will identify how the needs of inequality groups will be met, for example, targeting smoking in SIMD groups.</p> <p>This will relate to all planning and policy sections.</p> <p>This action is from our Disability Framework section.</p>	<p>We continue to pursue EQIAs of health improvement programmes and workstreams.</p> <p>We shall continue to embed our local Clinical Governance and Rights workplans.</p> <p>We will participate in the Board-wide Learning Disability Health Improvement Group to increase access to care services.</p>	<p>EQIAs completed.</p> <p>Workplans in place and routine audited.</p> <p>TBC as work plan of this group develops.</p>
<p><b>Goal 4:</b> Each Partnership has risk management systems that prevent unlawful discrimination</p>	<p>During year 1 we will work with the wider NHSGGC system to identify examples of good practice, and once completed this will be disseminated to all relevant front-line staff.</p>			
<p>There is evidence of innovative solutions to address the challenges of disabled people in using services</p>				

<p>Each part of NHSGGC demonstrates compliance with interpreting protocols and how demand will be met on an annual basis</p>	<p>By the end of year 1 we will have a local plan to:</p> <ul style="list-style-type: none"> <li>- ensure routine assessment of communication and language support needs</li> <li>- monitor and report demand</li> <li>- communicate interpreting protocols to staff.</li> </ul>	<p>This will relate to all planning and policy sections.</p> <p>Audit the process to ensure compliance.</p>		
<p><b>Goal 4:</b> There is evidence of an increase in information in accessible formats</p>	<p>By the end of year 1 we will have developed a process for monitoring use of new accessible information in priority settings.</p>	<p>This will relate to all planning and policy sections.</p> <p>Our Accessible Information Policy lead is taking responsibility for the quality and format options of the information provided to patients in our area i.e. by collecting in all patient letters disseminated within our area and put plans in place for ensuring all new templates for letters / correspondence are signed off via the Head of Administration.</p> <p>Accessible Information Policy leads will be trained (via the Board) and in turn have a responsibility to deliver information/awareness sessions to staff re; providing accessible information / awareness of the Accessible Information Policy toolkit and offering staff assistance in taking this forward.</p> <p>We have (and continue to) provide staff with information to assist them in meeting the requirements of the Accessible Information Policy such</p>	<p>We will engage with AIP training for AIP leads and carry out development sessions with staff for awareness raising</p> <p>We will complete the audit of letters to develop a standard letter format for communications from any of our services</p> <p>We will agree a process for all leaflets to go through our AIP lead via CHCP Communications Group</p>	<p>Training rolled out</p> <p>Standard letter agreed and being used in services</p> <p>Process agreed</p>

<p><b>Goal 5:</b> Service plans resulting from new planning and policy arrangements clearly demonstrate how they will promote equality and remove discrimination using EQIA where appropriate</p>		<p>as guidelines do's/don'ts and continue to reiterate this to staff to improve consistency across the CHCP.</p> <p>We monitor any new literature and address issues where accessible information are not being addressed in particular departments and again assist staff with providing them with the relevant information.</p>		
<p><b>Goal 5:</b> Service plans resulting from new planning and policy arrangements clearly demonstrate how they will promote equality and remove discrimination using EQIA where appropriate</p>	<p>EQIAs plan produced and implemented or in progress as detailed in the tables below.</p>	<p>These actions relate to all planning and policy sections.</p> <p>CLDT – Telephone Access (service User)</p> <p>Older People – CC specified</p> <p>OPMS – user satisfactory</p> <p>Drug – Integrated (service specification)</p> <p>Alcohol – integrated service specification in process</p> <p>Crown House – Access / service specification in process</p>	<p>Continue to embed EQIA as an approach and routinely analyse to what extent resultant actions from EQIAs are followed up. We will link this to our work on quality assurance to ensure quality is continually driven up in all services.</p>	<p>No EQIAs undertaken.</p> <p>EQIA actions are delivered on to improve equality and inequality sensitivity.</p>
<p><b>Goal 6:</b> Each part of NHSGGC can demonstrate an increase in the number of services using inequalities sensitive inquiry in GBV</p>	<p>By the end of year 1 we will have developed a local implementation and training plan, based on the overall Corporate Implementation Plan.</p>	<p>This will relate initially to Community Nursing, Addictions and Children's services, with a view to extending to other services beyond year 1.</p>	<p>Training will continue to be delivered by the central Violence Against Women Team.</p>	<p>Training delivered</p>
<p><b>Goal 6:</b> All cost saving financial planning decision are subject to EQIA</p>	<p>By the end of the year we will be able to evidence that our Financial Plan and cost savings have been EQIAed to prevent potentially unlawful decisions.</p>	<p>This will relate to all planning and policy sections.</p> <p>Our financial plan is reflected in our Development Plan which is subject to EQIA. We are developing a routine process in the CHCP for</p>	<p>We have undertaken EQIAs of the CHCP savings plan for 2011/12 and will work to reduce any potentially discriminatory aspects.</p>	<p>EQIAs of savings plan and improvement actions reference</p>

		equality impact assessing financial decisions where appropriate/possible. These actions relate to all planning and policy sections.		
<p><b>Goal 8:</b> Evidence is provided of how system is meeting the Learning and Education Plan and targets</p> <p>Each part of the system can demonstrate implementation of a plan to promote positive attitudes to equality groups</p>	<p>By the end of the year we will have a system in place to record and report the numbers and staff being equalities trained.</p> <p>By the end of year 1 we will have evaluated and implemented the recommendations from our Equalities Champions work.</p>		<p>We will complete the evaluation of our Equalities Champions scheme and build on the learning via the Corporate Equalities Group, linking with CTT for system wide learning.</p>	<p>Actions to be derived from the evaluation.</p>
<p><b>Goal 10:</b> Partnership activity with income inequality e.g. referral pathways on financial inclusion and employability increased.</p>	<p>By the end of year 1 we will have a local plan for Employability, Financial Inclusion and Responding to the recession in place.</p>	<p>This will relate to all planning and policy sections, but has not been completed due to the CHCP development and a change in responsibility focus for the Council dimensions.</p>	<p>All employability and financial inclusion workstreams form both NHS and Social Work now sit together, so we will progress an integrated plan during 2011/12</p> <p>We will maximise the work of our SOA employability outcome delivery group in taking forward this action, especially through the employability and inclusion sub group.</p> <p>See previous actions re the Financial Inclusion Strategy.</p>	<p>Plan in place and implementation processes agreed.</p>

2.6 Unpaid Care:

Outcome	Action Identified for 2010/11	Change/Progress/ Performance Indicator	Action 2011/12	Change/ Progress/ Performance Indicator
<p>We understand who our carers are</p> <ul style="list-style-type: none"> <li>- Numbers of carers known to CHCP.</li> <li>- Profile of carers in CHCP - age, sex, ethnicity, socio-economic status (where carers agree to divulge this information).</li> </ul>	<ul style="list-style-type: none"> <li>- Numbers of staff utilising carers leave.</li> <li>- Clear systems in place to identify those with caring responsibilities and record this.</li> <li>- Develop systems to identify where CHCP staff have a caring role.</li> <li>- Identify and involve carers in the Ravenscraig redesign and</li> </ul>	<p>Carers registers are in place in general practice in Inverclyde – there are currently 1124 registered carers (around 20% of the number of carers registered with our Carers' Centre). We continue to work to increase this number.</p> <p>We have also began work to ensure all primary carers (distinct from next of kin) are noted on SMIFT Social Work records.</p> <p>We have begun to consider how we can support practices to release disaggregated information on registered carers but are also aware that some carers refuse to divulge equalities group status. The same will apply to carers noted on SMIFT.</p> <p>Between April and August 2010 13 NHS staff utilised carers leave. In 2009/10 18 social work staff utilised carers leave (although some of this would have been for child care). So far in 2010/11 the figure is 10 social work staff.</p> <p>Carers, and service users, have been at the heart of the Ravenscraig</p>	<p>We will consider, through our local Carers Development Group the use of Carers Information Strategy Funding to support the buy-in of GP practices in identifying and responding to carers needs (e.g. via a local enhanced service)</p> <p>We will complete this work in relation to SMIFT</p>	<p>GP Carers Register figures</p> <p>Principal carers field on SMIFT records</p> <p>Numbers of staff who are undertaking caring roles at hon :</p> <p>Number of staff making use of flexible working/carers leave</p>



	<p>the partnership beds.</p>	<p>Reprovision programme with regular communications and engagement opportunities identified throughout the process.</p> <p>Local work was acknowledged as an example of best practice in the NHS GG&amp;C Participation Standard Performance submission.</p>	<p>including carers, as we progress the final stages of the reprovision of Ravenscraig Hospital.</p>	
<p>We recognise and enhance the role of carers in supporting self care and reducing demand for services.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Increased the numbers on GP carers registers through raising awareness in services of the role of carers and the need to ensure they are adequately supported.</li> <li>- Worked with the wider system to develop a Board-wide Older People's Strategy that includes a clear plan for responding to the changing age profile and expected rise in demand for unpaid care.</li> <li>- Developed actions to help carers achieve a better balance between their caring role and other aspects of their lives.</li> </ul>	<p>We continue to support practices to respond sensitively to the needs of registered carers, and to help patients identify themselves as carers. Wherever possible practices are supported/ encouraged to sign post carers to our PASS nurses and/or to the Carers Centre.</p> <p>The Older People's Strategy will be taken forward by means of the Reshaping Care for Older People Change Plan.</p> <p>We are running phase two of Time Out Inverclyde – as health improvement/health maximisation programme for carers which helps to build capacity amongst carers to look after their own health needs, whilst still fulfilling their caring responsibility. Our ability to learn more about who best to fulfil this action in relation to health services will be enhanced by our moves to CHCP.</p>	<p>We will consider, through our local Carers Development Group, the use of Carers Information Strategy Funding to support the buy-in of GP practices in identifying and responding to carers needs (e.g. via a local enhanced service)</p> <p>Complete work on our local Change Plan</p> <p>We will deliver a third programme of Time Out Inverclyde, encouraging carers into relevant courses and provision of support upon completion.</p>	<p>Change Plan actions taken forward</p> <p>Time Out – 3 evaluation forms.</p>

<p>We can identify carers and assess their needs.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Developed and implemented a local programme of carer awareness training.</li> <li>- Increased the number of carers assessments.</li> </ul>	<p>This work was not undertaken in year 1</p> <p>We have begun a piece of work to pilot all carers assessments being undertaken through our Short Breaks Bureau (14 assessments have been undertaken to date). We are developing a business process to ensure that all carers assessments can be tracked through SWIFT 0 this is currently not the case.</p>	<p>Implement the findings of our Carers Assessment pilot.</p> <p>Implement a solution via SWIFT to track carers assessments electronically.</p>	<p>Solution implemented on SWIF</p> <p>Number of carers assessment started</p>
<p>We have a comprehensive programme of training and information support available for carers.</p>	<p>By the end of year 1 we will have:</p> <ul style="list-style-type: none"> <li>- Evidence of consultation with carers.</li> <li>- Joint Carers' Strategy in place based on the Inverclyde Carers Charter and supported by robust intelligence, and routinely updated.</li> </ul>	<p>We have good evidence of carers having been directly engaged in various workstreams including the Ravensraig retraction programme; palliative and end of life care; kinship care.</p> <p>We have Joint Carers Strategy in place, reviewed regularly by our local carers development group, and a local carers charter outlining our commitment to supporting carers.</p>	<p>We will include the engagement of carers in an operational policy on people engagement for the CHCP to be delivered by April 2011.</p> <p>We will deliver the 2011-13 Carers Strategy via the Carers Development Group.</p>	<p>Completed CHCP People Involvement Framework</p> <p>We will have completed our new Carers Strategy for 2011-13 by April 2011.</p>
<p>Carers are fully supported in their caring role.</p>	<p>By the end of year 1 we will have evidence of carers having been involved in care planning and review of patient care plans.</p>	<p>We are working to evidence the involvement of carers in care planning and review. In the case of the Liverpool Care Pathway roll out we have good examples of carer involvement which we will build on. As we progress with the implementation of the care management model we will be able to increase involvement of carers in all aspects of care management and review.</p>	<p>We will pursue this action in Year 2</p>	<p>Evidence of carer involvement in care planning</p>

<p>We understand and respond to the impact of caring on health, wellbeing and economic status.</p>	<ul style="list-style-type: none"> <li>- Provide services to carers in a way which takes account of the impact of their caring role, for example on ability to travel, make appointments, comply with treatment, prioritise their own health.</li> <li>- Support carers to be economically and socially active <ul style="list-style-type: none"> <li>- maintaining or supporting access to work, education, volunteering. This may involve signposting to non NHS services or sources of advice.</li> </ul> </li> <li>- Each CH(C)P should have a clear local understanding of the services available for carers and access arrangements, including financial inclusion and benefits advice, employability, support to access work and education.</li> </ul>	<p>We have used the Carers Information Strategy to deliver a range of alternative services such as Carers Counselling and increased respite. We are reviewing our respite arrangements to ensure equity and the use of alternative breaks.</p> <p>Carers information is available in all bases and for staff to distribute, information on CHCP services to carers is displayed on CHCP solus screens and websites.</p>	<p>We will review our 2010/11 CIS funded projects</p> <p>We will complete a review of our Short Breaks Bureau</p> <p>We will develop an operational policy and set of guidelines on respite provision for use across the CHCP.</p>	
<p>Support carers in their caring role by providing a range of flexible, reliable and quality short breaks / respite.</p>	<p>By the end of year 1 we will have increased provision of short breaks/respite opportunities.</p>	<p>Our Short Breaks Bureau functions well and has arranged an increased level of alternative breaks so far in 2010/11 compared to 2009/10. 2009/10 there were 2041 nights of respite arranged through the bureau, at 25.11.10 2242 nights have been arranged.</p>		





