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**Report To:** Health & Social Care Committee      **Date:** 25 August 2011

**Report By:** Robert Murphy  
Corporate Director  
Inverclyde Community Health &  
Care Partnership      **Report No:**  
SW/02/2011/HW/AW

**Contact Officer:** Helen Watson  
Head of Planning, Health  
Improvement and Commissioning      **Contact No:** 01475 715369

**Subject:** CHCP Directorate Plan 2011 - 2012

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## 1.0 PURPOSE

- 1.1 To present to Committee members the final draft of the CHCP Directorate Plan 2011/2012, and seek agreement that the planning context of the CHCP is accurately represented in terms of both Council and NHS GG&C planning requirements for the current planning round (2010 – 2013).
- 1.2 To seek agreement from members that the Directorate Plan accurately reflects the good work undertaken by Inverclyde CHCP in taking forward actions relating to key performance targets, the Council's Corporate Plan, Organisational Improvement Plan, Community Plan and the Single Outcome Agreement (SOA).
- 1.3 To seek agreement from members for the actions identified for delivery in 2011/2012 in line with key strategic priorities.

## 2.0 SUMMARY

- 2.1 A Directorate Plan is required from the CHCP to cover the last year of the current Inverclyde Council planning round (2011/2012), prior to the development of a new Three Year Plan from April 2012.
- 2.2 The Directorate Plan meets our requirements to produce a Council Directorate Plan which forms part of a suite of Plans that combine to articulate the Council's planning priorities. It also aims to harmonise with the existing CHCP Development Plan, which meets the needs of the NHS Greater Glasgow and Clyde Planning Guidance. The Development plan is included for completeness at Appendix 1, and the two should be regarded as partner documents for the remainder of the current planning round.
- 2.3 The two documents should be considered in tandem, but a decision has been taken by the CHCP Senior Management Team for business reasons that locally we will use the Directorate Plan as our principal guiding document and action plan for this year, with the Development Plan Update 2011/2012 providing the finer detail.
- 2.4 As we enter the next planning round, we aim to rationalise the document into a single Directorate Plan that meets the requirements of both parent organisations.

## 3.0 RECOMMENDATION

- 3.1 Committee is asked to approve the CHCP Directorate Plan 2011 – 2012.

- 3.2 Committee is asked to note the actions identified in the plan for completion in 2011/2012 and the indicators associated with these actions.

## 4.0 BACKGROUND

4.1 The initiatives outlined in this Directorate Plan provide an overview of the scale and diversity of service provision within the CHCP and the contribution that will be made to the corporate outcomes of the Council and our partners over the coming year. In addition the Directorate Plan reflects the ambition of the CHCP Sub-Committee and our parent organisations to continue to fight the serious health and social inequalities which prevail in our communities. In so doing the CHCP will work towards our agreed vision statement '*Improving Lives*' and in line with the four strategic objectives of the CHCP:

1. We put people first.
2. We work better together.
3. We will strive to do better.
4. We are accountable.

4.2 The Inverclyde Community Health and Care Partnership (CHCP) was formally established on 1st October 2010. While social work and community health services have always worked closely together, the CHCP will enhance opportunities to improve outcomes for the people of Inverclyde at many levels, taking a more co-ordinated approach to delivering services and supporting people to manage their own health and social care needs where this is possible and appropriate.

4.3 The most visible outworking of this development is the integration of social work and health teams in both new and refurbished buildings. This includes:

- The creation of a CHCP headquarters at Kirn House.
- The new purpose built Wellpark Centre, incorporating health and social work alcohol services.
- The refurbishment of Crown House bringing together mental health teams from social work and health.
- The refurbishment of Cathcart Centre as premises for both an integrated drugs service and co-location of learning disability teams.
- The bringing together of various community care and children's social work teams to Dalrymple House.

All of these developments are with the view to creating a modern and innovative organisation which delivers high quality services in the most effective way.

4.4 The CHCP is a new entity with an organisational culture, and there are obvious opportunities for 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.

4.5 The CHCP makes a significant contribution to the Council's strategic objectives as outlined in the Community Plan, Single Outcome Agreement, and Corporate Plan, with particular lead responsibilities in tackling poverty, reducing offending, tackling health inequalities, alcohol misuse and by working closely with the Education and Communities Directorate in ensuring that every child is nurtured to have the best start in life.

The CHCP leads on a number of key national and corporate initiatives including:

- Positive culture change in attitudes towards alcohol (SOA).
- Financial Inclusion.
- Health Inequalities (SOA).

- Reshaping older people's services using Change Fund monies to facilitate this.
- Support to Carers.
- Looked After Children's Champion Scheme.
- Choose Life Inverclyde.

## 5.0 PROPOSALS

5.1 It is proposed that the CHCP will focus in 2011/2012 on the actions that are reflected in the Directorate Plan Action Plan. Actions have been aligned to the 5 Strategic Objectives of Inverclyde Council, and referenced against the NHS GG&C Planning Frameworks.

## 6.0 IMPLICATIONS

6.1 Legal: None

6.2 Finance: The 2011/12 CHCP budgeted resources are:

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments
Health Council	Revenue	2011/12	£72.3 m	n/a	n/a
Health Council	Revenue		£48.6 m		
Health Council	Capital		£5.6 m		
Health Council	Capital		£1.3 m		

6.3 Personnel: None

6.4 Equalities: None

## 7.0 CONSULTATION

7.1 There has been extensive consultation across the CHCP of senior and service managers. Public consultation has been used to inform the content however public consultation on this document has been limited. There has not been a new consultation exercise on this plan given that it only covers one year, and largely focuses on actions already agreed through earlier consultations. A full public consultation will take place for the Directorate Plan 2012 – 2015.

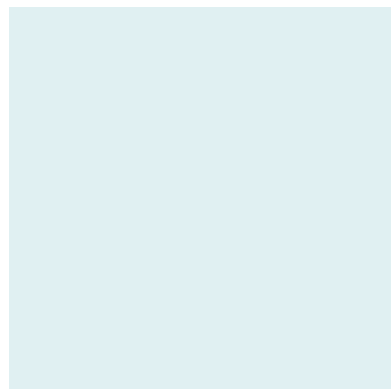
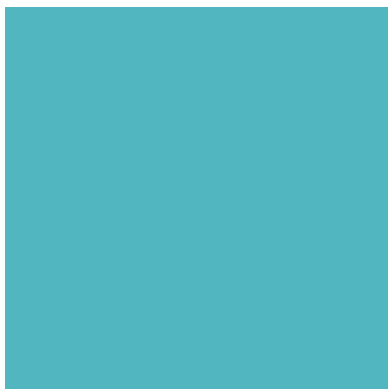
## 8.0 LIST OF BACKGROUND PAPERS

8.1 Inverclyde Council Directorate Planning Guidance 2011/2012.

8.2 Inverclyde CHCP Development Plan Update 2011/2012 – **Appendix 1.**

**Robert Murphy**  
**Corporate Director**  
**Inverclyde Community Health & Care Partnership**

# Inverclyde Council Community Health and Care Partnership Directorate Plan 2011 - 2012



**This document can be made available in large print, audio tape, computer disk and in a variety of Community Languages, on request.**

Arabic

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

Cantonese

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Gaelic

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

Hindi

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

Mandarin

本文件也可應要求，制作成其它语文或特大字体版本，也可制作成录音带。

Polish

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

Punjabi

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

Urdu

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

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## Glossary of Terms

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- SCSWIS – Social Care and Social Work Information System
- SWIA – Social Work Inspection Agency (now part of SCSWIS)
- SWIA ISLA – Initial Scrutiny Level Assessment
- HMIE - Her Majesty’s Inspectorate of Education
- CJSW – Criminal Justice Social Work
- DAS – Debt Arrangements Scheme
- CAMHS – Child and Adolescence Mental Health Services
- ASN – Additional Support Needs
- GIRFEC – Getting it Right for Every Child
- MAPPA – Multi-Agency Public Protection Arrangements
- NHS GG&C - NHS Greater Glasgow and Clyde
- PPF – Public Partnership Forum
- CEN – Community Engagement Network
- VOICE – Visioning Outcomes in Community Engagement
- EQIA – Equality Impact Assessment
- SSPU – Short Stay Psychiatric Unit
- DATIX – Electronic System for complaints used by NHS GG&C
- NSCJA – North Strathclyde Community Justice Authority
- EEI – Early and Effective Intervention
- SEQ – Self Evaluation Questionnaire
- KSF – Knowledge and Skills Framework



## 1. INTRODUCTION BY THE CHCP DIRECTOR

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### Welcome to the Community Health and Care Partnership Directorate Plan 2011/12

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. Health and social 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 higher levels of these poorer outcomes, and are committed to working to find ways to respond by improving lives; preventing ill-health and social exclusion; protecting good health and wellbeing and promoting healthier living.

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 2009-2011*** is another key document which underpins our approach to addressing health inequalities and thereby securing a platform for improved outcomes in the future. In addition we will continue to work to the ***Getting it Right for Every Child*** key principals and wellbeing indicators in developing a nurturing ethos across our services and partnerships.

The latest population projections estimate that by 2033 Inverclyde's population will have fallen to 66,611, a projected population decrease of 18%. This is a higher percentage than any local authority in Scotland. In this regard we have a declining, though ageing population. This has implications both for the current and future profile of need, and for the provision of care and support to vulnerable members of the community.

In respect of prevailing levels of deprivation within the area, the Scottish Index of Multiple Deprivation figures for 2009 indicate that:

- Inverclyde has the second highest local share with 38% of its data zones in the 15% most deprived in Scotland.
- Inverclyde has the second highest percentage of employment deprived people in Scotland with a local share of 38.2% of its data zones in the 15% most deprived in Scotland in the employment domain.



- Inverclyde has the second highest local share of the 15% most health deprived datazones at 42% in the health domain.

The most significant achievement in 2010 / 2011 is the development of the Community Health and Care Partnership (CHCP) which was formally established on 1<sup>st</sup> October 2010. While social work and community health services have always worked closely together, the CHCP will enhance opportunities to improve outcomes for people of Inverclyde at many levels, taking a more co-ordinated approach to delivering services and supporting people to manage their own health and social care needs where this is possible and appropriate.

The most visible outworking of this development is the integration of social work and health teams. This includes:

- The creation of a CHCP headquarters at Kirn House.
- The new purpose built Wellpark Centre, incorporating health and social work alcohol services.
- The refurbishment of Crown House bringing together mental health teams from social work and health.
- The refurbishment of Cathcart Centre as premises for both an integrated drugs service and co-location of learning disability teams.
- The bringing together of various community care and children's social work teams to Dalrymple House.

All of these developments are with the view to creating a modern and innovative organisation which delivers high quality services in the most effective way.

The CHCP is a new entity with an organisational culture which needs time to settle. There are obvious opportunities for 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.

The CHCP makes a significant contribution to the Council's strategic objectives as outlined in the Community Plan, Single Outcome Agreement, and Corporate Plan, with particular lead responsibilities in tackling poverty, reducing offending, tackling health inequalities, alcohol misuse and by working closely with the Education and Communities Directorate in ensuring that every child is nurtured to have the best start in life.

The CHCP leads on a number of key national and corporate initiatives including:

- Positive culture change in attitudes towards alcohol (SOA).
- Financial Inclusion.
- Health Inequalities (SOA).
- Reshaping older people's services using Change Fund monies to facilitate this.
- Support to Carers.
- Looked After Children's Champion Scheme.
- Choose Life Inverclyde.

In addition the CHCP makes a significant contribution to key corporate initiatives, including:

- Single Outcome Agreement (including leading on those outlined above).
- Nurturing Inverclyde – every child is nurtured to have the best start in life (SOA)
- Community Planning.
- Modernising and Efficiency Programme.
- Corporate Equalities Agenda.
- Integrated Children's Services.
- Services to Protect Children and Adult Protection
- Multi-Agency Public Protection Arrangements
- Community Safety through provision of Criminal Justice social work services.
- Business continuity/Civil Contingencies.

The initiatives outlined in this Directorate Plan provide a flavour of the scale and diversity of service provision within the CHCP and the contribution that will be made to the corporate outcomes of the Council and our partners over the coming year.

## **2. MAJOR ACHIEVEMENTS IN 2010 - 2011**

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The following are the major achievements regarding the Council's corporate plan objectives for the CHCP in 2010 / 2011:

### **Educated, Informed Citizens**

- Inverclyde was the first local authority area to have a mainstream secondary school achieve Right's Respecting Schools level 1 in Scotland, and the first ASN School to achieve level 1 and 2. There are now 3 schools at level 1 and 4 at level 2 and we are the first local authority area to be self sufficient in assessors including trained young people. The CHCP's Children's Rights Coordinator has been central to this success.
- A significant level of work to inform local people and partners of our business has taken place; this has specifically been in respect of the Reshaping Care for Older People Agenda (Change Fund) in recent months.
- We have developed a new approach to people involving for the CHCP via the creation of a CHCP Advisory Group involving patients, service users, carers and members of the public.

### **Healthy Caring Communities**

- On 1<sup>st</sup> October 2010 an integrated Community Health and Care Partnership was established, bringing together the NHS Community Health Partnership and the Council's Social Work Services into one organisation. This has enhanced opportunities to improve outcomes for the people of Inverclyde, taking a more coordinated approach to delivering services and supporting people to manage their own health and care needs where this is possible and appropriate.
- There are 14 internal services provided by Inverclyde CHCP that is inspected by the Care Commission (now part of SCSWIS) on a minimum of an annual basis. Inspection reports overall include 20% of indicators being rated excellent; 55% rated as very good and 24% as good.
- A Short Breaks Bureau has been developed, receiving funding from the Council to assist individuals and their carers to experience alternative breaks away from residential / nursing type accommodation to more community based, natural breaks. This has been cited as an example of good practice within the National Carers Strategy 2010 – 2015. There has been a renewed focus on meeting the needs of young people who are carers (young carers).
- We have progressed with work to improve services for Kinship Carers and foster carers and have increased the numbers of both. Our work in this was recognised by HMIE.

- The CHCP achieved full UNICEF Baby Friendly Accreditation in 2010.

## **Safe, Sustainable Communities**

- In the area of protecting children, Her Majesty's Inspectorate of Education (HMIE) undertook a multi-agency review of services to protect children and young people where Inverclyde was found to be one of the best performing areas in Scotland with 2 indicators rated as excellent and 15 rated as very good.
- The Social Work Inspection Agency completed a thematic inspection of Prison Based Social Work and a follow-up thematic inspection of high risk offenders. Inverclyde Criminal Justice Social Work (CJSW) was highly commended in both inspection processes.
- Criminal Justice Social Work, along with Action for Children, submitted a self evaluation to the Effective Practice Unit, (Justice Section, Scottish Government) with regards to the delivery of the accredited programme, Constructs. Feedback from this indicated Inverclyde scored the 2<sup>nd</sup> highest in Scotland with regards to the quality and effectiveness of service delivery and the culture of continuous improvement.
- The Community Service Team celebrated national success when they were named the Best Service Team in Social Care at the Association for Public Service Excellence (APSE) awards in 2010.
- The Young Person's Alcohol Team reached 5,500 school children at over 250 school based sessions. The target was to engage with 70% of young people living in areas within the 15% most deprived SIMD areas and this was exceeded.
- The Inverclyde Alcohol and Drug Partnership has been established and action plans have been developed.
- An Inverclyde Alcohol Strategy has been completed and launched as a component of Inverclyde Alcohol and Drug Partnership Strategy.
- All three of our children's residential units retained their grading of excellent in their Care Commission Inspections during 2010.

## **A Thriving, Diverse Community**

- Money Matters received DAS approval-the only agency in Inverclyde that can offer this service free to their clients. The Debt Arrangement Scheme (DAS) is a statutory debt management scheme introduced by the Scottish Government to allow people to repay their debts over an extended period of time.

- The Scottish National Standards for Information and Advice Providers is a quality assurance framework developed for the Scottish Government Social Inclusion Division and in August 2010, the Welfare Rights Unit achieved accreditation to Type III level in all eighteen areas of welfare benefit advice competencies. In doing so, the Welfare Rights Unit became only the third Local Authority Welfare Rights Service in Scotland to achieve Type III accreditation. The accreditation remains in place until August 2014 and the Welfare Rights Unit remains to date the only accredited agency at any level in Inverclyde.
- A number of young people from our children's units have participated in the national anti-stigma campaign around looked after and accommodated young people.

### **A Modern, Innovative Organisation**

- The establishment of the Inverclyde Community Health and Care Partnership (CHCP), effective on 1<sup>st</sup> October 2010.
- The creation of a CHCP headquarters at Kirn House.
- The opening of a new office base and service centre at Crown House facilitated the further integration of Mental Health service teams through joint relocation.
- Cathcart House has also been completely refurbished to accommodate both the integrated Drugs service and Learning Disability services.
- The rebuild of Wellpark Centre for the integrated Alcohol service was completed in 2010.

### 3. STRATEGIC OVERVIEW

#### Directorate Objectives

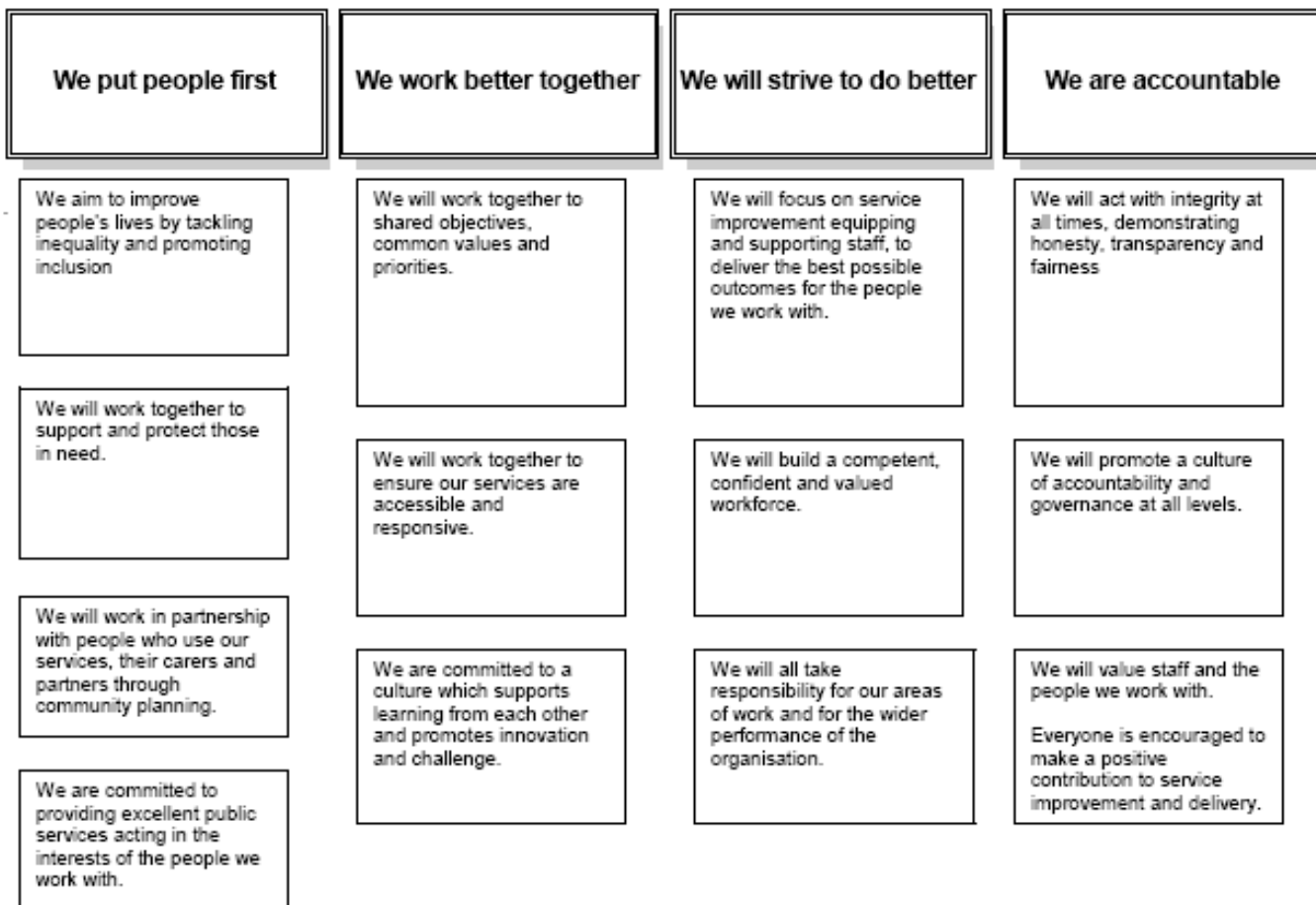
Inverclyde Community Health and Care Partnership was formed on 1<sup>st</sup> October 2010. The overall vision of the CHCP is “**Improving Lives**”. This vision has four strategic objectives underpinning it:

1. We put people first.
2. We work better together.
3. We will strive to do better.
4. We are accountable.

The diagram below outlines further the CHCP principles and values.

### INVERCLYDE COMMUNITY HEALTH AND CARE PARTNERSHIP

#### Improving Lives



## Role and Purpose of the CHCP

With the development of the Community and Health Care Partnership, this Directorate is the largest within the Council in terms of resources, staff and service functions. A new senior management and service management structure has been established (Refer to Appendix 4, CHCP Structure Chart). There is a service manager who has responsibility for each of the functions below:

- Children's Services
- Specialist Children's Services
- Criminal Justice
- Mental Health and Wellbeing
- Addiction Services
- Mental Health Inpatient Adult Services
- Mental Health Inpatient Older People Services
- Homelessness Services
- Older People's Services
- Rehabilitation and Enablement
- Assessment and Care Management
- Planning and Performance
- Commissioning, Contracting and Complaints
- Health Improvement, Inequalities and Personalisation
- Administration and Business Support

The types of services delivered or commissioned include:

- assessment of need
- income maximisation
- care and support at home (including nursing care at home)
- protection of vulnerable children and adults
- supervision of sex offenders and serious and violent offenders in the community
- day care and day services
- equipment and adaptations
- rehabilitation and reablement
- support to vulnerable families and young people
- fostering and adoption, and kinship care
- residential child care and secure care, including throughcare and after care
- supported living
- support to carers and young carers
- youth support and youth justice
- respite and short break services
- counselling

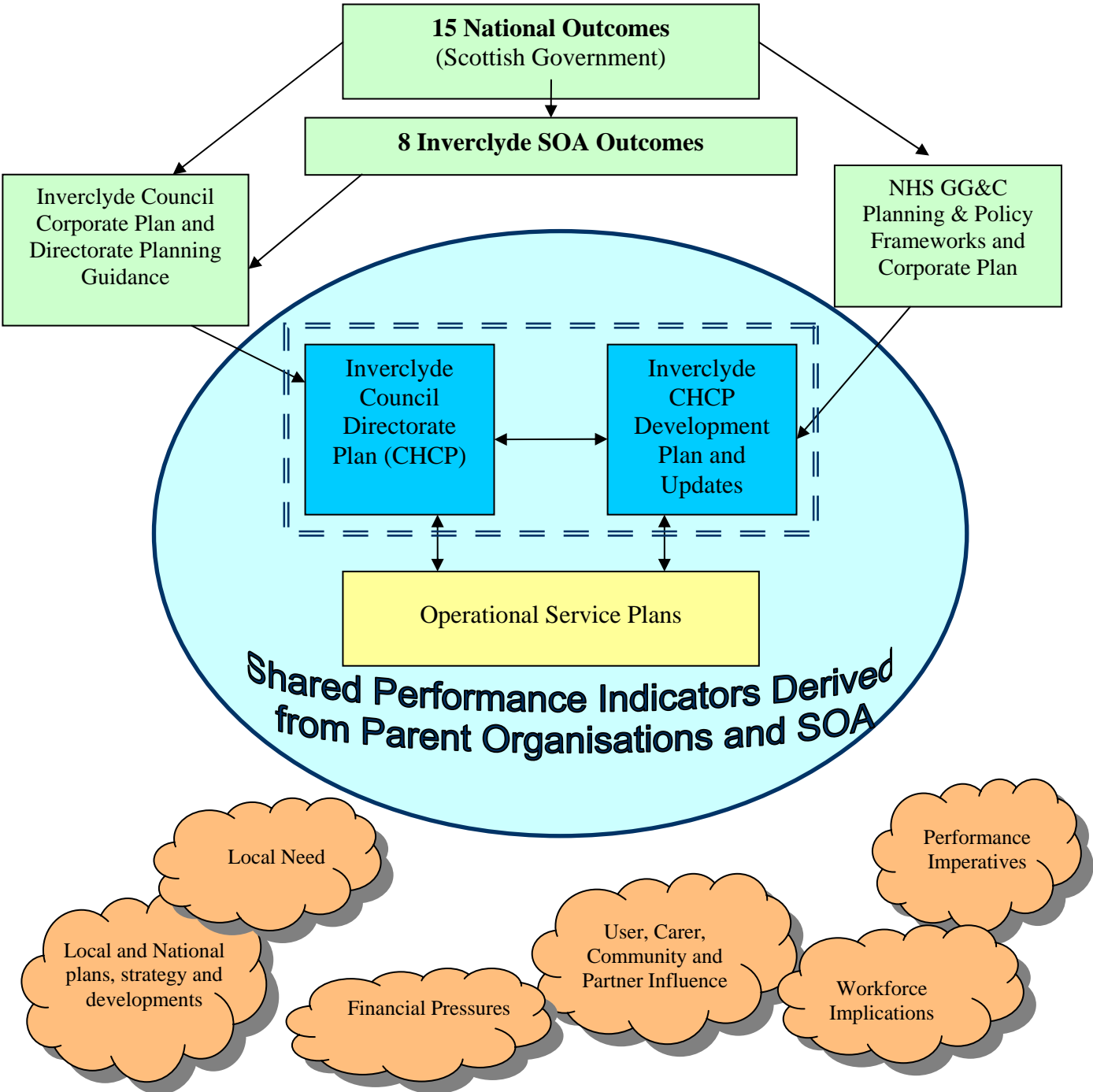


- primary care services (GP's, Dentists, Opticians, Pharmacy)
- health improvement
- palliative and end of life care
- Child and Family Health Teams (Health Visiting and School Nursing)
- early intervention and preventative services including infant nutrition, maternal health and parenting programme
- specialist children's health services including speech and language therapy, Child and Adolescent Mental Health Services (CAMHS) and services for children with additional support needs (ASN).

**Strategic Statement**

The role of the Directorate is highly congruent with those of the Council’s Corporate Plan, Single Outcome Agreement and the revised Community Planning themes.

The diagram below shows the CHCP planning architecture, and illustrates the joint nature of our planning landscape in respect of the ‘parent’ organisations.



## Single Outcome Agreement

The Directorate contributes specifically to the following of the 8 SOA outcomes:

SOA2	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.
SOA4	Economic activity in Inverclyde is higher, and skills development enables both those in work and those furthest from the labour-market
SOA5	The health of local people is improved, combating health inequality and promoting healthy lifestyles
SOA6	A positive culture change will have taken place in Inverclyde to alcohol resulting in fewer associated deaths, health problems and reduced crime rates.
SOA7	All our children and young people are nurtured to have the best start in life.
SOA8	Inverclyde is a place where people want to live now whilst at the same time safeguarding the environment for future generations

Some initiatives which contribute to these include:

SOA5	Leading the corporate agenda on the use of Health Impact Assessments to ensure there is no detrimental impact on health of new developments/events etc.
SOA6	Consolidate initiatives aimed at promoting cultural change and attitudes to alcohol.
SOA7	Promoting the Getting it Right for Every Child (GIRFEC) principles and wellbeing indicators to ensure every child and young person is nurtured to have the best start in life.

In addition to these priorities within the SOA, the CHCP will lead on the commitment to increase respite services as outlined within the Concordat with Local Authorities.

Carers Support was highlighted as a specific commitment within the Concordat through the delivery, nationally, of 10,000 extra respite weeks per annum at home and in care homes over the next three years. The CHCP will seek to ensure that appropriate services are commissioned to meet increased demand.

## Community Plan

The Directorate will contribute to the following outcomes:

1. Health Inequalities
2. Alcohol Misuse
3. Employability and Enterprise
4. Responsible, Active Citizens
5. Protecting the Environment and Reducing Carbon Footprint

Initiatives which contribute to these include:

CP1	Promoting the Getting it Right for Every Child (GIRFEC) principles and wellbeing indicators to ensure every child and young person is nurtured to have the best start in life.
CP1	Leading the corporate agenda on the use of Health Impact Assessments to ensure there is no detrimental impact on health of new developments/events etc.
CP2	Strengthen initiatives aimed at promoting cultural change and attitudes to alcohol.

## Corporate Plan

The Directorate will contribute to the following objectives:

1. Educated, Informed, Responsible Citizens
2. Healthy and Caring Communities
3. Safe and Sustainable Communities
4. A Thriving, Diverse Community
5. A Modern, Innovative Organisation

Initiatives which contribute to these include:

1B	Improve educational attainment for Looked After and Accommodated Children.
1E	The CHCP has a leading role in the Alliance Community Engagement Network as a community engagement and people involvement champion across the partnership.
2A	Leading the corporate agenda on the use of Health Impact Assessments to ensure there is no detrimental impact on health of new developments/events etc.
2D	Support carers in their caring role by providing a range of flexible, reliable and quality short breaks / respite.
2D	Further developments are being proposed in the redesign of services for older people as part of the Change Fund action plan. This is part of the

	“shifting the balance” of care agenda.
2E	Choose Life facilitates a strong local network and continues to develop considerable capacity in improving mental health and wellbeing.
3B	Fulfilling our duties in line with the Multi-Agency Public Protection Arrangements (MAPPA).
3B	Meeting our duties and responsibilities with partner agencies of the Adult Support and Protection (Scotland) Act 2007.
3C	The CHCP is instrumental in the Alcohol and Drugs Partnership in taking forward its aims.
4D	A shared direction has been agreed for how we tackle the employability and financial inclusion agendas as a CHCP, and in partnership
5B	Criminal Justice Social Work hosts the North Strathclyde Community Justice Authority MAPPA unit and the Throughcare services for Inverclyde, Renfrewshire and East Renfrewshire Local Authorities.
5C	The CHCP has achieved Silver accreditation in Scotland’s Healthy Working Lives, and are working towards Gold.
5E	We fully engage in the work of the Corporate Equalities Group and are working to embed an inequalities sensitive approach across the CHCP.

## Organisation Improvement Plan

The Council’s Organisational Improvement Plan identifies several key work streams that will be targeted in order to achieve change and improvement, these include:

- Leadership, Governance and Management
- Organisational Transformation and Improvement
- Workforce Development
- Strategic Planning and Performance Management
- Management of Assets
- Management of Resources

Initiatives involving the Directorate which contribute to these include:

- As the CHCP consolidates new opportunities for further development, this will reflect organisational improvement.
- Introduction of the corporate performance appraisal system.
- Utilising the SWIA (now SCSWIS) self-evaluation tool to drive quality and improve service delivery.
- Support our employees to develop the skills and knowledge to meet our organisational objectives, driven through an integrated approach to learning and development through a CHCP Development Group.

There are many service areas and projects being delivered or progressed through the Directorate's services which influence or impact upon the SOA, Community Planning and the Corporate Plan and these are referenced within the service and joint planning arrangements.

### **Public Service Improvement Framework (PSIF)**

PSIF was piloted in Criminal Justice Social Work Services during 2009. While an improvement plan was developed, the actions reflected those of the existing Criminal Justice Business Plan.

It was agreed at the Policy & Resources Committee (March 2010) that "self evaluation undertaken for both SWIA and HMIE (with regard to Child Protection) represent a robust self evaluation process for Social Care" and in light of this, the CHCP is removed from the PSIF programme.

While the inspection regime nationally is changing, the CHCP is undertaking self assessment on a regular ongoing basis for these purposes. This includes Care Commission inspection of thirteen Social Work services; SWIA ISLA assessment of Social Work, a SWIA Self Evaluation Questionnaire for Criminal Justice Social Work for a thematic inspection of Prison Based Social Work; a peer reviewed (by East Renfrewshire Council) SWIA thematic self evaluation of high risk offenders and a self evaluation for the Effective Practice Unit of the accredited Constructs programme and a follow up HMIE inspection of the Child protection network. An Improvement Plan is developed and reviewed as part of each of these inspections and on-going self assessments. These are all closely monitored by the SCSWIS link Inspector.

We recognise the central role that governance and quality improvement has in ensuring we deliver effective, efficient, safe and equitable services. We are undertaking a programme of quality improvement across services, and are reviewing our approach to clinical and care governance to ensure the best possible outcomes through safe and effective service delivery.

In addition, the CHCP is in the process of reviewing and redesigning a variety of services to further improve efficiency.

## Planning Context

In common with other directorates the CHCP will face a complex range of challenges and opportunities over the next few years. The range of services provided in the CHCP is central to achieving the corporate objectives of the authority, and of NHS GG&C as our other CHCP parent organisation. The Concordat between the Scottish Government and local government will be reflected in the policy direction of the CHCP, as well the policy direction of the Scottish Government. A full list of the national legislation and policies which guide our work is included at **Appendix 5** of this plan.

### 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 will be further compounded by the welfare reform programme, specifically in relation to the change from Job Seekers Allowance to Employment Support Allowance, which 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.

## **Local Context**

The CHCP operates within a complex and wide ranging context not only in terms of its statutory duties and responsibilities but also in terms of the number and range of planning and performance arrangements in which we are engaged, further complicated by the integrated nature of the CHCP in respect of delivering on the planning requirements of both the Council and NHS Greater Glasgow and Clyde.

The CHCP also leads or contributes to the following multi-agency plans:

- Community Care Plan
- Learning Disability Strategy
- Carers Strategy, including a Young Carers Strategy from 2011
- Financial Inclusion Strategy
- Alcohol and Drugs Partnership Strategy
- Youth Justice Strategy
- Mental Health Strategy
- North Strathclyde Community Justice Authority Area Plan
- Integrated Children's Services Plan
- Homelessness Strategy
- Reshaping Older People's Services – Change Plan
- Family Support Strategy
- Child and Maternal Health Strategy
- Inverclyde Child Protection Committee Business Plan

Putting the people who use our services or potential users of our services at the heart of all we do is central to the core values of the CHCP.

We will build on the successes of both the former Social Work Directorate and CHP in respect of customer focus and develop a new People Involvement Framework for the CHCP. We have an excellent track record in respect of involving the public in our business and the creation of the CHCP provides an opportunity to enhance this record.

In line with legislation the CHCP will have a Public Partnership Forum (PPF) which acts as the main formal vehicle for the involvement of patients, service users, carers and the general public in the work of the CHCP. Inverclyde CHCP's PPF will however, be a far larger and more inclusive structure than is in place in other CHP and CHCP areas. Our planned approach has been commended by the Scottish Health Council.

A CHCP / PPF Advisory Group is being established to act forum of public partners and officers to direct and review the work of the CHCP in respect of people involvement. The Advisory Group will support the initiation and review of people involvement work, with users, carers and members of the public at the heart of this, in line with the People Involvement Framework. The CHCP will work closely with Your Voice (Inverclyde Community Care Forum) in running the PPF network and CHCP Advisory Group. The Chair of the Advisory Group will have a seat on the CHCP Committee as a core part of the governance of the CHCP.

Internal, service level people involvement in respect of patient stories, user feedback and ongoing engagement will continue and be strengthened. The People Involvement Framework which will help us develop an integrated approach to involving users, carers and the public internally and a means of supporting staff to do this, and share practice.

The CHCP will continue to be a leading participant in the Inverclyde Alliance Community Engagement Network (CEN) and have a focus on Communication with all partners, including the general public, through our Communications Group which is supported by the Communications teams of both parent organisations. We are committed to the use of Visioning Outcomes in Community Engagement (VOiCE) and Viewpoint as key tools in harnessing the engagement of the users of our services and communities in what we do.

### **Equalities**

A focus on tackling inequality is at the core of how we deliver local health and social care services. We are obliged through Equalities Legislation to routinely examine our services and other business to ensure that what we do does not adversely affect or discriminate against anyone who uses or may use our services. The new Equality Act 2010 received Royal Assent on 8th April 2010, and came into effect on 1 October 2010, bringing together and strengthening the previous equalities legislation. The Act gives the UK a single Act of Parliament, requiring equal treatment in access to employment and provision of public services, irrespective of age, disability, gender reassignment, marriage, maternity or pregnancy, race, religion or belief, sex and sexual orientation.

Inverclyde CHCP reports to both NHS GG&C Equalities Scheme and Inverclyde Council's Corporate Equalities Group, in terms of progress of the equalities agenda. It is our aspiration that Equalities Impact Assessments are carried out on any new policies, strategies, existing and redesigned services. Application of EQIA will be an area of focus in the lifetime of this Directorate Plan. Our approach and plans are supported by the Inverclyde Council Corporate Equalities Group, of which we are an active participant.

### **Sustainability**

We are committed to the shared corporate aspirations of both our parent organisations in respect of sustainability. We aim to ensure there is a sustainable approach to new capital developments, as evidenced by the building and refurbishment of our new mental health and addictions services centres. In addition we aim to reduce the impact on the environment of our business, specifically with regards to carbon footprint by encouraging reduced private car use wherever possible in the delivery of our services.

We are participating in the Clyde Valley Social Transport Review which further aims to reduce Carbon Footprint impact, and bring increased efficiency and value for money in respect of service user transport.

We will continue to progress sustainability actions in the areas of waste reduction, recycling and reduced energy consumption in the lifetime of this plan, in line with Council aspirations. We will also participate in the NHS GGC Sustainability Planning and Implementation Group and deliver on the actions derived through that forum.

The CHCP is participating in the programmes of both parent organisations to look at agile/ mobile working and the Council's accommodation strategy to

ensure a more modern, sustainable approach to staff accommodation and office facilities for the future.

## Competitiveness

The CHCP recognises the need to review our commissioning arrangements and are participating in the Corporate Commissioning Work Stream. In addition, in the lifespan of this plan, we will put in place commissioning strategies for our services, prioritising Older People and Learning Disabilities Services in 2011/2012.

Whilst a significant proportion of social work services are currently externally commissioned, the foregoing will allow us to determine which of our own services are 'market ready', thus delivering on our requirement to identify services which could be made available for tender from third sector and other organisations.

We are engaging in the Scotland Excel commissioning programme, and the Clyde Valley partnership schemes. We are part of the national contract that has been agreed via Scotland Excel for Secure Care and Foster Care. Work is in progress via the Clyde Valley partnership in respect of fostering, Autistic Spectrum Disorder services and alternatives to secure care for girls, and via Scotland Excel in relation to prepared meals and telecare.

## 4. KEY PROJECTS AND IMPROVEMENT ACTIONS

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- We will support work to raise awareness of Gender Based Violence (GBV) and support the roll out of training across out services by the NHS GG&C Violence Against Women team.
- Use the CHCP Communications Group to ensure that information about the CHCP, its services and support/improvement programmes is communication widely to the public.
- Progress the 'health literacy' agenda to ensure understanding of health issues amongst those affected by them.
- Create and implement the CHCP People Involvement Framework, making use of VOiCE and the SHC Participation Toolkit.
- Introduce Viewpoint as a modern and innovative means of communicating and engaging with young people.
- Continue to support the implementation of the Curriculum for Excellence.
- Introduction of Imagination Library for Looked After Children.
- Implement Phase 2 of the Clyde Mental Health Strategy and local redesign.
- Contribute and respond to national developments pertaining to mental health improvement based on improving population wellbeing, and progress the Flourishing Inverclyde agenda.
- Strengthen initiatives aimed at promoting cultural change and attitudes to alcohol.
- Deliver faster access to specialist drugs and alcohol services.
- Roll out the 'Nurturing Inverclyde' programme via SOA 7 to ensure every child and young person is nurtured to have the best start in life.
- Implement the population wide Parenting Strategy.
- Deliver on the year one priorities of the Reshaping Care for Older People Plan.
- Early intervention and support for people with dementia and their carers.
- Secure the best possible outcomes for service users.
- Develop and implement a model of NHS provision of prison health services.
- Implement the 2011/2012 Inverclyde Sexual Health LIG Action Plan.
- Develop a Tobacco Action Plan for Inverclyde.
- Deliver, via co-production with local carers, the 2011 – 2013 Carers and Young Carers Strategy.
- Support carers in their caring role by providing a range of flexible, reliable and quality short breaks / respite, and undertaking assessment of needs of carers where these are requested.

- Consolidate and continually improve our approaches to the protection of children, adults and vulnerable groups.
- Following a supported self evaluation with SWIA on high risk offenders that was peer reviewed by East Renfrewshire, an Improvement Plan has been developed.
- Agree arrangements that will enable all MAPPA agencies across NSCJA to measure and audit its performance.
- Lead the implementation of the actions regarding the 'Safe' wellbeing indicator in the SOA 7 Outcome Delivery Plan, in line with the nurturing Inverclyde principle.
- Extend the provision of the Family Placement Strategy.
- Establish Early and Effective Intervention (EEI) process across Inverclyde to ensure children and young people engaged in offending and anti-social behaviour receive appropriate intervention.
- Develop whole system approach to responding to young people involved in offending currently being dealt with by Criminal Justice Services and/or Children's Hearings.
- Continue to maximise the health and social benefits of being in work through the Employability Agenda.
- Reinvigorate the Inverclyde Financial Inclusion Partnership and develop a Financial Inclusion Strategy.
- Support the Changing Lives Practitioners Forum.
- Complete Phase 2 of the mental health service redesign.
- Move towards a re-ablement model of care in homecare in line with the "Reshaping Care for Older People" agenda.
- Adopt a systematic approach to self assessment, using the SCSWIS e tool and others, to drive quality and improve service delivery.
- Support our employees to develop the skills and knowledge to meet our organisational objectives, in line with the Corporate Performance Appraisal procedure and KSF.
- Implementation of the National Payment for Quality Agenda in the Care Home Sector in Inverclyde.
- Replace our Redholm Children's Unit with a new purpose built 6 bedded unit.
- Review and refocus our approach to performance management.
- Finalise an Accommodation Strategy for the CHCP in line with requirements of Council and NHS GG&C accommodation and agile working aims.
- Deliver a policy the CHCP can work to on sustainable, economic and responsible procurement.
- Implement Eligibility Criteria and the Personalisation / Self Directed Support Agenda.
- Complete the review of the CHCP Admin and Business Support Service.



- Develop an integrated approach to care governance and clinical governance.
- Implement a risk management programme.
- Develop a range of strategies and commissioning plans for Older People's Services, Learning Disability Services, Physical disability Services and Long Term Conditions.
- Strengthen and embed our approaches to Equalities in line with new legislation.
- Achieve the Healthy Working Lives Gold Award.

## **5. MANAGING OUR PERFORMANCE**

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As highlighted in the CHCP Planning Architecture diagram (refer to pg11), there is a need to continue to report to the respective parent organisations of both Inverclyde Council and NHS Greater Glasgow & Clyde existing planning frameworks. To ensure this is not burdensome on services the CHCP is adopting a new approach involving a quarterly service area performance review for each Head of Service and their respective Service Managers using a bespoke balanced scorecard model to review performance, outputs, improvement actions and outcomes. This information, as well as forming the basis for discussion at the actual review, will also be used to populate the majority of the reporting imperatives of that service area.

A second Head of Service will also be in attendance at the reviews, having a role as a "critical friend". This approach will ensure a high level of accountability and a cyclical forum for a greater level of internal scrutiny, as well as a firm foundation for continuous improvement and continuous improvement.

## 6. RESOURCE STATEMENT

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### Financial Information

#### National Context

The Comprehensive Spending Review announced by the Westminster Coalition in October 2010 provided information on Public Sector expenditure over the period 2011/2015 and identified significant resource reduction over this period; 2011/2012 (6.4%), 2012/2013 (0.8%), 2013/2014 (2.9%), 2014/2015 (1.9%).

Given the inflationary and demographic pressures this will result in a significant reduction in real cash terms over this period.

The Scottish Government's response was to set a one year budget for 2011/2012 with a three year budget announcement expected in autumn 2011 from the new Scottish Government.

#### Local Context

Inverclyde Council has set a two year budget for the period 2011/2012 and 2012/2013 and NHSGG&C a one year budget for 2011/2012.

The net revenue budget for the CHCP for 2011/2012 is £120.9 million (m) inclusive of savings targets of £2.1m to be achieved through a number of initiatives whilst minimising the impact on front line services.

- The Inverclyde Council Social Work budget is £48.5m including a savings target of £1.7m being 3.5% of the net total budget.
- The NHSGG&C Inverclyde budget is £72.3m 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 capital budget for 2011/2012 is £6.9m with the two significant projects being:

- £1.3m within Social Work Children & Families relating to Redholm Children's Home.
- £5.4m within Mental Health Inpatient Services relating to the SSPU at Inverclyde Royal Hospital.

Budgeted Resources:	£'000
NHSGGC	72,338
Inverclyde Council	48,522
Total Partnership Budget 2011/2012	120,860
Corporate Director & Support Functions	1,763
Children & Families	14,086
Health and Community Care	33,445
Planning, Health Improvement & Commissioning	8,737
Mental Health & Addictions – Community	6,206
Mental Health – Inpatient Services	8,358
Family Health Services	22,458
Prescribing	17,161
Resource Transfer & Delayed Discharge	8,646
Total Partnership Budget 2011/2012	120,860

### **Criminal Justice Social Work**

Criminal Justice Social Work (CJSW) receives 100% funding from Scottish Government and the annual budget for 2011 / 2012 is £1,858,852. This includes monies to provide an enhanced Throughcare service across the three Local Authorities of Inverclyde, East Renfrewshire and Renfrewshire and to host the Co-ordinator for the Multi-Agency Public Protection arrangements which cover the six Local Authorities comprising the North Strathclyde Community Justice Authority (NSCJA). In addition, CJSW receives £202,889 from the Scottish Prison Service to provide a Prison Based Social Work Team in HMP Greenock.

### **Change Fund**

In 2011/2012 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 release of this funding is dependant on delivery of planned initiatives, as approved by the Scottish Government.

## Staffing Information

As the CHCP beds down our reporting of staffing compliments across NHS and Council employed staff will be integrated and refined. The following gives the picture of our staffing resource and the change over time as it currently stands in current reporting format.

The following tables give a breakdown of all staff by employer, service user group and staff group. The information has been extracted from Staff of Scottish Local Authorities Social Work Services 2009, (2010), National Statistics Publications, Scottish Government published 29th June 2011, and from NHS GG&C HR services.

Please Note: WTE is an abbreviation for Whole Time Equivalent.

	2009	2009	2010	2010
<i>Service User Group</i>	<i>Number</i>	<i>WTE</i>	<i>Number</i>	<i>WTE</i>
Inverclyde Council Employed Staff				
<b>Children and Families</b>	192	170	187	164
<b>Community Care *</b>	773	561	708	523
<b>Criminal Justice</b>	51	48	49	45
<b>Generic Provision **</b>	120	112	122	110
<b>Management and Admin.</b>	79	66	74	65
Total	<b>1,215</b>	<b>957</b>	<b>1140</b>	<b>908</b>
NHS Greater Glasgow and Clyde Employed Staff				
	Headcount	WTE	Headcount	WTE
<b>Administration &amp; Management</b>	45	35.69	60	44.2
<b>Children &amp; Families</b>	100	75.01	113	86.5
<b>Health &amp; Community Care ***</b>	106	88.34	128	102.0
<b>Mental Health and Addictions</b>	63	61.19	60	58
<b>Planning &amp; Health Improvement</b>	24	21.77	25	22.6
Total:	<b>338</b>	<b>282</b>	<b>386</b>	<b>313.3</b>
<b>CHC GRAND TOTAL:</b>			<b>1526</b>	<b>1221.3</b>

Notes:

\* This includes, for example, Home Helps and Day Care staff.

\*\* This includes, for example, Information Workers and Welfare Rights Officers.

\*\*\* Learning disabilities in 2009 was part of Mental Health and by 2010 was included as part of Health and Community Care

It can be seen from the above table that 93.5% of all staff are directly involved in the delivery of services in 2010.

Staff Resources in 2010 for Social Work has decreased by 6.2% in 2010 and by 5.1% WTE compared to the same period in 2009.

As of 1<sup>st</sup> May 2011 in-patient Mental Health services transferred into the CHCP increasing NHS mental health staffing by a headcount of 210, equating to 187.39 WTE.

## CHCP Structure

The establishing of the CHCP and merging of Social Work Services and the Community Health Partnership has involved a complete senior management restructure. The final appointment was made in January 2011. As well as the appointment of the senior management team, there has also been considerable discussion around service manager responsibilities to ensure the best model for service delivery. Each member of the management team has responsibility for managing both health and social work services within their respective service area. (Refer to Appendix 4, CHCP Structure Chart)

## 7. RISK MANAGEMENT

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The CHCP is committed to ensuring there is an effective risk management process in place across the Directorate. We are in the process of reviewing each area's service risk plans in order that a Directorate Risk Plan can be put in place for the CHCP in the lifetime of this plan.

We are piloting an integrated approach to Risk Management in our Children's Services and will use the learning from this process, as agreed across the Council and NHS GG&C, to develop our approach to risk management across the CHCP. Part of this endeavour will include the integration of risk management processes across the NHS and Council in terms of the use of different systems (e.g. DATIX in respect of NHS) for the analysis of incidents and significant events to inform risk management.

## 8. APPENDIX 1 Service Identification and Market Competitiveness

**See comments at section 3 - Competiveness**

Service as Identified by DMT	Responsible Officer	Remit and Scope of Service	Market Assessment Categorisation	Evidence / Rationale for this Assessment

## 8. APPENDIX 2 Action Plan

### Corporate Plan Strategic Outcome 1: Educated, Informed, Responsible Citizens

Strategic Planning References				Project / Improvement Action	Key Performance Measures	Lead Officer	Timescale
Corporate Plan	SOA	OPR	ICHCP Development Plan				
1E	SOA2	CT4 CO8	2.3	Create and implement the CHCP People Involvement Framework, making use of VOiCE and the SHC Participation Toolkit	Users, carers and the public have a voice in all we do	Head of Planning, Health Improvement and Commissioning	December 2011
1E	SOA 7	CT4 CO8	2.3 1.5	Introduce Viewpoint as a modern and innovative means of communicating and engaging with young people.	Project implementation in respect of residential units and youth justice and extend to children affected by child protection issues, Foster Care & Throughcare All Looked After Children	Head of Children's Services and Criminal Justice	December 2011
1B	SOA 7	CO4	1.5	Introduction of Imagination Library for Looked After Children	All Looked After Children under 5 years old to receive 1 book a month	Head of Children Services and Criminal Justice	
1E	SOA5	CO13	2.3	Support the Changing Lives Practitioners Forum	Quarterly reporting of feedback from Practitioners Forum.	Chief Social Work Officer	March 2012



## Corporate Plan Strategic Outcome 2: Healthy, Caring Communities

Strategic Planning References				Project / Improvement Action	Key Performance Measures	Lead Officer	Timescale
Corporate Plan	SOA	OPR	ICHCP Development Plan				
2E	SOA5	CT2	1.2	Implement Phase 2 of the Clyde Mental Health Strategy and local redesign	Various as per strategy and implementation plan	Head of Mental Health, Addictions and Homelessness	March 2013
2E	SOA 5	CO4	1.2	Contribute and respond to national developments pertaining to mental health improvement based on improving population wellbeing, and progress the Flourishing Inverclyde agenda.	Improvements in population wellbeing and reduced incidence of suicide and mental illness	Head of Mental Health, Addictions & Homelessness	March 2012  Long term objective
2D 3C	SOA 6	CT4	1.3	Strengthen initiatives aimed at promoting cultural change and attitudes to alcohol.	Various as per ADP Performance Framework	Head of Mental Health, Addictions & Homelessness	Long term  March 2012
2A	SOA 6	CT7	1.3	Deliver faster access to specialist drugs and alcohol services	21 days target for access to specialist drugs and alcohol services	Head of Mental Health, Addictions and Homelessness	March 2012
2A	SOA5	CT4	1.4 1.8	Implement Year 2 of the Inverclyde Palliative Care Action Plan	Various as per Action Plan	Head of Health & Community Care/ Clinical Director	March 2012
2A	SOA7	CT4	1.5	Implement the 'Healthy Child' programme	Heath Visitor Audit completed	Head of Children and Families & Criminal Justice	August 2012
2A	SOA 7	CT4	1.5	Roll out the 'Nurturing Inverclyde' programme via SOA 7 to ensure	Various as per SOA 7 Outcome Delivery Plan	Head of Children and Families &	3 year plan with staged goals

				every child and young person is nurtured to have the best start in life		Criminal Justice	
2D	SOA 7	CT4	1.5	Implement the population wide Parenting Strategy	Number of staff trained to deliver Number of programmes delivered to parents	Head of Children and Families & Criminal Justice	Long Term Strategy reviewed annually
2D	SOA 5	CT4	1.6	Deliver on the year one priorities of the Reshaping Care for Older People Plan	Year 1 performance indicators show improvement	Head of Health & Community Care	March 2012
2D	SOA5	CO4	1.6	Early intervention and support for people with dementia and their carers	Numbers on dementia registers (TBC)	Head of Mental Health, Addictions & Homelessness/ Head of Health and Community Care	March 2012
2D	SOA	All outcomes	All outcomes	Secure the best possible outcomes for service users.	Using National Outcomes Frameworks to establish effectiveness of our intervention.	Senior Management Team	March 2012
2B	SOA5	Primary Care	1.8	Develop and implement a model of NHS provision of prison health services	New prison health service model in place	Clinical Director/ Head of Mental Health, Addictions and Homelessness	December 2011
2A	SOA 5	CT4	1.9	Implement the 2011/2012 Inverclyde Sexual Health LIG Action Plan	Various as per action plan	Head of Planning, Health Improvement and Commissioning	March 2012
2A	SOA5	CO10	2.2	Develop a Tobacco Action Plan for Inverclyde	Action Plan in place and rates of smoking reduced	Head of Planning, Health Improvement & Commissioning	March 212
2D	SOA2	CT2	2.6	Deliver, via co-production with local carers, the 2011 – 2013 Carers and Young Carers Strategy	New carers and young carers strategy in place	Head of Planning, Health Improvement and Commissioning	December 2012

2D	SOA2	CT2	2.6	Support carers in their caring role by providing a range of flexible, reliable and quality short breaks / respite, and undertaking assessment of needs of carers where these are requested.	Increased provision of alternative short breaks and respite.  Increased numbers of carers assessments evidenced	Head of Planning, Health Improvement & Commissioning	March 2012  Long term objective
2A	SOA 5	CT6 CO9	1.8	Progress the 'health literacy' agenda to ensure understanding of health issues amongst those affected by them	Increased knowledge of health conditions amongst those affected by them. Increased self management/self care	Clinical Director/ Head of Planning, Health Improvement and Commissioning	March 2012
2B	SOA7	C04	1.5 2.2	Continue to support the implementation of the Curriculum for Excellence.	Measurable improvement in learning and achievement, particularly amongst Looked After and Looked After/Accommodation Children	Head of Children Services and Criminal Justice	March 2012

## Corporate Plan Strategic Outcome 3: Safe, Sustainable Communities

Strategic Planning References				Project / Improvement Action	Key Performance Measures	Lead Officer	Timescale
Corporate Plan	SOA	OPR	ICHCP Development Plan				
3B	SOA 2	All Outcomes	All outcomes	Consolidate and continually improve our approaches to the protection of children, adults and vulnerable groups	Various as per child protection and adult protection legislation and guidance	Chief Social Work Officer, Chair – Child Protection Committee, Independent Convenor – Adult Protection Committee	March 2012  Long term objective
3B	SOA 2	C09	2.3	Following a supported self evaluation with SWIA on high risk offenders that were peer reviewed by East Renfrewshire, an Improvement Plan has been developed.	Fully implement Improvement Plan.	Head of Children's Services and Criminal Justice	March 2012
3B	SOA 2	C09	1.3	Agree arrangements that will enable all MAPPA agencies across NSCJA to measure and audit its performance.	A Quality Assurance sub-group was formed in November 2010 to progress this key area and will be providing regular reports from August 2011 to the NSCJA MAPPA Strategic Oversight Group.	Head of Children's Services and Criminal Justice	March 2012
3B	SOA 7	C09	1.5	Lead the implementation of the actions regarding the 'Safe' wellbeing indicator in the SOA 7 Outcome Delivery Plan, in line with the nurturing Inverclyde principle	Address this relevant point in the Action Plan in response to HMIE Integrated Inspection of Children's Services Quarterly / Annual reporting to various committees on all Looked After / Accommodated children and young	Head of Children's Services and Criminal Justice	March 2012

					people. Measures from Quality Improvement Framework and output from the Participation Strategy.		
3B	SOA 7	CT2	1.5	Extend the provision of the Family Placement Strategy	Improved quality and speed of kinship care Assessments  There will be a reduced cost to Inverclyde Council  Increased number of foster carers in the Inverclyde area  Earlier access to adoptive placements for children that require them.	Head of Children's Services and Criminal Justice	2011 / 2012
3B	SOA 7	CO4	1.5	Establish Early and Effective Intervention (EEI) process across Inverclyde to ensure children and young people engaged in offending and anti-social behaviour receive appropriate intervention	Number of children and young people receiving appropriate intervention	Head of Children's Services and Criminal Justice	2011/2012
3B	SOA 7	CT4	1.5	Develop whole system approach to responding to young people involved in offending currently being dealt with by Criminal Justice Services and/or Children's Hearings	Develop Integrated processes and services across children and adult services and opportunities for alternatives to custody and secure care for young people	Head of Children's Services and Criminal Justice	2012
3A	SOA 2	CT3 CO 5	1.3 1.5 2.5	We will support work to raise awareness of Gender Based Violence (GBV) and support the roll out of training across out services by the NHS GG&C Violence Against Women team	Reduced gender based violence	Head of Children's Services and Criminal Justice	March 2012  Long term strategy with regular review

## Corporate Plan Strategic Outcome 4: A Thriving, Diverse Community

Strategic Planning References				Project / Improvement Action	Key Performance Measures	Lead Officer	Timescale
Corporate Plan	SOA	OPR	ICHCP Development Plan				
4E	SOA 4 SOA 5	CT4	2.1	Continue to maximise the health and social benefits of being in work through the Employability Agenda.	As per SOA 4 Outcome Delivery Plan	Head of Planning, Health Improvement & Commissioning	March 2012
4E	SOA 4 SOA 5	CT4	2.1	Reinvigorate the Inverclyde Financial Inclusion Partnership and develop a Financial Inclusion Strategy	Partnership up and running and strategy in place	Head of Planning, Health Improvement & Commissioning	March 2012

## Corporate Plan Strategic Outcome 5: A Modern, Innovative Organisation

Strategic Planning References				Project / Improvement Action	Key Performance Measures	Lead Officer	Timescale
Corporate Plan	SOA	OPR	ICHCP Development Plan				
5A	SOA 5	CT4	1.2	Complete Phase 2 of the mental health service redesign.	Shift in the balance of care.	Head of Mental Health, Addictions & Homelessness	March 2012
5A	SOA 5	CT2	1.6	Move towards a re-ablement model of care in homecare in line with the "Reshaping Care for Older People" agenda.	Implement a re-ablement model in homecare services.	Head of Health & Community Care	December 2011
5C	SOA 4	C09	2.3	Adopt a systematic approach to self assessment, using the SCSWIS e tool and others, to drive quality and improve service delivery.	Complete SEQ's and develop and implement improvement action plans.	Head of Planning, Health Improvement and Commissioning	March 2012
5A 5C	SOA 4 SOA 8	CT7	2.3	Support our employees to develop the skills and knowledge to meet our organisational objectives, in line with the Corporate Performance Appraisal procedure and KSF.	% staff that have undergone CPD staff appraisal. % Care staff in Local Authority residential children's homes with appropriate qualifications for the level of post held. % eligible staff who have registered with SSSC. % staff with a signed of e KSF Personal Development Plan	Senior Management Team	March 2012
5A	SOA 5	CT7	2.3	Implementation of the National Payment for Quality Agenda in the Care Home Sector in Inverclyde.	Achievement of the national Cosla Contractual Performance Targets.	Head of Planning, Health Improvement & Commissioning	March 2012

5A	SOA 7	CT2	1.5	Replace our Redholm Children's Unit with a new purpose built 6 bedded unit	Tender complete and construction started	Head of Children's Services and Criminal Justice	May 2012
5A	SOA5	CT7	2.3	Review and refocus our approach to performance management	Fully implement a revised Planning and Performance Cycle and the Quarterly Performance Review model	Head of Planning, Health Improvement & Commissioning	December 2011
5A	SOA5	CT1	2.3	Finalise an Accommodation Strategy for the CHCP in line with requirements of Council and NHS GG&C accommodation and agile working aims	Accommodation review and strategy complete	Director	March 2012
5A	SOA5	CT1	2.3	Deliver a policy the CHCP can work to on sustainable, economic and responsible procurement	New policy in place in line with new procurement/commissioning arrangements	Head of Planning, Health Improvement & Commissioning	March 2012
5A	SOA5	All outcomes	All Outcomes	Implement Eligibility Criteria and the Personalisation / Self Directed Support Agenda	Eligibility Criteria KPI SDS KPI	Head of Health & Community Care	March 2012
5D	SOA 2 SOA 5	CT7 CO 11 CO12	2.3	Use the CHCP Communications Group to ensure that information about the CHCP, its services and support/improvement programmes is communication widely to the public	There is increased public awareness of the CHCP an of important health and social care information (e.g. national campaigns and local changes to services)	Head of Administration	March 2012



Strategic Planning References				Project / Improvement Action	Key Performance Measures	Lead Officer	Timescale
Corporate Plan	SOA	OPR	ICHCP Development Plan				
5A	SOA5	CT7	2.3	Complete the review of the CHCP Admin and Business Support Service	Review complete and redesign implemented.	Head of Mental Health Addictions and Homelessness	October 2011
5A	SOA5	C09	2.3	Develop an integrated approach to care governance and clinical governance.	Robust governance arrangements implemented.	Clinical Director	March 2012
5A	SOA5	C09	2.3	Implement a risk management programme.	CHCP Risk Register implemented.	Clinical Director	December 2011
5A	SOA5	CT7	1.6	Develop a range of strategies and commissioning plans for Older People's Services, Learning Disability Services, Physical Disability Services and Long Term Conditions	Strategies and Plan in place	Head of Health & Community Care	March 2013
5A	SOA5	C06	2.5	Strengthen and embed our approaches to Equalities in line with new legislation	Audit of EQIAs Equalities training delivered	Head of Planning, Health Improvement & Commissioning	March 2012 Long term objective
5A	SOA5	C013	2.2	Achieve the Healthy Working Lives Gold Award	Award achieved	Director	March 2012

## 8. APPENDIX 3 Performance Information

### Homecare

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
<b>Home care / home helps</b>	SPI (Audit Scotland)							
a) The number of people age 65+ receiving homecare		1112	1,152	1,140	tba	1152	1112	2.1% of Scotland Total
b) The number of homecare hours per 1,000 population age 65+	SPI (Audit Scotland)	663.2	761.8	713.5	tba	761.8	663.2	491.2
c) From the total home care clients age 65+, the number & percentage receiving:	SPI (Audit Scotland)							
- personal care		1112 100%	1,074 93.2%	1,046 91.8%		100%	91.8%	86.9%
- a service during evenings/overnight		207 18.6%	261 22.7%	107 9.4%		22.7%	9.4%	39.5%
- a service at weekends		770 69.2%	811 70.4%	760 66.7%		70.4%	66.7%	70.7%
Discharge from Hospital Number of people delayed in hospital for more than 6 weeks.	SPI (Audit Scotland)	0	2	0	0	2	0	GGC average 32.9

*The upper and lower limits are the variations from target at which performance out with becomes an exception.*

## Homelessness

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
<b>Homelessness</b>								<b>N/A</b>
<b>a) Council duty to secure accommodation for the household and to secure temporary accommodation, provide advice and guidance take reasonable measures to retain accommodation</b>								
<b>i. Number of households assessed during year</b>	<b>SPI (Audit Scotland)</b>	<b>356</b>	<b>326</b>	<b>304</b>				
<b>ii. % of decision notifications issued within 28 days of date of initial presentation</b>	<b>SPI (Audit Scotland)</b>	<b>71.4%</b>	<b>67.2%</b>	<b>73%</b>				
<b>iii. the % who are housed</b>		<b>54.8%</b>	<b>45.6%</b>	<b>28.1%</b>				
<b>iv. % of cases reassessed within 12 months of completion of duty</b>	<b>SPI (Audit Scotland)</b>	<b>5.35%</b>	<b>7.7%</b>	<b>3.5%</b>				
<b>b) The proportion of those provided with permanent accommodation in council stock who maintained their tenancy for at least 12 months.</b>	<b>SPI (Audit Scotland)</b>	<b>No Service</b>	<b>No Service</b>	<b>No Service</b>				

<b>Average time between presentation and completion of duty by the council for those cases assessed as homeless or potentially homeless.</b>	<b>SPI (Audit Scotland)</b>	<b>18.8 weeks</b>	<b>17.8 weeks</b>	<b>25.6 weeks</b>		<b>27.2</b>	<b>17.8</b>	
<b>Complaints - % acknowledged within 5 days of receipt.</b>	<b>SPI (Audit Scotland)</b>	<b>100%</b>	<b>100%</b>	<b>82.8%</b>	<b>100%</b>	<b>100%</b>	<b>83%</b>	<b>N/A</b> <b>Local KPI</b>
<b>The average number of working days per employee lost through sickness absence as % of total available work days.</b>	<b>SPI (Audit Scotland)</b>	<b>6.32</b>	<b>5.95</b>	<b>6.23</b>	<b>6</b>	<b>7.7</b>	<b>5.95</b>	

## Self Directed Support

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
Number of People accessing Self Directed Support	SPI	65*	22		tba			

\* The figure for 2010/11 includes direct payments and indirect payments

## Respite Adult 18-64

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
<b>Respite Care for Carers of Adults Aged 18-64:</b>	SPI	Figures Not Yet Available						
a) Overnight respite in a care home (nights)			1,878n	1,969n				
b) Other overnight respite not in a care home (Number of nights and %)			726n 27.9%	447n 18.5%				
c) TOTAL OVERNIGHT RESPITE (nights & weeks)			2,604n 372w	2,416n 345w				
d) DAY centre respite (hours)			76,178h	60,713h				
e) Other daytime respite (hours)			61,620h	67,905h				
f) TOTAL DAYTIME RESPITE (hours & weeks)			137,798h 2625w	128,618h 2450w				
<b>GRAND TOTAL RESPITE VOLUMES (weeks)</b>			2,997w	2,795w	3,288	2,795	4.1% of Scotland Total	

## Respite 65+

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
<b>Respite Care for Carers of Adults Aged 65+:</b>	<b>SPI</b>	<b>Figures Not Yet Available</b>						
a) Overnight respite in a care home (nights)			2,488n	2,320n				
b) Other overnight respite not in a care home (number of nights and %)			956n 27.8%	937n 28.8%				
c) TOTAL OVERNIGHT RESPITE (nights & weeks)			3,444n 492w	3,257n 465w				
d) DAY centre respite (hours)			65,592h	103,512h				
e) Other daytime respite (hours)			411,367h	278,812h				
f) TOTAL DAYTIME RESPITE (hours & weeks)			476,959h 9085w	382,324h 7282w				
<b>GRAND TOTAL RESPITE VOLUMES (weeks)</b>		9577w	7,747w		7,748w	3,422w	9.1% of Scotland Total	

## Respite Carers of Children

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
<b>Respite Care for Carers of Children 0-17 with disabilities:</b>	SPI	Figures Not Yet Available						
a) Overnight respite in a care home (nights)			694n	719n				
b) Other overnight respite not in a care home (number of nights and %)			55n 7.3%	89n 11%				
c) TOTAL OVERNIGHT RESPITE (nights & weeks)			749n 107w	808n 115w				
d) DAY centre respite (hours)			0	0				
e) Other daytime respite (hours)			5,170h 98w	6,900h 131w				
f) TOTAL DAYTIME RESPITE (hours & weeks)			5,170h 98.5w	6,900h 131w				
<b>GRAND TOTAL RESPITE VOLUMES (weeks)</b>				205w	246w		282w	205w



## Criminal Justice

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
<b>Criminal Justice Social enquiry reports</b>  a) The number of reports submitted to the courts during the year  b) The proportion of these submitted by the due date.	KPI	993	1061	987	95%	100%	90%	N/A Local KPI
<b>Criminal Justice Probation</b>  a) The number of new Probation Orders issued during the year  b) The proportion of new probationers seen by a supervising officer within one week.	KPI	99	175	166	95%	97%	80%	N/A Local KPI
<b>Criminal Justice Community Service</b>  a) The number of new Community Service Orders issued during the year  b) The average	KPI	140	157	156	4	4.5	3.5	N/A Local KPI

<b>number of hours per week taken to complete orders.</b>								
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## Children & Families

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
<p>Children's Reported liaison Children's Hearing system reports:</p> <p>a) The number of SBR reports submitted to the Reporter during the year</p> <p>b) The proportion of reports requested by the Reporter which were submitted within target time.</p>	KPI	559	543	519				N/A  Local KPI
<p>Looked after children Academic achievement:</p> <p>The number and % of young people ceasing to be looked after, who achieved SCQF level 3 or better in English and Maths or other subjects:</p>	KPI	Figures Not Yet Available	33 51.5%	23 65.7%		65.7% Long term aspiration of year on year improvement.	51.5%	N/A  Local KPI
<p>Balance of Care Looked after and accommodated children Community placements as % of</p>	KPI	87.5%	88%	88.5%	85%	88.5%	84.6%	N/A  Local KPI

<b>total placements.</b>								
<b>Children on the child protection register as % child protection referrals.</b>	<b>KPI</b>	<b>31.3%</b>	<b>23.9%</b>	<b>28.6%</b>	<b>tba</b>	<b>28.6</b>	<b>23.9</b>	<b>N/A</b> <b>Local KPI</b>
<b>Number of Children with completed Integrated Assessment Framework (IAF)</b>	<b>KPI</b>	<b>114</b>	<b>-</b>	<b>-</b>				

## Disability

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
Number of people with a Learning Disability (LD) receiving employment opportunities as a % of those with LD known to LA	KPI	15.2%	10.5%	5.2%*	tba			
Number of people with a Learning Disability (LD) with a person centred plan and/or a Single Shared Assessment as a % of those with LD receiving a service(s) funded by the LA	KPI	54.7%	-	-	tba			
Number of people with a Learning Disability (LD) for whom a health check was undertaken as % of those with LD recorded on the GP register	KPI	31.8%	-	-	tba			

\* Only based on those in paid employment (not including those in training for)

## NHS HEAT Targets (Health Improvement, Efficiency, Access and Treatment)

Key Performance Measures	Indicator Type	Performance			Target	Upper Limit	Lower Limit	Rank/National Average
		2010/11	2009/10	2008/09				
Achieve agreed completion rates for child healthy weight intervention programme by 2010/11.	H1	69 (Mar11)			59			
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.	H2	996 (Apr08 – Mar11)			1365 (Apr08 – Mar11)			
Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/ suicide prevention training programmes by 2010	H3		Staff trained – 269 (48%) as at Dec10	Suicide Rate 2009 – 11.2 (crude rate per 100,000)	GGC Target – 50%			

Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/9 - 2010/11.	H4		331 (Dec10)  Quit rate in Acute – 33% Quit rate in Community – 55% Quit rate in Maternity – 78% Quit rate in Pharmacy – 27%		369			
Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.	H5		16% (2010)		21.9%			
Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2010/11.	H6	2397 (March11)			1929			
At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.	H7	Under development						
To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are managed	E4	94.33% (Apr11) 94.06% (Mar11) 92.12% (Feb11)			90%			

electronically to 90% from December 2010.								
NHS Boards should ensure that all staff on Agenda for Change permanent contracts takes part in an annual review against a KSF post outline. Information on levels of competence and identified training needs must be made available through Boards recording summary information from at least 80% of development reviews on eKSF by end of March 2011.	E6	71.47% (Mar11)			80%			
Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team by 2010/11.	A1		100%		90%			
By March 2013 no one will wait longer than 26 weeks from referral to treatment for specialist CAMHS services. During 2010/11 the Scottish Government will work with NHS Boards to develop an access target for psychological therapies for inclusion	A5	Min wait: 0 wks Max Wait: 51 wks Avg Wait: 21 wks (Apr11)			52 Weeks			



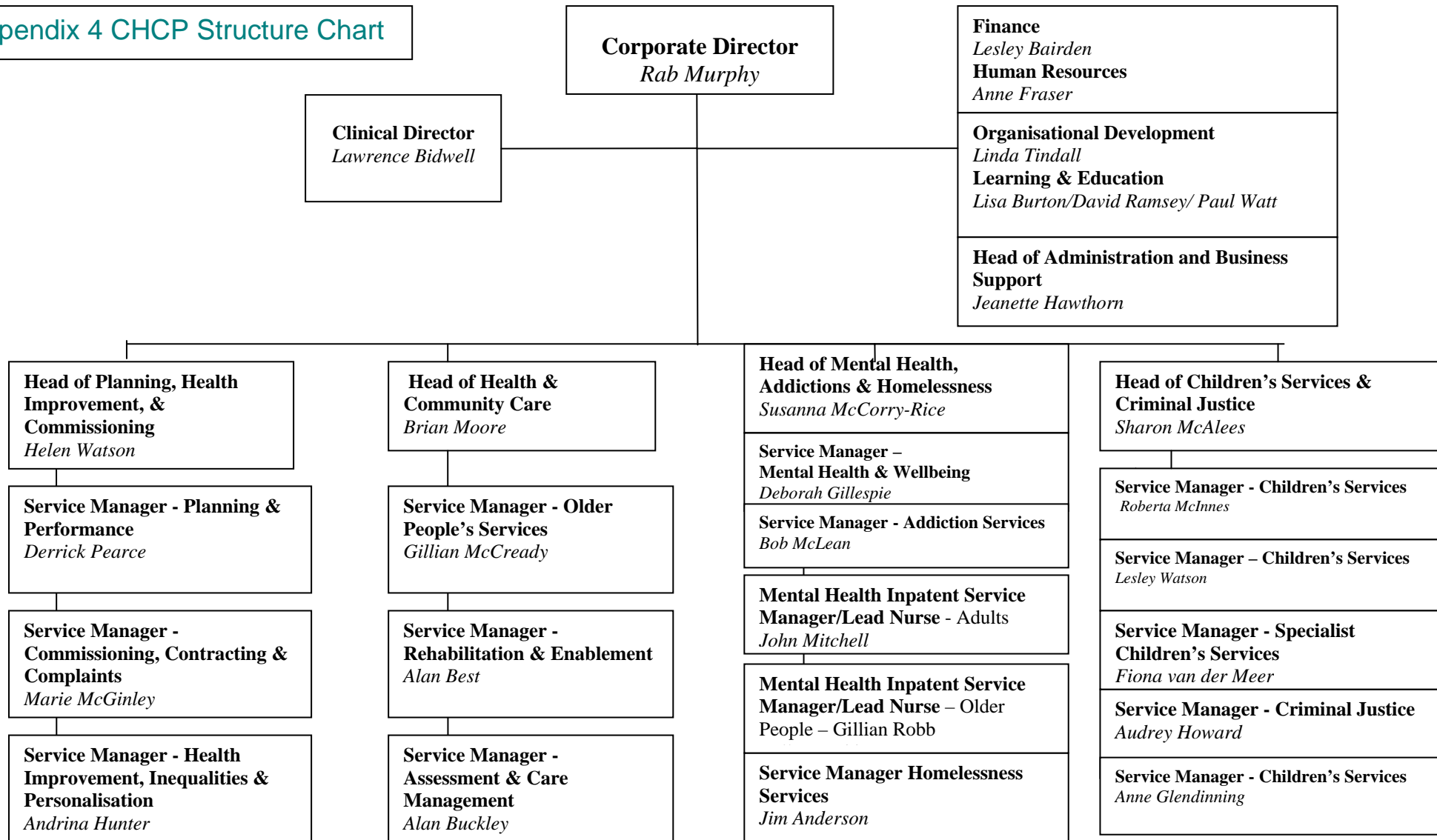
in HEAT in 2011/12.								
To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/07 to 2010/11.	T1		COPD(CR) – 587.2 COPD LOS – 6.6 Asthma(CR)- 163.3 Asthma LOS- 2.2 Diabetes(CR)- 203.2 Diabetes LOS- 9.0 CHD(CR)- 1163.2 CHD LOS- 3.9					
Increase the level of older people with complex care needs receiving care at home (10+ hours Homecare)	T2	46% (Sept 10)			36%			
To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E	T4	2884 (Feb11)						
By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05.	T6		25342 as at Sep10  Cumulative figure for 2010 60275					

Local Indicators								
Reduction in anti-depressant prescribing (DDD per capita – GP list size)	Local		49.67 per capita					
Number of HEAT staff trained to deliver ABIs	Local		10 (Dec10)					
Number of Non HEAT staff trained to deliver ABIs	Local		209 (Dec10)					
Alcohol Fast Screening Tool	Local	697 (Mar11)						
Proportion of GP practices signed up to deliver ABIs	Local	68.8% (Dec10)						
Number of drug related deaths (per 100,000 pop)	Local			8.7 (per 100,100 pop.)				
Reduce rate of alcohol related admissions	Local		3.1 (sept10)					
Alcohol related hospital discharges	Local	991			Not exceed 1102			
Number of alcohol related deaths	Local		32 (Aug10)		Reduce to 40			
Respondents who have said that they believe excessive drinking of alcohol is a particular problem in Inverclyde.	Local		71%		Reduce to 89%			

Numbers of problem drug users still in treatment 3 months after treatment commencing	Local		82% (Aug10)		Maintain minimum at 75%			
Uptake of cancer screening programmes: Cervical Bowel Breast	Local		76.7%(Dec10) 54.1%(Dec10)	68.3%	80% 60% 70%			
Triple P: Number of staff trained	Local	43 (Mar11)						
Number of 3 – 5 year olds registered with a dentist	Local		86.3%		76%			
Number of schools participating in the Childsmile programme	Local	34 Nurseries (100%)						
MMR Vaccinations 24 Months 5 Years	Local		90.5% 99.1%		95% 95%			
Smoking in Pregnancy	Local		20.9%		20%			
Smoking in Pregnancy most deprived quintile	Local		28%					
Improve low birth weights	Local		4.8%					
Advance booking to an appropriate member of GP Practice teams	Local		81.7%		90%			
% positive	Local		100%					

responses in overall care provided by GP			(Neutral)					
Reduction in teenage pregnancy rates per 1,000 girls aged 13-15 years in deprived	Local			37.9 per capita				
Life expectancy at birth (males and females)	Local		2007/09 Males: 73.1 Females: 79.0					
Number of carers known to CHCP	Local	1182 (GP Register) 1612 (Carers Centre)*  *Duplict'n expected (Mar11)						
Sickness Absence (NHS) Short Term (NHS) Long Term (NHS)	Local	3.28% 1.09% 2.19%			4%			
Uptake of HPV vaccinations Routine Cohort (S2)	Local		86.5%					
HPV vaccinations Routine and Catch Up Cohorts (S2; S4 & S6)	Local		84.6%					

**Appendix 4 CHCP Structure Chart**



## 8. APPENDIX 5 Strategic Planning References

### Single Outcome Agreement References

Single Outcome Agreement Priority	Reference
<ul style="list-style-type: none"> <li>Inverclyde's population is stable with a good balance of socio-economic groups.</li> </ul>	SOA1
<ul style="list-style-type: none"> <li>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.</li> </ul>	SOA2
<ul style="list-style-type: none"> <li>The area's economic regeneration is secured.</li> </ul>	SOA3
<ul style="list-style-type: none"> <li>Economic activity in Inverclyde is increased, and skills development enables both those in work and those furthest from the labour market to realise their full potential.</li> </ul>	SOA4
<ul style="list-style-type: none"> <li>The health of local people is improved, combating health inequality and promoting healthy lifestyles.</li> </ul>	SOA5
<ul style="list-style-type: none"> <li>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.</li> </ul>	SOA6
<ul style="list-style-type: none"> <li>All our young people have the best start in life.</li> </ul>	SOA7
<ul style="list-style-type: none"> <li>Inverclyde is a place where people want to live now whilst at the same time safeguarding the environment for future generations.</li> </ul>	SOA8

### Corporate Plan References

Strategic Outcome	Action	Reference
Outcome 1: Educated, Informed, Responsible Citizens	<ul style="list-style-type: none"> <li>Invest in the renewal of the school estate to ensure that children are educated in modern schools fit for the demands of the 21<sup>st</sup> century and that are schools are used for a range of community, cultural and leisure activities.</li> </ul>	1A
	<ul style="list-style-type: none"> <li>Improve the educational attainment of all children, particularly that of our most vulnerable young people, such as looked after and accommodated children.</li> </ul>	1B
	<ul style="list-style-type: none"> <li>Work with partner agencies and local communities to develop and support projects that secure an increase in the level of adult numeracy and literacy.</li> </ul>	1C
	<ul style="list-style-type: none"> <li>Identify and address the training and support needs of young people to provide them with more choices and chances to succeed.</li> </ul>	1D
	<ul style="list-style-type: none"> <li>Work with our partners in the Inverclyde Alliance to develop a new, shared approach to community engagement, building community networks that will enable individuals and communities to actively participate in influencing policies and decisions that affect them or the area in which they live.</li> </ul>	1E

Strategic Outcome	Action	Reference
Outcome 2: Healthy, Caring Communities	<ul style="list-style-type: none"> <li>Work with the new Community Health Partnership and our partners in the Inverclyde Alliance to tackle health inequalities, particularly in those areas where specific social, economic and environmental challenges have caused acute health problems.</li> </ul>	2A
	<ul style="list-style-type: none"> <li>Promote the wellbeing and social inclusion of those individuals and groups who, for various reasons, are unable to fully participate fully in the life of their community by working in partnership with the Inverclyde Alliance and the voluntary sector.</li> </ul>	2B
	<ul style="list-style-type: none"> <li>Work with partners including the private sector to promote investment in our sport and leisure infrastructure and support initiatives that improve physical health and increase participation for all age groups.</li> </ul>	2C
	<ul style="list-style-type: none"> <li>Strengthen formal and informal social care networks that meet the needs of the most vulnerable groups.</li> </ul>	2D
	<ul style="list-style-type: none"> <li>Work with partner agencies and the voluntary sector to promote positive mental health and wellbeing, raise awareness of mental health issues and improve the quality of life of people at risk of, or experiencing, mental ill health.</li> </ul>	2E

Strategic Outcome	Action	Reference
Strategic Outcome 3: Safe, Sustainable Communities	<ul style="list-style-type: none"> <li>Work with partner agencies and local communities to reduce fear of crime, as well as actual instances of crime, by implementing initiatives to tackle anti social behaviour.</li> </ul>	3A
	<ul style="list-style-type: none"> <li>Keep vulnerable adults and children safe and protected by working with our partners through the Inverclyde Alliance.</li> </ul>	3B
	<ul style="list-style-type: none"> <li>Work with partners in the Inverclyde Alliance and Scottish Government to tackle the culture associated with alcohol, reduce the negative impact on community safety and change attitudes towards alcohol.</li> </ul>	3C
	<ul style="list-style-type: none"> <li>Facilitate the development of initiatives that encourage communities and individuals to reduce waste and increase recycling to promote environmental sustainability.</li> </ul>	3D
	<ul style="list-style-type: none"> <li>Lead the development of a new Local Housing Strategy and, in partnership with other agencies, increase the supply of new, affordable homes and improve the quality of existing housing stock.</li> </ul>	3E
	<ul style="list-style-type: none"> <li>Protect and care for the environment by addressing climate change by reducing the amount of energy used in Council buildings, street lighting and transport and identifying further opportunities for carbon reduction.</li> </ul>	3F

Strategic Outcome	Action	Reference
Strategic Outcome 4: A Thriving, Diverse, Local Economy	<ul style="list-style-type: none"> <li>Work with partners, the private sector and local communities to promote Inverclyde nationally and internationally as an attractive location to live, work and visit.</li> </ul>	4A
	<ul style="list-style-type: none"> <li>Ensure that our services work in partnership with Riverside Inverclyde to realise the potential of Inverclyde's waterfront to be a driver of economic and social regeneration.</li> </ul>	4B
	<ul style="list-style-type: none"> <li>Work with partner agencies and the voluntary sector to improve the range and quality of services available to new and developing businesses, promote entrepreneurship and support and develop social enterprise.</li> </ul>	4C
	<ul style="list-style-type: none"> <li>Develop through the Inverclyde Alliance, a coherent approach to employability to improve employment opportunities for people furthest from the labour market.</li> </ul>	4D
	<ul style="list-style-type: none"> <li>Develop a distinctive area based approach to regeneration, in partnership with other public agencies and local communities, which recognises that different areas have specific social, economic and environmental challenges that require different solutions, for example, the town centres of Port Glasgow, Greenock and Gourock.</li> </ul>	4E
	<ul style="list-style-type: none"> <li>Work with our partners to expand public transport infrastructure including the development of the Gourock interchange.</li> </ul>	4F

Strategic Outcome	Action	Reference
Strategic Outcome 5: A Modern, Innovative Organisation	<ul style="list-style-type: none"> <li>Focus on modernising services across the organisation to improve responsiveness, increase accessibility and provide a high level of customer service.</li> </ul>	5A
	<ul style="list-style-type: none"> <li>Explore opportunities with other local authorities and public agencies to work in partnership to improve the services we provide to our customers.</li> </ul>	5B
	<ul style="list-style-type: none"> <li>Support and develop our employees through a variety of initiatives including training, flexible working, Scotland's Healthy Working Lives, Investors in People (IIP) to help our employees develop new skills and knowledge that will enable them to provide an improved service to customers.</li> </ul>	5C
	<ul style="list-style-type: none"> <li>Implement a coherent approach to internal and external communications that will keep communities and our employees informed, strengthen our reputation and increase understanding of the role of the Council.</li> </ul>	5D
	<ul style="list-style-type: none"> <li>Ensure that our services do not directly or indirectly discriminate against people on the basis of race, gender, age, disability, sexual orientation, religion or belief by mainstreaming equality and diversity across all services.</li> </ul>	5E



## ICHCP Organisational Performance Review References

CT	<b>NHS GG&amp;C Corporate Themes</b>
CT1	Improve Resource Utilisation
CT2	Shift the Balance of Care
CT3	Focus Resources on Greatest Need
CT4	Modernise Services
CT5	Improve Accessibility
CT6	Improve Individual Health Status
CT7	Effective Organisation
CO	<b>NHS GG&amp;C Consolidated Outcomes</b>
CO1	Efficient and economic services are provided based on best practice and value for money
CO2	Financial resources are allocated recognising the mutual interdependence of primary and secondary care services
CO3	People are supported to live independently through the provision of a full range of care services available locally
CO4	Early intervention is understood by staff, service users and carers and has begun to become the norm, facilitated through supporting services
CO5	Resources are targeted at specific high risk groups in order to mitigate the risk of ill health
CO6	Inequalities are addressed through effective planning, practice and service redesign
CO7	Facilities are planned and invested in to reflect the services and patient requirements and are environmentally sustainable
CO8	Services seek and are responsive to patients views
CO9	Services are provided in a way which maximises quality and safety
CO10	Patients can access services at a time they need in the appropriate location
CO11	The public is informed on issues of public health to enable prevention and early detection of health problems
CO12	Information is managed and disseminated effectively to support planning and service delivery
CO13	The workforce is engaged, feels valued and is representative of the population

	Development Plan Framework
1.1	Acute Services
1.2	Adult Mental Health
1.3	Alcohol and Drugs
1.4	Cancer
1.5	Children and Young People and Maternity Services
1.6	Updated Outcomes – Long Term Conditions, Disability and Older People
1.7	Disability
1.8	Primary Care
1.9	Sexual Health
1.10	Unplanned Care
2.1	Employability, Financial Inclusion and Responding to the Recession
2.2	Health Improvement
2.3	Quality – Creating a Person-centred and mutual NHS
2.4	Sustainability
2.5	Tackling inequality
2.6	Unpaid Care

## Appendix 6: Legislation and Policy

### National Policies and Legislation

Services provided by the CHCP are guided by national policy drivers and the following is an outline of some of the key policy drivers:

- *Meeting National Care Standards.*
- *Same as You? A Review of Services for People with Learning Disabilities, (2000), Scottish Executive.*
- *Scottish Executive Response to Care 21 Report: The Future of Unpaid Care in Scotland, (2006), Scottish Executive.*
- *All our Futures: Planning for a Scotland with an Ageing Population, (2007), Scottish Executive.*
- *Plan for Action on Alcohol Problems – Update, (2007), Scottish Executive*
- *The Road to Recovery: A New Approach to Tackling Scotland’s Drugs Problem, (2008), Scottish Government.*
- *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011, (2009), Scottish Government.*
- *Respect and Responsibility: The Sexual Health Strategy, (2005), Scottish Government.*
- *Equally Well: Report of the Ministerial Task Force on Health Inequalities, (2008), Scottish Government.*
- *NHS Quality Improvement Scotland Quality Assurance Framework, (2010) NHS QIS*
- *Living and Dying Well: A national action plan for palliative and end of life care in Scotland, (2008), Scottish Government*
- *Early Years and Early Interventions, (2008), Scottish Government.*
- *For Scotland’s Children: Better Integrated Children’s Services, (2001), Scottish Executive.*
- *“Its Everyone’s Job to Make Sure I’m Alright”: Report of the Child Protection Audit and Review, (2002), Scottish Executive.*
- *Getting Our Priorities Right: Good Practice Guidance for Working with Children and Families Affected by Substance Misuse, (2003), Scottish Executive.*
- *Hidden Harm, (2004), Scottish Executive.*
- *Getting it Right for Every Child, (2005), Scottish Executive.*
- *Changing Lives Implementation Plan, (2006), Scottish Executive.*
- *Personalisation: An Agreed Understanding, (2007), Scottish Government.*
- *Performance Improvement Framework, (2006), SWIA.*
- *Quality Improvement Framework, (2006), Scottish Executive.*
- *National Strategy for the Development of the Social Services Workforce in Scotland: A Plan for Action 2005 – 2010, (2005), Scottish Executive.*

- *Improving Front Line Services: A Framework for Supporting Front Line Staff, (2005), Scottish Executive.*
- *Transforming Public Services: The Next Phase of Reform, (2006), Scottish Executive.*
- *Government Economic Strategy, (2007), Scottish Government.*
- *Concordat between the Scottish Government and Local Government, (2007), Scottish Government.*
- *Scotland's Choice: Report of the Scottish Prisons Commission, (2008), Scottish Prisons Commission.*
- *Protecting Scotland's Communities: Fair, Fast and Flexible Justice, (2008), Scottish Government.*
- *Towards 2012: Homelessness Support Project, (2008), Scottish Government.*
- *Guide to Support Self Evaluation, (2009), Social Work Inspection Agency.*
- *NHS Scotland Quality Strategy (2010)*

There are over one hundred legislative and policy requirements that impact on service provision from the CHCP. The following is an outline of recent legislation and developments in this area:

- Carers Support and Recognition Act 1995
- Children (Scotland) Act 1995
- Adults with Incapacity (Scotland) Act 2000
- Housing (Scotland) Act 2001
- Freedom of Information (Scotland) Act 2002
- Community Care and Health (Scotland) Act 2002
- Local Government in Scotland Act 2003
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Criminal Justice (Scotland) Act 2003
- Homelessness etc. (Scotland) Act 2003
- Anti-Social Behaviour etc. (Scotland) Act 2004
- Management of Offenders etc. (Scotland) Act 2005
- Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006
- Adoption and Children (Scotland) Act 2007
- Adult Support and Protection (Scotland) Act 2007
- Protection of Vulnerable Groups (Scotland) Act 2007
- Criminal Justice and Licensing (Scotland) Act 2010
- Equality Act 2010
- Public Services Reform (Scotland) Act 2010
- Children's Hearing (Scotland) Act 2011
- Improving Maternal and Infant Nutrition: A Framework for Action (2011)

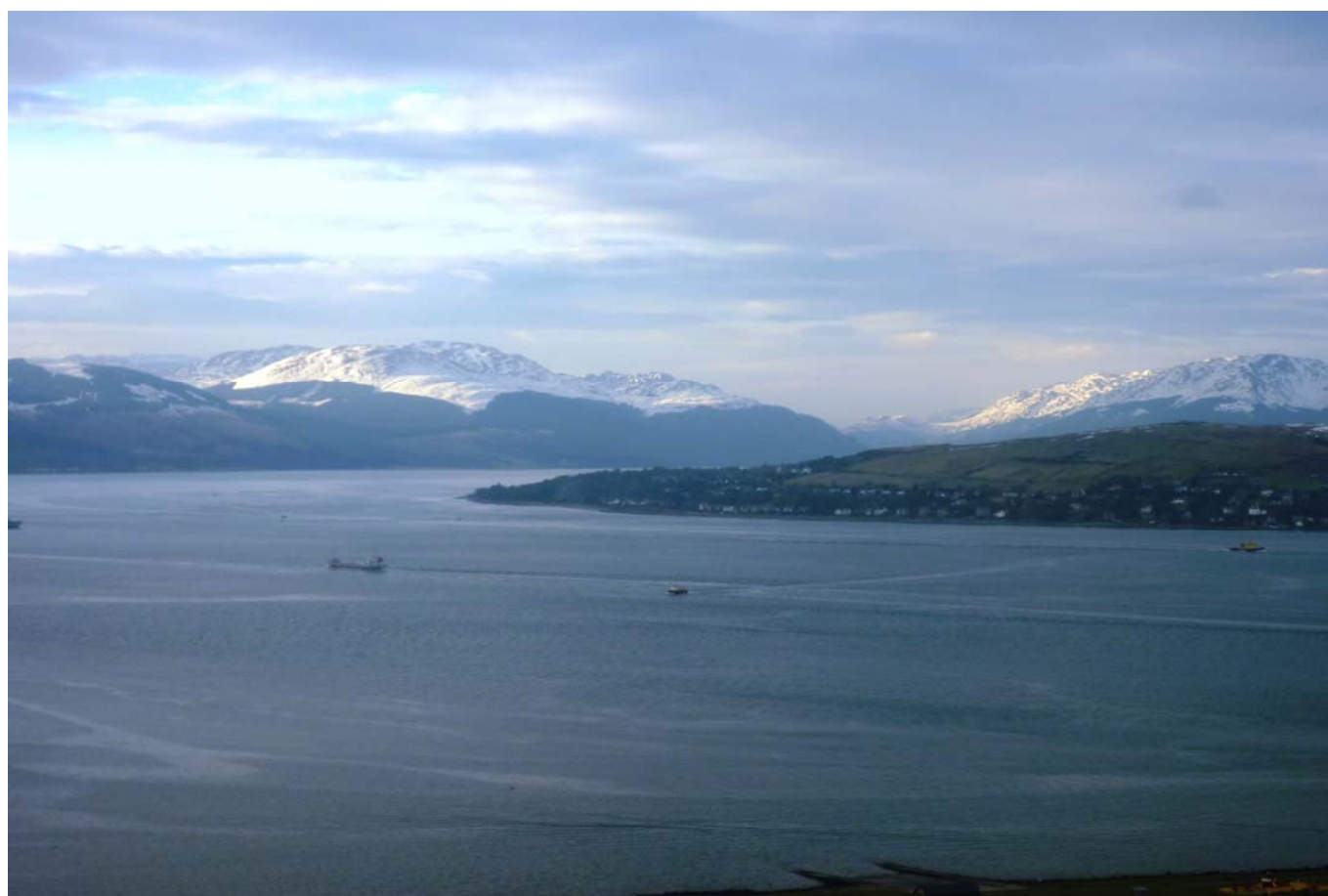
Inverclyde CHCP Directorate Plan  
2011 – 2012

For further information and feedback about this  
report please contact:

Team Leader  
Quality Assurance  
Strategic Planning & Performance  
Inverclyde CHCP  
Kirk House  
Ravenscraig Hospital  
Greenock  
PA16 9HA

**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 in 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 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%
NHS Scotland 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
NHS Scotland 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	Actual 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.

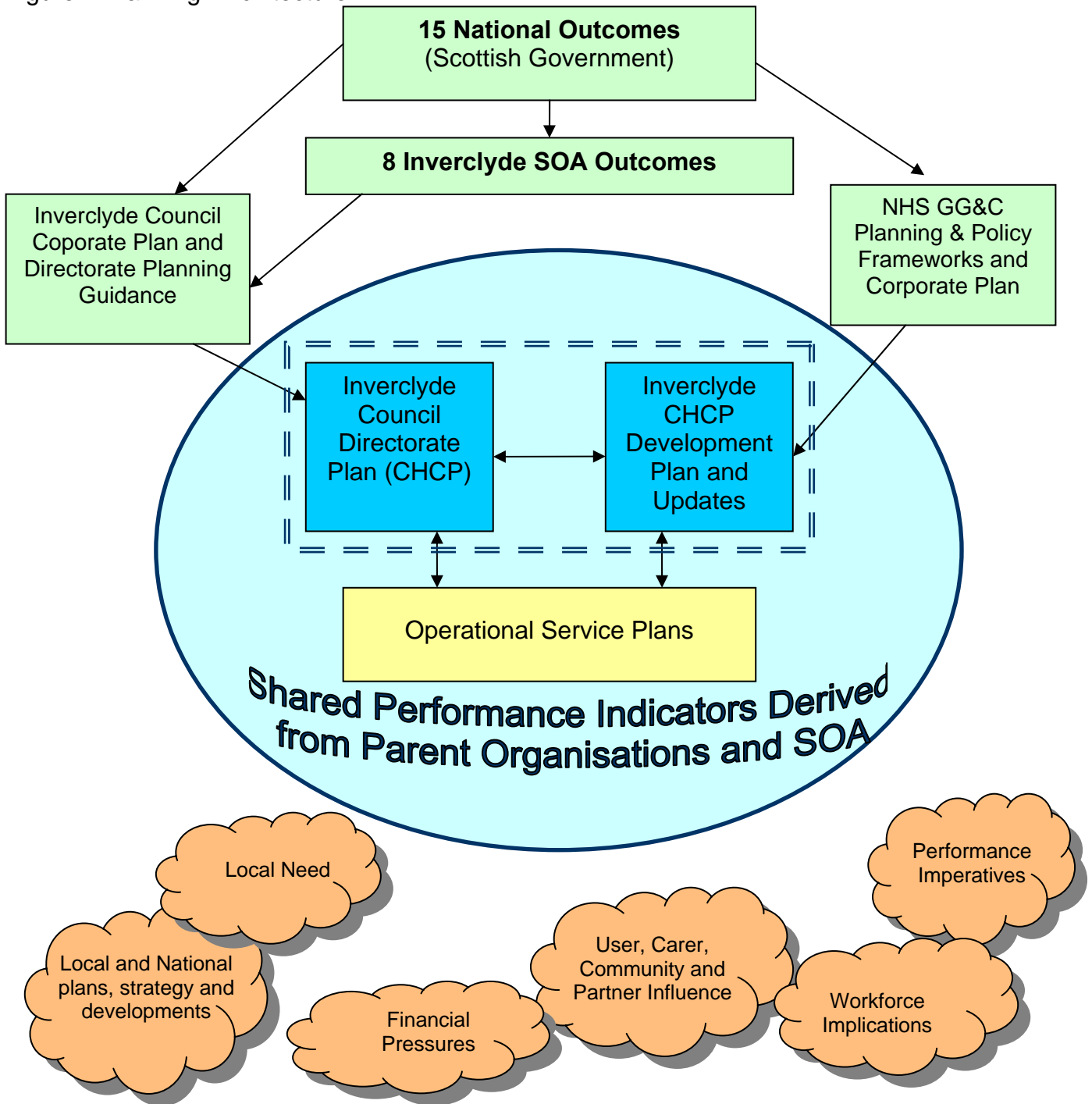
Alcohol is being driven through our Alcohol and Drugs Partnership, with further strategic underpinning through our Alcohol and Drugs Strategy (Inverclyde Alcohol and Drugs Partnership Strategy, 2010) which has been informed by the NHS GG&C Alcohol and Drugs planning framework.

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 developed 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).

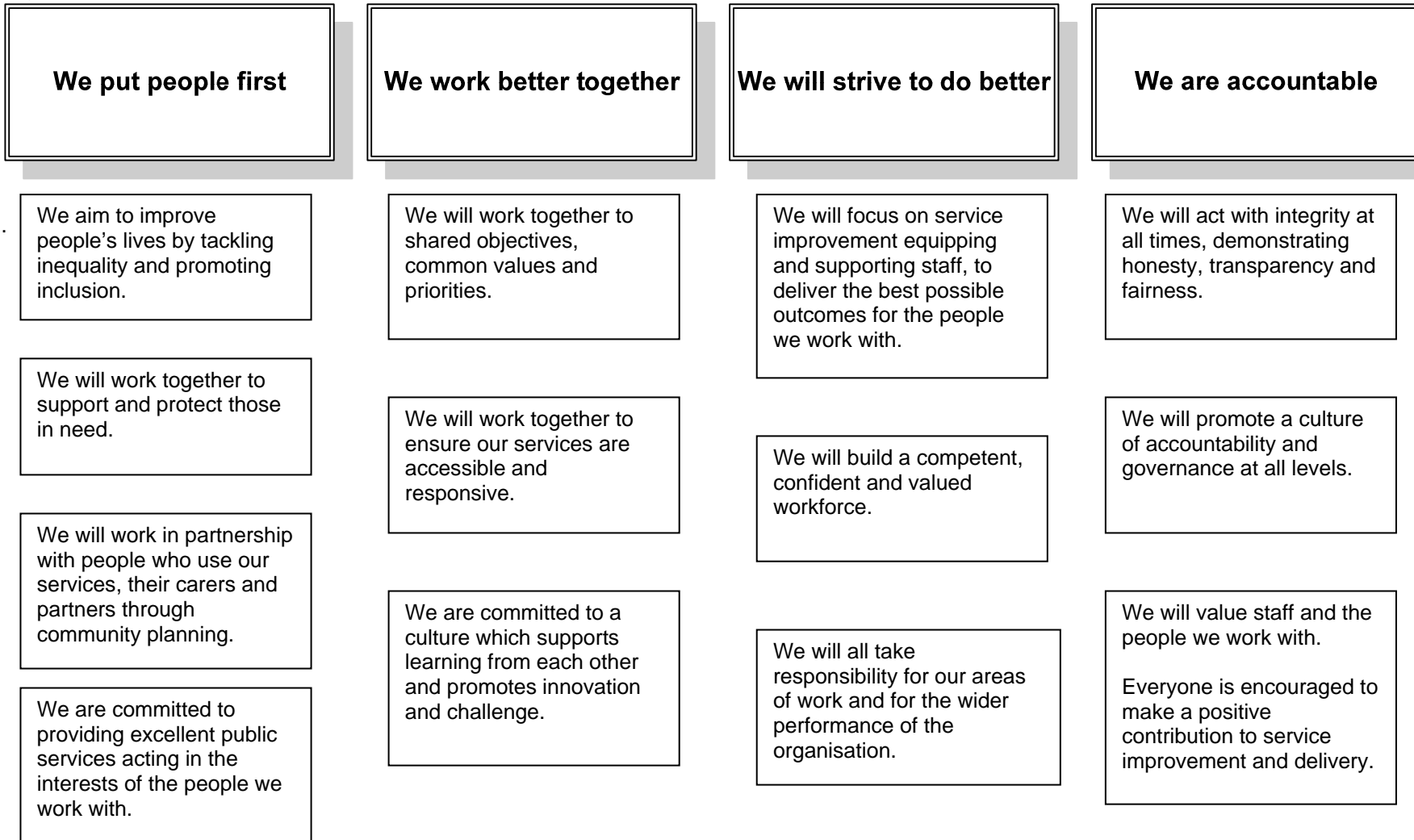
The CHP Development Plan 2010 – 2013 reflected the following specific priorities which remain relevant to us as a CHCP:

- 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
<p>2010/11 Services provided meet national access targets</p> <p>2010/11 Improved management of GP to hospital referrals through better use of technology resulting in a quicker and safer referral process for patients.</p> <p>2011/12 Improved access and engagement with services.</p> <p>2011/12 Modernise services</p>	<p>We will work with colleagues in the Acute Sector to support the delivery of the 18 week RTT</p> <p>By the end of year 1, electronic referrals from GPs will have been increased in respect of Inverclyde Patients</p>	<p>We participate the 18 week RTT both in terms of awareness raising within community, and via several of the working groups.</p> <p>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.</p>	<p>Improve the management of GP to hospital referrals through better use of technology resulting in quicker and safer referral processes for patients.</p>	<p>HEAT re SCT refs</p>
<p>2010/11 Acute Services provided based on systematic review of demand on services</p> <p>2011/12 Improve secondary care interface with Primary Care and other parties.</p>	<p>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</p>	<p>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.</p>	<p>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.</p> <p><b>OPR Action</b> – Delayed Discharges, continually review progress and processes to improve</p>	<p>4. Key demand areas identified</p> <p>5. Streamlining opportunities identified</p> <p>6. Maintenance of the Delayed Discharges standard of 0 delays over 6 weeks.</p>

	secondary care and vice versa.			
2010/11 Efficient and economic services  2011/12 Improve resource utilisation.	Develop a comprehensive approach to demand management with CHCPs  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.	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&E and medical specialties.	We will use interface intelligence to streamline patients, transitions between acute, primary and community health and social care services.	<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>
2010/11 There are agreed benchmarking, efficiency and effectiveness measures for Acute Services which demonstrate productivity and value for money  2011/12 Improve resource utilisation.	Length of stay reduced by improving patient flows and improving discharge planning.  DNA rate reduced.  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.  By the end of year 1 we will have defined and reinforced the primary care role in encouraging attendance.	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.  Attention is being paid to inaccurately completed discharge paperwork. It has been decided these inaccuracies will be handled as an incident to facilitate improvement.  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.	Beyond year 1 we will undertake an in-depth analysis of the relationships between DNAs in primary and secondary care.  We will complete the notification of Death pilot commenced in year 1.  We will establish a process of having discussion of incidents related to hospital discharge and maximise learning.	<ul style="list-style-type: none"> <li>• Pilot evaluation complete. We will establish systems to report DNA's across a range of key services.</li> <li>• DNA reports established.</li> <li>• Incident reports and improvement plan process in place.</li> </ul>
2010/11 There is whole system consideration of resources and how they shift as the balance of care changes.  2011/12 Shift the Balance of Care.	Work with partners to consider how we shift the balance of care including the resource implications.  By the end of year 1 we will have scoped the longer term implications of our changing	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.	We will develop a commissioning strategy to support the redesign of services for older people.	Commissioning strategy agreed and in place, and associated action plan developed.

	demography, and considered potentially feasible options where services and their resources might be transferred from secondary care to primary care.			
2010/11 Reduced admissions to Acute Hospitals and reduced bed days.  2011/12 Shift the Balance of Care.  Improve Health  Improve secondary care interface with primary care and other parties.	Reduced rates of admission and bed days for patients with a primary diagnosis of COPD, Asthma, Diabetes or Heart Disease.  By the end of year 1, Fast Track input to multi-disciplinary diabetes consultant clinic will be fully developed.	Discharge rated per 100,00 population as at Oct 09 – Sept 10  COPD – 571.0 (increase) Asthma – 158.3 (decrease) Diabetes – 192.0 (increase) CHD - 1133.3 (increase)  This action is complete.	Develop a process to ensure that anticipatory care plans are developed and implemented as soon as possible.  In 2011/12 we will further develop this service making use of telehealth to facilitate the treatment of diabetic foot ulceration.	Local LOS target  Improved community services through reshaping care for older people.  Number of new anticipatory care plans agreed.  Fast track service referral rates and endorse service expansion.
2010/11 Patients treated in the right place by the right person.	Care pathways between primary and secondary care are planned and designed in partnership with agreed feedback arrangements about utilisation and appropriateness.  By the end of year 1 we will have developed routine access to acute sector management information.	This workstream is being progressed on a system-wide basis as part of the remit of the Corporate Strategic Information Group.	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.	Key demand areas identified  Patient pathways mapped.
2010/11 Integrated Health and Social care and Support for People in need and at risk.  2011/12 Improved secondary care interface with primary care and other parties.	Appropriate multi-agency arrangements in place to support vulnerable children, adults and their families/carers.  By the end of year 1 we will have established Inverclyde CHCP	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.	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  Consolidate our local arrangements for adult support and protection.	<ul style="list-style-type: none"> <li>Regular CHCP Committee meetings.</li> <li>Adult support and protection steering group and Committee established.</li> </ul>
2010/11 Secondary care provides the full range of services required by primary care in the timeline and model required.	Explore changes to processes and systems needed to ensure that there is clear joint ownership of challenges across the acute and	This workstream is being progressed on a system-wide basis as part of the remit of the Corporate Strategic Information Group.	We will maximise involvement of key local fora to develop anticipatory care and the older people's commissioning strategy.	<ul style="list-style-type: none"> <li>Number of new anticipatory care plans agreed.</li> </ul>



<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>		<ul style="list-style-type: none"> <li>• Commissioning strategy agreed and in place, and associated action plan developed.</li> </ul>
<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>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>	<ul style="list-style-type: none"> <li>• Key responsibilities identified and improvement actions agreed.</li> <li>• Criteria developed for high demand services.</li> </ul>
<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>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>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>		

<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: 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>
<p><b>Financial Update</b></p> <p>There do not appear to be any financial implications with regards to Enhanced Services or Quality and Outcomes Framework in Inverclyde CHCP.</p>				
<p><b>Workforce Implications</b></p> <p>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.</p>				

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. 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. 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 PCMHT.</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>Collect sign posting data.</p> <p>Complete the design and draw up implementation.</p> <p>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 PCMHT service to all GP Practices</li> <li>• Audited the PCMHT service implementation.</li> </ul>	<p>Operating at benchmark bed levels for adult mental health in SSPU &amp; IPCU</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>Completed.</p> <p>Arrangements set up.</p>	<p>Implement the relocation of IPCU, SSPU, adult mental health day hospital and Millan Suite n December 2011 to IRH.</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>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>
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	<ul style="list-style-type: none"> <li>• Monitored referrals to PCMHT 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>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>Implement action plans and monitor progress against key actions.</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>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>	<ul style="list-style-type: none"> <li>• Targets achieved</li> <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: - Waiting times for psychological therapy services will be</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>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 line 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 PCMHT 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>

			improvement in taking a local population approach to improving mental wellbeing.	
	<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>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>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>Number of people with dementia etc. accessing support, including CHCP financial inclusion services.</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>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>By the end of year 2 we will have established routes into</p>	<p>New service model commissioned.</p> <p>Review complete.</p> <p>Model established.</p> <p>Clear path into employability services established.</p>



	<ul style="list-style-type: none"> <li>- Reviewed the mental health day services provision - ongoing (older people and adults).</li> </ul>	<p>This action has been carried forward to year 2.</p>	<p>employability.</p> <p>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 model 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-build 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
2010/11 Deliver care in the right settings	<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> <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>

		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.		
2010/11 Deliver better care through early intervention	Local Alcohol and Drug Strategies incorporate 12 core elements of the NHS GGC Prevention and Education (health improvement) model.	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.	During year 2 we will continue to implement the prevention and education framework, based on the completion of a needs assessment.  Launch the user friendly version of the ADP Strategy in April 2011..	Further implementation of the framework. Needs assessment completed. User friendly version in place.
2010/11 Focus on the most vulnerable people	Substance misuse services address unmet need and barriers to access through a range of targeted services.  By the end of year 1: - 75% of new referrals to specialist drug and alcohol services will have been seen within 21 days of the referral being made. - We will have developed a local implementation and training plan to deliver sensitive inquiry training in GBV for specialist addictions staff.	At Sept 2010 94% of new referrals to specialist drug and alcohol services were seen within 21 days  This action has not been progressed in the addictions services in year 1, we have prioritised Health Visiting	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  We will work to maintain this positive performance.  We will build GBV awareness raising training into induction for new staff and through PDP's for existing staff.	<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>
2010/11 Focus on the most vulnerable people	Participate in the ADSW/SWIA High Risk Offenders follow-up of	We have completed a supported self evaluation with SWIA on high	If year 1 action completed it should inform year 2 action.	

	<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>		
2010/11 Focus on the most vulnerable people	<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>During 2011/12 we will implement the actions from the MAPPA Business Plan.</p>	<p>Key indicators from MAPPA</p>
2010/11 Prevent ill health	<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>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>
2010/11 Improve Access	<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 Inverclyde 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 began 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.	Key measures referenced within Fairer Scotland contractual arrangements.
2010/11 Finalise reprovision 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 reprovision programme will have been completed.	We have completed the build, refurbishment programme and co-location of relevant staff teams.	No further action in 2011/12	
<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 specialties 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 though 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>Inverclyde Palliative Care Planning and Implementation Group is well established and functioning well. All aspects of this action are being addressed through the Inverclyde 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. 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, and relevant strategic planning forum operational.</p> <p>Improve multi professional service working re vulnerable children and families.</p> <p>CFHT establish effective links with Health and Homeless action group.</p> <p>Briefing sessions and audit have taken place.</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 Board.</p> <p>Workplan is in place.</p> <p>Increased knowledge across professionals.</p> <p>Number of IAFs completed</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 HMle 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>	<p>The CPU will carry out an evaluation of the Child Protection medical protocol as required by new inspection.</p> <ul style="list-style-type: none"> <li>• We will act on the agreed recommendations of the December 2010 Child Protection inspection.</li> <li>• Implement revised CP procedures including introduction of Pre-Birth Assessments and registration.</li> <li>• Review integration and co-location plans for Children and Disabilities, Skylark Centre and L North and scope potential for integration to</li> </ul>	<p>Re-established local planning links with maternity services and locate within SOA planning structure.</p> <p>Development days have taken place by August 2011.</p>

			<p>include CAMHS.</p> <ul style="list-style-type: none"> <li>• Introduction and development of practitioner forum across children's services.</li> </ul>	Forums are up and running.
<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 HMle 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>Inverclyde developed a workplan from the strategy Group Document "<i>These are our Bairns</i>". Most of the outcomes have been achieved and we will now like to look at developing capacity to support children in kinship arrangements.</p> <p>Audit Scotland report being analysed alongside commissioning activity</p> <p>Nursing rep on fostering resources panel.</p>	<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 HMle 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>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 2011/12 is 1 new Level 4 carer)</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>FSF funding has been secured in order to purchase shareware. This will be in place by end of March 2011, the use of this will then roll out across the remainder of the year.</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>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>Implementation of the Adoption and Children (Scotland) Act 2007.</p>	<p>By the end of year 1, we will have implemented actions agreed.</p> <p>Training provided for staff in respect of new legislation Introduce post-adoption support plans</p>	<p>33 Social Work staff have been trained. All adoptive carers during adoptions in 2009/10 have received written information re post adoptive support and plans are in place for post adoptive support to be given to adoptive carers.</p>	<p>Consolidate practice around new legislation. Deliver and implement adoption and permanency procedures in line with above.</p>	<p>Adoption activity fully compliant with revised legislation.</p>

2010/11 We will Improve the lives of the most vulnerable children.	<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 GG&amp;C review of School Nursing remit.</p> <p>Clinical supervision established 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>Training will be delivered by central Violence Against Women Team. (see health improvement section)</p>	<p>Training delivered</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>Continue to engage in the Board redesign plans and identify resource implications for redesign care pathways within acute.</p>	<p>Board redesign complete and local actions implemented.</p>
	<ul style="list-style-type: none"> <li>- Replace the existing Children's Units with three modern, more homely houses.</li> <li>- Complete community</li> </ul>	<p>Phase 1 – Planning for replacement Redholm granted. Building on schedule.</p> <p>Community engagement re design and planning concluded successfully.</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>Revised working model agreed.</p> <p>New unit open and operational.</p>

	<p>engagement.</p> <ul style="list-style-type: none"> <li>- Complete tender process.</li> <li>- Construction underway</li> </ul>			
<p>T02010/11 The care of children and young people is planned and delivered through a collective approach across NHSGGC.</p> <p>2010/11 Children and families will have Improved access to services that are equitable and appropriate</p>	<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 GG&amp;C. 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 paed's 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, SIMD</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>decay.</p> <ul style="list-style-type: none"> <li>- Define an understanding of healthy snack options.</li> </ul>	<p>to experiencing health inequalities are fully engaged</p> <ul style="list-style-type: none"> <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 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>We provided additional support to the Joint Action Group through 0.2 wte 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. 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. As at January 2011 47 families have engaged with the ACES service (of those 23 male and 24 female). 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>Every secondary school using these 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 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>

2010/11 We will Improve the quality of the services we deliver.	Develop support for Young Carers.  By the end of year 1 we will have worked to identify who our young carers are, and scope their support needs.	There is an active support group for young carers and dedicated Social Work support.	Establish integrated multi-agency provision for this group, and ensure the interests of young carers are considered at our Carers Development Group.	Integrated group work provided.  Young Carers explicitly referenced in Local Carers Strategy.
2010/11 Our service planning reflects demand, evidence base and views of service users and their carers.	By the end of year 1 we will have: - Fully implemented the IAF which considers the views of children and carers. Children and families involved in the redesign of services.	Evaluation has been completed and reflects good progress. Very positively completed by HMIE inspectorate.	Update with outcomes from evaluation of IAF pilot.  Implement the Participation strategy and View Point.	Outcomes updated  Participation Strategy and View Point implemented
2010/11 Remove barriers to learning and improve the outcomes for our most vulnerable children and young people through effective integrated children's services	Year on Year improvement on SOA Attainment Levels.  We will have actions in place to improve SOA attainment levels.  Implementation of the "We Can and Must Do Better" Strategy.	Specialist LAAC teaching team in place.  Rolling programme of training	Funding secured to have further term of letter box initiative and chatter books.	Number of children receiving additional teaching support.  Minimum 50 children inclusive of LAAC and children looked after at home.
2010/11 Ensure the redesign of Youth Justice and Youth Support Services are fully implemented and delivering an effective service.	Undertake an evaluation of these services.  We will implement the redesign of Youth Justice and Youth Support Services.	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.	Planned relocation of staff from the Mearns Centre to the refurbished St. Lawrence's Primary School.  Review Youth Justice Co-ordinator arrangements for Inverclyde.  Develop intensive support and monitoring service within Inverclyde.	Relocation complete.  Review complete and staff in place.  New service model.
2010/11 Deliver safe and high quality services	By the end of year 1 will have continued to build strong relationships between midwifery and primary care staff.	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.	OPR Action – continue to work collaboratively with the Inverclyde CMU to increase breastfeeding rates  We will take steps to ensure that	HEAT target - Breastfeeding rates

			<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 GGNB&amp;C thereafter).</p>	<p>Model used universally in Children and Families service.</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>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/ SIMD smoking rates</li> <li>• Peer Support network numbers – Supporters, Supported Woman</li> <li>• Low Birth Weight stats improved .</li> <li>• Infant mortality rates improved.</li> </ul>
<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.</p> <p>Acute midwifery service pressures</p>	<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	<p>By the end of year 1 we will have:</p> <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>	<p>Smoking in pregnancy/ cessation rates (whichever we have)</p> <p>Priority areas of breastfeeding and smoking agreed.</p> <p>Agreed through SOA.</p> <p>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.</p>	<p>We will work with colleagues in Acute Health Improvement Team to support the role out of the smoking in pregnancy service within IRH.</p> <p>Ensure development of seamless referral pathways to community smoke free services.</p> <p>Progress these actions through our SOA Children's Outcome Delivery Group. Supported by the SOA Health Inequalities Outcome Delivery Group.</p> <p>Review care pathways in light of refreshing maternity strategy.</p>	
<p>Financial Update</p> <p>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.</p>				



## 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> </ul>	
<p>Our services provide value for money and are efficient and effective.</p>	<ul style="list-style-type: none"> <li>- Review inpatient bed usage for older people's services.</li> </ul>	
<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 NHSGGC 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
<b>Disability</b>				
People are supported to live as independently as possible in their communities for as long as possible	<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 CHCP 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 model.</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 CHCP.</p> <p>Improved access to equipment via CHCP dedicated transport.</p>
We involve people in the assessment, planning and delivery of services.			<ul style="list-style-type: none"> <li>- Develop robust and sustainable processes for disabled people to be part of all services PFPI 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 – CHCP framework for public involvement in place.</li> </ul>
We have the right information to support effective service planning and delivery, and this is shared across agencies.			<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.
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.	Roll out further training for front line staff to improve consistency of IORN scanning.	- IORN used comprehensively - Eligibility criteria applied universally.
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	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.	Complete redesign and deliver SLA with financial fitness.	Redesign complete SLA developed and in place.
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.

			understand their role in the employability pipeline.	
Services will be better organised to meet people's needs and will demonstrate a rehabilitative approach to meeting people's holistic needs	<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>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>	Transition is easier and more seamless.
People get access to the right level of care and support when they need it	<ul style="list-style-type: none"> <li>- Deliver community rehabilitation and enablement service redesign</li> </ul> <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 reprovision and seek appointments for integration.</p> <p>Continue to address performance issues in AHP waiting times.</p> <p>Continue to support, roll out and embedding of the LCP</p>	<p>Integrated community rehab team in place.</p> <p>Waiting times reduced.</p> <p>Increase use of LCP in all settings.</p>
People are encouraged to determine their own support needs	<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>

	- We have clear links between disability services and financial inclusion and employability services.	to address identified gaps and improve transition arrangements between acute and community care.	benefits are being maximised appropriately.  Establish clearer and stronger links between Inverclyde Centre for Independent Living and local financial inclusion resource.	Links established and operational.
People are supported to stay as healthy as possible	By the end of year 1 we will have reviewed our local self management approach and identified any gaps in provision.	This work will be advanced as we develop a CHCP approach to supported self management through GP forum; PEG; Clinical governance and community pharmacy.	Progress this agenda in year 2.	Systems to support self management are in place.
We will ensure that we are meeting our new duties and responsibilities with partner agencies of the Adult Support and Protection (Scotland) Act 2007.	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.	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.  We have undertaken analysis on the number of adult protection investigations and the outcome to inform systems and processes.	To use the outcome of Adult Protection investigation reviews to improve systems and progress and identify training needs.	A comprehensive training plan is in place.  Input from multi agency staff groups is clearer.
<b>Long Term Conditions</b>				
People are supported to live independently and safely as possible in their communities for as long as possible.			- 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. - Use patient involvement groups	- Proportion of COPD admissions followed up by Early Supported Discharge Service. - Increase the number of integrated LTC care plans. - Number of people self directing their care and support.

			<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 CHD.</li> <li>- E7: Electronic management of referrals</li> <li>- E4.2: Non-routine inpatients ALOS.</li> </ul>
Staff are trained to ensure that they have the right knowledge, skills and approach.			<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>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>	
<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>			<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> <p>- Develop explicit signposting to</p>	



			the appropriate intervention and clinician. - Publish appropriate protocols and guidelines, including referral guidelines.	
We involve people in assessment, planning and delivery of services.			- 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.	
Patients have an improved experience of care and are empowered to be full partners in their care.	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.	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.	We will progress the roll out of the chronic medication service in conjunction with PPSU and pharmacy colleagues.	Chronic medication service is fully implemented.  Polypharmacy and older peoples pharmacy reviews are in place and contribute to reduced hospital admissions.
	By the end of year 1 we will have: - Scoped anticipatory care models, informed by initiatives	Local SPARRA work has shown that most of the high risk patients are not presenting with LTCs (bias		

	<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>	H8 – Targeted cardiovascular health checking.
A systematic and integrated multi-agency approach to care is in place, which optimises outcomes for individuals.			<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>	
Individuals have a clearer understanding about their	<ul style="list-style-type: none"> <li>- Where possible, support people on long term benefits</li> </ul>	A workshop has been arranged for late April 2011 to begin the process	We will re-establish the Inverclyde Financial Inclusion Strategy Group	Group operational strategy complete.

<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.</p> <p>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>		

	<p>management.</p> <ul style="list-style-type: none"> <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>
<b>Older People</b>				
<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 PCMHN 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>	<ul style="list-style-type: none"> <li>- Monitor implications for existing services of local authority plans for personalisation</li> </ul>	

	<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>	<ul style="list-style-type: none"> <li>- Confirm the level and quality of nutritional advice and support is appropriate.</li> </ul>	
<p>People live as independently and safely as possible.</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 re-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 Kempock 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 CMHT. 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>	<ul style="list-style-type: none"> <li>- Implement policies and procedures to support and protect adults at risk of harm in line with Adult Protection legislation.</li> <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>	<ul style="list-style-type: none"> <li>- HEAT T8: to increase the level of older people with complex care needs receiving care at home.</li> </ul>

	<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>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>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>	

			<ul style="list-style-type: none"> <li>- Establish early intervention and support service for people with dementia and their carers.</li> </ul> <p>Expand on work already undertaken (e.g. into other care settings such as general hospital).</p>	
<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>- 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>	

			<ul style="list-style-type: none"> <li>- 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</li> <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>	
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>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>	We have developed an initial change fund plan for Inverclyde, which will form the basis for our more detailed plan.	<p>OPR 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>Reshaping Care for Older People Change Plan in place</p> <p>Review complete.</p>



	<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</p> <p>OPR Action – write up and share how we are using SPARRA data, and the outcome being achieved</p>	<p>Scheduling module in place.</p> <p>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 CHCP 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
2010/11 Patients can access primary care at the place and time they need it, including out of hours.	<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 CHCP 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</p> <p>Improved cognition of the health message</p> <p>48 hour access stats.</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. 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 PFPI/ Engagement</li> </ul> <p>CHCP action plan in place for PFPI/ 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 CHCP 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>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 CHCP 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>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 continue to explore more efficient modes of primary care (eg in community)</p> <p>Deemed not to feasible to move</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 GDPs 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>health. Crisis service being developed in MH, CAMHS, Psychological services now in place. Issues regarding access to primary care data.</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>Near patient testing, coming out of QOF previously secondary care</p> <p>Sign 121 – re dermatology</p> <p>Annual assessments await CGIG.</p> <p>Links to above. Also linked into Scottish Centre for telehealth re diabetics.</p>	<p>Await outcome of CGIG 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 Kirn 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>Dalrymple 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 Ravenscraig to crown House</li> </ul>		
<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>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>	

	<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>2010/11 The independence of primary care practices is balanced with cooperation where that is in the interests of patients.</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>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 CP 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>	

		tracking tool which has not proven fruitful in Inverclyde		
2010/11 The primary care workforce is appropriately trained and professionally developed.	<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>	<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> </ul> <p>Support independent contractors to work together including professional development.</p> <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: <ul style="list-style-type: none"> <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> </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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	<p>perspective to inform the CHCP interface with secondary care.</p> <ul style="list-style-type: none"> <li>- Supports independent contractors to work together including professional development.</li> </ul>			
<p>2010/11 There is a robust and clear plan to ensure the future workforce for primary care.</p>	<p>Reach collective agreement with the LMC (and other contractor representative bodies) to collect comprehensive workforce information to support effective workforce planning arrangements.</p> <p>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.</p>	<p>Contribute to the Board wide programme to reach collective agreement with LMC workforce information. Implement any agreed actions.</p>	<p>Awaiting direction from Lead Director (David Leese)</p>	
<p>2010/11 Effective and agreed partnerships are in place between primary care, Local Authority and other services.</p>	<p>Implement an agreed model of NHS provision of Prison Health Services in line with Scottish Government Health Department Policy</p>	<p>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.</p>	<p>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.</p>	
<p>2010/11 Primary care services have clear and consistent approaches to engage patients and the public and respond to their views.</p>	<p>Engage with carers in line with the Carers Charter and improved access to primary care and community health services</p> <p>By the end of year 1 we will have improved our intelligence about the profile of our unpaid carer population.</p>	<p>As at November 2010 there were 1112 carers registered with GP practices.</p> <p>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</p>		

<p>2010/11 Primary care can access the full range of supporting secondary services it 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 CH(C)P/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>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>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>Take any relevant action as a result of the pilot.</p>	
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	<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>2010/11 Gaps and challenges to services are fully considered in reviewing and changing the distribution of resources.</p>	<p>CHCP 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 mapped our current primary care resources and capacity, and have agreed a process to map current and projected demand.</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>

<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/CH(C)P Directors Group) to ensure short term delivery of specific improvements to the Acute/Primary Care interface,</p> <p>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>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>Developed a process for improving links between secondary/primary care to implement more effective ways of communicating medication changes to patients and GPs and Pharmacists.</p> <p>Development of clinical improvement steering group and GP/Consultant forum to direct areas of joint work.</p> <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>Ongoing engagement with contractor forums to identify areas of improvement in service, delivery process and pathways.</p> <p>We will follow up these actions specifically in relation to the change fund work.</p>	
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**Financial Update**  
The financial implications are small and should have little impact locally. The financing of the change of practice premises in Kilmacolm 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 gay men's health needs assessment.

Outcome	Action Identified for 2010/2011	Change/Progress/ Performance Indicator	Action 2011/12	Change/Progress/ Performance Indicator
Deliver efficient and economic services	<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 (VAWMAP) 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 distributed 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>Deliver the 'Girl Power' programme.</p>	<p>We are working with the estates department to secure agreement to upgrade the Sandyford Hub premises which will also resolve the 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>		
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.	These data are published on an annual basis and will be available from Sandyford in the annual data report due in May 2011.		
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.	The C-card review is now complete and recommendations will be incorporated into our local action plan.		
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). CH(C)Ps 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 Inverclyde Schools.</p> <p>We commissioned a bespoke sexual health citizen's panel through the council which indicated that there are some communication 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-Sahara Africans.</p>	<p>Condom distribution data reports.</p>

	<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>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>Local plan under development as described earlier.</p> <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>		
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**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 the 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 though 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 CHCP 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 service,.</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> 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> 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 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 CHP 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>HWL 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 HWL award and have healthy catering in place for members of staff and the general public.</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 HWC.</p> <p>We have engaged in the future jobs fund scheme in 2010/11.</p>	<p>Engage through the FSF appraisal group in awarding contracts and monitoring to SOA Programme Board.</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>(1 year) KPIs in FSF specifications.</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 Indicator
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> <p>Smoke free play park signs in place.</p>
We reduce the initiation and uptake of smoking in young people.	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.	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	We will continue with this action and develop sustainability via capacity building with school staff.	<p>School staff trained in approach.</p> <p>Number of sessions delivered.</p>

		<p>units are smoke free.</p> <p>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.</p>	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 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.	<p>-Active living strategy to be published in 2011.</p> <p>-HIA results of HIA of Gourrock Highland Games as rationale for development of smoke free events policy.</p>	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.	<p>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.</p> <p>Ongoing.</p> <p>MHI now firmly embedded in CHCP HI team.</p> <p>Develop TAMFS and actions</p> <p>MH improvement lead identified.</p>		
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 system

drugs and alcohol prevention and education strategy.		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.	Alcohol team/ Culture Change Team	
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.	By the end of year 1 we will have trained all appropriate staff in Baby Friendly Policies and received UNICEF friendly accreditation Stage 3.	See children's services section		
We reduce the prevalence of childhood emotional and behavioural problems and improve parental confidence & well - being through evidence based population parenting programmes.	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.	See children's services section	We will work with Alliance partners to secure future funding to enable us to roll out the Triple P programme further.	Indicators dependent on securing funding, but if so, should align with FSF monitoring data.
We achieve an improvement the oral health of young children in NHSGCC.  2011/12 – We ensure that the NHS investigates the impact of child poverty.	By the end of year 1 we will have: - Increased the number of GDPs participating in the Childsmile programme - Increased the number of children participating in the Childsmile programme - Begun a programme of targeted fluoride brushing.	All but one of our GDPs (n) is participating in the Childsmile programme.  We have supported the co-ordination and administration elements, and consent element of this work in conjunction with the OHD.	Work with OHD to increase numbers of participating GDPs to 100%.  Continue to support OHD.	Number of participating GDPs.  New HEAT fluoride target.
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.			We will develop and implement the Inverclyde active living strategy and Inverclyde nutrition policy.  Youth Sexual Health worker.	Policy/ Strategies developed and implemented.

**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
<p>2010/11 We understand and take account of patient experience in the planning and delivery of services.</p> <p>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.</p> <p>2011/12 We are accountable to population of NHS Greater Glasgow and Clyde.</p>	<p>By the end of year 1 we will be able to demonstrate that we are:</p> <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>	<p>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).</p>	<p>Implement the use of VOICE (visioning outcomes in community engagement) and the SHC participation Toolkit across the CHCP.</p> <p>Develop and implement mechanisms for gathering of patient/user/carer experience data.</p> <p>Create and implement CHCP Public Involvement Framework. Re-organise our PPF structures to better reflect local needs.</p>	<p>VOICE plans in place for engagement activity.</p> <p>Training on Participation SHC Toolkit delivered.</p> <p>Patient experience reports available for service improvement.</p> <p>Revised Public Involvement arrangements and redesigned PPF.</p>
<p>2010/11 We understand the impact of inequality and discrimination on patient experience and access.</p> <p>2011/12 We have a co-ordinated approach across the organisation to public involvement, person centred care, safety and effectiveness with clear</p>	<p>By the end of year 1 we will have:</p> <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>	<p>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</p>	<p>Support an increase in local capacity to independently undertake EQIAs via Lead Reviewer. Training and maximising use of our Equalities Champions.</p> <p>CHCP arrangements planned for 01.04.10 did not actually come into effect until 01.10.10; therefore this</p>	<p>EQIA delivered.</p> <p>Local Reviewer trained</p> <p>Audit complete. Action plan agreed.</p>

<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>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 and 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>After early development work this was put on hold due to CHCP implementation</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.	

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

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
<b>Goal 1:</b> All planning processes explicitly use disaggregated data	<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 SWIFT (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>	Show evidence of use of disaggregated data to meet the needs of inequality groups.	Evidence use of data.
<b>Goal 2:</b> Each part of NHSGGC demonstrates that equality groups are part of all public and patient involvement activity	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>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>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>We continue to pursue EQIAs of health improvement programmes and workstreams.</p>	<p>EQIAs completed.</p>
<p><b>Goal 4:</b> Each Partnership has risk management systems that prevent unlawful discrimination</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>This will relate to all planning and policy sections.</p>	<p>We shall continue to embed our local Clinical Governance and Rights workplans.</p>	<p>Workplans in place and routinely audited.</p>
<p>There is evidence of innovative solutions to address the challenges of disabled people in using services</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>This action is from our Disability Framework section.</p>	<p>We will participate in the Board-wide Learning Disability Health Improvement Group to increase access to care services.</p>	<p>TBC as work plan of this group develops.</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>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)          Older People – CC specified          OPMHS – user satisfactory          Drug – Integrated (service specification)          Alcohol – integrated service specification in process          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 inequalities sensitivity.</p>
<p>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 referenced.</p>

		equality impact assessing financial decisions where appropriate/possible.		
<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>These actions relate to all planning and policy sections.</p>	<p>We will complete the evaluation of our Equalities Champions scheme and build on the learning via the Corporate Equalities Group, linking with CIT 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 locus for the Council dimensions.</p>	<p>All employability and financial inclusion workstreams from 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
We understand who our carers are	<p>By the end of year 1 we will have:</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 SWIFT 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 SWIFT.</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 SWIFT</p> <p>We will consider with HR in health and the council how we can collect this information routinely to determine how many staff have made use of flexible working polices and/or taken advantage of Carers' Leave, and the extent of caring amongst our workforce</p> <p>We will continue to work closely with relevant stakeholders,</p>	<p>GP Carers Register figures</p> <p>Principal cares field on SWIFT records</p> <p>Numbers of staff who are undertaking caring roles at home</p> <p>Number of staff making use of flexible working/carers leave</p>

	the partnership beds.	<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>	including carers, as we progress the final stages of the reprovision of Ravenscraig Hospital.	
We recognise and enhance the role of carers in supporting self care and reducing demand for services.	<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 began 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 SWIFT</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 Ravenscraig 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 - maintaining or supporting access to work, education, volunteering. This may involve signposting to non NHS services or sources of advice.</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>		