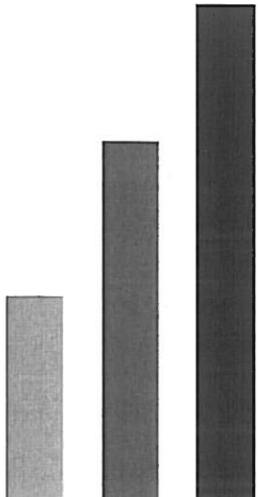
Inverclyde council

Agenda 2014

Inverclyde Community Health & Care Partnership Sub-Committee

For meeting on:

9	January	2014



Inverclyde council

Municipal Buildings, Greenock PA15 1LY

Ref: SL/AI

Date: 11 December 2013

A meeting of the Inverclyde Community Health & Care Partnership Sub-Committee will be held on Thursday 9 January 2014 at 3pm within the Municipal Buildings, Greenock.

ELAINE PATERSON
Head of Legal & Democratic Services

BUSINESS

1. **Apologies, Substitutions and Declarations of Interest**

PERFORMANCE MANAGEMENT

2. **Community Health & Care Partnership - Financial Report 2013/14 as at Period 7 to 31 October 2013**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

3. **Update on Report of Care Inspectorate Inspection of McPherson Centre January 2013**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

4. **CHCP Corporate Directorate Improvement Plan - Progress Update**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

5. **Workforce Monitoring Report**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

6. **Integrated Performance Improvement Exceptions Report**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

NEW BUSINESS

7. **Working Towards a Dementia Friendly Inverclyde: Inverclyde's Dementia Strategy**
   Report by Corporate Director Inverclyde Community Health & Care Partnership
   (**NB** There will also be a presentation on this item)

8. **Joint Strategic Commissioning Plan for Older People 2013-2023**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

9. **Caladh House (Turning Point Scotland), 14-16 Bank Street, Greenock - Building/Service Redesign Proposal**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

Healthy Working Lives
Positive About Disabled People

The documentation relative to the following item has been treated as exempt information in terms of the Local Government (Scotland) Act 1973 as amended, the nature of the exempt information being that set out in paragraph 6 of Part I of Schedule 7(A) of the Act.

PERFORMANCE MANAGEMENT

10. **Governance of CHCP Commissioned External Organisations**
Report by Corporate Director Inverclyde Community Health & Care Partnership on the governance process for externally commissioned services

Enquiries to - **Sharon Lang** - Tel 01475 712112

Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 2

Report To:	**Community Health & Care Partnership Sub-Committee**	**Date: 9 January 2014**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/06/2014/LB**
Contact Officer:	**Lesley Bairden**	**Contact No: 01475 712257**
Subject:	**Community Health & Care Partnership – Financial Report 2013/14 as at Period 7 to 31 October 2013.**	

1.0 PURPOSE

1.1 The purpose of this report is to advise the Inverclyde CHCP Sub-Committee of the 2013/14 Revenue and Capital Budget current year position as at Period 7 to 31 October 2013.

2.0 SUMMARY

REVENUE PROJECTION 2013/14

2.1 The total Health and Community Care Partnership revenue budget for 2013/14 is £120,065,000 with a projected underspend of £240,000 being 0.2% of the revised budget. This is a further projected underspend of £18,000 since last reported to the Sub-Committee at period 5 to 31 August 2013.

2.2 The Social Work revised budget is £49,049,000 with a projected underspend of £226,000 (0.46%). This remains primarily due to turnover savings, partly offset by overspends on the current client commitment costs and is a further underspend of £15,000 since last reported at period 5. This underspend is net of Residential Childcare, Fostering and Adoption as any under / over spend is now managed through the approved earmarked reserve. At period 7, it is projected that there will be a £795,000 increase in the reserve at 31 March 2014.

2.3 It should be noted that the 2013/14 budget includes agreed savings for the year of £480,000 with a projected over recovery of £225,000 mainly from early implementation.

2.4 The Social Work revenue underspend will be utilised to fund improvement works to Caladh House, subject to Sub-Committee approval of a detailed report included on the agenda. To allow for potential winter pressures at this stage only £145,000 of the projected £226,000 underspend has been included within funding proposals for Caladh House works, the final contribution from revenue will be dependent on the year end out-turn and the final cost of works.

2.5 The Health revenue budget is £71,016,000 with a projected underspend of £14,000 (0.02%). This remains due to a number of supplies pressures, offset by vacancy and increment savings and is a further projected underspend of £3,000 since last reported to the Sub-Committee.

2.6 The Health budget for 2013/14 does not include any local savings target and has been adjusted to reflect the centralisation of the Continence Service, now hosted by Glasgow.

2.7 Prescribing is currently projected to budget. There remain ongoing issues with drugs on short supply. It is anticipated that there will be an overall GG&C overspend in 2013/14 but this will be funded non-recurringly to effect a cost neutral position each CHCP.

CAPITAL 2013/14

2.8 The total Health and Community Care Partnership approved capital budget for 2013/14 is £285,000 and is projected on budget.

2.9 The overall Social Work capital budget has increased by £80,000 to reflect the additional respite bed at Hillend; capital works are funded from revenue reserves as previously agreed by Policy & Resources. This will enhance the service by 25% with the works expected to commence mid March 2014, subject to Sub-Committee approval to proceed and appropriate receipt of building warrants and tender process.

EARMARKED RESERVES 2013/14

2.10 The Social Work Earmarked Reserves for 2013/14 total £3,672,000 with £2,160,000 projected to be spent in the current financial year. To date £1,059,000 spend has been incurred which is 49% of the projected 2013/14 spend. The spend to date per profiling was expected to be £1,451,000 therefore slippage equates to £392,000 27%. Given the number and nature of the projects this slippage is manageable.

2.11 This position includes the additional two new earmarked reserves previously agreed by the Policy & Resources Committee:

- £50,000 for aids and adaptations will fund additional equipment to support more people to live at home. This will be spent in full during 2014/15 on a range of equipment such as hoists, specialist chairs, bath lifts, and stair climbers).
- £65,000 to support young carers, to appoint a dedicated post for an 18 month period. The budget is currently phased to commence April 2014, if the post commences earlier this will be revised accordingly.

2.12 As previously reported £70,000 has been identified within the Independent Living earmarked reserve to develop a Dementia Strategy, with a detailed report included on the agenda.

3.0 RECOMMENDATIONS

3.1 The Sub-Committee note the current year revenue budget and projected underspend of £240,000 for 2013/14 as at 31 October 2013.

3.2 The Sub-Committee note the potential revenue contribution to fund works on Caladh House, subject to approval of a report elsewhere on the agenda.

3.3 The Sub-Committee note the current projected capital position:

- Social Work capital projected to budget at £183,000 in the current year and on target over the life of the projects.
- Health capital projected to budget at £102,000.

3.4 The Sub-Committee note the current Earmarked Reserves position.

3.5 The Sub-Committee approve the proposals for the use of the new earmarked reserves for:

- Expansion of Hillend Respite Unit by 25% £80,000 (capital)
- Aids and Adaptations £50,000
- Support Young Carers £65,000

3.6 The Sub-Committee approve the Social Work budget virements detailed on Appendix 7.

3.7 The Sub-Committee note the position on Prescribing.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 The purpose of the report is to advise the Sub-Committee of the current position of the 2013/14 CHCP revenue and capital budget and to highlight the main issues contributing to the £240,000 projected revenue underspend and the current capital programme position.

4.2 The current year consolidated revenue summary position is detailed in Appendix 1, with the individual elements of the Partnership detailed in Appendices 2 and 3, Social Work and Health respectively. Appendix 4 shows the year to date position for both elements of the Partnership. Appendix 5 provides the capital position; Appendix 6 provides detail of earmarked reserves.

4.3 Detail of the employee cost underspend is included as a new Appendix 8, as requested at the last Sub-Committee. This provides an overview position on turnover by service.

5.0 2013/14 CURRENT REVENUE POSITION: UNDERSPEND £240,000

5.1 SOCIAL WORK £226,000 PROJECTED UNDERSPEND

The projected underspend of £226,000 (0.46%) for the current financial year remains predominantly due to turnover and early savings of £540,000 offset by projected overspends mainly within the current client committed spend. This is a further projected underspend of £15,000 from the last reported projection as at 31 August 2013.The material projected variances and reasons for the movement since last reported are identified, per service, below:

a. **Strategy: Projected £42,000 (1.85%) underspend**

The projected underspend remains due to vacancy and secondment savings, with the further underspend of £13,000 due to further turnover.

b. **Older Persons: Projected £17,000 (0.08%) overspend**

The projected overspend is mainly a result of increasing costs in Homecare which is projected to overspend by £118,000, offset by a £29,000 underspend in Residential and Nursing purchased places per the current number of clients receiving care, along with underspends in staffing and other services.

This is an increase in projected spend of £69,000 reflecting current Homecare and Nursing & Residential client costs.

The budget virements reflect the planned shifting balance of care and budgets continue to be reviewed on an ongoing basis to evidence the recurring saving requirement and realign budgets accordingly.

The 2013/14 budget includes a £60,000 income budget for charging orders and whilst the nature of this income is not easily predictable, at period 7, £52,000 has been received and the full year is projected to budget. Whilst this indicates that an over recovery is likely it would not be prudent to project this, given the nature of the income.

c. **Learning Disabilities: Projected £195,000 (3.23%) overspend**

This remains primarily due to the current costs of client residential packages projected to overspend by £59,000 and external day care projected to overspend by £129,000. Work remains ongoing to review the day opportunities packages of a number of clients to mitigate the costs.

The projected costs have increased by £93,000 due to;

- £37,000 Service user with complex needs changing provision and requiring additional support
- £32,000 increased respite allocations
- £25,000 reduction in income from other Local Authorities, previously over projected

The Service Manager is reviewing all care packages on an ongoing basis to minimise the cost pressures within this service. Additional budget of £350,000 for pressure funding is included in the 2014/15 budget, with a further £200,000 in 2015/16 reflecting the pressures expected within this service. Work is ongoing to ensure that the full year impact of the current year overspend is containable in 2014/15.

d. **Mental Health: Projected £10,000 (0.71%) underspend**

This reflects the ongoing legal costs of £35,000 relating to guardianship issues, offset by client package underspends and vacancy savings.

This is a reduction in spend of £15,000 mainly from client commitment costs reducing by £39,000, offset in part by further legal costs of £22,000.

e. **Children & Families: Projected £175,000 (1.72%) underspend**

The main reason for the underspend remains as previously reported: slippage in filling vacant posts combined with projected savings in overtime and sessional staff costs.

This is a reduction in projected costs of £118,000 due to a further £85,000 turnover (£46,000 from new vacancies and £23,000 from slippage in existing vacancies and £16,000 from a combination of reduction in hours, maternity and other minor changes) along with a reduction of £21,000 in Kinship & Carers support costs.

There is significant projected underspend within residential childcare, adoption and fostering of £795,000, however given the volatile nature of the service and the high cost implications this is impossible to predict and, as previously reported, the under or over spend at year end will be transferred to or from the earmarked reserve set up to smooth budgetary pressures.

f. **Physical & Sensory: Projected £105,000 (4.47%) overspend**

The projected overspend remains primarily due to client commitment costs.

This is an increase in costs of £19,000, mainly due to adjustments for prior year utility costs relating to an unregistered meter. This was highlighted to the Sub-Committee last year, with this increase being over and above the estimated provision of £40,000.

The Service continues to review the cost of commissioned services.

g. **Addictions / Substance Misuse: Projected £125,000 (10.11%) underspend**

The projected underspend is mainly due to the two areas previously reported:

- £79,000 employee cost vacancy savings, net of sessional backfill costs.
- £32,000 underspend on client commitment costs based on the current cost of packages.

This is a further projected underspend of £27,000 due to further turnover and associated impact on running costs along with a modest reduction in client costs .

h. **Support / Management: Projected £80,000 (3.7%) underspend**

The projected underspend remains a result of turnover as previously reported with a further projected underspend of £41,000 from a further turnover of £25,000 and a reduction in projected secure document disposal cost of £16,000.

i. **Assessment & Care Management: Projected £15,000 (0.91%) underspend**

The projected underspend mainly relates to vacancies as previously reported. This is a reduction in the projected underspend of £15,000 due to further turnover and revised projections in non staff costs.

j. **Homelessness: Projected £96,000 (15.17%) underspend**

The main reason for the projected underspend is an over-recovery of Hostel Grant income, in line with prior year income as last reported. This underspend of £80,000 is not recurring as the distribution of the grant is changing in 2014/15.

This is a minor cost increase of £4,000.

5.2 **HEALTH £14,000 PROJECTED UNDERSPEND**

The Health budget is £71,016,000 and is currently projected to underspend by £14,000 with the main reasons for this underspend and the movements from the position as at 31 August detailed below. This is a further projected underspend of £3,000 since last reported.

a. **Children & Families: Projected £108,000 (3.54%) overspend**

This remains due to historic supply pressures within CAMHS of £35,000 along with salary overspends within CAMHS of £65,000 and £12,000 within SALT due to RAM adjustments.

At this stage non recurring funding has not been applied as the CHCP are containing these cost pressures within the overall position and work remains ongoing to establish a recurring solution.

The projected overspend is a reduction of £4,000 since last reported.

b. **Health & Community Care: Projected £39,000 (1.06%) underspend**

The 2013/14 budget has been reduced by £204,000 as the Continence Service has now transferred to Glasgow.

The projected underspend relates to vacancy savings, offset in part by supply pressures, mainly within Diabetes, Podiatry and Pharmacy and is an increase in spend of £16,000.

c. **Management & Admin: Projected £50,000 (2.62%) overspend**

This is due to two main factors: pressures within Portering exacerbated by removal of £14,000 budget to fund a hosted ASD Co-ordinator post in another partnership. This is further projected spend of £8,000.

The budget has increased by £474,000 for rates transferred from the Acute Service; this is cost neutral as the associated expenditure has also been transferred.

d. **Learning Disabilities: Projected £41,000 (7.30%) underspend**

The projected underspend remains due to vacancy and maternity savings, a further underspend of £6,000.

e. **Addictions: Projected £37,000 (1.95%) underspend**

The projected underspend results from slippage in both salaries and supplies and is a further underspend of £15,000.

f. **Mental Health Communities: Projected £42,000 (1.73%) underspend**

This remains due to historic pressures within pharmacy costs, offset by underspends in nursing staff costs due to vacancy and maternity savings. This is a further projected underspend of £3,000.

g. **Mental Health Inpatient Services: Projected £3,000 (0.03%) underspend**

Whilst a minimal underspend is reported it should be noted that savings will be achieved from the rationalisation of the Ravenscraig wards to one building; however any saving achieved is ring-fenced for investment into the closure programme.

h. **Planning & Health Improvement: Projected £10,000 (1.01%) underspend**

The underspend is due to slippage in filling a temporary post, offsetting historic travel cost pressures and is an increase in spend of £3,000.

i. **Prescribing: Nil Variance**

Prescribing is currently projected to budget. There remain ongoing issues with drugs on short supply. It is anticipated that there will be an overall GG&C overspend in 2013/14 but this will be funded non-recurringly to effect a cost neutral position each CHCP.

6.0 CHANGE FUND

6.1 The allocation over service areas for 2013/14 is:

Service Area Budget 2013/14	£'000	
Acute – Health	205	11%
CHCP – Health	203	11%
CHCP – Council	1,017	57%
Community Capacity - Health	75	4%
Community Capacity - Council	301	17%
Grand Total	**1,801**	100%
Funded By:		
Change Fund Allocation	1,403	
Slippage brought forward from 2012/13	398	
Total Funding	**1,801**	

6.2 The Change Fund Executive Group meet on a regular basis and review all projects in detail. The latest current year position is:

Service Area Budget 2013/14	Current Budget £'000	Projected Outturn £000	Projected Variance £000
Acute – Health	205	183	(22)
CHCP – Health	203	188	(15)
CHCP – Council	1,017	1,032	15
Community Capacity - Health	75	75	0
Community Capacity - Council	301	323	22
Grand Total	**1,801**	**1,801**	**0**
Projected Slippage at 31 October 2013			**0**

Project performance is continually reviewed and budgets will be reallocated as required to ensure funding is fully utilised and slippage minimised. Any slippage in 2013/14 will be committed in 2014/15.

The proposed £100,000 contribution towards the costs of the proposed Caladh House works will be met from slippage and / or reprioritising of projects.

7.0 2013/14 CURRENT CAPITAL POSITION – £nil Variance

7.1 The Social Work capital budget is £1,394,000 over the life of the projects with £183,000 for 2013/14, comprising £123,000 for Kylemore (replacement residential children's unit) and £60,000 SWIFT Financial software package.

The Kylemore Children's Home opened in March 2013 and is fully operational.

The overall Social Work capital programme has increased by £80,000 since last reported to include the expansion of the Hillend respite unit by 25%. The plans have been completed and subject to appropriate approvals work is expected to commence mid Match 2014. At this stage the budget is profiled to 2014/15.

7.2 The Health capital budget of £102,000 is on target with no reported slippage. This will fund two areas of spend within Health Centres:

- £52,000 Reception upgrades to improve patient confidentiality issues.
- £50,000 Ceiling replacement tiles at Port Glasgow to address infection control and fire compliance issues.

In addition to the capital funding a further £61,000 works will be funded from revenue maintenance:

- £38,000 Treatment rooms within health centres
- £18,000 Car park resurfacing at Boglestone Clinic
- £5,000 Replacement surgery door.

7.3 Appendix 5 details capital budgets and progress by individual project.

7.4 Work remains ongoing with the development of the CHCP Asset Management Plan.

8.0 IMPLICATIONS

8.1 The current projected revenue outturn is a £240,000 projected underspend.

8.2 The current projected capital outturn shows a nil variance as projects are to budget.

9.0 EARMARKED RESERVES

9.1 The Social Work Earmarked Reserves for 2013/14 total £3,672,000 with £2,160,000 projected to be spent in the current financial year. To date £1,059,000 spend has been incurred which is 49% of the projected 2013/14 spend. The spend to date per profiling was expected to be £1,451,000 therefore slippage equates to £392,000, 27%. Given the number and nature of the projects this slippage is manageable.

9.2 This position includes the additional two new earmarked reserves previously agreed by the Policy & Resources Committee:

- £50,000 for aids and adaptations will fund additional equipment to support more people to live at home. This will be spent in full during 2014/15 on a range of equipment such as hoists, specialist chairs, bath lifts, and stair climbers).
- £65,000 to support young carers, to appoint a dedicated post for an 18 month period. The budget is currently phased to commence April 2014. If the post commences earlier this will be revised accordingly. This post will develop a family pathway approach to young carers which will aim to develop a sustainable service to young carers and their families.

9.3 As previously reported, £70,000 has been identified within the Independent Living earmarked reserve to develop a Dementia Strategy, with a detailed report included on the agenda.

10.0 VIREMENT

10.1 The virement requests are detailed in Appendix 7 and are reflected within this report.

11.0 EQUALITIES

11.1 There are no equality issues within this report.

12.0 OTHER ISSUES

12.1 Work remains ongoing to develop protocols and processes relating to the Integration of Health and Social Care.

12.2 The cost of all known pay awards is reflected within this report.

13.0 CONSULTATION

13.1 This report has been prepared by the Corporate Director, Inverclyde Community Health & Care Partnership and relevant officers within Partnership Finance have been consulted.

APPENDIX 1

INVERCLYDE CHCP

REVENUE BUDGET PROJECTED POSITION

PERIOD 7: 1 April 2013 - 31 October 2013

SUBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
Employee Costs	46,547	47,552	46,928	(624)	(1.31%)
Property Costs	2,732	3,119	2,991	(128)	(4.10%)
Supplies & Services	59,346	60,248	60,657	409	0.68%
Prescribing	16,238	15,912	15,912	0	0.00%
Resource Transfer (Health)	8,863	8,863	8,863	0	0.00%
Income	(15,215)	(15,629)	(15,526)	103	-0.66%
Contribution to Reserves	0	0	0	0	0.00%
	118,511	**120,065**	**119,825**	**(240)**	**(0.20%)**

OBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
Strategy / Planning & Health Improvement	2,803	3,264	3,212	(52)	(1.59%)
Older Persons	20,731	21,101	21,118	17	0.08%
Learning Disabilities	6,105	6,598	6,752	154	2.33%
Mental Health - Communities	3,790	3,844	3,792	(52)	(1.35%)
Mental Health - Inpatient Services	9,544	9,296	9,293	(3)	(0.03%)
Children & Families	12,922	13,246	13,179	(67)	(0.51%)
Physical & Sensory	2,355	2,351	2,456	105	4.47%
Addiction / Substance Misuse	3,122	3,138	2,976	(162)	(5.16%)
Assessment & Care Management / Health & Community Care	5,077	5,312	5,258	(54)	(1.02%)
Support / Management / Admin	4,221	4,271	4,241	(30)	(0.70%)
Criminal Justice / Prison Service **	0	0	0	0	0.00%
Homelessness	629	633	537	(96)	(15.17%)
Family Health Services	20,708	20,911	20,911	0	0.00%
Prescribing	16,238	15,912	15,912	0	0.00%
Resource Transfer	8,863	8,863	8,863	0	0.00%
Change Fund	1,403	1,325	1,325	0	0.00%
Contribution to Reserves	0	0	0	0	0.00%
CHCP NET EXPENDITURE	**118,511**	**120,065**	**119,825**	**(240)**	**(0.20%)**

** Fully funded from external income hence nil bottom line position.

PARTNERSHIP ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
NHS	70,020	71,016	71,002	(14)	(0.02%)
Council	48,491	49,049	48,823	(226)	(0.46%)
CHCP NET EXPENDITURE	**118,511**	**120,065**	**119,825**	**(240)**	**(0.20%)**

( ) denotes an underspend per Council reporting coventions

** £2.3 million externally funded

APPENDIX 2

SOCIAL WORK

REVENUE BUDGET PROJECTED POSITION

PERIOD 7: 1 April 2013 - 31 October 2013

2012/13 Actual £000	SUBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
	SOCIAL WORK					
25,997	Employee Costs	25,961	25,998	25,458	(540)	(2.08%)
1,585	Property costs	1,504	1,491	1,428	(63)	(4.23%)
886	Supplies and Services	867	822	856	34	4.14%
456	Transport and Plant	374	389	468	79	20.31%
1,013	Administration Costs	813	900	1,006	106	11.78%
32,591	Payments to Other Bodies	32,884	33,451	33,506	55	0.16%
(14,304)	Income	(13,912)	(14,002)	(13,899)	103	(0.74%)
(577)	Contribution to Earmarked Reserves	0	0	0	0	
47,647	**SOCIAL WORK NET EXPENDITURE**	**48,491**	**49,049**	**48,823**	**(226)**	**(0.46%)**

	2012/13 Actual £000	OBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over / (Under) Spend £000	Percentage Variance
		SOCIAL WORK					
	2,066	Strategy	2,098	2,273	2,231	(42)	(1.85%)
	21,103	Older Persons	20,731	21,101	21,118	17	0.08%
	6,223	Learning Disabilities	5,547	6,036	6,231	195	3.23%
	1,159	Mental Health	1,412	1,412	1,402	(10)	(0.71%)
3	10,101	Children & Families	10,191	10,197	10,022	(175)	(1.72%)
	2,396	Physical & Sensory	2,355	2,351	2,456	105	4.47%
	804	Addiction / Substance Misuse	1,227	1,237	1,112	(125)	(10.11%)
	2,293	Support / Management	2,830	2,163	2,083	(80)	(3.70%)
	1,528	Assessment & Care Management	1,471	1,646	1,631	(15)	(0.91%)
1	0	Criminal Justice / Scottish Prison Service	0	0	0	0	0.00%
2	0	Change Fund	0	0	0	0	0.00%
	551	Homelessness	629	633	537	(96)	(15.17%)
	(577)	Contribution to Earmarked Reserves	0	0	0	0	0.00%
	47,647	**SOCIAL WORK NET EXPENDITURE**	**48,491**	**49,049**	**48,823**	**(226)**	**(0.46%)**

( ) denotes an underspend per Council reporting coventions

1 £1.9m Criminal Justice and £0.3m Greenock Prison fully funded from external income hence nil bottom line position.
2 Change Fund Expenditure of £1.4 million fully funded from income.
3 Children & Families outturn includes £410k to be transferred to the earmarked reserve at year end 2013/14
4 £8.9 million Resource Transfer / Delayed Discharge expenditure and income included above.

5 Original Budget 2013/14	48,491
Pay & Infaltion	525
Living Wage	12
Transport	14
Insurance	13
Telephone Savings / other	(6)
Revised Budget 2013/14	49,049

APPENDIX 3

HEALTH

REVENUE BUDGET PROJECTED POSITION

PERIOD 7: 1 April 2013 - 31 October 2013

2012/13 Actual £000	SUBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
	HEALTH					
21,861	Employee Costs	20,586	21,554	21,470	(84)	(0.39%)
1,453	Property	1,228	1,628	1,563	(65)	(3.99%)
3,491	Supplies & Services	3,700	3,775	3,910	135	3.58%
21,172	Family Health Services (net)	20,708	20,911	20,911	0	0.00%
15,828	Prescribing (net)	16,238	15,912	15,912	0	0.00%
8,869	Resource Transfer	8,863	8,863	8,863	0	0.00%
(1,145)	Income	(1,303)	(1,627)	(1,627)	0	0.00%
71,529	**HEALTH NET EXPENDITURE**	**70,020**	**71,016**	**71,002**	**(14)**	**(0.02%)**

2012/13 Actual £000	OBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
	HEALTH					
3,319	Children & Families	2,731	3,049	3,157	108	3.54%
3,919	Health & Community Care	3,606	3,666	3,627	(39)	(1.06%)
1,686	Management & Admin	1,391	2,108	2,158	50	2.37%
534	Learning Disabilities	558	562	521	(41)	(7.30%)
1,829	Addictions	1,895	1,901	1,864	(37)	(1.95%)
2,380	Mental Health - Communities	2,378	2,432	2,390	(42)	(1.73%)
9,697	Mental Health - Inpatient Services	9,544	9,296	9,293	(3)	(0.03%)
1,127	Planning & Health Improvement	705	991	981	(10)	(1.01%)
1 1,169	Change Fund	1,403	1,325	1,325	0	0.00%
21,172	Family Health Services	20,708	20,911	20,911	0	0.00%
15,828	Prescribing	16,238	15,912	15,912	0	0.00%
8,869	Resource Transfer	8,863	8,863	8,863	0	0.00%
71,529	**HEALTH NET EXPENDITURE**	**70,020**	**71,016**	**71,002**	**(14)**	**(0.02%)**

( ) denotes an underspend per Council reporting coventions

1	Change Fund Allocation to CHCP 2013/14	1,403
	Less: Transfer to Acute Projects:	
	Stroke Outreach Team	(53)
	Palliative Care CNS 0.5wte	(25)
		1,325

2	Original Budget 2013/14	70,020
	Pay & Infaltion	63
	Carers Information Strategy	85
	GMS Cross Charge	76
	CAMHS	217
	Skylark Physio	100
	Change Fund to Acute	(78)
	Rates from Acute	474
	Other	59
	Revised Budget 2013/14	71,016

APPENDIX 4

REVENUE BUDGET YEAR TO DATE

PERIOD 7: 1 April 2013 - 31 October 2013

SOCIAL WORK SUBJECTIVE ANALYSIS	Budget to Date as at Period 7 £000	Actual to Date as at Period 7 £000	Variance to Date as at Period 7 £000	Percentage Variance
SOCIAL WORK				
Employee Costs	14,875	14,563	(312)	(2.10%)
Property costs	848	811	(37)	(4.36%)
Supplies and Services	570	591	21	3.68%
Transport and Plant	203	245	42	20.69%
Administration Costs	295	356	61	20.68%
Payments to Other Bodies	17,513	17,546	33	0.19%
Income	(8,989)	(8,923)	66	(0.73%)
SOCIAL WORK NET EXPENDITURE	**25,315**	**25,189**	**(126)**	**(0.50%)**

HEALTH SUBJECTIVE ANALYSIS	Budget to Date as at Period 7 £000	Actual to Date as at Period 7 £000	Variance to Date as at Period 7 £000	Percentage Variance
HEALTH				
Employee Costs	12,634	12,585	(49)	(0.39%)
Property Costs	872	834	(38)	(4.36%)
Supplies	2,203	2,282	79	3.59%
Family Health Services (net)	12,099	12,099	0	0.00%
Prescribing (net)	9,385	9,385	0	0.00%
Resource Transfer	5,170	5,170	0	0.00%
Income	(1,222)	(1,222)	0	0.00%
HEALTH NET EXPENDITURE	**41,141**	**41,133**	**(8)**	**(0.02%)**

( ) denotes an underspend per Council reporting coventions

APPENDIX 5

INVERCLYDE CHCP - CAPITAL BUDGET 2013/14

Period 7: 1 April 2013 to 31 October 2013

Project Name	Est Total Cost	Actual to 31/3/13	Approved Budget 2013/14	Revised Est 2013/14	Actual to 31/10/13	Est 2014/15	Est 2015/16	Future Years	Start Date	Original Completion Date	Current Completion Date	Status
	£000	£000	£000	£000	£000	£000	£000	£000				
SOCIAL WORK												
Prudential Borrowing												
Kylemore Childrens Home (see 1 below)	1,244	1,121	123	123	0	0	0	0	01/10/11	30/06/12	19/03/13	The home opened on 19 March. The final cost is a projected £156k underspend, subject to final account adjustments with the contractor, with the underspend returned to the Council's capital programme.
Capital Funded From Revenue Contributions												
SWIFT Finance Module	70	10	60	60	12	0	0	0	03/09/12		31/08/14	Budget allocated for Development and Implementation of SWIFT Finance module.
Hillend Respite Unit (note 3)	80					80	80		tbc		tbc	Increase of one bed within respite unit. Final costs and phasing subject to tender.
Social Work Total	**1,394**	**1,131**	**183**	**183**	**12**	**80**	**80**	**0**				
HEALTH												
CHCP Formula Allocation 2013-14 (see 2 below)												
Health Centres Reception Upgrades	52		52	52	0	0	0	0	Oct-13	by 31/03/14	31/03/14	To improve patient confidentiality.
Port Glasgow Health Centre Ceiling Tiles	50		50	50	0	0	0	0	Oct-13	by 31/03/14	31/03/14	To resolve infection control and fire compliance issues.
Health Total	102	0	102	102	0	0	0	0				
Grand Total CHCP	**1,496**	**1,131**	**285**	**285**	**12**	**80**	**80**	**0**				

Note:

1. Original budget was £1.4m with the underspend of £156k returned to the Council's capital programme per Policy & Resources Committee 24/09/13.
The underspend related to £109k furniture and fittings and £47k building works. This offsets a shortfall in receipt from the sale of the building of £100k.

2. Funding comprises £102k local formula capital allocation and £0 capital backlog maintenance (as was accelareated in 12/13).

A further £61k of works will be funded through revenue maintenance:	£000
Port Glasgow Health Centre - replacement practice door	5
Treatment Rooms (all Health Centres)	38
Boglestone Clinic Car Park	18
	61

3. The expansion of the service is funded from a contribution from revenue reserves, as agreed by Policy & Resources Committee 24/09/13.

EARMARKED RESERVES POSITION STATEMENT — CHCP SUB COMMITTEE — APPENDIX 6

Project	Lead Officer/ Responsible Manager	Total Funding 2013/14 £000	Phased Budget To Period 7 2013/14 £000	Actual To Period 7 2013/14 £000	Projected Spend 2013/14 £000	Amount to be Earmarked for 2014/15 & Beyond £000	Lead Officer Update
Telecare Grant	Joyce Allan	60	35	49	60	0	Full carried forward allocation will be utilised in 13/14 on tools and equipment. Profiling is based upon the expenditure being evenly spread over the full financial year.
Self Directed Support / SWIFT Finance Module	Derrick Pearce / Andrina Hunter	391	74	71	166	225	SDS project and SWIFT financial module. Current staff costs for SWIFT are included within the deferred income balance below. Profiling is based upon the project being split over the last 9 months of the financial year. The SDS lead is currently working on an expenditure plan for the remainder of the financial year.
Growth Fund - Loan Default Write Off	Helen Watson	30	1	1	4	26	Loans administered on behalf of DWP by the credit union and the Council has responsibility for paying any delinquent debt. This requires to be kept until all loans are repaid and no debts exist. The profiling assumes that all expenditure will be incurred evenly through out the year.
Advice Services - MacMillan	Andrina Hunter	35	19	19	35	0	Funding from 14/15 will come from recurring welfare reform monies. The profiling is based upon the timing of the staff payroll.
Deferred Income	Brian Moore	458	229	105	195	263	A number of historical deferred income streams have been brought forward to 2013/14. Profiling takes account of a month's delay at the start of the financial year. However there are 8 individual projects, so the phased budget is difficult to predict. There are plans in place for the full £263k being carried forward inclusive of £70k for Calladh House subject to approval.
Change Fund - Older People	Brian Moore	1,314	767	623	1,314	0	Brought forward reflects Council elements of NHS Change Fund. Detailed costs by Project are reviewed on a regular basis by the Change Fund Executive Group and is reported to the CHCP sub committee as an integral part of the financial report. Any slippage in year will be carried forward to 2014/15. Profiling assumes that all expenditure will be incurred evenly through out the year, however with a large number of projects this is not exact.
Support all Aspects of Independent Living	Brian Moore	630	315	180	337	293	This fund will be spent over the next 2 financial years. The £180k spent to date includes a contribution to the 2013/14 Sheltered Wardens' saving of £70k. Of the £293k earmarked to be spent in 2014/15, £245k is allocated (including £70k Dementia Strategy) with the balance of £48k allocated to Calladh House, subject to approval. Profiling takes account of a month's delay at the start of the financial year, however the nature of the spend is not predictable.
Local Autism Action Plan	Alan Best	35	0	0	18	17	£18k projected to be spent in 13/14 including £6.5k for Health employees providing Speech Therapy and Psychology services.

EARMARKED RESERVES POSITION STATEMENT **CHCP SUB COMMITTEE** **APPENDIX 6**

Project	Lead Officer/ Responsible Manager	Total Funding 2013/14 £000	Phased Budget To Period 7 2013/14 £000	Actual To Period 7 2013/14 £000	Projected Spend 2013/14 £000	Amount to be Earmarked for 2014/15 & Beyond £000	Lead Officer Update
Adoption/Fostering/Residential Childcare	Sharon McAlees	519	0	0	0	519	The £300k of new funding from reserves was approved at the Policy and Resources Committee on 13 November 2012 to meet an increase in adoptions to be progessed in 2013/15. A potential contribution to the cost of the new build Children's unit, (to replace Neil St), is being considered. The final contribution to this reserve will be identified at year end. The in year operation of this budget will be reported through normal Revenue Monitoring.
Information Governance Policy Officer	Helen Watson	85	11	11	31	54	Post now filled (2 year post), employee in post from July and budget phased accordingly.
Joint Equipment Store	Beth Culshaw	50	0	0	0	50	This new reserve was approved at Policy & Resources Committee on 24 Sept 2013 and is to fund a range of equipment to meet the emerging demand linked to increasing frailty of older people and increased incidence of dementia. Budget will be phased once detail agreed.
Support for Young Carers	Sharon McAlees	65	0	0	0	65	This new reserve was approved at Policy & Resources Committee on 24 Sept 2013 and is for an 18 month period to enable the implementation of a family pathway approach to young cares, which will aim to develop a sustainable service to young carers and their families. Budget will likely be phased over the next 18 months once detail is agreed.
Total		3,672	1,451	1,059	2,160	1,512	

APPENDIX 7

CHCP - HEALTH & SOCIAL CARE

VIREMENT REQUESTS

Budget Heading	Increase Budget £'000	(Decrease) Budget £'000
1. Homecare - External	113,000	
1. Homecare - Internal		(113,000)
2. Various Budgets - Employee Costs	249,000	
2. Pay Inflation		(249,000)
3. Children and Families - Employee Costs	10,000	
3. Support Management - Employee Costs		(10,000)
4. Workstream Saving	4,370	
4. Telephones		(4,370)
	376,370	**(376,370)**

Notes

1 Shifting the balance of homecare provision from in house services to external provision
2 Allocation of pay inflation for 1% agreed pay award
3 Reallocation of savings to fund employee bottom up deficit
4 Application of workstream saving

APPENDIX 8

EMPLOYEE COST VARIANCES

PERIOD 7: 1 April 2013 - 31 October 2013

	ANALYSIS OF EMPLOYEE COST VARIANCES	Early Achievement of Savings £000	Turnover from Vacancies £000	Total Over / (Under) Spend £000
	SOCIAL WORK			
1	Strategy	(5)	(64)	(69)
2	Older Persons	(100)	16	(84)
3	Learning Disabilities	(36)	23	(13)
4	Mental Health	0	(22)	(22)
5	Children & Families	(29)	(115)	(144)
6	Physical & Sensory	(30)	29	(1)
7	Addiction / Substance Misuse	0	(81)	(81)
8	Support / Management	(10)	(106)	(116)
9	Assessment & Care Management	0	(22)	(22)
10	Criminal Justice / Scottish Prison Service	0	(8)	(8)
11	Homelessness	(7)	27	20
	SOCIAL WORK EMPLOYEE UNDERSPEND	**(217)**	**(323)**	**(540)**
	HEALTH			
12	Children & Families		99	99
13	Health & Community Care		(50)	(50)
14	Management & Admin		12	12
15	Learning Disabilities		(43)	(43)
16	Addictions		(27)	(27)
17	Mental Health - Communities		(60)	(60)
18	Mental Health - Inpatient Services		0	0
19	Planning & Health Improvement		(15)	(15)
	HEALTH EMPLOYEE UNDERSPEND		**(84)**	**(84)**
	TOTAL EMPLOYEE UNDERSPEND	**(217)**	**(407)**	**(624)**

1 Include 6 vacancies which are in the process of being filled plus early achievement one 1 post.
2 Early achievement relates to 7 Home Support Worker posts. This is after £113,000 virement to external.
3 Early achievement of savings on 4 posts. Sessional costs are overspent - being reviewed.
4 Turnover savings include 2 vacancies which are in the process of being filled.
5 Includes 12 vacancies which are in the process of being filled plus early savings on 1 post.
6 Early savings from reduction in hours (6 posts) offset by lost external funding.
7 Includes 6 vacancies which are in the process of being filled along with some maternity leave savings.
8 Includes 12 vacancies and maternity leave savings plus early achievement on 1 post.
9 Includes 2 vacancies which are in the process of being filled plus maternity leave savings.
10 Turnover savings, posts being recruited.
11 Early achievement of £7k, offset by overspend on overtime and turnover shortfall.
12 Ongoing impacts of CAMHS and SALT RAM allocations.
13 2 vacant band 6 posts currently out to advert.
14 Pressures from porters costs.
15 Impact of maternity savings, no current vacant posts. Earlier vacancies now filled.
16 Slippage in increments and impact of joint funded post.
17 Maternity leave (2 posts) impacts of turnover and two vacant band 5 posts being recruited.
18 Nil impact between adult and elderly in patient services.
19 Maternity leave, recruiting Smoking Cessation & Keepwell.

Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 3

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 9th January 2014**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/08/2014/BC**
Contact Officer:	**Beth Culshaw Head of Health & Community Care Inverclyde Community Health & Care Partnership**	**Contact No: 01475 715387**
Subject:	**Update on Report of Care Inspectorate Inspection of McPherson Centre January 2013**	

1.0 PURPOSE

1.1 To advise Members of the update of actions as a result of the inspection conducted by the Care Inspectorate in relation to the McPherson Centre in January 2013.

2.0 SUMMARY

2.1 The Care Inspectorate carried out an unannounced inspection of the McPherson Resource Centre in January 2013 and a report was submitted to the Sub-Committee in August 2013 of its findings.

2.2 The grades achieved reduced from previous inspections as follows:-

Quality of Care and Support	5 Very Good to 3 Adequate
Quality of Environment	5 Very Good to 4 Good
Quality of Staffing	5 Very Good to 4 Good
Quality of Management and Leadership	5 Very Good to 3 Adequate

(See Appendix 1)

3.0 RECOMMENDATION

3.1 That the Sub-Committee note the actions put in place as a result of the inspection and the continuing subsequent actions to ensure quality service delivery.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 The McPherson Centre provides a service for adults with a learning disability, many of whom also have profound and complex physical disabilities. It was inspected in January 2013 by the Care Inspectorate. The Centre is registered to provide a service to a maximum of 30 people. The inspection considered the quality themes of Care and Support, Environment, Staffing and Management and Leadership.

4.2 The inspection was conducted on a low intensity basis. This reflects the grading history of the service and the fact that there had been no complaints, serious incidents or accidents since the last inspection.

4.3 Since the inspection and subsequent committee report of August 2013 there has been an ongoing review of the recommendations and completion of an improvement plan.

5.0 PROPOSALS

5.1 The actions and proposals in respect of the requirements and recommendations contained within the inspection report are listed below, with details of actions in response:-

Quality Theme 1: Quality of Care and Support – Adequate - 3

Quality Statement 1.1

We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Action:

- Negotiation to take place with care management, accommodation services and other main providers to hold joint reviews on a six monthly basis, with it being minuted that it is a joint review in order to meet the statutory requirement for each service that is subject to care inspection.
- The manager will ensure that the current good practice with carer and other appropriate signatures is maintained.
- The manager will via staff supervision, make sure that such documents are presented for checking.

Update:

- Six monthly reviews have been implemented and are ongoing across day services with review documentation embedded within this process across all day service areas.
- A service user file audit has been undertaken to ensure discussion at supervision with staff with respect to individual care.

Quality Statement 1.3

We ensure that service users' health and wellbeing needs are met.

Action:

- Following the first visit by the inspector a revised medication chart was drawn up to ensure signing by two members of staff at both the preparation and administration stages.
- In addition a secure medication trolley has been ordered in order to aid the preparation and administration of medications.

- The requirement for staff undertaking PEG feeding to be trained from a qualified external agency took place on 21 March.
- A protocol in relation to PEG feeding and training was compiled by the service.
- The service is receiving staff training in relation to epilepsy, diabetes, Moving and Handling, CALM (Crisis and Aggression Limitation Management).
- A staff audit of training is already maintained by the service.
- More detailed weight and oral hygiene charts were introduced immediately after the inspection visit. Carers were also notified of the need for their consent for weight monitoring where applicable.

Update:

- The Medication administration policy has been reviewed and updated with changes to practice implemented across all day services including unifying practice in the preparation and administration of medication, the introduction of error proformas and management monitoring documentation.
- A review of medication protocols in conjunction with NHS Community Learning Disability Team and CHCP Lead Pharmacist including review of practice within the McPherson Centre has been undertaken.
- All service user medication files have been reviewed and updated.
- A Review of the PEG feeding policy in conjunction with the Lead Pharmacist with follow up of recommended changes in practice, including updated training where required with an associated audit trail.
- Detailed PEG feeding charts continue to be implemented and are reviewed on an ongoing basis.

Quality Theme 4: Management and Leadership

Quality Statement 4.4

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.

Action:

- Notifications to Care Inspectorate if subsequently undertaken, following clarification by Care Inspector of required timing of notifications.

Update:

- All day service unit managers are aware of the responsibility for Care Inspectorate online notifications. This is a standing item on all Day Services Management meetings.

5.2 **Quality Theme 2:** Quality of Environment – Good – 4

Quality Statement 2.2.

We make sure that the environment is safe and service users are protected.

5.3 **Quality Theme 3:** Quality of Staffing – Good – 4

Quality Statement 3.1

We ensure that service users and carers participate in assessing and improving the quality of staffing the service.

Action:

- The Care Inspectorate commented on eight areas of positive comments from staff service users and carers that the service is currently developing further e.g. regular staff meetings and minutes produced, regular supervision, regular appraisals and the recording of comments from staff regarding team and

management, staff induction programme, key worker system, care planning with other stake holders and carers comments.

Quality Statement 3.3

We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Action:

- The service ensures that the limited use of sessional/agency staff is monitored to promote staff continuity for service users.

Update:

- The service has limited the number of agency staff utilised where no other option is available within internal resources to allow continuation of service. One service user continues to use an agency staff member through personal choice as part of a Direct Payment. This is a trend that may increase in the future as a result of the implementation of Self Directed Support Legislation.

5.4 **Quality Theme 4:** Management & Leadership – Adequate - 3

Quality Statement 4.4

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of the service we provide.

Action:

- The service must ensure that managers are aware of their legal obligations around notifications to the Care Inspectorate.
- Future development of a quality assurance system for the service in conjunction with Contracts and Commissioning.

Update:

- The Service Manager and Contracts colleagues have met with the Care Inspectorate inspector to discuss the report and the responsibility for notifications. The Care Inspectorate has commented on good communication links in terms of reporting back ongoing actions and review.
- The development and implementation of a Service User Satisfaction electronic survey across day services.
- The new management structure for Day Opportunities will be embedded by March 2014 with robust communication links between the Service Manager and unit managers having a clear remit of responsibility supported by senior day care officers and support staff.

6.0 IMPLICATIONS

6.1 Legal: None

6.2 Finance: None

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

6.3 Personnel: As per recommendations of the report.

6.4 Equalities: None

6.5 Repopulation: None

7.0 CONSULTATION

7.1 N/A

8.0 LIST OF BACKGROUND PAPERS

8.1
- Care Inspectorate – Care Service Inspection Report – McPherson Service Without Care at Home 30th January 2013

APPENDIX 1

Inverclyde council

NHS Greater Glasgow and Clyde

Recent History of Grades

	Quality Theme: Care & Support	**Quality Theme: Environment**	**Quality Theme: Staffing**	**Quality Theme: Management Leadership**
2013	1.1 Good 1.3 Adequate Overall: Adequate	2.1 Good 2.2 Good Overall: Good	3.1 Good 3.3 Very Good Overall: Good	4.1 Good 4.4 Adequate Overall: Adequate
2010	1.1 Very Good 1.2 Excellent 1.3 Overall: Very Good	Not undertaken	3.1 Very Good 3.4 Excellent Overall: Very Good	Not Undertaken
2009	1.1 Very Good 1.2 Very Good Overall: Very Good	2.1 Very Good 2.3 Very Good Overall: Very Good	3.1 Very Good 3.2 Very Good Overall: Very Good	4.1 Very Good 4.3 Very Good Overall: Very Good
2008	1.1Good 1.2 Very Good Overall: Good	2.1 Good 2.2 Good Overall: Good	3.1 Good 3.2 Very Good Overall: Good	4.1 Good 4.4Good Overall: Good

Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 4

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 9th January 2014**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/05/2014/HW**
Contact Officer:	**Helen Watson Head of Service; Planning, Health Improvement and Commissioning**	**Contact No: 01475 711833**
Subject:	**CHCP CORPORATE DIRECTORATE IMPROVEMENT PLAN – PROGRESS UPDATE**	

1.0 PURPOSE

1.1 To present to members a progress update against the agreed actions of the Community Health and Care Partnership's Directorate Improvement Plan 2013 – 2016.

2.0 SUMMARY

2.1 In common with each Directorate of Inverclyde Council, Inverclyde CHCP has prepared a three year Directorate Improvement Plan, approved by Sub Committee members in March 2013.

2.2 The CHCP Directorate Improvement Plan is an integrated plan designed to articulate the key development and improvement focused actions for the CHCP in the next three years, taking account of both Council and NHSGGC planning requirements.

2.3 The CHCP Directorate Improvement Plan is informed by the Corporate Statement of the Council, the Corporate Plan and the Planning and Policy Frameworks of NHS GG&C, and by a number of self-assessment activities undertaken in the CHCP to determine our areas of greatest urgency and importance. The Plan is not exhaustive of every action being undertaken in the CHCP rather it is a list of the areas within which we will undertake significant change or redesign to improve performance quality, and outcomes for local people. The detail of service level activity is contained within each Head of Service's Quarterly Service Review template and in team work plans.

3.0 RECOMMENDATION

3.1 Sub-Committee members are asked to note the reported progress against each action in the CHCP Directorate Improvement Plan 2013 – 2016.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 Inverclyde CHCP has prepared a three year Directorate Improvement Plan, to satisfy the planning guidance of both Inverclyde Council and NHS Greater Glasgow and Clyde. The Plan will be extant until 2016.

4.2 The Plan focuses on key areas of improvement and development action, which have the greatest need for detailed work and which will result in significant change and/or redesign to services to improve performance, quality and outcomes for local people. Day to day actions of the Partnership are not rehearsed in this plan.

4.3 This Plan provides an integrated articulation of the key areas of activity for the CHCP in the next three years, in addition to the core purpose of the CHCP of providing community health and social care services to the people of Inverclyde.

5.0 PROPOSALS

5.1 It is proposed that the Sub-Committee note the reported progress against each CHCP Development and Improvement Plan, and offer comments on what has been achieved to date and where action is needed.

6.0 IMPLICATIONS

6.1 Legal: Any legal implications of the actions proposed have been considered individually with Legal Services and the relevant Head of Service.

6.2 Finance: There are no specific financial and workforce implications from the actions proposed to be undertaken in the Directorate Improvement Plan, as these are an intrinsic part of the operational budget and management process.

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

6.3 Personnel: Any personnel implications of actions will be addressed via the usual agreed process.

6.4 Equalities: There are no equalities implications. There are key actions in the Plan designed to impact favourably on people with protected characteristics, and to address the inequalities that persist in Inverclyde.

6.5 Repopulation: There are no negative environmental or population implications detailed in the actions within the Plan that require attention

7.0 CONSULTATION

7.1 Actions contained in the Plan are derived from ongoing engagement with users, carers and the community as well as from staff and other stakeholders. This ongoing consultation is a key feature of the CHCP's daily business.

8.0 LIST OF BACKGROUND PAPERS

8.1 NHS G&C Planning Guidance 2013 – 2016.

8.2 Inverclyde Council Directorate Planning Guidance 2013 – 2016.

8.3 Inverclyde CHCP Heads of Service Self-Assessment 2013.

Ref	Area of CHCP Activity	Where are we now?	Where do we want to be?	How will we get there (including timescale)?	How will we know we are getting there?	Who is responsible?	How much will it cost?	SOA, SHANARRI, Commissioning Theme and Corporate Plan Priority
1.1	Carers	Carers can access self-assessment and independent assessments	Carers feel supported in their caring role. Carers' needs are assessed in their own right.	**We will deliver on the commitments of the Inverclyde Carers and Young Carers Strategy 2012 – 2015.** -	Carer feedback. Strategy outcomes. Numbers of assessments completed. PI Ref. 1,2a,2b	HoS PHIC HoS HCC	**Core resources** **NHS Carers Information Strategy Fund** **Reshaping Care for Older People Change Fund**	SOA 2, 4, 8 Healthy Nurtured Respected C2, 3 CP4
1.2	Carers	Working towards enabling users and carers to be more involved in the planning and delivery of care	Carers are involved as Equal Partners in the delivery of care	**We will implement training programmes for staff to support them in involving carers are equal partners in the planning, deliver and review of care**	Analysis of feedback from service users and carers Evidence of carer involvement in care planning and review PI Ref. 2b,2c, 2d	HoS PHIC HoS HCC HoS C&F/CJ HoS MHAH	**Core resources** **NHS Carers Information Strategy Fund** **Reshaping Care for Older People Change Fund**	SOA 4 8 Healthy C3 SOA 2 Nurtured / Respected C2

Inverclyde CHCP has been selected as one of the demonstrator/pilot sites for the implementation of the NES/SSSC training programme EPIC (Equal Partners in the delivery and planning of Care) for staff. The pilot will run from September 2013 to March, 2014 and a steering group has been established to oversee its implementation. Through the Piloting of the EPiC training more staff will become more aware of the need to identify carers and develop their skills and knowledge in supporting carers as Equal Partners in the delivery of care.

The self-assessment form and leaflet has gone to print and will be rolled out across the CHCP and in the public domain by end of 2013. This will be a joint area of work with Inverclyde Carers Centre. All self-assessments will be routed through the Carers Centre in order that carers can access supports available there and that a clear pathway is established for carers to access further support. Analysis of Information will be forwarded to the CHCP on a monthly basis. Requests for full assessments will be forwarded to the Community Care teams.

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1.3	Young Carers	Identified young carers have access to support and advice/ information	Increase in numbers of young carers known to services and receiving support	**We will work to maximise the potential for young carers through increased identification, assessment, support and referral by implementing the year 2 actions of our Young Carers Strategy 2012 – 2015**	Number of young carers known to services. Number of young carers accessing key supports PI Ref. 2d,2e	HoS C&F/CJ	**Core resources** **NHS Carers Information Strategy Fund**	SOA 6 Active, Included CP5 C4
The young carers group is creating a video project to illustrate the issues affecting the lives of young carers. A development day involving all young carer partner agencies will be held in January 2014, aiming to highlight the roles and tasks of all partners delivering services to young carers. Funding was released from Council earmarked reserves with the aim of developing a whole system approach to young carers ensuring clear pathways across universal and intensive services.								
1.4	Information Governance	Agreement reached that Records Management Plan required	To have a robust Records Management Plan in place by 2014/15	**We will work with Internal Audit; Legal; ICT and practitioners to develop the CHCP Records Management Plan by 2014/15.**	Plan will be completed and agreed.	Corporate Director	Within existing resources	SOA 8 Respected CP4
The Keeper of the Records of Scotland has scheduled Inverclyde Council to submit its Records Management Plan (RMP) in June 2015. The Information Governance Officer is in post, and the Information Governance Group (IGG) will oversee development of the Plan. IGG meetings have been scheduled for the next year and its sub-groups will follow a similar format. Memberships consist of representatives from Internal Audit, Legal, ICT and the CHCP. Its priority actions for 2013/15 will be to deliver the Information Governance Framework, the RMP and associated evidence.								

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1.5	Tackling inequality and promotin g equality	Established and agreed Equalities Delivery Plan	All staff have a greater awareness of the needs of groups with protected characteristics	**We will fully implement our existing Equalities Delivery Plan by March 2014.**	Number of assessment and improvement plans Evidence of listening to the views of people with protected characteristics Equalities legislation compliance	HoS PHIC	**Within existing resources**	SOA 4 Respected Included CP5
The Equalities Network is now well established with representation from across the CHCP. Our equalities plan sets out our goals; the first of which was to establish the Champions Network and identify the areas for prioritising EQIAS.								
1.6	Service Supports	As a CHCP we are still operating split HR arrangements supported by services in both Parent Organisations	We want to make better use of the Partners' resources with regard to HR	**We will continue to explore the options of honorary contracts and a HR/ Personnel Service Level Agreement between both parent organisations.**	New HR support model agreed and implemented	Corporate Director	Within existing resources	SOA8 Respected and Responsible CP4
No progress to report at this stage								

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1.7	Accommo-dation	Plans for future accommo-dation agreed.	Clyde Square and Port Glasgow accommodation open	**We will implement the CHCP Accommodation Strategy, move to new accommodation in Clyde Square and Port Glasgow.**	Move to Central Library, new Port Glasgow office.	Corporate Director	Within agreed financial framework	SOA 8 Healthy CP4
We have arranged four accommodation workshops help CHCP staff prepare for mobile working. We have set up an Accommodation Strategy Group and a CHCP Accommodation Users group to which all services have been invited.								
1.8	Mobile Working	Agreement reached for pilots of agile and mobile working.	More efficient ways of working, from fewer sites are in place for the CHCP.	**We will implement agile/mobile working by March 2014**.	Agile working pilot completed	Corporate Director	Within agreed financial framework	SOA 8 Healthy CP4
Pilot project being developed with staff in Port Glasgow Hub, and in advice services.								
1.9	Environ-ment	Low levels of staff awareness of the Council's environmental agenda.	Improved employee environmental awareness and understanding.	**We will provide staff with information and training to change our environmental behaviour.**	Increased awareness. Reduction in commodities consumption Reduction in business mileage	Corporate Director	Contained within existing budgets	SOA 7 Nurtured CP4
Initial session held with EMG, cascaded to teams for local consideration.								

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2.1	People Involve-ment	People Involvement Framework is agreed	Users, Carers and communities are involved in shaping our priorities	**We will implement the CHCP People Involvement Framework across all services by March 2014**	Monitoring of the Framework and reports to CHCP Sub-Committee	HoS PHIC	**Within existing resources**	SOA 2 Respected Responsible Included CP4
Briefing sessions on People Involvement Framework and demonstration of the online tool are being carried out with staff teams over a three month period with a view to the system and People Involvement Framework being fully operational by March 2014. All new initiatives that require input from patients/service users and carers are routed through our local People Informant Advisory Network and Carers Network to encourage engagement.								
2.2	Quality Assurance	Governance meetings with providers and commission-ers	There is a culture of continuous review and improvement in all services	**We will develop a CHCP Quality Assurance Framework by March 2014.**	Framework in place and service improvements documented	HoS PHIC	**Within existing resources**	SOA 8 Healthy CP4
An initial outline of a proposed Quality Assurance Framework has been developed and will be progressed early 2014.								
2.3	Commissi oning	Draft CHCP Commission-ing Strategy developed.	Commissioning intentions of the CHCP are clearly articulated to assist planning amongst providers	**We will agree and implement CHCP overarching Commissioning Strategy by March 2014**	Monitoring of the Strategy and reports to CHCP Sub-Committee	HoS PHIC	**Within existing resources, and looking a disinvestment reinvestment opportunities**	SOA 8 Healthy CP4
Our Overarching Commissioning Strategy has been revised to form a statement of principles and intention. A Commissioning Steering Group has been set up as a clearing house for redesign and commissioning decisions, underpinned by revised commissioning officers role descriptor and clarified roles for support services.								

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2.4	Service Improve-ment	We make inconsistent use of bench-marking opportun-ities	To be sure we are delivering the best possible services for local people, based on learning from other areas and other models	**We will undertake 3 benchmarking projects per year across the CHCP, making use of the Scottish Community Care Benchmarking Network and other benchmarking groups**	3 Benchmarking reports presented to Heads of Service per annum	HoS PHIC	Within existing resources	SOA 4,5,6 & 8 Healthy CP2,3 & 4
Inverclyde CLDT Core Nursing Standards Audit is benchmarked quarterly with all other LD nursing services in NHS GG&C. We are participating in a West of Scotland benchmarking club and are making better use of our membership of the Scottish Community Care Benchmarking Network.								
2.5	Service Improve-ment	Inconsistent use of outcome models and outcome focused assessment	Agree outcome based assessment tools to determine outcomes to be achieved in working with people	**Determine, agree and implement a consistent model of outcome focused assessment across all frontline services**	Outcomes focussed assessments in place for each client by 2016	CHCP-wide led by operational Heads of Service	Within existing resources	SOA 4,5,6 & 8 Respected & Responsible CP1 & 4
A working group has planned briefing sessions on outcomes-focused assessments which will be conducted across CHCP teams by end of 2013.								

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2.6	Service Improve-ment	Services occasionally operate in isolation, with limited sharing of practice and learning	Working to achieve our objectives and deliver best outcomes for people	**We will ensure there is more frequent sharing of information and experience across the CHCPs services**	CHCP Reflection Framework Established Theme/ development based Extended Management Team sessions inplace	Corporate Director	Within existing resources	SOA 4,5,6 & 8 Healthy CP4
Networks and fora have been established to share information and good practice. FTFT considering workplace exchange of ideas and practice.								
2.7	Service Improve-ment	We use significant incidents as an opportunity for reflection and learning but could do so more fully	The CHCP is learning and reflective organisation that grows and strengthens our response to need based on learning from experience	**We will learn and grow as a CHCP from considering and reflecting on significant incidents and case reviews**	Significant incident reports considered at Heads of Service meeting and improvement/ learning plans developed CHCP Reflection Framework in place	Corporate Director	Within existing resources	SOA 4,5,6 & 8 Healthy CP4
Being progressed through the Heads Of Service Meetings.								

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2.8	Service Supports	No clear process of reviewing policies and procedures	All policies and procedures are reviewed and developed using a clear process	**We will utilise the Quarterly Service Review process to identify policies and procedures workstreams**	Review effectiveness of this process on an annual basis	HoS PHIC	Within existing resources	SOA8 Respected and responsible CP4
Actions and timescales being scoped for progression in 2014.								
2.9	Service Supports	Multiple data streams that vary in quality and currency	Have robust benchmarking activity	**We will rationalise performance information by December 2013**	OPR; reports to CHCP Sub-Committee	HoS PHIC	Within existing resources	SOA 8 Healthy CP4
Planning & Performance service have developed a data collection system (repository) which is continuing to evolve and improve. A demonstration and presentation was given to the CHCP sub-committee on 9th August 2013.								
2.10	Commun-ication	CHCP Website requires updating	Information on service access is more routinely available and informs service planning	**Review our communication channels by March 2014.** **Deliver the Communication Support and Language Plan and associatied policies.**	We will monitor use of translation, alternative formats and website, and monitor implementation of CSLP; AIP and CSP.	Corporate Director	Within existing resources	SOA 8 Responsible Included CP5
The Communications Group has a short life working group designed to gather information on services and update the Website content for transfer to Inverclyde Council website by March 2014.								

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2.11	Clinical and Care Govern-ance	Arrangements are in place but require to be strengthened	Clinical and care governance is robust across the CHCP	**We will develop an integrated approach to care governance and clinical governance by December 2013.**	Monitoring of the CCG Action Plan through the CCG Committee	HoS HCC Clinical Director PI Ref. 40,42	Within existing resources	SOA 4 Healthy CP4
The Actions of the Care and Clinical Governance Group will be outlined in the Quality Assurance Plan, to be developed early in 2014.								
2.12	Working with Acute Services	No formal arrangements for whole system working across primary, community and acute services.	Achieve closer working between primary and secondary care Achieve closer working with Maternity Services.	**We develop and implement a programme of joint working between primary and secondary care including improved referral process and deliver the Integration of Community and Secondary Care Pilot in Inverclyde by 2015.**	Monitoring of the programme and reports to CCG Committee	HoS HCC Clinical Director	Within existing resources	SOA 4 Healthy CP2, 4
Under a professional development banner we are rotating staff through the LA discharge team to improve integration and joint working. We are progressing well with the Inverclyde interface pilot with good clinical engagement.								

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2.13	Welfare Reform	Impact of welfare reform anticipated to be severe in Inverclyde	People in Inverclyde are supported to negotiate the benefits system, maximise their income and are more able to manage their money effectively and efficiently	**We will ensure we have a robust Advice Services Team who are able to support clients . We will ensure CHCP staff are trained in all aspects of welfare reform to ensure they can best support their clients.**	Increased numbers of staff trained in Welfare Reform.	HoS PHIC	Within agreed financial framework	SOA 3 Achieving CP5
Ongoing training in relation to elements of the Welfare Reform.Redesign of the Advice Information team continues to be implemented with the development of the Port Glasgow Hub.								
2.14	Financial Inclusion	There are many vulnerable people and families who require support	Improved access to financial inclusion services, particularly for families at risk of poverty	**We will continue to be a key partner in the delivery of the Inverclyde Financial Inclusion Partnership and Strategy.**	Monitor Financial Inclusion Strategy outcomes Number of referrals Development of the Financial Inclusion pathway.	HoS PHIC	Within agreed financial framework	SOA 3 Achieving CP5
Financial Inclusion Partnership (FIP) continues to meet quarterly and will have a development session in 2014 to undertake review of strategy and outcomes. Successful partnership approach taken to recent funding with 2 successful applications to the Big lottery Support and Connect funding. Scottish Legal Aid Board (SLAB) funding has been awarded to the FIP and will progress the strategy.								

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2.15	Gender Based Violence	We believe GBV is under-reported in Inverclyde	People subject to GBV feel supported	**We will deliver shared Gender Based Violence approach with GPs by March 2014.**	Increased number of people accessing GBV support.	HoS C & F Clinical Director	**Within existing resources**	SOA 4 Safe CP1, 5
Basic awareness training via the Violence Against Women Multi-agency Partnership (MAP) is open to anyone from CHCP, and was offered to all SW staff, key contacts in Children and Families services and specialist children's services and GP surgeries and other independent contractors. Three such sessions were delivered in 2012-13 with more planned for 2013-14. The theme for this years annual Child Protection Committee Conference was Gender Based Violence.								
2.16	Child and Adult Protection	There were 427 new Adult Protection and 186 Child Protection referrals in 2011/12	Children and vulnerable adults are protected from harm, neglect, abuse and exploitation	**We will consolidate and continually improve our approaches to the protection of children, adults and vulnerable groups.**	Adult and Child Protection Case Reviews PI Ref. 3a,3b, 3c,3d,4a,4b,4c	HoS C & F HoS HCC	**Within existing resources**	SOA 2 Safe C2 CP5
The AP Module has now been implemented. Extracting information will provide a range of performance management information, facilitating identification of patterns and trends and influencing future planning. The module is new, all staff have been trained but will need to become familiar and confident with using in practice. The Child Protection Committee used Inverclyde citizen's panel findings to develop a campaign focused on a general 'call to action' message which aims to tackle the barriers to reporting concerns about a child. The powerful image of the campaign will be displayed in prominent sites throughout Inverclyde and postcards providing useful contact numbers will be available through health centres, social work offices and other council buildings.								

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2.17	Child and Adult Protection	GP involve-ment in child and adult protection could be improved	There is improved GP participation in child and adult protection	**We will increase the % of child protection case conferences attended by or reports provided by GP**	5% increase on baseline by April 2014 PI Ref. 5	HoS C&F HoS HCC Clinical Director	Within existing resources	SAFE SOA5 CP1
GPs have attended case conferences on some occasions, and agreement has been reached for GP representation on the AP Committee, to ensure a multiagency view and for advice on specific issues.								
2.18	Working with the 3rd sector and local people	Co-production approach agreed via Change Fund Governance meetings.	Improved partnership working with the 3rd sector	**We will continue to implement community capacity building and co-production**	Co-production embedded in the CHCP Community capacity maximised	HoS HCC	Within existing resources Reshaping Care for Older People Change Fund	SOA 2, 3 Included CP2, 4
Funding has been successfully allocated to develop some areas of work through the Community Capacity Network to develop Coproduction. We have actively contributed to the Engagement Matrix which reflects our commitment to working with the Third Sector around issues of joint commissioning and other areas.								

Ref	Area of CHCP Activity	Where are we now?	Where do we want to be?	How will we get there (including timescale)?	How will we know we are getting there?	Who is responsible?
3a.1	Children's Services Early Years Collaborative	Work has begun locally with our partners on the Early Years Collaborative.	Deliver tangible improvement in outcomes and reduce inequalities for Scotland's vulnerable children, shifting the balance of services towards early intervention and prevention by 2016	**We will be active partners in Early Years collaborative** **This collaborative is introducing a cultural shift for all organisations and agencies to work together in achieving the stretch aims represented in the national guidance and the desired measures indicated in the next column.**	15% reduction of rates of stillbirth and Infant mortality by 2015 85% of all children within each CPP reach 27-30 month developmental milestone by 2017 90% of all children reach developmental milestones by primary school by 2017 PI Ref. 6,7,8a,8b,8c	HoS C & F HOS Education IC Chief Executive All Organisations and Agencies
Since the last update 2 further national EYC Learning sessions have been hosted by Scottish Government. These were well attended by CHCP, Education, and Council colleagues together with other partner organisations.						
3a.2	Children's Services Children's Hearing Bill	Training in Children's Hearing Legislation is currently being developed.	Front line practitioners and managers to be familiar the new Children's Hearing legislation	**We will Implement local actions as part of the enactment of new Children's Hearing Legislation.**	Each young person will continue to have a child's plan and the SHANARRI wellbeing indicators will inform outcomes PI Ref. 9a, 9b, 10,11,12a,12b	HoS C & F
The training programme for the new Children's Hearing Legislation has been completed for all front line practitioners and managers. Training was delivered in 3 ways; Awareness Training delivered by the CHCP giving staff initial grounding prior to the implementation of the act, Commissioned CLAN to deliver National Training at local venues, Commissioned Professor Kenneth Norrie to deliver specialist training, offered places to SCRA to build shared local knowledge.						

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3a.3	Children's Services Children and Young People's Bill	This will impact on Kinship, thoroughcare services, and corporate parenting	Every child has a named person and those children with additional support needs have a lead professional.	**We will roll out the named professional role in Health Visiting.** **Once the Children & Young People's Bill is passed and the necessary guidance and regulation is developed, we will revise our corporate parenting strategy.**	Named professional role in place PI Ref. 9a, 9b, 10,11,12a,12b,13,	HoS C & F
As part of our overall Nurturing Inverclyde approach we are pursuing an explicit policy of placing Inverclyde Children within Inverclyde (with the exception of adoption). The number of Inverclyde Children placed in residential schools is at its lowest ever level and the number of children placed in community based settings is at its highest at 90.1%. We continue to support increasing numbers of children in kinship placements. These are children who would otherwise be looked after in residential or fostering placements. Both our fostering and our adoption and permanence services were inspected in Jan /Feb of this year. Both services were graded as very good across all inspection themes with the exception of "quality of care" in fostering services which was graded as excellent and was described as "sector leading".						
3a.4	Children's Services	Special Needs in Pregnancy (SNIPS) services are currently in place.	We want to embed the roll out of the named person and lead professional.	**We will develop and agree a joined up model for the delivery of maternity services to vulnerable women through the delivery of SNIPs and the Family Health Nurse Partnership**	Number of first time teenage mothers participating in Family Health Nurse Partnership Each unborn child will have a plan with either a named person or lead professional identified. PI Ref. 14	HoS C & F
Our SNIPS service picks up vulnerable children and families. We have an Additional Support Needs Monitoring Forum which considers assessments of pre-school, primary and secondary school children and young people who may require additional support. We have been successful in securing short term Scottish Government funding to form a multi-agency team to undertake assertive outreach to engage vulnerable families who are not routinely engaging with services.						

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3a.5	Children's Services	Overall smoking rates reducing but smoking in pregnancy remains high.	Fewer pregnant women smoke	**We will work with maternity Smoke Free Services to provide all possible support for women to reduce the incidence of smoking in pregnancy**	Increased quit rates in pregnancy. Reduced smoking prevalence in pregnancy. PI Ref. 15a,15b,16	HoS C&F HoS PHIC
We have agreed to hold a workshop with children and families, health improvement and maternity to look at the broader aspects of crossover across these 3 service areas and how we can ensure seamless pathways, and will take place in December 2013.						
3a.6	Children's Services Early and Effective Intervention	77 alleged offence cases screened April –Sept 12. 34 referred to Social Work Services.	Establish Early and Effective Intervention (EEI) across Inverclyde	**We will implement the current work plan for Early and Effective Intervention and achieve agreed targets**	Number of EEI referrals screened. % EEI referred to Social Work % of EEI referred with other outcomes PI Ref. 17a,17b,17c	HoS C & F
The EEI system expanded on 1/4/2012 to include children under 16 who are on Supervision. This has significantly increased the number of children who can receive an early intervention response, avoiding the need for Police, Social Work and other reports. On the 17th of June this year we will open Lomond View Academy which is our new integrated school for our most excluded young people. The school will have capacity for 24 young people and will have a fully integrated multi-disciplinary staff team.						

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3a.7	Children's Services National Parenting Strategy	Parenting strategy agreed and implemented.	Parents are equipped to provide their children with the best start in life	**Deliver targeted and universal Triple P parenting support.**	Number of positive parenting programme (PPI) session delivered. Number of parents attending. PI Ref. 18a,18b	HoS C & F
The SOA6 is the strategic oversight group for the local parenting strategy, although the work is progressed mainly via the Early Years Sub Group. The Inverclyde Parenting Strategy is currently being reviewed and a revised strategy reflecting the National Parenting strategy is nearing completion. For the period 2012-13 the number of Sessions and interventions by level are as follows: • 213 - 1-2-1 Sessions • 410 - Parents attending • 280 - Level 2 interventions • 191 - Level 3 interventions • 42 - Level 4 interventions						
3a.8	Children's Services Healthy Child Programme	Targets met for Child Healthy Weight and Childsmile Dentists. 30 Month Assessment due to go live on 1st June 2013.	Reduce childhood obesity and injuries to children and improve mental health of children and young people. and oral health	**Improve identification and support for vulnerable children and families.** **.**	% of children receiving 30 months assessment % of LAC that have received a health check PI Ref. 9a,9b,19	HoS C&F
Work is heavily focused toward the implementation of the 30 month assessment, however performance against targets remais on track.						

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3a.9	Children's Services	Children wait too long for access to Child and Adolescent Mental Health Services	**Children and young people can access child and adolescent mental health services within18 weeks by December 2014**	**We will implement the 26 weeks referral to treatment guarantee for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks by December 2014.**	CAMHS waiting times indicators PI Ref. 24	HoS C&F
In February 2013 we finally exceeded our target of waiting times at 22 weeks. Our action plan is now focussed on sustaining and improving performance.						
3a.10	Transition from Children's to Adult Services	Pathways between children's and adult services need to be improved	Transition from children's to adult services is more seamless and less stressful	**We will map transition pathways for children with disability moving to adult services by March 2014**	Mapping completed by March 2014	HoS C & F HoS HCC
This is currently being undertaken for transitional health checks for young people with LD and will be incorporated into the overall transition plan. Through Inverclyde Child Protection Committee and Adult Mental Health services, a working group has been set up to develop a practice framework around the interface between Children's services and Child Protection in particular and Adult Mental Health Services.						
3a.11	Criminal Justice	Consultation underway regarding future of Community Justice services in Scotland	New arrangements for Community Justice implemented	**We will offer our local response to consultation by April 2013 and participate in the roll out of agreed model from 2014 onwards.**	Consultation response submitted. Following SG announcement planning for chosen option put in place to facilitate/mitigate impact on CHCP.	HoS C&F and CJ
Develop integrated processes and services across children and adult services and opportunities for alternatives to custody and secure care for young people. Scottish Government funding has enabled us to put a team in place for this project. Diversion from Prosecution service is now operational. The Court Support Service for young people is currently being implemented. This will provide specialist support to under 18s including a bail support service as an alternative to remand.						

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3b.1	Adult Services	Anticipatory Care Planning is not used to maximum benefit	Increase early intervention and prevention using the anticipatory care framework	**Review the range of approaches to anticipatory care planning being employed and agree a consistent practice approach by August 2013.**	Review of Anticipatory Care Planning for care home residents complete. Anticipatory Care Planning embedded	HoS HCC Clinical Director
Adult Community Nursing are reviewing over 400 patients aged 65+ to further Anticipatory Care Planning and to prevent avoidable hospital admissions.						
3b.2	Reshaping Care for Older People	Project in place funded via Change Fund to develop long term and emergency planning for carers.	Older carers are supported to develop emergency and long term care arrangements	**We will support older carers to complete anticipatory care plans with Carers Centre staff working jointly with CHCP staff.**	Review range of carer funding complete and sustainably secured for this project.	HoS HCC
Carers Centre staff continue to work with older carers to prepare for long term planning for their loved ones. To date this has included the development of - emergency planning/long term planning and information related sessions for carers. Carers centre staff have joined the CHCP anticipatory care planning group.						
3b.3	Disability	Agreement to undertake Health Needs Assessment of adults with LD	The health of people with a learning disability is improved	**We will undertake a health needs assessment of adults with a learning disability and implement recommendations by March 2014**	Monitor implementation of the HNA action plan	HoS HCC
Inverclyde CLDT along with Community Children's nursing (school nurses) and LD Liaison Team at NHS GG&C have completed the first year of offering transition health checks to all young people leaving schools for people with LD. 54% uptake this year and plans to improve on this uptake in place for next years leavers.						

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3b.4	Shifting the Balance of Care	424 people are in receipt of telecare as at March 2013	More people are able to manage their own health conditions	**We will increase the number of people with telecare support by 5% by March 2015**	The number of people with telecare support increased by 5% by March 2015 PI Ref. 20	HoS HCC
Currently 5 COPD patients using telehealth. Intention to increase to twenty by Jan 2014.						
3b.5	Shifting the Balance of Care	Data regarding the number of people able to die at home or in their preferred place of care is not robust	More people are able to die at home or in their preferred place of care	**We will develop and report a performance measure as part of the QPSR process from April 2013 to help increase the number of people able to die at home or in their preferred place of care**	Date gathering to inform target setting complete by summer 2013	HoS HCC
The CHCP's latest data (2011) shows that approximately 44% of people died in a community based setting (23% at home, 14.7% in a care home, 6.2% in a hospice and 0.1% in "other" setting), with 56% of people dying in a hospital setting. These data are currently being refreshed for 2012.						
3b.6	Primary Care	Data gathering is underway to identify variations in referral patterns from primary to secondary care.	A consistent approach for referral from primary to secondary care is in place	**We will undertake a systematic review of referral data and take action to address variation and issues by June 2014**	Review complete and actions agreed by June 2014	HoS HCC Clinical Director
We are progressing this action via the Inverclyde interface pilot, and will report in March 2014 with a plan for further action.						

Ref	Area of CHCP Activity	Where are we now?	Where do we want to be?	How will we get there (including timescale)?	How will we know we are getting there?	Who is responsible?
3b.7	Older People	Pharmacy reviews will be reported at QPSR	Polypharmacy is reduced for older people.	**We will develop and implement systematic pharmacy reviews by March 2014**	Number of pharmacy reviews. POMs reduced	HoS HCC
All 16 GP practices are participating in the Polypharmacy LES. The CHCP Prescribing Team is supporting this by providing prior work up for GP face to face reviews in all GP practices and also undertaking targeted pharmacist medication reviews.						
3b.8	Dementia	Work on the Inverclyde Dementia Strategy is well underway and steps to help make Inverclyde a dementia friendly community are progressing.	Inverclyde Dementia Strategy is in place Standards of care for Dementia are fully implemented	We will deliver the Inverclyde Dementia Strategy priorities and improve early diagnosis by: - increasing the numbers of people with a dementia diagnosis on the QOF dementia register - providing post diagnostic support	Proportion of people with a dementia diagnosis on the QOF dementia register Number of people diagnosed with dementia receiving post diagnostic support PI Ref. 21a,21b	HoS HCC HoS MHAH
The final Inverclyde Dementia Strategy will be submitted to CHCP Sub Committee in January. The Implementation plan is being developed by the Dementia Strategy Working Group to take forward the areas of work required. Additional investment is being allocated to support the strategy implementation. Evaluation of the post diagnostic support development at 6 months is being concluded. This will inform the future shape of this element of service. In this period 60 referrals have been received by the PDS, of which 48 people have been offered post diagnostic support.						

Ref	Area of CHCP Activity	Where are we now?	Where do we want to be?	How will we get there (including timescale)?	How will we know we are getting there?	Who is responsible?
3b.9	Older People's Services	Bed days lost to delayed discharge are reducing. Emergency admissions for people over 65 are higher than we want them to be.	Only people who really need to be are in hospital, and only for as long as is clinically necessary Older people who are able to be supported to live independently at home are able to do so.	**We will implement the Joint Strategic Commissioning Strategy for Older People**	Performance Measures 31 – 38 PI Ref. 31,32a,32b,33,34,35,36,38a,38 b,	**HoS HCC**
Resource worker to support review of day services for older people has been appointed and started in November 2013. Home care framework agreement and service specification currently being developed with a view to implementation from April 2014. Feedback has been received from JIT and our public engagement events and the strategy is being updated in light of this. The strategy will also undergo EQIA before the end of the year.						
3c.1	Health Improve-ment	There is inconsistent understanding and awareness of health improvement and tackling inequalities	All CHCP staff and partners including elected members can more readily understand their role in improving health and tackling inequalities	**We will undertake a survey to determine knowledge and attitudes towards everyone's roles in the health improvement and tackling inequalities agenda.** **We will deliver training and awareness raising tailored to the results of the survey.**	Survey undertaken and results analysed by April 2014 Training delivered and evaluated Survey repeated by April 2015.	HoS PHIC
The focus and scope of this work is being developed with a view to conducting the survey and training by January 2014.						

Ref	Area of CHCP Activity	Where are we now?	Where do we want to be?	How will we get there (including timescale)?	How will we know we are getting there?	Who is responsible?
3c.2	Alcohol and Drugs	Overprovision statement produced for Licensing Board to consider	Alcohol licensing applications are granted with a focus on reducing/ preventing harmful drinking.	**We will continue to engage with the local licensing forum and advise on licensing applications.**	Number of licensing applications subject to discussion in respect of impact on health	HoS PHIC
Eight applications have been received including 5 for new off sales provision. One not approved.						
3c.3	Cancer	Cancer screening uptake good Incidence of cancer in Inverclyde high	There is a reducing level of cancer for Inverclyde people, supported through an increasing uptake of cancer screening programmes	**We will Increase the uptake of cancer screening through the delivery of universal and targeted public health campaigns and programmes relating to bowel, breast and cervical cancer.**	Uptake of cancer screening programmes: - Bowel - Breast - Cervical PI Ref. 8a,8b,8c	HoS PHIC Clinical Director
• July-August – skin cancer awareness to staff via the Healthy Working Lives group • September – Breast and Bowel cancer screenings and awareness promoted via a MacMillan Cancer Care coffee morning at East Kirk Court (35 people attended) • September – cancer awareness promoted to staff by holding a Macmillan Coffee morning at HQ (30 staff attended and 10 staff involved in the planning) • September – breast, bowel and cervical cancer promoted at WOOPI-do event in Port Glasgow Town Hall to 22 persons						
3c.4	Self-Directed Support	Seven workstreams identified.	Individuals have the opportunity to direct their own carer / support	**We will implement the Self Directed Support action plan for the CHCP**	Monitoring of the SDS Action Plan PI Ref. 22	HoS PHIC
Event took place in October to review current position and redesign the membership of the subgroups to involve fieldwork staff to take forward key areas of the SDS strategy.						

Ref	Area of CHCP Activity	Where are we now?	Where do we want to be?	How will we get there (including timescale)?	How will we know we are getting there?	Who is responsible?
3c.5	Wellbeing	Strong foundations have been built in relation to Choose Life.	Stronger focus on population wellbeing learning from implementing the Choose Life agenda.	**We will implement "Making Well-being Matter" the Inverclyde Mental Health Improvement Framework.**	Development of Making Wellbeing Matter framework complete.	HoS PHIC
High level delivery plan has been developed with key actions identified and re-establishment of Forum to take forward implementation.						
3d.1	Mental Health	2011/12 psychological therapies waiting time 26wks: 24	Improved access to psychological therapies and PCMHT to 18 weeks maximum wait and extend to older people	**We will implement Phase 2 of the Clyde Mental Health Strategy and local redesign.**	18 weeks referral to treatment for Psychological Therapies from December 2014. PI Ref. 25	HoS MHAH
		Ravenscraig not fit for purpose	High quality health provision that meets older people's mental health needs		New inpatient provision fully implemented by 2014.	
		MH Strategy developed	Improved crisis response in relation to adult mental health and clear clinical and care pathways		Crisis response and pathways in place.	
		Redesign of OPMH and process to improve access to older people with mental	Integration of OPMHT and integration into inpatient services to operate as one system to prevent admission to hospital	**We will complete the redesign of the Older People's Mental Health Team.**	Redesign complete.	HoS MHAH

Ref	Area of CHCP Activity	Where are we now?	Where do we want to be?	How will we get there (including timescale)?	How will we know we are getting there?	Who is responsible?
		health problems				
CMHT and Psychology have completed migrating the recording of their activity to the Patient Management Information System (PiMS). Patients who are not seen within the 18 weeks target are mostly Psychology patients, and the main reason is the recruitment difficulty the Psychology Team has been facing. A new psychologist has been appointed but will not start until April 2014. The model and pathway process for community response service is now concluded. Detailed implementation of this is being progressed to commence in January 2014. Redesign of older people's mental health services is complete. Implementation to date includes a single point of access to OPMH service; commencement of memory assessment service to support early diagnosis of Dementia, and pathway to post diagnostic support; fast track assessment for people with rapidly changing needs; and dedicated staff within liaison service to all Care Homes from OPMHT, and to Acute from the Argyll Unit.						
3d.2	Drugs and Alcohol	2011/12 – 30 people died from alcohol related issues	Reduce the number of people who die due to alcohol consumption.	**We will strengthen initiatives aimed at promoting cultural change and attitudes to alcohol, through our contribution to the Inverclyde ADP Strategy**	Reduce alcohol related deaths Number of ABIs delivered	HoS MHAH
With support of ADP funding the recovery movement is now well established within Inverclyde. Funding has been provided to create a Support Worker post within the 3rd Sector in combination with access to premises for meetings and social events. A programme of Licensing Seminars are being held (in partnership with Police Scotland and IIAS) with the Licensed trade locally to promote responsible licensing practice raising awareness of alcohol related harm (health /crime) and the role that licences can play in reducing harm. Referral processes to IIAS have been redesigned to include a FAST assessment. This provides the opportunity for referring organisations to carry out a brief intervention and provides the specialists alcohol service with early access to information providing faster access to services and better targeting of services.						

Ref	Area of CHCP Activity	Where are we now?	Where do we want to be?	How will we get there (including timescale)?	How will we know we are getting there?	Who is responsible?
3d.3	Homeless-ness	Homelessness Service has been reviewed and actions to improve the service have been identified	One Stop Shop and housing options fully implemented. Modern, fit for purpose Homelessness Prevention and accommodation service in place	**We will complete the review of CHCP Homelessness Service and Implement the one-stop-shop in partnership with Oak Tree Housing Association.** **We will increase the number of flats in the Inverclyde Centre from 23 to 25**	Reduction in statutory homelessness presentations 25 flats in place in Inverclyde Centre PI Ref. 23a,23b,23c,23d	HoS MHAM
Homelessness review complete with the appointment of Team Leader Assessment and support.						
3d.4	Health and Homeless-ness	Baseline 2011/12 - 30% increase in outcomes assessed as 'very good' in comparison to 2010/11. First and second annual homeless service user consultations undertaken.	**Year One Target 2013-14 for HHAP:** Independent evaluation of the CHCP's HHAP to show a 10% increase in outcomes assessed as 'very good'. **2016 Target for HHAP:** Independent evaluation of the CHP's HHAP to show a 10% increase in outcomes assessed as 'very good'..	**We will implement the ICHCP Health and Homelessness Action Plan (HHAP)**	Independent evaluation of the HHAP showing evaluation ratings of 'good' and 'very good', and increases year on year of evaluations from 'good' to 'very good'; all in relation to the implementation of the Health and Homelessness Standards. PI Ref. 24	HoS MHAH
Increased Access to mainstream health services for persons affected by homelessness confirmed through homeless service user consultation, including maintaining the target of 30 homeless service users to be consulted. We have continued our activities to support the delivery of the Scottish Government's Health and Homelessness Standards.						

Ref	Area of CHCP Activity	Where are we now?	Where do we want to be?	How will we get there (including timescale)?	How will we know we are getting there?	Who is responsible?
3d.5	Advocacy	Shared advocacy services in place	People have independent support to challenge us if required, and access to advocacy services is improved.	**We will improve access to advocacy services.**	Monitor uptake of advocacy services	HoS MHAH
In July 2012 we commissioned Circles Network Advocacy Project to run initially for 3 years with an option to extend for 1 year, plus 1 year on mutually agreed terms and conditions. Additional advocacy services have been purchased through the Change Fund to provide further support to adults aged 65+. Other funding from Scottish Government secured a dedicated post for a Self Directed Support Advocate located within the Circles Network Advocacy Project in order to offer independent support and advice on SDS to carers and people with long-term conditions.						
3d.6	Criminal Justice	Good partnership working with Greenock Prison to improve prisoner's health. SPS an active partner in the ADP.	The health of prisoners is improved. The health needs of male and female prisoners are addressed equitably Supported transition on release for mental health, addictions or homelessness needs.	**We will undertake a Health Needs of Prisoners Assessment by March 2014**	HNA completed and action plan agreed by March 2014	HoS MHAH
Prison Alcohol Nurse post established. Training on waiting times system provided by ADP to prison staff to support monitoring of access to services. Liaison and referral arrangements with HMP Greenock and CHCP Community Addictions teams continue to operate., including: procedure in place which supports minimising the time lag between release from prison and engagement with services; and supporting access to prescription for Opiate Replacement Therapies without gaps in this process. The process also ensures key worker continuity for prisoners at this very vulnerable time and a further process ensures prisons have access to Naloxone through this process.						

Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 5

Report To:	**Community Health & Care Partnership Sub-Committee**	**Date: 9th January 2014**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/02/2014/HW**
Contact Officer:	**Helen Watson Head of Service Planning, Health Improvement and Commissioning**	**Contact No: 01475 715369**
Subject:	**Workforce Monitoring Report**	

1.0 PURPOSE

1.1 The purpose of the Workforce Monitoring Report is to ensure that the CHCP Sub-Committee is kept up to date on workforce issues and developments including progress in terms of workforce targets. The report provides an update on attendance management, staff appraisals, progress on Healthy Working Lives and an overview of the CHCP staff profile

2.0 SUMMARY

2.1 There has been significant improvement with attendance management since the last Committee report in August albeit we are still above the NHS 4% and Local Authority 4.75% targets.

2.2 Staff appraisals are below the NHS 80% and Local Authority 75% targets, Senior Management and HR teams are working with managers to address this.

3.0 RECOMMENDATION

3.1 The Sub-Committee is asked to note the content of this report and progress in meeting workforce targets.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 This monitoring report provides an update on the workforce profiles, sickness absence levels, Healthy Working Lives and eKSF/PDP and Appraisal information.

5.0 WORKFORCE INFORMATION

WORKFORCE STAFFING NUMBERS AS AT 1.11.13

SERVICE AREA	PLANNING HEALTH IMPROVEMENT & COMMISSIONING		HEALTH & COMMUNITY CARE		MENTAL HEALTH ADDICTIONS & HOMLESSNESS		CHILDREN, FAMILIES & CRIMINAL JUSTICE	
	NHS	COUNCIL	NHS	COUNCIL	NHS	COUNCIL	NHS	COUNCIL
HEAD COUNT	22	166	122	631	282	87	106	177
FTE	18.17	138.47	97.96	472.47	255.11	83.21	78.10	164.37
TOTAL CHCP	POSTS 188 WTE 156.64		POSTS 753 WTE 570.43		POSTS 369 WTE 338.32		POSTS 283 WTE 242.74	

Additional temporary posts information

Inv Change Fund	Sum of WTE	4.30
	Headcount	5
Inverclyde CHCP: Management & Admin	Sum of WTE	41.89
	Headcount	57

Total CHCP Staff	1655
Total WTE	1354.32

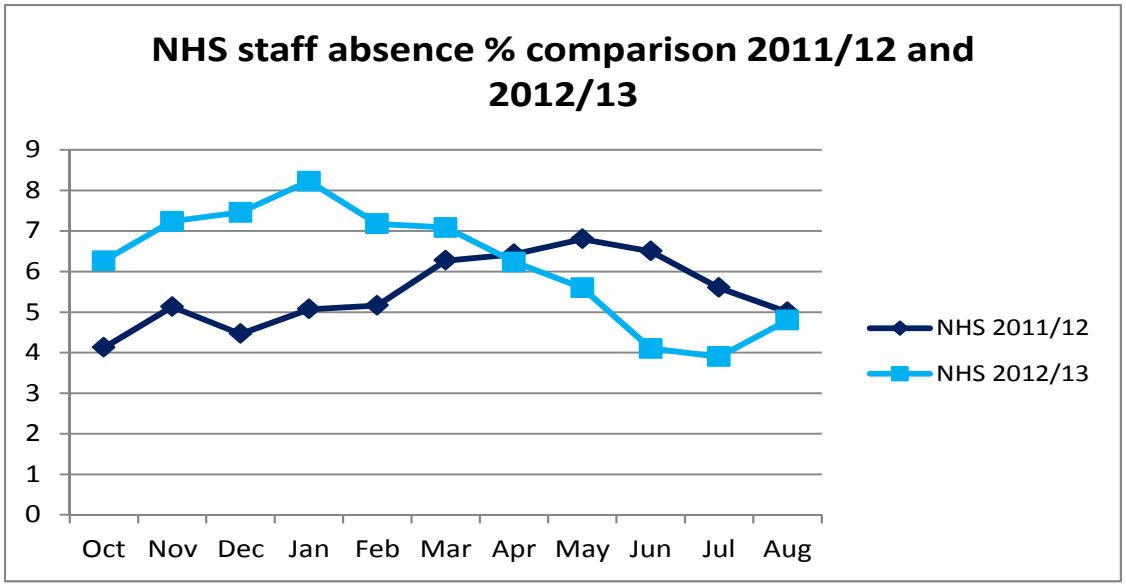
6.0 ATTENDANCE MANAGEMENT

6.1 As indicated in previous workforce reports there are different targets applying to sickness absence levels within the NHS and Local Authority. The NHS target is 4% and the Local Authority target is 4.75%.

6.2 **NHS EMPLOYED STAFF ABSENCE**

Chart 1 below shows absence levels of NHS employed staff in Inverclyde CHCP during the period September 2012 – August 2013. This shows a comparison against last year depicting that although there has been an increase in absence levels this month, the overall out turn is level with this time last year. Of significant note this month, all service areas reported an increase in absence levels with the exception of Business Support Services where there has been a decrease of 5% since last month. Short term and long terms absence rates in Mental Health Addictions and Homelessness Services have unfortunately increased respectively impacting on the overall CHCP rates. Please refer to Chart 1.

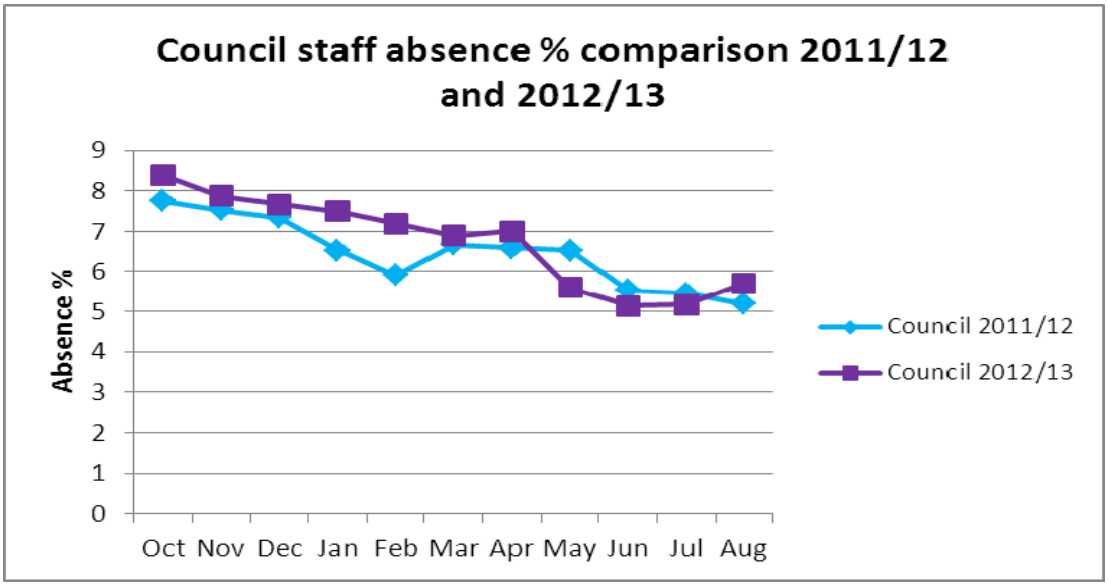
CHART 1



6.3 COUNCIL EMPLOYED STAFF ABSENCE

Sickness absence levels for Council-employed staff have remained relatively consistent over the two comparison years, with the start of 2013 being slightly higher than the previous year. During the period October 2012 – June 2013 there has been a downward trend in absence levels with a slight increase in July and August which is still above the target of 4.75%. Please refer to Chart 2.

CHART 2



6.4 Types of Absence

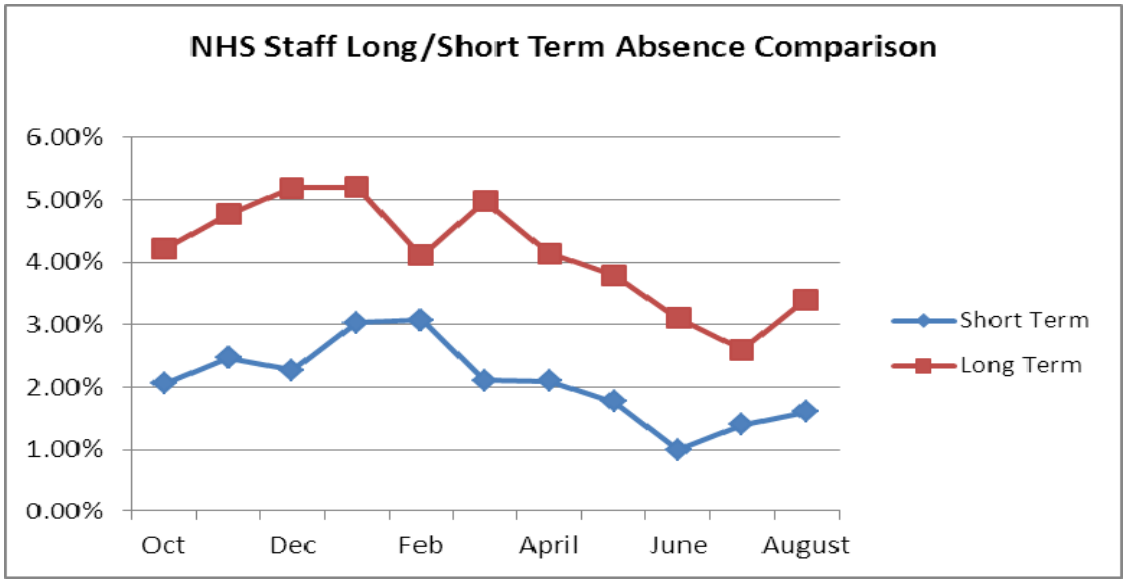
Due to differences in national reporting requirements, Inverclyde Council considers sickness absence in terms of either self-certified or medically certified, whilst the NHS requires absence to be considered in terms of short and long term absence (up to 28 days; over 28 days respectively).

NHS EMPLOYED STAFF

This makes direct comparison difficult, however chart 3 highlights that for NHS-employed staff, long term absence remains the greater contributing element, peaking at over 5% in December 2012 and January 2013, and not going below 4% until May and further reducing below 3% in July 2013. Short term absence peaked above 3% in January and February 2013 again reducing below 2% in August 2013.

It is recognised that short term absence is generally more manageable than long term absence, so the data indicate that reducing absence levels requires a more robust approach by management. Over the past 6 months managing attendance has become a core priority for the Senior Management Team.

CHART 3

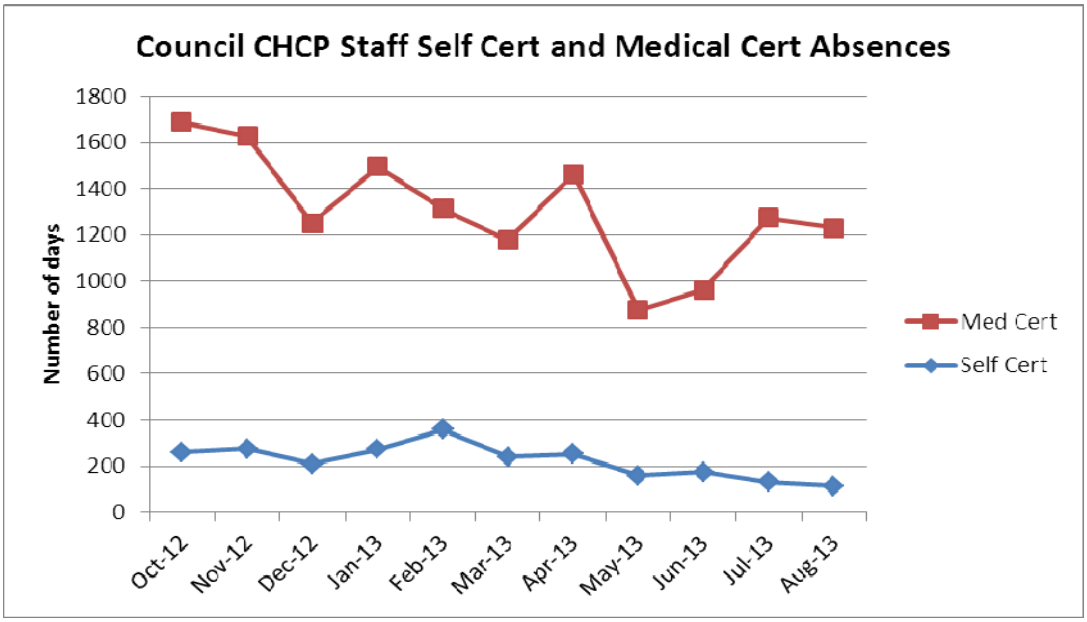


COUNCIL EMPLOYED STAFF

Chart 4 illustrates that over the reporting period more days were lost to medically certified absence than to self certified absence. With regard to medically certified absence the rate of 1,700 days in October 2012 reduced to 1200 days in August 2013. This represents an improvement but also that much remains to be done. In similar vein to the NHS position with long and short term absence, it is recognised that more can be done to manage self certified versus medically certified absence. Chart 4 also highlights that while self certified absence remains relatively constant, there is clearly room for improvement.

Despite working with two systems, it is clear that the actions to improve attendance management – either short-term or self-certified – will be similar across the whole CHCP staffing.

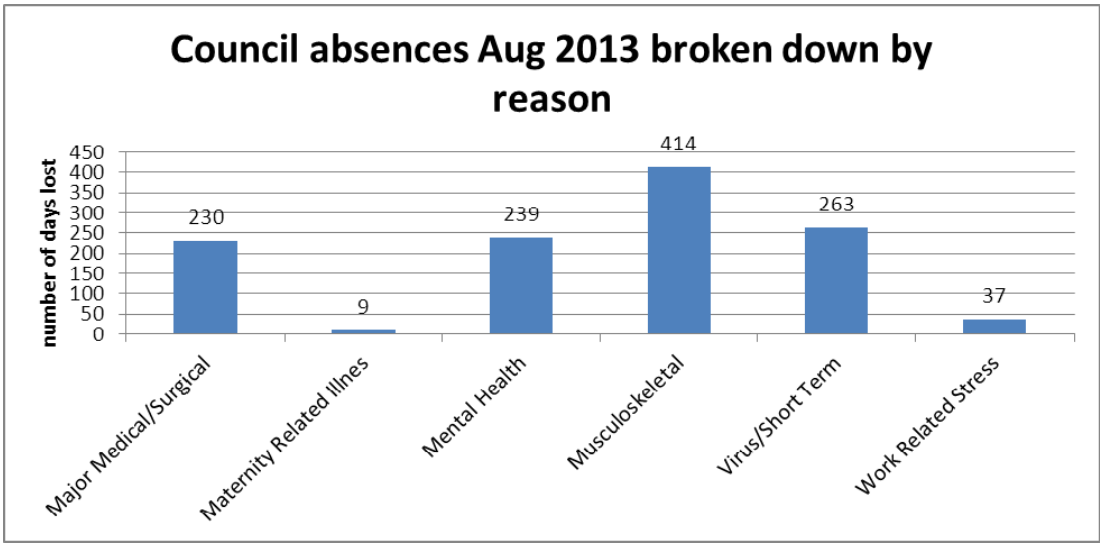
CHART 4



6.5 Reasons for Absence

Chart 5 illustrates that the most common reason for Council-employed staff being absent through sickness is musculoskeletal. The information displayed in the chart shows the numbers of days lost. The second most common reason is reported as "virus or short term illness".

CHART 5

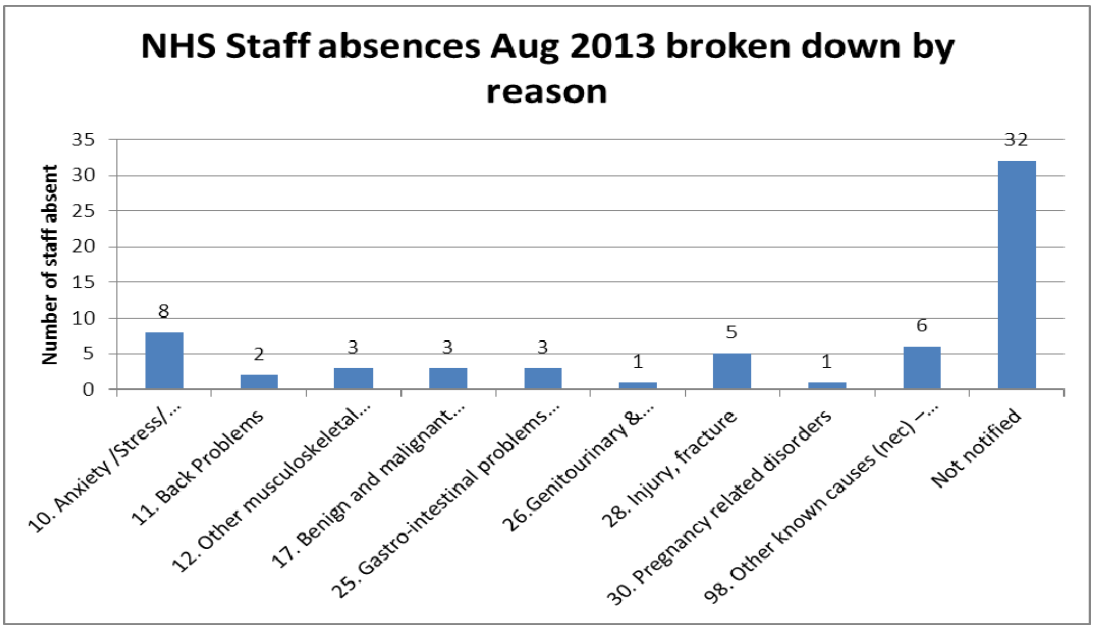


6.6 **NHS EMPLOYED STAFF**

Chart 6 illustrates reported reasons for absence with regard to NHS-employed staff, with the highest number being in the "not notified" category. This is a priority for Senior Management to look at the system to have a clearer understanding on all absence types. The numbers below indicate the number of staff absent.

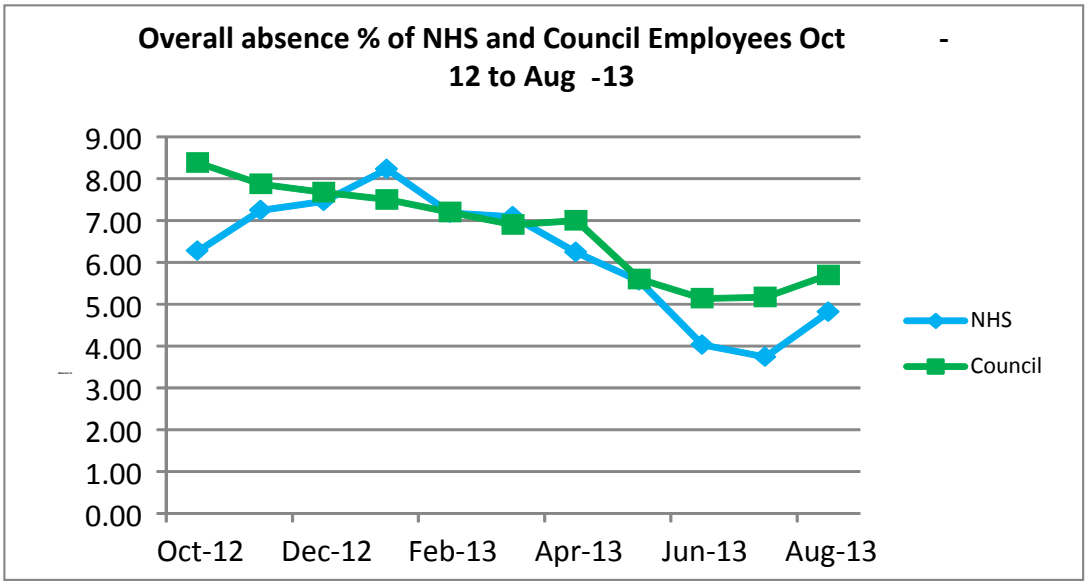
It is important to support staff through illness, regardless of employing organisation, but equally there might be more we can do to enable staff to undertake some dimensions of their remit whilst perhaps not fully fit, but able to take on some tasks. This has been shown to promote recovery and help staff to remain feeling connected to their teams and jobs.

CHART 6



6.7 Whilst workforce information continues to come from two separate streams and uses two sets of parameters, it is still possible to take an overview of sickness absence across the CHCP. Chart 7 shows a welcome downward trend in overall sickness absence levels, albeit we are still some way aware from our target performance level.

CHART 7



6.8 **Management Focus**

As stated, attendance management is a central focus for the CHCP management teams, and we have rolled out five Attendance Management Information Sessions with almost 200 CHCP managers, focusing on our policies and their robust and consistent implementation. The Corporate Director attended all the sessions. At the sessions examples of complex cases were discussed and we revisited the attendance management policies to reinforce the message.

The CHCP Absence Champion continues to work with both HR services to identify further actions that will improve attendance levels.

7.0 HEALTHY WORKING LIVES (HWL)

7.1 Following the successes of the Healthy Working Lives (HWL) working group in achieving bronze, silver and gold awards on behalf of the CHCP, they have continued to push the boundaries of achievement by attaining the Mental Health Commendation Award.

7.2 It is important to acknowledge that these awards are not easily attained. Apart from the activities the group encourages us to participate in and the administration required for recording and evaluating the process, there are strict criteria to adhere to and, in the case of the Mental Health Commendation Award, the staff stress survey was a key component.

7.3 In addition, attendance at the Stress in the Workplace Training for Managers was integral to the award. This training is being run again for those who were unable to attend

7.4 The Award ceremony for the Mental Health Commendation Award took place at the Sir Chris Hoy Velodrome on 10th October 2013. The award is not an end in itself however and a CHCP wide subgroup has been established to implement any changes based on the findings from the stress survey and this will be recorded for maintenance of awards.

7.5 <u>Gold Award Review and Assessment.</u>

Once awards have been achieved they have to be maintained. This is a pivotal part of the process. It is therefore a welcome announcement that the CHCP has passed its first review for the maintenance of the gold award.

7.6 <u>Healthy Working Lives; a fit for work, fit for purpose structure</u>

Changes to the way the HWL group is structured need to take place in order to reach more people in the organisation and have a greater impact on the health of our workforce. It is necessary to remind ourselves that Inverclyde CHCP operates as a single organisation with a workforce contracted to both the NHS and the Local Authority. The CHCP currently has 2 HWL strategies operating for both organisational groups. The CHCP now needs to bring together these two disparate HWL strategies and structures into a single strategic approach.

7.7 A workshop was arranged by the Director to facilitate this process and was planned for 29th October 2013. However due to unforeseen circumstances this has had to be postponed until later in the year.

The outcomes anticipated from the workshop are that:

- By achieving a joint strategy and action plan the CHCP workforce are safer and healthier.
- More people are engaged in securing this from the Director through the Heads of Service to every level and service in the organisation.
- The organisation continues to thrive with consistent strategies across the CHCP .

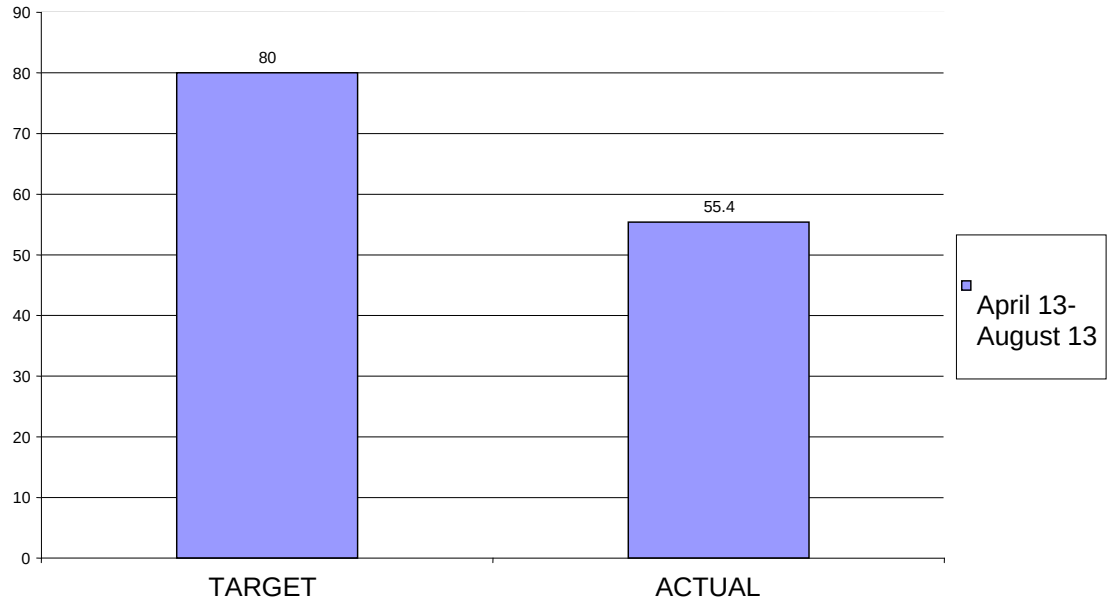
7.8 <u>The HWL Walking Challenge</u>

Between 19th August and 29th September the HWL GG&C group put out a walking challenge to all areas. Again our local stalwarts rallied 11 teams with 5 people in each team with the objective to gain as many steps collectively within the 6 week timescale. This mainly included walking to work or walking at work. The 55 people involved gained a staggering 14,146811 steps with our lead team locally coming in the first 20 places with 4,355,188 steps.

8.0 NHS GGC KNOWLEDGE AND SKILLS FRAMEWORK (KSF)

8.1 KSF compliance continues to be a challenging area. Performance at the end of August was 55.4%, reflecting a downward trend over the summer months. Support for managers and staff to update personal development plans and reviews will continue to be provided, with more emphasis placed on one-to-one support where this is required to supplement the range of online support and training available via the KSF team corporately. Activity in this area usually peaks in the January to March period, reflecting the dates of annual reviews. KSF progress reports will be made available to all service areas to identify where improvements in performance are required to comply with organisational targets.

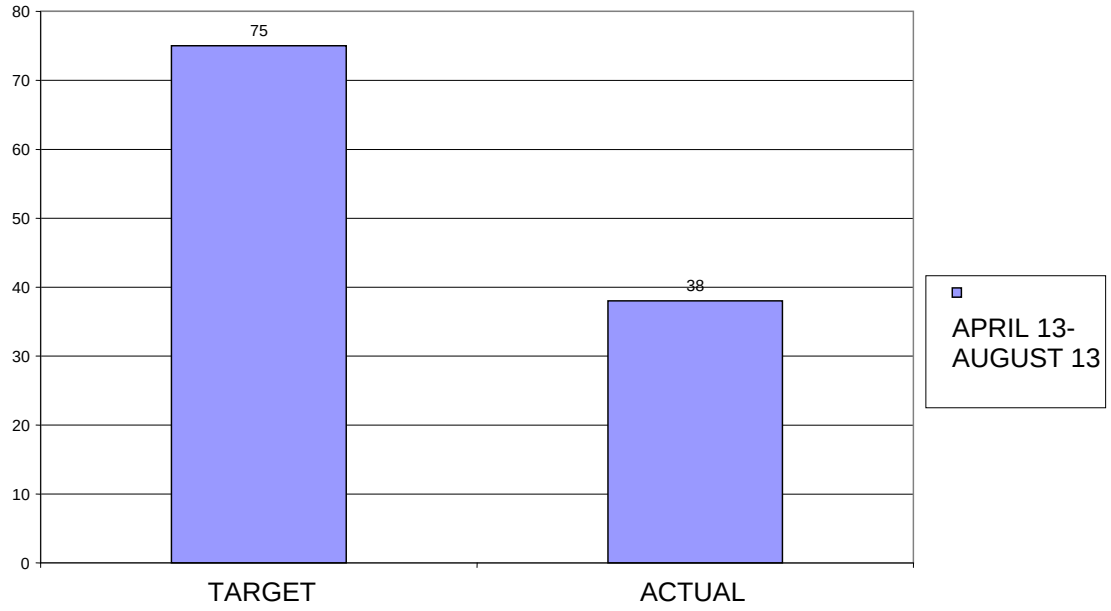
NHS STAFF EKSF COMPLIANCE Period April 13-August 13



9.0 INVERCLYDE COUNCIL – APPRAISALS AT INVERCLYDE

Similar to KSF Appraisals continues to be a challenging area. Performance at the end of August was 38%. There is usually an influx between the January to March period, reflecting the dates of annual appraisals. Progress reports will be made available to all service areas to identify where improvements in performance are required to comply with organisational targets.

COUNCIL STAFF APPRAISALS PERIOD APRIL 13-AUGUST 13



10.0 PROPOSALS

10.1 It is proposed that the CHCP Sub-Committee agrees to receive further workforce monitoring reports.

11.0 IMPLICATIONS

11.1 Legal:

None at the time of this report.

11.2 Finance:

There are no financial implications in respect of this report.

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

11.3 Personnel: None at this time of this report.

11.4 Repopulation:

None at this time of this report.

12.0 CONSULTATION

12.1 The policies that underpin this report have been agreed through the Joint Staff Partnership Forum.

13.0 LIST OF BACKGROUND PAPERS

13.1 None

Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 6

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 9th January 2014**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/15/2013/HW**
Contact Officer:	**Helen Watson Head of Service Planning, Health Improvement & Commissioning**	**Contact No: 01475 715369**
Subject:	**Integrated Performance Improvement Exceptions Report**	

1.0 PURPOSE

1.1 To present to the Sub-Committee an exceptions report of performance (Appendix 1) as proposed in a previous committee paper dated 28th February 2013. It is intended that this performance report will support the Sub Committee's scrutiny role in respect of the Inverclyde CHCP, and that the Sub-Committee find the process for developing such routine performance reports to be relevant and clear, and reflect the pressing issues or priorities of our communities.

2.0 SUMMARY

2.1 The CHCP Management Team currently undergoes six-monthly joint Organisational Performance Reviews (OPRs) which are reported regularly to Sub-Committee. At OPR, officers are required to provide an account of performance against key targets including HEAT, SOA and our Directorate Plan.

2.2 Most of the targets that are examined through the OPR process are high level ones that are shaped through national policy, and are often put in place as a proxy to give an indication of our overall functioning. On that basis they do not always directly reflect the pressing issues or priorities of our communities.

2.3 The CHCP Planning and Performance Team have now developed a fully integrated system and process for the management of performance through the introduction of the Quarterly Performance Service Reviews (QPSR) and our new Performance Data Repository. This is a system which captures all local and national data measures that we are required to report for statutory or non statutory purposes, for a range of business functions relating to Inverclyde CHCP. The repository holds a vast range of information where each measure is mapped to a SHANARRI Wellbeing indicator.

2.4 Our February 2013 report outlined a proposed process to develop a regular report that is more reflective of local issues. We have developed such a report using existing data, and have presented this in a more accessible and meaningful format that will bring a clearer understanding of how people experience health and social care in Inverclyde and also support Sub-Committee members in their scrutiny function.

2.5 It is intended that this performance exceptions report will be produced for the Sub-Committee on a quarterly basis and will also feed into the twice yearly May and October Organisational Performance Review (OPR) to the Health Board and Council.

3.0 RECOMMENDATION

3.1 Members are asked to comment on the relevance and usefulness of this performance report at appendix 1 and to provide views as to its final structure and content to inform with future performance reports.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 Inverclyde Community Health and Care Partnership (ICHCP) is a partnership between Inverclyde Council and NHS Greater Glasgow and Clyde bringing together both NHS and Local Authority responsibilities for community-based health and social care services within a single, integrated structure. The Integrated CHCP has accountability to NHSGGC and Inverclyde Council.

4.2 The CHCP Sub-Committee has a scrutiny function in terms of performance. The structure ensures that our efforts are focused on improving performance in line with our key commitments, as agreed through the CHCP Sub-Committee, and that the ambitions of the CHCP are implemented at the front line of service delivery.

4.3 A new quarterly performance service reporting structure (QPSR) was established 18 months ago for each Head of Service within the CHCP. The structure is illustrated in the chart at **Appendix 2**. The purpose of the QPSR is to present key performance information and statistics for analysis to identify strengths and weaknesses in performance. A critical aspect of the QPSR process is also to update and review the progress of key actions and outcomes for each of the service areas on their strategic priorities. The QPSR process is being embedded into our performance reporting framework to assist with the demands of all the reporting requirements both locally and nationally.

4.4 We have developed a fully integrated system and process for the management of performance through the introduction of the Quarterly Performance Service Reviews (QPSR) and our new Performance Data Repository. This is a system which captures all local and national data measures that we are required to report for statutory or non statutory purposes, for a range of business functions relating to Inverclyde CHCP.

4.5 The repository holds a vast range of information including all of the measures we are required to report on the SOLACE indicators. Performance measures are aligned to the SHANARRI (Safe, Healthy, Achieving; Nurtured; Active; Respected; Responsible and Included) wellbeing indicators which provides a full picture of our performance, and measures progress and outcomes for individuals and communities through which we promote and measure success.

4.6 Each of the QPSR reports are combined into a full report with an accompanying summary, which is provided to each Head of Service and the Director for scrutiny at their quarterly performance Management Meeting. Through this process, exceptional performance is identified and selected measures are reported to Committee.

4.7 The report at **Appendix 1** aims to highlight a relatively small number of areas where performance is out with the normal range that we would expect, either positively or negatively. The indicators have been chosen to reflect a cross section of CHCP services as well as the range of SHANARRI outcomes.

4.8 The report at **Appendix 3** highlights the SOLACE benchmarking Indicators specifically relating to the CHCP. One of the SOLACE indicators is also included in the children and families exceptions reports (% children looked after in the community) highlighting the rankings for each year.

4.9 We will aim to develop a regular report that is reflective of local issues, that is balanced and coherent, using existing data, and is presented in a more accessible and meaningful format that will bring a clearer understanding of how people experience

health and social care in Inverclyde, and explicitly highlight what aspects work well and where improvements need to be made. By using established data sets whenever possible, there should also be scope for us to benchmark our performance across other areas whilst recognising that as a CHCP it would not make sense to disaggregate local information into NHS or Social Work components where we have brought our data together under a single reporting system.

4.10 Whilst initially we are using quantitative data sources, it is recognised that we may have to develop some qualitative measures for the future to reflect our need to evidence improved outcomes. However this would be in line with the strategic direction of the CHCP in moving towards outcomes-focused planning, commissioning and delivery across our services. The report itself will be presented in a consistent format, but the content will evolve over time to remain reflective of local issues.

5.0 PROPOSALS

5.1 CHCP Sub-Committee Members are asked to review the report and agree its format as an acceptable way of describing performance exceptions.

6.0 IMPLICATIONS

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6.1 Legal: There are no legal implications in respect of this report.

6.2 Finance: There are no financial implications in respect of this report.

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

6.3 Personnel: There are no personnel implications in respect of this report.

6.4 Equalities: There are no equalities implications in respect of this report.

6.5 Repopulation: There are no repopulation implications in respect of this report.

7.0 CONSULTATION

7.1 Consultation has taken place with services through the Quarterly Service Review process. Various presentations of the repository and final combined performance reports have been provided to Heads of Service. A presentation of the proposed exceptions report, the repository and processes was made to Members on 9th August this year and was received positively by them at that time.

8.0 LIST OF BACKGROUND PAPERS

8.1
1. Performance Structure Chart
2. CHCP Integrated Performance Exceptions Report
3. Summary SOLACE measures

Appendix 1

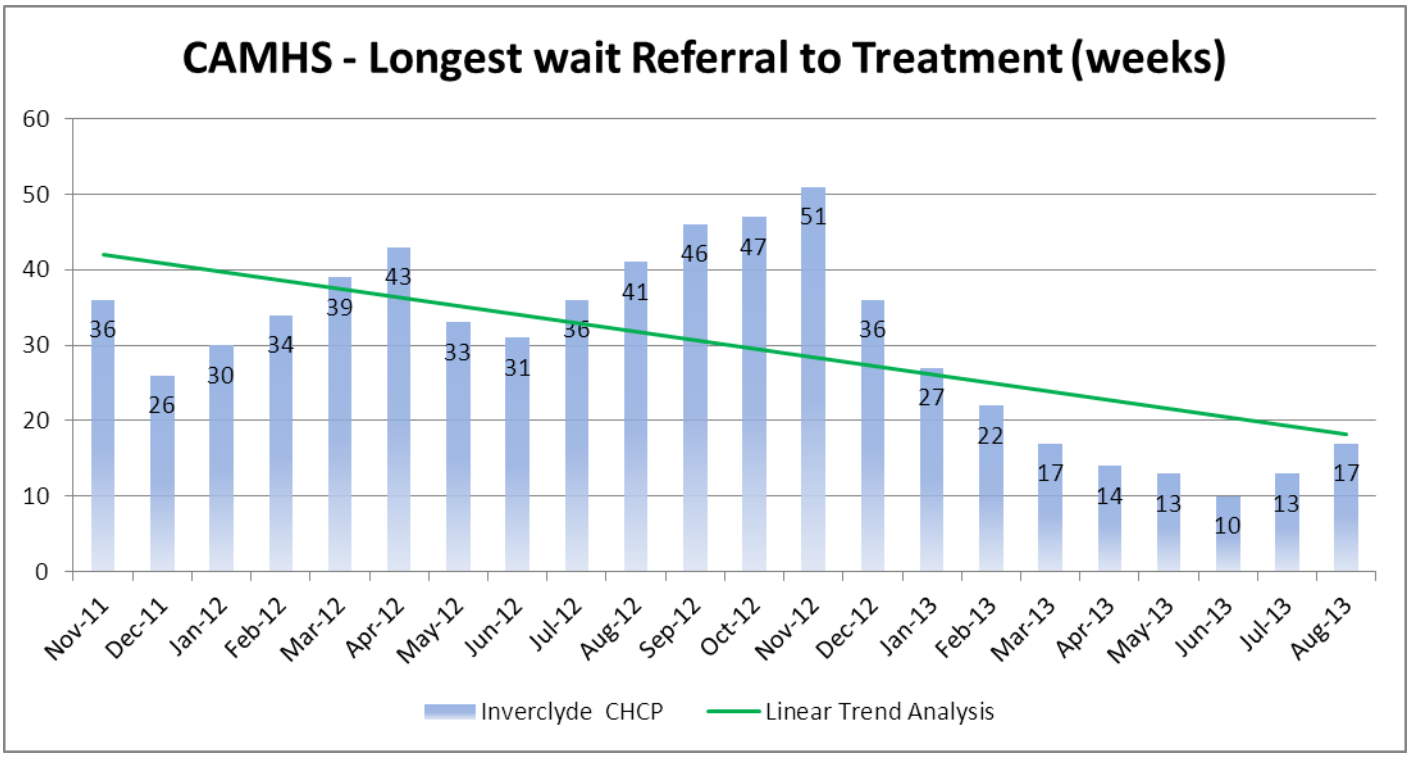
Integrated Performance Improvement Exceptions Report for Committee Period to September 2013

Report produced by CHCP Planning & Performance Team November 2013

Table of Contents

Child and Adolescent Mental Health Services (CAHMS)

Objective	Vulnerable young people can access services
Wellbeing	**Healthy**
Measure	CAMHS – Referral to Treatment (longest wait at month end in weeks)
Current Performance	17 as at August 2013



	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13
Glasgow City CHP	32	29	26	26	21	20	24	19	17	20	23	24
Inverclyde CHCP	**46**	**47**	**51**	**36**	**27**	**22**	**17**	**14**	**13**	**10**	**13**	**17**
Renfrewshire CHP	42	51	28	23	21	18	19	16	17	16	18	18
West Dunbartonshire CHCP	19	21	17	12	14	16	18	14	15	18	16	16
NHSGGC	46	51	51	36	27	22	24	19	17	20	23	24
Target	28	27	26	26	26	26	26	25	24	24	23	23

Commentary

In February 2013 we exceeded the set target of 26 weeks waiting time, achieving the longest wait at 22 weeks. This was largely due to the focused management of a number of issues and challenges, including:

- an increase in the age range of young people eligible for the service from 16 -18 resulting in increased referrals;
- implementation of the Board-wide Resource Allocation Model (RAM) which meant a reduction in resource for CAMHS in Inverclyde;
- Significant LT sickness in Nursing and Psychology teams; and several unsuccessful attempts to recruit to backfill posts to address the reduced capacity resulting from long term sickness

These issues were managed and addressed, and our action plan is now focussed on sustaining our renewed level of resilience.

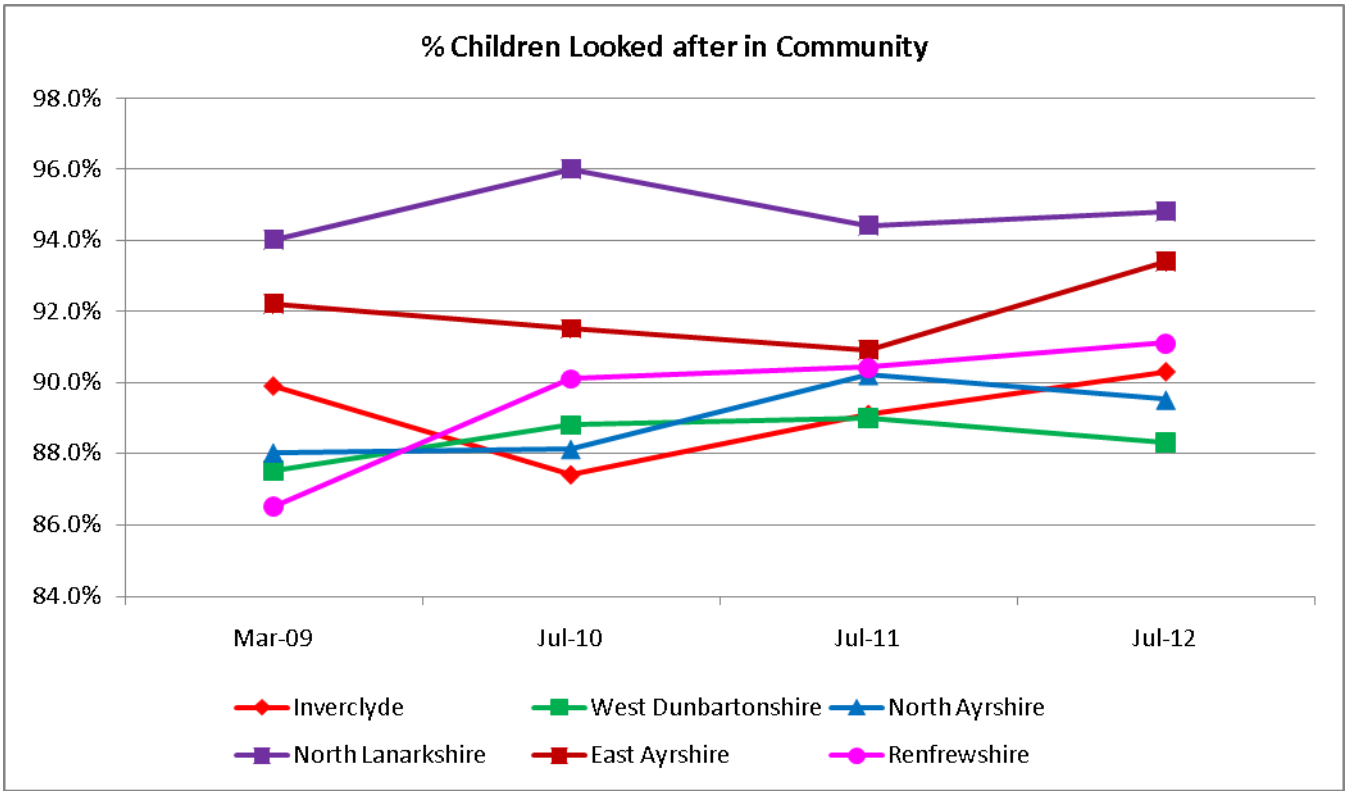
Comparative analysis for Inverclyde shows that despite meeting the target in February 2013 and matching the NHSGGC average, we still had some catching up to do, showing the longest wait in the group of authorities tabled above, however by March 2013 we surpassed all other authorities tabled and our performance at that point was 'best in the group' at 17 weeks. This downward trend continued until Jun 13 with the longest waiting times falling to 10 weeks for Inverclyde. However, although still well within target, the figure begins to climb again in July and August showing a slight increase back to 17weeks in August 2013 and sitting 'second best in the group' after West Dunbartonshire at 16wks.

Actions

- Continue to review and make service improvement by moving towards full use of the Choice and partnership Approach. This will improve access and engagement with the children, young people and families who require our service.
- Work closely with Cowal and Bute colleagues to ensure service is value for money and accessible to children and young people in these communities
- Monthly review of how the team is performing working towards the 18 weeks referral to treatment target.
- Continue to monitor the performance of the HEAT target through the Quarterly Performance Service Review process.
- Monitor the number of young people in need of this service locally through the clinical outcome data that is available.
- Ensure that whole team/skill set resource can readily be in place to meet demand.

Looked After and Accommodated Children (LAAC) in Community

Objective	Vulnerable children have a nurturing environment
Wellbeing	**Nurtured**
Measure	Percentage of Children Looked after in Community Placements (snapshot at end of reporting period)
Current Performance	90.01% as at March 2013



% Children Looked after in Community	Mar-09	Jul-10	Jul-11	Solace Ranked 2011	Jul-12	Solace Ranked 2012	Change in Rank
Inverclyde	89.9%	87.4%	89.1%	17	90.3%	16	1
West Dunbartonshire	87.5%	88.8%	89.0%	18	88.3%	19	-1
North Ayrshire	88.0%	88.1%	90.2%	16	89.5%	17	-1
North Lanarkshire	94.0%	96.0%	94.4%	2	94.8%	1	1
East Ayrshire	92.2%	91.5%	90.9%	14	93.4%	6	8
Renfrewshire	86.5%	90.1%	90.4%	15	91.1%	13	2

Commentary

As part of our overall Nurturing Inverclyde approach we are pursuing an explicit policy of placing Inverclyde Children within Inverclyde (with the exception of adoption). We are pleased to report that the number of Inverclyde Children placed in residential schools is at its lowest level and the number of children placed in community based settings is at its highest at 90.3% at July 2012

Annual trends of children looked after and cared for in the community have been consistent for a number of years around 88% in Inverclyde. This has risen to 90.3% at July 2012 and 90.01% in the latest quarterly stats at March 2013.

This measure has been adopted by SOLACE as a national benchmarking indicator and the chart above illustrates our performance against the 'family benchmarking authorities' ranked 17th in Scotland in 2011.

The % change in value from 2010-11 shows an improvement for Inverclyde from **89.1** to **90.3%** and an improved ranking position to **16** from the previous year.

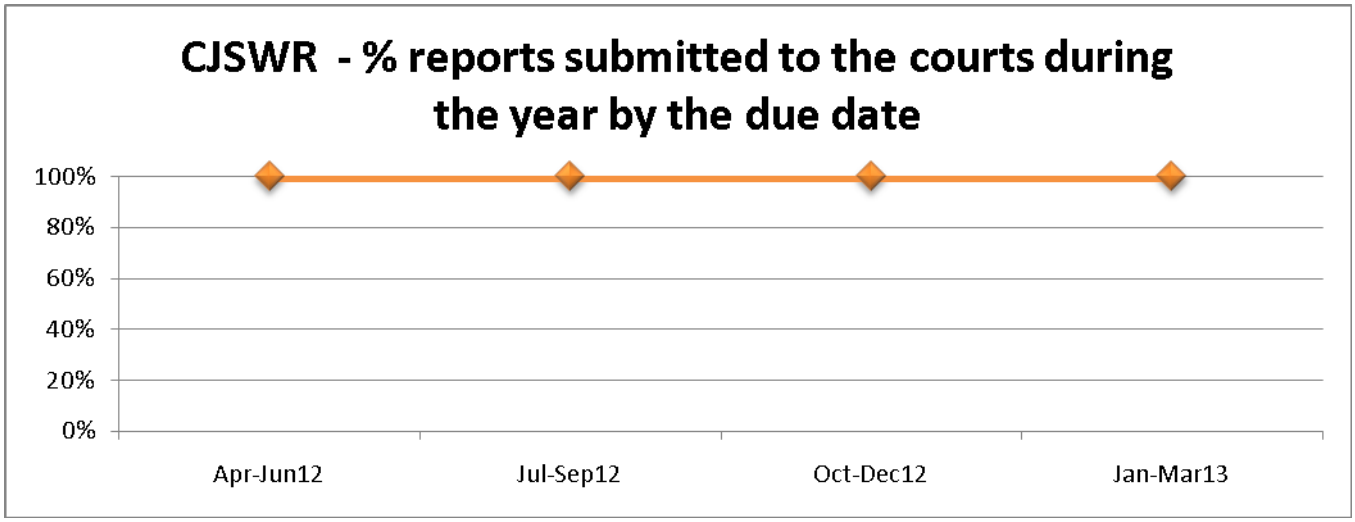
*Nb. It is worth noting that the definition of 'community placement' in the indicator is strictly in terms of all types of placements other than in **residential establishment** i.e. foster, adoption, at home, with friends/family other community. Children looked after in a local residential establishment is included as a 'residential' placement' and is not defined as a community placement for this indicator.*

Actions

- Continue with the implementation and provision of the Family Placement Strategy to ensure that every looked after child is placed appropriately and in a nurturing environment.
- Continue to monitor the balance of care for looked after children: % of children being looked after in the community as part of our established Regular Quarterly Performance Service Reviews (QPSR).

Criminal Justice

Objective	Offenders are supported to be respected and responsible citizens
Wellbeing	**Respected and Responsible**
Measure	Criminal Justice Social Work Reports (CJSWR) - % reports submitted to the courts during the year by the due date
Current Performance	100% as at March 2013



	Apr-Jun12	Jul-Sep12	Oct-Dec12	Jan-Mar13
CJSWR - % reports submitted to the courts during the year by the due date	100%	100%	100%	100%

Commentary

The introduction of the new Community Payback has been one of the most significant reforms for criminal justice for many years, replacing and extending most of the existing community based sentences. The establishment of a more structured approach to working with offenders has been part of the criminal justice social work service, however, the new legislation re-emphasises this and stresses the need for a systematic, evidence based approach, related to national standards.

Preparing assessments and reports are crucial parts of the social work tasks in the Criminal Justice System to ensure that the right decisions are made and appropriate interventions are agreed. The assessment process has the following key elements: information gathering, interviewing, analysis and report writing. Reports should be accurate, timely and fit for purpose to ensure that the right decision can be made at the right time for each individual.

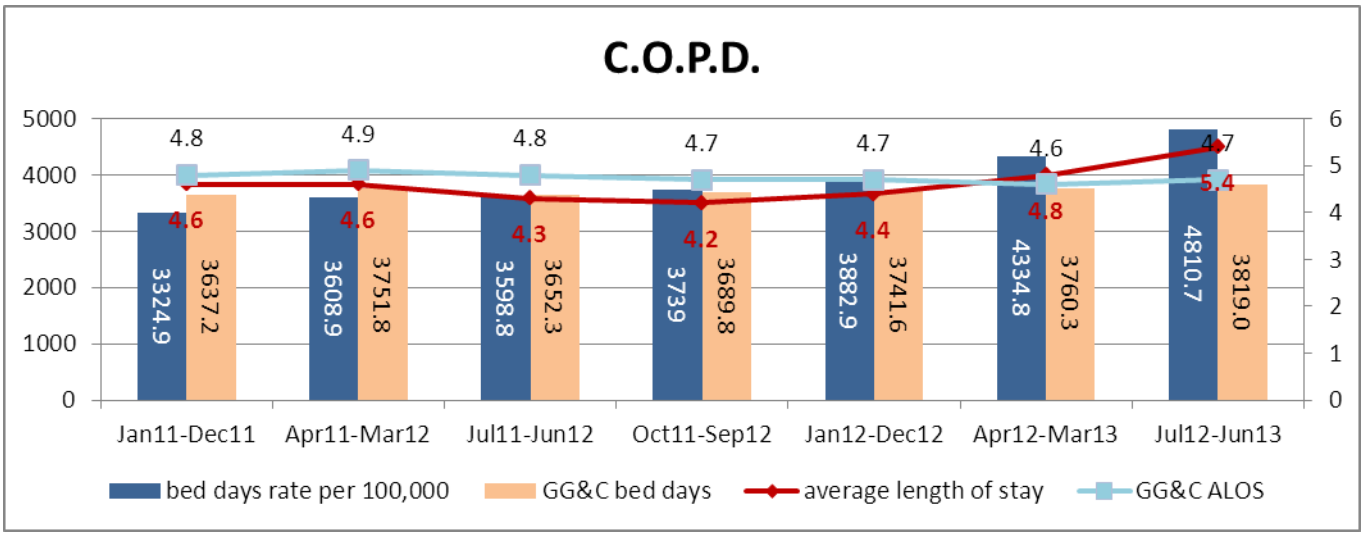
Criminal Justice social work services in Inverclyde have continued to deliver a high standard of service across the full spectrum of their responsibilities. This is evidenced above illustrating that every Criminal Justice Social Work Reports requested by courts was submitted within the agreed timescales. The service provides an underpinning resource to community safety and endeavours to ensure that individuals involved in the criminal justice system can have the best opportunity to be active, positive, respected and responsible members of our communities.

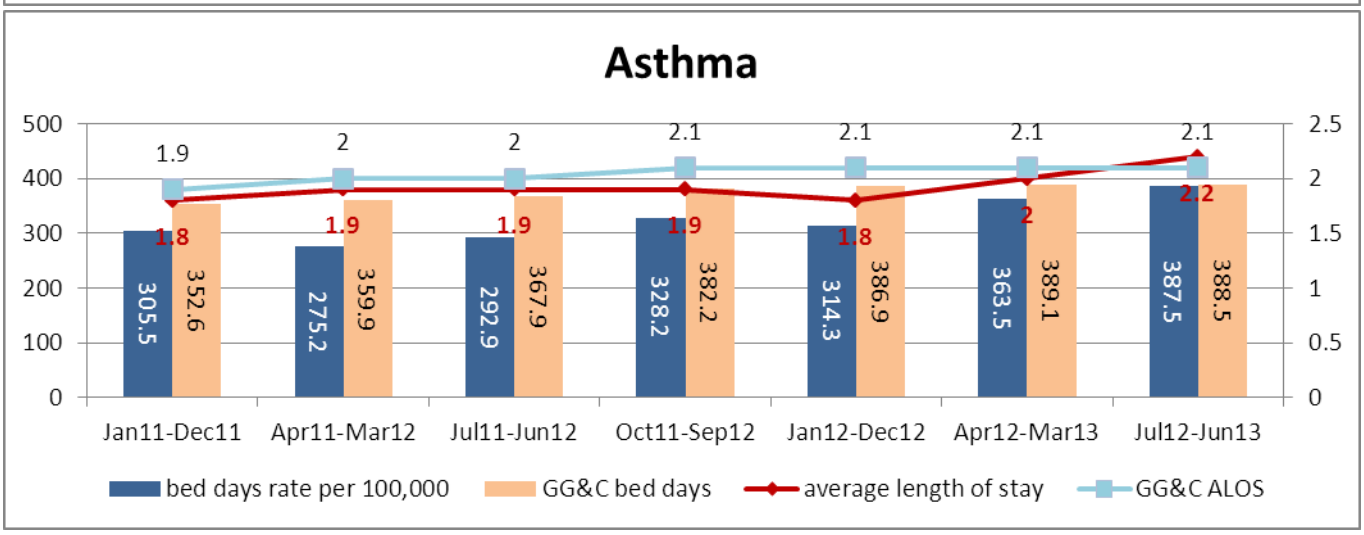
Actions

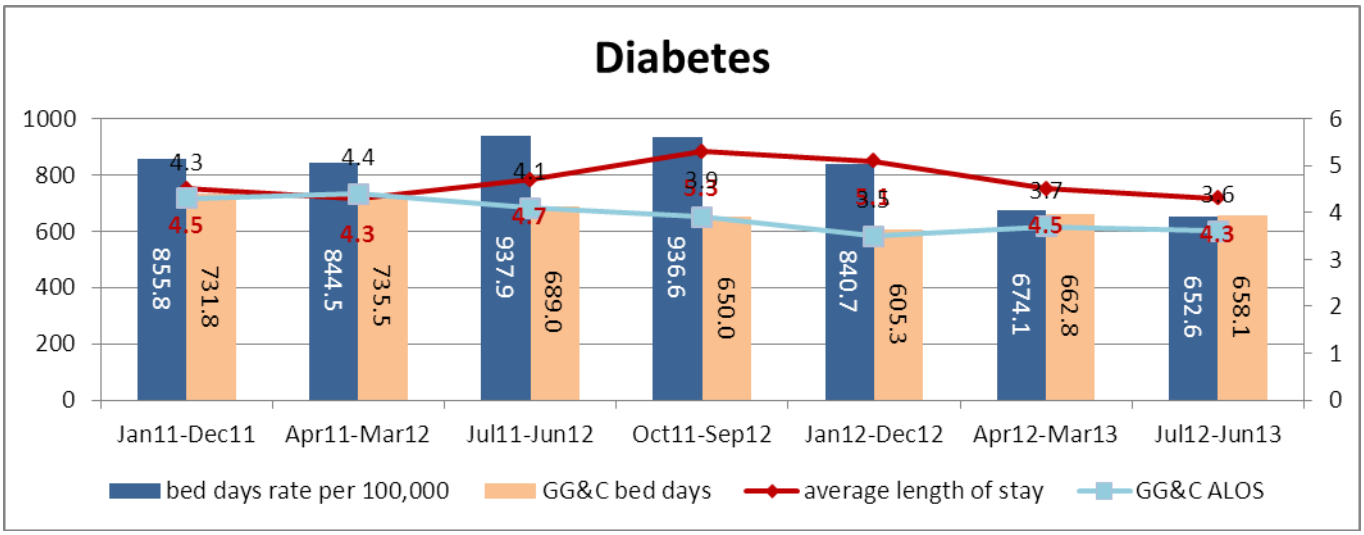
- Continue to monitor performance for this measure and ensure that we continue to deliver within agreed timescales

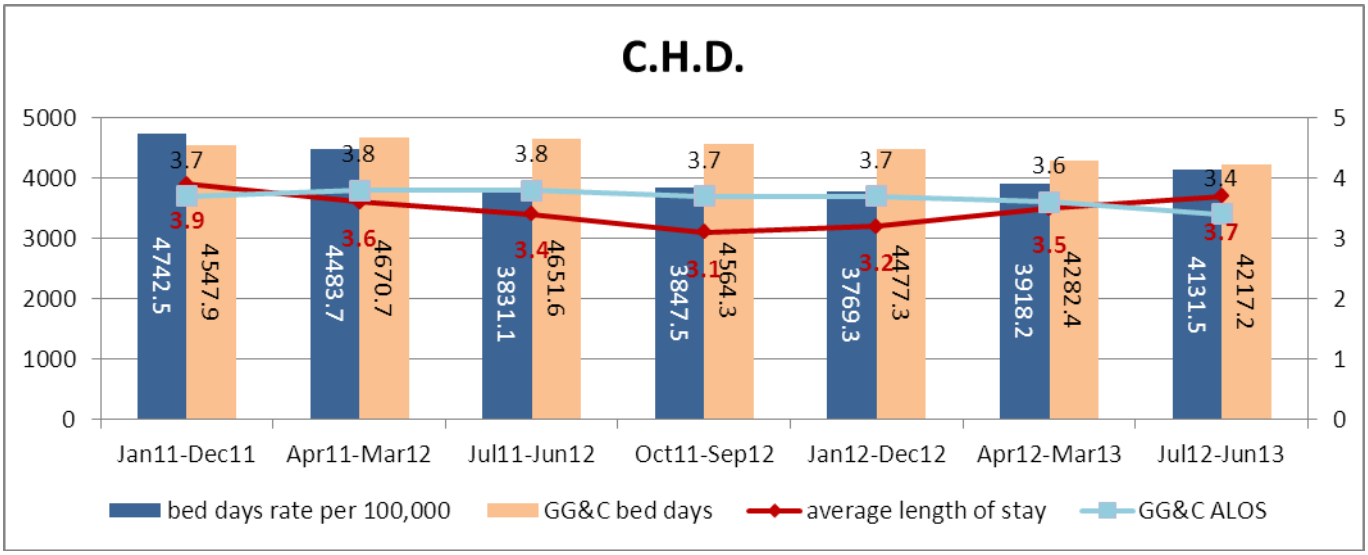
Long Term Conditions

Objective	Implement the LTC plan to reduce the use of hospital inpatient care through a collaborative approach to the patient journey
Wellbeing	**Healthy**
Measure	Reduce the number of acute bed days consumed by each LTC (Crude bed days rate per 100,000 pop)
Current Performance	COPD – 4810.7, Asthma – 387.5 Diabetes – 652.6, CHD – 4131.5









Commentary

Dialogue with acute diabetes service for development of community in-reach service to include Local Enhanced Service for Diabetes Team to support Type 1 and 2 patients with diabetes. This would allow a community approach to diabetes management moving away from traditional outpatient appointments within the acute system. Commitment to Huntington's three year project across NHS GG&C to support patient's with early Huntington's within the community. Continue to support locally patients with Multiple Sclerosis via occupational therapy rehabilitation services. Review of COPD telehealth use with increase in availability of service to patients within the community.

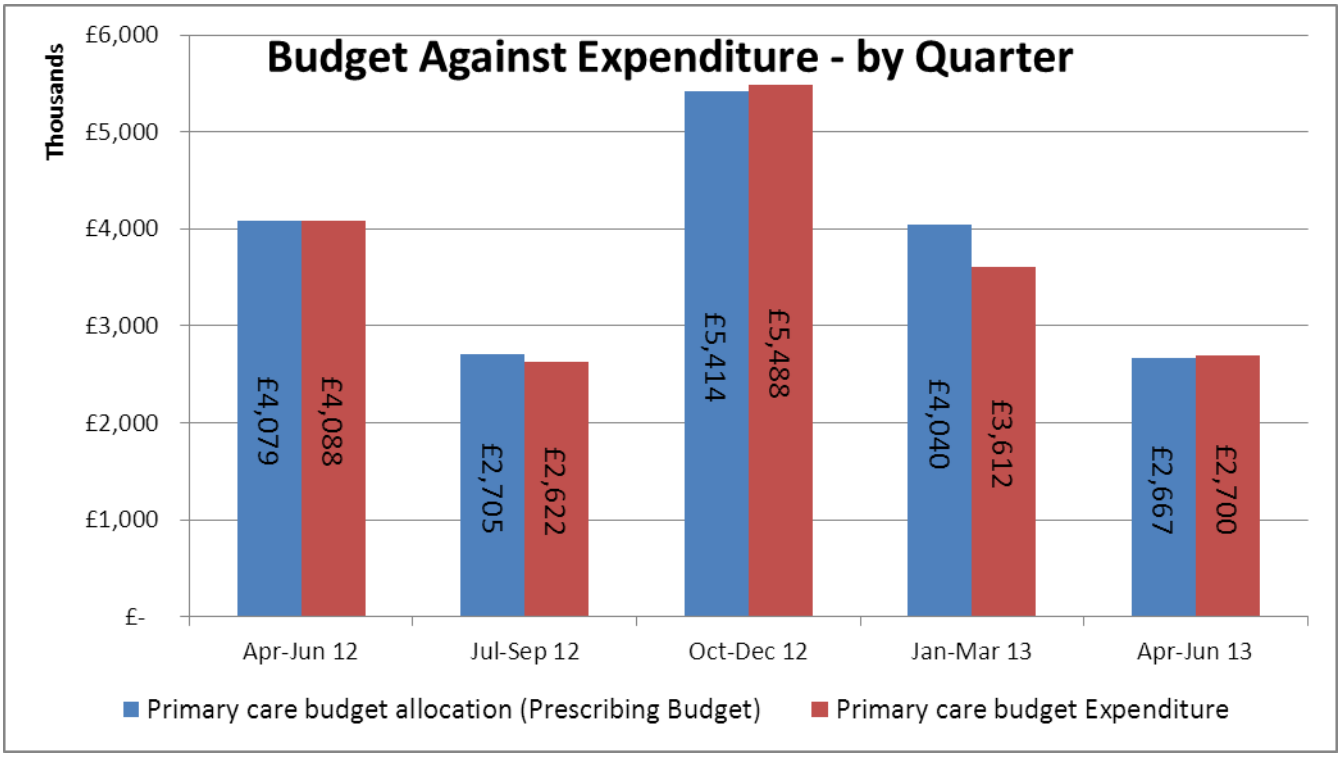
Actions

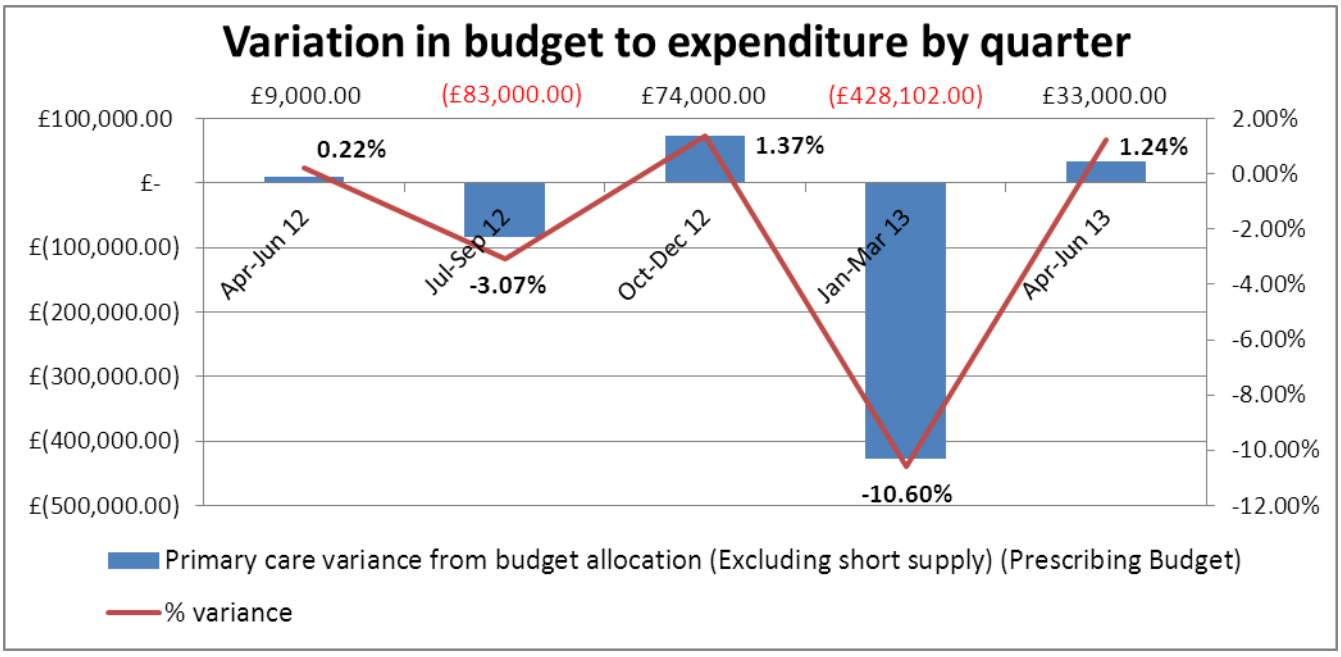
- Implement the LTC plan to reduce the use of hospital inpatient care through a collaborative approach to the patient journey to
    - Reduce hospital follow up
    - Increase range and level of community service responses to LTCs.

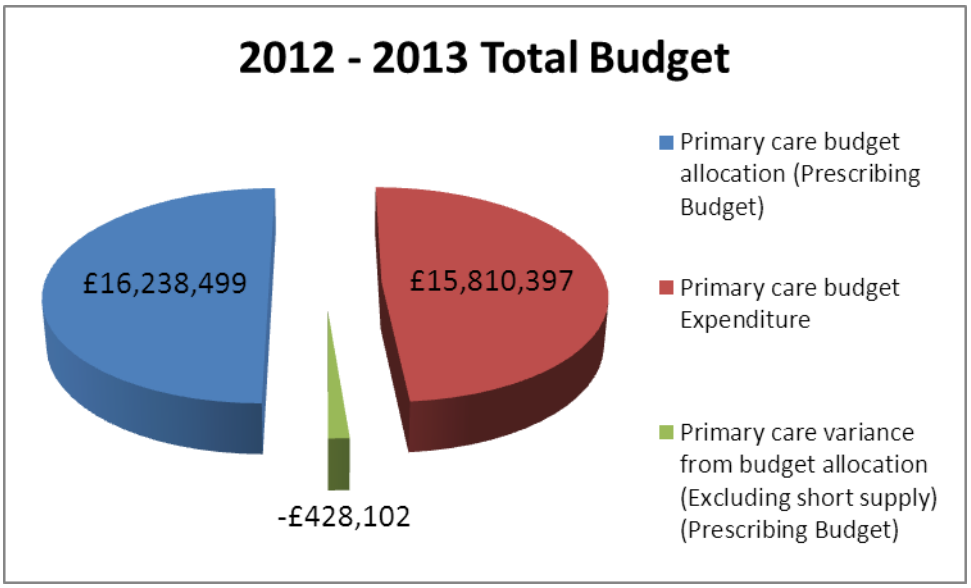
This will be supported by our work to review acute service usage data by Inverclyde patients as part of the further integration pilot

Prescribing

Objective	Ensure that money spent on medication targets need and provides best value
Wellbeing	**Healthy**
Measure	Primary care budget allocation (Prescribing Budget), expenditure and variance
Current Performance	2012-2013: 2.64% under budget 2013-2014 to June 2013: 1.24% Over budget







Commentary

A CHCP Prescribing Savings Plan is in place. 2013/2014 initiatives include

- Polypharmacy LES
- Medicines Management LES
- GMS indicators
- Medication reviews (particularly focussing on pain, respiratory, care homes, unlicensed medicines, medicines reconciliation, supporting Reablement and cost efficiency).

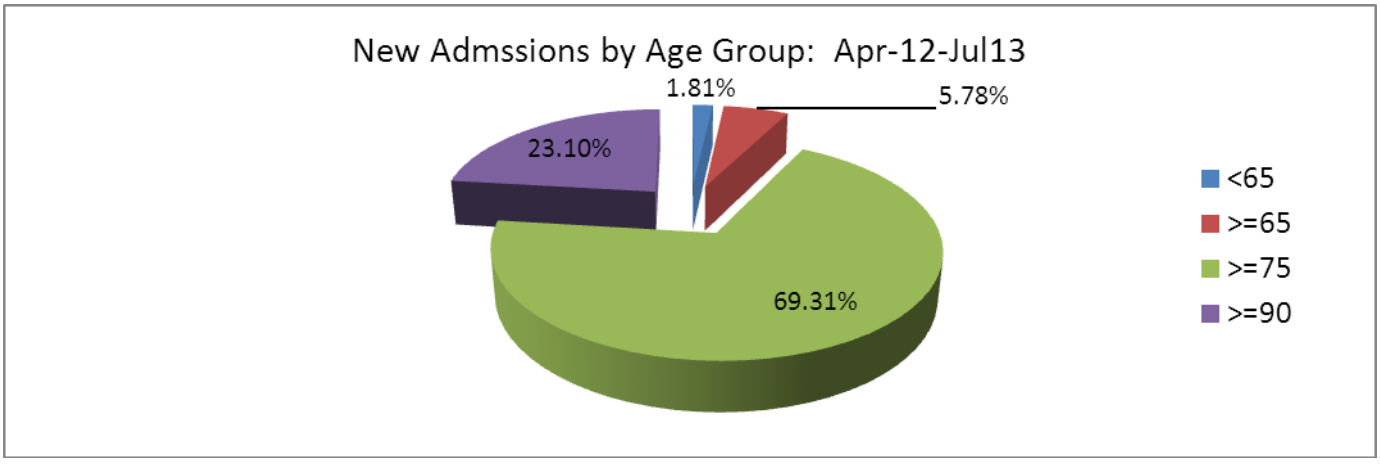
Four GPs actively participate in CHCP Prescribing Group and Prescribing is a standing item on GP Forum agenda.

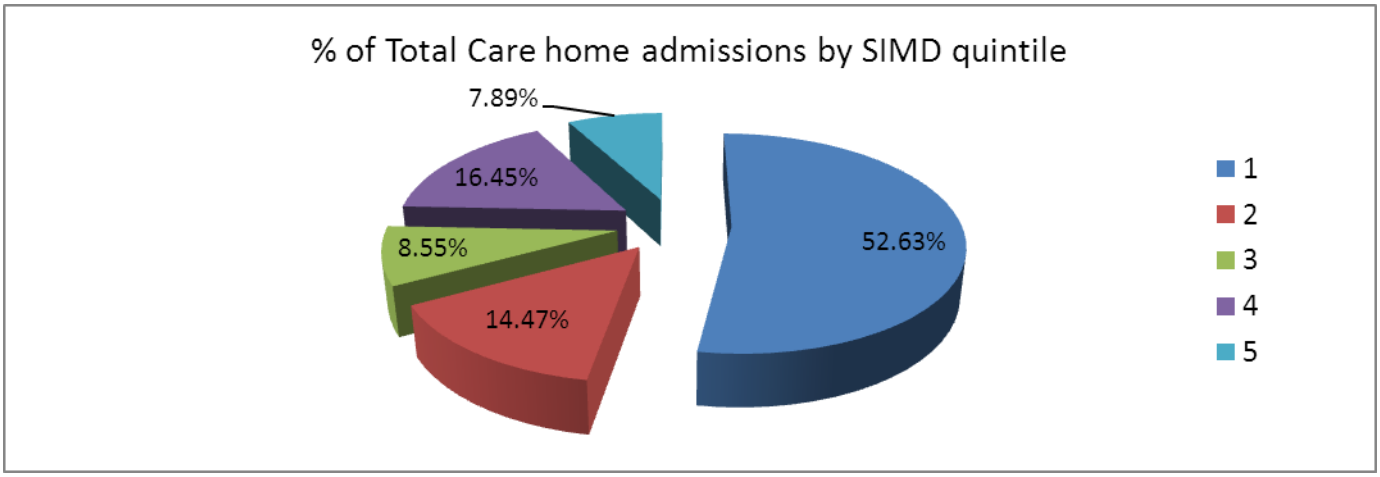
Actions

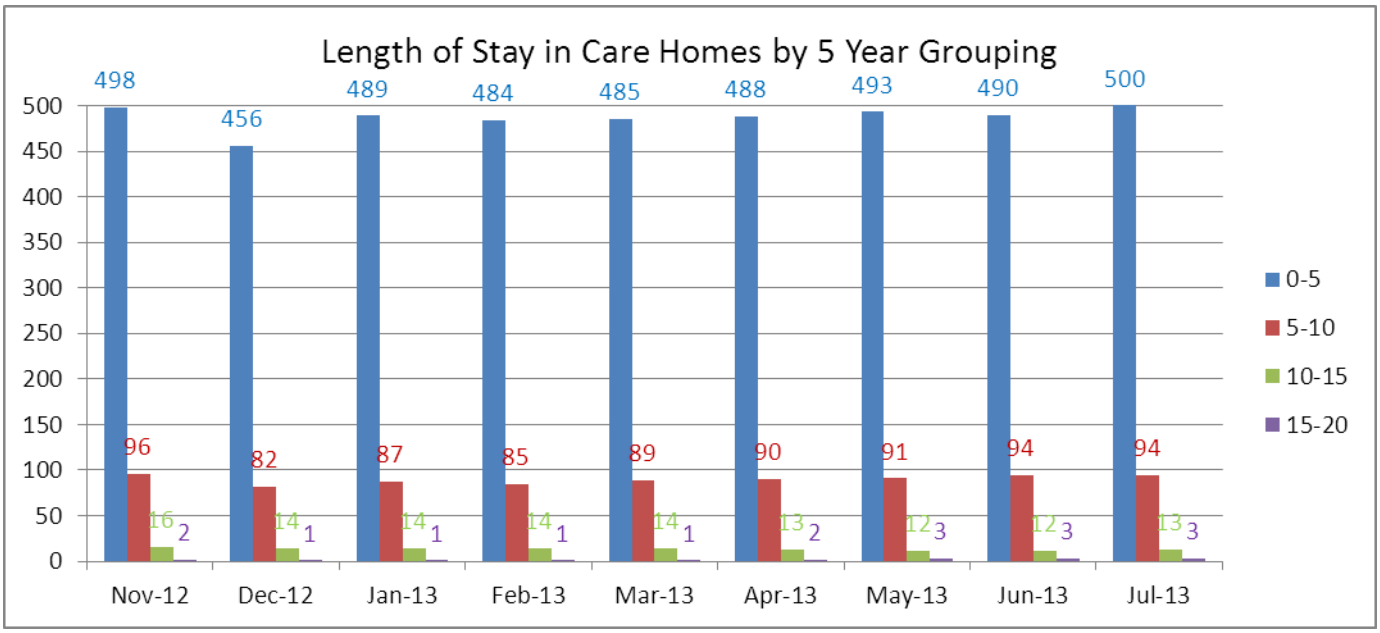
- We will continue to closely monitor our prescribing savings plan and the progress being made across the identified initiatives.

Care Home Beds

Objective	More people are cared for in settings which are appropriate for their needs
Wellbeing	**Nurtured**
Measure	Number of new admissions to care homes for people aged 65 years+
Current Performance	April to June 2013 – 54 new admissions







Commentary

From April 2012 to July 2013 there have been 227 new admissions to Care Homes in the Inverclyde LA area. The highest age group being admitted to Care Homes is in the 75-90 year old bracket. This age group accounts for nearly 70% of all the new admissions, with the next age bracket (90+) making up 23% and the other 2 age groups (under 65 and 65 – 75) making up the rest (1.18% and 5.78%).

Over half the new admissions to care homes live in the most deprived areas of Inverclyde. These areas are classified under the Scottish Governments Single Index of Multiple Deprivation (SIMD) which has a rating from 1 to 5 with 1 being the most deprived.

Long stays (10 yrs +) in Care homes remains overall fairly stable although stays in care homes between 0-5 year and 5-10 years shows a trend that is slightly increasing since November 2012. As people live longer, it is likely that the lengths of stay in the 10-15 and 15-20 lengths of stay will start to increase as the people who are currently in the lower brackets move into the upper brackets.

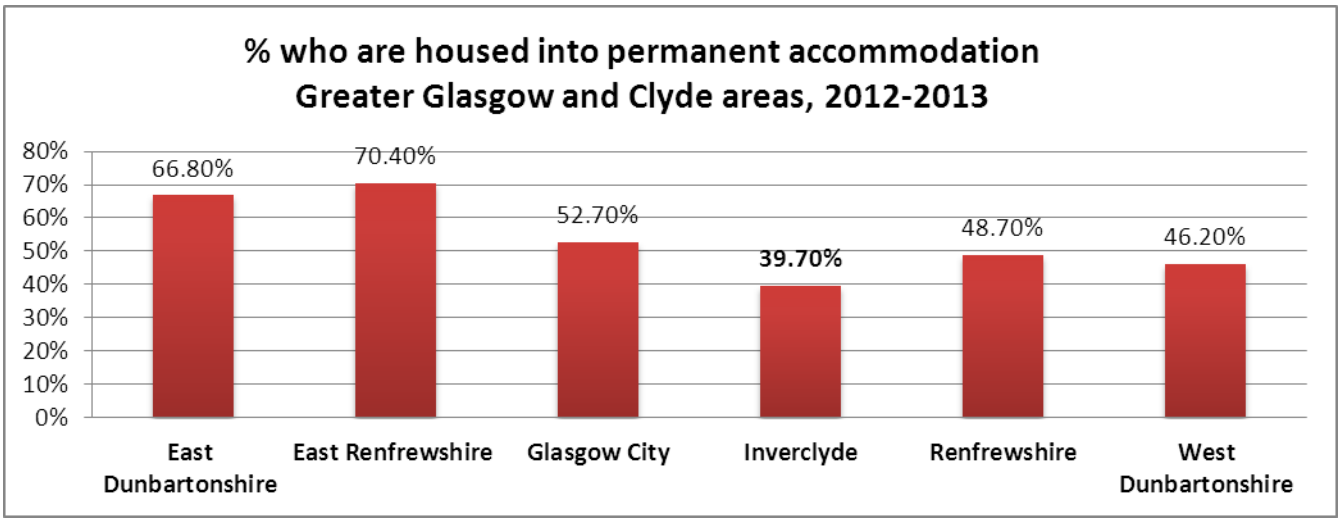
Actions

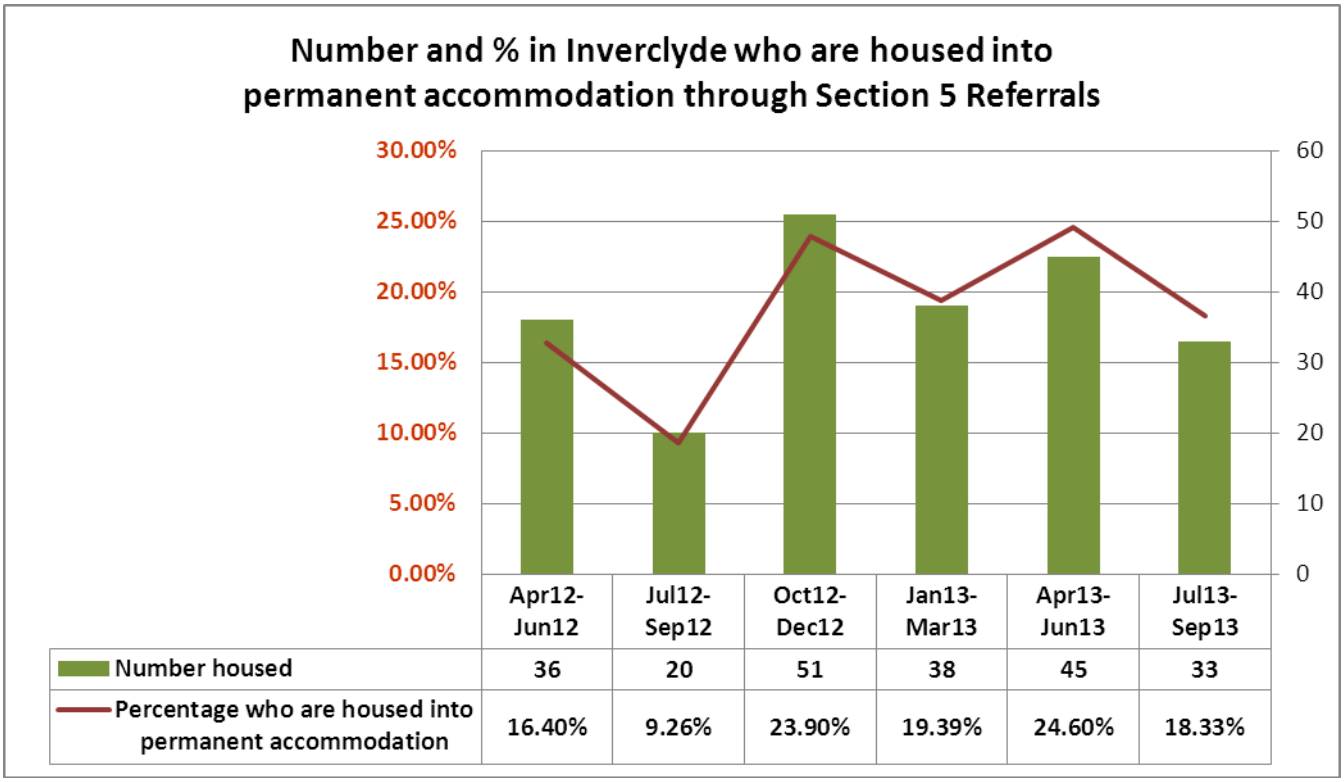
We have committed to reducing the number of older people inappropriately admitted to care homes and we are seeing a shift in the age range of those admitted, with these tending to be older with an increasing number aged over 90. We expect our increased focus on ACP, weekly monitoring of care home admissions and move to integrated teams to help us continue to shift this balance. Where admission to care home is appropriate to need, delivery of the ‘My Home Life’ development programme for care home managers in Inverclyde will improve quality of life and clinical outcomes for residents.

A number of options for intermediate care beds have been identified and these will be tested as alternatives to emergency respite or acute admission and for step down rehab where appropriate. There is much improved communication with RSL’s and we are beginning to develop much clearer transparent processes across CHCP around housing allocation including chairing multi-disciplinary housing allocations meeting to influence best use of extra care housing provision and testing processes for allocation of adapted or specialist housing with one provider.

Homelessness

Objective	Anticipate and prevent homelessness whenever possible
Wellbeing	**Safe**
Measure	Number and percentage who are housed into permanent accommodation
Current Performance	**33 (18.3%)** as at September 2013





Commentary

It is a key priority in Inverclyde to tackle and prevent homelessness and to ensure vital prevention activity continues to result in many more people avoiding the misery of homelessness.

Homelessness affects a wide diversity of households with a range of needs. It can affect those who

have suffered a disaster (such as a fire or flood), people with debt problems, people with unresolved health or addiction problems, those who have experienced abuse, family breakdown and a whole range of other circumstances. Very often a homeless person may be affected simultaneously by a number of different but interrelated issues. Homelessness affects families with children, childless couples, same sex couples, single people (both men and women), and single parents, all ethnic groups including gypsy travellers and refugees, and all age groups.

The Homelessness Service currently has 174 homeless applications with a further 195 live advice cases which have the potential to become homeless. The 174 cases are at various stages of the homeless process however of that number we have 41 single households that have been waiting re-housing for over 3 months. We are experiencing difficulty in obtaining housing for this client group due to the welfare reforms and the single room rent.

The RSL's are at the moment addressing the issues of under occupancy within their own tenancies. This is likely to place additional strain on the need for temporary accommodation. However, through our continued RSL liaison meetings this remains a topic for discussion and we are aware that one RSL is looking to expand the number of one bedroom properties in their portfolio.

Actions

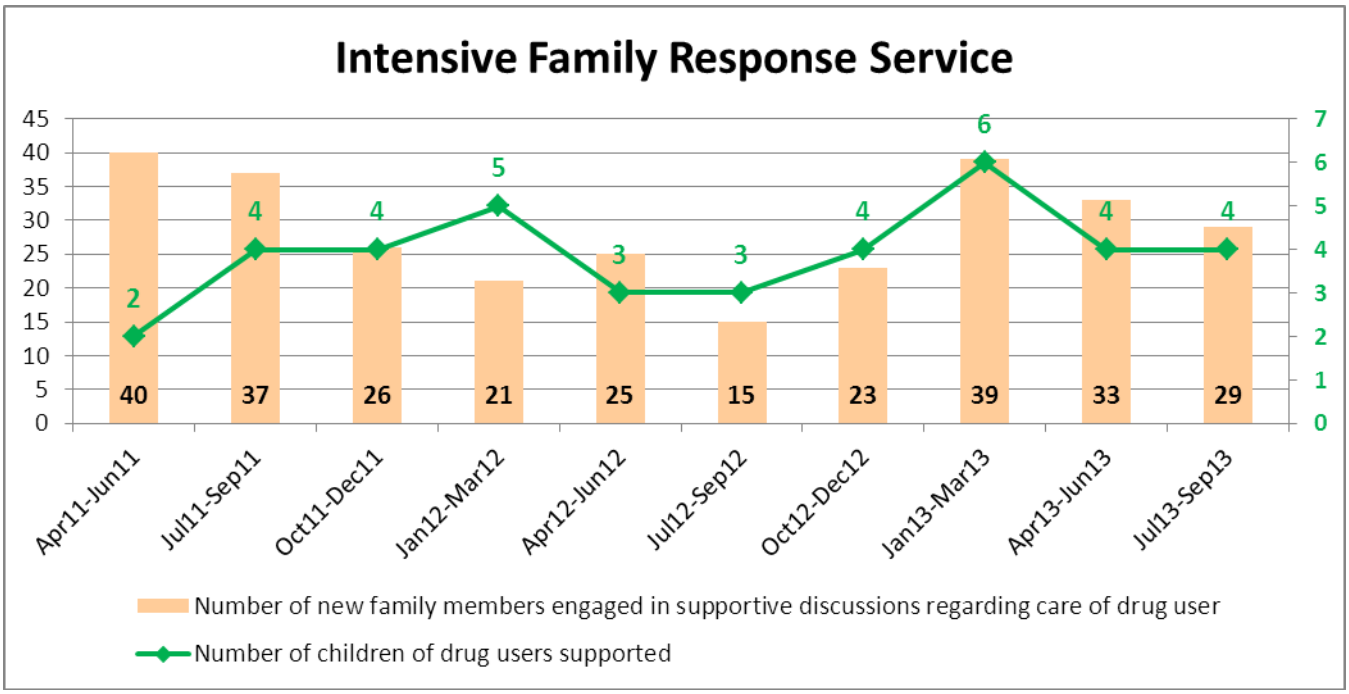
- Continue to work with RSL partners to improve the options available to homeless people through Section 5 referrals and through direct applications for housing.

- Continue to work closely with housing providers and mortgage lenders to prevent homelessness occurring as the result of eviction and repossession procedures by providing advice, assistance, and mediation services to tenants and owner occupiers.

- Continue to monitor performance on a regular basis through the new reporting framework of the Quarterly Performance Service Review.

Addictions

Objective	Supporting families, young people and children who may be providing carer support for parents with addictions issues
Wellbeing	**Nurtured** **Included**
Measure	Number of new family members engaged in supportive discussions regarding care of drug user (Included) Number of children of drug users supported (Nurtured)
Current Performance	**29** Families, **4** Children (Jul-Sep ,2013-2014) **102** Families, **16** Children (2012-2013)



Commentary

In Scotland this project is unique in terms of its governance, aims and objectives and methods of delivery. It is the only service specifically dedicated to supporting the families of those with drug dependency problems which is managed by a statutory organisation, and uses social work qualified staff. In its short life it has developed from a service with limited aims and aspirations to a holistic family care service, constantly innovating and devising new approaches to family support. These innovations have anticipated and aligned perfectly with local and national government policies aimed at tackling and reducing health inequalities.

The Intensive Family Response Service (IFRS) has taken an approach of developing the service to meet needs as they come to be recognised and prioritised. It started by promoting the service in the community, setting up support groups, and drop in centres. Recognising that stigma prevented many families from coming forward with their problems, the service formed a partnership with the local Carers Centre and provided many services from there. This had the dual advantage of reinforcing that carers of drug users were indeed carers and had needs just as other carers, and ensuring that these carers were introduced to wider health, welfare and financial support resources in the area.

IFRS have also linked local support groups into national family support networks through Scottish Families Against Drugs (SFAD), Family Addiction Support Services (FASS) and IFRS arrange for groups to attend national seminars of these agencies.

Starting with one support worker it was soon found that the needs of the area were overwhelming. Families presented with a broad range of issues - psychological, relationship, physical health, financial and practical. Parents with drug using sons and daughters were not only trying to help them but often being left with the care of grandchildren. A decision was made to bring in an additional Qualified Social Worker to better meet the needs. As it became apparent that there were limited services to support children of drug users IFRS set up its own, developing a model of work involving individual supports to these children incorporating personal workbooks and discussion as well as fun outings, all aimed at lifting their morale and self esteem.

With a number of families experiencing one or more bereavements through drugs IRFS again identified a gap in support services for these clients, and undertook to provide this. Reflecting the workers' strong desire to provide the best service the Social Worker undertook a new qualification in Bereavement Counselling, while the other worker sought a further qualification in the Psychology of Addiction.

IFRS takes its message to the wider community in a number of ways - by delivering training to other agencies; by developing a website page which allows families to make contact, ask questions and just learn about the resource and by taking part in national and local health awareness events.

IFRS is now playing a significant role in Adult Protection as parents, particularly elderly parents often find themselves being bullied and abused by the drug user. IFRS now offers families access to leisure passes for local sports resources and accesses complementary therapies for families to relieve stress.

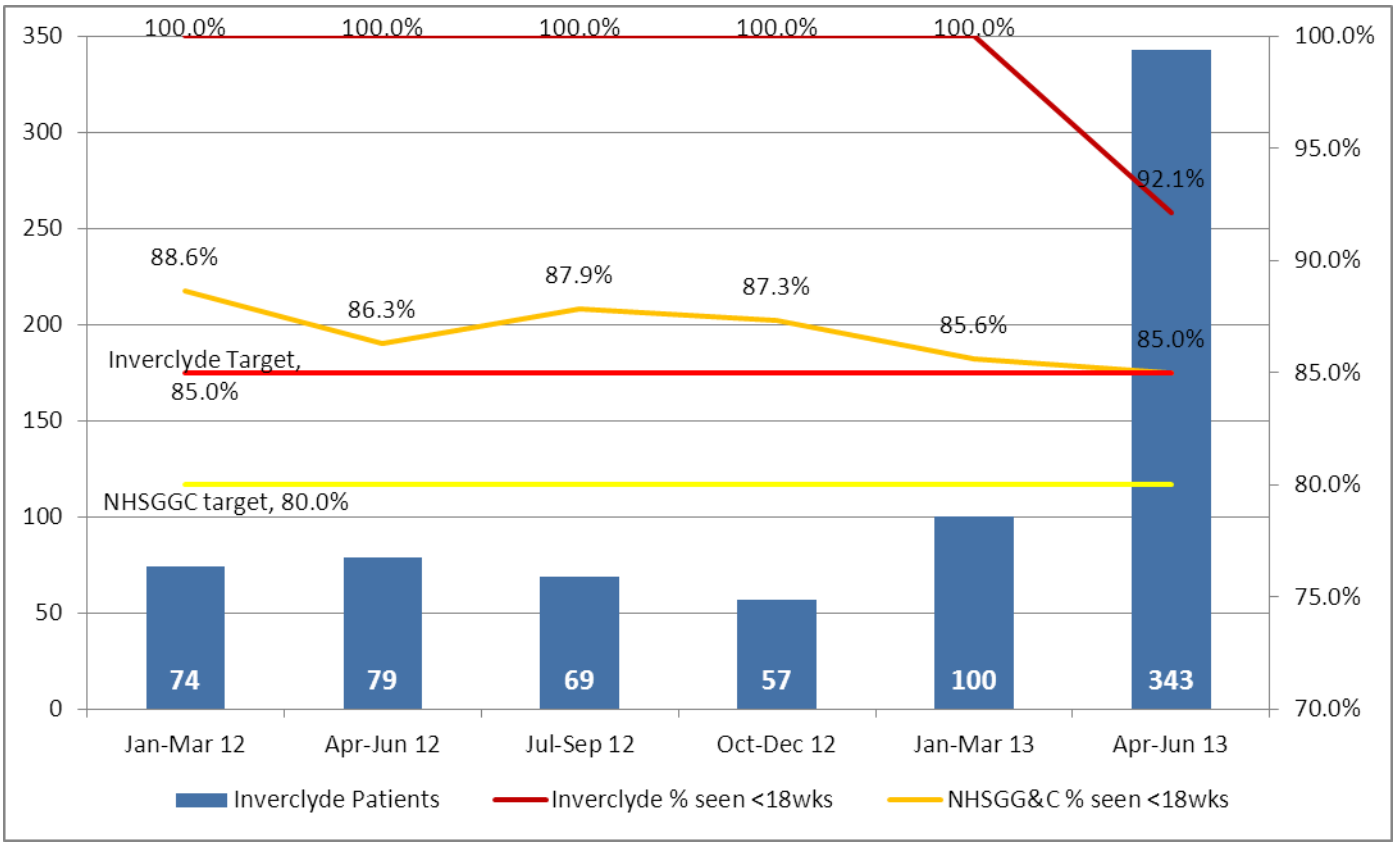
It should also be noted that the Project was recently submitted for a COSLA Excellence Award.

Actions

- Confirming permanent funding which would allow for more extensive forward planning, longer term goal setting and prioritization, as well as ensuring the retention of highly skilled and experienced staff.
- Continue to disseminate information about carer's addiction issues and the support available for children and young people.
- Continue to provide access to addictions training for those who come into contact with children and young people where parental substance misuse is impacting on their lives.
- Continue to provide education in schools around awareness of drug misuse issues
- Map local provision of information and education about addictions to young people from ADP Partner agencies and identify gaps.
- Continue to monitor performance on a regular basis through the Quarterly Performance Service Review process.

Psychological Therapies

Objective	People who need psychological therapies will be able to access them in a timely manner
Wellbeing	**Healthy**
Measure	% Patients who started treatment within 18 weeks of referral:
Current Performance	92.1% as at June 2013



	Jan-Mar12	Apr-Jun12	Jul-Sep12	Oct-Dec12	Jan-Mar13	Apr-Jun13
Inverclyde	**100%**	**100%**	**100%**	**100%**	**100%**	**92.1%**
East Renfrewshire	**97.3%**	**90.3%**	**100%**	**58.3%**	**56.0%**	**77.7%**
Renfrewshire	**93.9%**	**84.4%**	**85.5%**	**87.9%**	**97.4%**	**84.1%**
West Dunbartonshire	**80.0%**	**69.8%**	**76.3%**	**92.9%**	**78.6%**	**85.8%**
Glasgow City	**79.6%**	**81.2%**	**82.8%**	**79.8%**	**74.2%**	**81.2%**
GG&C	**88.6%**	**86.3%**	**87.9%**	**87.3%**	**85.6%**	**85.0%**

Commentary

The Psychological Therapies HEAT target is aimed at improving access to mental health services and requires that by December 2014 no-one will wait longer than 18 weeks from referral to the start of a

psychological therapy treatment.

The HEAT Target is a measure of all psychological therapies being delivered by health services across the Board area and includes the following care groups in both inpatient and community settings: - Adult Mental Health, Older Peoples Mental Health, CAMHs (beyond March 2013), Forensic Services, and where there is an associated mental health problem in Learning Disability, Addiction and Acute Physical Health Services.

Within Inverclyde teams/services are migrating the recording of their activity to the Patient Management Information System (PiMS) – there is a PiMS implementation plan in place for this migration process.

Currently, the Primary Care Mental Health Team average of 22 days for referral to initial assessment – 73% under 28 days (a special GG&C target), with remaining patients not seen in the target timescale due to their own choice or circumstances rather than service reasons. Self referral has dedicated admin in place.

The dramatic increase in number of patients seen in the period Apr–Jun 13 is a data-recording phenomenon – it is due to the inclusion of CMHT and Psychology patients in the PiMS reporting process from that point onwards. Prior to that, the reported data only referred to PCMHT cases.

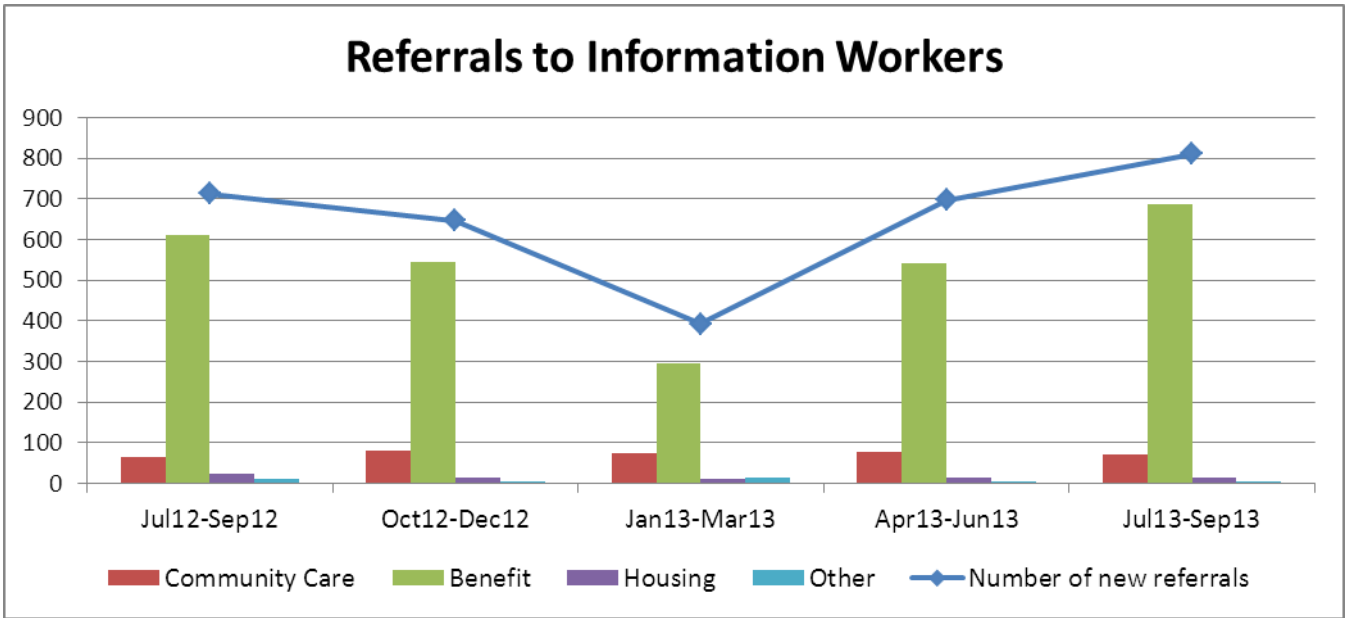
Patients who are not seen within the 18 weeks target as recorded from Apr 2013 are mostly Psychology patients, and the main reason is the recruitment difficulty the Psychology Team is facing. There is a vacant Psychologist post from the beginning of this year, and although a new psychologist has now been appointed, she will not start until April 2014. In the meantime, the Psychology Team has taken the interim measures of increasing the hours of one part-time psychologist and trying to use the budget underspend to employ a temporary therapist, in order to enhance clinical capacity.

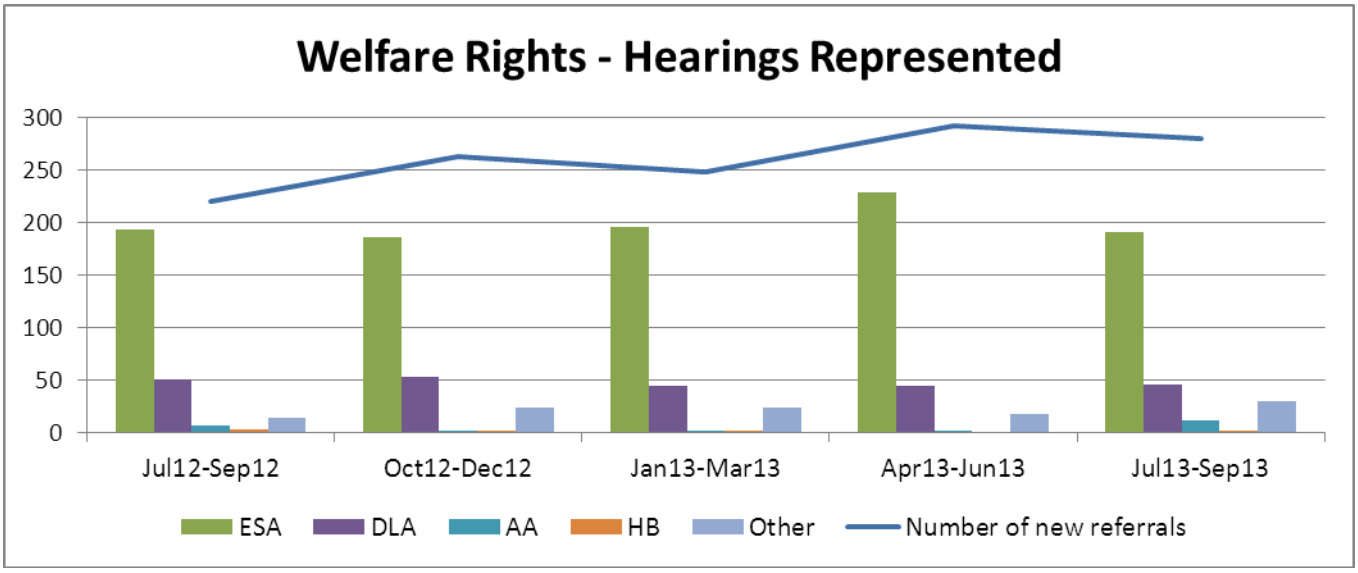
Actions

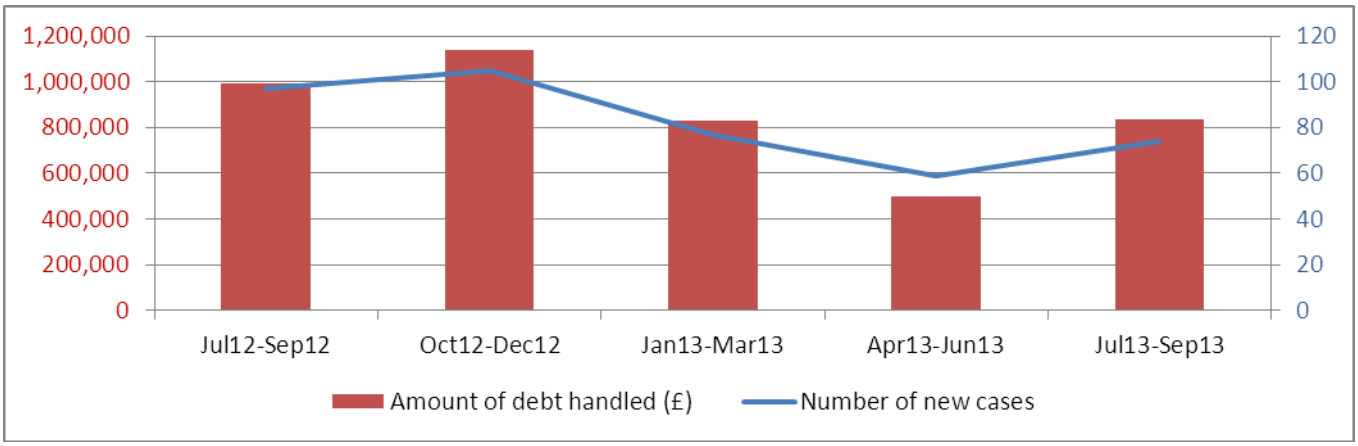
- Continue to monitor performance for this measure and ensure that the information from the data is used to better understand the capacity of the service to meet the demands of the service users and to guide service improvements.
- The Psychology Team will continue to manage the issue of clinical capacity robustly.

Advice Services

Objective	To provide a robust Advice Service for the people of Inverclyde.
Wellbeing	**Included**
Measure	Advice Services: Information Workers referrals, Welfare Rights Hearings and Debt Advice
Current Performance	







Advice Services - Information Workers	Jul12-Sep12	Oct12-Dec12	Jan13-Mar13	Apr13-Jun13	Jul13-Sep13
Number of new referrals	714	647	392	698	811
Community Care	65	81	73	79	71
Benefit	613	546	295	543	688
Housing	24	14	11	13	14
Other	12	6	13	4	5
Advice Services - Welfare Rights					
Number of new referrals	220	263	248	292	280
ESA	194	186	196	229	191
DLA	51	53	45	44	46
AA	7	2	1	1	11
HB	3	2	2	0	1
Other	14	24	24	18	30
Advice Services - Debt Advice					
Number of new cases	97	105	77	59	74
Amount of debt handled (£)	991,088	1,136,941	827,265	500,453	833,751

Commentary

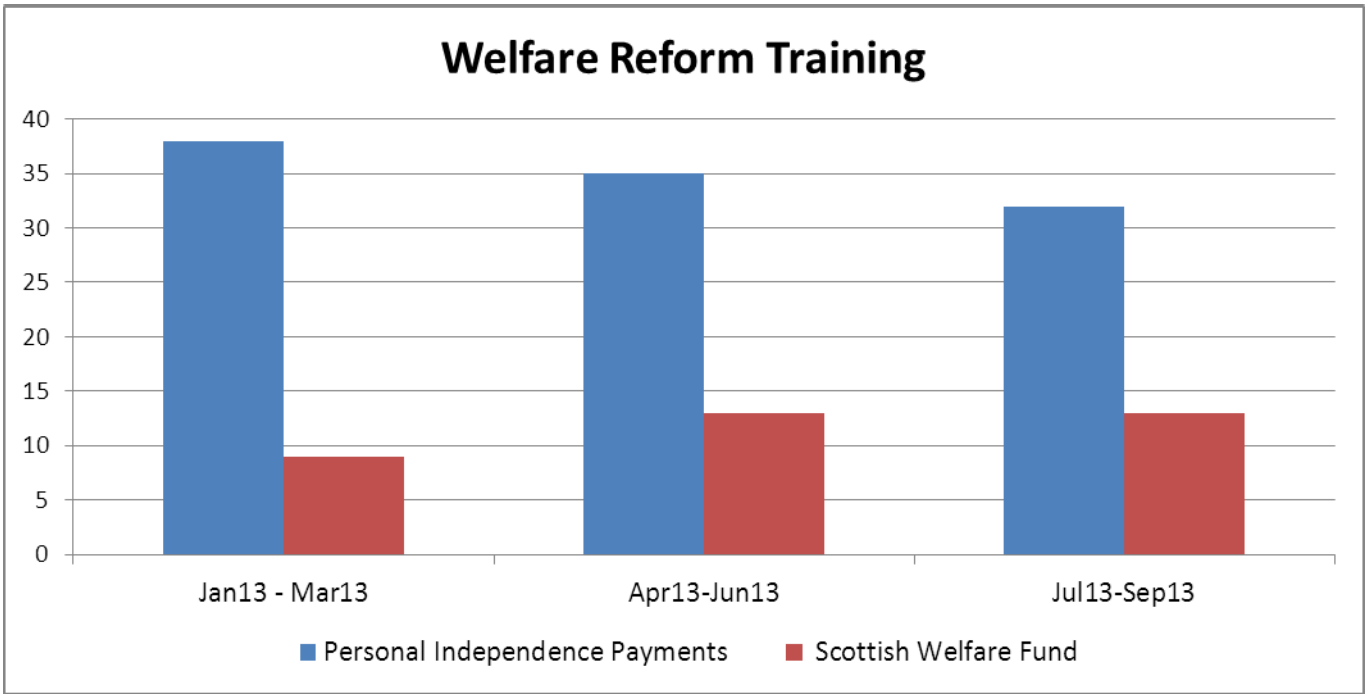
- Welfare reform has impacted on the advice services team with clients presenting with a more complex range of issues looking for advice and support. The team have responded to this through a range of support mechanisms including more telephone triage, outreach sessions etc.
- The ongoing issue of client recording and robust performance management for the advice services team is of major concern however we are currently procuring a robust case management system for this team which will also be utilised by a range of financial inclusion partners.
- The advice services team have continued to develop close working relationship with a range of partners involved in the Inverclyde Financial inclusion partnership will a range of joint bids being submitted to new funding streams.

Actions

- Recruitment of new posts funded through additional monies
- Procurement of case management system
- Development of resources for staff and clients to use particularly around PIP and the move to universal credit.

Welfare Reform Training

Objective	Provide staff with knowledge of reforms in welfare system to be able to advise Service Users
Wellbeing	**Achieving**
Measure	Number of staff attending Welfare Reform training sessions
Current Performance	PIP – 67, SWF – 26 at September 2013 (218 for 2012/13)



Number of staff attending Welfare Reform training sessions	Jan13 - Mar13	Apr13-Jun13	Jul13-Sep13
Welfare Reform	171		
Personal Independence Payments	38	35	32
Scottish Welfare Fund	9	13	13

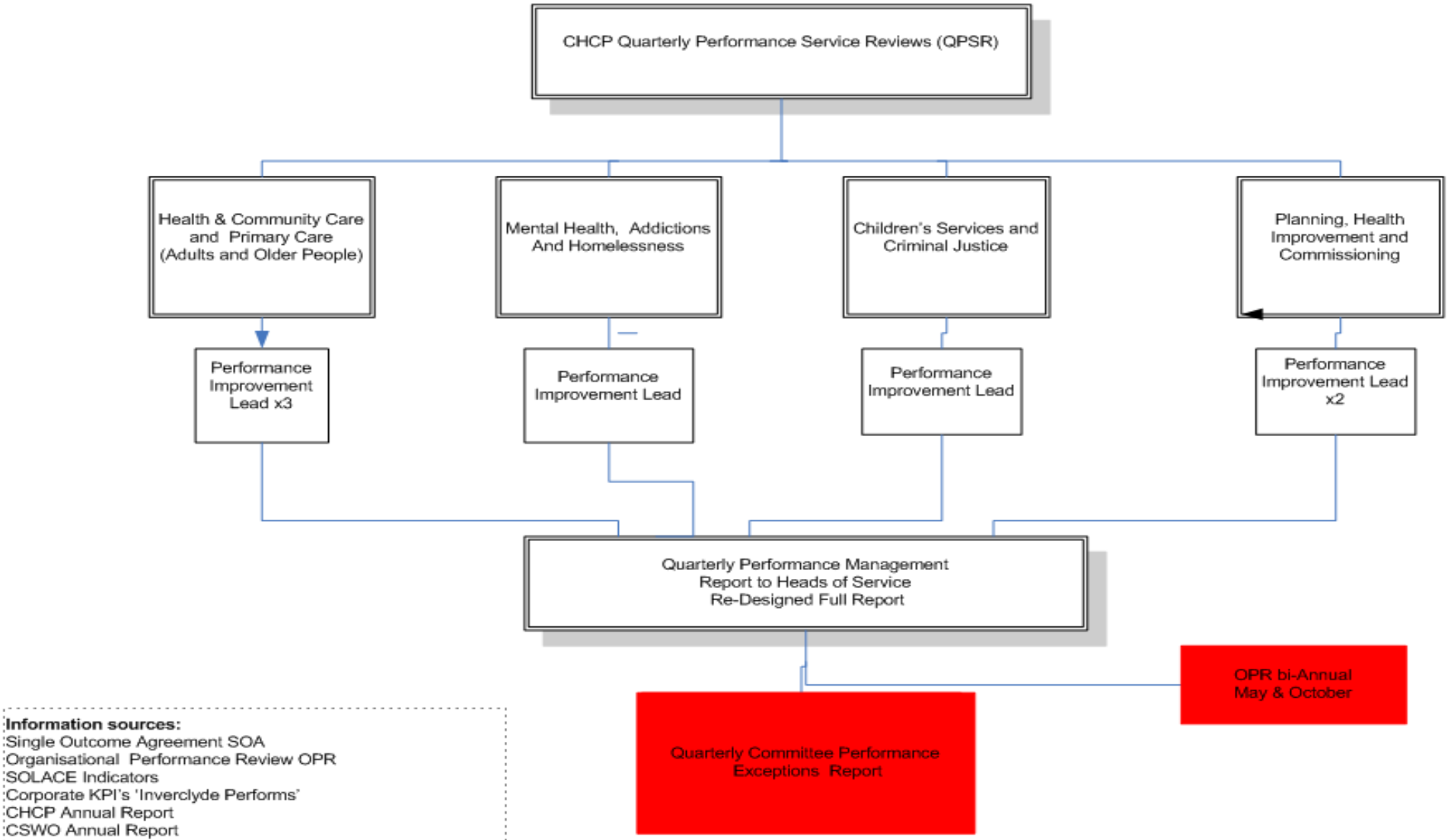
Commentary

- The advice team have provided a robust training programme on Welfare Reform to many CHCP staff and in addition developed a range of resources and materials for staff and clients to use.

Actions

- Continue to deliver a programme of training for CHCP staff and in particular encourgae NHS staff to attend to ensure they have a good awareness and understanding of welfare reform in order to best support their clients

Appendix 2


CHCP Quarterly Performance Service Reviews (QPSR)
Health & Community Care and Primary Care (Adults and Older People)
Mental Health, Addictions And Homelessness
Children's Services and Criminal Justice
Planning, Health Improvement and Commissioning
Performance Improvement Lead x3
Performance Improvement Lead
Performance Improvement Lead
Performance Improvement Lead x2
Quarterly Performance Management Report to Heads of Service Re-Designed Full Report
OPR bi-Annual May & October
Quarterly Committee Performance Exceptions Report
Information sources:
Single Outcome Agreement SOA
Organisational Performance Review OPR
SOLACE Indicators
Corporate KPI's 'Inverclyde Performs'
CHCP Annual Report
CSWO Annual Report
Councillor Enquiries
FOI Requests
Complaints
Directorate Plan
New Proposed Health Measures
SG Early Years Collaborative Approach Workstream Indicators

Appendix 3

Inverclyde CHCP: SOLACE Indicators Analysis

2010-11 - 2011-12

SOLACE : CHCP	Ranking (2011-12)	Quartile
Indicator CHN8a: The gross cost of 'children looked after' in residential based services per child per week	**21 ***	**3**
Indicator CHN8b: The gross cost of 'children looked after' in a community setting per child per week	**3 ***	**1**
Indicator CHN 9: The % of children looked after cared for in the community	**16 ****	**3**
INDICATOR SW 1: Home Care Costs per Hour (65 and over)	**11 ***	**2**
INDICATOR SW2: Self Directed Support Spending on Adults 18+ as a % of total SW spend on adults 18+	**24 ****	**3**
INDICATOR SW 3: % people 65+ with intensive needs receiving care at home	**17 ****	**3**
SW4: % adults satisfied with social care of social work services	**10 ****	**2**

*** Costs rank 1 means lowest cost and rank 32 highest costs**

****rank=1 highest**

Children and Families

There are several indicators that relate to looked after children that can be considered together:

Indicator CHN8a: The gross cost of 'children looked after' in residential based services per child per week

Indicator CHN8a: The gross cost of 'children looked after' in residential based services per children per week							
Inverclyde 2011/12	Ranking	National Mean	Median	LA Quartile	2010/11	2010/11 Ranking	Change in Rank
£3064	21st	£3276	£2776	3rd	£3109	22nd	1

- **Cost reduced in 2011-12 by -1.4% placing Inverclyde in ranking place 21 from 22 the previous year and LA Quartile 3rd.**

Indicator CHN8b: The gross cost of 'children looked after' in a community setting per child per week

Indicator CHN8b: The gross cost of 'children looked after' in community based services per child per week							
Inverclyde 2011/12	Ranking	National Mean	Median	LA Quartile	2010/11	2010/11 Ranking	Change in Rank
£101	3rd	£ 209	£211.2	1st	£93.88	3rd	0

- **Costs increased in 2011-12 by 7.6% however ranking remains in 3rd place and LA Quartile 1st**

Indicator CHN 9: The % of children looked after cared for in the community

Indicator CHN8b: The gross cost of 'children looked after' in community based services per child per week							
Inverclyde 2011/12	Ranking	National Mean	Median	LA Quartile	2010/11	2010/11 Ranking	Change in Rank
90.3%	16th	89.4%	89.9%	3rd	89.1%	17th	1

- **A slight increase to 90.3% in 2011-12 brings Inverclyde into 16th ranking place and above the national median percentage rate for the balance of care.**

What the Data Tells Us

The data shows that costs for children looked after in a residential setting are above the national median, however Inverclyde's costs are significantly lower that other authorities when it comes to children that are looked after in a community based setting. The percentage of children looked after /cared for in the community fell marginally below the average and median in 2010-11 but shifted a ranking point in 2011-12 increasing to 90.3%

Social Work

INDICATOR SW 1: Home Care Costs per Hour (65 and over)

Performance Data:

Indicator SW1: Home Care Costs per Hr (65 and over)							
Inverclyde 2011/12	Ranking	National Mean	Median	LA Quartile	2010/11	2010/11 Ranking	Change in Rank
£16.35	11th	£18.80	£19.46	2nd	£19.37	13th	2

What the Data Tells Us

The data shows that Inverclyde's homecare costs for those aged over 65 fell slightly in 2011/12, leading to an improvement in ranking relative to other authorities. Inverclyde's costs are also lower than the national average and median.

INDICATOR SW2: Self Directed Support Spending on Adults 18+ as a % of total SW spend on adults 18+

Performance Data:

Indicator SW2: Self Directed Support spending on adults 18+ as a % of total SW spend on adults 18+							
Inverclyde 2011/12	Ranking	National Mean	Median	LA Quartile	2010/11	2010/11 Ranking	Change in Rank
0.8%	24th	2.6	1.6	3rd	0.6%	25th	1

What the Data Tells Us

The data for the above indicators shows that Inverclyde's SDS costs increased slightly from 2010/11 to 2011/12. The costs vary widely between councils from 18% in Eilean Siar to 0.1% in West Dunbartonshire (2011/12 figures). Inverclyde's costs are well below the Scottish average and median.

INDICATOR SW 3: % people 65+ with intensive needs receiving care at home

Performance Data:

Indicator SW3: % of people with 65+ with intensive needs receiving care at home							
Inverclyde 2011/12	Ranking	National Mean	Median	LA Quartile	2010/11	2010/11 Ranking	Change in Rank
35.6%	17th	33.3%	36.2%	3rd	37.9%	10th	-7

What the Data Tells Us

The data shows that there has been a slight fall in the number and % of people aged 65+ with intensive needs receiving care at home, although the percentage is higher than in Inverclyde than the national average, however it is slightly lower than the Scottish median.

INDICATOR SW4: % adults satisfied with social care of social work services

Performance Data:

Indicator SW4: % adults satisfied with social care of social work services				
Inverclyde %	**Ranking**	**National Mean**	**Median**	**Quartile**
67.6%	**10th**	**63%**	**62.8%**	**2nd**

What the Data Tells Us

There are concerns about the robustness of data extracted from the Scottish Household Survey, particularly for smaller Councils. This has been recognised by SOLACE and the Improvement Service and the use of SHS survey data is a short term measure.

Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 7

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 9th January 2014**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/03/2014/SMcCR**
Contact Officer:	**Susanna McCorry-Rice Head of Service, Mental Health Addictions and Homeless**	**Contact No: 01475 715375**
Subject:	**WORKING TOWARDS A DEMENTIA FRIENDLY INVERCLYDE: INVERCLYDE'S DEMENTIA STRATEGY**	

1.0 PURPOSE

1.1 To update the CHCP Sub-Committee of progress in respect of the Inverclyde Dementia Strategy and to specifically consider the following;

i. Consultation feedback
ii. Final Strategy and Implementation Plan

1.2 To build on previous reports to the CHCP Sub-Committee, update the position in relation to Inverclyde's response to Scotland's First National Dementia Strategy, 2010 and set this in context with the publication of Scotland's Second National Dementia Strategy 2013.

1.3 To advise the CHCP Sub-Committee of the feedback from the public consultation in respect of Inverclyde's Draft Dementia Strategy and proposals for the implementation of the Strategy.

2.0 SUMMARY

2.1 The Sub-Committee received a report in February 2013 in respect of the development of a local Dementia Strategy for Inverclyde.

2.2 Inverclyde's Draft Dementia Strategy and Consultation were launched in April 2013; the consultation period was extended until the end of August 2013 to allow more time for feedback.

2.3 Feedback from the consultation indicated that the draft strategy had been well received with wide ranging support for the emphasis for people with Dementia to live and participate fully and actively in the community. Suggestions were received for more detailed references and linkages being made with other Council wide strategies. Suggestions were also made about developing targeted awareness raising campaigns both among agencies, professionals and within the broader community to embed good practice and support promotion of a 'Dementia Friendly Inverclyde'.

2.4 The consultation responses relate to the need to focus on the following areas:

- Involvement and Consultation arrangements
- Communication strategy - communication materials

- Learning and development
- Linking with other strategies
- Promoting a Dementia Friendly Inverclyde

2.5 These themes will be addressed through incorporating the feedback from the consultation within the more detailed implementation plan. This will be done by setting up work streams through relevant subgroups to develop and implement actions and further embed good practice in dementia care.

2.6 The aim will be to accelerate action to:

- Promote a Dementia Friendly Inverclyde
- Promote Excellence- education, learning and development.
- More emphasis on Housing, design how adaptations, Telehealthcare and Reablement can support people with Dementia in the community.
- Continue to build on what we are doing.
- Have a focus on community development.

3.0 RECOMMENDATIONS

3.1 The CHCP Sub Committee is asked to note the ongoing work and progress being achieved in respect of the Inverclyde Dementia Strategy and developments and proposals as set out in this report.

3.2 The CHCP Sub Committee is asked to endorse Working Together Towards a Dementia Friendly Inverclyde, the Inverclyde Dementia Strategy for 2013 -16, and the Implementation Plan (Appendix A).

3.3 The CHCP Sub Committee is asked to support the investment of £70,000 as outlined in para 5.2 to implement the Dementia Strategy (Appendix B).

3.4 The CHCP Sub Committee is asked to receive annual reports on the updating of the Strategy and Implementation Plans.

Brian Moore
Corporate Director
Inverclyde Community Health & Care
Partnership

4.0 BACKGROUND

The CHCP Sub-Committee has received reports on the requirements of Scotland's National Dementia Strategy, 2010 with updates on Inverclyde's response in 2012 and 2013. Local work has been informed by two key areas for service delivery change in respect of improving support after diagnosis and improving care within general hospital. The first national strategy emphasised change across the whole system of health and social care to improve our work with people and dementia and their families

4.1. The second national Dementia Strategy for Scotland was published in June 2013.

The Strategy is continuing with work already underway from 2010, with a greater emphasis on the following areas;

- Consolidate and build upon the work taken forward since 2010;
- Identify areas where extra support and leverage are needed to support service transformation; and
- Promoting Dementia Friendly Communities

4.2 The national strategy describes three main challenges which will continue to require to be addressed over the next three years. These are:

- Care and support to people with Dementia and their families and carers must be offered in a way which promotes wellbeing and quality of life, protects their rights and respects their humanity.
- Continue to improve services and support from when someone presents for diagnosis throughout the course of the illness including support for carers.
- There is an ongoing expectation that the process of service redesign will ensure care and support people with Dementia are at the heart of effective services delivered.

4.3 The key outcomes for the second national strategy are defined as follows:

- more people with dementia living a good quality of life at home for longer
- dementia-enabled and dementia-friendly local communities that contribute to greater awareness of dementia and reduce stigma
- timely, accurate diagnosis of dementia
- better post diagnostic support for people with dementia and their families
- more people with dementia and their families and carers being involved as equal partners in care throughout the journey of the illness
- better respect and promotion of rights in all settings, together with improved compliance with the legal requirements in respect of treatment
- people with dementia in hospitals or other institutional settings always being treated with dignity and respect

4.4 The Inverclyde Dementia Strategy was written to reflect progress already made in relation to meeting key elements of Scotland's First National Dementia Strategy and in anticipation of key elements now included in the Scottish Government's Second National Dementia Strategy.

The Inverclyde Strategy has a strong emphasis on promoting dementia friendly communities and was written with reference to other strategies in respect of health and social care extending to arrangements that require to be put in place through community planning and the single outcome agreement to enhance the focus of our strategy to progress work within the community and make dementia a priority with more services and partners.

Therefore Inverclyde has adopted an approach which is consistent with national directions. This puts Inverclyde in a good position going forward.

4.5 The Dementia Strategy Working Group has had a pivotal role in developing Inverclyde's Dementia Strategy. Membership of both the working group and Forum is being reviewed. The working group will become an implementation group and subgroups will be established to take forward the following themes arising from consultation on the draft strategy:

- Involvement and Consultation of people with Dementia, carers and the public
- Communication strategy including accessible communication materials and leaflets
- Learning and development to aid understanding of Dementia
- Linking with other strategies so every policy has an impact for Dementia perspective
- Promoting a Dementia Friendly Inverclyde in every aspect of life locally

A report on the consultation is available which explores the key themes to emerge from the consultation requiring a shift in focus as outlined above (Appendix A).

4.6 Over the summer members of the existing working group, including community representatives, pursued the following which were aimed to inform the group of best practice and develop specific proposals and actions for development and implementation of the strategy which reinforced some key messages arising from the consultation feedback, aligned to national directions. Examples of work reinforcing these messages are as follows:

4.6.1 **National Housing and Dementia Events**

Organised jointly between the Scottish Government, Chartered Institute for Housing and the Joint Improvement Service. This aligns with work to develop a CHCP Housing and Accommodation Strategy, and inform work to engage with local Registered Social Landlords. This will allow us to raise the profile of housing and dementia and is aligned to our intentions stated within the CHCP Commissioning Strategy to provide care and support at home or in more homely environments, raising the profile and interface required on housing, health and social care more widely.

4.6.2 **Dementia Friendly Communities**

Members of the group have visited projects to learn from experience from other areas to develop a proposal to promote a dementia friendly Inverclyde. Community representatives have provided examples that could be built upon within Inverclyde Suggestions include consideration of:

- A dementia friendly award scheme and enlisting support from corporate communications in design of materials and website development for general information and communication about services and resources, as well as specific awareness raising campaigns through creation of a communication plan, timeline and planner.
- Creating events like Dementia Awareness week.
- To develop guidance for the Council on developing Dementia Friendly Communities, setting a standard linked to national guidance for Local Government; this will be taken forward through the revised dementia forum and working group, which will become an overarching implementation and review group.

4.6.3 These examples could provide the potential to lever in support from local businesses and harness wider engagement of organisations to become involved with the strategy. This concurs with recommendations within the Scottish Government's Second National Dementia Strategy.

4.6.4 **Interface with Mental Health- Recovery, Inclusion and Regeneration**

This is aligned to work currently progressing to scope the potential of a proposal with third sector partners; a key element of this work includes people with dementia, their families and carers. This will involve an event early 2014 involving key people across the Council to reinvigorate elements of our existing commitments for mental health and wellbeing, with a community focus support.

4.6.5 **Single Outcome Agreement**

Work is underway to develop a proposal which will engage more partners through community planning arrangements and align with the outcomes identified within the Single Outcome Agreement. This is important as Inverclyde's Dementia Strategy and the commitment to work towards a dementia friendly Inverclyde require a corporate approach.

4.6.6 **HEAT Target Post-Diagnostic Support**

The Scottish Government remains committed to HEAT targets, in particular the target introduced in April 2013. This requires NHS Boards:

"To deliver the expected rates of dementia diagnosis and, by 2015/16, which is that all people newly diagnosed with dementia will have a minimum of a year of post diagnostic support coordinated by a link worker that will lead with service users and carers the building of a person centred support plan".

4.6.7 Inverclyde CHCP has progressed this work through the employment of a Dementia Link Worker for an initial 12 months supported by Reshaping Care for Older People Change Fund. The Link Worker is employed by Alzheimer Scotland and is based within the Older People's Mental Health Team.

4.6.8 An evaluation of this initiative has concluded that the provision of post diagnostic support will be required as a discrete element of the care pathway for people with dementia, their families and carers.

4.6.9 There has been no new funding allocated to Local Government to specifically implement the Dementia Strategy and existing developments have been achieved through the Reshaping Care for Older People Change Fund and the redesign of older people's mental health services. However, £70,000 has been identified from the CHCP Independent Living Fund, which provides the opportunity to maintain and take forward key elements of the strategy as outlined in Section 5.

5.0 PROPOSALS

5.1 <u>Implementing the Inverclyde Dementia Strategy</u>

The Dementia Strategy Working Group will become an implementation Group, with a revised membership informed by the work stream requirements. The Working Group will report to the Inverclyde Dementia Strategy Forum, a wider stakeholder group.

5.2 £70.000 has been identified from the CHCP Independent Living Fund and it is proposed that this funding is used to:

i. Further develop post-diagnostic support for people newly diagnosed with Dementia
ii. Develop communication strategy and public information leaflets and learning materials to enhance understanding of Dementia
iii. Invest in community development worker to support the Dementia Forum and implementation group to undertake community development work to develop dementia friendly community initiatives and peer support networks across Inverclyde

iv. Launch a Dementia Friendly Community Award Scheme to encourage local businesses to participate in promoting a Dementia friendly approach.

6.0 IMPLICATIONS

6.1 Legal: None.

6.2 Finance:

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments
Mental Health	Various	2014/15	£70,000	NA	Funded from Independent Living Earmarked Reserve

At this stage the detail of spend and associated timing profile is still to be finalised, the indicative areas of spend are expected to be:

- Post Diagnostic Support, to be provided by the 3rd sector £35,000
- Community Development Worker £25,000
- Awareness/ Information/Toolkit/ Award £10,000

6.3 Personnel: None

6.4 Equalities: Improve services and participation of people with dementia, their families and carers within Inverclyde

6.5 Repopulation: The ageing population profile in Inverclyde will increase the prevalence of Dementia.

7.0 CONSULTATION

7.1 This report refers to the consultation undertaken on the draft strategy and refers to how the consultation has influenced and improved the strategy with proposals being brought forward in response to the consultation feedback and in line with national guidance.

7.2 It is intended that there will be ongoing consultation with our community throughout the implementation of the strategy.

8.0 LIST OF BACKGROUND PAPERS

8.1 Inverclyde Dementia Strategy 2013 - 2016

8.2 Scotland's Second National Dementia Strategy June 2013

8.3 Inverclyde Dementia Strategy Progress Report 2012

8.4 Scotland's National Dementia Strategy 2010

8.5 Standards of Care for Dementia, Scottish Government 2011.

8.6 Remember I'm Still Me – Inverclyde Progress Report April 2010.

APPENDIX A

Working Towards a Dementia Friendly Inverclyde:
Inverclyde Dementia Strategy 2013-2016: Consultation Feedback Report.

1. Introduction

This document gives feedback on the responses received to the consultation of the Draft Inverclyde Dementia Strategy and explains how the feedback has influenced the strategy and the changes which will be made as a result of the consultation process.

This report includes a summary of the general themes arising from the consultation feedback.

We would like to thank everyone who has given their time to respond and contribute to this consultation.

2. Background

The aim of the strategy is to ensure significant improvements are made across four key areas and six strategic outcomes.

- Improve Dementia Awareness and knowledge
- Improving Community Inclusion
- Early Diagnosis and Support
- Living Well with Dementia

1. Improve coordination, collaboration and continuity of care across services
2. Improve access to services
3. Improve flexibility of services
4. Improve capacity of services to be responsive
5. Increase awareness of dementia in the general public and community
6. Increase opportunities for people with dementia and their families and carers to contribute to service planning

The strategy was launched in April 2013, developed in partnership by the Dementia Strategy Working Group; members of the group were looking to improve dementia care across Inverclyde to plan for the future, anticipating an increase in the numbers of people with dementia, their families and carers within Inverclyde. The drafting of the strategy, adopting an inclusive approach, encouraged participation from a wide range of stakeholders during the consultation process. In particular, enabled the voice of users and carers to be represented which was evident in the design of the programme to launch the draft strategy, with the contributions from people reflecting the lived experience. Followed up by a number of focus groups, facilitated by our partners and third sector organisations.

Members of the Dementia Strategy Working Group recognised that there is a unique opportunity to review current services and generate a system that can work for people with dementia for the future that empowers people with dementia, their families and carers so they are in control, with a system that delivers the outcomes they need.
The strategy was written reflecting progress within Inverclyde since publication of Scotland's National Dementia Strategy in 2010 and anticipated further direction from the Scottish Government with Scotland's Second National Dementia Strategy which was published in June 2013.

3. Overview of the consultation process

On 26th April 2013 Inverclyde CHCP published the draft strategy and consultation. The published document invited all interested stakeholders to comment on the draft strategy to see if the outcomes identified were the correct ones, and invited all interested parties to offer their views on how the outcomes might be achieved.

The formal consultation took place over a sixteen week period involved a range of opportunities for people to contribute as follows.

This report summarises feedback from people who attended the launch event, focus groups or completed a consultation questionnaire.

The launch event hosted 15 round table discussions involving 155 people.

Your Voice (Inverclyde Community Care Forum) and the Inverclyde Carer's Network facilitated 7 Focus Groups involving 54 people.

37 people completed the consultation questionnaire. The questions we asked are available in the Appendix.

246 people contributed to the consultation.

Some respondents consulted the draft strategy and responded independently, some attended the launch event and some did both. Some responses addressed all consultation questions, some addressed points of particular interest. A number of respondents provided feedback from both a personal and a professional perspective whilst some provided feedback in a dual professional representation capacity.

The highest number of responses was received from the third sector (advocates, not providers) and carers. There were 4 responses to the questionnaire from people who identified themselves as a person with dementia. The focus groups reached more people affected by dementia and therefore provides a more balanced response overall to this consultation. Future consultation and engagement work will need to consider more carefully the arrangements required to involve people with dementia to ensure their views are reflected.

4. What people told us: General themes arising from the consultation feedback.

4.1. Raising Awareness and Knowledge

The focus and priority the strategy will bring was welcomed, the need for raising awareness and publicity along with targeted awareness raising campaigns was commented on by the majority of respondents.

Some concern was held regarding capacity of the system with comment that sufficient resources need to be in place with investment in key areas of health and social care, as well as other areas such as housing. The role of public health was mentioned by several respondents.
It was suggested raising awareness in public and professional arenas should form a more developed work stream for implementation.

A number of respondents supported the view that school based educational activity would be beneficial, with the aim of raising awareness of younger people. The need to ensure that campaigns are positive and deliver a message that early intervention and planning can improve capacity to live well with dementia was highlighted.

The place of awareness raising was a re-occurring theme with the aim of encouraging people throughout the life course to recognise and understand the impact of dementia, to enable people with dementia to be treated with dignity and respect. The promotion of inter-generational work was raised as relevant in relation to targeting awareness more broadly within our community.

'Take the time to get to know me, what is important to me and support me, taking account of my changing needs and abilities'.

4.2. Training

The requirement for better training, skills and knowledge across all health and care sectors was raised with a particular focus on accredited training, continuous professional development, undergraduate and post graduate education.
Many respondents commented on the need for good relevant training to be available illustrated by the following example;

'I did not receive any training on working with people with dementia when I was at university which would have helped me in my current role'.

A number of people expressed the view that people with dementia, their families and carers should be involved in training and awareness programmes.
This was supported by the involvement of a member of the Scottish Dementia Working Group, a national campaigning group whose membership is made up of people with dementia, who shared their lived experience at the launch event. Along with a contribution from local people who shared their experience as a family member or carer. Many respondents commented on the importance of involving people with dementia and their families and carers as follows.

'I feel that personal stories and sharing experiences is powerful to help others understand the impact of dementia on a persons life and describe what would make a difference, in a far more effective way than written text could ever achieve'.

Many respondents commented on how powerful and effective the presentations at the launch event where. in considering how staff across a wide range of services could develop the skills to respond more appropriately and effectively with people with dementia, their families and carers.

Training of staff within care homes and home care staff was mentioned frequently with a particular focus on the need to raise the status and pivotal role of staff within these sectors.

4.3. Early diagnosis and Intervention

There was a general consensus that early diagnosis is essential there were questions raised and mixed views as to the process in relation to knowledge and skills development, reflecting a mixed response centring on whether or not practitioners at first point of contact had the skills and knowledge and up to date practice required to be able to recognise the need for early referral.

There was a mixed response to understanding existing referral mechanisms and opening up a debate about the circumstances and conditions in which people currently access services raising the importance of consistency of response. This debate also raised the importance of continuity of care.

The requirement for flexible ongoing support for people with dementia, their families and carers from the point of diagnosis onwards was raised.

Respondents recognised the key role GP's play and expressed a view that there were opportunities for other professionals within GP practices, for example, practice nurses to become more involved in dementia care. Equally comments were received on the potential opportunities and role of health professionals in a wide range of settings to have a role, particularly within general hospitals.

A number of respondents requested the right for family members to have access to GP's for early diagnosis on behalf of the cared for person where a person may be unaware of or in denial of symptoms.

A number of respondents expressed a need to ensure care is taken not to over diagnose.

4.4. Acute Hospitals

A number of comments were received regarding the need for general ward staff to understand the needs of people with dementia, which also relates to point 4.3 above, which relates to developing the care pathway further to enable an appropriate response to the needs of people with dementia in that setting.

4.5. Home Care

Comments received regarding home care were broadly in line with comments received in relation to care homes with regard to quality of care, skills and knowledge of staff.

The need for flexible respite care in a person's home, together with the need for better quality day care. The increased use for example of tele-health care and adapted housing was raised by many respondents.

Some respondents highlighted the need for funding to be more easily accessible to avoid assessment and funding processes becoming a burden to existing responsibilities of carers.

The necessity of carers to be able to take short breaks and respite was strongly voiced.

'Carers need to be aware about the possibility of short breaks, which can be arranged by the Short Breaks Bureau, with the family or having a break from their caring role'.

4.6. Communication and Nutrition

Reduced communication skills and the resultant health implications were mentioned by a number of respondents and anticipated increased role of speech and language therapists and dieticians for staff training purposes and the need for more collaborative working between these specialism's and other health and social care professionals to support people in the community.

A number of responses referred to the need for more joined up working between health and social care professionals to;

'Ensure an individual their family and carers are aware of the range of support available and how to sustain support adopting good practice in care'.

'Family members and carers require information and support in providing personal care to people with dementia.'

5. Responses on areas which require to be strengthened in the strategy

We invited general comments with regard to the draft strategy and respondents used this opportunity to tell us the following;

5.1. Advocacy and legal advice

Some respondents raised the enhanced role of advocacy and legal advice in the context of the need to ensure people engage with future care planning and to afford protection for people who become more vulnerable. The strategy will be adjusted to reflect the role of advocacy and access to legal advice as a result of this feedback.

5.2. Creative Therapies

Respondents were keen to promote the beneficial aspects of creative interaction and increase in the range of activities available to people in a range of settings in care homes and in hospital in particular. Emphasising the positive psychological impact this can have on people with dementia and their quality of life. This point relates to the emphasis in the strategy on inclusion and is discussed further in the following sections.

5.3. Dementia ~Café

Some respondents felt that dementia cafes should be positively encouraged as it was felt they could play a significant role in enabling people with dementia to interact and socialise in a safe, positive and supportive environment.

5.4. Crisis

Crisis support and intervention was raised by a number of respondents with specific suggestions for an Out of Hours Service and support in the evenings which could enable more people to live at home.

5.5. Environment

Most respondents commented that the environment in which a person with dementia experiences has an influence on health and wellbeing, stability and outlook, with many

comments received that a disabling environment can lead to challenging behaviour. A view was expressed that housing and the built environment are of equal importance to the standard of care provided.

'The environment people live in, whether its their own home, care home or hospital should be dementia friendly, encouraging independence'.

5.6. Structured Activities

The subject of access to structured and meaningful activities was raised throughout the consultation with many respondents highlighting the benefits of structured activities in the context of community inclusion.

Many statements were made asking for;

'A programme of activities to be made available in a communal environment'

In order to achieve this there needs to be investment in creating a cultural shift dealing with barriers that can limit opportunities for people to participate in the community. Reflected in many comments from respondents as follows;

'We must all work together to address perceptual barriers and stigma people can experience, to create opportunities that enable people to be active participants in the community they live.'

5.7. Carers

Respondents felt strongly that increased respite care services and short breaks should be available. Some respondents commented that an increase in day care opportunities would help ease a carer's workload. Respondents felt there is a lack of information regarding the support that is available to carers. Reinforced with statements like the following;

What does it mean in practice to be on a carers register?

Some respondents felt that a communication strategy is required detailing and promoting services available with local emergency contacts.

A number of respondents commented that existing carer and user support groups were a good source of help and information, but that more support groups, including peer support initiatives, will be required in the future.

5.8. Living Alone

Some respondents commented that there are particular issues in relation to people who live alone which will require further exploration. Issues were raised in relation to access to day care and support services The importance of transport as part of the infrastructure to support people to participate in the community was highlighted.

Some respondents felt that people with dementia who live alone may be susceptible to greater isolation limiting access to support services. This led to more suggestions for neighbourhood befriending schemes and peer support.

'There needs to be greater emphasis on the reduction of social isolation as a preventative measure and increased opportunities for socialisation'.

5.9. Befriending and Volunteering

As outlined above a number of respondents were in favour of promoting the benefits of befriending and volunteer schemes for providing one to one interaction and basic daily support. The importance of these schemes was stressed by many respondents for people who live alone. Some respondents were keen to see the development of a Dementia Friends Scheme to support people to participate in the community.

5.10. Publicity

Respondents were keen to see more localised targeted campaigns to promote the strategy, information and awareness raising and support available. Specific suggestions included website development, communication materials, leafleting, use of media and marking significant events, for example, Dementia Awareness Week. Suggestions were received that in order to promote a dementia friendly community this could be supported with the introduction of a Dementia Friendly Award Scheme.

'more information is required to be available in offices, surgeries and public places like libraries. Followed up by awareness raising through talks, seminars targeted to people of all ages'.

'A Dementia Friendly Award Project could engage local businesses to consider how they provide a service to people with dementia'.

5.11. Specific needs

Most respondents supported the focus on links with other strategies for example people with a learning disability and younger people. Some respondents want to see more detailed reference to the needs of people affected by alcohol related dementia.

5.12. Self Directed Support and Personalisation

Some respondents were positive about the potential of self directed support and the potential opportunities this could bring for people with dementia, their families and carers. Some respondents made specific comments about the strategies focus which give people a lead role in directing and managing their health and care. Having an outcomes approach to support a person in tailoring support in principle was supported.
Some respondents referred to the use of tools like This is me as being crucial to realising the potential of directing a persons support and should be promoted as part of a wider communication strategy.

'Self Directed Support could improve opportunities for choice, autonomy and independence'

6. Developing proposals to promote dementia friendly community

Most of the feedback from respondents commented positively to the concept of a Dementia Friendly Community and the emphasis of the strategy on community inclusion, with many suggestions about how to develop an initiative to promote the concept and make this a reality. Better linkages with community planning and the single outcome agreement will be crucial to this aim.

'*The local environment could be dementia friendly with special signage, coloured paving and banisters to help people find their way about. specially designed public gardens, providing industries such as the retail industry with information and guidance and how they can provide a service to people with dementia*'.

Many suggestions were received on elements of a dementia friendly community. With a general consensus of the model adopted within the draft strategy. Suggestions ranged from dementia friendly design, access to facilities and amenities, open spaces, increased range of venues and activities people can participate along with a proposal for a dementia friendly award scheme to enhance partnership and involvement of local businesses.
A proposal will be developed building on the proposed model within the draft strategy.

'There needs to be presentations undertaken in schools, community centres along with Dementia Friendly Community promotions'

7. Conclusion
The draft strategy was well received with the overarching structure, aims and outcomes identified within the strategy viewed positively by many respondents.

There have been a number of important suggestions on how the proposed strategy could be improved. The areas outlined in this feedback report will be given greater prominence and will be incorporated into the final strategy and implementation plan.

Respondents expressed the need for the strategy to be properly funded, and information on how services will be delivered through the number of redesign of services people were aware of was already taking place. Questions where raised as to what this would mean in practice, there was support for an outcome focus as follows,

'By adopting an outcomes approach based on recognising my autonomy and right to make choices while I am able to express an opinion'.

Respondents were supportive of the focus and linkages with other strategies and were keen to see more detail in the implementation and action plan.

This will be achieved by bringing forward proposals to consolidate and build upon work taken forward since 2010. Identify areas were extra support and leverage is required to support implementation and more specifically proposals to support promotion of a dementia friendly Inverclyde.

8. Summary
The consultation feedback received can be grouped under the following headings which will support development of the work streams required to implement the strategy;

- Engagement and involvement of people with dementia, their families and carers.
- Development of a robust Communication Strategy and Action Plan.
- Creating more learning and development opportunities along with a Skills and Knowledge Action Plan, involving people with dementia, their families and carers.
- Promoting joined up work to facilitate action and links with other strategies, translating these into more tangible outcomes for people with dementia, their families and carers.
- Taking forward specific proposals to promote a Dementia Friendly Inverclyde.
- Ensure implementation of Promoting Excellence is evidenced across a range of settings.

- A particular focus on the environment will be developed, including Housing, design and tele-health care, re-ablement, managing transitions and support.

- Undertake an impact assessment on the strategy and proposals with a particular focus on the costs and benefits in several areas of work underway within the existing strategy and more specifically utilising research and best practice aligned to national developments applied to the local context. This recommendation was illustrated by the following comment.

‘Future budgets, policies and services should be screened in respect of the impact on people with dementia, their families and carers’.

Following the consultation feedback we will adjust the strategy and increase the recommendations within the objectives to reflect the comments made by people who contributed throughout the consultation period and reflected in this report.

13th November 2013

APPENDIX B

Working Towards a Dementia Friendly Inverclyde

Inverclyde Dementia Strategy 2013-2016

Forward

We are committed to working towards a dementia friendly Inverclyde.

Most people will know somebody who has dementia, either a member of their family, someone in their neighbourhood or wider networks. Some people will spend time in hospital, nursing home or residential care, many people with dementia will live at home. The more people with dementia can remain engaged with their communities, using their skills and their confidence, the better their quality of life will be. This also supports their continuing contribution to our community.

Communities that are dementia friendly have more opportunity to support people in the early stages of dementia, maintaining and boosting their confidence and their ability to manage everyday life.

What is good for people with dementia is good for everybody. Places and neighbourhoods that provide good housing transport and facilities will not only be more dementia friendly, but will also make life easier for everyone.

The number of people living with dementia in Inverclyde will increase over the next 20 years. This is due to an aging population, lifestyle factors and improvements in identifying and diagnosing dementia. At 2013 in Inverclyde there are 1385 people predicted to have dementia. Dementia mainly affects older people however, it can affect younger people and in Inverclyde there are 49 people under the age of 65 predicted to have dementia.

We know dementia increases with age and in the context of the demographic changes across Scotland's whole population there is a strong national focus on the needs of people with dementia, their families and carers. We have worked towards recommendations and directions set out in Scotland's National Dementia Strategy, published in 2010 and this strategy incorporates additional priorities and actions anticipated in the second national strategy to be published later this year.

There is considerable work being undertaken within the Inverclyde Community Health and Care Partnership through a range of change programmes which will have an impact on people with dementia, their families and carers. This strategy will seek to influence these change initiatives in order that a coordinated approach is achieved to maintain our commitment to people with dementia, their families and carers.

This strategy and high level action plan builds on work well underway in Inverclyde, and aims to raise the profile of dementia as a strategic concern, which seeks to promote inclusion and improve outcomes for people with dementia, their families and carers throughout the lifespan. We are basing the strategy on key outcomes for people with dementia, their families and carers. We have identified four themes on which the action plan is based, and identified areas of improvement work which will help deliver our outcomes.

The overarching aim of the strategy is to ensure that our community embraces people with dementia, and services are developed which have direct relevance to people with dementia, providing care and support appropriate to need and demand.

It is recognised that services need to be flexible, local and delivered by appropriately skilled and supported staff to ensure a good quality of life for people with dementia, their families and carers.

There are many things that can be done to support people with dementia to remain independent and participate in a range of activities to contribute as active citizens. Our challenge is to create the opportunities to enable people to live well with dementia. We recognise that this strategy will be a dynamic process.

The strategy was launched in April 2013, developed in partnership by the Dementia Strategy Working Group; members of the group were looking to improve dementia care across Inverclyde to plan for the future, anticipating the increase in the numbers of people with dementia, their families and carers within Inverclyde. The drafting of the strategy, adopting an inclusive approach, encouraged participation from a wide range of stakeholders during the consultation process.

On 26th April 2013 Inverclyde CHCP published the draft strategy at a launch event in Greenock Town Hall. The event enabled the voice of users and carers to be represented with contributions from people reflecting the lived experience. The published document invited all interested stakeholders to comment on the draft strategy to see if the outcomes identified were the correct ones, and invited all interested parties to offer their views on how the outcomes might be achieved.

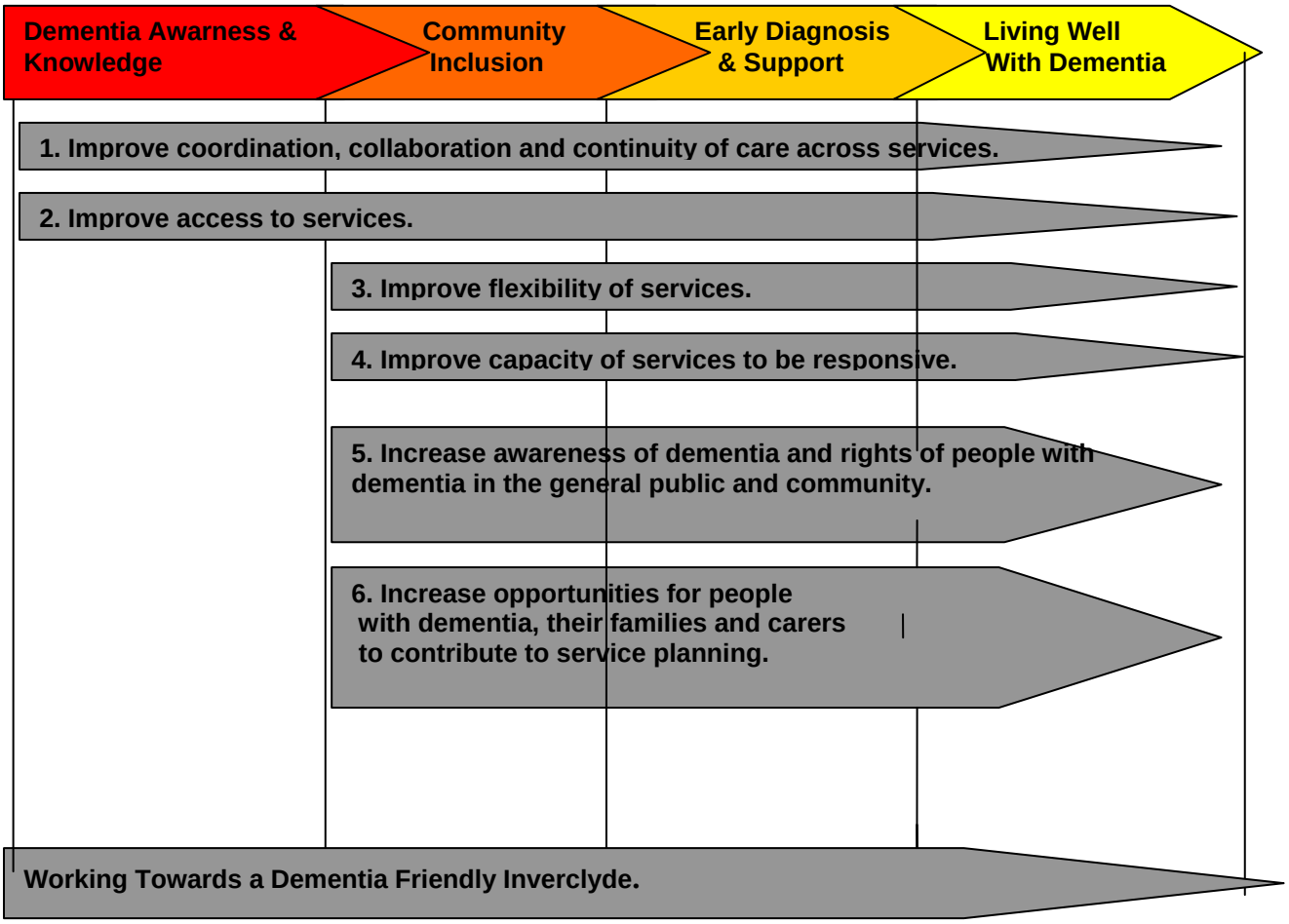
The formal consultation took place over a sixteen week period involved a range of opportunities for people to contribute. This included direct responses to a survey, and via a number of focus groups, facilitated by our partners and third sector organisations.

We would like to thank all those who have shared their experiences and ideas in developing Inverclyde's Dementia Strategy, and who responded to the consultation.

The Dementia Strategy and action plan will be taken forward through the Dementia Strategy Forum Implementation working group.

Inverclyde Dementia Strategy Forum Working Group.
November 2013

Getting It Right for People with Dementia, their families and carers in Inverclyde



Contents

1. Introduction

The Community Planning Partnership vision for Inverclyde is Getting It Right for Every Child, Citizen and Community. This means the Inverclyde Alliance will work in partnership to create a confident inclusive Inverclyde with safe, sustainable, healthy, nurtured communities and a thriving prosperous economy, with active citizens who are resilient respected and responsible and able to make a positive contribution to the area.

The aim is that our communities are more capable and resilient and are co-producers in achieving positive outcomes for themselves, moving away from dependency to self reliance.

The Single Outcome Agreement and partnerships are committed to

- All older people living in Inverclyde have healthy, productive, active and included lives preferably living in their own homes with access to the services they need, when they need them
- All our communities have good mental health and wellbeing integral to the achievement of all the local outcomes for Inverclyde.
- There is high level political commitment to working towards a Dementia Friendly Inverclyde.

We intend to develop specific elements of the single outcome agreement to raise the profile of people with dementia, their families and carers. Taking a wider perspective, community capacity building will enable people to avoid social isolation and live more independently.

On this basis this strategy sets out Inverclyde's response to Scotland's National Dementia Strategy. Its purpose is to outline what services for people with dementia, their families and carers exist at present, what we want to develop, identifying where we think there are gaps.

The Inverclyde Dementia Strategy Forum, established in 2012, includes a wide range of statutory, non-statutory representatives, within its membership.
We have drawn on the experience and knowledge from forum members in developing this strategy and action plan. The action plan has been developed in partnership to ensure the specific needs of people with dementia, their families and carers are articulated and represented. The Inverclyde Dementia Strategy Forum will continue to have a lead role in helping to develop the services and increase knowledge and skills regarding dementia within Inverclyde.

In January 2013 the Inverclyde Dementia Strategy Forum spent the day as a group to consider the needs of people with dementia their families and carers in Inverclyde. The outcome of the event evolved into this outline strategy document. Our strategy is based on a whole system understanding of the inter-relationship between the

services and the support people with dementia, their families and carers need and receive, in context of the community in which we live.

2. Aim of the strategy

The primary aim of the strategy is to ensure that significant improvements are made to the lives of people with dementia, their families and carers.

The strategy is underpinned by 4 objectives and 6 strategic outcomes, which will contribute to influencing action on dementia.

- Improve Dementia Awareness and Knowledge
- Improving Community Inclusion
- Early Diagnosis and Support
- Living Well with Dementia

1. Improve coordination, collaboration and continuity of care across services
2. Improve access to services
3. Improve flexibility of services
4. Improve capacity of services to be responsive
5. Increase awareness of dementia in the general public and community
6. Increase opportunities for people with dementia, their families and carers to contribute to service planning.

Our Commitment to Older People Living in Inverclyde

Our commitment to Older People living in Inverclyde, as set out in the Inverclyde Community Health and Care Partnership Older People's Strategy, is that they should:-

- Feel valued and respected as part of their community
- Be able to live a full and active life in safe and secure surroundings
- Have every opportunity to remain independent, to have freedom of choice and control over how they live their lives
- Be treated with dignity, courtesy and consideration
- Get timely access to the right level of support, information and intervention at times of crisis or transition

The belief that most people, including those with complex care needs, can and would prefer to be supported in their own homes underpins this commitment.

3. Why do we need a strategy?

The development work being undertaken in respect of dementia is informed by Scotland's National Dementia Strategy, which was published by the Scottish Government in June 2010. This was a three year strategy which identified the challenges and key actions to support change to improve the outcomes for

people with dementia and their families. Within this two key areas for service delivery change were prioritised to improve support after diagnosis and improve care within the general hospital. The strategy emphasises the need for change across the whole system of health and social care to address these challenges.

The Scottish Government's second National Dementia Strategy is due to be published later this year. We anticipate the Scottish Government will consolidate work taken forward since 2010, and identify areas where extra support and leverage is needed to support service change. With an increased focus on:

- Health improvement
- Supporting people to live independently
- Nurturing dementia friendly communities and
- Safe, appropriate and dignified care in hospital and care homes

Since the publication of the national strategy the Scottish Government has published national documents to support the action for change in relation to dementia care. The Standards for Care for Dementia in Scotland were published in 2011. These standards relate to everyone with a diagnosis of dementia in Scotland, regardless of where they live, their age, the supports they receive or the severity of their illness. Based on the Charter of Rights for People with Dementia and their Carers in Scotland, 2009, the standards were developed to help people with dementia understand their rights, and how these rights can help make sure that they receive the support they need to stay well, safe and listened to. [Appendix 5.]

Promoting Excellence: A framework for health and social care staff working with people with dementia, their families and carers was published in June 2011. The framework outlines the skills and knowledge health and social care staff should have depending on the role they play in supporting people with dementia. In order to ensure continuing improvement in the care provided and received, the framework needs to work in conjunction with the standards for care.

The strategy emphasises the expectation that partnership working at national and local level would develop further to deliver the objective of transforming dementia services. Within Inverclyde the existing partnership work has been enhanced with the implementation of the CHCP.

HEAT targets and performance:

In order to support the improvement work for people with dementia, their families and carers, the Scottish Government has introduced HEAT targets specific to dementia. The purpose of these targets is to focus NHS Boards on key priorities and measure how these are being achieved.

In 2008, pre the National Dementia Strategy, a target was introduced to identify people with dementia living within our community:

"From April 2008 each NHS Board is required to deliver agreed improvements in the early diagnosis and management of patients with dementia by March 2011."

This target established the need for dementia registers within GP practices, and the requirement to review these people within 15 months of diagnosis.

In addition in January 2010 Greater Glasgow and Clyde Health Board introduced a local improvement measure within mental health services, to ensure people receiving a diagnosis were provided with appropriate information about the condition.

In 2012 the Scottish Government made a commitment to guarantee that people receiving a diagnosis of dementia will be offered a minimum of one year post diagnostic support:

"To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan"

In respect of dementia the Life Changes Trust will support the Scottish Government's one year Post Diagnostic Support guarantee by investing in peer support and community connection projects to enable people to live well in their communities. There will also be a focus on supporting the needs of carers throughout the carer journey.

Our strategy will include the development of performance measures in respect of dementia, to enable us to look at progress towards our objectives.

4. Context

The implications of an aging population and the increased incidence of dementia mean that the development of policy and services for people with dementia, their families and carers are affected by the wider policy context.

Developing our response to meet the needs of people with dementia is set in the context of national policy for health and social care. The key themes integral to our approach are:

- Care is delivered as close to home as possible
- Self directed and personalised care
- Delivery of care based on what works
- Carers support and education
- Providing support in the early stages of illness
- Effective collaboration and joint working
- People with dementia are enabled to live independently within their own community for as long as possible

[A list of related policy is referenced in appendix 2]

A significant culture change will be required within both our community and our local services in respect of dementia. People's perceptions and understanding of dementia will need to shift in order to focus on how services can be delivered to

enable a response which is personal and flexible, and which meets the needs of people with dementia, their families and carers. This needs the whole community to recognise the role they have in enabling people with dementia to live independently and participate in community life for as long as possible.
There will be the need for ongoing engagement with social care providers, community, third sector organisations, local housing associations and housing providers.

What do we mean by a dementia friendly community?

The concept is based on inclusion, building on what people can do and contribute to society. Supporting people to live well with dementia as active citizens has benefits for the person with dementia, their families and carers and for the community.

Communities that are dementia friendly have more opportunity to support people in the early stages of dementia, maintaining and boosting their confidence and their ability to manage everyday life. This involves cultural and attitudinal change within our community towards people with dementia, and developing confidence and skill to enable a person with dementia to maintain daily activities, quality of life and feel comfortable, safe and included.

The Joseph Rowntree Foundation describes an approach to developing dementia friendly communities. The 4 cornerstones model suggests that a dementia friendly community needs some essential building blocks or cornerstones.

Place; how does the physical environment, housing, neighbourhood and transport support people with dementia?

People; how do carers, families, friends and neighbours health and social care professionals and the wider community respond to and support people with dementia?

Resources; are there sufficient services and facilities for people with dementia and are they appropriate to their needs and supportive of their capabilities? How well can people use the ordinary resources of the community?

Networks; do those who support people with dementia communicate collaborate and plan together sufficiently well to provide the best support and to use people's own assets well?

Reference: Crampton, J. Eley, R. Dean, J. Creating a dementia-friendly York. London: Joseph Rowntree Foundation (JRF), October 2012.

Inverclyde has a history of community development, evident by a strong voluntary and community sector. The enhanced role of our community is central to achieving the aims of this strategy.

5. What we are doing in Inverclyde

Inverclyde Community Health and Care Partnership developed an action plan in 2010 which focused on the work streams which are contained within the National Strategy.

- Treatment and improving the response to behaviours that carers and staff find distressing
- Assessment, diagnosis and implementation of an integrated care pathway- improving the journey of people and with dementia and their carers
- Improving the general service response to dementia
- Rights, dignity and personalisation
- Health improvement, public attitudes and stigma
- Implementing standards of care

The Dementia Strategy has been taken forward through the Reshaping Care for Older People and Mental Health and Wellbeing structures. The work has been targeted to improve the interface between mental health and wider services for older people, encouraging all services to consider the needs of people with dementia their families and carers.

The examples of work progressed include:

- Identify levels of training available in dementia; identifying staff groups to train and to what level. Including training for carers.

- Inverclyde CHCP has achieved the HEAT target: 'Making Improvements in the Diagnosis and Management of People with Dementia' by March 2011 through the identification of people with dementia within the dementia register in GP practices. Greater Glasgow and Clyde Health Board is the best performing Health Board in the UK in respect of this.

- Review of existing information, ensuring people receive appropriate educational information relevant at stages of dementia for people with dementia, their families and carers.

- Review of existing approaches to assessment, and use of complementary assessment tools to focus on enabling people with dementia to live safely at home for as long as possible, facilitate effective care at times of transition, including use of advance statements and life story work.

- Fast track mental health assessment with the aim of preventing hospital admission and facilitating appropriate care at home.

- Developments within acute hospital and care home settings to enable appropriate support and care where mental health needs are identified and are changing.

- Enabling access to the Dementia Care Pathway for people whose care is provided in these settings.

- Development of psychological approaches and interventions across services.

- Implementation of Service Impact Assessments of the Standards of Care for Dementia in Scotland and development in services of action plans to meet requirements.

- Inverclyde CHCP and NHS Greater Glasgow and Clyde adopted the Scottish Inter-collegiate Guidelines Network (SIGN 86-Management of Patients With Dementia) and the Planning, Organisation and Delivery of joined up Services for those with Dementia and Their Carers (NHS HDL(2004) 44). This document defines the pathway for people with dementia as pre-diagnosis; diagnosis; post diagnosis; community services; continuing care and coordination and care management. This formed the basis of the 2010 action plan

- Identifying and training a Dementia Champion within the acute hospital. This will support implementation of patient pathways, for people with dementia, in acute hospital settings. The focus is on values, knowledge, skills and training to support the identification of needs and the care and treatment of people with dementia in Inverclyde Royal Hospital.

- NHS Greater Glasgow and Clyde is one of three Health Board areas funded by the Scottish Government to employ an Allied Health Professional (AHP) consultant in Dementia. The focus of the post is on acute care and the role of the AHP.

- Training of all Home care staff within Inverclyde; and the development of an e-learning course about dementia which will be available to the whole community via Inverclyde Council's website.

- The pilot of approaches with Alzheimer Scotland in respect of early interventions to support people with dementia, their families and carers through the Regeneration Fund;

- The provision of post diagnostic support for people diagnosed with dementia and their family, in partnership with Alzheimer Scotland. Inverclyde CHCP is taking forward the commitment to offer a minimum of one years post diagnostic support, through the employment of a Dementia Link Worker. The Link Worker is employed by Alzheimer Scotland, and based within the Older Peoples Mental Health Team. This is currently supported by the Change Fund.

- The redesign of older people's mental health services, incorporating the requirements of Scotland's National Dementia Strategy and the Dementia Care Pathway;

- Piloting of different approaches to supporting people with dementia at home within the local Tele-care development work;

- Our Single Shared Assessment Procedures have been updated to reflect the Community Care Outcomes Framework. Assessment, care planning and review lie at the heart of identifying and improving outcomes for people with dementia, their families and carers.

- Designing improved facilities and delivery of care for people with complex mental health needs who require continuing NHS care. This is the basis of current work which includes redesign and reprovision of services from Ravenscraig Hospital, by 2015.

- The creation of the Inverclyde Dementia Strategy Forum (IDSF), based on the objective of a Dementia Friendly Inverclyde.

The review of our existing plan highlighted the potential to build on existing work and develop our response to promote greater collaboration and co-ordination across partnerships, including health and social care, community planning and the single outcome agreement.

Areas identified include strengthening our focus on the following:

- Further Implementation of the Promoting Excellence Framework, to support a skilled and knowledgeable work force;

- The needs of younger people with dementia;

- The needs of people with a learning disability with dementia;

- Health improvement activity is targeted on interventions and lifestyle changes which may reduce or slow progress of dementia;

- Access to End of Life and palliative care;

- Linking with wider services including housing providers;

- Research and sharing of best practice;

- Developing community capacity, peer support and networks of support.

6. What we intend to do:

In taking forward the strategy we are committed to:

- Enabling people with dementia, their families and carers to take charge of their health and abilities to ensure people experience the best possible quality of life and sense of wellbeing.

- By collaborative work minimise barriers so that people with dementia can receive what they need, when they need it with services working together.

- Delivering services in line with evidence about what works to improve the care for people with dementia, taking into account individual circumstances.

- Adopt an outcomes based approach that recognises a person with dementia's quality of life is affected by a combination of their dementia, physical health, life experience, their relationship with those around them, and the physical environment in which they live.

- Respect the dignity of the individual, treat people with compassion and see people as partners in their care.

- Provide services that recognise the importance of families, friends and networks of support.

- Promote dementia friendly communities to enable the participation of people with dementia, their families and cares in social, educational and community activities.

- Involving people with dementia, their families and carers in the planning, delivery, monitoring and review of services

These commitments will enable us to take forward our aims, objectives and outcomes detailed below.

7. Strategic Outcomes

Outcome 1 Improve coordination, collaboration and continuity of care across services

Collaborative and coordinated working across services will enable people with dementia, their families and carers to receive what they need, when they need it with services working together. This requires us to develop methods to facilitate improved communication and take a holistic approach to meeting need. Further development of single shared assessment and personalised care plans, providing joint training and shared dementia resources will contribute to this outcome.

Outcome 2 Improve access to services

Work in partnership to implement the care pathway for people with dementia, their families and carers. This requires us to clarify routes of referral and criteria for service use, developing gradual and supported introductions to services through transitions, will help to make services more accessible for people with dementia, their families and carers. This will enable a responsive approach to service provision, based on an individual's need.

Outcome 3 Improve flexibility of services

Building on improving access to services, working with care providers, and local community groups to develop alternative models of care will ensure services are

more flexible and better able to meet the needs of people with dementia, their families and carers. Adopting an outcomes based approach, with people with dementia being partners in their care together with their wider networks of support will enable creative approaches to support.

Outcome 4 Improve capacity of services to be responsive

Services which are responsive to the individual needs of people with dementia are provided by individuals and organisations that have a good level of knowledge and skill and have the resources to adapt services to individual needs. Increasing knowledge about dementia will be a key to the success of this strategy, alongside the development of a culture that embraces creative approaches to supporting people with dementia, their families and carers. Methods for achieving this include Promoting Excellence, developing new and utilising current expertise on dementia, and sharing best practice.

Outcome 5 Increase awareness and understanding of dementia and rights of people with dementia in the general public and community

To enable the development of dementia friendly communities requires the participation of people with dementia, their families and carers, and an understanding of dementia, and how it affects individuals. This will encourage help seeking and help offering within our communities, and reduce the stigma and exclusion experienced by people with dementia, their families and carers. Listening to what people say about what makes a difference will enable services to respond better. Using health improvement approaches to enable our understanding of behaviours and lifestyles that contribute to the risk of developing dementia will support preventative work.

Outcome 6 Increase the opportunities for people with dementia, their families and carers to contribute to service planning.

The strategy aims to achieve this by building on current work, to enable people with dementia, their families and carers to contribute to service redesign, through community capacity building and developing our community involvement and engagement mechanisms. This includes demonstrating how we are meeting the standards of care for dementia, self assessment, peer review, and benchmarking. There is a need to mainstream dementia as a community wide issue, where it is everybody’s business across all sectors of our community.

8. Linkage to other work and developments that support outcomes

All the work described in relation to wider strategies is governed by the Inverclyde Single Outcome Agreement and the Community Health and Care Partnership Directorate Improvement Plan.
In order to take forward our four objectives, and six outcomes, we have identified key areas of work that are currently underway, and within which there is an opportunity to progress key elements of the Dementia Strategy.

Promoting Excellence

We will develop our strategy to increase skills development, knowledge and awareness raising activity. This will be supported by the implementation of Promoting Excellence and integrating activity within learning and development and workforce development plans. By improving understanding about dementia what it is, what can be done and what the benefits are of receiving an early diagnosis it is likely more people will be able to acknowledge their condition and seek help. In turn all staff in all organisations who work with adults and older people must be informed and educated in a manner that allows them to understand and provide a person centred service for the person with dementia, their families and carers.

Learning and development opportunities must be ongoing as part of personal and professional development. This will include the identification, development and improvement of dementia expertise. Access to educational materials by utilising methods, including new technology ensuring these are widely available within Inverclyde. This work will be aligned with public awareness activity and a communication strategy.

Research and developing a community of good practice

We aim to develop the strategy on evidence of what works. We will endeavour to develop our links with appropriate bodies learning from research to develop practice, for example:

- Scottish Social Services Council,
- NHS Education Scotland,
- Alzheimer Scotland Centre for Dementia and Practice, University of the West of Scotland, Paisley,
- Dementia Services Development Centre, University of Stirling.

This will also link to our learning and development work across the CHCP and our partners.

Developing community capacity, peer support and networks of support

Taking a wider perspective, community capacity building will enable people to avoid social isolation and live more independently. Increasing awareness of dementia in Inverclyde will support people with dementia to maintain their independence for longer and has the potential to reduce the incidence of stigma and discrimination. Community capacity building is a priority as an area of investment through the Reshaping Care for Older People Change Fund.

There are also existing strategies that need to explicitly incorporate the objectives of this dementia strategy:

End of Life and Palliative Care

Inverclyde CHCP has a commitment to working across agencies to establish access to services required for End of Life Care. We aim to build on work underway to enhance care and support for people with dementia that integrates a palliative approach. Care and support is based on planning by the person with dementia their family and carers which is completed following diagnosis and reviewed regularly.

Linking with wider services including housing providers

We need to support people with dementia to access housing options which meets their lifestyle and care needs and ensure they are given appropriate housing choices. Models of housing provision will need to reflect people's requirement for care and support which is delivered at home.

This requires improved joint working between housing providers and care providers to increase awareness of the needs of people with dementia when it comes to building, design, structure and support arrangements. Better use of existing housing alongside new models of housing incorporating for example, use of adaptations, adapted houses and selection of suitable properties to meet individual needs. Ensuring people have access to appropriate housing and support has a role in preventing inappropriate admission to hospital and residential care.

The Local Housing Strategy is the governing strategy to develop our response to housing need and proposals which will include people with dementia, their families and carers will be taken forward in partnership through the CHCP's Housing and Accommodation Subgroup.

Early onset dementia

In the years to come there will be an increase in the number of people with dementia, many of these people maybe under the age of 65 and have unique needs which will not be met by traditional services. This strategy is therefore not age specific and seeks to influence service development to have due regard for the needs of anyone affected by dementia. Early onset dementia is an area which requires further research and development.

Learning disability

There will be an increase in the number of people with dementia with a learning disability. Methods of provision of services will need to change which will enable earlier diagnosis and support with transitions into services to access support care and treatment which is appropriate to need. The Learning Disability Strategy for Inverclyde is currently being reviewed and will be updated to reflect this strategy.

The local Learning Disability Strategy is guided by national policy, "The Same As You" and followed a review of services for people with learning disabilities in Scotland. The main aim of both national and local action is to support people with a learning disability to be included in community life. The local strategy sets out

proposals for developing sustainable models of services for people with complex needs, including dementia.

Health Improvement

The Scottish Government intends to increase its focus on Health Improvement and lifestyle changes which may reduce the incidence or slow progress of dementia in the second national dementia strategy.
Within Inverclyde CHCP there are ten strategies in place for health improvement and health inequalities. We have highlighted the main ones relevant to people with dementia.
There is a focus on anticipatory care and prevention through the Keep Well and Active Living programmes. The nutrition strategy is also relevant to inform healthy lifestyles contributing to prevention.

Health Inequalities

Inverclyde CHCP has agreed a strategic framework to provide local action on the principles set out in the national policy Equally Well. This is one of an interlinked set of policies to reduce poverty and inequality.

Mental Health and Wellbeing

The CHCP is progressing 'Towards a Flourishing Inverclyde' by developing an action plan for 'Making Wellbeing Matter in Inverclyde'. This will ensure peoples mental wellbeing will be improved and sustained. The action plan is targeted for completion in the autumn of 2013. A key focus of 'Making Well-being Matter in Inverclyde' will be the re-establishment of the Inverclyde Anti-Stigma Partnership and that of the awareness-raising activities through the Inverclyde Mental Health Awareness Planning Group and its-sub group the Inverclyde Creative Forum for the annual Scottish Mental Health Arts & Film Festival.

NHS –Healthcare Quality and Clinical Strategies

The Health Care Quality Strategy for NHS Scotland, 2010, is a development of Better Health Better Care which builds on significant achievements made within the NHS over the past few years. It aims to deliver safe, effective person centred care, supporting people to manage their conditions making the patient experience and personal outcomes integral to services.

The strategy aims to address opportunities to;

- Support longer healthier lives for the population as a whole
- Reduce health inequalities
- Improve the health of the increasing older population including people with dementia
- Developing a skilled workforce

A key aim of NHS Glasgow and Clyde's Clinical Strategy is the development of integrated pathways for all patient groups and conditions over the next five to ten years. Through a programme of clinical led service redesign the aim is to deliver the following for patients and the public;

- Safe effective person centred care to every person
- A focus on maintaining good health
- More support to anticipate, prevent and minimise health problems
- More and better care in the home and community settings
- Increase outpatient and day case treatment for most planned hospital care
- Safe, timely admission and discharge for those who require inpatient care
- Reducing avoidable admission to hospital
- More focus on the use of telehealth care to support people to manage conditions at home.

Mental Health Services

The delivery of mental health services in Inverclyde is guided by Scotland's National Mental Health Strategy which sets out 14 recommendations. The Modernising Mental Health Services Inverclyde programme is currently being implemented. In addition there is currently a programme of clinically led redesign work within NHS Greater Glasgow and Clyde, which will further inform clinical service development over the next 5 to 10 years.

Dementia Care Pathway

Using a model for the care pathway based on the clinical Integrated Care Pathway for Dementia will support the delivery of services in line with evidence about what works to improve services of people with dementia. The aim of the pathway is to support all people with suspected dementia to access diagnosis, assessment and ongoing support if required. [Appendix 4]

Carers Strategy

The Dementia Strategy also links closely with Inverclyde Carers' Strategy 2012-15, which sets out the CHCP's commitment to carers in Inverclyde. Carers are recognised by Inverclyde CHCP, as equal partners in the planning and delivery of care and the action plan sets out how the CHCP and its partners will support carers to continue in their caring role. The Carers Strategy identifies the key outcomes, which carers across Inverclyde in a variety of caring situations have identified as being the most important priorities for them.

Inverclyde Commissioning Strategy

A high level joint commissioning strategy for the Community Health and Care Partnership has been developed with actions for services to develop and bring forward commissioning plans.

There will be a shift in the model of care with a focus on prevention and early intervention with a significant effort to ensure that community capacity building is maximised. The range and flexibility of care, support and treatment will need to grow to meet increased needs, expectations and the outcomes desired by people with dementia, their families and carers. By altering models and methods of service provision we aim to provide services which are relevant to people with dementia,

their families and carers in a more effective way. This is anticipated to impact on what services are commissioned for people with dementia.

The implementation of Self Directed Support will also provide an opportunity for people with dementia to create and manage personalised and flexible support plans. This will be implemented from April 2014.

9. Consultation and involvement

We will continue to develop our consultation and involvement arrangements involving people with dementia and their carers in the planning, development and delivery of the strategy. Consultation and engagement will continue to be developed through the Inverclyde Dementia Strategy Forum.

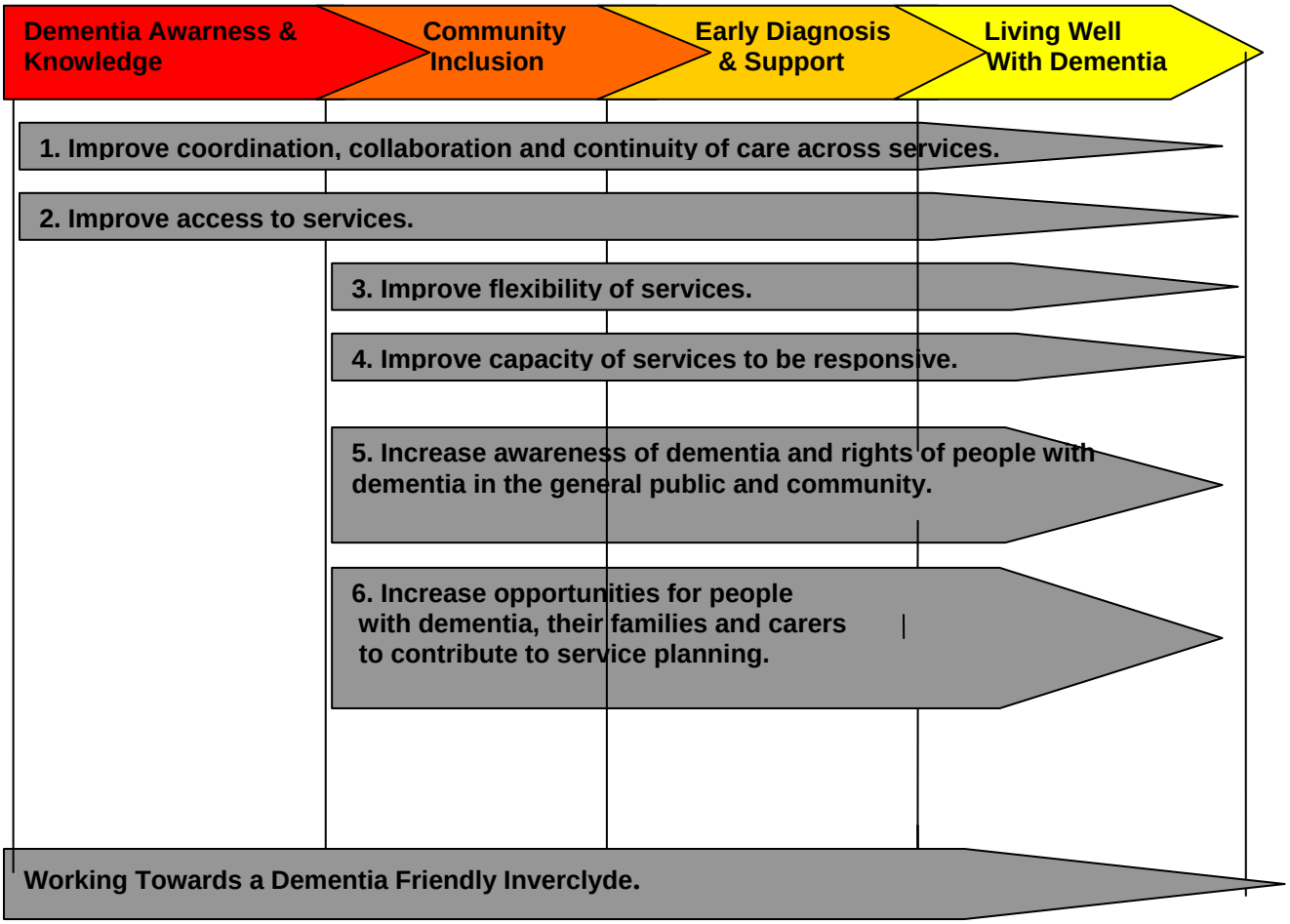
The Inverclyde Community Health and Care Partnership is committed to involving people guided by the CHCP People Involvement Framework. The Public Partnership Forum and CHCP Advisory Group provide a mechanism which will allow for regular gathering of views and feedback.

10. Implementation, monitoring and review of the strategy

The Dementia Strategy will be taken forward through the Dementia Strategy Forum Implementation working group. The Working Group will report to the Inverclyde Dementia Strategy Forum, a wider stakeholder group. The strategy sits within the CHCP governance arrangements for Reshaping Care for Older People as outlined in Appendix 3.

Dementia Action Plan

Getting It Right for People with Dementia, their families and carers in Inverclyde



Crosscutting Themes

1. Improve Dementia Awareness and Knowledge
2. Improving Community Inclusion
3. Early Diagnosis and Support
4. Living Well with Dementia

Strategic Outcomes

Outcome 1 Improve coordination, collaboration and continuity of care across services

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Outcome 4 Improve capacity of services to be responsive

Services which are responsive to the individual needs of people with dementia are provided by individuals and organisations that have a good level of knowledge and skill and have the resources to adapt services to individual needs. Increasing knowledge about dementia will be a key to the success of this strategy, alongside the development of a culture that embraces creative approaches to supporting people with dementia, their families and carers. Methods for achieving this include Promoting Excellence, developing new and utilising current expertise on dementia, and sharing best practice.

Outcome 5 Increase awareness and understanding of dementia and rights of people with dementia in the general public and community

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Outcome 6 Increase the opportunities for people with dementia, their families and carers to contribute to service planning.

The strategy aims to achieve this by building on current work, to enable people with dementia, their families and carers to contribute to service redesign, through community capacity building and developing our community involvement and engagement mechanisms. This includes demonstrating how we are meeting the

standards of care for dementia, self assessment, peer review, and benchmarking. There is a need to mainstream dementia as a community wide issue, where it is everybody's business across all sectors of our community.

Outcome	Areas for action	Themes	Linkages/Enabling Work
Outcome 1 Improve coordination and collaboration across services to enable improved continuity of care	Implement training needs analysis across all services, and promote training opportunities Continue to develop use of single shared assessment	**Dementia Awareness and Knowledge** **Living well with Dementia**	CHCP Learning and Development plan SWIFT development work
Outcome 2 Improve access to services	Implement dementia care pathway, including access from acute services Develop and implement models of post diagnostic support	**Early Diagnosis and Support** **Living well with Dementia**	Modernising Mental Health in Inverclyde Carers Strategy HEAT target and standards End of Life and Palliative Care
Outcome 3 Improve flexibility of services	Implement asset based and outcome focussed assessment and support planning including Pillars of support models Develop and promote alternative models of care	**Living well with Dementia**	Self Directed Support Reshaping Care for Older People Strategy CHCP Commissioning Strategy
Outcome 4 Improve capacity of services to be responsive	Promote Dementia Champions across services Implement Promoting Excellence Framework Evaluate services using Dementia standards and promote use within	**Dementia Awareness and Knowledge** **Community Inclusion**	CHCP Commissioning Strategy Inverclyde Housing strategy CHCP Learning and Development plan

	service development		
Outcome 5 Increase awareness of dementia- in the general public and community	Develop project for promotion of Dementia Friendly Inverclyde Develop communication strategy Promote the charter of rights for people with dementia Develop Health Improvement work to inform and promote lifestyle changes which may reduce or slow the onset of dementia	**Community Inclusion** **Living Well with Dementia**	Anti stigma Partnership Single Outcome Agreement Health Improvement; Health Inequalities; Mental Health and Wellbeing
Outcome 6 Increased opportunities for people with dementia, their families and carers to contribute to service planning, development and redesign.	Develop consultation and involvement arrangements Sustain and support the development of peer support for people with dementia and their families and carers	**Community Inclusion** **Living Well with Dementia**	People Involvement Strategy Carers Strategy

Glossary

Carers: informal Carers, who may be family or close friends.

Co-morbidity / co-existing: the presence and the effect of one or more disorders or illnesses in addition to the primary disorder or illness.

Dementia: A collective term used to describe a range of progressive conditions that affect mental abilities such as memory, communication and reasoning.

Dementia friendly communities: Positive communities which help people with dementia and their Carer to live their lives as normally as possible for as long as possible, and reduce the stress of isolation.

Demographic changes: Description of how the number and characteristics of people who live in an area are predicted to change over time.

Early intervention: An approach based on detecting and responding to needs and illness as early as possible to aim for better outcomes for people.

HEAT Targets: Scottish government key priorities for NHS services covering:

Health Improvement
Efficiency and Governance improvements
Access to services
Treatment appropriate to individuals

Integrated Care Pathway (ICP) Based on available evidence and guidance, this is a joined up approach to providing services for people with specific needs which identifies what care will be provided, who will provide it, how it will be provided and when it will be provided

Learning disability: A significant, lifelong condition, which includes significant impairment of intellectual functioning (IQ<70) and significant impairment of adaptive and social functioning.

Life Limiting Condition: A wide range of conditions for which there is no reasonable hope of cure.

Long term conditions: Conditions which have a clear diagnosis require ongoing medical care and limit what a person can do for a year or more are generally included e.g. coronary heart disease, diabetes. The definition also includes many conditions which, although long-term and life limiting in some cases, can also be acute or easily managed in others e.g. back pain, skin disorders.

Motor skills: Actions that involve movements of bodily muscles.

Outcomes based: An approach to providing services which focuses on achieving positive results (outcomes) for people with needs.

Outreach: An approach based on bringing and providing services to people at home or where they live or spend time.

Palliative Care: The active holistic care of people with advanced progressive illness including the management of pain and other symptoms and the provision of psychological, social and spiritual support, aimed at achieving the best quality of life for people.

Personalised services / Personalisation: A Scottish Government initiative to allow people to individually tailor their care by giving them more control over health and social care provided for them.

Short breaks (respite): short breaks are provided with the aim of enhancing and developing the quality of life of a person who has support needs and their Carer (where there is one) and to support their relationship. The distinctive feature of a short break is that it should be a positive experience for both. Short breaks can be provided within or out with an individual's home. Short breaks cover all situations including:

• where there is no Carer present, but the person with care needs requires a break from their normal situation
• breaks from caring where the Carer needs a break
• emergency crisis support

Telecare / Telehealth / Assistive Technology: The use of technology to enable individuals to master the tasks at home, increase independence and improve quality of life.

Young onset dementia / early onset dementia: Terms used to describe the diagnosis of dementia in anyone under the age of 65.

APPENDICES

Appendix 1. Dementia and incidence

Dementia is the collective term used to describe a progressive condition with a range of symptoms such as increasing memory impairment, reduced communication skills and reasoning. Alzheimer's disease is the most common. Vascular dementia is the second most common diagnosis. Other types of dementia include Lewy body dementia and Frontotemporal dementia.

The chance of developing dementia increases with age, and it is recognised as a life limiting condition. Dementia is a complex condition which affects people in different ways, symptoms can be difficult to identify and diagnose, particularly when other symptoms or other conditions exist. Dementia can eventually affect all aspects of everyday living, but presents different challenges for the person with dementia, their families and carers at different stages in the illness.

Our aging population will result in a significant increase in the number of people living with dementia in the years ahead. This demographic shift will impact on health, social care, and housing services in particular. There are also implications for wider services in terms of enabling people with dementia to live well and participate in our community.

Population Profile

In Inverclyde there are 1385 people predicted to have dementia. Dementia mainly affects older people however, it can affect younger people and in Inverclyde there are 49 people under the age of 65 predicted to have dementia.

Under 65	65+	Total
49	1336	1385

The prevalence rates for older people with dementia aged 65+ is approximately 10% of the older population and an anticipated 30% for people aged over 80. In Inverclyde we anticipate there will be an increase of 10% of those aged 85-89 year with dementia and a 26% increase in those aged 90 or above.

[Data taken from Alzheimer Scotland website Inverclyde data calculated from GROS (General Register Office from Scotland) data applying Euroderm prevalence rates.]

At March 2013 there were 673 people on the Dementia register held within GP practices.

The table below outlines the projected population changes in Inverclyde by age band.

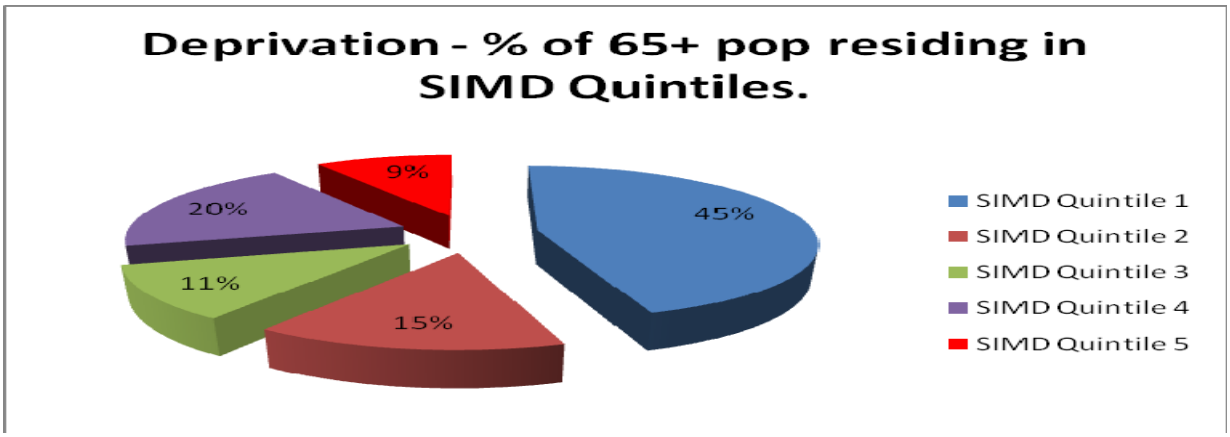
Projected Population Changes in Inverclyde

Category / Year	2015	2020	2025	2030	2035
Inverclyde All Ages	-3%	-5%	-9%	-12%	-17%
Inverclyde 0-15	-4%	-5%	-10%	-18%	-27%
Inverclyde Working Ages	-2%	-6%	-11%	-18%	-24%
Inverclyde Pensionable Ages	-2%	-3%	1%	9%	11%
Inverclyde 75+	7%	16%	31%	42%	58%

The age group in Inverclyde which will increase the most is the 75+ age group. As dementia increases with age, combined with a growing elderly population we anticipate an increase in the prevalence of dementia.

The levels of deprivation within Inverclyde are significant. Many of our highest concentrations of older people live in areas of multiple deprivation, and many live alone.

The graph below shows that 45% of people over 65 living in Inverclyde, live in the Scottish Index of Multiple Deprivation (SIMD) quirtile 1, the most deprived. 9% of our older people live in SIMD quintile 5, our most affluent areas.



	2009 SIMD Profile	Number	% of entire 65+ pop.
Most Deprived ▲ ▼ Least Deprived	SIMD Quintile 1	6282	45%
	SIMD Quintile 2	2084	15%
	SIMD Quintile 3	1568	11%
	SIMD Quintile 4	2743	20%
	SIMD Quintile 5	1322	9%

Appendix 2 Local and National Policy Context

National Policy:

- Better Outcomes for Older People
- Changing Lives
- All our futures: Planning for a Scotland with an Aging Population (2007)
- Shifting the Balance of Care
- Community Care Outcomes Framework
- NHS HEAT Targets
- National Dementia Strategy and Standards for Dementia Care
- National Carers Strategy
- NHS Scotland Quality Strategy 2010
- National Older People's Housing Strategy
- Reshaping Care for Older People: A Programme for Change 2011-21
- Self-Directed Support
- Living and Dying Well
- 2020 Vision

Local Policy:

- Inverclyde Reshaping Care for Older People Change Plan
- Inverclyde Local Housing Strategy
- Inverclyde Carers Strategy 2012 – 15
- Inverclyde Joint Community Care Plan 2010 – 2012
- Inverclyde CHCP Directorate Plan
- NHS GG&C Clyde Mental Health Strategy
- NHS GG&C Long Term Conditions Strategy
- NHS Greater Glasgow and Clyde Planning and Policy Frameworks (Older People/ Disability/ Long Term Conditions/Carers)
- Inverclyde Council Corporate Plan
- NHS GG&C Acute Services Review (ASR)
- NHS GG&C Clinical Services Review
- Inverclyde CHCP People Involvement Framework
- Inverclyde Single Outcome Agreement

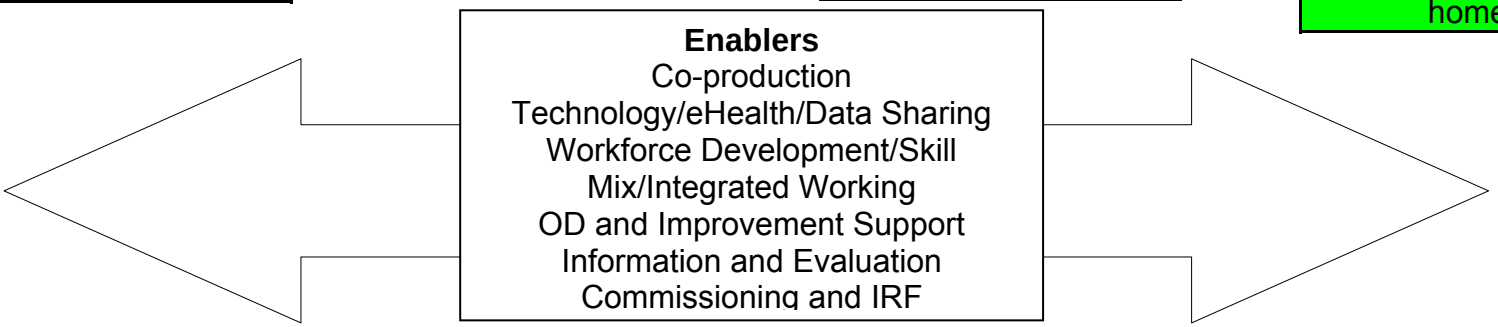
Key Strategic Drivers:

- Reablement
- Integration of health and social care services
- Rehabilitation Framework
- Self Directed Support and Personalisation
- Telecare and Telehealth
- Community Capacity Building/ Community Development
- Co-production – working together with users and carers to develop services and supports

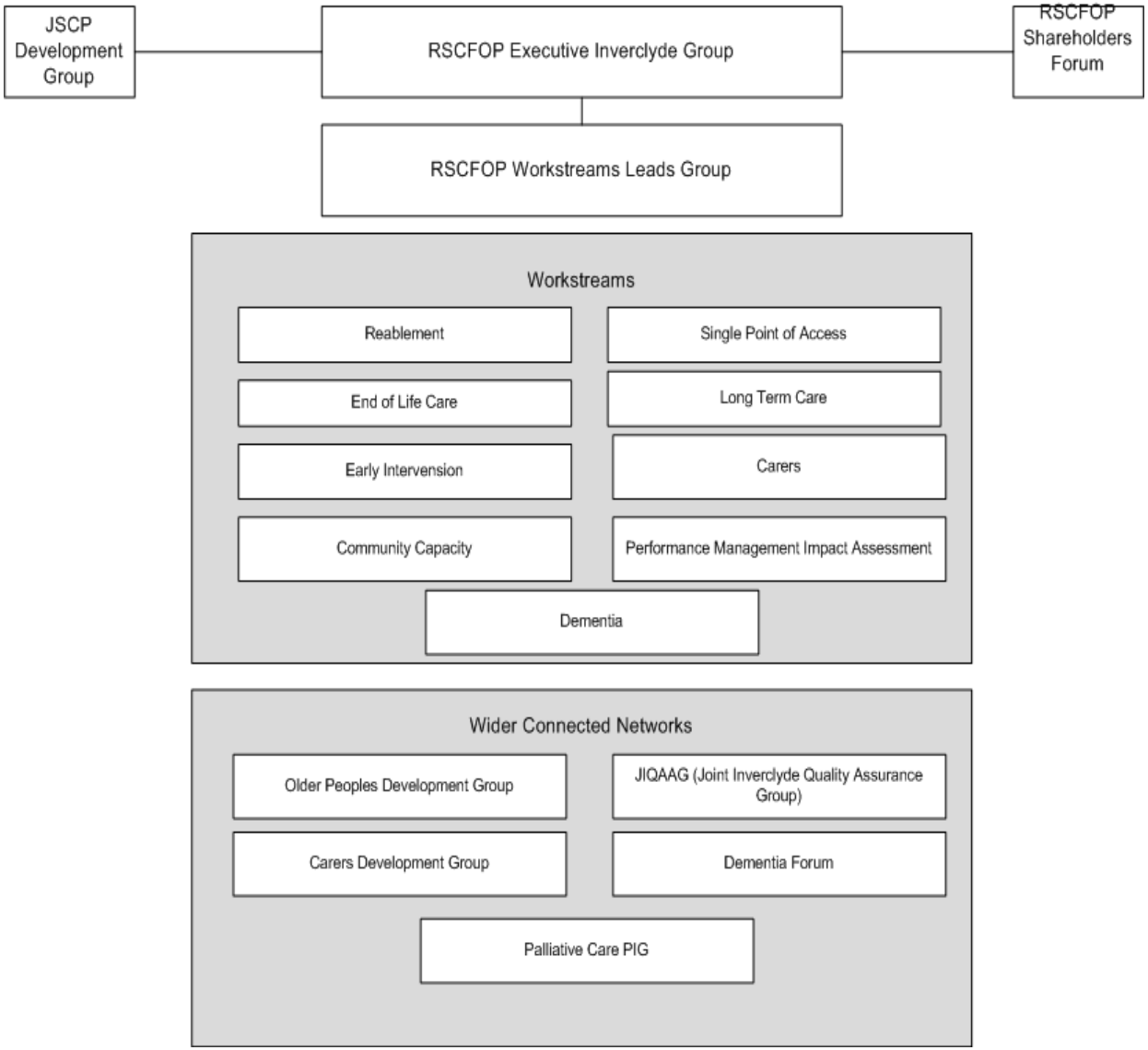
Appendix 3 Reshaping Care for Older People

RESHAPING CARE PATHWAY

Preventative and Anticipatory Care	Proactive Care & Support at Home	Effect Care at Times of Transition	Hospital and Care Home(s)
Build social networks and opportunities for participation.	Responsive flexible, self-directed home care.	Reablement & Rehabilitation.	Urgent triage to identify frail older people.
Early diagnosis of dementia.	Integrated Case/Care Management.	Specialist clinical advice for community teams.	Early assessment and rehab in the appropriate specialist unit.
Prevention of Falls and Fractures.	Carer Support and Respite.	NHS24, SAS and Out of Hours access ACPs.	Prevention and treatment of delirium.
Information & Support for Self Management & self directed support.	Rapid access to equipment.	Range of Intermediate Care alternatives to emergency admission.	Effective and timely discharge home or transfer to intermediate care.
Prediction of risk of recurrent admissions.	Timely adaptations, including housing adaptations.	Responsive and flexible palliative care.	Medicine reconciliation and reviews.
Anticipatory Care Planning.	Telehealthcare.	Medicines Management.	Specialist clinical support for care homes.
Suitable, and varied, housing and housing support.		Access to range of housing options.	



Governance of the Joint Strategic Commissioning Plan
Reshaping Care for Older People in Inverclyde



Appendix 4. Dementia Care Pathway

Diagnosis

The experience of memory loss can be alarming and frustrating. People whose lives are affected by memory loss need to know if the symptoms are caused by a form of dementia and seek an appropriate medical response. Access to comprehensive diagnostic services is essential to ensure that appropriate advice and support is given to individuals at the earliest opportunity, including access to local services if required.

Post-Diagnostic Support

Access to information and advice will enable people with dementia and their family put in place a support system which can adjust to changing needs at a pace and level which best meets their needs and circumstances. Post diagnostic support enables people to plan for the future, maintain independence and live well with their condition.

Community Services

People with dementia should be supported to maintain a normal life, sustaining family and community relationships. This support should be provided in the home for as long as possible and appropriate.

Access to support is arranged when it is needed and tailored to meet personal choices.

Care in other Settings

There will be occasions where people with dementia can no longer be cared for within the home. When this occurs support will be given to ensure ongoing care is provided within the most appropriate setting be this hospital or care home.

Coordination and Case Management

Services will be provided based on individual need delivered flexibly to take account of changing circumstances. A partnership approach will be taken to assessment, monitoring and review to ensure people with dementia have their needs assessed and services are delivered in a seamless way.

We will make our decision making processes transparent recognising that carers have needs and a carer's assessment will be offered where possible. There will be a named worker for each person with dementia or, where this is not desired, contact routes given.

A Model of Care and Care Pathway For Living Well With Dementia

Need for help	Interventions	Access	Step up to more intense care when:	Level of Care/ Intensity of care	Service users can expect	People living with dementia should be able to say:
Raising awareness and understanding • to encourage help seeking and help offering • Prevention	Dementia awareness Dementia risk reduction Anti stigma	Everyone	Service user chooses	**1. Public** Community mental health and well being	**To define Living Well with Dementia goals between user/carer & service** **Progress towards personal and quality of life goals for living well with dementia**	I was diagnosed early I and those around me & looking after me feel well supported I have a personal plan to help me to: • Understand the illness and manage the symptoms • Support community connections • Access peer support • Plan for future care • Plan for future decision-making
Anyone concerned about their own health or other peoples health	Information Carer support Peer support	Open self referral	Service user chooses, GP referral, referral from other healthcare professionals	**2. Open Access**		
Early Diagnosis and support • for people concerned about their own or other people's memory problems	Memory assessment service Early diagnosis Post Diagnosis Support Continuity of support Involvement of carers and family	Referral including self referral	Service user chooses, GP referral, referral from other healthcare professionals	**3. Early response/ brief intervention** (ERBI)		

Living Well with dementia • quality of life for people diagnosed with dementia	Specialist assessment & treatment • management of stress & distress Dementia friendly: • Intermediate care • Care home care • Housing with telecare • End of life care Personal support/ anticipatory care p Continuity of post diagnostic support Peer support	GP or secondary care	By referral only	**4. Longer term multi disciplinary care**			I can enjoy life I am given the right information at the right time and in the right way, so I make good decisions and provide for future decision making
Acute illness	Inpatient dementia care: • Dementia friendly care in general hosp • Risk management • Physical healthcare	GP or secondary care		**5. Intensive treatment**			I am treated with dignity and respect I get the treatment and support which are best for my dementia, and my life I am confident my end of life care wishes will be respected. I can have a good death

Appendix 5. Charter of Rights, and Standards of Care for People with Dementia, their family and their Carers in Scotland 2009.

Preamble

In pursuance of Human Rights Act 1998 and The Scotland Act 1998 the rights contained within this charter are based on internationally agreed human rights and are intended to promote the respect, protection and fulfilment of all human rights of people with dementia and their Carer, as guaranteed in the European Convention of Human Rights, the Universal Declaration of Human Rights, the International Covenants on Economic, Social and Cultural Rights and Civil and Political Rights, and the Convention on the Rights of Persons with Disabilities, the key principles of which are:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality or opportunity
- Accessibility
- Equality between men and women

The Charter also reflects other legal provisions and in particular the principles of the Adults with Incapacity (Scotland) Act 2000; the Mental Health (Care and Treatment) (Scotland) Act 2003, and the Adult Support and Protection (Scotland) Act 2007.

The Charter is guided by a human rights-based approach (known as the **PANEL** approach, endorsed by the United Nations).

It emphasises the rights of everyone to:

Participate in decision which affects their human rights
Accountability of those responsible for the respect, protection and fulfilment of human rights
Non-discrimination and equality
Empowerment to know their rights and how to claim them
Legality in all decisions through an explicit link with human rights legal standards in all processes and outcome measurement

People with dementia and their Carer, at every stage of the illness and wherever they are, have the following rights

Participation

1. People with dementia and their Carer have the right to be provided with accessible information and the support they require in order to enable them to exercise their right to participate in decisions which affect them

2. People with dementia and their Carer have the right to live as independently as possible with access to recreational, leisure and cultural life in their community

3. People with dementia and their Carer have the right to full participation in care needs assessment, planning, deciding and arranging care, support and treatment, including advanced decision making

4. People with dementia and their Carer have the right to be assisted to participate in the formulation and implementation of policies that affect their well-being and the exercise of their human rights

Accountability

5. People with dementia and their Carer have the right to be able to enjoy human rights and fundamental freedoms in every part of their daily lives and wherever they are, including full respect for their dignity, beliefs, individual circumstances and privacy

6. Public and private bodies, voluntary organisations and individuals responsible for the care and treatment of people with dementia should be held accountable for the respect, protection and fulfilment of their human rights and adequate steps should be adopted to ensure this is the case.

Non-discrimination and equality

7. People with dementia and their Carer have the right to be free from discrimination based on any grounds such as age, disability, gender, race, sexual orientation, religious beliefs, social or other status.

Empowerment

8. People with dementia have the right to access appropriate levels of care providing protection, rehabilitation and encouragement.

9. People with dementia have the right to help to attain and maintain maximum independence, physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life

10. People with dementia and their Carer have the right to access opportunities for community education and lifelong learning

11. People with dementia have the right to access to social and legal services to enhance their autonomy, protection and care

12. People with dementia have the right to health and social care services provided by professionals and staff who have had appropriate training on dementia and human rights to ensure the highest quality of service

Legality

13. People with dementia and their Carer have the right to have the full range of human rights respected, protected and fulfilled. In addition to those explicitly contained in the Human Rights Act 1998, these include:

- the right to live in dignity and security and be free of exploitation, violence and physical, mental or sexual abuse;
- economic, social and cultural rights including the right to an adequate standard of living including social protection; and
- the right to the highest attainable standard of physical and mental health

14. People with dementia and their Carer have the right to information, to participation in decision making and, where rights are not observed, the right to seek remedy through effective complaint and appeal procedures

15. People with dementia have the right, regardless of diagnosis, to the same civil and legal rights as everyone else. Where someone lacks capacity to take a specific action or decision due to their mental disorder, anyone acting for them must have regard for the principles and provisions of the Adults with Incapacity (Scotland) Act 2000. These principles are enshrined in Article 12 of the Convention on the Rights of Persons with Disabilities which sets out international standards in relation to legal capacity. In summary, any intervention on behalf of the person with dementia who lacks capacity must:

- benefit the person
- restrict the person's freedom as little as possible whilst still achieving the desired benefit
- take account of the person's past and present wishes (with appropriate support to assist communication)
- take account of the views of relevant others and
- encourage the person to use their existing abilities and to develop new skills

Reproduced from the Charter of Rights for people with dementia and their carer in Scotland; a full copy is available from the link below:

http://www.dementiarights.org/charter-of-rights/

Standards of Care

The standards were developed by the Scottish Government and the Mental Welfare Commission in 2011 to help people with dementia, their families and carers understand their rights, and how these rights can help make sure that they receive the support they need to stay well, safe and listened to.

People with dementia retain the same rights as anyone else in society but the nature of their illness means that they may have difficulty in protecting these rights.

These standards relate to everyone with a diagnosis of dementia in Scotland regardless of where they live, their age, the supports they receive or the severity of their illness. This includes younger people, people with a learning disability and people with rare types of dementia. They apply to people living in their own homes, care homes or hospitals, especially general hospitals.

The two main sources of information which underpins these standards are:

1. The Charter of Rights for People with Dementia and their Carers in Scotland.

2. What people with dementia and their carers in Scotland have identified as being important to them and what they want from services.

The standards should be used in conjunction with Promoting Excellence: A framework for health and social care staff working with people with dementia, their families and carers. The framework outlines in detail the skills and knowledge health and social care staff should have depending on the role they play in supporting people with dementia. Organisations are identified that have the main responsibility to make sure that each standard is met. The standards require organisations to work together and reflect a right's based approach to reduce barriers ,stigma and discrimination, improving opportunities for people with dementia to access care, support and treatment.

The Standards framework

- I have the right to a diagnosis
- I have the right to be regarded as a unique individual and to be
- treated with dignity and respect
- I have the right to access a range of treatment, care and supports
- I have the right to be as independent as possible and be included in
- I have the right to have carers who are well supported and educated
- about dementia
- I have the right to end of life care that respects my wishes

This section has been reproduced and adapted from the Standards for Care for Dementia in Scotland: Action to support the change programme, Scotland's Dementia Strategy 2011, the full document is available from the following link:
http://www.scotland.gov.uk/Resource/Doc/350188/0117212.pdf

References and links

1. Scotland's Dementia Strategy 2010
http://www.scotland.gov.uk/Publications/2010/09/10151751/0

2. Charter of Rights for people with dementia and their carers in Scotland 2009
http://www.dementiarights.org/charter-of-rights/

3. Standards for Care for Dementia in Scotland: Action to support the change programme, Scotland's Dementia Strategy 2011
http://www.scotland.gov.uk/Resource/Doc/350188/0117212.pdf

4. Remember I am still me (2009) Care Commission & Mental Welfare Commission, Edinburgh
http://library.nhsggc.org.uk/mediaAssets/dementiasp/remember_im_still_me_-_may_09[1].pdf

5. An estimate of the number of people with dementia in your Scottish local authority area:
http://www.vhscotland.org.uk/library/vol/dementiastats09.pdf

6. The number of people on the Quality and Outcomes framework dementia register and other equivalent resources:
http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance/

7. NICE Dementia Guideline:
http://www.nice.org.uk/cg42

8. Management of patients with Dementia: A National Clinical Guideline
NHS Quality Improvement Scotland:
http://www.sign.ac.uk/pdf/sign86.pdf

9. The planning, organisation and delivery of joined up services for those with dementia and their carers, NHS HDL 2004 44
http://library.nhsggc.org.uk/mediaAssets/library/qis_OOH_LRP_ARGC06.pdf

10. NHS Quality Improvement Scotland Integrated Care Pathway Toolkit Dementia:
http://library.nhsggc.org.uk/mediaAssets/dementiasp/mentalhealth_standardsforICP_DEC07[1].pdf

11. Leading For Outcomes: Dementia 2011, Institute for Innovation and Research in Social Services:
http://www.iriss.org.uk/resources/iriss-leading-outcomes-guide01
www.iriss.org.uk

12. Dementia Gateway: Getting to know the person with dementia
http://www.scie.org.uk/publications/windowsofopportunity/journey/index.asp

13. Alzheimer Society (2007) Dementia UK available at
http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=342

14. The Scottish Dementia Working Group, the independent group of people with dementia, www.sdwg.org.uk

15. Facing dementia: how to live well with your diagnosis, Health Scotland, http://www.scie.org.uk/publications/windowsofopportunity/personalresources/index.asp

16. Coping with Dementia: a practical guide for carers, (2009), NHS Health Scotland www.healthscotland.com/documents/1469.aspx

17. Talking Mats help involve people with dementia and their carers in decision-making, Joseph Rowntree Foundation, 2010 : http://www.jrf.org.uk/publications/talking-mats-decision-making

18. Crampton,J.Eley, R. [and] Dean, J. (2012).Creating a dementia-friendly York. London: Joseph Rowntree Foundation (JRF), October 2012 http://www.jrf.org.uk/sites/files/jrf/dementia-communities-york-summary.pdf

19. Supporting those with dementia: reminiscence therapy and life story work, IRISS Insights, 2010 available at: http://lx.iriss.org.uk/collections/IRISS%20Insights

20. Improving communication around outcomes: a resource to support reflection and practice development http://www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/communication-skills/

Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 8

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 9th January 2014**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/09/2014/BC**
Contact Officer:	**Beth Culshaw Head of Health & Community Care Inverclyde Community Health & Care Partnership**	**Contact No: 01475 715387**
Subject:	**JOINT STRATEGIC COMMISSIONING PLAN FOR OLDER PEOPLE 2013 - 2023**	

1.0 PURPOSE

1.1 To provide the Joint Strategic Commissioning Plan for Older People 2013 – 2023.

2.0 SUMMARY

2.1 The vision set out by Government in the strategy 'Reshaping Care for Older People' is that "Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting". The 10 year strategy 2011- 2021 A Programme of Change, sets out the Scottish Government vision for improving care quality and outcomes for older people in our communities, and presents unique challenges with regard to rapidly changing demographic trends, expectations and economic drivers. Plans outlining how associated change fund investment monies would be utilised have been required on a yearly basis, and have previously been submitted to the CHCP Sub Committee.

2.2 The Scottish Government and COSLA agreed that partnerships should develop longer term commissioning plans which would be ready for the financial year 2013/14. These should include a Joint Strategic Needs Assessment and a Housing Contribution Statement.

2.3 Inverclyde CHCP and local partners developed the draft Joint Strategic Commissioning Plan for Older People 2013 – 2023 and following public engagement and subsequent review, the final version is submitted to the CHCP Sub Committee.

3.0 RECOMMENDATION

3.1 The Community Health and Care Partnership Sub Committee is asked to:

Approve the Joint Strategic Commissioning Plan for Older People 2013 – 2023.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 Audit Scotland in their report *Commissioning Social Care* recommended that Councils along with NHS Boards and other relevant partners develop commissioning strategies. Local Change Fund Plans should evolve into Joint Strategic Commissioning Plans.

4.2 The National Steering Group agreed the following definition, based on earlier work by SWIA: "Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place." Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget. The Public Bodies (Joint Working) Bill will facilitate integration of commissioning budgets for adult services and the joint commissioning process is required to support this.

4.3 The National Steering Group proposed that:

- One year investment plans will provide the details of delivery arrangements for the short term change agenda. These will form the required older people's Change Fund Plans for 2013/14.
- Detailed 3 year implementation plans relating to the care group Strategic Commissioning Plans; will be detailed rolling three year planning documents refreshed on an annual basis;
- Partnership Commissioning Strategies and Strategic Commissioning Plans should be of 10 year time-frame reviewed and refreshed regularly consistent with related local planning cycles;

4.4 As per national guidance, Inverclyde CHCP developed the Joint Strategic Plan for Older People 2013-2023 in partnership with Inverclyde Carers Council, CVS Inverclyde, Your Voice, Scottish Care and Inverclyde Carers Centre in Spring 2013. A subsequent period of public engagement followed, facilitated by Your Voice.

The Joint Improvement Team reviewed all Partnerships' Joint Commissioning Plans in March/ April and together with our local public feedback; this has informed the final version presented here.

4.5 The Joint Commissioning Plan evidences the current position of health and social care for older adults in Inverclyde through a Joint Strategic Needs Analysis and outlines our commitments, illustrating the changes we will make to achieve the desired outcomes for older people living in Inverclyde. The delivery plan (p.17) shows our approach over the short (1 year), medium (1-3 years) and long term (3-10 years).

5.0 PROPOSALS

5.1 The ten year Joint Strategic Commissioning Plan continues to be implemented and governed subject to the arrangements outlined on p9 of the plan.

5.2 The Reshaping care for Older People Executive Group will be responsible for ensuring the plan is reviewed and updated as required and remains sensitive to current requirements throughout its ten year life.

6.0 IMPLICATIONS

6.1 Legal: None

6.2 Finance: None

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

6.3 Equalities:

The Joint Strategic Commissioning Plan will be subject to an NHSGG&C Equality Impact Assessment commencing in December 2013.

6.4 Repopulation: None

7.0 CONSULTATION

7.1 During the period (21st February 2013 – 18th March 2013) Your Voice Inverclyde organised and engaged with 21 Focus Groups, 268 older people, including 81 carers/ex-carers, were involved in the groups. The information gathered forms part of the appendix.

8.0 LIST OF BACKGROUND PAPERS

8.1 Joint Strategic Commissioning Plan for Older People 2013 - 2023

JOINT STRATEGIC COMMISSIONING PLAN FOR OLDER PEOPLE

2013 – 2023

INVERCLYDE PARTNERSHIP

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W O R K I N G D R A F T
21.11.13

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1 OUR JOINT STRATEGIC COMMISSIONING PLAN

1.1 Introduction

The Inverclyde Joint Commissioning Plan for Older People 2013-2023 covers care and support services to older people over 65 years of age, which are delivered by the following partners, working closely with older people, carers, carers organisations and local communities:-

Inverclyde Community Health and Care Partnership
NHS Greater Glasgow and Clyde, including Primary and Secondary Care
Inverclyde Council
Third sector
Independent sector providers
Housing Providers

Our new plan outlines the partnership's vision for the next ten years. It explains how we will improve outcomes for older people and the approaches we are taking, including significant changes we will make to the ways in which we deliver care and support working with older people in Inverclyde.

The plan sets out a high level vision and future direction, along with specific areas for action and change, to show how we will work in partnership to develop new models of care and support to reshape services and improve outcome for older people, their families and carers. The plan is intended to reflect the CHCP's role as an ***assessor, purchaser, provider and safeguarder*** in relation to older people, and is designed to support business planning amongst our provider partners in the voluntary, community and independent sectors. The plan is also intended to stimulate creative, collaborative service planning and service delivery across organisational and sectoral boundaries, and to signal to existing and future providers of support potential service changes.

We intend to develop an older people specific elements of our Single Outcome Agreement to facilitate this through Community Planning.

This plan is also set in the context that the CHCP seeks through commissioning and strategic planning over the next 10 years to focus on delivering services that support ***involvement, empowerment, enablement*** **and** ***recovery*** for all citizens of Inverclyde, within the context of the Nurturing Inverclyde Agenda; where all citizens and communities can be ***Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible,*** *and* ***Included,*** *as demonstrated in the picture below:-*

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The plan has been developed within a challenging and ever-changing context where public services are facing financial constraints while demand for services is increasing.

Major policy changes are also in development that will reshape services for older people, including the integration of health and social care services and the introduction of legislation to support Self-Directed Support and the delivery of more personalised services. These changes are described in more detail throughout this document.

The CHCP is still a relatively new and young organisation. It is our intention, with partners, that we commit to looking afresh at our business and at the ways in which we support our older people. We aim not to be bound by traditional views of services or need, or by what has gone before, but to be inspirational and develop services that will be flexible and adaptable to change over time to meet the needs of people who use them, and their carers, strongly guided by the views and aspirations of local people as our key partners in improving services and delivering on outcomes.

We recognise that to deliver on our aspirations will require determined and committed leadership from all partners, and are confident that this approach is already evidenced by our achievements to date.

The aim of the document is to clearly signpost our direction of travel, providing a guide for partners to craft new ways of working to deliver on our shared ambitions.

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Signatories

Robert Calderwood: ……..
(Chief Executive, NHS GG&C)

John Mundell: ……..
(Chief Executive, Inverclyde Council)

Gloria McLaughlin: ……..
(Depute CEO, Scottish Care)

Ann Walsh ……..
(Chair, CVS Inverclyde)

Nell McFadden MBE ……..
(Chair, Your Voice – Inverclyde Community Care Forum)

Ann Price ……..
(Chair - Inverclyde Carers Centre Board)

Irene Pollard ……..
(Chair - Inverclyde Carers Council)

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1.2 Governance/Planning Arrangements

There is a long and fruitful history of partnership and cross sector working in Inverclyde. This plan will strengthen and deepen such partnerships, through Community Planning and the achievement of the Inverclyde Single Outcome Agreement.

As is the case with our Reshaping Care for Older People Programme, this plan is a product of the partnership between Inverclyde CHCP, NHS Greater Glasgow and Clyde, Inverclyde Council, Scottish Care and local independent sector providers, CVS Inverclyde, the local Third Sector, Your Voice – Inverclyde Community Care Forum, Inverclyde Carers Council and Inverclyde Carers Centre. The partnership is underpinned by continuous and deepening engagement and involvement of local people, service users and carers, through means such as the Inverclyde CHCP People Involvement Advisory Network, Inverclyde Carers Network, Inverclyde Elderly Forum and the Hillend Service Users Group

It is planned that there will be ongoing engagement with social care providers, community and third sector organisations and local housing associations and housing providers.

This will ensure a consensus on direction of travel, facilitating an environment of trust through transparency and a sense of ownership through the mutual recognition of the presenting challenges and opportunities, informing the development of shared solutions.

The governance of this plan will be through the partnership's Reshaping Care for Older People Programme Executive Implementation Group, underpinned by our Reshaping Care for Older People Programme Stakeholders Forum.

Statement of Governance

The graphic below is a statement of the decision making process in the CHCP related to Reshaping Care for Older People, and related agendas such as strategic joint commissioning.

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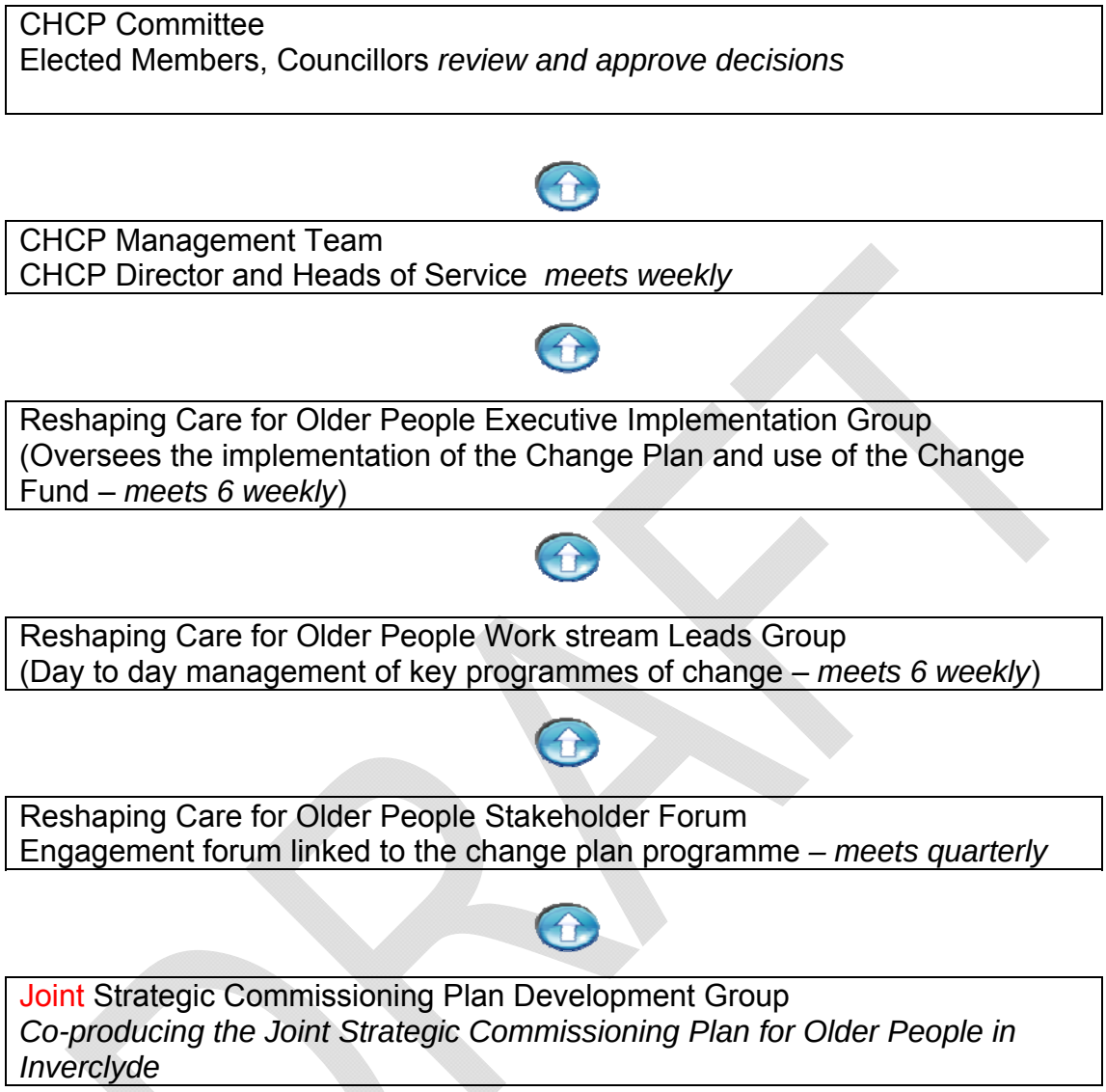
Figure 1:

Governance of the Reshaping Care for Older People in Inverclyde



Statement of Roles and Responsibilities of Each Partner

The roles and responsibilities of each partner are set out below:-

Inverclyde CHCP takes the lead role in strategic commissioning. On behalf of NHS Greater Glasgow & Clyde and Inverclyde Council the CHCP combines the interests of community health and social care. The CHCP provides a co-ordinating function and supports the partners in developing the strategic document by facilitating the process and mechanism of engagement around strategic joint commissioning and service change development.

The independent sector via Scottish Care is engaged in all joint strategic commissioning development through membership of the various groups depicted in the governance diagram (below). The CHCP also facilitates regular provider forum sessions to engage with independent sector provider organisations.

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The local Third Sector is represented in the governance structures by the involvement of CVS Inverclyde/Inverclyde Third Sector Forum (I3SF). The Third Sector are partners in all aspects of the RCOP agenda, with a particular role in relation to community capacity building and co-production.

Services users, patients and the public are key equal partners and their engagement is facilitated via the CHCP and our people involvement partners Your Voice - Inverclyde Care Community Forum, though the Inverclyde People Involvement Network and CHCP Advisory Group, including the Inverclyde Elderly Forum.

Carers are equal partners in care, with a right to a voice in care planning, review and in relation to the development, planning and commissioning of services. Inverclyde Carers Council and Inverclyde Carers Centre Board are signatures to the plan and undertake regular engagement with carers in the Inverclyde Carers Network and represent their interests via the reshaping Care for Older People Stakeholders Forum. The core element of our Carers Strategy 2012-2015 have been used to inform the Joint Commissioning Plan to further ensure commissioning intentions are concurrent with the needs and aspirations of carers.

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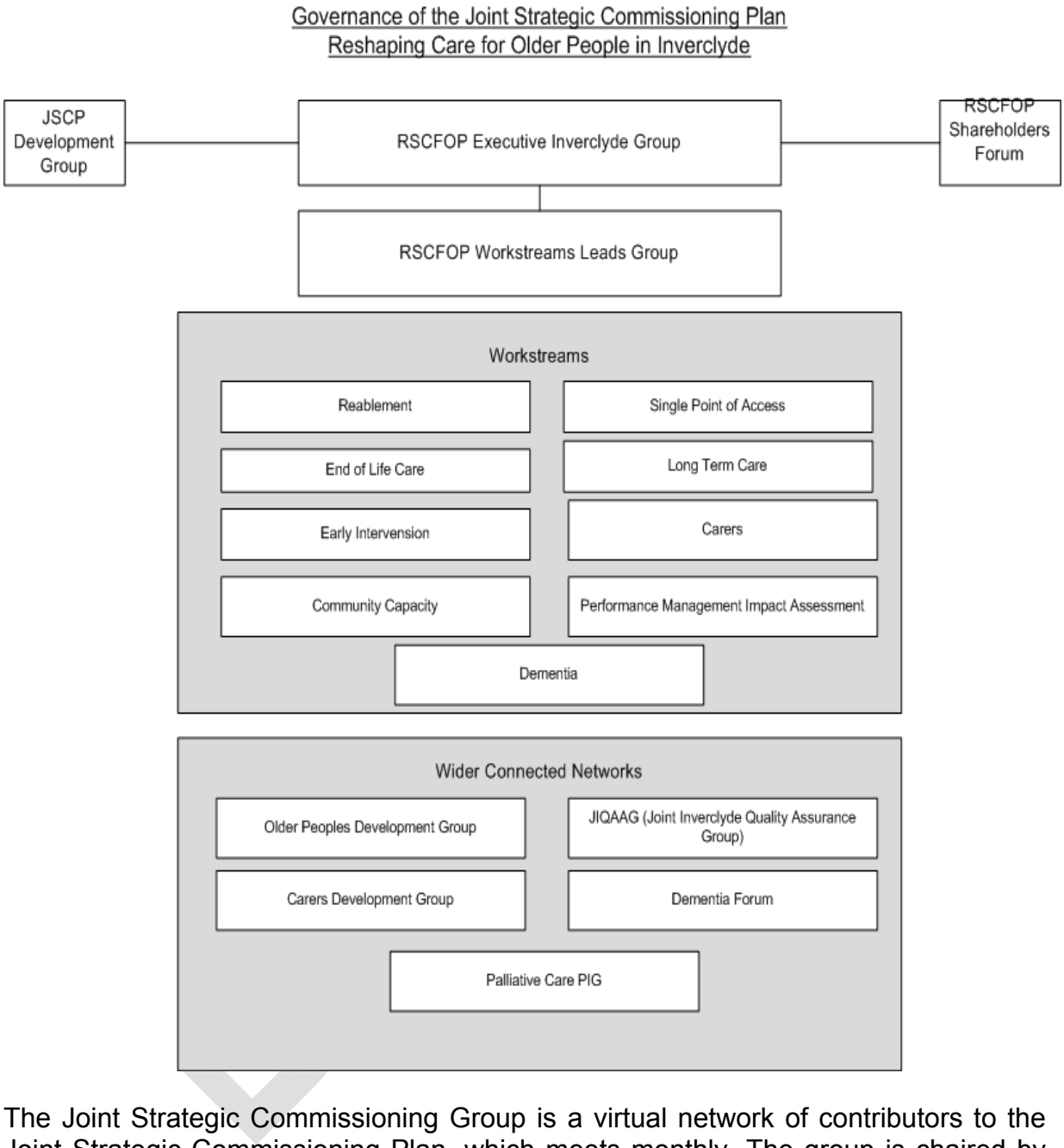
Figure 2:

Governance of the Joint Strategic Commissioning Plan



The Joint Strategic Commissioning Group is a virtual network of contributors to the Joint Strategic Commissioning Plan, which meets monthly. The group is chaired by the CHCP Head of Health and Community/Primary Care and has representation from a range of clients and sectors.

Regular communication is undertaken as part of the development work to engage views and opinions and this takes many forms including participating in existing forums.

Links with other Local Plans

This Joint Strategic Commissioning Plan has been developed through ongoing consultation with providers, users, carers and other interested parties predominantly linked to the Reshaping Care for Older People Change Plan, and will be an ongoing process.

This has enabled effective links with local planning activities, as well as maintaining a profile of its progress via the established governance frameworks supporting the Reshaping Care for Older People programme since 2011.

From a wider NHS GGC perspective, Inverclyde has an established representation on the NHSGGC Ageing Population Group, which facilitates linkages with the key themes of the NHS Local Delivery Plan, as well as emerging developments with the Clinical Services Review.

The intentions of this Joint Strategic Commissioning Plan are consistent with the aspirations of the Inverclyde Single Outcome Agreement and the CHCP Directorate Improvement and Development Plan, as well as the CHCP's Overarching Strategic Commissioning Plan which is in development.

Timescale of Plan

The submission of this plan sits within the Change Fund submission timetable, where a mid-year progress update was reported to the Joint Improvement Team (JIT) in September 2012, submission of the JIT reporting template on 28 February 2013, and publication of the draft Joint Strategic Commissioning Plan in February 2013. Subsequent review of the plan following public consultation has led to publication in November 2013.

The Inverclyde Joint Strategic Commissioning Plan for Older People is a 10 year vision of services for older people, which includes short term targets for change and the detail of which will inform our 2013/14 spend against the Older People's Change Fund.

We recognise that whilst planning for 10 years, the plan initially focuses on the next 2 to 3 years, and will continue to adapt and evolve as both service change and demographic change impacts.

Commissioning Approach - Stages

The Inverclyde Partnership is committed to the Social Work Inspection Agency Commissioning Model, depicted in the diagram below. Commissioning will take place via working through the 4 recognised stages: Analysis, Planning, Doing and Reviewing, and will focus on outcomes for our older people acknowledging that Joint Commissioning "*is a complex strategic activity combining traditional disciplines of strategic planning, service design, procurement, internal service planning and performance management, and applying these disciplines in a new multi-agency environment. Joint commissioning is not simply about contracting between purchasers and providers, but concerns a whole range of ways in which services are developed and secured, including grants, service agreements, voluntary and community contributions and co-production*".

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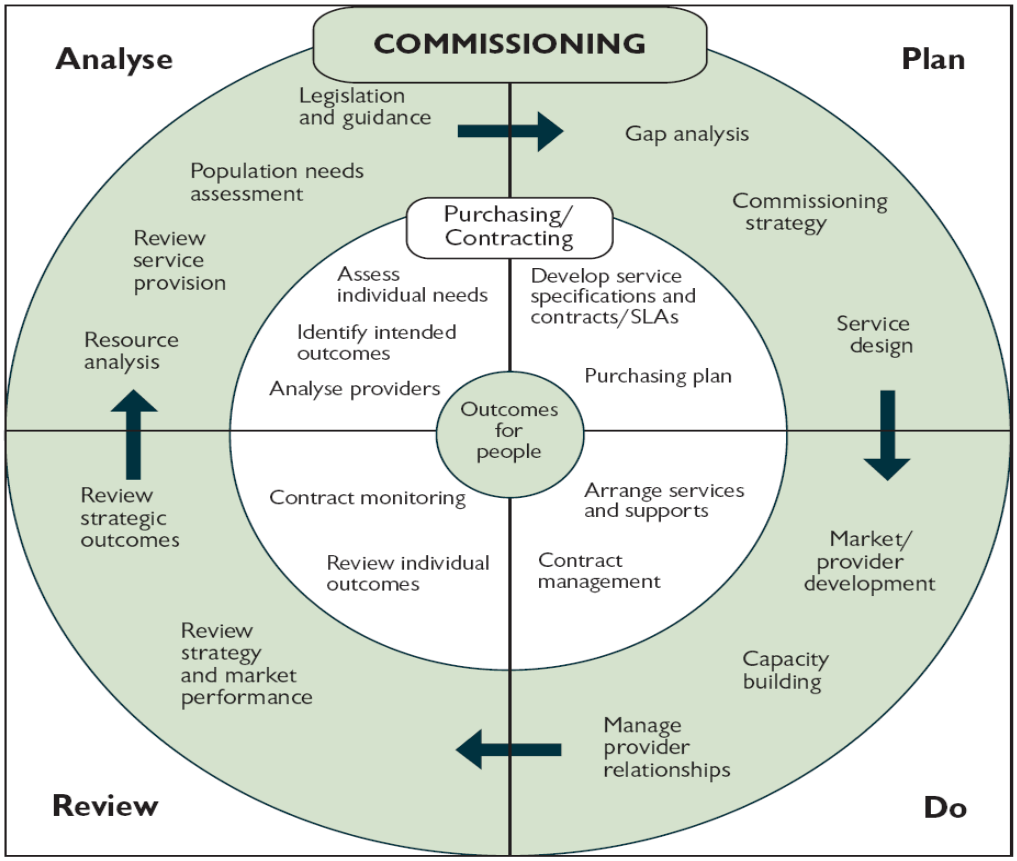
Figure 3:



1.3 Commissioning Approach – the market

Demand is expected to rise as a result of significant demographic change in the population of Inverclyde. Complexity is also increasing. This will have a substantial bearing on the care market, which has demonstrated vulnerabilities in the last twelve months, particularly in respect of independent care home providers.

The market will need to diversify the products and services offered to better meet the changing needs, expectations and outcomes of older people in Inverclyde and to develop in line with changing commissioning intentions and processes of purchasers.

A particular driver for this need for change will be the increase in use of self-directed support options by older people in realising their personal outcomes. Individual control over the delivery of personal outcomes will become a mainstream approach and people will choose from a range of self-directed support options instead of or in addition to statutory provision. We discuss this issue in more detail further on in this plan.

The range and flexibility of supports and services will need to grow to meet these changes while maintaining the highest quality of standards and value for money. In particular, there will be a shift in the model of care with an enhanced focus on rehabilitation and reablement. Prevention and early intervention will also be a focus

with a significant effort to ensure that community capacity building is encouraged and the use of community assets is maximised.

Models of housing provision will similarly need to reflect people's requirement for care and support which is delivered at home or in a homely setting. Commissioners and providers will be required to work together in partnership to develop approaches and service models to meet changing needs and expectations. At the same time quality assurance and monitoring arrangements will change to ensure that the effective delivery of desired personal outcomes for people is paramount regardless of the specific method of delivery chosen.

Overall public finance will reduce relatively over the course of the Joint Strategic Commissioning Plan and it is expected that a range of resources, personal and public, will be drawn upon in delivering care and support.

This Joint Strategic Commissioning Plan recognises the position of the public sector in working in partnership to lead and support diversification through engagement via provider fora to shape provision to deliver on the outcomes Inverclyde residents want to achieve. It also recognises the role to be played by Inverclyde residents, encouraging and maximising opportunities for individuals to take responsibility, for example, in the self management of care.

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2 OUR VISION AND COMMITMENTS

2.1 Our Commitment to Older People Living in Inverclyde

Our commitment to Older People living in Inverclyde, as set out in the ICHCP Older People's Strategy, is that they should:-

- Feel valued and respected as part of their community
- Be able to live a full and active life in safe and secure surroundings
- Have every opportunity to remain independent, to have freedom of choice and control over how they live their lives
- Be treated with dignity, courtesy and consideration
- Get timely access to the right level of support, information and intervention at times of crisis or transition

The belief that most people, including those with complex care needs, can and would prefer to be supported in their own homes underpins this commitment. This is a local view expressed recurrently in our conversations with older people and their carers.

Key Outcomes

The following key outcomes for Inverclyde's Older People will result from our commitment:

1. Older people are supported to be as independent as possible
2. Older people can determine how to live their lives and what support they want, should they require it
3. Older people contribute to their communities and public life
4. Older people are protected from harm and neglect and feel safe at home and in their communities.
5. People with dementia, and their carers, receive the treatment, care and support following diagnosis that enables them to live as well as possible regardless of setting.

The outcomes above are aligned to the continuum for older people's services in Inverclyde, as per the Older People's outcome wheel on page 14.

The continuum forms the basis of our key strategic drive to reshape care for older people and underpins our vision for older people's services, and our commissioning intentions as set out in this plan.

We are committed to looking afresh at how we enable and empower older people and their carers to take charge of their health and abilities to ensure that our older population experience the best possible quality of life and sense of wellbeing. Central to our ambition is the drive to optimise independence for older people, in their own homes whenever possible, and when this is not possible, then in a homely setting.

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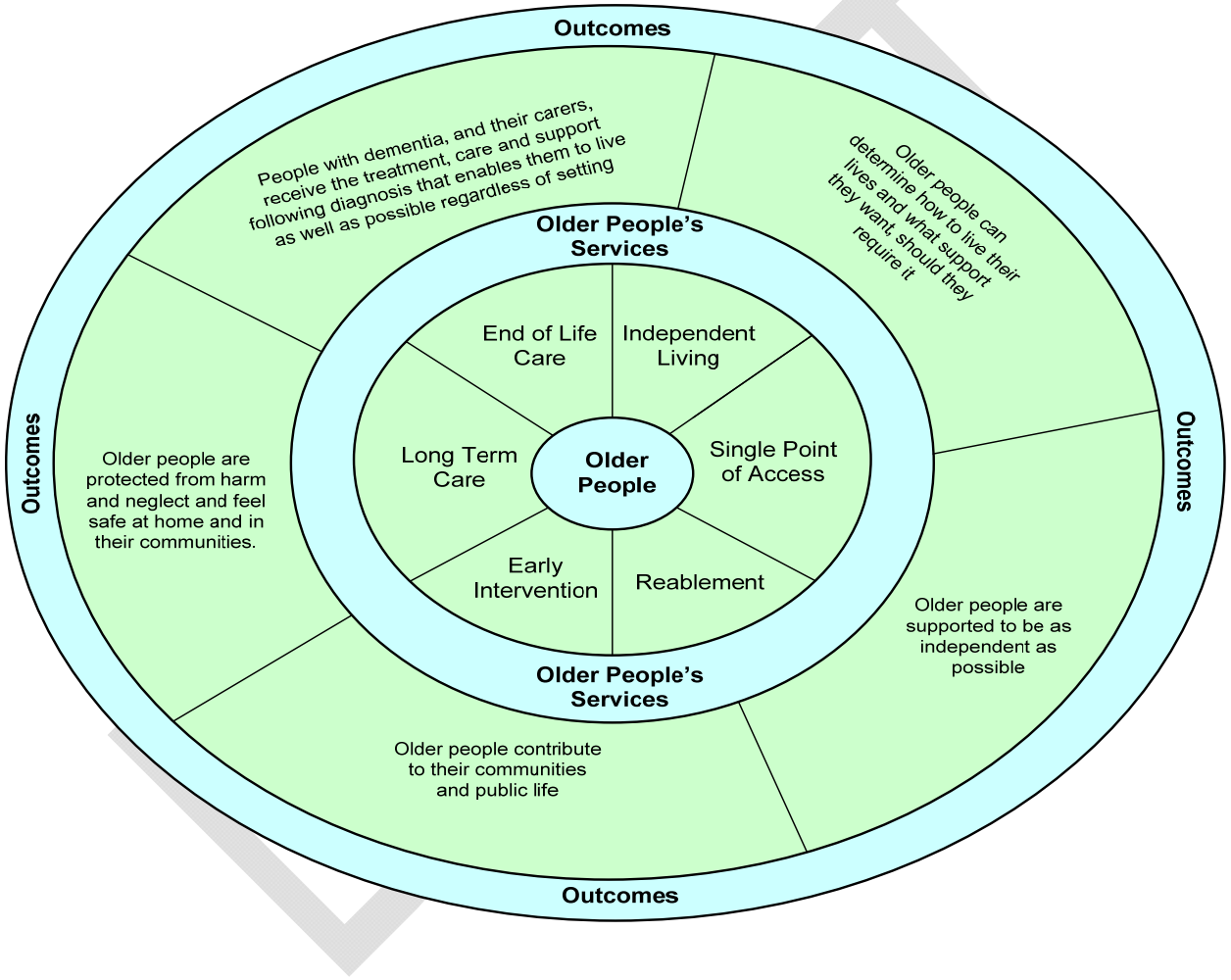
Figure 4:

Older People's Services Outcome



3 ENGAGEMENT

Engagement with local people, particularly older people and their carers, has been central to the development of our Commissioning Plan for Older People's Services. We have well established vehicles for engaging with local people which we have drawn on and seek to further develop over the lifetime of this plan, working with our local voluntary sector engagement partners such as Your Voice (Inverclyde Community care Forum) and the Inverclyde Carers Centre.

During the period (21st February 2013 – 18th March 2013) Your Voice Inverclyde organised and engaged with **21** Focus Groups, **268** older people, including **81** carers/ex-carers, were involved in the groups.

All group members watched the NHS Ayrshire & Arran 'Reshaping Care for Older People' DVD to set the scene. Your Voice staff distributed copies of the draft Joint Strategic Commissioning Plan for Older People, provided an overview and referred to the 'Our Challenges and Intentions' section of the plan. Members then took part in a conversation and gave feedback around the following agreed questions:

- What do you think are the most important areas for action?
- What would help you to be more independent or involved in your community?
- What would assist you as carers (if relevant) to continue your caring role?
- What practical assistance could we work together to develop to achieve the aims discussed in the DVD and in the Joint Strategic Commissioning Plan?

Group members also took home a copy of the working draft and questionnaire to read over and feedback at their leisure. Individual feedback forms which were returned were been incorporated into the feedback analysis.

Through this process we gathered a wealth of intelligence, including ideas for action, which we have used to scope and refine our intentions. In some cases, such as in relation to the development of care and support at home and reducing social isolation, the feedback from local people helped us to clarify what our direction of travel should be and reinforced our aspirations.

We undertook a high level analysis of the feedback received in relation to each question asked. Responses have been themed as far as possible and particular responses of note were highlighted to particular service areas who could take action. Different themes emerged for each question and were not exhaustive or all encompassing. Rather, they were used to highlight key areas for action going forward.

Through our joint work with our engagement partners the local statutory sector will continue to involve local people in reviewing, developing and assessing the impact of services, and the changes we make.

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4 OUR CHALLENGES AND INTENTIONS

Development of the Commissioning Plan has naturally led to a reconsideration of the many issues and challenges raised within it, and generated debate as to our priorities as we move forward in commissioning and procuring services over the next 3 and 10 years. We recognise that whilst planning for 10 years, the Plan initially focuses on the next 2 to 3 years, and will continue to adapt and evolve as both service change and demographic change impacts.

The development of the Inverclyde Joint Strategic Commissioning Plan for Older People has benefited significantly from engagement undertaken with local older people, their carers, professionals and other stakeholders. This engagement has shaped the development of a comprehensive and focussed Delivery Plan. To date the range of interventions progressed under the auspices of the Change Fund in Inverclyde have delivered a range of positive outcomes for our population. However, in developing our Delivery Plan we will achieve clarity and transparency in understanding the results of our interventions by;

- Undertaking a strategic needs analysis
- Carrying out contribution analysis and where necessary utilising a service improvement evaluation framework
- Reviewing practice and service models
- Employing Options Appraisals
- Measuring impact against our agreed joint performance framework

We face continued challenge, in common with other health and social care organisations, in relation to reducing bed occupancy related to delayed discharge. Our performance in reducing bed days in the hospital setting, not only in relation to Delayed Discharges but also for over 65s and over 75s generally, has improved at a greater rate than elsewhere within NHS Greater Glasgow and Clyde. However, in moving forward we must further focus on this key area of performance to achieve both the targets in relation to Delayed Discharges and the reduction in length of stay assumed in the acute bed model.

Currently in Inverclyde there are 20 Frail Elderly Continuing Care beds, with recent censuses showing that there is potential to reduce this number. However, there are still a number of patients who are fit for discharge being cared for in these beds. Similarly, in Frail Elderly Rehabilitation and Assessment beds in Inverclyde the average length of stay is 23 days, higher than in many other areas, and almost 50% greater than the future bed model target of 15.4 days.

Delivery of any reduction of these beds is dependent on reduced length of stay for patients, including the length of time awaiting discharge and the successful service redesign of community health and social care services as we further embed integration.

We have set out our intentions in relation to addressing key challenges in the delivery plan component of this document.

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4.1 Delivery Plan 2013-2023

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
INDEPENDENT LIVING					
Housing					
There is disparate and inconsistent provision of housing for older people, with particular impact in areas of deprivation.	Accurately identify and have a plan to respond to future requirements for older people; numbers, type and location of housing	Identify a project lead within existing resources to scope and review the current situation and develop models for the future.	Develop closer working with the Council's Strategic Housing Team and housing associations to develop a shared vision of housing for older people.	Review pathways and processes to ensure availability of appropriate accommodation at times of need/ transition. Scope provision of new build/ develop existing stock.	We will have a stock of housing appropriate to different levels of need and disability. There will be clear process to address supply and demand.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Self Directed Support					
There is limited uptake of direct payments amongst people over 65 and there will be a focus on offering self directed support from April 2014.	Services will be developed & adapted to facilitate flexible and person led delivery of care and support, in order to meet personal outcomes.	Review current systems of support and advice to ensure fit for purpose	Raise awareness of new legislation and develop systems which can enable self directed support.	Promote self directed support for all those newly assessed and subsequently review existing service recipients. Demonstrate satisfaction and improved quality of life through use of an outcomes approach	People are empowered to make decisions about their own care and hold their own budgets should they choose to.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
EARLY INTERVENTIONS					
Day Care					
There is a range of traditional long term day care options following historic provision patterns. There is a decline in the demand for traditional long term care models, realign funding to reinvest in areas of new demand.	There will be a reablement and rehabilitative goal centred approach. Day care will be integrated in the community and supported by continued capacity building to facilitate moving on.	Scope current provision and identify future service models and develop a new service model. We will disinvest in care home beds by 5% over the next year and a further 5% over the next 3 years.	Undertake a rounded evaluation of provision, centred on the views of users and providers' perspectives.	Develop, engage and consult on a revised model of day service provision, encompassing health and social care. Commission and implement revised service models. We will re-invest and shift resources where appropriate.	We will have a broader range of day opportunities appropriate to the needs of service users delivered by a variety of providers. We will be able to evidence the benefit to short and long term health and social care outcomes of the revised model.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Long Term Conditions					
There is a range of uncoordinated work across services in relation to long term conditions, and a lack of clarity in respect of impact on access to services.	Provide individualised multi-disciplinary, multi-agency support for individuals with long term conditions and their families/carers.	Scope current provision and identify future service models to embed consistent approach and communication across services. We will deliver this via more effective use of existing resources and existing staffing models.	Review the NHSGG&C Supported Self Care Framework to ensure individuals are skilled to self care and monitor own condition for as long as possible or with minimal intervention.	Reablement and Rehabilitation Services will support individuals to recover from exacerbations of their condition and wherever possible to return to their previous level of function. Demonstrate satisfaction and improved quality of life through the use of outcomes and redesigned service provision.	Individuals will be part of the planning process and contribute to managing their own condition and planning for their future needs.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Anticipatory Care Planning					
There is a range of uncoordinated work across services, and a lack of appreciation of the benefits to be realised through effective anticipatory care planning.	The philosophy of anticipatory care will be embedded across multi-disciplinary teams and partners highlighting service users of particular vulnerability. Individuals are supported to make choices and plan for future care needs.	Identify Anticipatory Care Lead and develop action plan with steering group involving all partners.	Scope the range of individuals who would benefit from an ACP and identify the most appropriate lead professional. Implement an ACP pathway and design processes which will support effective information sharing across all partners. Continue to utilise the skills of the carers centre in emergency planning for carers.	Train and empower staff to initiate discussion around future care needs such as Power of Attorney. Evaluate implementation to consolidate effective anticipatory care planning for all. Monitor individual outcomes associated with Anticipatory Care Plans; reduction in exacerbations, admissions, use of additional support services.	All individuals who would benefit from an ACP will have one in place and have been involved in the planning where appropriate. The ACP and other relevant information is shared in a timely and secure fashion to ensure that planned interventions can be delivered. There will be a reduction in unplanned admissions to hospital and use of A&E which is attributed to the ACP approach.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Falls					
There are gaps in the data and knowledge in respect of who falls and what happens to them following a fall. The support and care for people who have fallen, whether injured or not, is not always consistent.	Robust data is available to inform planning and intervention. There is a robust pathway in place for someone who has experienced or who is at risk of a fall. Falls and hospital admissions linked to falls are prevented.	Work with acute services and SAS, community alarms service to identify the data and improve communication and pathways. Identify a lead to co-ordinate this work.	Establish a baseline position and scope the current pathways. Identify future potential pathways and methods of information sharing.	Implement a pathway with SAS, rehabilitation teams, telecare and reablement which supports individuals who do not need to be conveyed to hospital. Implement a pathway between telecare and rehabilitation for individuals experiencing multiple falls. Undertake baseline training of staff in all sectors. Undertake proactive work with people who are at risk of	There will be clear pathways for 1. Individuals at risk of falls 2. Individuals who fall but are uninjured 3. Individuals who fall and sustain an injury 4. Individuals who experience multiple falls We will reduce the amount of people attending A&E following a fall. We will reduce the amount of people suffering an injury as a result of a fall.

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				falls to mitigate that risk. Address the recording of falls related presentations at A&E.	

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
SINGLE POINT OF ACCESS					
There are multiple access points to services	More effective signposting and easier access to services provided by all partners including the Third Sector	Identify the range and scope of services to be included in a Single Point of Access model. Consider support staff and IT needed to administer single point of access	Add immediately appropriate services to the existing single point of access. This change is cost neutral and will involve some workforce change	Review user experience of the changes to service to inform longer term planning. Undertake options appraisal to determine further extension of Single Point of Access within Health & Community Care Services. Establish the long term vision for the CHCP as a whole.	There will be a Single Point of Access to all Health & Community Care Services.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
REABLEMENT AND CARE AT HOME					
We have introduced a reablement service to facilitate optimum independence and decrease reliance on long term homecare services	Reablement as an approach is embedded across multi disciplinary teams and across our community supported and complemented by the development of community resources	Ensure current information management systems provide appropriate data to inform decision making processes	£684,000 from the 2013/14 Change Fund is being used to fund development in care at home and the development of reablement. Continue to embed a reablement approach across all services with a particular focus on dementia services.	Consider future development of service and pathways with an emphasis on bringing reablement, occupational therapy and rehabilitation closer together. To consider the benefit of reviewing all existing clients using an enablement approach Increase external provision of care to maximise available budget	More people will be enabled to remain independent for longer or to require a reduced level of social care support following a period of reablement. All care at home services either commissioned or in house will retain the reablement approach and maintain independence in the long term with clients.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
LONG TERM CARE					
Care Home Provision					
There is reducing demand for care home placement as the range of community services develops, resulting in vacancies in funded beds.	There will be 10% fewer local authority funded care home beds by 2016/17. The resource released from this reduction will have transferred to services to support people in their own homes	We will engage with care home providers and others to scope the potential for alternative models of providing care via care homes on a non residential basis, such as step up/step down day-care and/or a different model of residential care.	£20,000 from the 2013/14 change fund is being used to fund a Scottish Care Development Worker to facilitate engagement with the care home sector, particularly in respect of maintaining a stable and vibrant local care home sector. We will disinvest from care home beds and through options appraisals we will identify potential areas for reinvestment.	We will further disinvest from care home beds and evaluate the alternative models of care that have been put in place to inform future commissioning.	Sustain the reduced level of care home admissions as demographic changes become more pressing. People with more complex needs will be cared for at home rather than in long term care.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Hospital Continuing Care					
There is a recurring under-occupancy of frail elderly continuing care beds at IRH of 50%, with the remainder being used to accommodate delayed discharge patients undergoing the assessment process.	The delayed discharge target of no patient being delayed is hospital by more than 4 weeks by April 2013, and by 2 weeks by April 2015 will be achieved. The resource currently spent on hospital continuing care beds, can be considered for reinvestment in preventative and home based care.	Review the delayed discharge processes to reduce delays in the assessment process and facilitate faster transition.	£42,000 2 social work posts from 2013/14 allocation of Change Fund to facilitate the assessment process. This is complemented by £96,000 AHP capacity from the 2013/14 Change Fund allocation. Quantify the impact on bed days of reducing delayed discharges.	To revisit the balance of care in terms of local need for continuing care beds and explore further the options for appropriate resource transfer.	Sustain a 0 delayed discharged target particularly as demographic changes become more pressing.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
END OF LIFE CARE					
There are well established palliative care services, requiring further effort to ensure seamless provision.	We need to reduce time spent in hospital in last 12 months of life, supporting people's wishes as to place of death	Establish and implement further expertise, choice and rapid access to appropriate services required for end of life care	£59,000 from Change Fund to support GP Facilitator, Practice Development and Clinical Nurse Specialists Implement work plan in response to scoping exercise.	Progress actions from scoping exercise, including setting targets for Gold Standards Framework, Liverpool Care Pathway, SPAR, and Advanced Care Planning Evaluate impact and identify gaps	Inverclyde is recognised as a Compassionate Community. Individuals are supported to die in the place of their choice.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
COMMUNITY CAPACITY BUILDING					
Community and voluntary sector supports and resources are not used to their optimum benefit to augment statutory services, and support people.	People can access a range of supports in their own community that meet needs and support inclusion, empowerment, involvement and recovery.	Invest time and resources in working across the statutory third sector to build the capacity of communities, groups and individuals to help themselves. Re-energise a culture across all services and sectors of seeking to make best use of community and individual resource based on an asset model, in harmony with interventional based approaches	£100,000 from our 2013/14 change fund has been allocated to supporting community capacity building projects to strengthen the involvement of community and third sector organisations and their work in relation to older people. Scope the range of needs and desires of local people in terms of community based provision and partnerships with the statutory sector.	Promote where possible the opportunity for involving local people and groups in delivery of services, in partnership with the statutory sector.	Commissioning services will enhance the local third sector and empower communities to sustain themselves and support their members, through delivery of services in a co-production model.

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
CARERS					
There is inconsistency of approach across services & client groups, supporting carers to be equal partners in care	Carers are recognised as equal partners in care across all settings and across all care groups Carers are fully supported to undertake their caring role	Implement the actions from the carers strategy 2012/15. Increase the number of carers assessments undertaken	£97,000 from 13/14 change fund has been allocated to Inverclyde Carers Centre to deliver hidden older carers, carers and hospital discharge project and carers emergency and long term planning project. Begin to implement the Equal Partners in Care (EPiC) principles.	Scope the opportunities to mainstream the work being undertaken in year 1 by redesigning the core work of key services Ensure carers are aware of the opportunities provided to them by Self Directed Support in improving the care that can be provided	Carers can fully participate in the planning and evaluation of care for the person they care for. We have process which allow us to learn from the experience of carers

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Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
DEMENTIA					
Currently implementing the redesign of Older People's Mental Health	Provide early intervention and post diagnostic support to service users and carers	We will work closely with partners to improve care pathways and to improve support for people diagnosed with dementia	We will use £35,000 of the 2013/14 Change Fund to deliver post diagnostic support to people with dementia	Introduce a tiered approach reflecting levels of need. We will implement Promoting Excellence to improve the way our staff work with people with dementia, their families and carers.	Inverclyde will be a dementia friendly community.

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5 JOINT STRATEGIC NEEDS ASSESSMENT AND PERFORMANCE SUMMARY

5.1 Current Profile

Inverclyde is one of the smallest local authorities within Scotland, and is comprised of towns of Greenock, Gourock, Port Glasgow, Inverkip, Weymss Bay and the villages of Kilmacolm and Quarriers. Inverclyde has a very small ethnic minority population with less than 1% of its residents coming from an ethnic minority background.

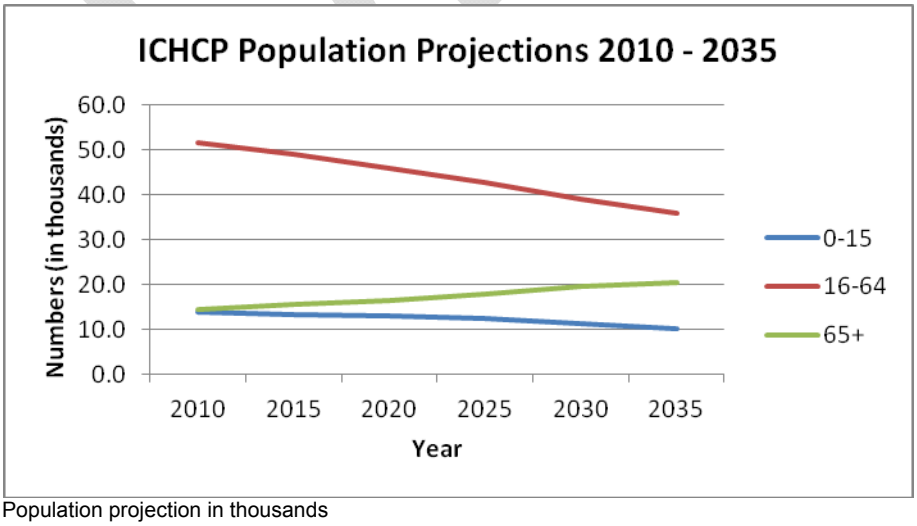
Inverclyde's mid-year population estimate for 2012 was 80,860 people[1]. The number of young persons aged 0-15 years of age was 13,403, for the age group 16-64 years of age the number of people was 52,076 and 15,201 people are in the 65 and over age bracket with 7,003 of these people being aged 75 and over.

5.2 Projections

Inverclyde's 65 and over population is set to rise significantly over the next 22 years according to the latest figures published by the NRS (National Records of Scotland, formerly named the General Register Office for Scotland).

Overall, Inverclyde's population is falling year on year, with people in the age bracket of under 65 continuing to decrease as time moves on, this is in stark contrast to our older population (65+) which is projected to rise from 14400 (approx.) in 2010 to 20500 (approx.) by 2035, a rise of 70%.

The first chart shows the population age brackets in actual numbers (thousands). This demonstrates the trend of the total number of people under 65 falling steadily while people over 65 steadily rising. The second chart shows a more pronounced picture when the data is analysed as a percentage change in the population.



Population projection in thousands

[1] http://www.gro-scotland.gov.uk/statistics/theme/population/estimates/mid-year/2012/list-of-tables.html

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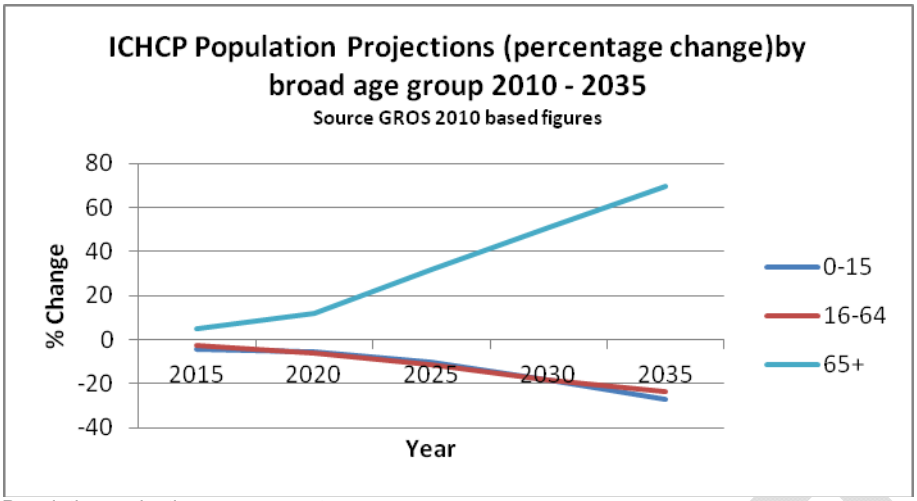
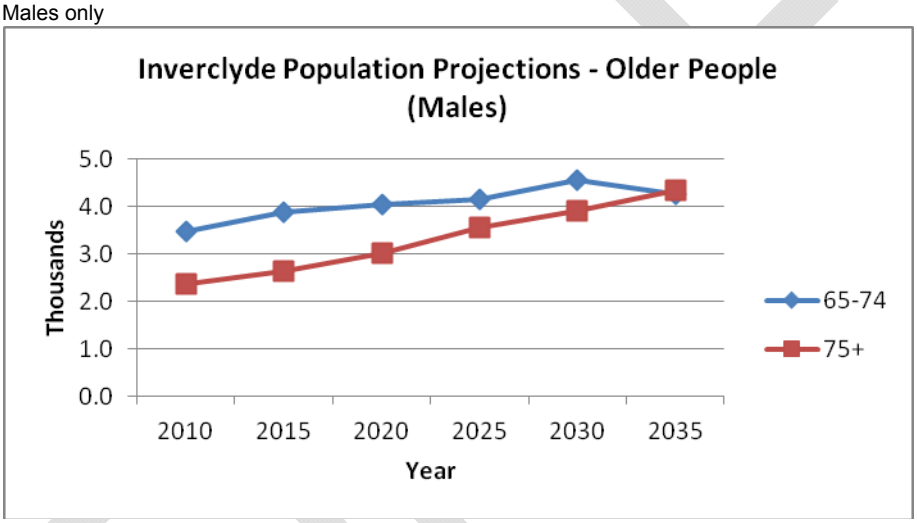
Source NRS



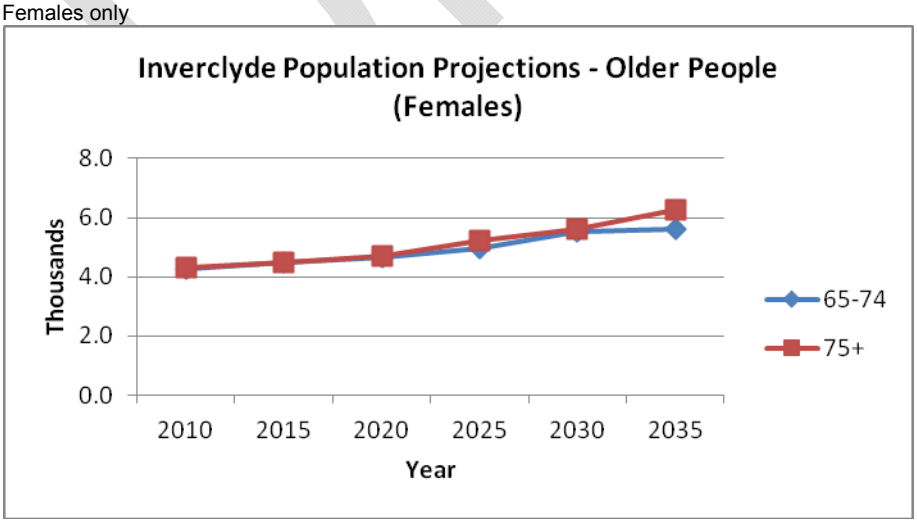
Population projection as a percentage
Source NRS

The following charts show the gender split projections for the same period and also show the additional grouping of those people aged 75+. These charts clearly show a sharper increase in the 75+ age group.

Males only



Females only



5.3 Deprivation

Another consideration that has to be taken into account is the level of deprivation and health inequalities.

Inverclyde has a total of 325 datazones. Most of these datazones are found in the most deprived deciles according to the key findings from the Scottish Index of Multiple Deprivation (SIMD) 2012.

This is an increase since 2004 and to demonstrate the significance of this, Inverclyde had 6 datazones in the 5% most deprived areas, and 36 in the 15% most deprived in the year 2004.

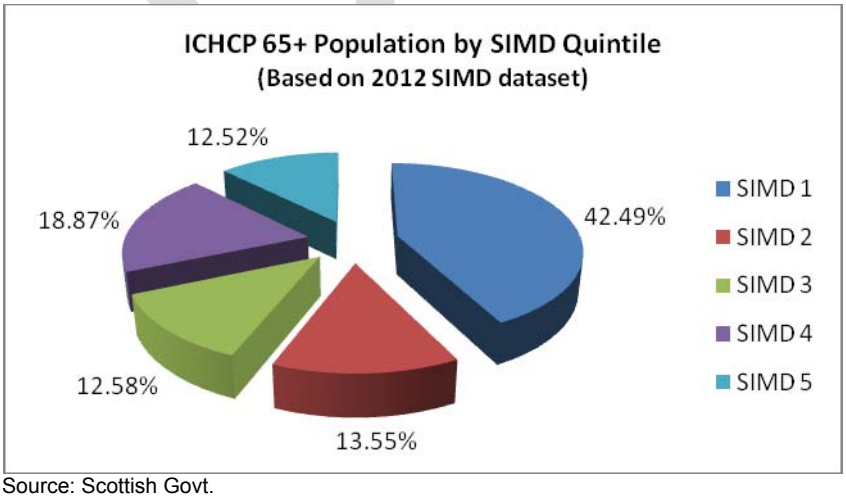
Number of Inverclyde datazones in deprived areas		
Year	**5% Most Deprived Areas**	**15% Most Deprived Areas**
2012	14	44
2004	6	36

Source: Scottish Govt.

The majority of older people residing within Inverclyde are resident in the most deprived quintile (SIMD1) which has a major impact on their health and care needs. Based on the 2012 mid-year estimates from National Records of Scotland (NRS) and from the 2012 SIMD data set, 6,137 of Inverclyde 65+ persons were living within SIMD 1 areas (the most deprived quintile), that accounts for 42.5% of the entire elderly population in Inverclyde. Therefore, it is clearly evident that there will be significantly more pressure on local health and social care services as the elderly population continues to grow.

	SIMD Quintile	Population	% of total
▲	SIMD 1	6137	42.49%
Most Deprived	SIMD 2	1957	13.55%
	SIMD 3	1817	12.58%
Least Deprived	SIMD 4	2726	18.87%
▼	SIMD 5	1808	12.52%

Source: Scottish Govt.



Source: Scottish Govt.

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5.4 Life Expectancy

Inverclyde's Life Expectancy (LE)[2] rates are below the Scottish Average. For males at birth the Scottish average is 75.85, the figure for Inverclyde is 72.98. For females at birth the Scottish average is 80.43, in Inverclyde the figure is 79.15.

This may be attributed to a combination of deprivation levels and high prevalence of long term conditions. Conditions associated with smoking for example have a prevalence rate of 26.63 per hundred patients within Inverclyde.

If we examine the LE rates at age 65 for Inverclyde, the area has the second lowest LE for males out of the 32 local authorities with only Glasgow City having a lower rate. In relation to females, Inverclyde sits in 24th position of the 32 local authorities. In terms of Healthy Life Expectancy (HLE)[3], Inverclyde again sits only above the Glasgow City CHP for the male population. The HLE for Inverclyde males is 62.4. For females the HLE is 68.7, fairing marginally better than North and South Lanarkshire, West Dunbartonshire and again, the Glasgow City CHP area.

5.5 Dementia

In order to support the improvement work for people with dementia, their families and carers, the Scottish Government has introduced HEAT targets specific to dementia. The purpose of these targets is to focus NHS Boards on key priorities and measure how these are being achieved.

In 2008, pre the National Dementia Strategy, a target was introduced to identify people with dementia living within our community:

"From April 2008 each NHS Board is required to deliver agreed improvements in the early diagnosis and management of patients with dementia by March 2011."

This target established the need for dementia registers within GP practices, and the requirement to review these people within 15 months of diagnosis.

In addition in January 2010 Greater Glasgow and Clyde Health Board introduced a local improvement measure within mental health services, to ensure people receiving a diagnosis were provided with appropriate information about the condition.

In 2012 the Scottish Government made a commitment to guarantee that people receiving a diagnosis of dementia will be offered a minimum of one year post diagnostic support:

"To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan"

[2] LE Data Source – NRS 2008-2010 Life Expectancy tables
[3] SCOTpho report 1999-2003

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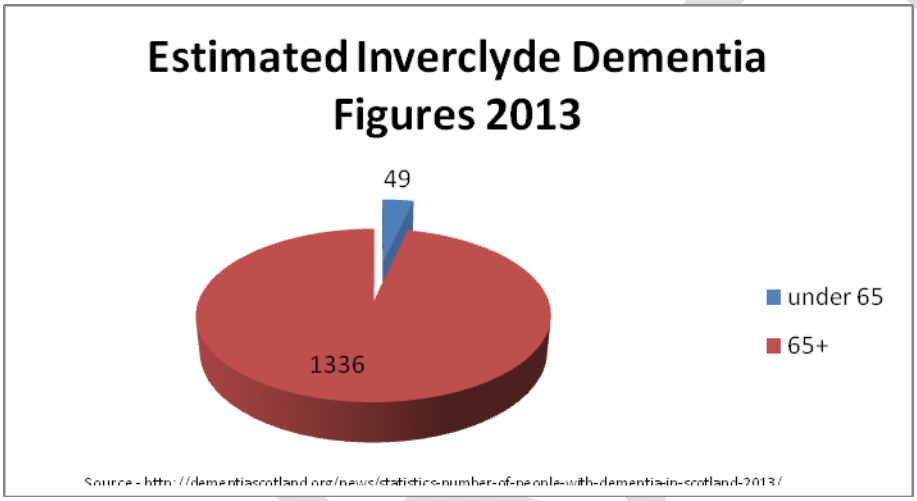
In respect of dementia the Life Changes Trust will support the Scottish Government's one year Post Diagnostic Support guarantee by investing in peer support and community connection projects to enable people to live well in their communities. There will also be a focus on supporting the needs of carers throughout the carer journey.

According to the Scottish Government's Dementia Strategy[4], the number of people suffering from dementia will double over the next 25 years. This estimates numbers of people with a dementia in Inverclyde in 2013 is 1385, 1336 of these people are aged 65 and over with the remaining 49 being under 65 (based on the EuRoCoDe and prevalence rates, see chart below). Based on this it is estimated that by 2037 this number will be approximately 2770. It should be noted however, that prevalence rates may change as time progresses and as such the projections will change in accordance with the rates of prevalence.



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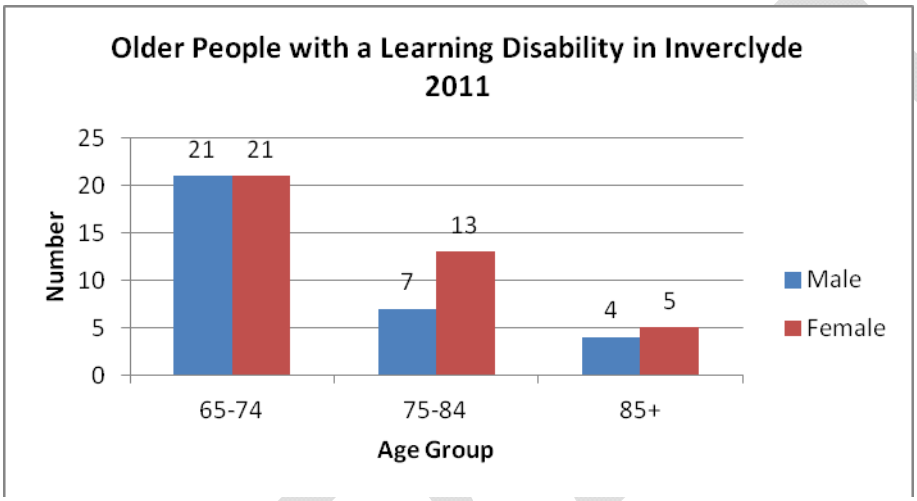
[4] http://www.scotland.gov.uk/Publications/2010/09/10151751/6

5.6 Learning Disabilities

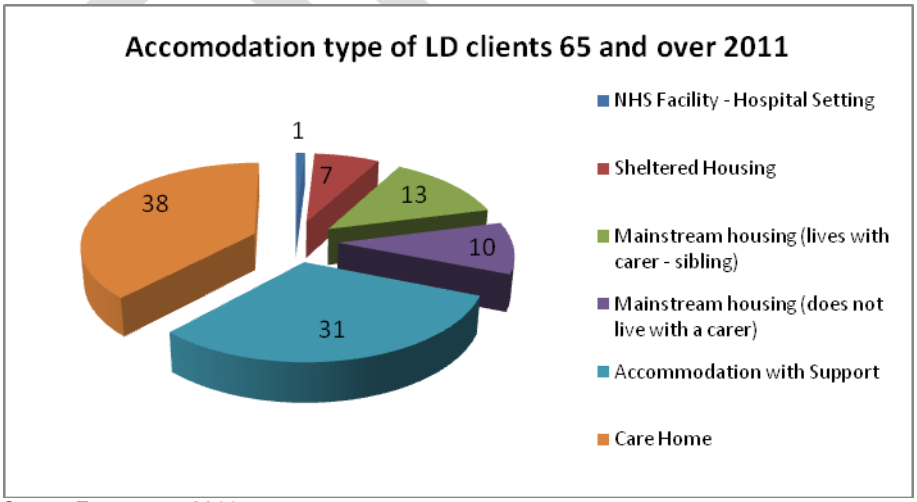
In 2011, there were 577 people in the Inverclyde locality with a diagnosed learning disability. (Approximately 8.8 adults per 1000 population, a rise 0.1 per 1000 in 2010). Of these 71 were aged 65 or over.

With advances in healthcare and treatments, people with a learning disability are expected to live longer. People with LD are more likely to develop dementia and in addition, about 50% of people who have Downs Syndrome and live to age 60 are likely to develop Alzheimer's. This implies that our learning disability service will come under increasing pressure in years to come.



Source Esay return 2011

The graph below demonstrates where people with a learning disability reside. The rise in the Learning disability population described above is anticipated to have an impact on this picture.



Source Esay return 2011

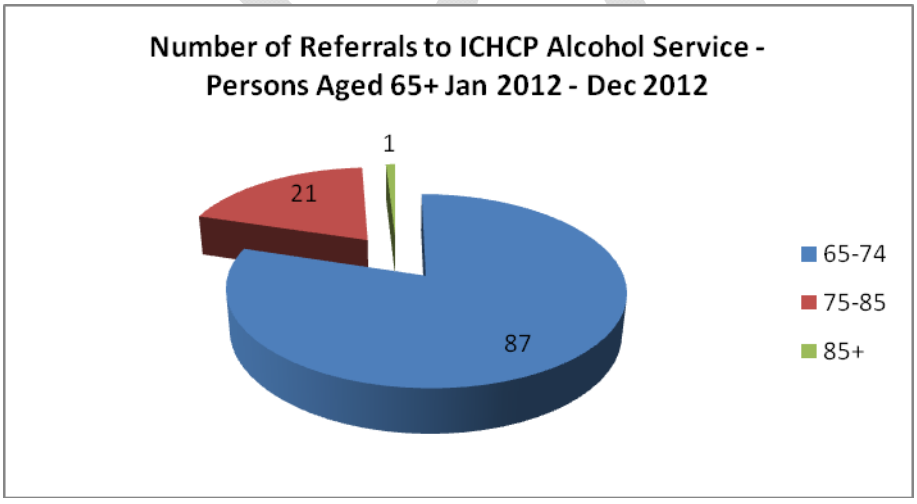
5.7 Alcohol Misuse

Alcohol misuse has been a historic problem within Inverclyde and continues to be a problem with large numbers of people affected directly and indirectly by alcohol misuse. Alcohol can have long term effects on an individual's health including conditions affecting the liver and also causing Alcohol Related Brain Damage and Korsakoff's syndrome. The Inverclyde Alcohol and Drugs Strategy[5] contains further information which supplements this section.

In 2005, the alcohol related death rate in Inverclyde was 44.7 per 100,000, the third lowest in the Greater Glasgow & Clyde NHS board area, since then however, Inverclyde has been consistently one of the worst areas for alcohol related deaths. In 2009 and 2010, for example Inverclyde had the highest rate of alcohol deaths, and in 2007, 2008 and 2011 it was the second highest in the board area.

Greater Glasgow and Clyde have set local targets for alcohol related admissions to hospital. The target for Inverclyde was 12.0 for every 1000 people. Rates of admission to hospital for alcohol related conditions in Inverclyde were consistently breaching the target until September 2012 which was 11.4 per 1000, a drop of 1.9 per 1000 on the previous month's figure. Inverclyde has recently been meeting its targets for lowering rates of admission for alcohol related conditions but more work needs to be done to ensure the downward trend continues.

During the period Jan 2012 – Dec 2012, a total of 109 older people were referred to ICHCP's Alcohol Service, the breakdown of the age groups of these referrals can be seen below.

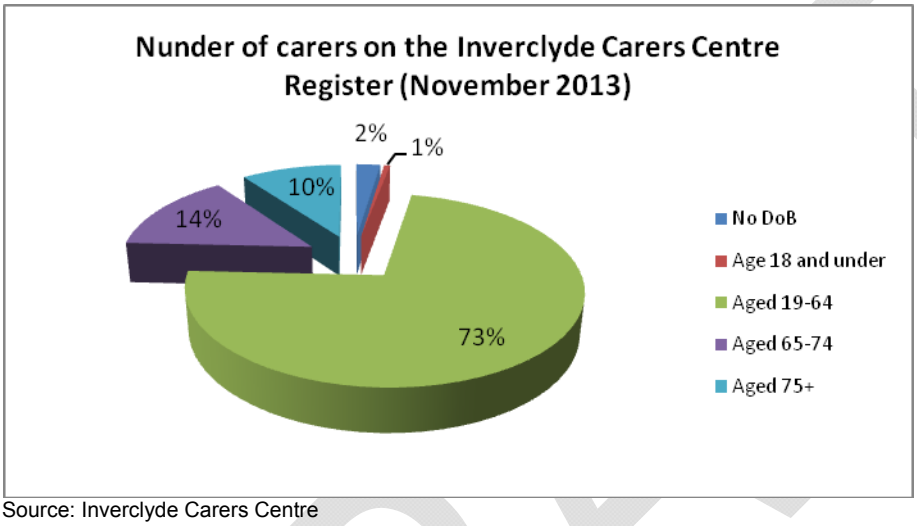


5 http://library.nhsggc.org.uk/mediaAssets/CHP%20Inverclyde/Development%20Plan%20Update%202011%2012%20Final%20Draft.pdf

5.8 Carers

According to the Scottish Governments Carer's Strategy, around 1 in 8 people will at some point in their life become a carer. On that premise, we can estimate that there around 9892 carers[6] in Inverclyde. As Inverclyde's age profile suggest that we have an ageing population, we can assume that the number of carers in Inverclyde will grow significantly in the near future.

Inverclyde Carers Centre has provided the CHCP with the age profile of the carers within Inverclyde, which can be seen below.



Source: Inverclyde Carers Centre

If we examine the data relating to long-term activity-limiting health problems in Inverclyde taken from the 2011 census data we can see that of our population, 12.5% felt that they were limited a lot by a limiting long term health condition, which is 2.6% higher than the overall Scottish figure. 11.3% of Inverclyde's population said that they were limited a little by a limiting long term health condition. This has a direct impact on the level of care a person may need, and in many cases this care falls to a relative of friend who is classed as an unpaid carer. The table below shows the levels of unpaid care in Inverclyde and in Scotland as a whole.

	Inverclyde		Scotland	
Description	**Percentage**	**Number**	**Percentage**	**Number**
Provision of unpaid care				
All people	100.0%	81,485	100.0%	5,295,403
Not providing care	89.9%	73,233	90.7%	4,803,172
Providing 1 to 19 hours of care a week	5.1%	4,120	5.2%	273,333
Providing 20 to 34 hours of care a week	1.0%	849	0.9%	46,315
Providing 35 to 49 hours of care a week	0.9%	721	0.8%	40,501
Providing 50 or more hours of care a week	3.1%	2,562	2.5%	132,082

Source: Scotland's Census 2011

[6] http://www.scotland.gov.uk/Publications/2010/07/23153304/30

Inverclyde GPs have a Carers Register, in which they keep a record of which of their patients is considered to be a carer. The figure for people registered in 2012/13 on the GP Carers Register was 1299 people, which is approximately 13% of our estimate of the total number of carers. In addition Inverclyde Carer's Centre also has a register, of which they have number of carers at 2181, which although much higher that the GP register is still only around 20% of our estimate.
Work is required on an on going basis around raising awareness and encouraging people to register as carers within Inverclyde, to reduce levels of hidden caring.

5.9 Care Homes

Inverclyde has a total of 15 care homes. 11 of these establishments are Nursing Care homes, with 4 being Residential only. Within the Nursing Care Homes there are a total of 622 beds, and 114 beds within the Residential Homes.[7]

The average age of people resident within care homes as at September 2013 was 84 years of age, and the average length of stay in the 15 care homes was 2.81 years, this is slightly above the national average of 2.4 years.

Between April 2012 and Sept 2013 there were, on average, approximately 17 new admissions to care homes per month. For the same period the total number of new admissions to care homes was 307, with 56% being referred from Hospital and 44% from the community. Nationally, 50% of admissions to care homes are from the hospital setting.

In addition to funded places, the CHCP access the remaining available places for short breaks/respite if and when required.

5.10 Care at Home Services

Inverclyde is currently undergoing a service redesign of its Care at Home service, including the implementation of the new CM2000 monitoring and scheduling system. The service currently has two operating models; Mainstream Care and Support and Re-ablement.

Mainstream Care and Support at Home caters for people with longer term domiciliary care needs (personal and social care). Re-ablement is a service intended to help people regain independence after a period of hospitalisation or recovery from some other major event such as long term illness.

In 2005, Care at Home provided a service for a total of 1032 65+ services users[8]. The latest 2013 figure is 1217[9]. The rate per 1000 population has been rapidly growing for the last few years; In 2010/11 the rate per 1000 was 77.4, as at August 2013 the figure stands at 83.9, an 8.39% increase in a 3 year period. As the number of service users and the complexity of their needs increases, then number of hours required from the service is likely to increase.

[7] Local Care Home data
[8] Data from Scottish Neighbourhood Survey
[9] Latest Home Care data CM2000

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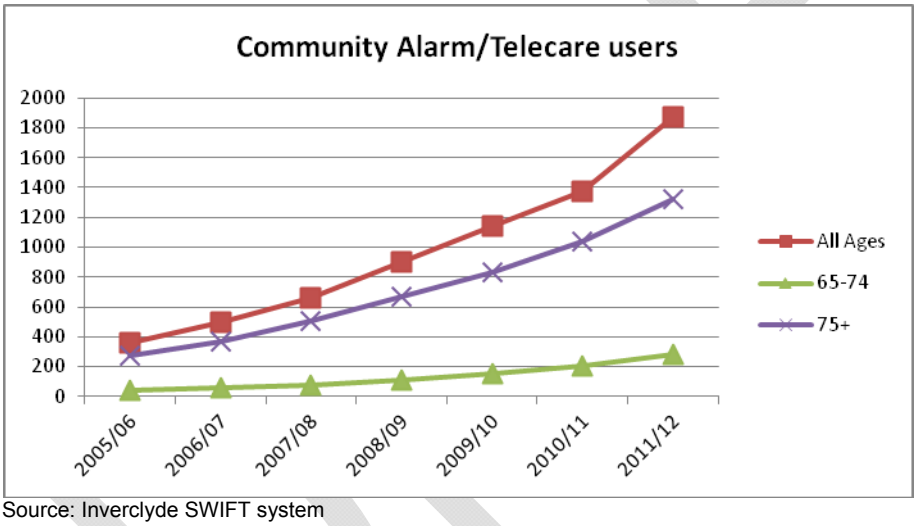
Inverclyde CHCP is currently uses both internal and external service providers. In May 2013, Inverclyde CHCP provided 70.79% of Care and support at Home services. External providers (independent, voluntary and also direct payments for home care) provided 29.3% of Care and support at Home services. In recent months this balance has continued to shift in favour of external provision; as at August 2013, the CHCP provided 59.5%% of home care services and 40.5% was provided by the external providers. In terms of percentage increase, external services were providing 8.3% more of the home care services during the reporting period.
Care at Home services also manages local Community Alarm/Telecare provision. This service provides emergency response to people living independently in their own homes. The equipment installed gives reassurance to these vulnerable people, knowing that at a touch of a button they can get support and assistance when it is needed.

The chart below[10] shows the increase of users of telecare services since 2005. The chart demonstrates the sharp rise in people age 75+ using this service. Telecare services enable people to live independently and facilitate prevention of hospital admission.



Source: Inverclyde SWIFT system

5.11 Secondary Care Services

Secondary Care services in Inverclyde are provided by Inverclyde Royal Hospital, delivering a local district general hospital service, and the adjoining Larkfield Unit which delivers continuing care, rehabilitation and day hospital services for older people.

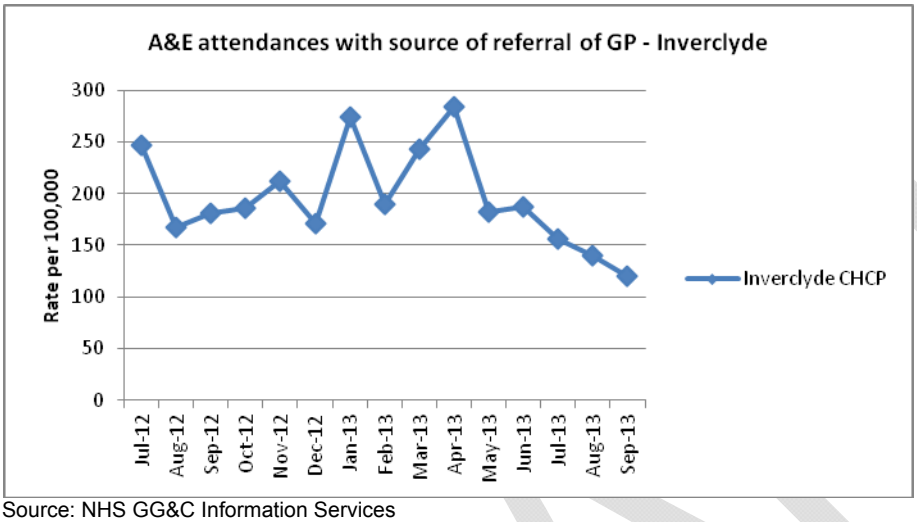
In relation to A&E attendances, the Scottish Government has a HEAT target around A&E services.

> "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."

[10] Inverclyde SWIFT system

Inverclyde CHCP has the second highest rate of attendance consistently in the GG&C board area, second only to Glasgow South. It should be noted however that the rate of attendance is decreasing but at a very slow rate. In the period July 2011 to June 2012, the rate of attendance per 100,000 was 3148. The latest figure for the period October 2012 to September 2013 was 2988 per 100,000.

A&E attendances with a referral from a GP have decreased from 247 in July 2012 to 120 in September 2013. The GP referral trend during this period is a downward one overall; however there are spikes in the trend over the winter months as shown in the chart below.



Source: NHS GG&C Information Services

One of the key strategic drivers of Reshaping Care for Older People is to reduce the need for emergency hospital care. This requires NHS Boards to work to achieve agreed reductions in emergency inpatient bed day rates for people aged 75 and over between 2009/10 and 201/12 through improved partnership working between the acute, primary and community care sectors. From March 2012 the target is to reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population by at least 12% between 2009/10 and 2014/15.

In terms of emergency admissions for people aged 65 and over, Inverclyde is showing an upward trend in the rate of admissions since March 2010. With regard to lengths of stay, the opposite is true. This demonstrates that although admissions are rising the patients are staying within the hospital for a shorter length of time. See charts below.

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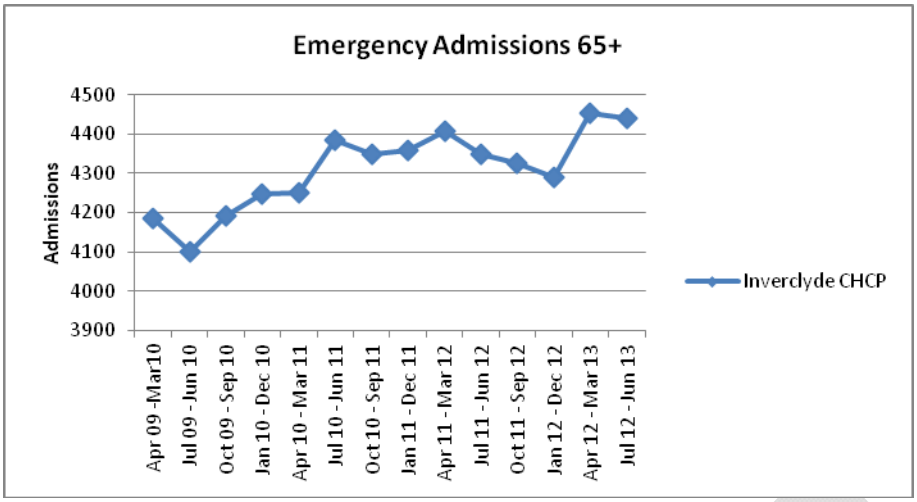
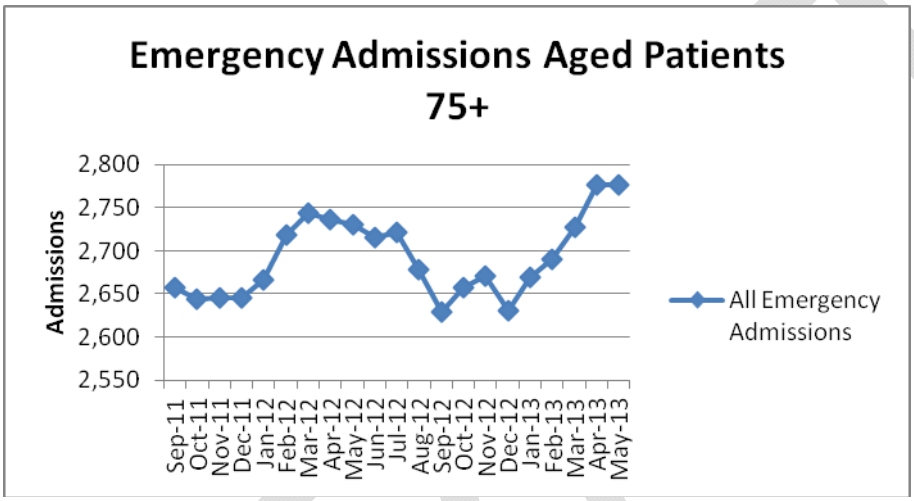
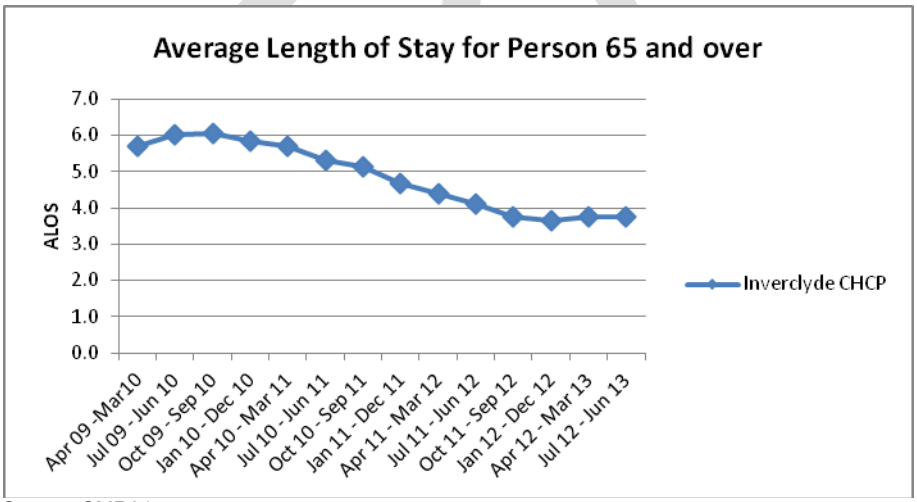
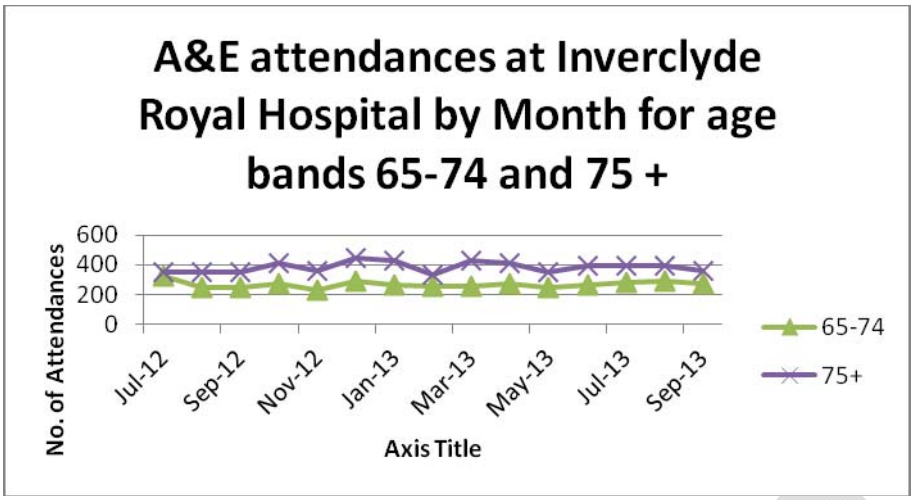


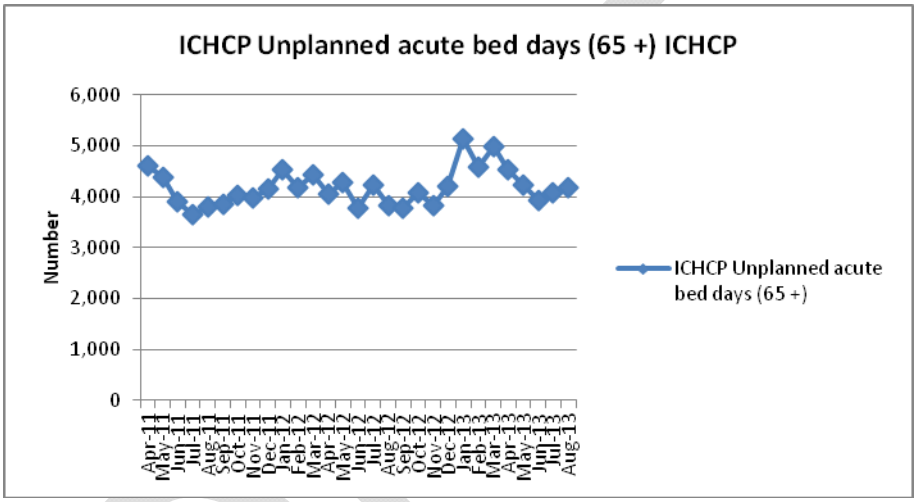


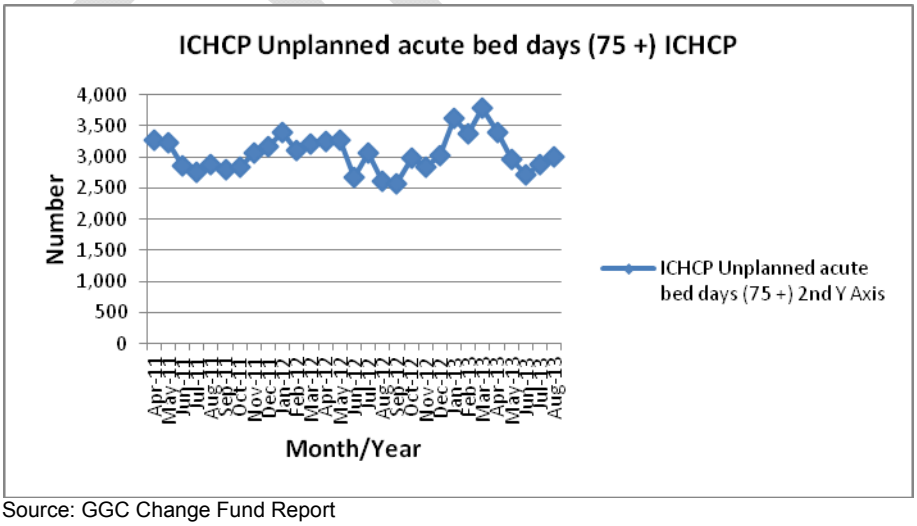


Source: SMR01

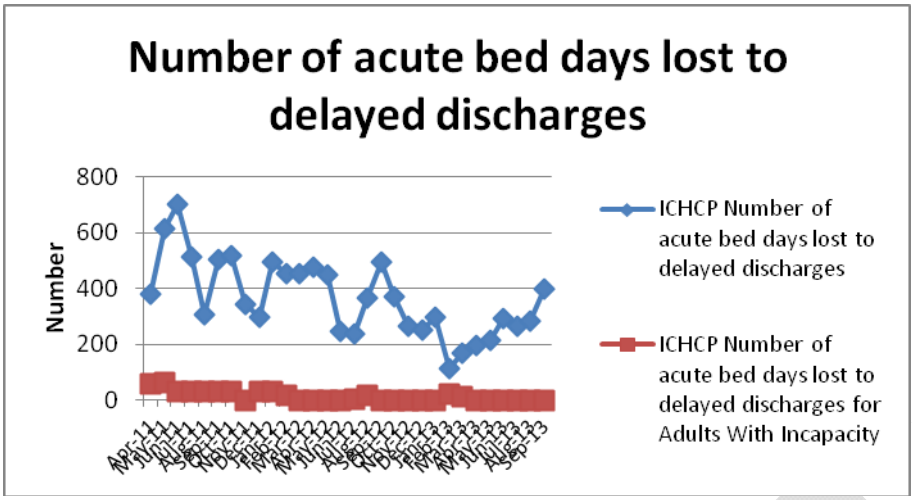


Unplanned Bed Days for Inverclyde residents 65+ and 75+ currently show no overall trend and remain fairly static only rising during the winter months, reflecting natural seasonal variation.





Source: GGC Change Fund Report



Source: NHS GG&C Information Services

Funding from Change Plan resources has provided additional social work assessment capacity within the hospital to provide flexibility at times of demand. However, recent experience and performance has demonstrated that this remains a risk for the partnership. Moving forward, with the Delayed Discharge target reducing to 4 weeks in April 2013 and 2 weeks in April 2015, we have committed to revisiting all processes supporting the Delayed Discharge pathway, with the aim of further streamlining.

In Inverclyde we have seen a significant and sustained reduction in unplanned acute bed days for both over 65s and over 75s. However, in common with other areas, we are experiencing a small rise in over 65s emergency admissions. Therefore, admissions are more frequent but of a shorter duration. This reflects our view that in terms of efforts to date we can see significant improvements from the range of interventions we have developed to support and facilitate effective discharge, with further work on going to consolidate efforts to prevent admission. In common with many of our earlier service changes this poses a challenge as it is difficult to demonstrate cause and effect, i.e. where should we concentrate our efforts to have the greatest impact. This challenge is compounded by the need to secure partnership commitment to anticipatory and preventative measures which are largely untested and lack evidence to support their introduction. However, given the progress to date in reducing bed days in Inverclyde, we are confident that the partnership can and will achieve progress in avoiding hospital admissions and sustaining older people at home.

Inverclyde CHCP regularly meets the 4 week delayed discharge target and as a partnership, we are committed to achieving the HEAT targets and contributing to the NHS GG&C overall achievement of the targets

5.12 Palliative and End of Life Care

Palliative and end of life care in Inverclyde is supported by many CHCP services and partner organisations.

The CHCP services include all 16 GP Practices and approximately 93 Community Nurses. These services can be at any one time supporting around 37 palliative and

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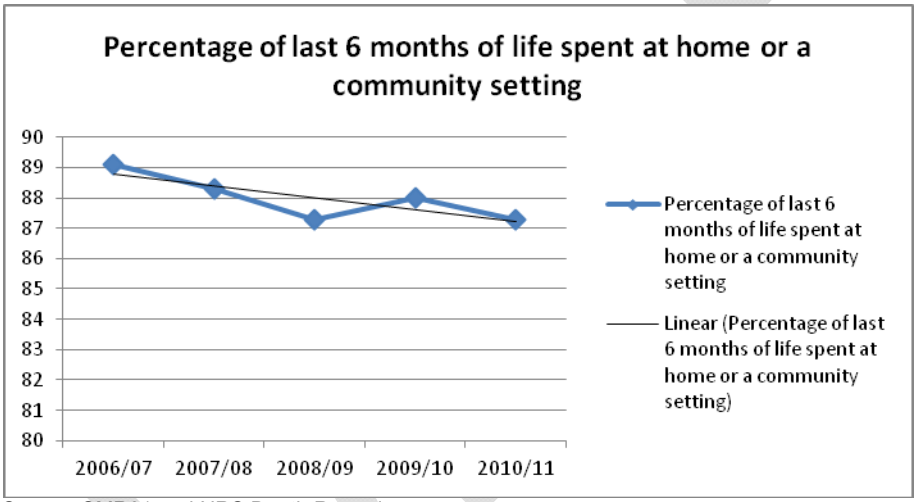
end of life patients and their families. Over a year this can amount to around 400 people.

The Liverpool Care Pathway was implemented in all 16 Practices in Inverclyde between 2009 and 2011, and is used by all GPs and community nurses to provide palliative and end of life care, although this is currently under review nationally. The LCP is also in care home and secondary care settings.

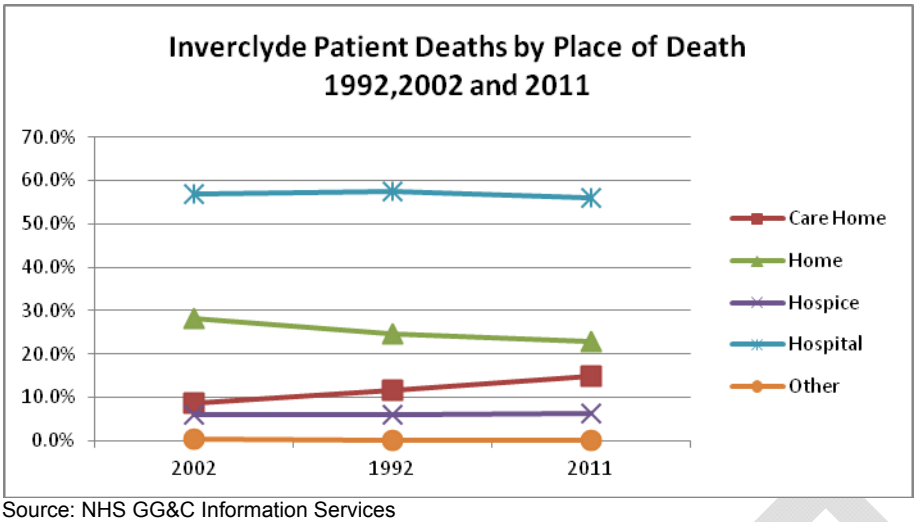
In addition to the services provided by the CHCP, the Marie Cure Nursing Service provides an overnight service supporting approximately 8 patients per month with an average of 27 visits for each of the patients.
Ardgowan Hospice provides specialist day support, drop in clinics and has 8 inpatient beds and can support over 700 people per year. The hospice also employs palliative nurse specialists who work in the community complementing the other CHCP and Marie Curie services.

One of the main aims of palliative and end of life care in Inverclyde is to allow people to be cared for and die in their own home, this being the preferred option for most patients. Since 2006/07 however, the percentage of patients spending their last 6 months of life at home has been gradually decreasing as shown in the chart below.



Source: SMR01 and NRS Death Records

In terms of deaths, there is large difference between the number of deaths in a hospital and deaths in a community based setting (such as home, care home of hospice). In 1992 the difference as a percentage between hospital deaths and community deaths was hospital 57.05% and community 42.95%. In 2011 the hospital percentage was 56.06% and community 43.94%. (see chart below) Although the gap has narrowed slightly, there is long way to go before the aim of allowing people to be cared for and die in the community is met. A more determined effort is required to achieve this goal.



Source: NHS GG&C Information Services

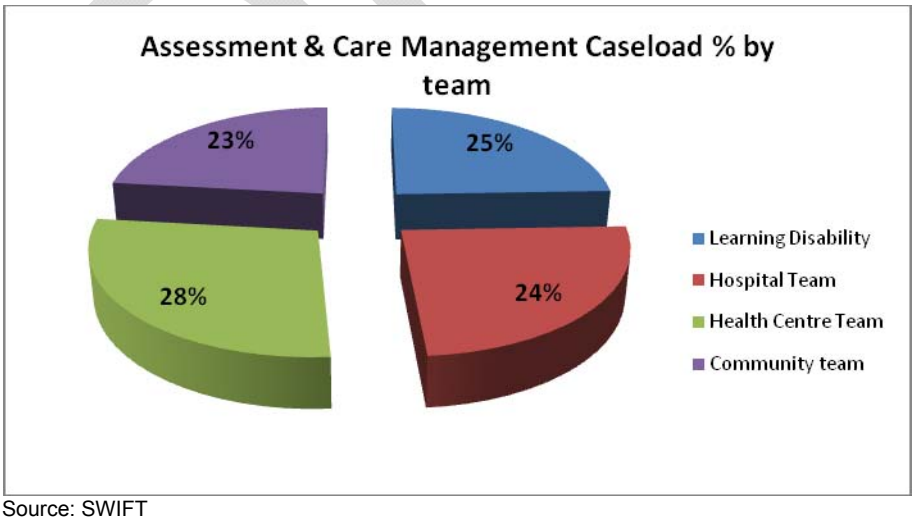
5.13 Assessment & Care Management

Inverclyde residents who require community care services need to be assessed by our Assessment and Care management service.

The 4 dedicated teams assessment and care management teams are:

- Learning Disabilities team
- Hospital Team
- Health Centre's Team
- Community Team

A recent analysis has shown that in terms of caseload weighting, all the teams have a reasonably even split at the present time, with the service supporting a total of 1055 individuals on average.



Source: SWIFT

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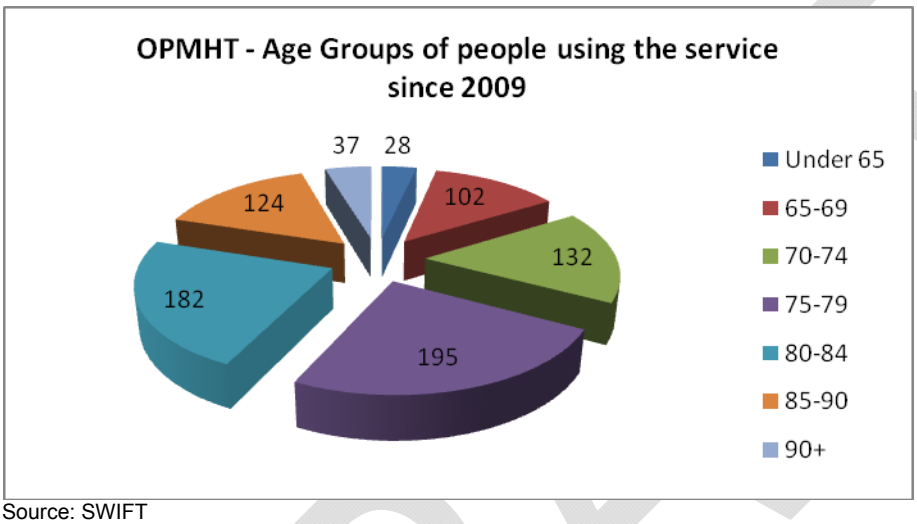
5.14 OPMH

The Older Peoples Mental Health Team (OPMHT) in Inverclyde provides mental health care for people over the age of 65 with a functional mental illness, including dementia. The objective of the OPMHT is to manage people with these conditions within their own home or the community. The team also assists older people returning home from hospital.

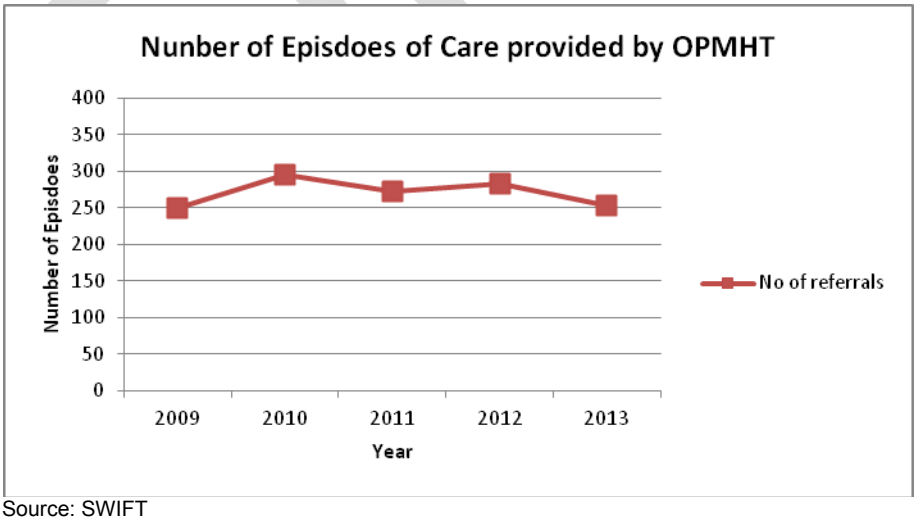
Since 2009 the team has provided approximately 1,300 episodes of care to 800 people. The breakdowns of the age groups are shown below.



Source: SWIFT

The small number of people under 65 may be explained by early onset of dementia in people with a learning disability or people with Down's syndrome.

Episodes of care provided by the service have remained fairly constant since 2009 with no overall trend.



Source: SWIFT

5.15 Equipment & Adaptations

The need of Inverclyde's residents for specialist medical and social care equipment is provided through the Joint Equipment Store. The store provides equipment for those people who have been assessed by suitably qualified staff to have a requirement for specialist equipment to enable them to remain on their own homes to support the level of care that they require.

In the period 1st November 2012 to 31st October 2013, a total of 2,186 people requested and were given equipment, which consisted of 3,387 orders. Further analysis shows this amounted to 6,615 pieces of equipment.

The store issues a wide variety of equipment to different CHCP services including Community Nursing, Occupational Therapy and Physiotherapy. The breakdown of types of equipment loaned in this period can be seen in the table below.

All Equipment Loaned over the Period 01/11/12 – 31/10/2013	
Type of Equipment	**Number of items**
Bariatric	16
Bathing	1181
Beds & associated Equipment	1482
Moving and Handling Equipment	748
Paediatric	3
Pressure Care	745
Seating	676
Small Aids	656
Toileting	1108
Grand Total	***6615***

Unsurprisingly, approximately 48% of these loans were to residents living in the most deprived areas of Inverclyde (SIMD 1 quintile).

People in care homes may also have equipment loaned to them. In this same reporting period (01/11/12 – 31/10/2013) only 0.73% of all loans were to people residing in care homes.

There have been approximately 500 adaptations to people homes since Apr 2013. The number of adaptions can greatly vary from month to month, for example in April 2013 there were 24 adaptions within that month. Whilst in June there were 169 adaptations. More work needs to be done to understand the trends within the adaptations service.

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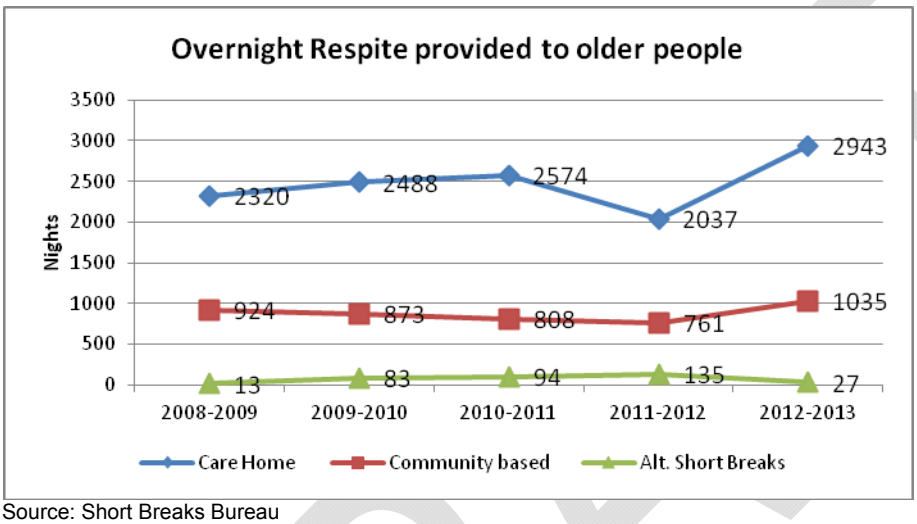
5.16 Respite Care/Short Breaks

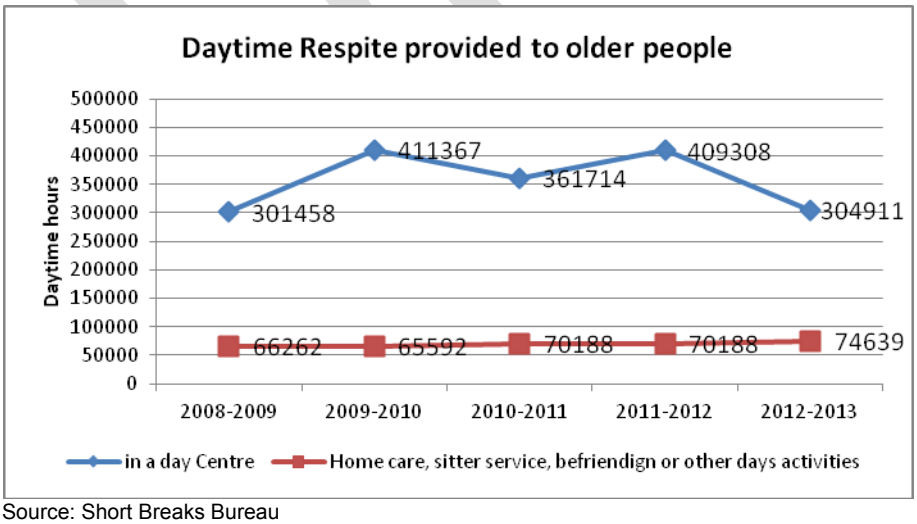
It has been consistently highlighted that carers benefit greatly from Respite/Short breaks from their caring role, enabling them to enjoy a quality of life away from their caring responsibilities and enable them to perform their caring role more effectively.

In Inverclyde, the total number of overnight respites provided to older people aged 65 and over has increased from 2902 in 2011/12 to 4005 in 2012/13. This is due to a high level of demand for respite provision in a care home setting due to complexity, the ageing population and responding to carer's needs.



Source: Short Breaks Bureau

For daytime hours, older people aged 65 and over has seen a decrease in 2012/13. In 2011/12 the total number of daytime hours provided was 479,496, in 2012/13 this shrank to 377,550 hours, a decrease of 97,777 hours. The reason for this decrease is due to a number of factors including an increase in demand and complexity which has had an impact on the services ability to provide domiciliary respite via Care and Support at Home.



Source: Short Breaks Bureau

The Inverclyde Short Breaks Strategy sets out the vision Inverclyde CHCP has in terms of providing breaks for individuals of all ages and developing the type of breaks on offer to produce better outcomes for individuals and their carers. The strategy will support the development of more creative types of breaks, away from the more traditional residential respite.

The Short Breaks Bureau acts a broker in arranging short breaks for individuals and their carers or family members. The Bureau aims to match the needs and preferences of service users to a variety of options on offer including city breaks, hotels and caravans. Many older people have begun to make use of the Louden Trust which offers financial assistance to older people and their carers to enable them to have a holiday and can be arranged through the Bureau. In addition, community based facilities such as Hillend Respite Unit and Rowan Gardens Sheltered Housing are popular options for older people, as indeed is care at home in the form of sitting services.

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5.17 Sheltered Housing

Sheltered housing is housing designed particularly for older people with the aim to help make their lives easier and to enable them to remain relatively independent. Community Alarm / Telecare, is for the most part, a main feature of such complexes and most also include a communal social area. It is also common for sheltered housing to have a warden.

Inverclyde currently has 20 Sheltered Housing complexes. These complexes comprise of 3 types of property:

- Bedsit – Bed/Sitting room (single occupancy)
- Single Flats – one bedroom
- Double – larger than single occupancy (but not necessarily 2 bedroom)

Inverclyde Council account for 35% (7) of the complexes, consisting of 1 bedsit, 22 single flats and 1 double.

The remaining 65% is provided by private organisations or housing associations that provide the service to the CHCP, the breakdown of which is shown in the table below.

		Accommodation Type			
Provider	Name of Accommodation	Bedsits	Single flats	Double	Total
Inverclyde Council	Monkton Place	1	22	1	**24**
Inverclyde Council	John Gault House	6	48	10	**64**
Inverclyde Council	Riverside Gardens	16	12	0	**28**
Inverclyde Council	Glebe Court	17	8	0	**25**
Inverclyde Council	Broadstone Gardens	1	31	5	**37**
Inverclyde Council	Seafield House	0	21	4	**25**
Inverclyde Council	Stewart House	0	21	6	**27**
Cloch Housing	Elliott Court	2	20	0	**22**
Margaret Blackwood	Macclehose Court	20	0	0	**20**
Bield HA	Carwood Court	43	0	23	**66**
Bield HA	Jamaica Court	0	14	15	**29**
Bield HA	Crosshill Gardens	0	26	16	**42**
Bield HA	Rowan Gardens	10	0	0	**10**
Bield HA	Armadale Court	0	17	16	**33**
Abbeyfield Society	Abbeyfield Ardgowan Sq	6	0	0	**6**
Abbeyfield Society	Abbeyfield Esplanade	7	0	0	**7**
Trust HA	East Kirk Court	0	18	12	**30**
Trust HA	St Margaret Court	0	8	19	**27**
Greenock Medical Aid Society	Bagatelle	0	10	18	**28**
Little Sisters Of The Poor	Holy Rosary Residence,	0	20	0	**20**
TOTALS		**129**	**296**	**145**	**570**

There are also 3 private Sheltered Housing complexes, who operate out with CHCP services, and provide only a private service. 2 of these are in Kilmacolm and the other is in Gourock.

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6 PLANNING CONTEXT

6.1 Local & National Policy

We are operating in a plethora of national policy and guidance, informing local policy and practice.

National Policy:

- Public Bodies (Joint working) Bill 2013
- Better Outcomes for Older People
- Changing Lives
- All our futures: Planning for a Scotland with an Aging Population (2007)
- Shifting the Balance of Care
- Community Care Outcomes Framework
- NHS HEAT Targets
- National Dementia Strategy and Standards for Dementia Care
- National Carers Strategy
- NHS Scotland Quality Strategy 2010
- National Older People's Housing Strategy
- Reshaping Care for Older People: A Programme for Change 2011-21
- Reshaping Care for Older People: 'Getting On' 2013
- Self-Directed Support
- Living and Dying Well
- 2020 Vision

Local Policy:

- Inverclyde Reshaping Care for Older People Change Plan
- Inverclyde Local Housing Strategy
- Inverclyde Carers Strategy 2012 – 15
- Inverclyde Joint Community Care Plan 2010 – 2012
- Inverclyde CHCP Development Plan/ Directorate Plan
- NHS GG&C Clyde Mental Health Strategy
- NHS GG&C Long Term Conditions Strategy
- NHS Greater Glasgow and Clyde Planning and Policy Frameworks (Older People/ Disability/ Long Term Conditions/Carers)
- Inverclyde Council Corporate Plan
- NHS GG&C Acute Services Review (ASR)
- NHS GG&C Clinical Services Review
- Inverclyde CHCP People Involvement Framework

Key Strategic Drivers:

- Reablement
- Creating mutual health and social care services

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- Rehabilitation Framework
- Self Directed Support and Personalisation
- Outcomes focussed assessment, care and support planning
- Telecare and Telehealth
- Community Capacity Building/ Community Development
- Co-production – working together with users and carers to develop services and supports

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6.2 Integration

Since the creation in October 2010 of the integrated Community Health and Care Partnership, we have been working to embed the ethos of integration across all levels of the organisation. In particular, we are keen to ensure the benefits of integration are maximised at an operational level, ensuring that patients, service users and carers experience as seamless a transition as possible when their needs span traditional organisational boundaries.

Recognising that we need to actively manage and develop the integration process, we are engaging in several pilots to inform this process. In spring 2013 we participated in a pilot inspection by the Care Inspectorate to examine the level of organisational integration in relation to Older People's Services. The outcome of this inspection was very positive, with good feedback about the quality and impact of our services and endorsement of our intended direction of travel.

In addition, Inverclyde CHCP is piloting an NHS GG&C model to create a shared approach to shaping demand and design for hospital services between Acute Services and primary/ community services. The model is based on:-

- a transparency of baseline activity, including age, disease and service information and cost of acute services for each partnership;
- analysis of how that baseline varies from population norms; results from differential primary care performance; might be reshaped by community health, social and primary care changes;
- defined whole system changes required to be delivered through joint plans to enable acute services to deliver quality and efficiency targets and focus on essential activity. Examples could include reducing delayed discharge or shifting place of death.
- a means of agreeing collective action to manage demand with the essential buy in of GPs.
- a joint planning process to deliver a three year change plan which will reshape the baseline;
- the joint planning process to have a core component of collective shared priorities but also the potential for each partnerships joint plan to reflect local issues and priorities; and focuses upon hospitals delivering only the care for which hospital is essential

6.3 Reshaping Care for Older People

In common with partnerships across Scotland, Inverclyde CHCP's approach to Reshaping Care for Older People is integral to many aspects of our working as a partnership. It has provided a framework for our revised governance arrangements, with the additional resources provided by the Change Fund proving to be pivotal in facilitating transition through a range of service redesigns. As we continue to address demographic and funding pressures, the principles of Reshaping Care for Older People will underpin how we plan and deliver care in Inverclyde. The pathway

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diagram on page 57 (Figure 5) demonstrates the range of services for older people, and where they sit within the Reshaping Care for Older People pathway.

Shifting the balance of care has been a priority for many years in moving from large institutional based provision to more appropriate community or home based settings. However, it continues to have resonance in achieving the other core policy drivers. The term shifting the balance of care also refers to the shift we want to make in terms of using more external provision of services rather than in-house services supported by, for example, the increased use of modern technology like telecare. Shifting the balance will require significant redesign of services, looking at how we use resources like day centres and day-care; intermediate care (bridging between hospital care and transition back to independent living at home), and reablement services.

Inverclyde CHCP's focus and performance upon the Delayed Discharges targets has been apparent for some years and is underpinned by our commitment that it is in everyone's best interest to spend as short a time as possible in hospital, returning to an appropriate, safe care setting upon discharge.

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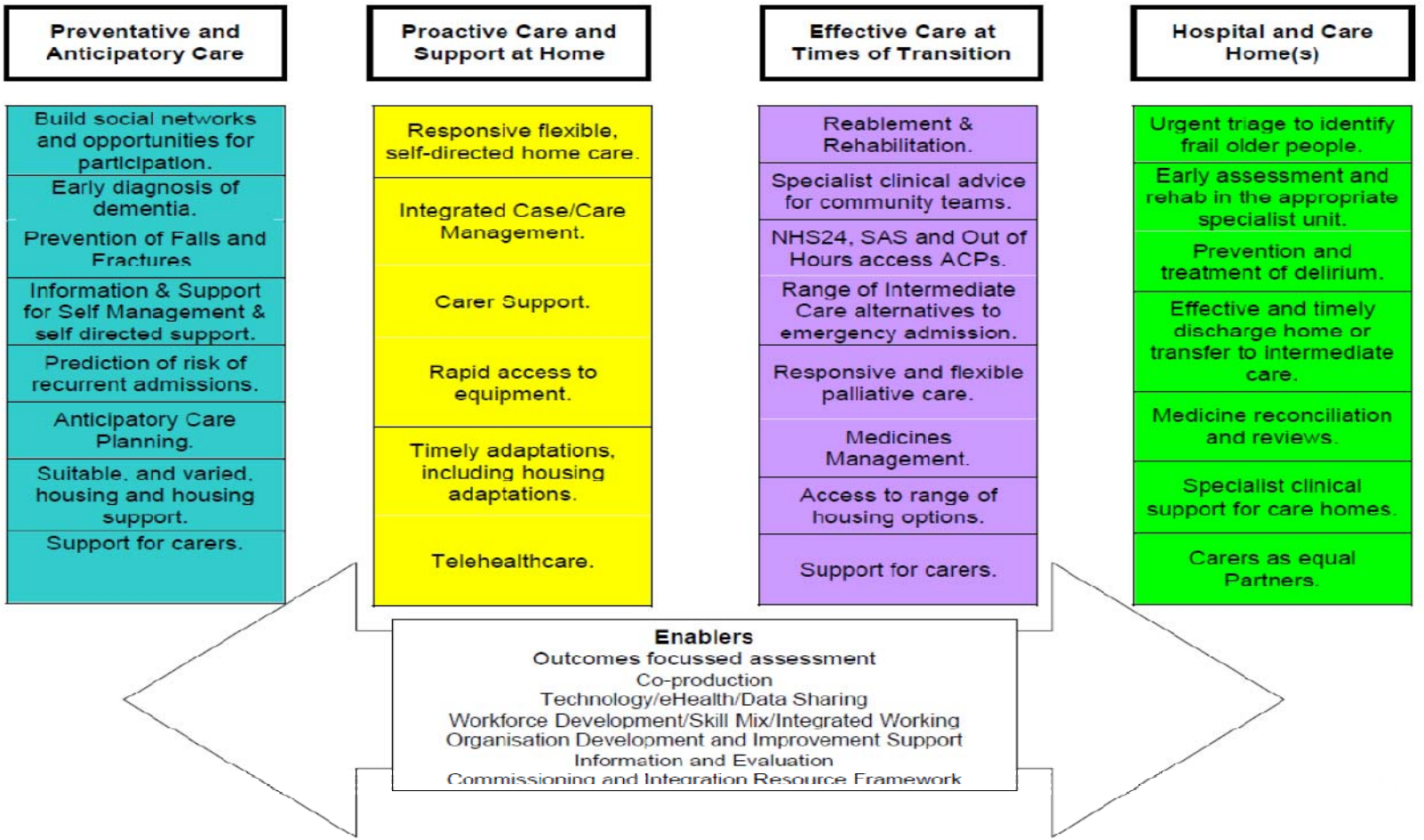
Figure 5:

Reshaping Care Pathway

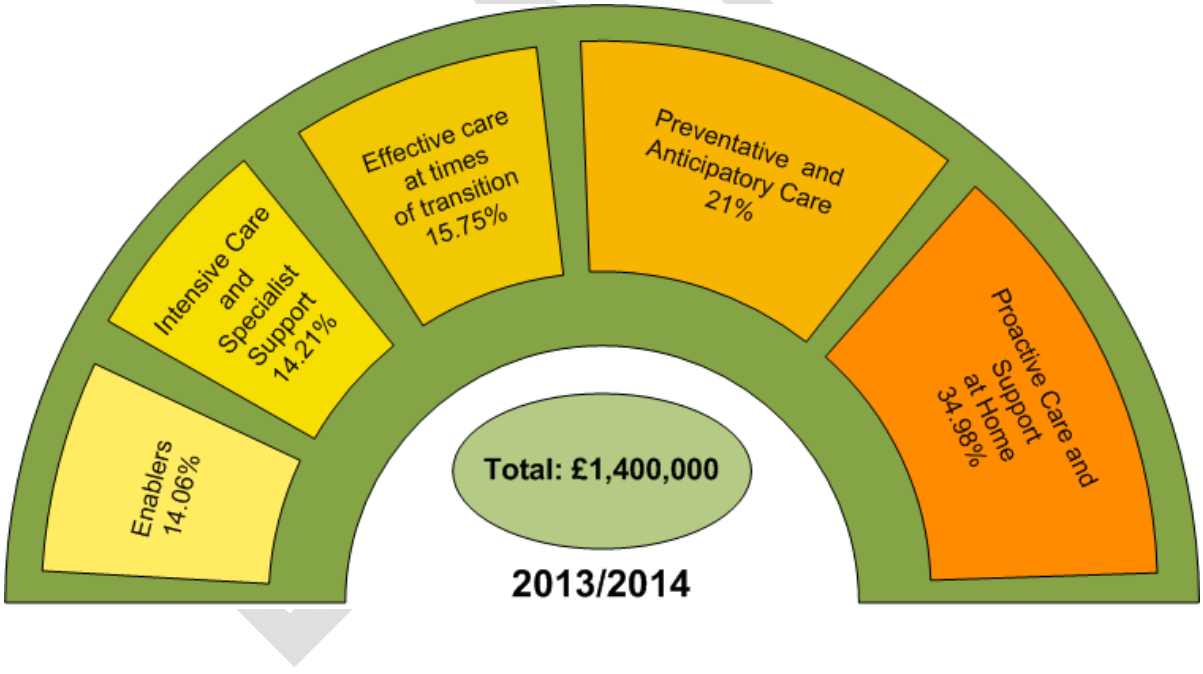


The recent refresh document *Reshaping Care for Older People 'Getting On' (2013)* acknowledges that nationally, much has changed, but that there is still much to do. Whilst outcomes and measures for success may continue to change, the actions and ambitions laid out in 2011 remain just as relevant:

> 'Older people are valued as an asset, their voices are heard And they are supported to enjoy full and positive lives in their own home or in a homely setting.'

We are investing now to reduce the cost of future ill health with a strategic shift towards prevention, promoting health, wellbeing and independence. This shift is clearly visible year on year in our change fund investment streams and will remain our focus. The percentage of funding against each pillar for 2013 - 2014 is shown below.

Figure 6:



6.4 Person centred approach

The definition of outcome is the impact of end results of interventions and/or services on a person's life "Outcomes focused services and support therefore aim to achieve the aspirations, goals and priorities identified by (assessment)" (Glendinning et al 2006).

Improving outcomes for service users is at the forefront of social care service, and increasingly community health services too, but social care and health providers have often struggled to measure and evidence improved outcomes in any meaningful way. Evidence of improvement can be obvious at an individual level but the 'soft' information that often demonstrates improved outcomes can be difficult to aggregate. This makes it difficult for service providers to be confident, at a strategic level, that our service inputs are delivering what they need to on a population wide basis.

Single Shared Assessment Procedures in Inverclyde CHCP have been updated to reflect the Community Care Outcomes Framework, and the SHANARRI wellbeing outcomes to help us reflect more easily what outcomes have been achieved individually and collective as a result of our collective efforts with service users, patients and carers. The Community Care Outcomes link to the Scottish Government National Outcomes which are:-

- Improved health
- Improved well being
- Improved social inclusion
- Improved independence and responsibility

Assessment, care planning and review lie at the heart of identifying and improving outcomes for people using community care services/support and their carers. The Talking Points Approach to outcomes which we aim to implement fully builds on research conducted over many years by the Social Policy Research Unit at York University and further research by members of the Talking Points team at the University of Glasgow (Petch et al).

By engaging with a range of services and community supports such as formal health and social work services, housing, voluntary organisations, community's own infrastructures, the person's own strengths and personal resources etc outcomes can be achieved. This collaborative and assets based approach underpins our Joint Strategic Commissioning Plan.

Personalisation of services was an explicit goal of 'Changing Lives', and is intended to put the person at the centre of decision-making about services and supports they receive. It is also intended to promote the development of personal and community capacity to reduce dependence on services. Again this is core to our Joint Strategic Commissioning Plan approach.
This will be through engaging with a range of services and community supports such as formal health and social work services, housing, voluntary organisations,

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community's own infrastructures, the person's own strengths and personal resources etc. This approach underpins our Joint Strategic Commissioning Plan.

Personalisation of services was an explicit goal of 'Changing Lives', and is intended to put the person at the centre of decision-making about services and supports they receive. It is also intended to promote the development of personal and community capacity to reduce dependence on services. Again this is core to our Joint Strategic Commissioning Plan approach.

6.5 Self Directed Support

The National Strategy for Self Directed Support (SDS) in Scotland was launched in November 2010. This 10 year strategy aims to set out and drive a cultural shift around the delivery of support that views people as equal citizens with rights and responsibilities, rather than passive recipients of services.

The strategy has 26 recommendations but the main themes are linked into the cultural shift of moving from needs led assessment to supporting a person to think about what they want to achieve and to support them to plan for this.

The Social Care (Self-Directed Support)(Scotland) Act 2013 received Royal Assent in January 2013. Draft regulations and guidance were published for consultation in April 2013 and are currently in draft form.

With the implementation of the SDS Act and the move to the personalisation agenda care provision is changing. We are now moving away from thinking "what services do we need to provide to ensure a persons needs are met "to be in a position of supporting the person to think about what they want to achieve (their outcomes) and to help them plan how to manage this.

Section 1 of the act places a duty on local authorities to have regard to certain principles in carrying out it's functions under the Act and apply to the local authorities' social welfare responsibilities (the provision of care and support) to both adults and children. These principles are related to:

- Involvement - giving the person as much involvement in the assessment of their social care needs and the planning of their support as they want
- Informed choice – providing reasonable assistance to assist someone to express their own views about the choices available to them and make an informed decision about their preferred choice
- Collaboration - authorities are required to collaborate with a person in both the assessment of their needs and the provision of support or services following the assessment

The act also provides a discretionary power to authorities in order that they can provide support to carers following a carer's assessment under section 12AA of the 68 Act or section 24 of the 1995 Act (section 3)

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The Act places a duty on local authorities offer four options to individuals they assess as needing care and support under:

- section 12A of the Social Work (Scotland) Act 1968 (the 1968 Act)
- section 3 of this Act (support for adult carers)
- section 24 of the Children (Scotland) Act 1995 (the 1995 Act)
-

The four options are:

- Option 1 – the person receives a direct payment to purchase their own support
- Option 2 – the person chooses the support who they want to provide their support and the local authority makes the arrangements on their behalf and pays the provider
- Option 3 – the local authority chooses the support and commissions the service on behalf of the person
- Option 4 – is a combination of options 1 to 3.

To be ready to deliver this part of the strategy:

- We need a system that can allocate funding to individuals which ensures equality, fairness and is transparent and which can meet the assessed needs
- We need an assessment tool which captures the information needed for the resource allocation as well as associated policies and guidance
- We need a training programme in place to support staff with all aspects of SDS and it's delivery
- We need good communication / relationships with providers, 3rd sector and the community to ensure that everyone understands and has the capacity to deliver on SDS and Personalisation
- We need to ensure that we can monitor packages and can quickly access the information required for all statutory returns

To facilitate this there is a team in place who are working with the established steering group to oversee the processes required to be ready for April 2014 and beyond. There are also work streams in place who will take forward particular aspects of the required tasks. These are:

- Finance and Resource Allocation
- Assessment Policy and Procedures
- Learning and Development
- Communication, Partners and Providers
- Reporting and Infrastructure

Self-directed support will give older people and their carers increased choice and control over the care and support provided, therefore this plan will have to be developed with the required flexibility to respond to any future, and indeed ongoing, changes in markets or demand.

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6.6 Welfare Reform

The UK Government is currently introducing a wide range of changes to the social security benefit system under the Welfare Reform Act 2012 and the Pensions Act 2011. In common with most other areas in Scotland, it is anticipated that these reforms will have a significant impact on the local economy, local people, and local services which we need to be aware of and responsive to. While not all of the planned changes will affect older people a number will impact directly, such as proposed changes to pensions and housing benefit and we are quantifying the likely increase in pensioner poverty and financial exclusion amongst older people. It is also anticipated that a number of the reforms planned which are anticipated to directly affect working age people, such as changes to unemployment benefit and disability benefit, will compound as these people get older. It is also anticipated that there are likely changes to the ways in which services are funded in the longer term, as a result of welfare reform and of the financial context in the UK economy generally.

The partnership is supported by work being undertaken in the statutory and voluntary sector to respond to the challenges of welfare reform and seeks to deliver services which as responsive to the needs of individuals, as their context changes, particularly in terms of financial exclusion and/or anxiety around such issues.

6.7 Carers

In 2010 the Scottish Government, in partnership with COSLA, launched a new Carers strategy for Scotland covering the period 2010-2015. “Caring Together” builds on progress made since the Care 21 report and sets out a shared vision of society where:

- Carers are recognised and valued as equal partners in care
- Carers are supported and empowered to manage their caring responsibilities with confidence and in good health and to have a life of their own outside of caring
- Carers are fully engaged as participants in the planning and development of their own personalised, high- quality, flexible support and are not shoe-horned into unsuitable support. The same principle applies to carers' involvement in the services provided to those for whom they care
- Carers are not disadvantaged, or discriminated against, by virtue of being a carer.

The Scottish Government required all partnerships in Scotland to develop initiatives as part of their Reshaping Care for Older People which support the carers of older people to maintain their caring role which is crucial to supporting older people to live as long as possible in their own homes and communities. Inverclyde’s response to this has been underpinned by our own local Carers and Young Carers Strategy 2012 – 20015, which was co-produced with carers and has been recognised nationally as an example of best practice.

There are an estimated 8000 carers in Inverclyde. 2181 are currently registered with the Carers Centre. 529 of this number are carers aged 65+ with 218 of these carers being aged 75+. More than half of the registered carers, 1386 are looking after someone over the age of 65.

We have in place a Carers Development Group to oversee the implementation of the Carers Strategy, and an advisory group to drive our carers projects linked to the Reshaping Care for Older People agenda. Both groups are inclusive in membership and provide strategic leadership on carers issues.

Specific investment to support unpaid carers relates to:-

- Supported hospital discharge – we have a carers support worker from our carers centre co-located in the local acute hospital to work alongside NHS staff to support carers before and at the time of discharge of their loved one.
- Emergency and Long Term Planning – a worker is in place to support older carers to consider longer term and contingency planning for their loved one should their needs change or an emergency arise.
- Befriending – facilitating partnerships between former carers and current carers to help promote natural supportive friendships based on common experiences and understandings.
- Carers Information Packs – we have continued to publish carers information packs for distribution to carers to increase awareness and information.
- The introduction of initiatives which support more personalised and flexible access to respite services through the publication of our new Short Breaks Strategy
- New approaches to carers and financial inclusion are being developed through our local Financial Inclusion Partnerships, with tailored intervention from advice workers to carers.
- Devolved budgets for Short Breaks to Inverclyde Carers Centre, which enable carers to have short breaks together or arrange for sitting services around their needs.
- Emotional support for carers at the Carers Centre through Counselling and Stress Management sessions
- Training opportunities for carers in relation to long term conditions and self improvement opportunities.

Inverclyde CHCP is fully committed to supporting carers and to delivering on the expectation that carers should be equal partners in care. To this end, we were successful in being chosen as a pilot area for the implementation of Equal Partners in Care (EPiC). EPIC is a joint project between NES and SSSC to implement the workforce education and learning elements of the Carers Strategy by linking three core principles to the current range of health and social care policies For the six months to March 2014, there will be a focus on embedding the Level 1 ‘Carer Aware’ and level 2 ‘Caring Together’ principles of EPiC within existing and planned training and development across the organisation.

Our Change Fund plan recognises the commitment of carers and the huge contribution they make to how services and support are currently delivered and how they will evolve in future.

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An engagement session took place in December 2012 with our local Carers Network focussed on carers and commissioning. From this event we know that:-

- Carers wish to be acknowledged and listened to as partners
- Carers wish to be fully involved in the planning and reviewing of individual care packages for their loved ones.
- Carers wish to be fully involved in hospital discharge planning
- Carers welcome the opportunity to be fully involved in the coproduction and monitoring of the Inverclyde Carers Strategy
- Carers welcome the opportunity to be able to influence and shape the future direction of services and support.
- Carers would welcome the introduction of SDS.

We are committed to building continuously on the strong partnerships between the CHCP and Inverclyde Carers Centre and Carers Council to ensure that carers have a strong voice in commissioning, and continue to develop their role as equal partners in the delivery of care and support.

6.8 Care Homes

In Inverclyde Residential and Nursing Home care is provided through a range of independent sector providers. There are 16 homes varying from small family run homes to larger purpose-built homes.

The Care Homes are supported by a range of Primary Care Services including District Nursing, General Practitioners and a range of Allied Health Professionals.

Between 1 December 2012 and 31 May 2013 GPs were invited to undertake a comprehensive review of their patients who resided in care homes. This review covered topics which are considered important when providing healthcare and anticipating future health or care needs for this particular group *(AWI, POA/guardianship, history of falls, DNACPR status, ACP, pharmacy review, palliative care).*

Practices visited all current care home patients and any new patients who were admitted to a care home and registered with the practice between 01 December 2012 and 31 March 2013. Not all GPs participated in the project and consequently not all patients were visited. A total of 458 forms were returned for analysis.

Feedback from GPs and Care Home staff reported positive outcomes in terms of raising awareness of the importance of the various aspects of anticipatory care amongst GPs, care home staff as well as care home residents and their relatives. Those residents who were visited will have benefited from an extensive review of their current and future care. Additionally, GPs and care home staff have indicated that they are now more likely to review other patients and have an increased understanding of the importance of carrying out such reviews.

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Data on A&E and acute admissions will continue to be collected and analysed as it becomes available with a view to establishing if the project has affected admission patterns from care homes.

Anecdotally, there has been a perception that admissions to hospital from Care Homes have been a source of concern, both in terms of frequency of admission and reason for admission. However, an audit of emergency admissions to Acute hospital services has refuted this perception, with admissions being in proportion and appropriate. However, it has recently been reported that admissions to EMI Inpatient facilities from Care Homes has been rising, and we have agreed to further work with Care Homes to improve our understanding of the reasons for this and develop joint approaches to address this.

Recently we have reviewed the range of performance measures relating to Care Homes and some interesting changes in patterns of activity are emerging, most notably:-

- that age on admission to Care Home is increasing;
- that length of stay is reducing;
- that for the first time we are seeing demand for Care Home places reduce.

This last point is reinforced by a rise in demand for more comprehensive homecare packages to maintain people at home, avoiding Care Home admission, leading us to conclude that an options appraisal is required to explore this key area further to establish where we could disinvest in Care Home places and reinvest in alternative provision of care.

A task force review "Reshaping Residential Care for Older People" is currently underway and due to report back to the Scottish Government and COSLA by the end of the year. This report will shape a strategy on future provision of residential care. Consultation, would then be required with recommendations being implemented later in 2014. Emerging themes from the review are:

- A long term 20 – 30 year perspective is required
- Attention must be paid to the personalisation agenda
- Workforce flexibility is crucial
- A range of approaches to future commissioning are required.

6.9 Homecare/Reablement

The Homecare service in Inverclyde is available to people living at home in the community, whether living alone or as a family member. The service is provided to a wide range of people including frail older people, people with physical or sensory impairments, people with learning disabilities, people with mental health problems and other vulnerable groups.

The key aim of the service is to enable people to live as normal and independent a life as possible in their own home. Services include personal care which is available

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free of charge to people aged over 65 years and non personal care services which are chargeable in line with the Council's Charging Policy.

An independent review of our Homecare services was commissioned in 2011 for a number of reasons:-

- Changes to the demographic profile with an increasing percentage of older people in conjunction with a reduction in people of caring age;

- The apparent increased costs and increased demands upon the service;

- Issues raised by the Care Commission inspection process in terms of the unmanageable span of control for managers of the service;

- The desire expressed by Inverclyde's older people to live independently at home for as long as possible, supported by services which were flexible to accommodate changing needs.

Key recommendations from the review which have been progressed in the last 12 months include:-

- The modernisation of rotas to meet service demands ;

- Investment in technology to facilitate mobile working, electronic monitoring and electronic scheduling;

- Restructuring of management to reduce the span of control, enhance day to day operations, improve leadership of teams whilst improving assessment/care management review functions;

- Development of the local mixed economy; and

- The development of a reablement model of care supported by Occupational Therapy staff.

The Reablement Homecare service was introduced in October 2011 in the East area of the CHCP. Funding from the Change Plan has supported the developmental stage of this major redesign. In common with many other areas of Scotland, Inverclyde has embraced the philosophy of reablement and cultural change that it brings, for both service users and staff.

Reablement builds upon the principle of homecare to support independence, taking it to the further stage of maximising the opportunity for longer term independence through more comprehensive assessment and supported interventions at an early stage.

Learning from our experience of the implementation of reablement in the East, from the beginning of June 2012, the reablement service rolled out to the 2 other geographical areas within Inverclyde, West and Central, supported by discrete

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reablement teams. Across the teams, we are now beginning to see some consistency in demand and outcomes for service users:-

- Around 10% of services stopping as a result of readmission to hospital, although retain the option of accessing the service again upon discharge;

- Around 25 - 30% of service users achieving independence following the process of reablement;

- Between 50 - 60% of service users moving to mainstream homecare services, however, reducing their hourly input by an average of 30%.

However, with the changes in Homecare and Reablement it is apparent that we are a complex, evolving environment.
The services we provide need to be sensitive to the scale and pace of change, both in terms of demand and in how we can flex delivery of services to meet this. The financial climate in which we are operating adds to this complexity, making the challenge not only to deliver a high quality and responsive service but one which is also efficient, cost-effective and affordable.

To inform our future plans for procurement, we are in the process of reviewing the implementation and planning assumptions which have informed our recent changes in both Homecare and Reablement, with the aim of integrating this level of scrutiny to our routine performance management of services. Further consideration is required to determine the extent of the shift in the balance of care between internal and external provision of this service, particularly following the Council budget-setting process.

6.10 Building capacity in our communities

Inverclyde has long been characterised by progressive community development, and by a strong and resilient voluntary and community sector presence.

We aim through this Joint Strategic Commissioning Plan to build on this tradition and reinvigorate the community based approach to supporting our local older people.

In the times of financial stringency we currently face, positive opportunities for more collaborative and dynamic forms of service delivery are required, as referenced by organisations such as The Health and Social Care Alliance in their initial scoping report on the Older People's Change Fund.

Enhancing the role of the Third Sector, this creates an opportunity for better partnership working; both across sectors and with service users and their informal support networks. We are committed to working with Community Planning partners to develop, agree and implement a third sector development strategy to develop organisations, volunteering, social enterprise, partnership and external funding.

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Community services are understood to include contributions by both communities (informal) and organisations (structured). These contributions are mostly resourced through a combination of contracted services, grant funding, donations and volunteering.

The spectrum of community services is very broad and includes:-

- Social transport
- Support to adopt and maintain a healthy lifestyle
- Social activities & day care
- Peer support & befriending
- Advocacy
- Maintenance / handyperson services
- Advice & Information
- Shopmobility and other support to access shopping
- Digital inclusion
- Intergenerational activity

These types of services are rarely a statutory requirement. However evidence, such as that produced by the London School of Economics in their paper "Building Community Capacity - Making an Economic Case" (http://www.thinklocalactpersonal.org.uk/_library/BCC/Making_an_economic_case_doc.pdf) demonstrates that the investment in preventative spend has a significant cost saving for public sector health and care services, whilst also improving quality of life for older people.

Community Capacity Building

Community capacity building is a key element of the long term national strategy to support individuals, families and communities to increase the level of support provided to people within and by their own communities.
An investment in capacity building allows development of greater long term capacity for people to be supported within their own community.

As part of the overall agenda to shift the balance of care towards preventative supports and promote independent living, Inverclyde CHCP is actively working with the third sector and other partners to develop community capacity. We work collaboratively particularly with our third sector partners and through the Inverclyde Alliance Community Engagement and Capacity Building Network (CECBN) to provide advice, guidance and other support to individuals, communities and organisations to develop resources and services which can support people to live safely and independently within their communities without the need for ongoing intervention from health and social care services.

Inverclyde's Reshaping Care for Older People Programme partners have taken a whole systems approach to rolling out the Reshaping Care for Older People agenda, particularly in relation to linking more traditional operational services with community capacity building opportunities. Partners include Inverclyde Community Health &

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Care Partnership, CVS Inverclyde, Scottish Care, Your Voice Inverclyde and local carers organisations.

Volunteering

We recognise the significant impact that volunteering has on the provision of services, as well as the greater impact that it could have with further development. Volunteering is not viewed as a cheaper way of delivering services; but instead as a way of improving the quality of the experience received by service users. Volunteering by older people themselves also has a positive impact on their physical and mental health and wellbeing, social connections and quality of life.

The proportion of people in Inverclyde who volunteer is recognised as being below the national average which creates significant challenges for both third and public sector organisations that do, or seek to, involve volunteers. This strategy recognises the need to raise the profile of volunteering, create exciting and relevant opportunities to volunteer and to ensure that volunteering is an enjoyable and rewarding experience.

Partnership with third sector providers

As stated above, there is a strong Inverclyde community ethos of working together and a long tradition of working in partnership across the statutory and third sector; particularly in relation to jointly developing innovative community based services. We seek to build upon this and use the Joint Strategic Commissioning Plan to explore further opportunities for communities to deliver services themselves through working in partnership with agencies and public bodies.
We recognise the value that the third sector brings to service delivery and wish to encourage more third sector organisations to take a 'social enterprise' approach; by entering into contracts with statutory agencies for the delivery of services and by identifying opportunities created through the use of Self-Directed Support.

To ensure that contracts with third sector organisations remain innovative, effective and outcome-driven we will investigate and pilot a Public Social Partnership approach to service design; providing opportunities for service users, communities and third sector organisations to be involved at an early stage of development and creating strong partnerships that allow for creativity and flexibility; rather than traditional commissioner/provider roles.

We will use the national experience of CEiS and Social Value Lab; alongside the knowledge of local partners (such as CVS Inverclyde); to progress a number of pilot Public Social Partnerships. These will begin with local "innovation" sessions to identify where third sector organisations can identify new ways of working. Alongside these our local providers forum are already active in bringing forward new models of service delivery fit for the future.

In addition to improved commissioning outcomes these innovations will create a stronger environment of partnership between the third and statutory sector provision. This will improve understanding and confidence across sectors, increase quality referrals to all services and strengthen the capacity of the third sector to

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attract external funding into local services that align with the agreed priorities of the partners.

COMMUNITY CAPACITY BUILDING PROJECTS

A number of projects were funded through the Community Capacity Workstream of the Reshaping Care for Older People Programme in 2012/2013 including, Contact the Elderly, Good Neighbourhood and Social Transport Service, Handyman Service, Financial Fitness, Care and Repair and the Cook School Project. The aim of supporting these projects was to assist local voluntary organisations to develop their capacity to support older people to continue living in their own homes and feel more connected with their community. Our engagement partners Your Voice highlighted these projects through the local People Involvement network and referred local people for support as appropriate.

To underline our commitment to community capacity building, £100, 000 has been allocated to another six projects during 2013/ 2014. Using an innovative approach, applications were assessed by a small group against the Reshaping Care for Older People outcomes and subsequent funding awarded. This group included an older carer, a member of the CHCP Older People's Advisory Group, a representative of CVS and the CHCP Key Partnerships Lead. Not all those awarded funding were third sector organisations but nevertheless demonstrated how they would support older people to build their own capacity and support within the community.

Muirshiel Rapid Response Handyman Service:

Initially funded during 2012/13, this service is aimed at older people over 65, who require assistance with odd jobs in their own homes in an emergency situation, to avoid them having to be admitted to care or hospital. The project can also assist with decorating, removing furniture and small jobs to allow people to be discharged from hospital into a comfortable environment. Funding for 2013/14 will allow the service to use the skills of a graduate placement to explore new opportunities, be more enterprising and enhance existing services.

Circles Advocacy:

Circles Advocacy in Inverclyde (formerly Inverclyde Advocacy) is providing advocacy support for Older People over 65 whether that be within a care home setting; hospital or living at home. Support will enable people to live as independently as possible including support to access Self Directed Support.

Inverclyde Council - Community Learning & Development:

Wider Opportunities in Inverclyde (WOOPI) project started in September 2009 and is funded for 5 years from the Big Lottery's Investing in Communities Programme. WOOPI provides a range of programmes designed to improve the physical, mental health and well being of Inverclyde residents who are 55+. WOOPI also aims to break down intergenerational barriers and cultural perceptions with a focus on skill sharing and generations working and learning together. As lottery funding declines, the focus will be on the development of the capacity building aspects of the model

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and towards older people who are 65+ and more vulnerable whilst still maintaining an early intervention approach.

Inverclyde Radio:

Inverclyde Radio is an internet based radio station with whom we will work in partnership to develop oral audio delivery of information about our services and those of partner organisations, agencies and third sector contributors. Relevant information and advice will be provided during promotional weeks such as carers week & falls awareness week.

Action on Hearing Loss:

Hear to help service will provide a drop in service for hearing aid maintenance, advice, support and signposting those who have hearing impairments.

Royal Voluntary Service

An outcomes based programme will enhance community transport, support assisted shopping, personal emergency planning and offer support during times of bad weather.

Keeping Active In Later Life:

Inverclyde's Keeping Active in Later Life Project is run by Your Voice Inverclyde Community Care Forum and works in partnership with Inverclyde Community Health & Care Partnership (CHCP) along with various voluntary/community organisations and private providers. Whilst not in receipt of change fund monies, this project is a positive example of enabling older people to remain living at home and to enhance their quality of life

The project aims to provide practical and emotional support to address social isolation and assist older peoples independence to remain at home. By facilitating access to flexible services that promote independence in partnership with Inverclyde Community Health & Care Partnership, it enables older people to shape and develop sustainable services to meet local need.

Working with older people to design a programme of support that highlights the importance of prevention and social inclusion, it encourages self management of long term conditions and/or disabilities, which fits with the peer support model. The project assists and stimulates a network of self help and peer support to build capacity and enable more able older people, through community buddies, to assist those less able to participate and get involved in their everyday life. It also co-ordinates a partnership approach to promote older peoples well being and prevent them slipping into risk situations.

Support will promote: the reablement model of care; recovery/rehabilitation; health & wellbeing; social engagement and improved social/community connections, leading to greater independence, inclusion and enable older people to remain living at home and enhance their quality of life. Key to the success of this project is the point of

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referral for individuals. Recently we have routinely referred to this project as service users complete their period of reablement, and are monitoring the impact and benefits realised through this approach.

6.11 Co-production

Co-production, defined as "delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours". Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change" (NEF, 2011), and is seen as key to meeting the challenge of delivering social care and health services in these difficult times.

In co-designing services we will increasingly use co-production as the default method of service delivery. Managers and staff across sectors will be trained, supported and encouraged to use co-production, asset based & personal outcome approaches to working with clients; recognising the skills and capabilities of people.

7 CARE CONTEXT

7.1 Dementia and Mental Health Interface with Change Fund: 2013-2014

Currently Inverclyde CHCP is engaged in implementing the Modernising Mental Health Services Strategy. This work includes the redesign of Older Peoples Mental Health Services and is based on the development of care pathways, including the dementia care pathway. The work in this area includes addressing the interface with wider community care services, older people's services and the acute sector; priority of the partnership and includes:-

- an existing Dementia Care Pathway action plan, updated to reflect Scotland's National Dementia Strategy 2010, and incorporating Standards of Care for Dementia in Scotland 2011;
- use of the Dementia ICP to inform service elements required and redesign of existing service provision;
- use of service improvement techniques within redesign work groups, including engagement with the Mental Health collaborative;
- the piloting of different approaches to supporting people with dementia at home within the local Telecare development work;
- pilot approaches with the third sector in respect of early interventions to support people with dementia and their carers;
- a robust partnership approach with GP's locally to improve early diagnosis, and post diagnosis support.
- Development of specialist support to non dementia inpatient services to improve quality of care and ensure appropriate care is provided.

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Within Older Peoples Mental Health services the future model for service delivery has been developed and current work is focused on the detail of this in operational processes to enable implementation. The model is based on a tiered approach to interventions matched to need, with functions identified as below, and cross referenced to the Reshaping Care pathway:

Tier 1: Primary Care: Preventative and Anticipatory Care; Proactive Care and Support at Home Pathway links.

- To enable single point of access to mental health services, with initial determination of level of need in context of the pathways applied by the GP.
- Provide diagnostic service either by the GP or in conjunction with Consultant;
- Provide treatment and support to GP prescribing and medication review;
- Post diagnostic support for people receiving a diagnosis of Dementia;
- Access to psychological interventions for people with functional illness presentations;
- Enabling access to wider support services at home and within the community, e.g. day activities, home care;
- Elective access to second tier mental health services when need indicates.

The focus within primary care mental health services is on a timed programme of intervention for people with functional illness presentations of Depression; Anxiety; Adjustment Disorders; and identification and assessment of people with Dementia and post diagnosis support.

Tier 2: Secondary health services, and specialist mental health teams.
Proactive Care and Support at Home, and Effective Care at Times of Transition, Hospital and Care Homes Pathway links.
Access to the mental health service for those with complex needs arising from Dementia; Psychosis; and more complex or enduring functional illness presentations may include:-

- fast track assessment for people within the community requiring assessment by the mental health service;
- supplementary mental health interventions within existing care arrangements in the community;
- fast track assessment to support care within other settings, i.e. General Hospital inpatient service; Care Homes;
- routine liaison to support care within other settings;
- Care management of people requiring ongoing mental health service intervention due to complexity of mental health needs.

The priority work is currently focused on the implementation of fast track assessment and Liaison services and during 2012 further work to enable implementation of the Primary Care elements of service will be taken forward.

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7.2 Palliative Care

Inverclyde CHCP has an explicitly stated commitment to working across agencies and in partnership with voluntary organisations to establish expertise, choice and rapid access to services required for End of Life care.

With relatively high levels of people with cancer and higher than the Scottish average levels of people with non-malignant life-limiting illnesses such as chronic lung disease, the palliative care needs of the Inverclyde population are significant.

The CHCP has a close working relationship with Ardgowan Hospice and are collaborating in progressing work to develop Inverclyde as a compassionate community.

From Change Plan resources we have invested in a number of Palliative Care initiatives, including:-

- An additional Acute based palliative care Clinical Nurse Specialist;
- A community based palliative care Clinical Nurse Specialist
- A community based Practice Development Nurse;
- GP funded sessions to facilitate the introduction of the Macmillan Gold Standards Framework and support primary care palliative care
- A programme of palliative care training for care and support and home staff
- An independent scoping project of palliative care services and pathways.

The independent palliative care scoping exercise reported at the end of March 2013 and has informed the three years workplan of the Inverclyde Palliative and End of Life Care Planning are Implementation Group, and include analysis of the impact and benefits gained from the range of investments and service changes.

The overall aim of the scoping work was to map current palliative care provision and identify those services/areas that are working well and those areas where attention, development or improvement may be beneficial, particularly around transition between services.

There have been 3 key elements of the work undertaken to date:-

Firstly, to elicit and analyse demographic epidemiological and service related data;

Secondly, to determine the palliative care services available and elicit the views of health and social care professionals as to the services that are working well and those that require attention and/or development;

Thirdly, to elicit the views of patients and carers as to the palliative care services that they experience as being beneficial and those they feel may benefit from attention.

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It may in some ways appear to be counter intuitive to set targets in relation to palliative care. However, we are keen to evidence the impact of our interventions and, following the scoping exercise, will be setting targets in relation to:-

- the use of Gold Standards Framework in GP Practices;
- the use of the Liverpool Care Pathway in all appropriate care settings;
- the use of Supportive and Palliative Action Register (SPAR) in Care Homes and NHS Continuing Care;
- the use of Advanced Care Planning;
- activity, both qualitative and quantitative, in relation to preferred place of care and preferred place of death.

The completed scooping project and the revised action plan of the local Palliative and End of Life Care Planning and Implementation Group resultant from that work, has ensured that out efforts in relation to improving and developing services in this arena are evidence based and informed by the views and aspirations of key stakeholders.

Key areas of effort we will focus on in relation to palliative and end of life care in this plan are in relation to transitions between mainstream community service and specialist supports and transition between secondary care and care/support at home for people who wish to die in their own home should their prognosis and clinical needs permit this.

7.3 Intermediate Care

In Inverclyde we have developed a range of services under the auspices of Intermediate Care, providing a network of interventions with the key strategic aim of reducing unnecessary admissions to hospital, supporting timely discharge, maximising opportunities for greater independence and reducing the demand for admission to Care Homes.

Fast Track Assessment

We have a well established Fast Track Assessment service provided in the Acute setting. This enables same or next day assessments to be accessed from primary care, resulting in both a medical and gerontology nurse specialist opinion with clear results demonstrating a reduction in hospital admissions. We are developing pathways which will include fast track assessment, for example when someone is frequently falling at home.

Rehabilitation and Enablement Team

Established in May 2011, by combining community and previously hospital based multi-disciplinary AHP services, the Inverclyde RES team provide a comprehensive service for those who require rehabilitation services to be delivered on a domiciliary basis.

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Progress has been made in reviewing previous referral criteria, ensuring that the combination and co-location of pre-existing teams facilitates closer working and economies of scale from a relatively small pool of Allied Health Professionals. The Gerontology Nurse Specialist is now part of RES bringing the additional nursing skills to the multi- disciplinary approach.

Single Point of Access

The co-location of the RES team at the Inverclyde Centre for Independent Living, and natural union arising from this, was opportunistic in creating the beginnings of an SPOA for a number of services and teams. All service provided from the Inverclyde Centre for Independent Living are now available via the SPOA and a joint triaging system is now in operation across the services. We will continue to consider how to build upon this, adding further teams incrementally and in line with the overall desire of the organisation. We consider this to be a key opportunity to improve appropriate access to services whilst maximising the efficiency of existing limited resources. The change fund has allowed additional resource to develop administrative processes and will also contribute to IT solutions should these be required going forward.

Telehealthcare

Complementing the emergency response service for community alarms in Inverclyde, which provides a 24 hour, 7 days per week service to almost 2,000 service users, we have developed a range of telehealthcare services. This aims to use a range of monitoring and assistive technology devices to support vulnerable older people to live independently and remain safe within their own homes. Equipment includes:-

- Door contact monitors
- Smoke/heat detectors
- Natural gas/CO monitors
- Bed exit monitors
- Flood detectors
- Epilepsy bed monitors
- Falls detectors

Anticipatory Care Planning

Within our services a number of initiatives are developing, reflecting the principles of Anticipatory Care Planning, including within District Nursing services and through the GP review of Care Home residents. We have an identified ACP Lead supported by a local steering group and the group is currently using Scottish Patients at Risk of Readmission and Admission (SPARRA) data to establish who would most benefit from an ACP and beginning to use a model of implementation. The steering group will monitor the work and review effectiveness of our plans and interventions, including our ability to maintain individuals in their own home and wherever appropriate avoid unnecessary hospital admissions.

Interface Pharmacy

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Recognising that medication is by far the most common form of medical intervention, as a partnership, and utilising Change Fund resources, a number of initiatives have been progressed in interface pharmacy:-

- Four out of five people aged over 75 years take a prescription medicine and 36% are taking four or more. However, we also know that up to 50% of drugs are not taken as prescribed, many drugs in common use can cause problems and that adverse reactions to medicines are implicated in 5 – 17% of hospital admissions.
- Pharmacist medication review by pharmacists currently working within the CHCP has shown improvements in prescribing by altering medication choice and formulation, discontinuing therapy no longer required or in response to adverse drug reactions, providing patient education, improving monitoring of medicines, addressing concordance issues and improving cost effectiveness.
- Currently 1.0 WTE CHCP Interface Pharmacist (50% Delayed Discharge/ 50% PPSU funding) provides medication review for older people and pharmaceutical advice and support at IRH Day Hospital and across the primary/secondary care interface.
- During 2012, we also had a pharmacy technician in post who November 2012 received the Scottish Pharmacy Award for Innovations in Prescribing Quality and Efficiency.
- We have again utilised change fund money to provide pharmacy technician support with a particular emphasis on working with our reablement and care at home services

Key Objectives and Areas of Work:-

1. To reduce avoidable medication-related issues in primary care.
1. To reduce emergency hospital admissions and readmissions for avoidable medication-related issues.
1. To undertake pharmacist medication reviews with elderly patients on polypharmacy and/or high risk medication.
1. To reduce avoidable readmissions by undertaking medicines reconciliation as soon as possible post discharge.
1. To report on pharmacy interventions.
1. To review medicine reconciliation on discharge.
1. To support elderly patients to manage their medicines in their own home.

This service has developed a range of positive interventions which we are now consolidating into mainstream services. It is also timely that following our successful project, within their contract GPs are now reviewing their most vulnerable patients with regard to polypharmacy.

<u>Potential Further Areas of Development in Intermediate Care</u>:-

Intermediate Care Beds

We continue to consider use of intermediate beds and have identified a number of potential options such as within a residential setting or the use of a flat within

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sheltered housing. Given the proposed changes to Care Home provision, we intend to explore further the use of the released capacity to provide options of both Step Up and Step Down care for consideration.

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8 FINANCIAL FRAMEWORK

8.1 How we use our resources

In this section we describe the NHS and Social Work resources used to support older people's services in Inverclyde.

This analysis remains at an early stage, pre-integration, and in order to get a complete picture of resources allocated to support older people in Inverclyde we plan to add in third and independent sector resources, as well as other partnership services such as housing and leisure.

For NHS, resources the 2013/14 budget was set in line with the Greater Glasgow & Clyde Health Board's financial plan. Work is ongoing to identify efficiency savings for 2014/15 and 2015/16.

For Inverclyde Council the 2013/16 Social Work budget was as part of the Council's three year budget on 14 February 2013 and this identified the resources for 2013/14 along with the following two financial years. This included decisions on both Social Work specific pressure and savings proposals along with the impact on Social Work from Council wide decisions.

Inverclyde CHCP has an annual revenue budget of £120 million of which £37 million relates to GP services and prescribing costs, the remaining £83 million is the operational CHCP budget with £48 million of this relating to Older People.

Below we highlight the current 2013/14 operational budgets for Older Peoples Services for health and social work, and data from the integrated resource framework based on 2011/12 which provides useful benchmarking information.

Operational Budget – Health

The operational budget for the NHS is summarised in **table 1** and highlights the main service components of the **Health** budget.

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Table 1 – Operational Budget Health

	£'000
Health & Community Care	4,209
Change Fund	1,403
Mental Health Services	5,593
Resource Transfer & Delayed Discharge	2,393
Total	13,598

Within the Health & Community Care budget £2.8m relates to Nursing, including District Nursing Services and £0.4m is for Rehabilitation.

Within Mental Health services £1.1m is spent on Community Services with £3.8m on Inpatient Services.

A detailed breakdown of the Change Fund activity is included at annex 2.

In addition, to the resources above the costs of Family Health Services (GP services) and GP Prescribing need to be included to identify the full NHS resources allocated to older people. The costs of these services that relate to Older People, as identified in the Integrated Resources Framework, is shown at table 2;

Table 2 – GP Services and Prescribing Costs

	£'000
Family Health Services	3,204
GP Prescribing	6,824
Total	10,028

A full breakdown of the Integrated Resource Framework for Inverclyde is included at annex 1 for information.

The total notional Health budget for Older People is shown at table 3;

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Table 3 – Total Notional Budget Health

	£'000
Health Operational Budgets	13,598
Family Health Services and GP Prescribing Costs	10,028
Total	23,626

Operational Budget – Social Work

The following information at table 4 highlights the main elements of the Social Work budget for 2013/14 totalling £24m.

Table 4 – Operational Budget Social Work Services

	£'000
Purchased Nursing & Residential Care	10,720
Purchased Homecare	2,289
Homecare Service	6,127
Other Services	4,997
Total	24,133

Within Other Services £1.8m is spent on Assessment and Support, £0.4m on Community Alarms with £1m on Daycare and Meals.

Within social work budgets there is no requirement for notional budgets to be added. However a significant proportion of Change Fund resources are deployed through Social Work.

Change Fund

To assist Partnerships in reshaping care the Scottish Government allocated Change Fund resources in 2010/11 for a four year period. The total resources available through the Change Fund in are outlined in **table 5** below and table 6 shows the current year spend across the five care pathways.

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Table 5 – Inverclyde Change Fund allocation 2011/12-2014/15

	£'000
2011/12	1,228
2012/13	1,400
2013/14	1,403
2014/15 (anticipated)	1,200
Total Inverclyde Change Fund	5,231

Table 6 – Inverclyde Change Fund allocation 2013/14 by Pathway

	£'000
Preventative & Anticipatory Care	295
Proactive Care & Support at Home	491
Effective Care at Time of Transition	221
Hospital & Care Homes	199
Enablers	197
Total Inverclyde Change Fund 2012/13	1,403

Table 7 – Inverclyde Change Fund allocation 2013/14 by Service Area

	£'000
Acute	154
CHCP - Health	154
CHCP - Council	800
Community Capacity Health	56
Community Capacity Council	239
Total Inverclyde Change Fund 2012/13	1,403

In addition to the funding above a further £396,000 will be spent on projects funded from 2012/13 slippage. A supporting list of projects and allocated resources is at annex 2.

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Integrated Resource Framework

The integrated resource framework is an exercise to map the totality of resources across health and social care consumed by different patient groups or users of the service. The latest figures from the integrated resource framework show that in 2011/12 people aged over 65 in Inverclyde consumed a total resource of £83m. This has been broken down in the different service areas as shown below.

Table 7 – Integrated Resource Framework Summary 2011/12

	£'000
Hospital based services	**41,139**
Health community services	**7,370**
Family health services (GPs, prescribing etc.)	**10,028**
Local authority social care services (1)	**24,133**
TOTAL	**82,670**

(1) Not available from 2011/12 IRF data so taken from Table 4

A break down of what is included in hospital based services is included in **annex 1** and table 8 below gives a summarised analysis, showing that of the hospital based services totalling £41m that £18m or 45%, is used on emergency admissions to hospital services. This is activity that by its definition is not planned but nevertheless results in a hospital stay.

The largest health community resource is prescribing, totalling nearly £7m in 2011/12. GP and other family health services make up the next highest total at £3m, followed by district nursing at just over £1m. Other community services account for a small proportion of the overall resource use.

Local authority social care resources include almost £11m spent on care homes (accommodation based services) and £8.4m on home care. Other totals include £3m on case work, equipment, adaptations, meals and services to carers. Just over £1m is spent on day care services and delivery of meals.

Table 8 – Integrated Resource Framework Hospital Based Services 2011/12

	£'000	%
Unplanned Admissions	18,331	45%
Planned Admissions including Day Cases	9,457	23%
Mental Health	5,319	13%
Geriatric Long Stay (being reviewed)	449	1%
Outpatients	7,582	18%
Total	41,138	

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Summary

In summary we can conclude that the annual base budget for health is **£23.6m** (comprising £13.6m operational budget and £10m notional allocation of Family Health Services and GP Prescribing costs) and for Social Work is **£24.1m** providing a combined total of **£47.7m**. This **£47.7m** is the overall total resource devoted to health and social work services for older people in Inverclyde for the financial year 2013/14.

9 HOUSING

The *National Housing Strategy for Older People* clearly defines expected outcomes and recommends clear strategic leadership which extends partnership working beyond the public sector. Information and advice is key to older people being empowered to make choices and have access to appropriate housing and support. This support may take the form of practical help such as Care and Repair and Telecare or information such as welfare rights and benefits advice. Taking a wider supportive perspective, community capacity building and co-production will enable older people to avoid social isolation and live more independently particularly when living alone.

Better use of existing housing alongside new, affordable and sustainable housing is imperative and the national strategy encourages new models of housing whilst ensuring proper use of adaptations, adapted houses and selection of suitable properties to meet individual needs.

The Inverclyde Local Housing Strategy 2011-2016 sets out a number of strategic outcomes:-

- Inverclyde residents have access to a range of suitable housing options including housing for particular needs and housing purpose-built or adapted to meet the needs of older people.
- Inverclyde residents are able to make best use of their housing. This includes provision of equipment and adaptations together with appropriate care and support services delivered direct to people in their own homes and communities.
- Inverclyde residents receive appropriate support when they experience changes to their housing needs including information and advice services and help with finding suitable alternative accommodation where necessary.

The current economic climate produces challenges to providing purpose-built housing for older people and, as such, alternative and innovative funding schemes are being pursued for new build affordable housing. This will require further discussion and strategic planning in the context of future requirements for older people.

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10 WORKFORCE

Our workforce, across all sectors, is key to the achievement of the aims of this Plan. Only through the continued development of our workforce, and continued support of informal carers and the community, will be able to ensure that we can respond to the challenges facing us in meeting the changing needs of our population.

The 'workforce', in its broadest sense, supporting older people and their carers is vast. In some cases there are specific groups of professionals in all sectors who specialist in supporting, caring for and treating older people. In the main, however, older people are supported via mainstream services.

As part of modernising and reviewing services for older people we are undertaking significant workforce analysis and workforce planning. The analysis of the workforce is underpinned by the work of national bodies that are supporting new approaches to service delivery and workforce development. These include:

- the Joint Commissioning Approach recommended by the National Joint Improvement Team. (Joint Strategic Commissioning Learning and Development Framework November 2012).
- the NHS Education for Scotland strategic framework and will incorporate the findings of the refreshed framework for 2014 to 2019 when it is published.
- Institute for research and Innovation in Social Services

It is intended that workforce development and planning will be a core feature for the lifetime of the Plan, and not a one off event. To determine the local workforce supporting older people and the roles in which they are engaged we need to understand how people are working and practicing and to help people develop to deliver optimum services and supports.

The NHSGG&C Clinical Services Review underpins that we need to support our workforce to meet future changes.

- All our services depend on having the right number of appropriately trained staff in place. Failure to plan for this could lead to services being unsustainable or facing crises.

- All professions are under pressure so we cannot just think about substitution of roles, but need to look at how services can be delivered better by teams working across professions and agencies.

Through this Joint Commissioning Plan we plan to carry out a learning and development needs analysis of the Older Peoples Workforce, across the statutory, independent and 3rd sector, in order to identify the skills and knowledge gaps which require to be addressed to embed the Joint Commissioning Plan.

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Detailed analysis of the learning and development needs of the Older People's workforce is well underway. This will provide a foundation for developing the workforce in a flexible way. It is recognised that practitioners are currently operating in a climate of substantial service redesign, organisational practice changes and ongoing service demands. Nevertheless a number of learning and development initiatives are underway. These are designed to support the workforce in the new ways of working that will be required under the Joint Commissioning Plan such as:

1. Outcomes
2. Self Directed Support
3. Dementia Strategy
4. Leadership
   - and governance
   - and reflective practice
5. Statutory Training
6. Reablement
7. Assessment and Support Planning
8. Risk Assessment and Risk Enablement
9. Protection
10. Co-production/ Joint Commissioning
11. Culture Change and Community
12. Learning Resources

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Appendices:

1. Financial Information
2. Change Fund Allocation by Project
3. Housing Contribution Template

Appendix 1

Integrated Resource Framework Extract 2011/12 Inverclyde

Mapping Section	Inverclyde (CHP: S03000018)		
	All ages	65 +	75+
a) Hospital *(SFRs 5.3 - 5.9)*			
Inpatient - Non elective (Acute+MH+GLS)	**£40,058,074**	£23,268,670	£15,587,693
Inpatient - Elective (Acute+MH+GLS)	**£15,110,617**	£7,292,872	£3,649,705
Inpatient - Acute non elective [2a]	***£30,627,116***	*£18,331,022*	*£12,820,104*
Inpatient - Acute elective [2a]	***£14,112,080***	*£6,462,606*	*£3,064,373*
Inpatient - Acute day cases [2a]	**£7,774,688**	£2,994,474	£1,416,145
Inpatient - Mental Health non elective [2b]	***£8,982,241***	*£4,488,932*	*£2,381,762*
Inpatient - Mental Health elective [2b]	***£998,536***	*£830,266*	*£585,331*
Inpatient - Geriatric Long Stay non elective [2c]	***£448,717***	*£448,717*	*£385,826*
Inpatient - Geriatric Long Stay elective [2c]	**-**	-	-
Inpatient - Maternity inpatients [2d]	**£1,800,435**	-	-
Inpatient - Maternity day cases [2d]	**£1,069,930**	-	-
Inpatient - Special Care Baby Unit [3]			
Outpatients - Accident & Emergency [4]	**£2,789,172**	£567,100	£327,264
Outpatients - Consultant - New [5]	**£3,781,183**	£1,015,764	£498,328
Outpatients - Consultant - Return [5]	**£6,171,990**	£1,723,421	£878,085
Outpatients - Nurse led clinics [6]	**£1,951,488**	£806,484	£506,071
Outpatients - AHP [7]	**£7,127,159**	£1,961,445	£985,607
Day patients [8]	**£3,078,832**	£1,509,209	£1,002,975
(a) Hospital Total	**£90,713,568**	**£41,139,439**	**£24,851,873**
b) Community *(SFR 8.3)* [9,10]			
District Nursing	**£1,556,282**	£1,189,714	£883,536
Health Visiting	**£1,168,499**	£76,938	£55,167
Midwifery	**£468,319**	£18	£9
Child Health	**£1,748,795**	-	-
Specialist Nursing	**£841,153**	£264,090	£131,210
Clinical Psychology	**£281,154**	£88,272	£43,857
Community Mental Health Teams	**£4,517,555**	£1,718,810	£916,750
Community Learning Difficulties Team	**£763,081**	£58,626	£13,939
Addiction Services	**£1,373,520**	£223,630	£63,314
Family Planning	**£763,345**	-	-
AHP - Physiotherapy	**£429,900**	£134,972	£67,059
AHP - Occupational Therapy	**£38,375**	£12,048	£5,986

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AHP - Chiropody	**£372,261**	£116,876	£58,068
AHP - Dietetics	**£213,938**	£67,168	£33,372
AHP - Speech Therapy	**£240,027**	£75,359	£37,441
Laboratory - Direct Access/FHS Practitioners	**£1,356,053**	£425,749	£211,528
GP Out of Hours	**£854,363**	£268,237	£133,271
Community Dentistry	**£453,503**	£46,262	£33,912
Incontinence Services	**£327,016**	£327,016	£152,290
Home Dialysis	**£75,223**	-	-
Breast Screening	**£406,012**	£85,019	-
Health Promotion	**£1,151,260**	£211,039	£98,280
Other (please specify)	**£6,306,270**	£1,979,927	£983,705
b) Community Total	**£25,705,904**	**£7,369,769**	**£3,922,693**
c) Family Health Services *(SFR 8.4 / Note 5)*			
GMS - Global sum [11]	**£5,860,749**	£1,637,888	£859,252
GMS - Enhanced services [11]	**£1,486,872**	£415,532	£217,992
GMS - QOF [11]	**£2,151,571**	£601,294	£315,445
GMS - IT, Premises, etc [11]	**£1,965,405**	£549,267	£288,150
Pharmaceutical services - GP prescribing [12]	**£16,974,896**	£6,824,023	£3,572,202
Pharmaceutical services - Other	**excluded**		
General Dental Services	**excluded**		
General Ophthalmic Services	**excluded**		
c) FHS - GMS and GP prescribing total	**£28,439,494**	**£10,028,003**	**£5,253,041**
d) Sub-contracting total *(SFR 24)* [13]			
e) Total Mapped Expenditure (a+b+c)	**£144,858,966**	**£58,537,212**	**£34,027,607**

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Appendix 2

Change Fund 2012/13 Allocation by Project

Total Funding £1.8m being £1.4m 2013/14 allocation and £0.4m slippage from 2012/13)

ACUTE - HEALTH	**£'000**
Stroke Out Reach Team	53
AHP weekend working	83
Palliative Care CNS 0.5wte	25
Practice Development Nurse	43
Total	**204**

CHCP HEALTH	**£'000**
Change Fund Lead/ Project Work	46
Rehabilitation - physio and triage of referrals, along with implementation of electronic referrals (SPOA)	50
Pharmacy Technician	35
Impact Analyst	37
Total	**168**

CHCP COUNCIL	**£'000**
Change Fund Lead / Project Work	71
2 Social Work posts to speed discharge process.	34
Reablement lead	39
Reablement Seniors 3 Senior home support workers for reablement teams	70
Reablement Workers	300
Admin support for pilot reablement team	57
Full time OT and 2 OTAs	91
Home care assessment and reviewing post	55
Homecare Pilot Extension Monitoring Officer	25
Telecare project extension and equipment	100
Business Support Manager	39
OTA -Community Alarms	22
Dementia Post	38
To provide capacity in Older Persons Mental Health Team to develop Dementia Strategy	35
Step down beds, bridging funding for 2 EMI beds	47
Administration and support	26
Total	**1,049**

COMMUNITY CAPACITY HEALTH	**£'000**
Practice Development Nurse	43
Administration and support	21
End of Life Care GP Facilitator	11
Total	**75**

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COMMUNITY CAPACITY COUNCIL	£'000
Supporting Voluntary Sector Community Groups - bidding process	100
Carers Support	127
Housing with Support & Care	50
Scottish Care - Development Worker	23
Total	**300**

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Appendix 3

HOUSING CONTRIBUTION TEMPLATE

This template should be completed jointly by appropriate lead officers from local authority housing and the health and social care partnership. Once completed the template should be incorporated as a discrete element within the Joint Strategic Commissioning Plan for Older People.

It should be signed off as part of the overall Joint Strategic Commissioning Plan for Older People by the signatories to that overall plan **and the Chief Housing Officer**.

Theme	Detail
Outcomes relevant to the housing contribution (*Note1)*	The following Inverclyde Alliance Single Outcome Agreement (SOA) priorities are relevant to the housing contribution: **SOA1** - Inverclyde's population is stable with a good balance of socio-economic groups **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 -** The health of local people is improved, combating health inequality and promoting healthy lifestyles **SOA7** - Inverclyde is a place where people want to live now whilst at the same time safeguarding the environment for future generations **SOA8** – Our public services are of high quality, continually improving, efficient and responsive to local people's needs The following manifesto commitments are also applicable to the housing contribution: **MHC11** – Lobby the Scottish Government for additional funding to provide new affordable housing for local people **MHC14** – Build on our existing partnership with Health, through the CHCP, to ensure that this integrated community service will enhance the health and social wellbeing of our communities

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	The Inverclyde Local Housing Strategy 2011-2016 (the LHS) also contains strategic outcomes that are of relevance to the housing contribution: **Outcome 1** – Inverclyde residents have access to a range of suitable housing options. This outcome includes housing for particular needs and housing purpose built or adapted to meet the needs of older and disabled people. Representative groups and organisations were fully consulted on the development of this outcome. This included participating in the options appraisal process, scoring and weighting of priorities and developing an action plan. **Outcome 2** – Inverclyde residents are able to make best use of their housing. This outcome includes the provision of equipment and adaptations together with appropriate care and support services delivered direct to people in their own homes and communities. **Outcome 4** – Inverclyde residents receive appropriate support when they experience changes to their housing needs. In addition to the assistance noted above, this outcome includes information and advice services and help with finding suitable alternative accommodation, where necessary.
Strategic direction of travel and proposed investment changes within the draft Joint Strategic Commissioning Plan for Older People *(Note 2)*	Inverclyde Council has a duty to meet housing need and demand and as part of the LHS development, the council fully engaged in a joint process with the seven other local authorities in the Glasgow and the Clyde Valley Strategic Development Plan area to produce a regional Housing Need and Demand Assessment (HNDA). The HNDA includes an assessment of the needs of older and disabled people together with those affected by limiting long-term illness. The Inverclyde LHS is the overarching strategic plan for housing, initially over a five-year period but also looking forward over the next ten to twenty years. Housing Supply Targets are included in the LHS to address demand and need identified through the HNDA process. These targets cover all tenures as there is a high level of private ownership in the council area and the needs of owners and tenants have to be included in future provision. Allowing people to maintain independence throughout their lifetime remains a high

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	priority for the council and housing developers. The LHS and the associated Strategic Housing Investment Plan (SHIP) set out our investment priorities and how we aim to develop the right products in both the social and the private housing markets. All new houses for social rent are built to varying needs standards and we are encouraging private builders to adopt the same standards to "future proof" the new homes that they build. The amount of Affordable Housing Supply Programme funding to Registered Social Landlords (RSLs) has reduced considerably and this has resulted in a complete re-prioritisation of investment in new affordable housing. The LHS also states how the council will continue to invest in Care & Repair services to assist private owners and private tenants to make the best use of their homes. The Council's Scheme of Assistance provides mandatory grants of up to 80% of the overall cost for adaptations in the private sector. These works are funded though the council's Private Sector Housing Grant which is under continuous review as the demand for assistance outstrips resources and this impacts on the level of adaptations being carried out.
The housing contribution – investment already planned on the basis of the LHS (and if appropriate the LA Housing Business Plan for its own stock) (*Note 3)*	Inverclyde Council transferred all of its housing stock to two locally-based RSLs in December 2007 and all affordable social rented housing is now provided by RSLs. The council is however the Strategic Housing Authority and we work in partnership with local and national RSLs to address the shortfall in affordable housing and in housing for particular needs identified in the HNDA. The SOA priorities and the LHS strategic outcomes noted above have been translated into Action Plans and some of the key actions are as follows: • RSL partners are working to achieve the Scottish Housing Quality Standard by 2015 (this includes providing equipment and adaptations, where appropriate, to allow tenants to make best use of their homes) • The Strategic Housing Investment Plan (SHIP) is updated annually in line with the LHS strategic outcomes and Scottish Government funding availability

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	• The council will continue to work in partnership with RSLs and developers to provide homes suited to the needs of older people, including those with disabilities • The council will continue to work with RSLs and developers to provide New Scheme Shared Equity (NSSE) options for older people who prefer to remain as owners rather than tenants • The Strategic Housing Team will work with RSLs and CHCP services to prioritise access to housing for community care groups based on level of risk and nature of need • Support the promotion and wider use of telecare/telehealth to enable older people to remain in their own homes • Widely promote and financially support the Inverclyde Care & Repair Scheme • Develop an evidence base which quantifies the need for specialist amenity or adapted housing to meet the SOA priorities and LHS strategic outcomes • Develop a database of specially adapted properties and ensure there is a good match of households to homes in the allocations system
Likely future impact of plan upon housing resources (*Note 4)*	The provision of housing purpose built to meet the needs of older people will be more costly than mainstream housing. Building more houses designed for older people with particular needs will therefore have an impact on the overall number of new affordable homes that can be constructed. Costs of new house building have been driven down substantially due to the economic climate and subsidy levels have been reduced accordingly. Although there is some scope to alter benchmark subsidy levels to reflect the additional costs of housing for particular needs, it will be difficult to include housing of this type in local development programmes due to ongoing budget constraints. The provision of additional housing advice, information and support for older people is being pursued through a Housing Options Guide in partnership with RSLs and through the development of a housing “one stop shop” incorporating a wide range of housing and service providers. The current level of resources per year, is as follows: • Adaptations to private sector properties - £950,000 • Adaptations to RSL properties – £300,000

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	• Care & Repair - £257,000
Process for integrating the housing contribution to the Joint Strategic Commissioning Plan for Older People in future *(Note 5)*	The Change Fund Programme Board includes a representative from the Strategic Housing Team who has been involved in the development of the JSCPOP by attending planning and development meetings with Health and CHCP staff. The Strategic Housing Team is also represented on the Housing & Accommodation Sub Group involving RSLs and accommodation and service providers. Private Sector Housing Grant funding and Affordable Housing Supply Programme funding will continue to be used to support the outcomes of the JSCPOP, as far as possible. Discussion of how to achieve better outcomes across Health, CHCP, and housing services is ongoing through the Housing & Accommodation Sub Group.
Outline and understanding of shared data sources , and gaps to be addressed *(Note 6)*	As previously noted, the LHS includes a two-tier HNDA encompassing the Glasgow and the Clyde Valley Strategic Development Plan Authority area (eight local authorities, including Glasgow City) and information for the Inverclyde Council area. Estimates of need and demand for affordable and private housing have been calculated up to 2025. Gathering information on future needs of older people has mostly been carried out at a regional level and work needs to be dome to provide information at a local, Inverclyde level. This secondary housing needs assessment requires to be carried out in partnership with Health, CHCP, RSLs and the Strategic Housing Team (see note 7). The Strategic Housing Team has produced a Housing Trend Monitoring Report that will form a useful starting point for further research and analysis of the housing scene in Inverclyde and of market segments including the needs of older people.
Key challenges going forward *(Note 7)*	• The secondary HNDA involving the need and demand for housing suitable for older / disabled people has to be completed to inform future investment decisions (LHS/SHIP/SLP) • Alternative and innovative funding schemes are being pursued in response to reduced Scottish Government funding for new build affordable housing and reductions in overall subsidy levels • The case for maintaining levels of Private Sector

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	Housing Grant (no longer ring-fenced) has to be made in order to meet ongoing demand • The housing contribution to future Change Fund proposals needs to be discussed further and incorporated into strategic planning • Existing good relationships with social and private sector housing providers have to be further developed in the light of reduced funding and Welfare Reform changes • The demographic profile of the Inverclyde Council area clearly shows that the housing needs of older people will become more acute over time and more effective planning is required to address these needs at this challenging time for both public and private finance

Note 1: This should reflect those health and social care measures, including outcomes that are considered most likely to be impacted by the housing contribution. They should include national and local measures, as detailed in the JSC Plan for Older People

Note 2: This should describe the proposed overall shift in the balance of care and outline the key service re-design proposals in the JSC Plan for Older People that are intended to deliver this shift

Note 3: This should detail those aspects of the current LHS that contribute to delivery of the JSC Plan for Older People focusing on change in service delivery to support health and social care outcomes, and should also reference the local authority's investment plans for its own stock where appropriate.

Note 4: This should outline the potential impact that the plan is likely to have on housing resources, both services and bricks and mortar, going forward

Note 5: This should explain local proposals for ensuring that the housing contribution is clearly articulated and how a stronger housing perspective will be incorporated into future JSC processes and plans

Note 6: This should describe the data sources that have been used by both health and social care and housing in compiling the JSC Plan for Older People and the Local Housing Strategy and identify any currently apparent gaps in the data that, were they to be addressed, would better support joint working between the sectors

Note 7: This should highlight any particular issues regarding housings' contribution that have emerged from discussions relating to the completion of this HCS and/or any other related processes

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Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 9

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 9th January 2014**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership (CHCP)**	**Report No: CHCP/07/2014/BM**
Contact Officer:	**Beth Culshaw Head of Health and Community Care Inverclyde Community Health & Care Partnership**	**Contact No: 01475 715365**
Subject:	**Caladh House (Turning Point Scotland) 14-16 Bank Street, Greenock – Building/Service Re-design Proposal**	

1.0 PURPOSE

1.1 Caladh House Turning Point Scotland (TPS) provide an Adult Residential Care Home service for 10 individuals with Learning Disability at the Inverclyde Council premises at 14-16 Bank St, Greenock.

The purpose of this report is to inform the Sub Committee of the proposal to re-configure the current Bank Street building, and resulting redesign of the service model from Adult Residential Care to a supported accommodation/supported living service.

2.0 SUMMARY

2.1 In January 2010, Caladh House Association (CHA) moved from their accommodation at Brachelston St Greenock to the building at 14-16 Bank St. The Brachelston Street building had been deemed by the Care Inspectorate as, 'not fit for purpose' and the move to Bank St facilitated enhanced support for service users in an improved enviroment, albeit on a temporary basis.

The Bank St building had been vacated by Quarriers in July 2009 following concerns expressed by the Care Inspectorate of, 'constraints of communal living', and the building being 'not ideal in meeting service users' needs'. The Care Inspectorate did acknowledge however, action being taken by Quarriers to promote opportunities for service users' choice and independence with the move to individual tenancies and the provision of a supported living service.

On the 17th December 2012, following extensive consultation, and in agreement with Inverclyde CHCP, Caladh House Association assigned the existing Adult Residential Care Contract to Turning Point Scotland (TPS) as their preferred provider.

The assigned contract which expired on 31st March 2013 has since been extended with TPS until 30th April 2014.

2.2 At a CHCP Sub-Committee of August 2013, approval was granted for the CHCP to negotiate directly with Turning Pont Scotland as per Rule 3.2.3. (2) Of the Rules of Procedure- Contract for Procurement of Social Care Services.

A new contract, currently being finalised, will be issued to TPS for the provision of Adult Residential Care for a period of 2 years commencing April 2014 until March 2016 (with an option of a 2 year extension).

2.3 As a first time registrant, the Care Inspectorate placed a condition on TPS registration specifying, ' The provider has until 1/12/2013 to ensure all bedrooms are en-suite or provide evidence to the Care Inspectorate that plans are in place to have this work carried out imminently'. The Care Inspectorate has also limited the number of service users to 10 until the work is carried out. Previous registration specified 13 places.

3.0 RECOMMENDATION

3.1 That the Sub-Committee approve the proposal (Option 1) to reconfigure the Bank St building using the identified funding package (7.1).

Brian Moore
Corporate Director
Inverclyde Community Health & Care
Partnership

4.0 BACKGROUND

4.1 In 2000 the 'Same as You' review of services for people with learning disabilities in Scotland was published. This review aimed to improve the quality of life for people with learning disability and their carers, focussing on individual need, informed choice and control over their lives, services and where they live.

As a result of the "SAY" review, 'Partnership in Practice' (PIP) strategies were established by all Local Authorities to progress the many recommendations from the review. Inverclyde's PIP prioritised modernising contracted residential services as a key action.

In June 2013 'Keys to Life' was published; the new Learning Disability strategy in Scotland, building on the principles and successes of the 'SAY' review. Over 50 recommendations are specified in the strategy many of which are focused on health improvement. The strategy has a clear emphasis on Independent living giving people with LD, freedom, choice, dignity and control in where they live and work.

In 2002 the Care Inspectorate was set up under the Regulation of Care (S) Act 2001 to regulate all adult, child and independent healthcare services in Scotland, monitoring care standards to ensure quality of care.

4.2 From 1993-2009, Quarriers provided adult residential care within the premises at 14-16 Bank Street, Greenock.

In 2008 the Care Inspectorate expressed concerns to Quarriers of, 'constraints of communal living', and the Bank Street building 'not ideal in meeting service user's needs'. The Care Inspectorate acknowledged action taken by Quarriers to promote opportunities for individual choice by plans to move service users to their own tenancies and deliver a supported living model of support. Quarriers moved from the Bank St building into the community in July 2009.

In April 2002 Caladh House Association (CHA) was registered by the Care Inspectorate to provide Residential Care for a maximum of 13 adults with a learning disability at the service in Brachelston Street Greenock**.**

In 2009 the Care Inspectorate deemed the CHA property at Brachelston Street 'not fit for purpose' and graded the environment 2 (Weak)

As Quarriers had relocated their service from Bank St it was agreed that CHA would move to the Bank St building in the interim, facilitating enhanced support for service users in an improved environment, albeit on a temporary basis. Longer term plans were to re-design and modernise the service with an emphasis on independent living.

On the 17th December 2012, following extensive consultation, and in agreement with Inverclyde CHCP, Caladh House Association assigned the existing Adult Residential Care Contract to Turning Point Scotland (TPS) as their preferred provider.

The contract which expired on the 31st March 2013 has since been extended with TPS until 30th April 2014.

At the CHCP Sub-Committee of August 2013, approval was granted for the CHCP to negotiate directly with Turning Pont Scotland as per Rule 3.2.3. (2) of the Rule of Procedure - Contract for Procurement of Social Care Services. A new contract will be issued to TPS for the provision of Adult Residential Care for a period of 2 years commencing in April 2014 until March 2016 (with an option of a 2 year extension).

5.0 CURRENT POSITION

5.1 Caladh (TPS) currently supports 10 adults with Learning Disability who have mixed care and support needs. Age ranges from 32-81yrs old. The service is provided within a two story building circa1992, located close to the centre of Greenock and within a local community with a mix of residential homes, shops, and amenities, such as college, sports facilities and social clubs.

As a first time registrant, the Care Inspectorate placed a condition on Turning Point Scotland's registration specifying all Caladh House (TPS) service users must have access to en-suite facilities by the end of the year (2013). The registered places for Adult Residential Care were also limited to 10 whilst the condition of the registration was met.

The National Care Standards for Care Homes for people with Learning Disabilities Standard 4 – Your Environment

- Your environment will enhance your quality of life and be a pleasant place to live.
- The following standards will apply to **first time registrations:**
- 20. – You will have your own en-suite bath/ toilet/ shower facilities.
- 21. – You will enjoy easy access with all inside doors having a clear opening width of 840mm, off wide corridors of at least 1200mm.
- 22. – You will be in a building with capacity to install modern equipment i.e. hoist tracking, grab rails, smart technology.
- 23. – If the home has more than one floor, there will be a passenger lift for you to use.

There is currently a lack of en-suite facilities and access to appropriate space, this falls short of the National Care Standards and undermines the principles of dignity, respect, privacy and choice for our service users.

5.2 In considering options for any future remodelling of the Bank St building and service Inverclyde Council Property, Assets and Facilities Management (PAFM) were commissioned by CHCP to provide an options appraisal, drawing up plans with costs.

Option 1

10 Flatlets (bedroom with en-suite, open plan sitting room with kitchenette) £445,000

Option 2

13 Bedsits (Bedrooms with en-suite shower/bathrooms) £376,000

The Technical Services Manager advises there would be additional associated costs.

Built in 1992, PAFM advise the Bank St building is required, as far as is possible, and giving cognisance to the existing physical facilities and construction of the building and space, to be brought up to building standards in line with Building Regs (Scotland) Act 2013 and Disability Discrimination Act (DDA)

5.3 An inspection of the Bank St building was undertaken by building surveyors 'Faithful and Gould' in 2012 , commissioned by Inverclyde Council, to establish the current condition of the premises prior to TPS taking over the lease with Inverclyde Council.

The report only details the general condition of the property based on a visual inspection and does not include any opening up of the structure, plumbing, electrical and heating systems, drainage, asbestos or other contaminants The survey was non-destructive and is therefore unable to comment on areas that are concealed or covered.

Around 90 issues were highlighted mainly in the poor, fair and good categories. .

Sound	0
Good	41
Fair	45
Poor	7
Generally	0

6.0 PROPOSALS

6.1 It is proposed that the Sub Committee consider the proposal as outlined in Option 1 as the preferred option.

10 Flatlets (bedroom with en-suite, open plan sitting room with kitchenette) £445,000

This option would meet both national and local strategies for people with learning disabilities in terms of Independent living, giving them freedom, choice, dignity and control in where they live, work and in their communities. Also in terms of the personalisation agenda (Self Directed Support) in that people will have the ability to have control over the support they need to live the life they choose.

It is anticipated that following robust multi-disciplinary person centred planning, involving service users and families, some individuals may move to alternative models of support to meet their specific needs. This would allow for additionality of provision of respite places within the new service and in a community setting.

7.0 IMPLICATIONS

7.1 Finance:

The non recurring financial implications are:

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments
Caladh House	Property Lift Works	2013/14 / 2014/15	£445,000 £30,000	Early achievement of savings / revenue underspend / reserves	To fund one off capital costs funded from revenue
Funded by:					
Revenue Underspend	Various		(£145,000)		Early Savings & Turnover
Director	Inflation		(£112,000)		Balance held
Change Fund	Various		(£100,000)		Preventative spend
Deferred	Various		(£118,000)		Reprioritised

Income / Independent Living Reserves					use of Reserves

The £112,000 inflation is currently held by the Director to fund non National Care Home Contract inflation pressures, as of October not allocated.

The funds outlined above will be transferred to a new earmarked reserve, subject to approval. The capital works will be phased accordingly and funded from this revenue reserve.

7.2 Personnel:

No implications.

7.3 Equalities:

Need EQIA

7.4 Repopulation: -

8.0 CONSULTATION

8.1 3 service users were consulted and participated in producing the slide presentation illustrating issues with access within the current building and advising of their specific lack of choice, dignity and privacy. TPS staff also provided information and views on the barriers and constraints to providing quality care and support to service users.

Views will be sought from all service users, carers and other key stakeholders in the re-design of the building and service model.

9.0 LIST OF BACKGROUND PAPERS

9.1 Inverclyde Council 14-16 Bank St Greenock Photographic Schedule of Condition 20/12/12.

9.2 Caladh Bank Street Slide presentation-CHCP.

INVERCLYDE COMMUNITY HEALTH CARE PARTNERSHIP

AGENDA AND ALL PAPERS TO:		
Councillor McIlwee		1
Councillor Jones		1
Councillor McCabe		1
Councillor Rebecchi		1
Councillor MacLeod		1
All other Members (for information only)		15
Officers:		
Chief Executive		1
Corporate Communications & Public Affairs		1
Corporate Director Community Health & Care Partnership		1
Head of Children & Families and Criminal Justice		1
Head of Community Care & Health		1
Head of Planning, Health Improvement & Commissioning		1
Clinical Director		1
Head of Mental Health & Addictions		1
Corporate Director Education, Communities & Organisational Development		1
Chief Financial Officer		2
Acting Corporate Director Environment, Regeneration & Resources		1
Head of Legal & Democratic Services		1
J Douglas, Legal & Democratic Services		1
S Lang, Legal & Democratic Services		1
Chief Internal Auditor		1
File Copy		1
Dr Mustafa Kapasi, NHS Greater Glasgow & Clyde		1
Ken Winter, NHS Greater Glasgow & Clyde		1
Diana McCrone, Staff Partnership Forum		1
Nell McFadden, Public Partnership Forum		1
	TOTAL	**41**
AGENDA AND ALL NON-CONFIDENTIAL PAPERS TO:		
Community Councils		10
Karen Haldane, "Your Voice", 12 Clyde Square, Greenock		1
	TOTAL	**52**