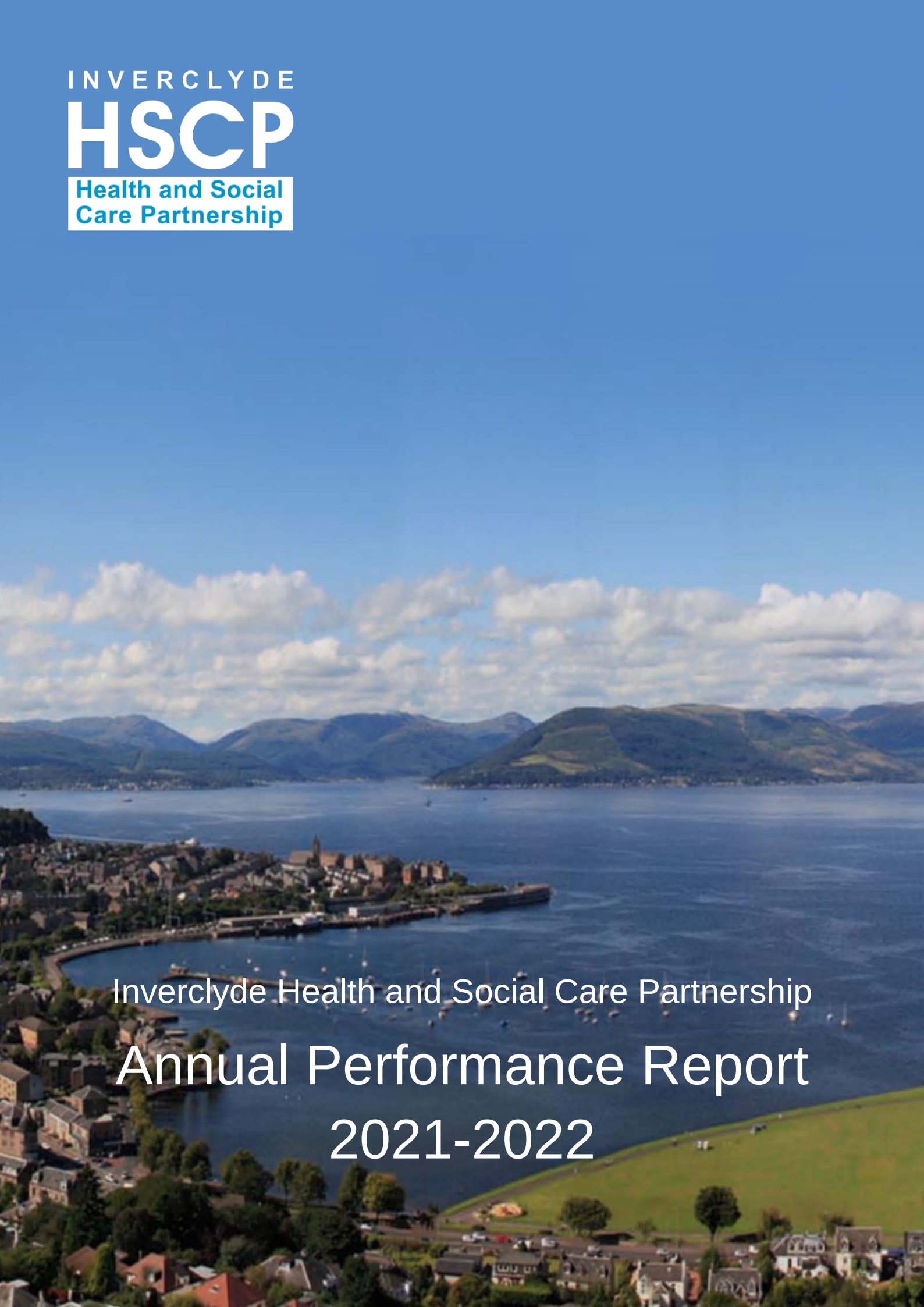


INVERCLYDE HSCP
Health and Social Care Partnership

Inverclyde Health and Social Care Partnership

Annual Performance Report 2021-2022

This document can be made available in other languages, large print, and audio format upon request.

Arabic

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

Cantonese

本文件也可應要求，製作成其他語文或特大字體版本，也可製作成錄音帶。

Gaelic

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

Hindi

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

Kurdisch

Li ser daxwazê ev belge dikare bi zimanên din, çapa mezin, û formata dengî peyda bibe.

Mandarin

本文件也可应要求，制作成其它语文或特大字体版本，也可制作成录音带。

Polish

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

Punjabi

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

Soraini

ئەم بەڵگەنامەیە دەتوانرێت بە زمانەکانی تر و چاپی گەورە و فۆرماتێکی دەنگی لەسەر داواکاری بەردەست بکرێت.

Tigrinya

እዚ ሰነድ እዚ ብኻልኦ ቋንቋታት፡ ብዓቢ ፊደላትን ብድምጺ ቅርጽን ምስ ዝሕተት ክቐርብ ይኽእል።

Urdu

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

Ukranian

За запитом цей документ може бути доступний іншими мовами, великим шрифтом та аудіоформатом.

Inverclyde HSCP, Clyde Square, Greenock, PA15 1NB

01475 715365

Foreword by Allen Stevenson – Interim Chief Officer Inverclyde HSCP

This is the Sixth Annual Performance Report and Year 3 of the 2019-2024 Inverclyde Integration Joint Board (IJB) Strategic Plan. This is my first Annual Performance Report as Interim Chief Officer.

Throughout 2021/2022, as a result of the continuing Covid-19 pandemic, service provision continued to be, by necessity, subject to change and reactive to Government guidance and restrictions. At the start of the first national lockdown action was taken to ensure that essential services continued to be delivered and where possible the core business of the HSCP was maintained, while at the same time ensuring the ongoing safety of both the workforce and the public. Investment in technology enabled many services to adapt and continue to support Inverclyde's communities, albeit in a 'virtual' capacity. Additional support mechanisms were put in place around all internal and external services during this time. We continued with our established regular safety meetings within the HSCP including: a weekly Local Resilience Management Team meeting (LRMT), fortnightly Covid-19 Recovery Group meetings, Humanitarian Aid Groups, regular care home safety huddle meetings and weekly multidisciplinary meetings.

Covid-19 has continued to impact on Inverclyde HSCP and commissioned services throughout 2021 and early 2022. The highly infectious Omicron variant whilst did not result in a high level of illness, did proportionally have a greater impact on staffing levels than the original outbreak in 2020. This has impacted HSCP services, Acute services and Primary Care as well as commissioned services, hampering the recovery of these services.

Our HSCP staff, those working for our external providers, as well as a number of local community groups worked tirelessly throughout the pandemic, following guidance that was changing on a daily basis in the early days of the pandemic our staff faced the pressures with a high degree of integrity despite our health and social care services being pushed to the brink. This enabled services to be delivered safely with support in place to protect the physical and mental health and wellbeing of people across Inverclyde. In response to the needs of our staff, Inverclyde HSCP developed a Wellbeing at Work Plan, supporting self-care and prioritising staff's wellbeing by reducing some of the anxieties and stresses staff experienced. A Wellbeing at Work week was held in March 2022 promoting, implementing and highlighting these support measures with a view to minimising the frustrations and anxieties, increase moral and give our staff a sense of self-worth.

We have continued to deliver our reprioritised Strategic Plan with our person centred approach and in ensuring a safe and effective delivery of our essential services. The APR can only ever provide a snapshot of the performance across the HSCP and hopefully this report will provide some of the key performance and operational highlights we have achieved throughout 2021/2022. We will continually review performance and develop our performance management arrangements with the aim of improving and scrutinising our performance to achieve better outcomes for our community.

It has been a privilege to lead the partnership throughout 2021/2022 and I continue to be proud of the work we do in and across Inverclyde.

Allen Stevenson

Corporate Director (Interim Chief Officer)

Inverclyde HSCP

Municipal Buildings

Clyde Square

Greenock

PA15 1LY

Contents

Section 1 – Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible.

This is the sixth report for Inverclyde Integration Joint Board (IJB) and in it we reflect on the last year (2021/2022) and consider the progress made in delivering the actions set out in our Strategic Plan (2019-2024); reflect on key service developments and innovation that has shone through as a result of the Covid-19 pandemic; and also review our performance against agreed National Integration Indicators and those indicators specified by the Ministerial Steering Group (MSG) for Health and Community Care.

Structure of this report

The key components of this report are:

Section 1 - Introduction and overview of Inverclyde HSCP. This also includes our high level demographic information, an overview of our resources / services and the strategic vision as set out in our Strategic Plan

Section 2 - Key performance information in relation the national outcomes and how we have been working to deliver our strategic priorities over the past 12 months.

Section 3 - Financial information relating to our Financial Summary by Service and the budgeted Expenditure vs Actual Expenditure per annum

Section 4 - Progress with Localities

Appendices – National Outcomes

Glossary – List of the abbreviations used in this report

Overview of Inverclyde HSCP

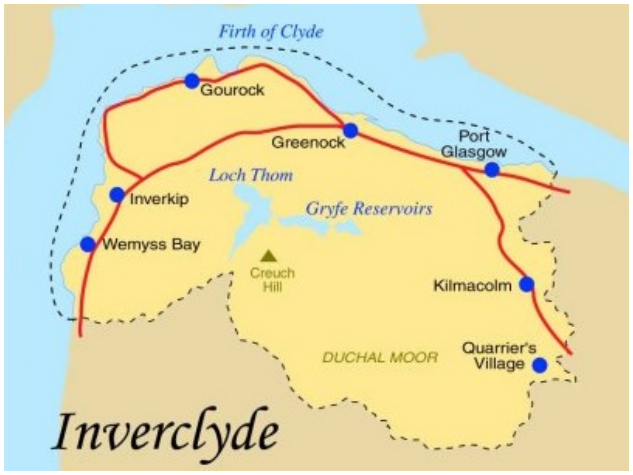
Inverclyde Health and Social Care Partnership (HSCP) was established under the direction of Inverclyde's Integration Joint Board (IJB) in 2015 and has been built on a long history of integrated ways of working locally. Our Partnership has always managed a wider range of services than is required by the relevant legislation, and along with adult community health and care services, we provide health and social care services for children and families and criminal justice social work.

Inverclyde HSCP is one of six partnerships operating within the NHS Greater Glasgow and Clyde Health Board area. We work closely with our fellow partnerships and continue to build on existing relationships with a focus on sharing good practice, developing and delivering consistent approaches to working with our colleagues in acute hospital services.

Inverclyde HSCP's population is spread in the main across the three towns of Greenock, Port Glasgow and Gourock with the remainder of the population living in the villages of Inverkip, Wemyss Bay, Kilmacolm and Quarriers Village.

The latest estimated population of Inverclyde was taken from the mid-year population estimates published by the National Records of Scotland (NRS) on 13th July 2022. This estimates a total population of 76,700 (down 360 from 77,060 last year) as at the end of June 2021.

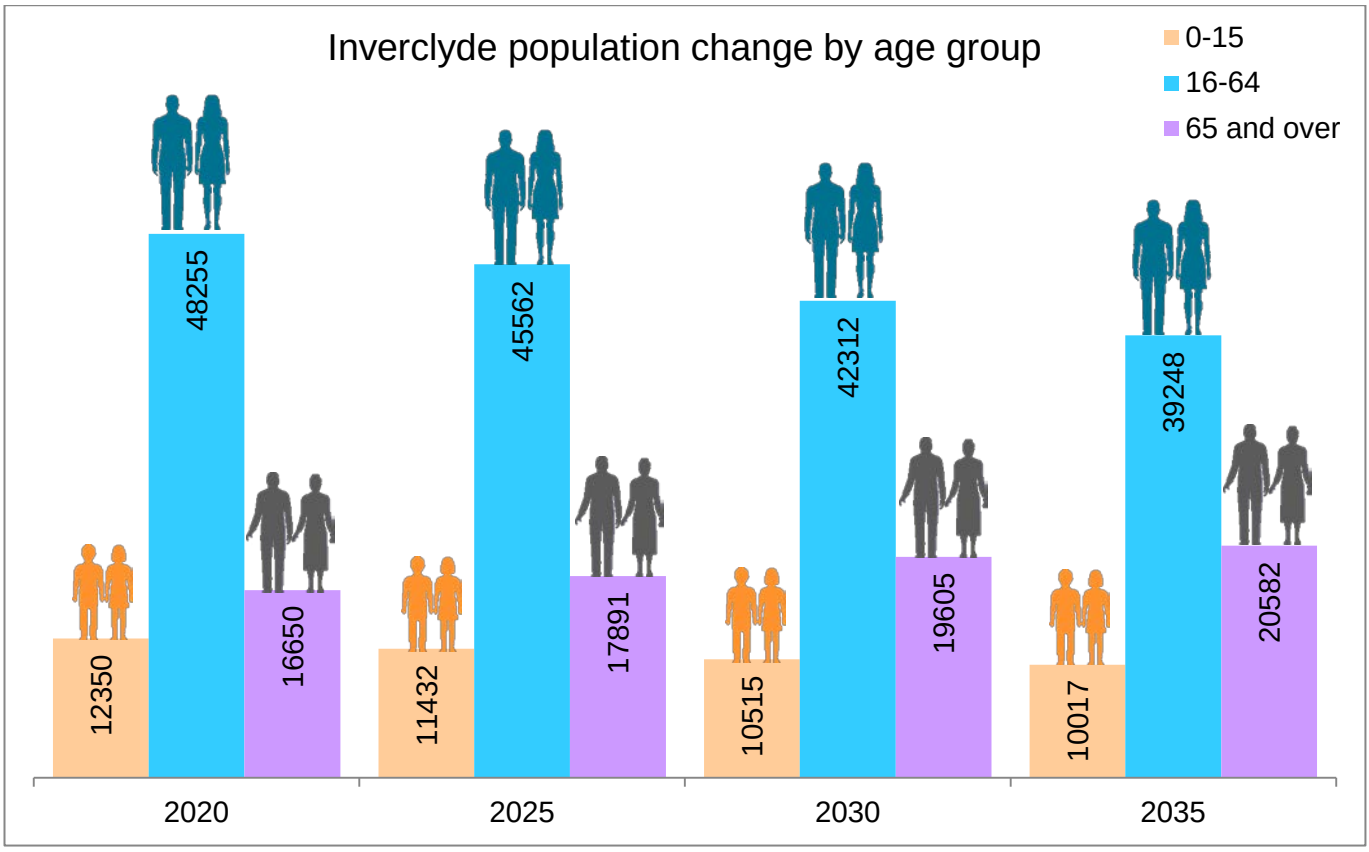
Using the most recent published data available that can be used for population projections



(Population Projections for Scottish Areas 2018-based), published by NRS on 24th March 2020, our population is expected to decline as is shown in the graphic below.

Population projections have limitations and there is a real focus through the Inverclyde Community Planning Partnership, Inverclyde Alliance to try to reverse this population decline which is affected by decreasing births and outmigration.

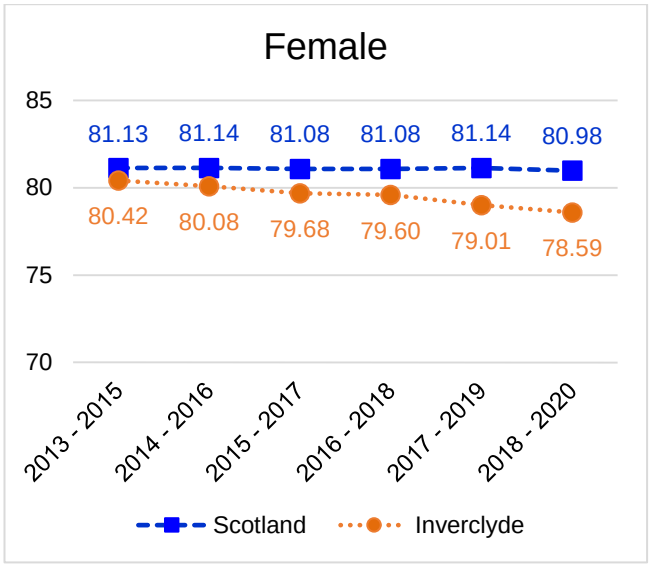
The profile of our population is also changing significantly. As is demonstrated in the graphic below our working age population will reduce whilst the numbers of people over 65 will increase.



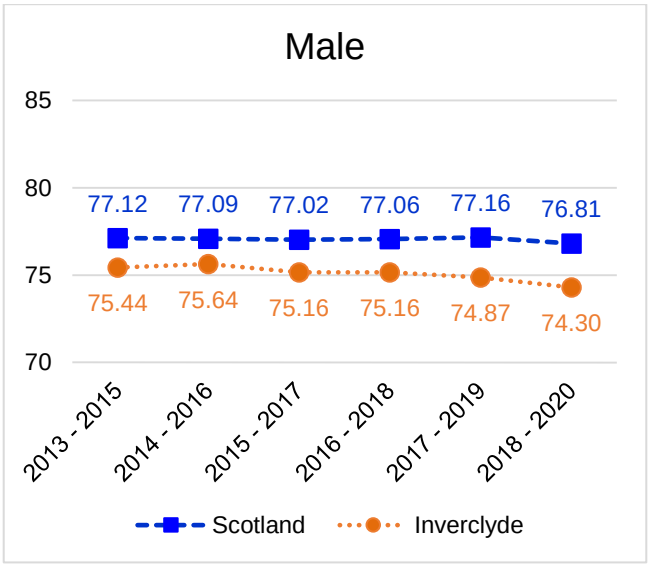
Source: NRS: population projections for Scottish Areas (2018-based)

Life Expectancy (from birth)

The latest figures available cover the 3 year 'rolling' period from 2018-2020 (published by National Records of Scotland in September 2021). The charts below compare the average life expectancy in years across Inverclyde and Scotland. Covid-19 deaths accounted for the vast majority of the drop in life expectancy for both males and females. Drug-related deaths also had a negative impact on life expectancy for males.



Source: NRS

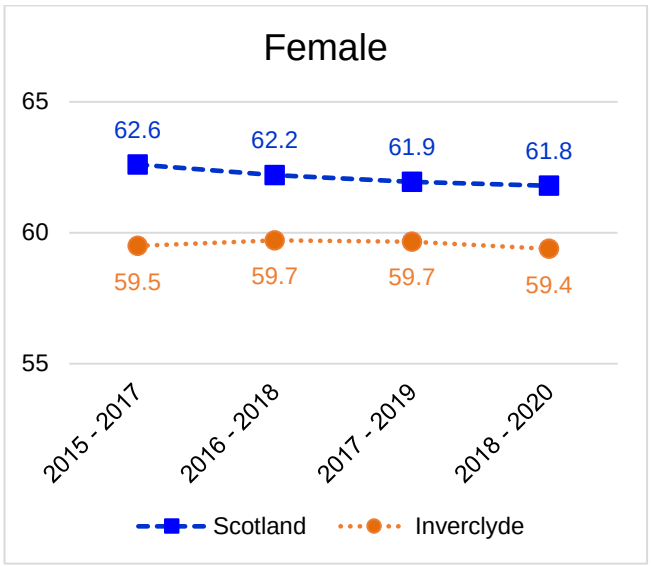


Source: NRS

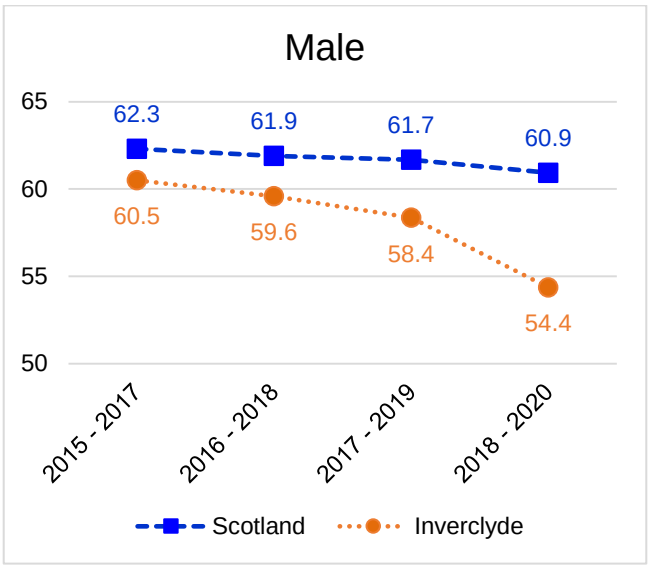
In the longer term, we aim to reduce the differences between Inverclyde and the Scottish average, and also the differences between men and women, however, the Covid-19 pandemic has had a notable negative impact locally.

Healthy Life Expectancy

Healthy life expectancy (HLE) is an estimate of the number of years lived in 'very good' or 'good' general health, based on how individuals perceive their state of health at the time of completing the annual population survey (APS).



Source: NRS



Source: NRS

Healthy life expectancy provides insight into the proportion of life expectancy spent in good health. HLE estimates are important to analyse alongside the life expectancy estimates, to understand the state of health the population is in, as well as their years of life expectancy.

The impact of population changes and levels of deprivation are real challenges for Inverclyde HSCP this impacts on the needs and demands of local health and care services in addition to this we are beginning to see the impact on our populations' health following the Covid-19 pandemic.

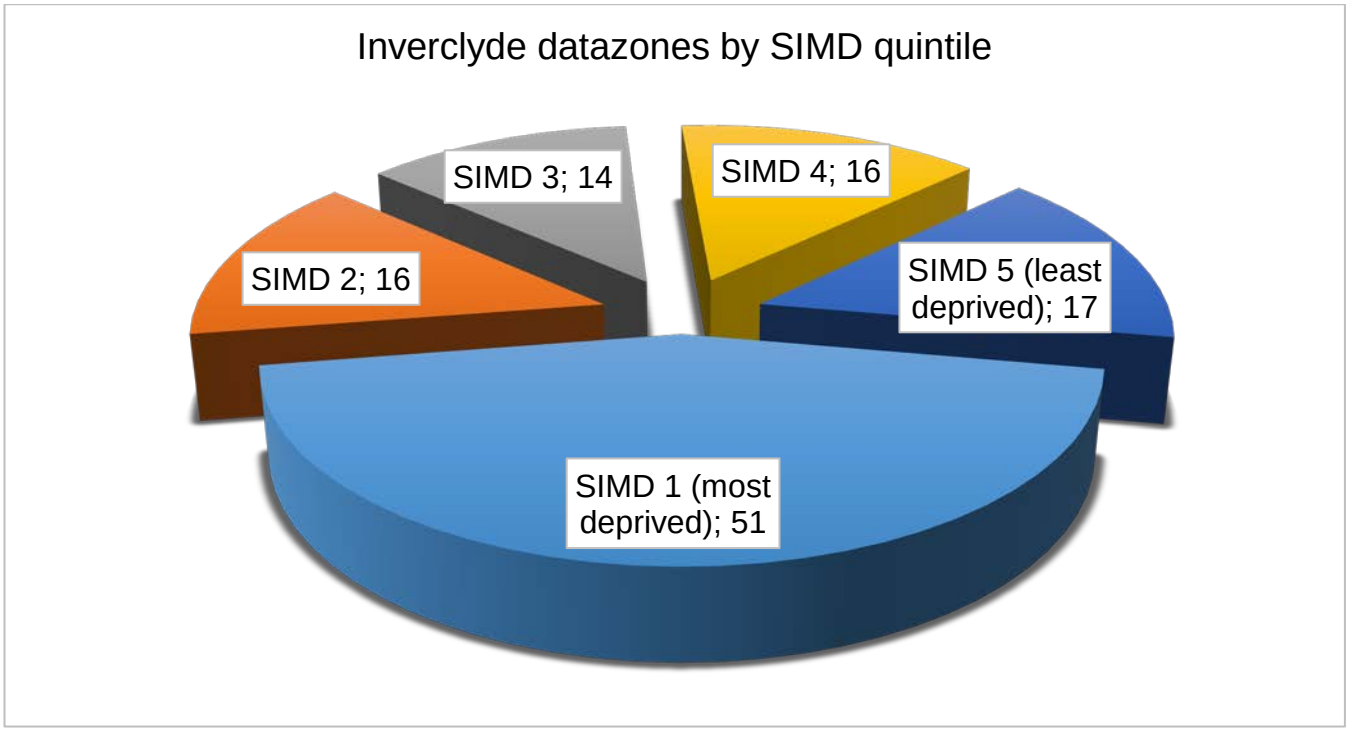
Deprivation

The Scottish Index of Multiple Deprivation (SIMD 2020) is a statistical tool for identifying areas of poverty and inequality across Scotland to support organisations in the decision making process of investing appropriately.

Areas of poverty and inequality across Scotland are measured by a number of different indicators to help organisations such as health boards, local authorities and community groups to identify need in the areas that require it the most. These are routinely published as part of the Scottish Index of Multiple Deprivation (SIMD).The SIMD ranks small areas called data zones (DZ) from most deprived to least deprived.

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

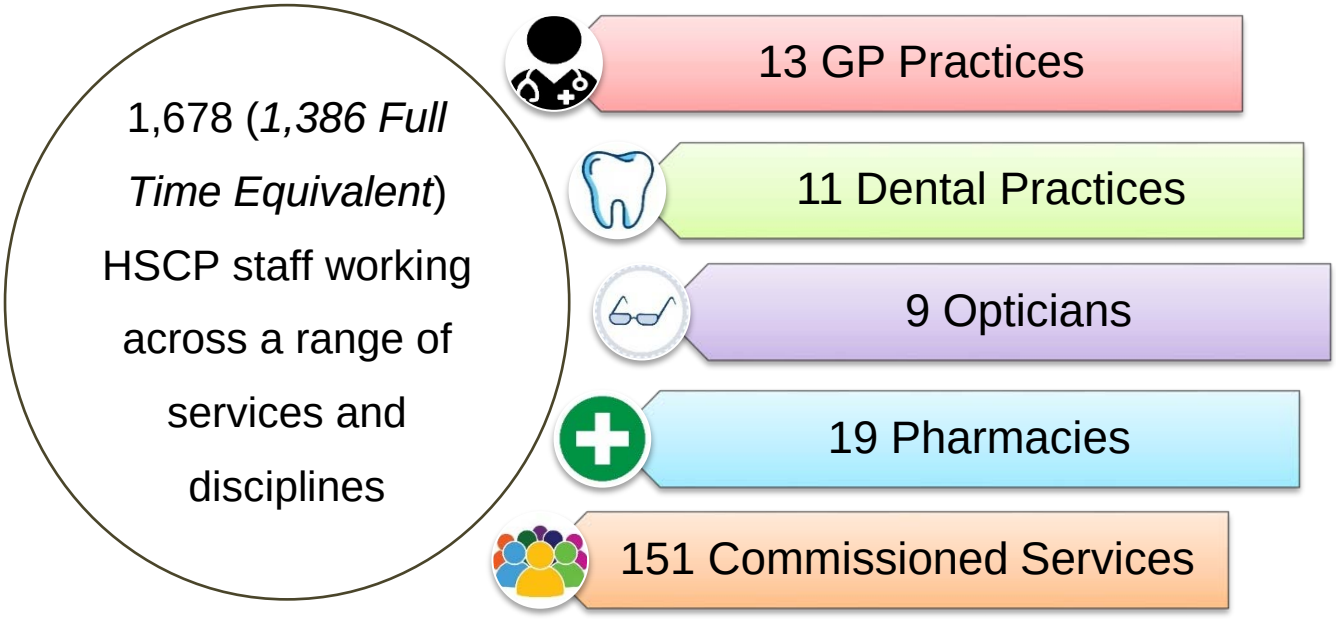
Deprived does not just mean 'poor' or 'low income'. It can also mean that people have fewer resources and opportunities. The highest deprivation areas of in Inverclyde are around Central and East Greenock. Unfortunately this now includes the most deprived area in Scotland.



Source: Scottish Government SIMD 2020

Our resources

The HSCP delivers an extensive range of services across primary care; health and social care and through a number of commissioned services.



Strategic Vision

Inverclyde IJB set out through its 5 year Strategic Plan (2019-24) and in particular our 6 Big Actions, our ambitions and our vision. These reflect the many conversations we have with the people across Inverclyde including our professional colleagues; staff; those who use our services including carers; and our children and young people across all sectors and services.

Within Inverclyde we fully support the national ambition of ensuring that people get the right care, at the right time, in the right place and from the right service or professional. We strongly believe that integration will continue to offer many different opportunities to reflect on our achievements and what we can improve on to benefit the local people and communities of Inverclyde.

The five year (2019-24) Inverclyde Strategic Plan set out the shared strategic priorities and ambitions for Inverclyde. The plan was always to be refreshed in 2022-23 with a revised plan in place for the remaining two year term focussed on our future challenges.

The Covid-19 pandemic impacted on the delivery of the original Strategic Plan and a two year Transition Plan has been in place since June 2020.The Strategic Needs Assessment undertaken originally in 2019 has been refreshed to update demographics and impacts from the Covid-19 pandemic

Through discussion at the Strategic Planning Group and with 3rd. sector and community representatives, there was a strong consensus that we should retain the original vision and priorities set out through the six Big Actions for Inverclyde. Feedback received is that these were set for five years and are still relevant, and importantly, well known and understood by our communities.

The refreshed draft Strategic Plan for 2022-24 contains 49 key deliverables under the 6 Big Actions which link clearly with the nine National Outcomes for Scotland and also the National Outcome Framework for Children, Young People and Community Justice. The draft plan can be accessed here.
https://www.inverclyde.gov.uk/meetings/documents/15427/03%20Inverclyde%20HSCP%20Draft%20Refreshed%20Strategic%20Plan%202019-2024.pdf

Our Vision

"Inverclyde is a caring and compassionate, community working together to address inequalities and assist everyone to live active, healthy and fulfilling lives"

Our 6 Big Actions

1	Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health
2	A Nurturing Inverclyde will give our Children & Young People the Best Start in Life
3	Together we will Protect Our Population
4	We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living
5	Together we will reduce the use of, and harm from alcohol, tobacco and drugs
6	We will build on the strengths of our people and our community

Section 2 - Performance

The Covid-19 pandemic continued to impact our strategic plan delivery throughout 2021/2022 due to varying levels of restrictions throughout the year. However we were able to deliver essential HSCP services whilst ensuring we supported both our staff and our local population, in addition to implementing our recovery plans during this unprecedented time. The vaccination programme delivered much needed hope and provided a solid base for allowing various restrictions due to Covid-19 to be relaxed and removed.

Within this context of pandemic recovery, we have still been able to make progress against our Strategic Plan priorities, building on our 6 Big Actions, adapting to new ways of working and all the time having our local population and staff at the heart of all we do.

This section of the report will focus on our key performance within 2021/2022 and will provide a range of data and activity, including examples of innovation structured around our six Big Actions.

We require to report on the nine National Health and Wellbeing Outcomes for adult health and social care services, and the national outcomes for Children & Families and Criminal Justice and again are all structured and reported using our 6 Big Actions. Appendix 1 shows all the National Outcomes.

Supporting the nine national Wellbeing Outcomes are 23 National Integration Indicators against which the performance of all HSCPs in Scotland is measured, the data for these is provided by Public Health Scotland (PHS) on behalf of the Scottish Government. These indicators are grouped into two types of complementary measures: outcome indicators based on survey feedback, and indicators derived from organisational or system data.

This section also contains information on Ministerial Steering Group (MSG) and Care Inspectorate Inspections.

Within each Big Action Section you will find:

- ✓ National Outcomes
- ✓ National Integration Indicators (where applicable)
- ✓ Local performance measures and activity

An overall summary of the National Integration Indicators and the MSG Framework is included at the start of this performance section for ease. We have also included an explanation as to where the data comes from.

National Integration Indicators

Those marked with an * (numbers 1 to 9) are taken from the 2020/21 biennial Health and Care Experience Survey.

Of the 19 currently reported measures we are at or better than the Scottish average in 10 (green), just below in 5 (amber) and behind in 4 (red).

In 6 measures we have seen an improving trend (green arrow), maintaining our performance in 5 (amber arrows) and reducing performance in 8 (red arrow). This trend analysis is based upon the 5 most recent reporting years.

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

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

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

PHS are still developing 4 of the 23 National Integration Indicators so these have not been included in the report. These are

10	Percentage of staff who say they would recommend their workplace as a good place to work
21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home
22	Percentage of people who are discharged from hospital within 72 hours of being ready
23	Expenditure on end of life care, cost in last 6 months per death

Outcome Indicators

The Health and Care Experience survey is sent to a random sample of patients who are registered with a GP practice in Scotland. Questionnaires were sent out in November 2021 asking about people's experiences during the previous 12 months. The results for 2021/22 were published on 10 May 2022 with local level results available via an interactive dashboards on the PHS website.

National Integration Indicator		Time Period	Inverclyde HSCP	Scottish Average	Change from previous period	Inverclyde Long-term Trend	Scottish Long-term Trend
1	Percentage of adults able to look after their health very well or quite well	2021/22	90.1% Amber	90.9%	→ ← Amber	→ ← Amber	↓ Red
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2021/22	82.9% Green	78.8%	↓ Red	→ ← Amber	↓ Red
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	2021/22	66.7% Amber	70.6%	↓ Red	↓ Red	↓ Red
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	2021/22	68.6% Green	66.4%	↓ Red	↓ Red	↓ Red
5	Total % of adults receiving any care or support who rated it as excellent or good	2021/22	81.3% Green	75.3%	↓ Red	↓ Red	↓ Red
6	Percentage of people with positive experience of the care provided by their GP practice	2021/22	58.7% Red	66.5%	↓ Red	↓ Red	↓ Red
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	2021/22	79.6% Green	78.1%	↓ Red	↓ Red	↓ Red
8	Total combined percentage of carers who feel supported to continue in their caring role	2021/22	28.7% Amber	29.7%	↓ Red	↓ Red	↓ Red
9	Percentage of adults supported at home who agreed they felt safe	2021/22	81.9% Green	79.7%	↓ Red	→ ← Amber	↓ Red

Data indicators

The primary source of data for these indicators are Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. The data presented here is the most up to date provided by Public Health Scotland (PHS) and communicated to all Health and Social Care Partnerships. The figures will be subject to review and data completeness and, therefore, likely to change in subsequent releases. PHS recommend that Integration Authorities do not report any time period for indicator 20 beyond 2019/2020 within their 2021/2022 APRs as NHS Boards were not able to provide detailed cost information for 2020/2021 due to changes in service delivery during the pandemic.

National Integration Indicator		Time Period	Inverclyde HSCP	Scottish Average	Change from previous period	Inverclyde Long-term Trend	Scottish Long-term Trend
11	Premature mortality rate per 100,000 persons	2021	508.7 Red	465.9	↓ Green	↑ Red	→ ← Amber
12	Emergency admission rate (per 100,000 population)	2021/22	12887 Red	11474.9	→ ← Amber	↓ Green	→ ← Amber
13	Emergency bed day rate (per 100,000 population)	2021/22	136305.9 Red	105956.6	→ ← Amber	↓ Green	↓ Green
14	Readmission to hospital within 28 days (per 1,000 population)	2021/22	87 Green	102.8	↓ Green	↓ Green	→ ← Amber
15	Proportion of last 6 months of life spent at home or in a community setting	2021/22	88.7% Amber	90%	→ ← Amber	↑ Green	↑ Green
16	Falls rate per 1,000 population aged 65+	2021/22	21 Green	22.4	→ ← Amber	↓ Green	→ ← Amber
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2019/20	85.1% Green	75.8%	→ ← Amber	→ ← Amber	↓ Red
18	Percentage of adults with intensive care needs receiving care at home	2021	68.1% Green	64.9%	↑ Green	↑ Green	↑ Green
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	2021/22	296.4 Green	761.4	↑ Red	→ ← Amber	↓ Green
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2019/20	21.9% Amber	21.0%	↓ Green	↑ Red	→ ← Amber

Ministerial Steering Group (MSG) Indicators

Integration Authorities have responsibility for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway, alongside primary and community health care and social care. This is known as unscheduled hospital care and is reflected in the set aside budget. The objective is to create a coherent single cross-sector system for local joint strategic commissioning of health and social care services and a single process through which a shift in the balance of care can be achieved.

The Unscheduled Care Commissioning Plan delivers a joint strategic commissioning approach to Unscheduled Care which will deliver on the intentions of the legislation.

The plan is focused on three main themes reflecting the patient pathway:

- ✓ prevention and early intervention with the aim of better supporting people to receive the care and treatment they need at or close to home and to avoid hospital admission where possible
- ✓ improving the primary and secondary care interface by providing GPs with better access to clinical advice and designing integrated patient pathways for specific conditions
- ✓ improving hospital discharge and better supporting people to transfer from acute care to appropriate support in the community

Essentially the aim is that each patient is seen by the right person at the right time and in the right place. For acute hospitals that means ensuring their resources are directed only towards people that require hospital-level care.

The emphasis is on seeing more people at home or in other community settings when it is safe and appropriate to do so.

The plan includes proposals for a major and ongoing public awareness campaign so that people know what services to access when, where and how. We will also work with patients to ensure they get the right care at the right time.

In recent years unscheduled care services in Greater Glasgow & Clyde have faced an unprecedented level of demand. The health and social care system, including primary and social care, has not seen such consistently high levels of demand before. While we perform well compared to other health and social care systems nationally, and overall the system is relatively efficient in managing high levels of demand, it can be challenging to meet key targets consistently and deliver the high standards of care we aspire to. Therefore change is needed if we are to meet the challenges ahead.

The MSG Performance indicators provide a focus on hospital based performance within HSCP/IJB geographies specifically around Unscheduled Care such as Accident & Emergency attends, Emergency Admissions and Unplanned Bed Days (in hospital).

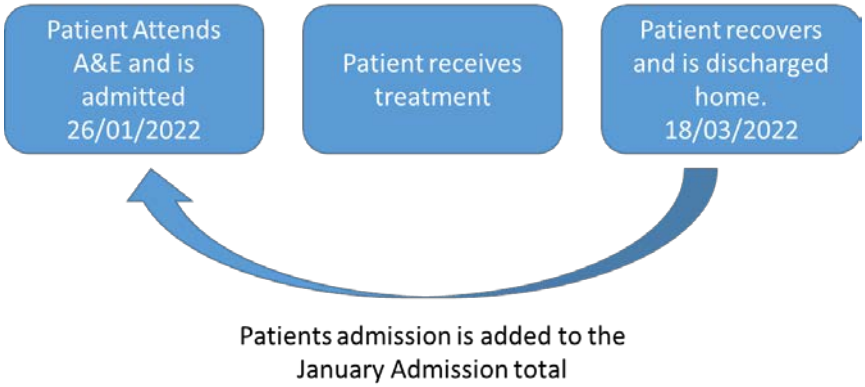
These indicators are also used extensively by services to predict surges in demand and to plan our services effectively. For example, a surge in A&E attends in the 65 and older age group is

likely to increase emergency admissions, which has a domino effect in that a fair proportion of this cohort of patients will likely require support when leaving hospital, which can involve multiple services such as Care at Home, Community Alarm and Community Nursing.

The MSG data is based on a patient's postcode. When an instance of Unscheduled Care occurs (i.e. an individual attends Accident & Emergency), the patient postcode is recorded and is used to assign to the relevant HSCP.

The MSG performance data is produced monthly by Public Health Scotland but has a 3 month time lapse due to the collection and cleansing of the data.

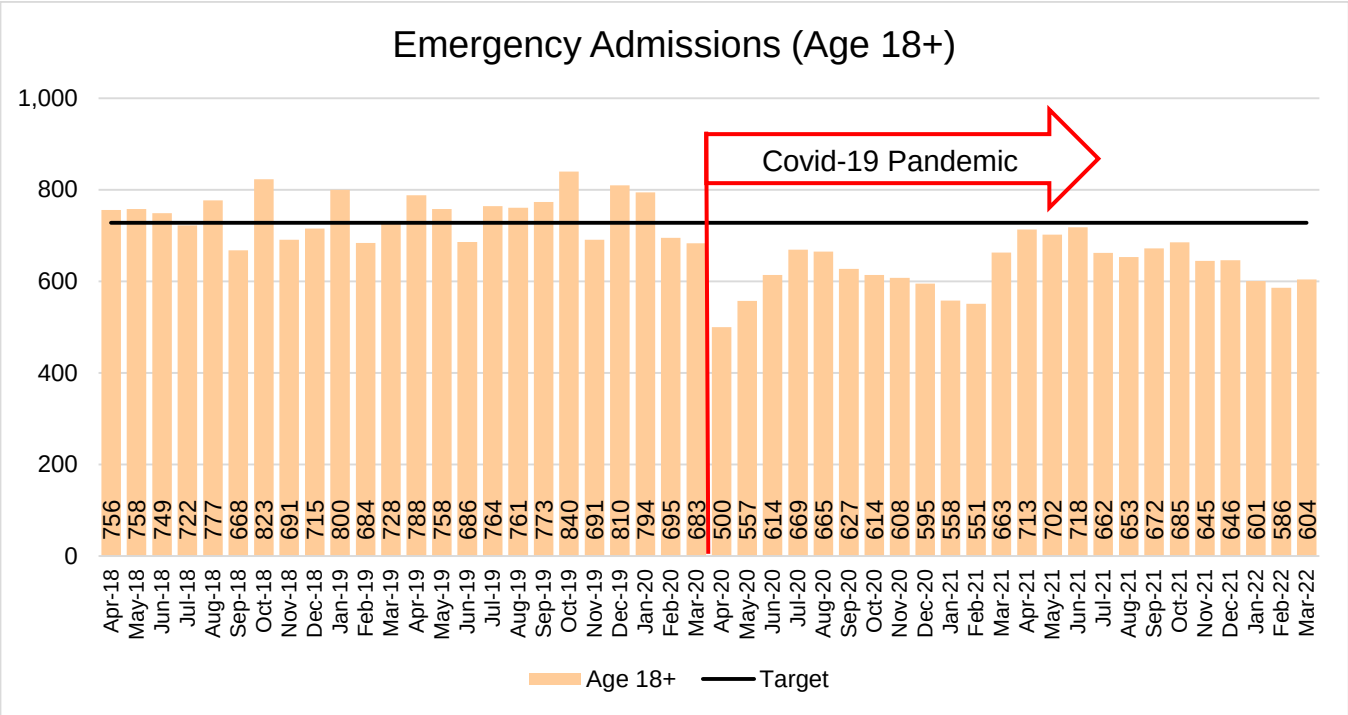
Even after this 3 month period, a number of the indicators are still affected by completeness issues. These issues centre on the Emergency Admissions and Unscheduled Bed Days indicators, and affect the totals for the previous 3 to 5 months. The reason for this issue is that Emergency Admissions are recorded and confirmed on the discharge of the Patients, which allows for a complete record including crucial information such as diagnosis, treatment, and discharge date (example below)



Summary of Ministerial Steering Group (MSG) Indicators

MSG Indicator		Baseline 2015/16	Inverclyde 2021/22	Target	Trend
1	Emergency Admissions (Age 18+)	9,388	7,887	7% reduction from baseline to 8731	↓ Green
2a	Unplanned Bed Days – Acute (All ages)	71679	73,738	6% Reduction on baseline to 67378	↑ Red
2b	Unplanned Bed Days - Geriatric Long Stay	6342	124	n/a	↓
2c	Unplanned Bed Days - Mental Health	26266	17,915	n/a	↓
3a	A&E attendances - All ages	29395	29,036	3% Reduction on baseline to 29395	↓ Green
3b	A&E % seen within 4 hours – All ages		76%	95%	↓ Red
4	Delayed discharge bed days - Age18+	2588	3,804	20% Reduction on baseline to 2070	↑ Red
5a	% of Last Six Months of Life by Setting (all ages) - **Community**	84.5%	88.5%*	2% increase on baseline to 86.5%	↑ Green
5b	% of Last Six Months of Life by Setting (all ages) - **Hospice**	1.4%	0.4%*	n/a	↓ Green
5c	% of Last Six Months of Life by Setting (all ages) - **Large Hospital**	14.1%	11.1%*	n/a	↓ Green
6a	Balance of care: % of population in community or institutional settings - **Home (Unsupported)**	86.7%	89.3% (2020/21)	Increase on baseline	↑ Green
6b	Balance of care: % of population in community or institutional settings - **Home (Supported)**	7.2%	6.3% (2020/21)	n/a	↓
6c	Balance of care: % of population in community or institutional settings - **Care home**	4.5%	3.4% (2020/21)	Decrease on baseline	↓ Green
6d	Balance of care: % of population in community or institutional settings – **Large Hospital**	1.4%	1.0% (2020/21)	Decrease on baseline	↓ Green

1. Emergency admissions (age 18+)



Source: PHS, Lower numbers = better performance

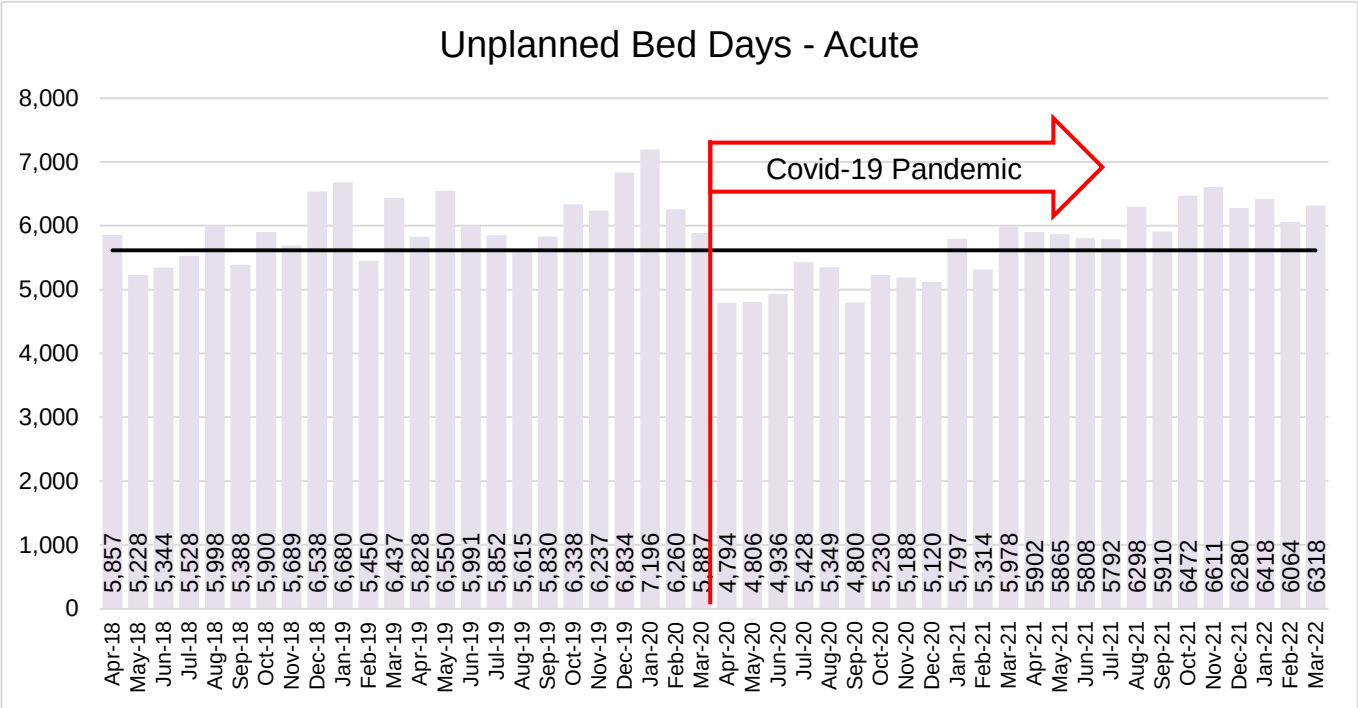
Note: 2021/22 figures are still affected by completeness levels

The number of emergency admissions for the periods 2020/21 and 2021/22 have reduced significantly compared to previous years, which is an effect of Covid-19 and subsequent measures to combat the spread of Covid-19 such as lockdown measures.

Admissions rose slightly in 2021/22 to 7881 (a rise of 9.14% on 2020/21 figure). The average number of emergency admission for 2021/22 was 657.3, which is an increase of 55.5 on 2020/21, but still well below 2019/20 levels.

Emergency admissions continue to exert significant pressures on HSCP services such as Care at Home following discharge from hospital.

2a. Unplanned bed days – Acute (all ages)

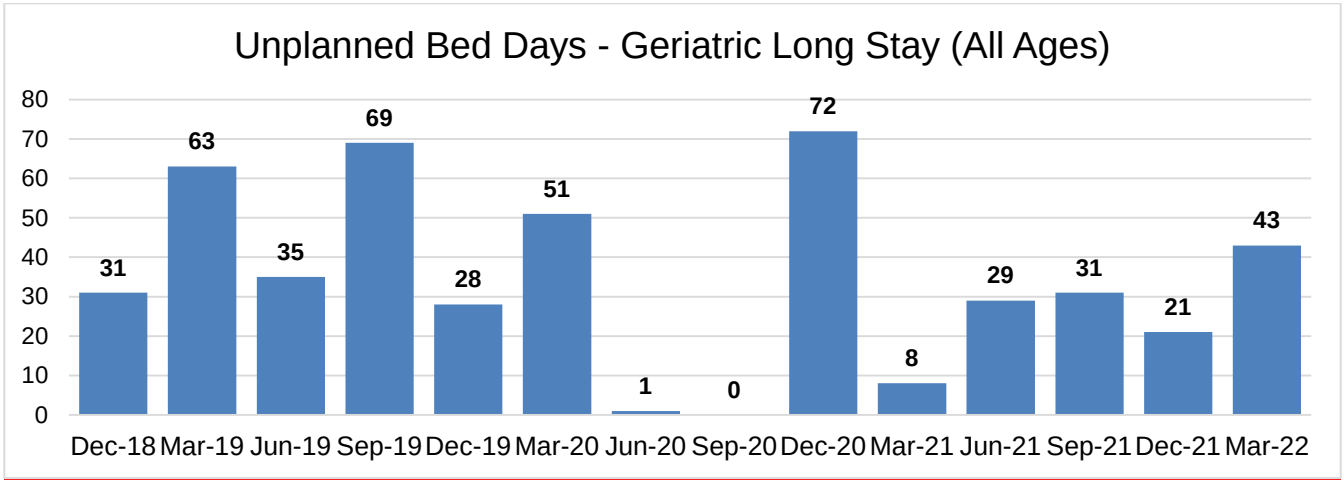


Source: PHS, Lower numbers = better performance Note: 2021/22 figures are still affected by completeness levels

The total number Unplanned Bed Days for Acute specialities for the financial year 2020/21 was 62,740, which equates to a 15.69% reduction on the 2019/20 figure (74,418).

In 2021/22 there was an increase to 73,738 (17.5% increase on the 2020/21) but is still well below the 2019/20 total. The average number of unplanned bed days for acute specialities for 2021/22 was 6144.8, a rise of 916.5 from 2020/21 average (5,228).

2b. Unplanned bed days – Geriatric Long Stay (all ages)

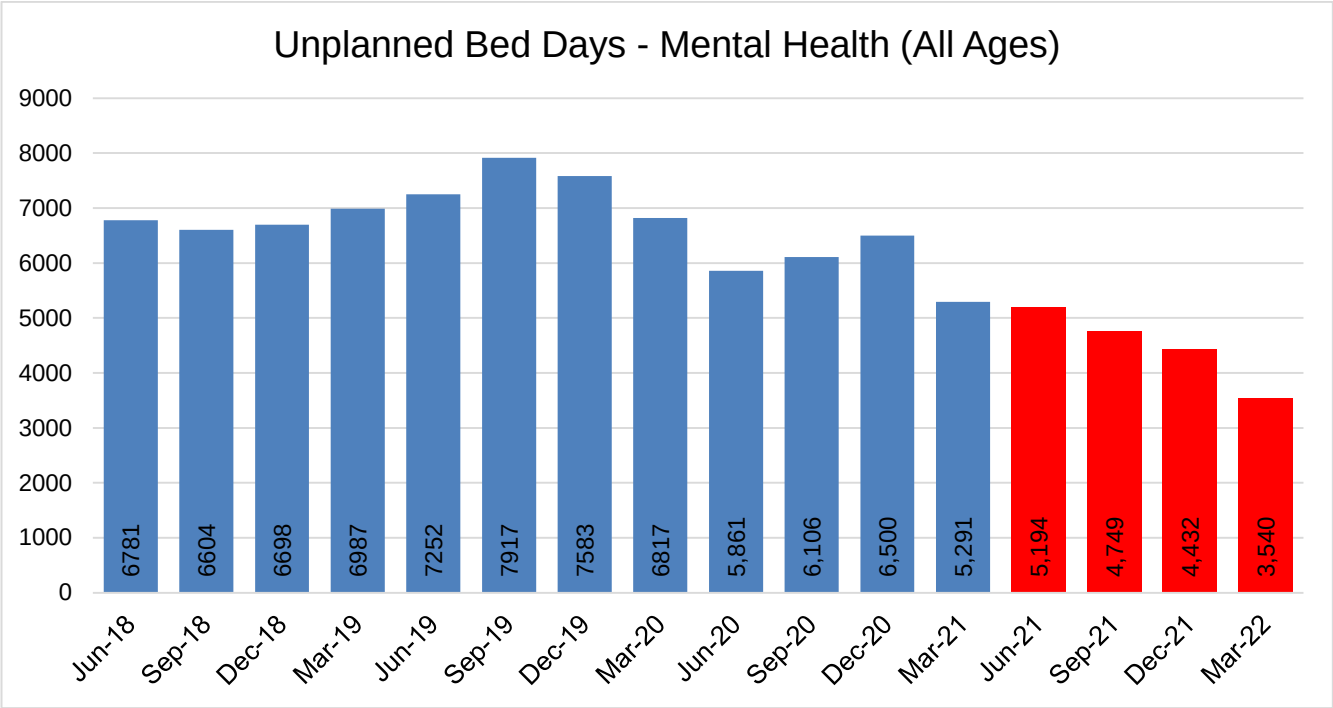


Source: PHS, Lower numbers = better performance Note: 2021/22 figures are still affected by completeness levels

Unscheduled Bed Days for Geriatric Long Stay continue to remain very low, with numbers staying below 50 for a number of quarters.

This is due to the transferral of these patients from hospital based care to a community based model, to improve support and outcomes for individuals.

2c. Unplanned bed days – Mental Health (all ages)

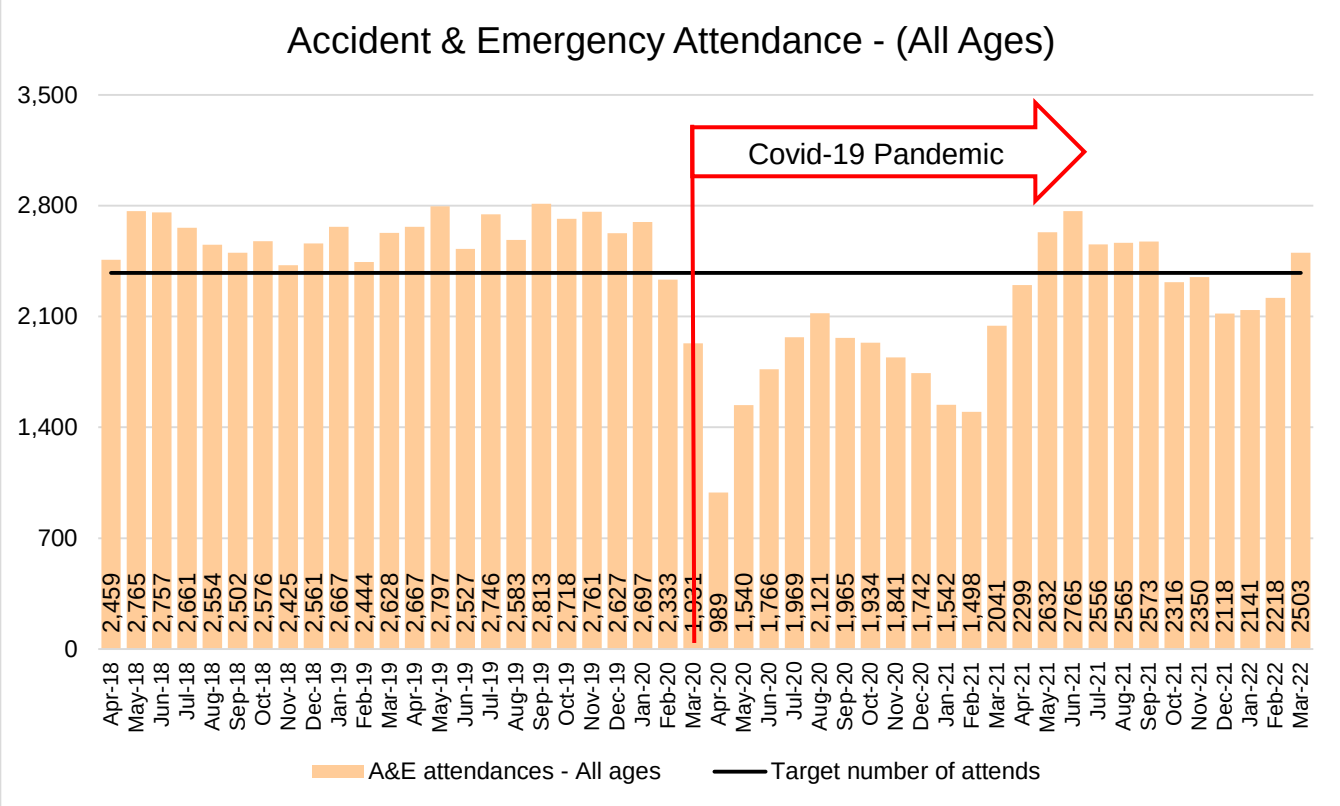


Source: PHS, Lower numbers = better performance

Note: 2021/22 figures are still affected by completeness levels

The number of Unscheduled Bed Days for Mental Health specialities shows a continuous reduction in bed days since December 2020. In 2021/22, this reduced further by 5,843 unscheduled bed days to 17,915. This represents a further reduction of 24.6%.

3a. Accident and Emergency Attendance (All ages)



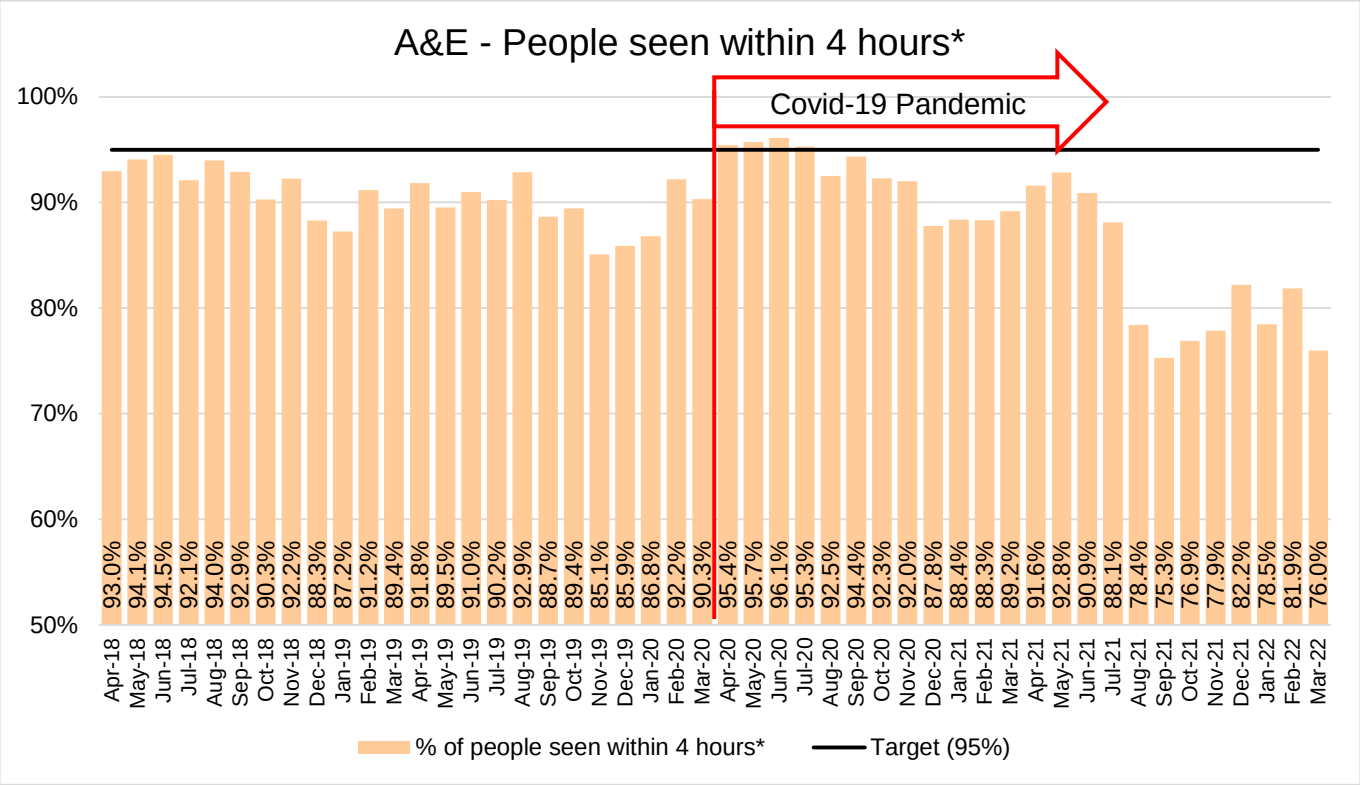
Source: PHS, Lower numbers = better performance

Note: 2021/22 figures are still affected by completeness levels

The number of A&E attends has followed a similar trend to other acute hospital's measures in that Covid-19 has had major impact on A&E attends, which can be clearly seen in the chart illustration above. The sharp drop in attends in March 2020 denotes the start of the pandemic and the combative measures put in place by the Scottish Government.

From an annual perspective, the total number of attends in 2019/20 (pre-pandemic) was 31,200. This reduced to 20,954 in 2020/21, a drop of 10,246 attends or a 32.8% decrease. In 2021/22, the number of attends increased again to 29,036, an increase of 8,082 attends, or a 22.6% rise.

3b. Accident and Emergency - % seen within 4 hours*



Source: PHS, Higher % = better performance

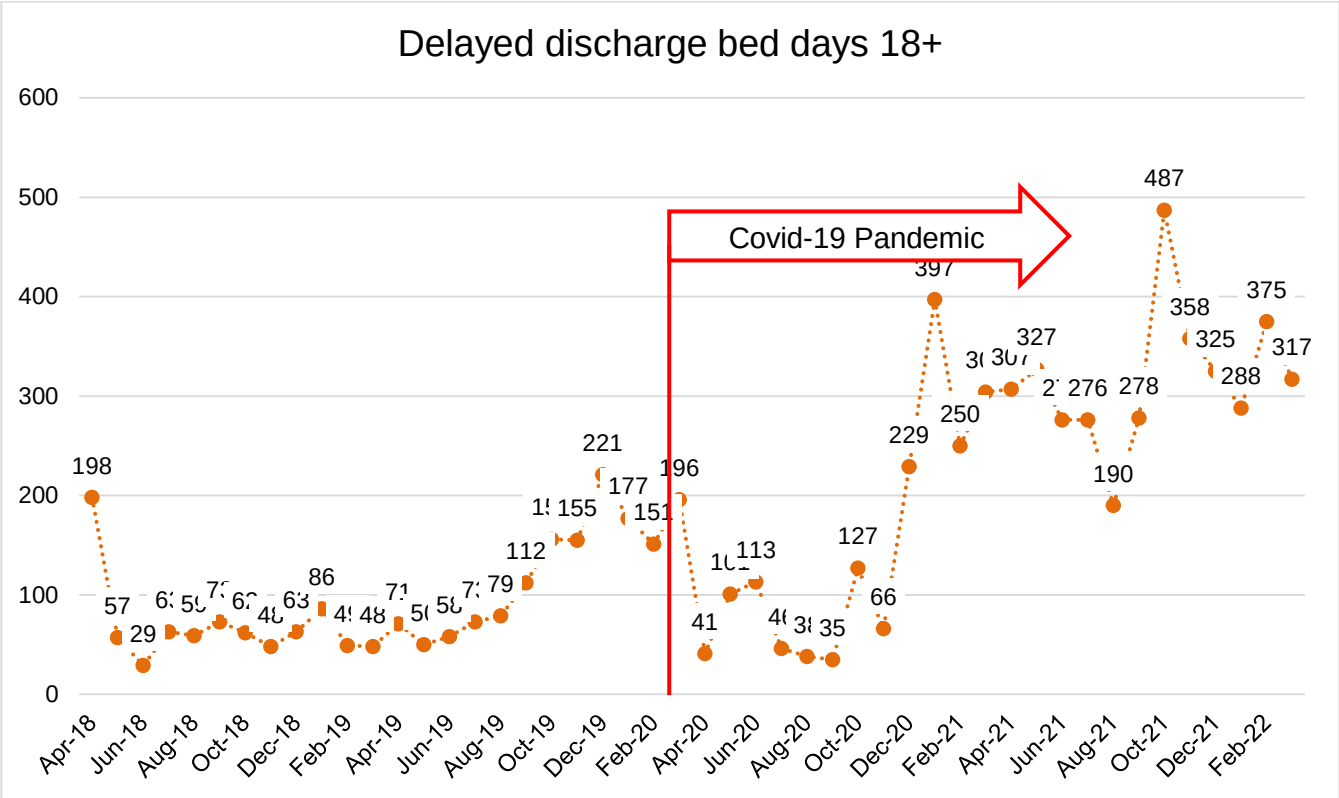
Note: 2021/22 figures are still affected by completeness levels

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

The 4 hour A&E waiting time performance indicator is long standing measure, which has a target of 95%. This indictor has been a challenge for the HSCP and acute colleagues alike. The target of 95% has been met only 4 times since April 2019, and those were the consecutive months of April, May, June and July 2020, which also marked the beginning of the pandemic.

Unfortunately this indictor has seen a marked drop since July 21, with the average being around 78% of those seen within the 4 hour target from July 2021 and Mar 2022.

4. Delayed discharge bed days (Age18+)



Source: PHS, Lower numbers = better performance Note: 2021/22 figures are still affected by completeness levels

Inverclyde had excelled in regards to Delayed Discharge performance for a number of years pre-pandemic, however Covid-19 has had a major impact on the number of bed days lost to delayed discharge, with unprecedented pressure on HSCP services to ensure a timely and safe discharge from hospital.

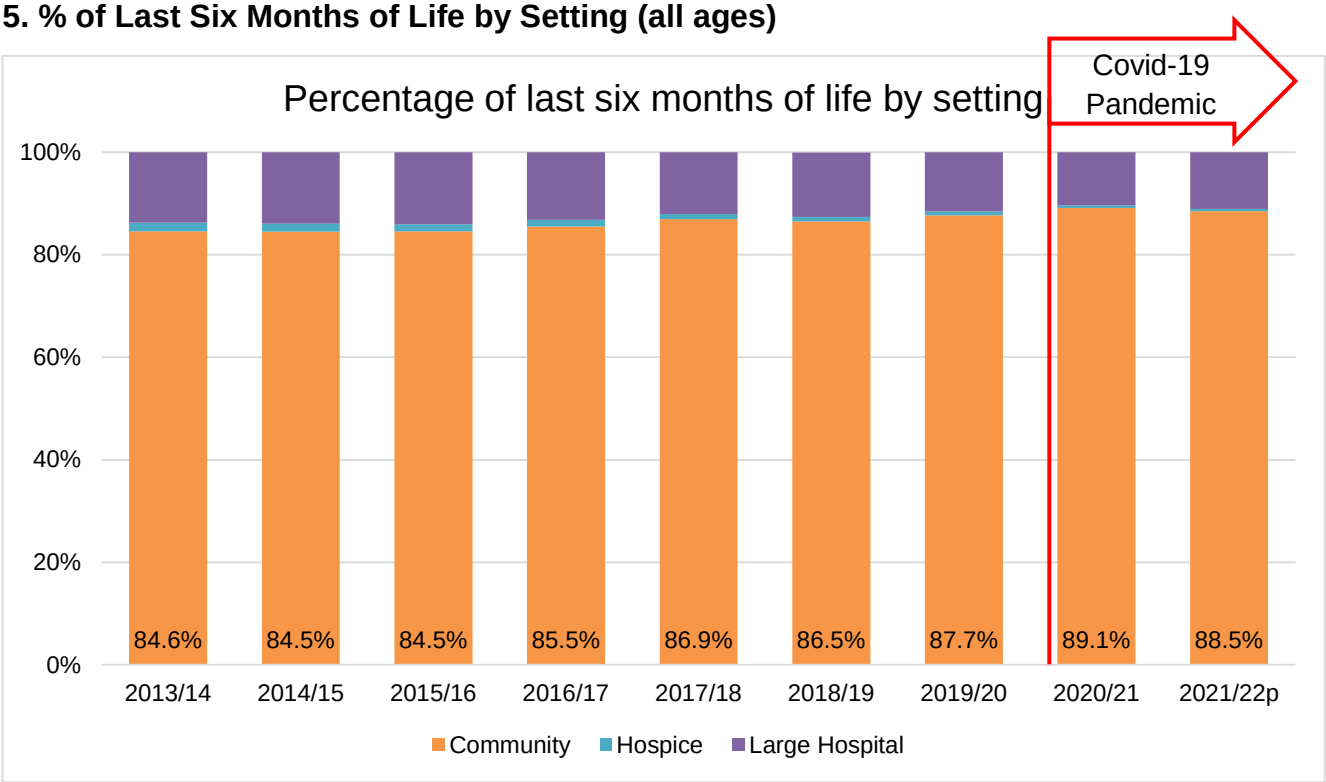
In 2019/20, Inverclyde recorded a total of 1,499 bed days lost, in the following year this increased to 1,747 bed days lost in 2020/21 (an increase of 248 bed days or 16.54%). A further increase in 2021/22 to 3,804 bed days lost to delayed discharge, which is an increase of 2057 bed days.

It is however, important to recognise these numbers in a national context. In 2019/20 Inverclyde was ranked 2nd best performing partnership in Scotland. In 2020/21 this ranking placed Inverclyde in 3rd, and in 2021/22, the ranking was 4th.Although this shows a gradual decline in the ranking, it demonstrates that Inverclyde was not isolated in facing increasing Bed Days Lost to Delayed Discharge, and nearly every HSCP on the Scottish mainland had also recorded large increases in Bed Days Lost.

There were of course other factors that had a negative impact on our Bed Days Lost. Among these would be the closure of Care Home facilities to new admissions due to outbreaks of Covid-19, and in hospital wards, who were unable to discharge anyone diagnosed as having Covid-19 without first providing 2 negative tests as per national guidelines.

In addition to these factors, the HSCP also faced challenges in recruitment, which had an adverse effect on HSCP services.

5. % of Last Six Months of Life by Setting (all ages)

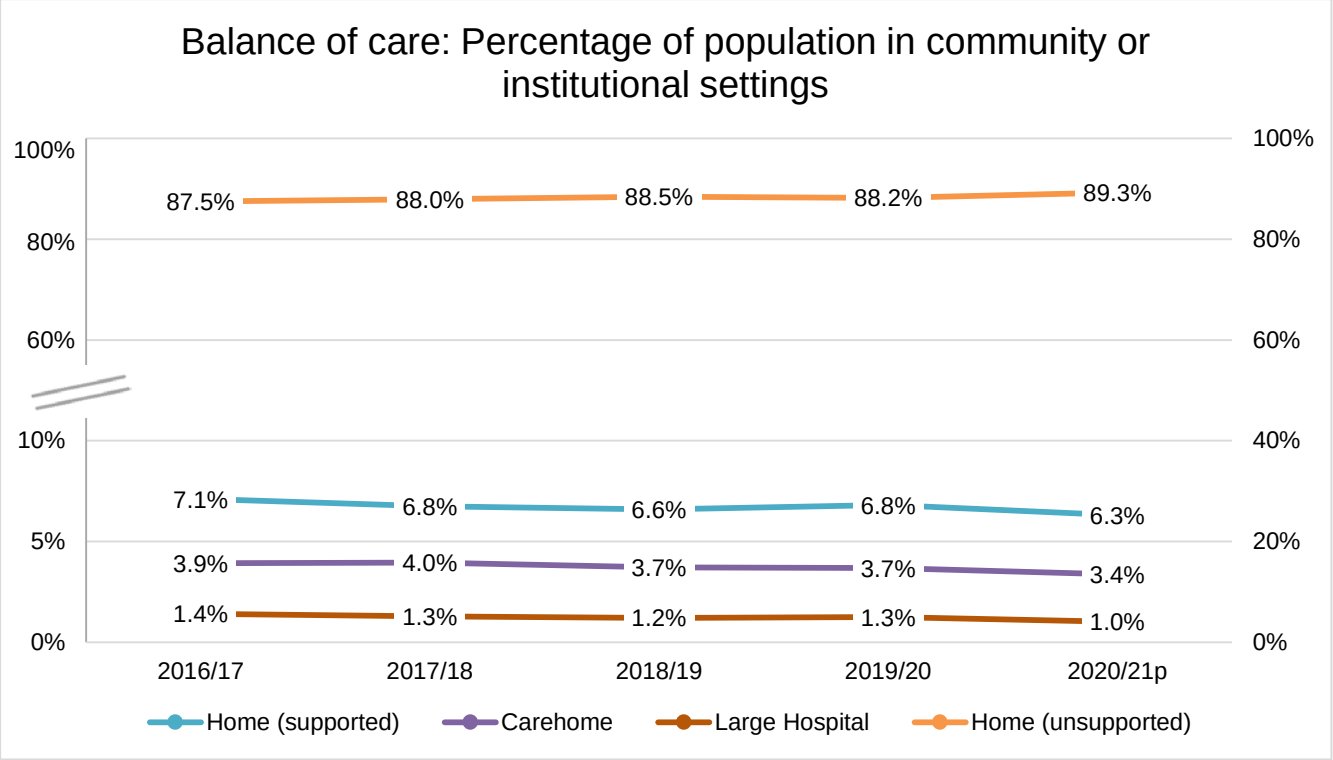


Source: PHS Note: 2021/22 figures are still affected by completeness levels

This performance measure looks to minimise the amount of time people spend in a hospital setting in the last 6 months of life and in doing so, providing care within their home or community setting.

This measure only sees small percentage changes year on year. Inverclyde has increased the percentage every year since 2018/19, with only 2021/22 showing a dip with the provisional figure of 88.5% however we expect this percentage will rise above 89.1% for 2021/22.

6. Balance of care: Percentage of population in community or institutional settings (age 65+)



Source: PHS Note: 2020/21 figures are still affected by completeness levels

The aim of this "Balance of Care" Measure is to promote care models within the community and reduce our reliance on acute hospitals.

As can be seen from the data, Inverclyde has slightly reduced those within a large hospital setting overall, and also in care homes. There has been a slight reduction in those who are supported at home going from 6.8% in 2019/20 to 6.3% in 2020/21.

The big positive in this indicator is those who remain at home unsupported has risen 88.2% to 89.3%, which may be an indicator of increasing independence in our older adult population.

The figures for 2020/21 are still provisional.

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

We will promote health and wellbeing by reducing inequalities through supporting people, including carers, to have more choice and control.

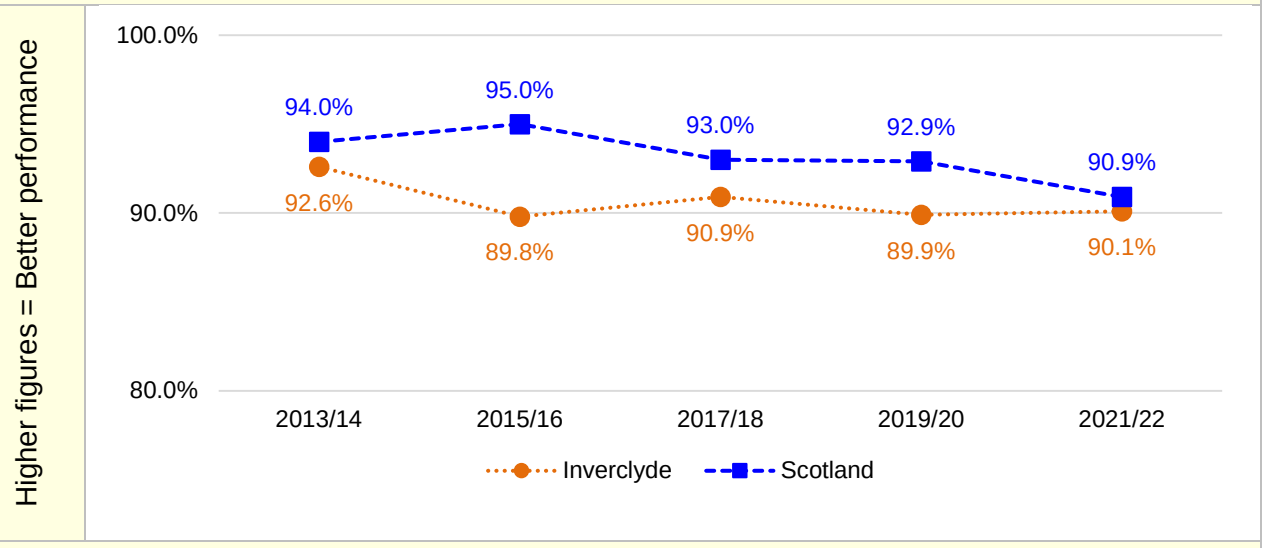
National Outcomes relating to this Big Action

2	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5	Health and social care services contribute to reducing health inequalities.

National Integration Indicators

1

Adults able to look after their health very well or quite well



After a dip in 2015/16 we improved in the next period and have remained consistent since.

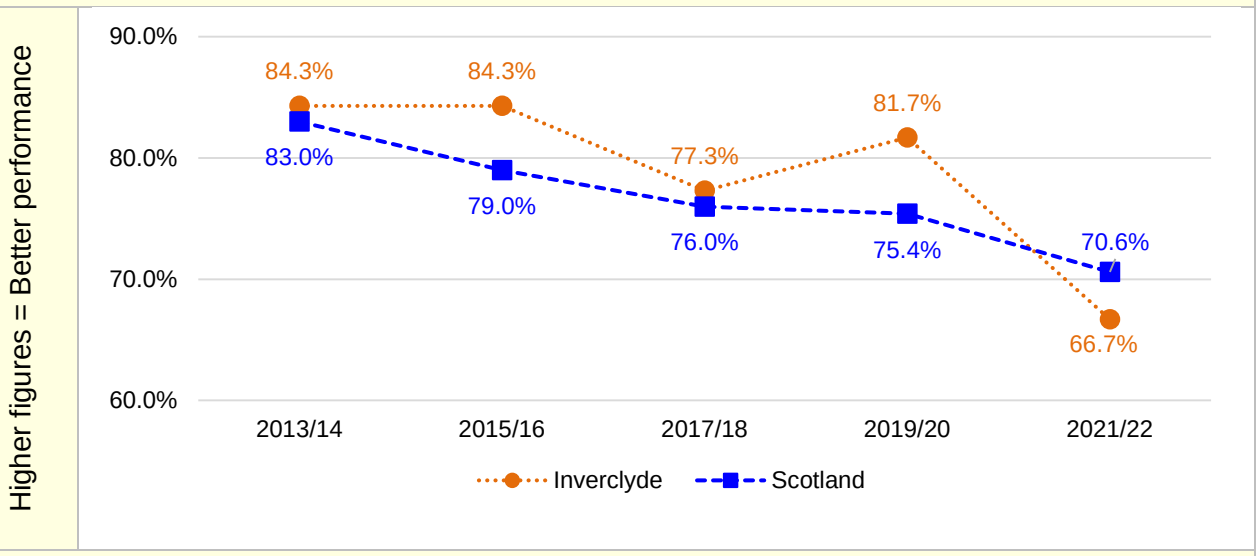
Source: PHS

	2013/14	2015/16	2017/18	2019/20*	2021/22*
Total responses	1855	1925	1946	2447	1918
Number agreed	1718	1729	1769	2200	1728

*2019/20 and 2021/22 figures are estimates

3

I had a say in how my help, care or support was provided



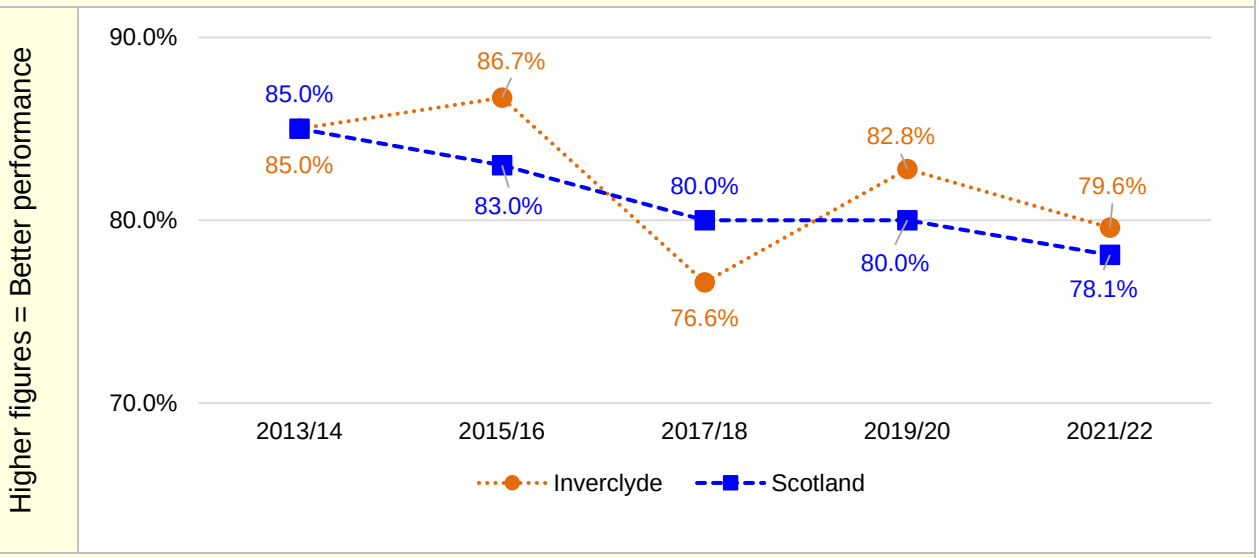
The effect of the Covid-19 pandemic on how we could deliver services meant that we were unable to provide the same level of choice that we strive to provide to everyone. With the recovery plans we expect this will improve significantly in the next survey.

Source: PHS

	2013/14	2015/16	2017/18	2019/20	2021/22
Total responses	183	197	147	284	155
Number agreed	154	166	114	232	103

7

The help, care or support improved or maintained my quality of life



Although the model of care delivery we could provide was very different, we only experienced a slight dip in performance in this area.

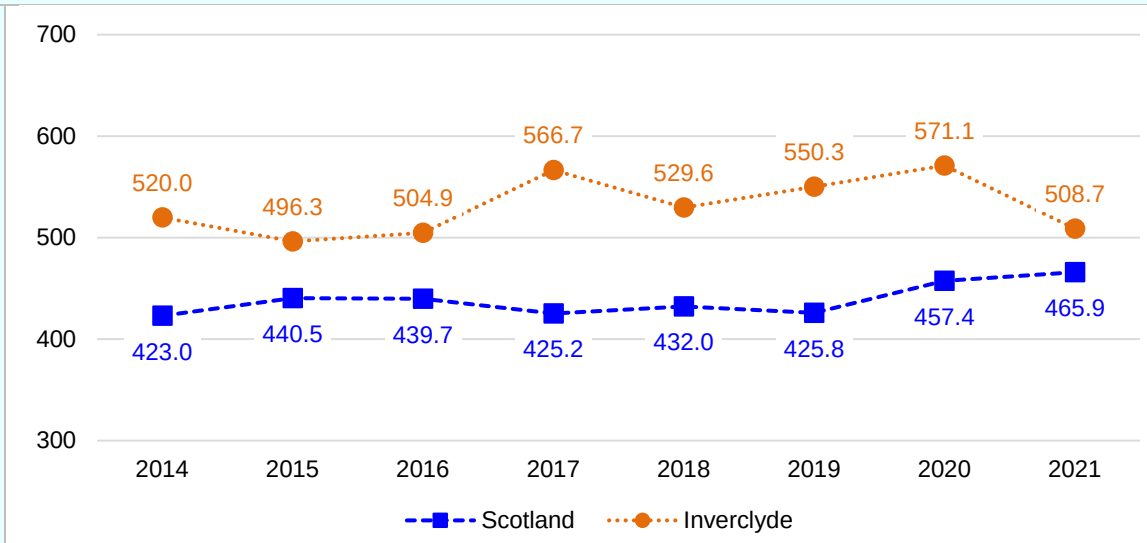
Source: PHS

	2013/14	2015/16	2017/18	2019/20	2021/22
Total responses	179	191	145	279	148
Number agreed	152	166	111	231	118

11

Premature mortality rate per 100,000 persons

Lower figures = Better performance



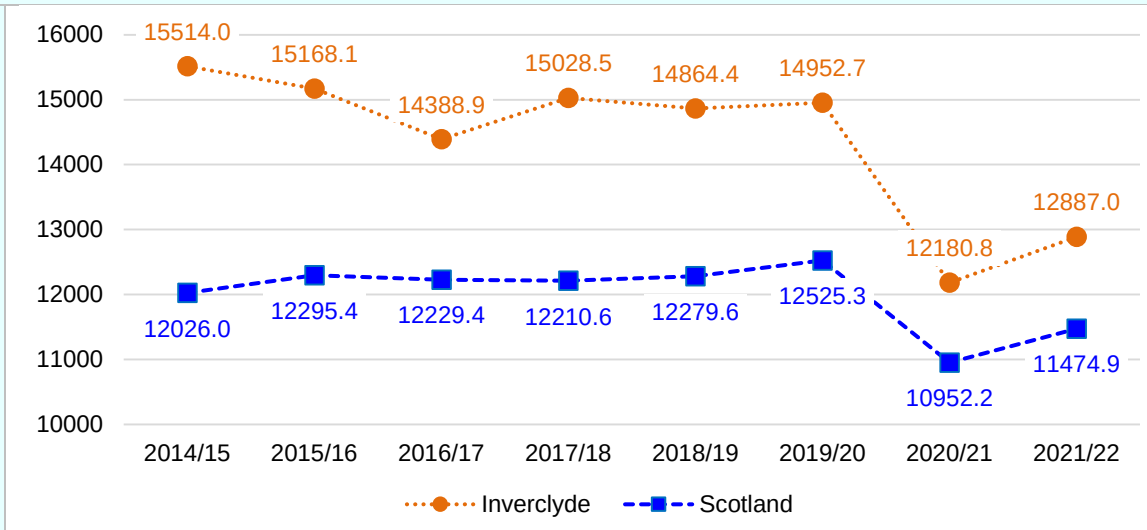
We are working hard to reduce this rate and we welcome the reduction in the most recent period. Some of this is due to the effect of the Covid-19 pandemic which had a notable impact nationally.

Source: PHS

12

Emergency admission rate (per 100,000 population)

Lower figures = Better performance



Whilst the significant reduction from 2019/20 is welcome the Covid-19 pandemic is, at least, a contributing factor.

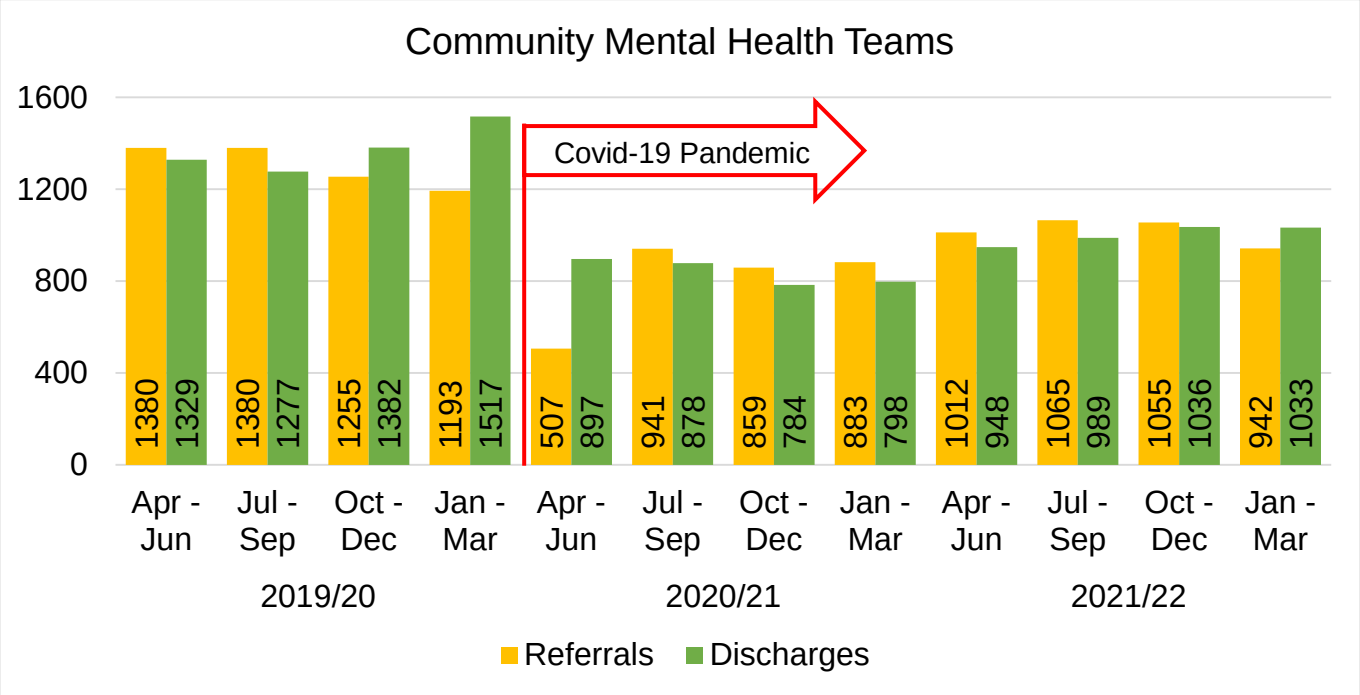
Source: PHS

Please note that the figures for 2021/22 are provisional and subject to change.

Local Activity

Mental Health

Community Mental Health Services



Source: EMIS Microstrategy Dashboard

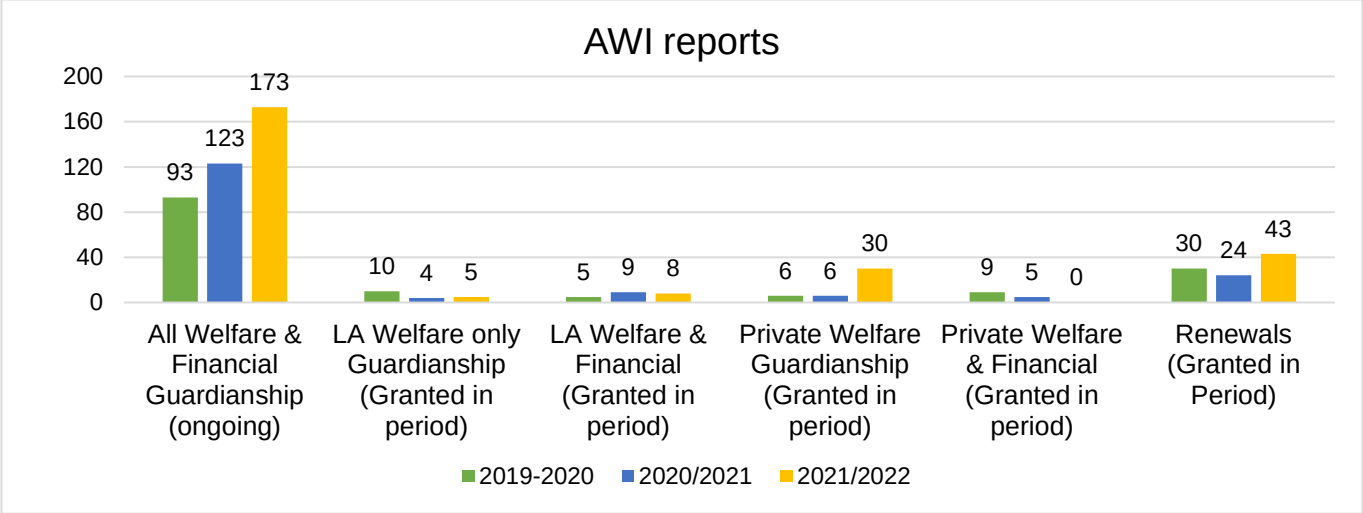
The Covid-19 pandemic caused a significant reduction in referrals to our community teams. These have increased over the reporting year but are still below pre-pandemic levels.

Mental Health Officer Service (MHO) Review

The action plan arising from MHO service review has been worked through with additional full time MHO staff recruited to. An element of the sustainability programme is continuing to attract and support existing qualified Social Workers in the HSCP to achieve the MHO qualification to build the staffing capacity required to meet a rising service demand. Additionally more robust recording, monitoring and reporting is now being provided via the existing SWIFT electronic record system.

The Adults with Incapacity (Scotland) Act 2000 creates provisions for protecting the welfare of adults who are unable to make decisions for themselves because of a mental disorder or an inability to communicate. It allows other people to make decisions on behalf of these adults about things like: arranging services.

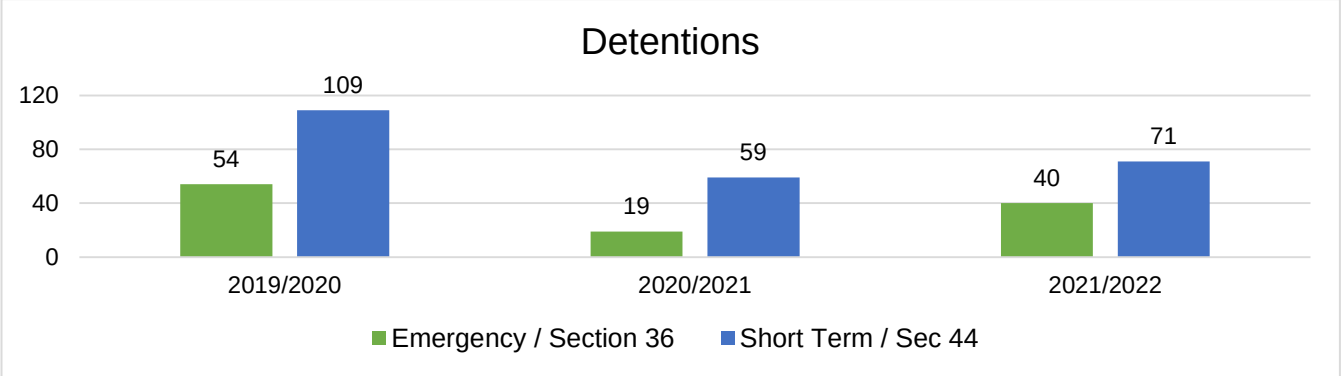
The graph below details the number of Adults with Incapacity (AWI) reports carried out from 2019 – 2022. There has been a significant increase in reports, rising by 80 over the three year period. Private Welfare Guardianship and renewals granted within the period have risen within the period 2021/22.



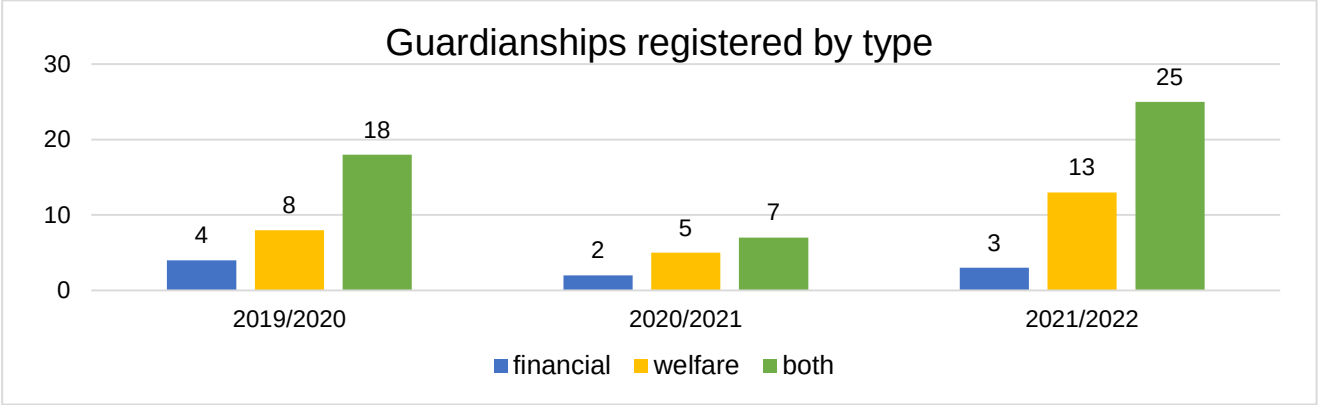
Section 44 of the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the procedure for granting a short-term detention certificate.

Section 36 is an emergency detention certificated which allows a person to be held in hospital for up to 72 hours while their condition is assessed.

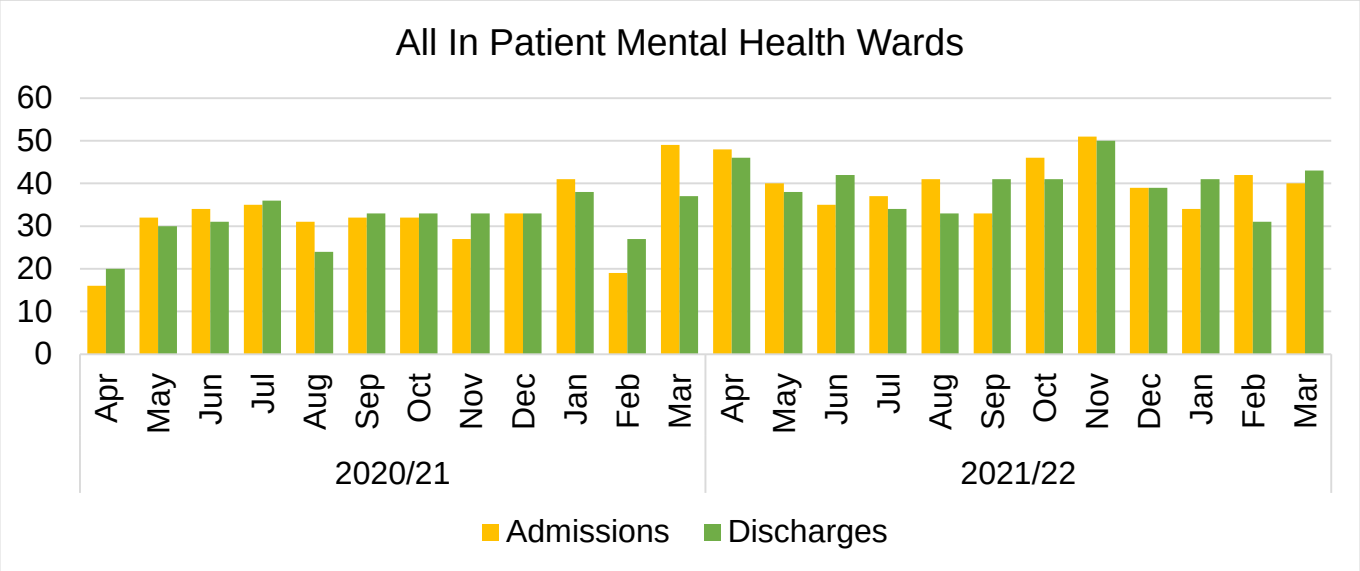
Detentions within Inverclyde have fluctuated in numbers from 2019 – 2022. There are a higher number of Section 44 short term detentions being granted each year compared to Section 36 emergency detentions.



A Guardianship Order is a court appointment which authorises a person to act and make decisions on behalf of an adult with incapacity. There has been an increase in guardianships registered over the last 3 years with 41 guardianships being registered in 2021/22 compared to 14 the previous year.



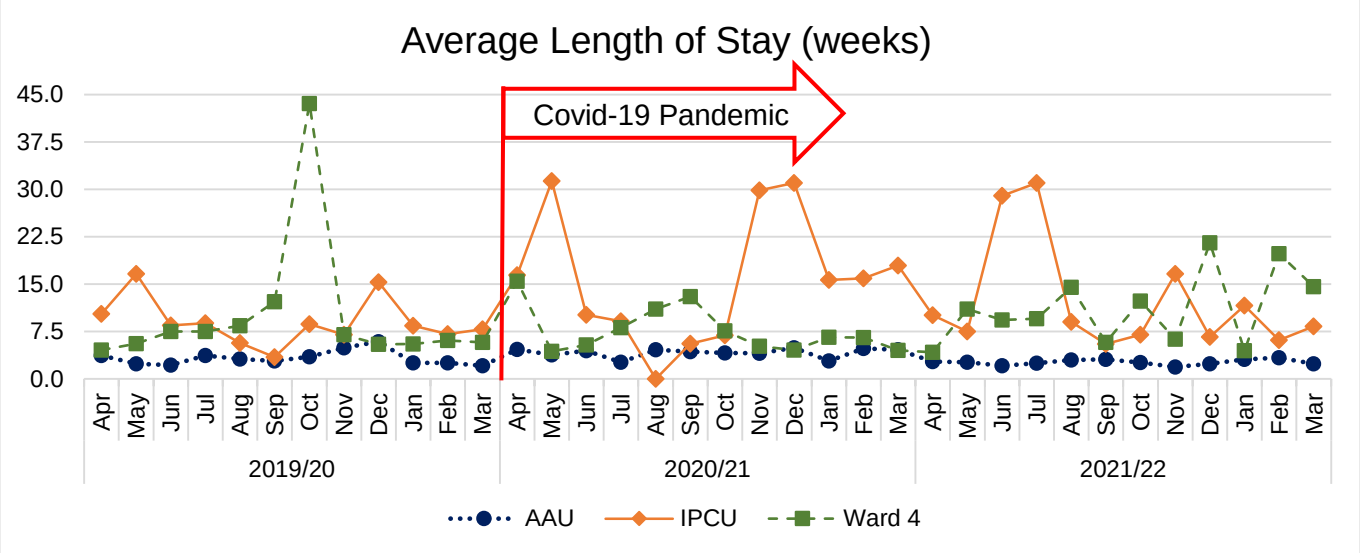
Inverclyde Mental Health Inpatient Services



Source: Inpatient Bed Days Management Report

All hospital admissions have been significantly impacted on during the pandemic and this has also been the case for mental health inpatient services. This has largely been due to an increase in admissions, particularly for general adult psychiatry and also due to ward closures across GG&C as a result of outbreaks in cases of Hospital Acquired Infections of Covid-19.

Admissions have also been limited by the lack of single room accommodation to ensure isolation of patients in hospital wards across GG&C, however Ward 4 (older adult admission ward) is the only ward that has been affected by these restrictions in Inverclyde. The admission rates to this ward have been lower than previous years, which has helped with safe and effective bed management, reducing the need to board patients out to other localities.



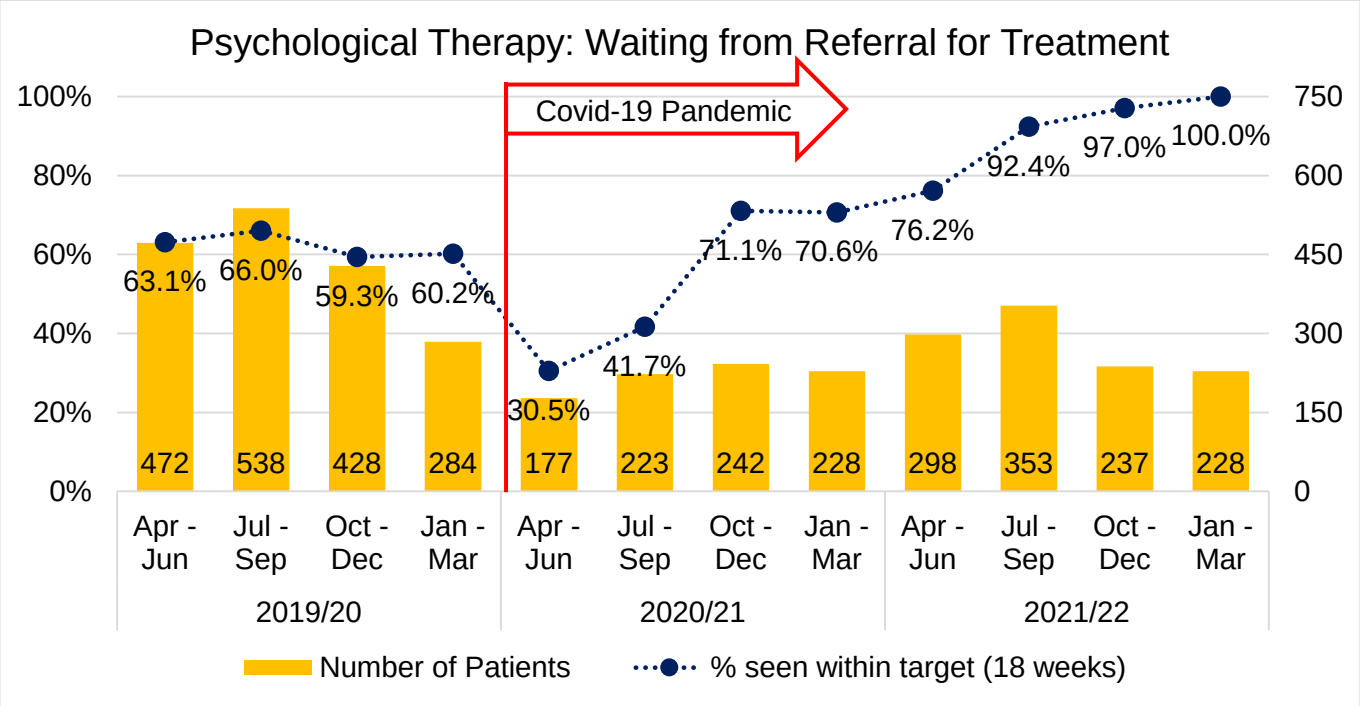
Source: Inpatient Bed Days Management Report

Langhill clinics Acute Admissions Unit (AAU) has the lowest length of stay in GG&C by almost 50% and one of the lowest admission rates in comparison with similar wards, therefore this has led to a higher number of boarders being admitted to AAU. These lengths of stay have tended to be longer than normal due to the delay in repatriation of patients as a result of ward closures and bed pressures across the system.

AAU in some months have experienced some difficulty achieving below the target bed occupancy rate of 95%, although their average bed occupancy is 83.8%. This has also been the case for the Intensive Psychiatric Care Unit (IPCU) who have been unable to achieve the target rate of below 85% at all this past year and the average bed occupancy is 94.8%.

Ward 4 has consistently achieved below the target occupancy rate of 95% and on average the bed occupancy has been below 60%. This has been despite known pressures around discharges to care homes and sourcing care packages to support patients' discharges back to the community.

Psychological therapies



Source: EMIS Microstrategy Dashboard

The significant drop in the numbers being seen for psychological therapies from the start of the Covid-19 pandemic has continued, primarily a result of the referral rate to the Primary Care Mental Health Team (PCMHT) being impacted.

A critical factor impacting on number starting a psychological therapy within the 18 week standard was psychology staffing turnover within the Community Mental Health Team. This last year we have seen continuous improvement across both primary and secondary care mental health services and achieved 100% in seeing people within 18 weeks.

Inverclyde Dementia Care Co-ordination Programme

The Care Coordination Programme concluded in March 2022 with end of programme events held for local stakeholders and on online webinar that highlighted the many achievements of the programme. Further details about the work including flash reports and documents can be found here: [Inverclyde Care Co-ordination - Inverclyde Care Co-cordination (ihub.scot)]

Summary of key achievements:

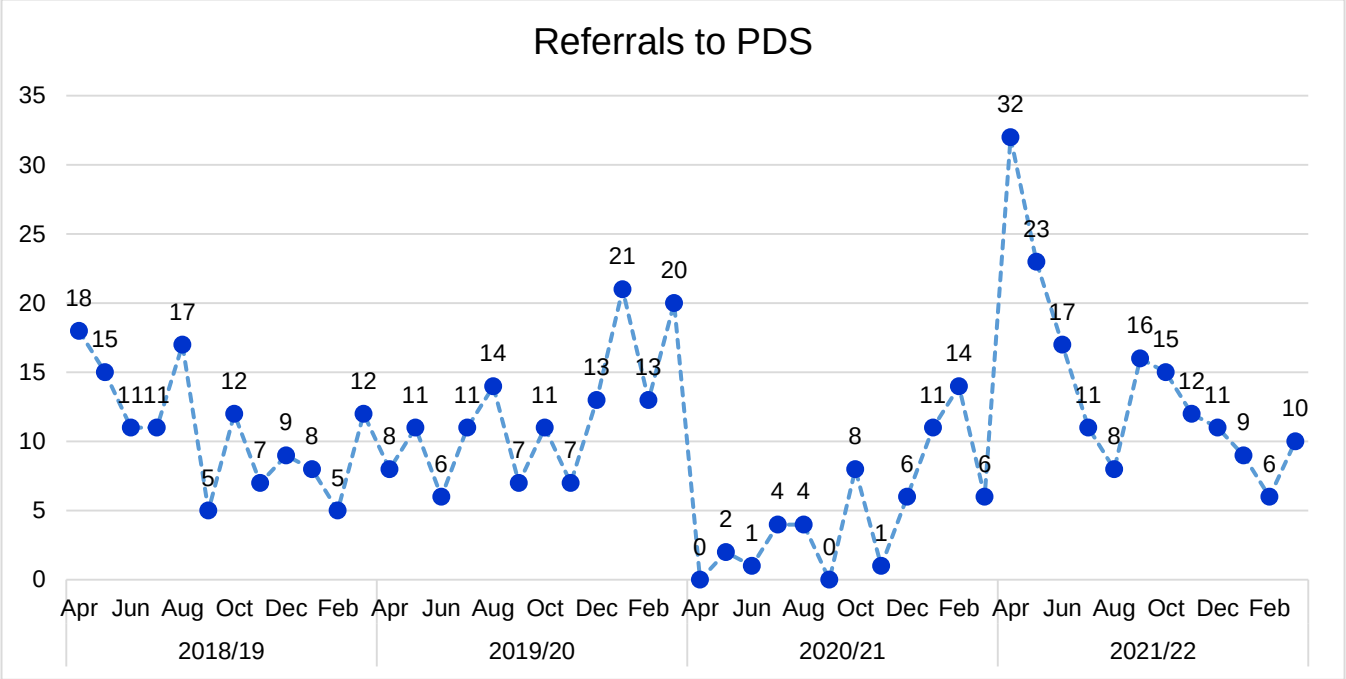
Post Diagnostic Support (PDS)	• Additional link worker resources was introduced in 2021. This led to significant improvements in waiting times with most people now being offered support within 8 weeks of diagnosis. • Regular PDS waiting list review meetings ensure that allocations are prioritised and issues are resolved quickly • The single quality question which was tested as part of the programme has been rolled out across other PDS services
Care co-ordination and application of critical success factors	• Learning sessions with local staff explored the concept of care co-ordination and supported the development of a shared understanding of the role • A document detailing local supports and services along with criteria and processes for accessing these has been produced
Advanced Dementia Practice Model (ADPM) for palliative and end of life care	• An Advanced Dementia Specialist Forum was established, tested and evaluated in Inverclyde. The evaluation found that the forum supported the effective management of coimplex cases • A working group set out to explore and report on tools that could effectively support the identification of Palliative and End of Life Care needs in individuals with dementia

Learning from the programme is now being shared across other Health and Social Care Partnerships by Healthcare Improvement Scotland in collaboration with Alzheimer Scotland. There are a number of legacy pieces of work that continue locally including:

- ✓ A Dementia Friendly and Enabled Inverclyde initiative that is working to support local communities across Inverclyde to be more inclusive and accessible to individuals with dementia
- ✓ The introduction of a dementia training coordinator who is setting up a sustainable training programme in line with the Promoting Excellence Framework across a range of staff groups in Inverclyde
- ✓ A data measurement and performance group that is working on a minimum data set that will support the evaluation of dementia services and also the development of a dementia register

Post Diagnostic Support for people with newly diagnosed Dementia (PDS)

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



Source: EMIS Microstrategy Dashboard

Due to Covid-19 pandemic restrictions and their impact of primary and secondary care service's the number of individuals who were formally diagnosed with dementia and referred to PDS reduced considerably during 2020. Additional link worker capacity in Inverclyde has enabled waiting times for the service to decrease in spite of the rise in referrals.

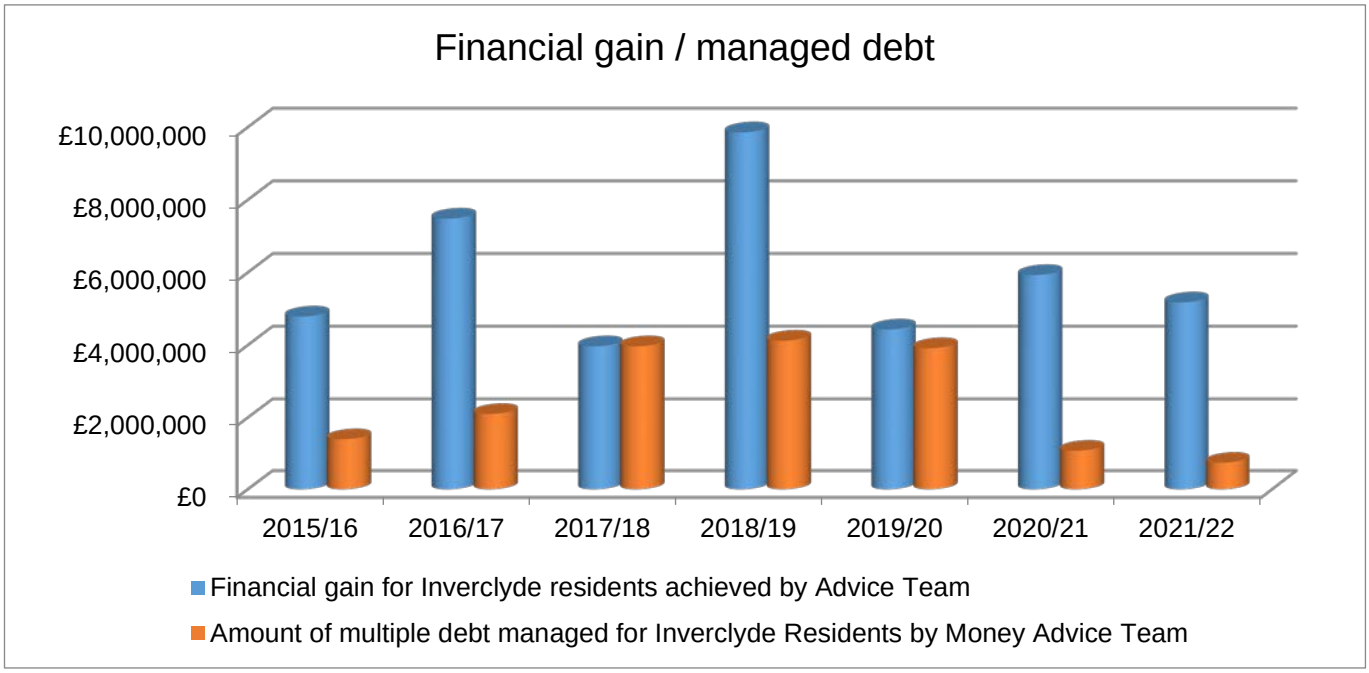
Financial Inequality

The HSCP Advice Service have continued to support people recovering from Covid-19 Pandemic during 2021/22. Most additional financial support provided throughout Covid-19 has now ceased or reduced such as the increased rate of Universal Credit. Evidence from our own and commissioned services is that clients are raising concerns around the future cost of living.

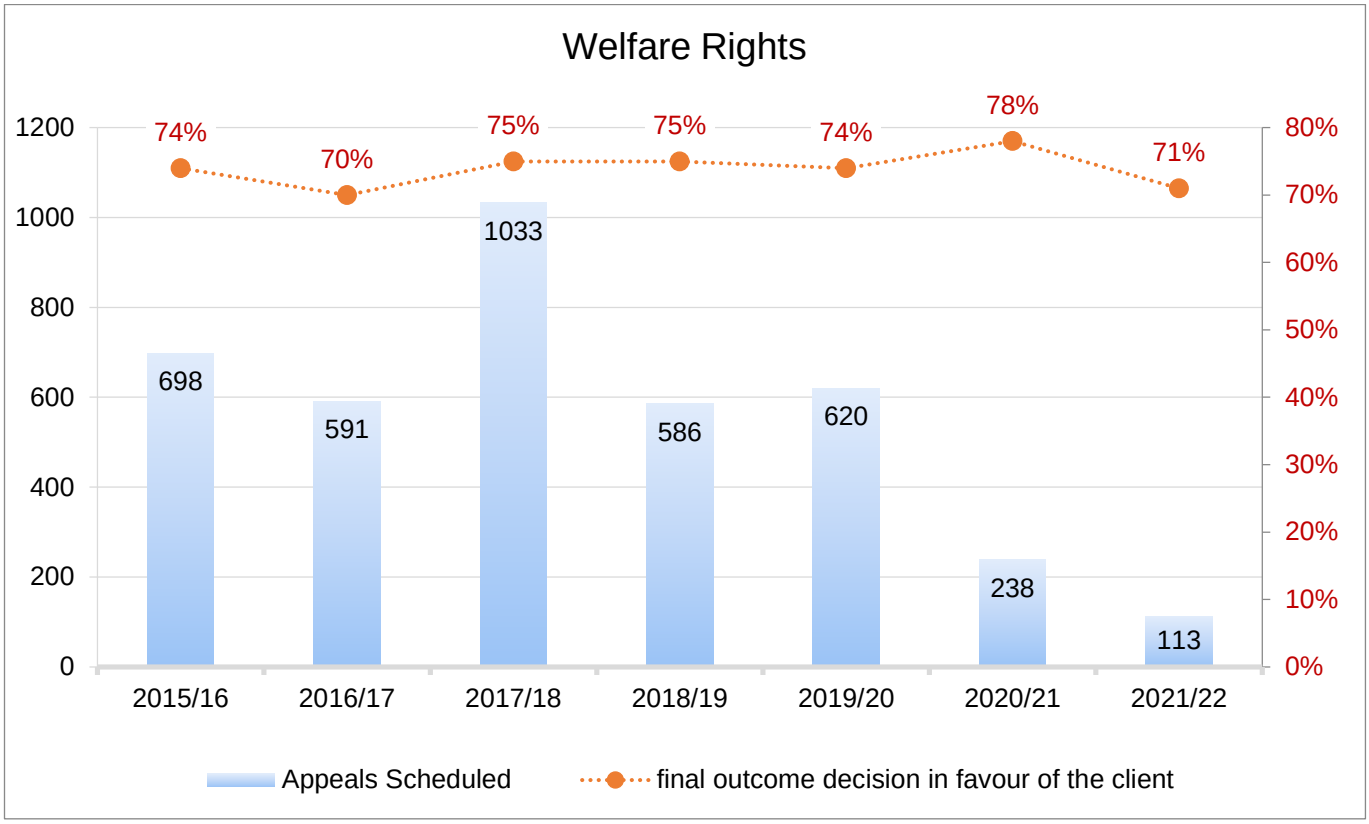
The service has been preparing for the implementation of the new Scottish Social Security benefits with Child Disability Payment being launched in November 2021 and Adult Disability Payment beginning in Inverclyde at the end of August 2022.

The Macmillan Benefits Service continued to support individuals with a cancer diagnosis and directly supported the development of the local plans and pathway for Improving the Cancer Journey.

Financial gains during 21/22 are shown in the chart below.



Source: Advice Pro



Source: Advice Pro

The chart above shows the number of benefits appeals supported. These remain lower than in previous years due to the continued use of virtual appeals by HM Courts & Tribunals and the continued use of extension period to existing awards therefore reducing the number of reviews and subsequent appeals. Final outcomes in favour of the client have remain consistently above 70%.

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

We will ensure our children and young people have the best start in life with access to early help and support, improved health and wellbeing with opportunities to maximise their learning, growth and development. For the children we take care of, we will also ensure high standards of care, housing and accommodation.

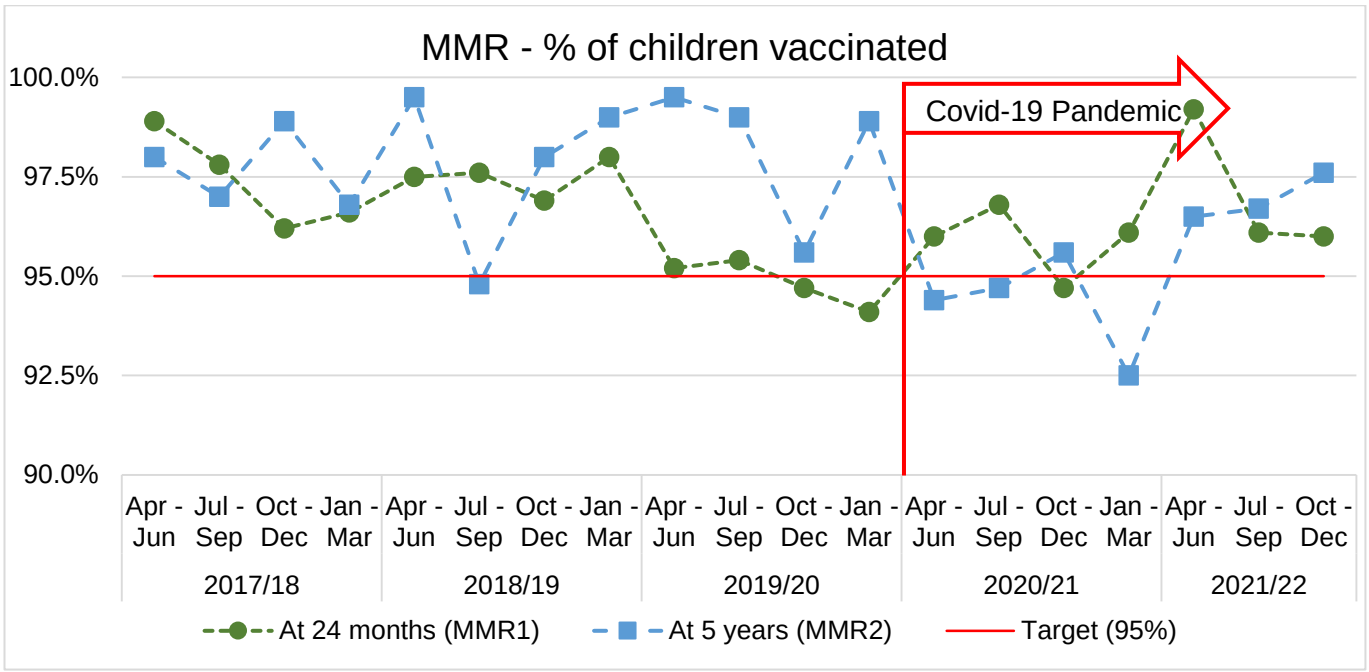
National Outcomes relating to this Big Action

10	Our children have the best start in life and are ready to succeed
11	Our young people are successful learners, confident individuals, effective contributors and responsible citizens
12	We have improved the life chances for children, young people and families at risk

Local Activity

Childhood Immunisations

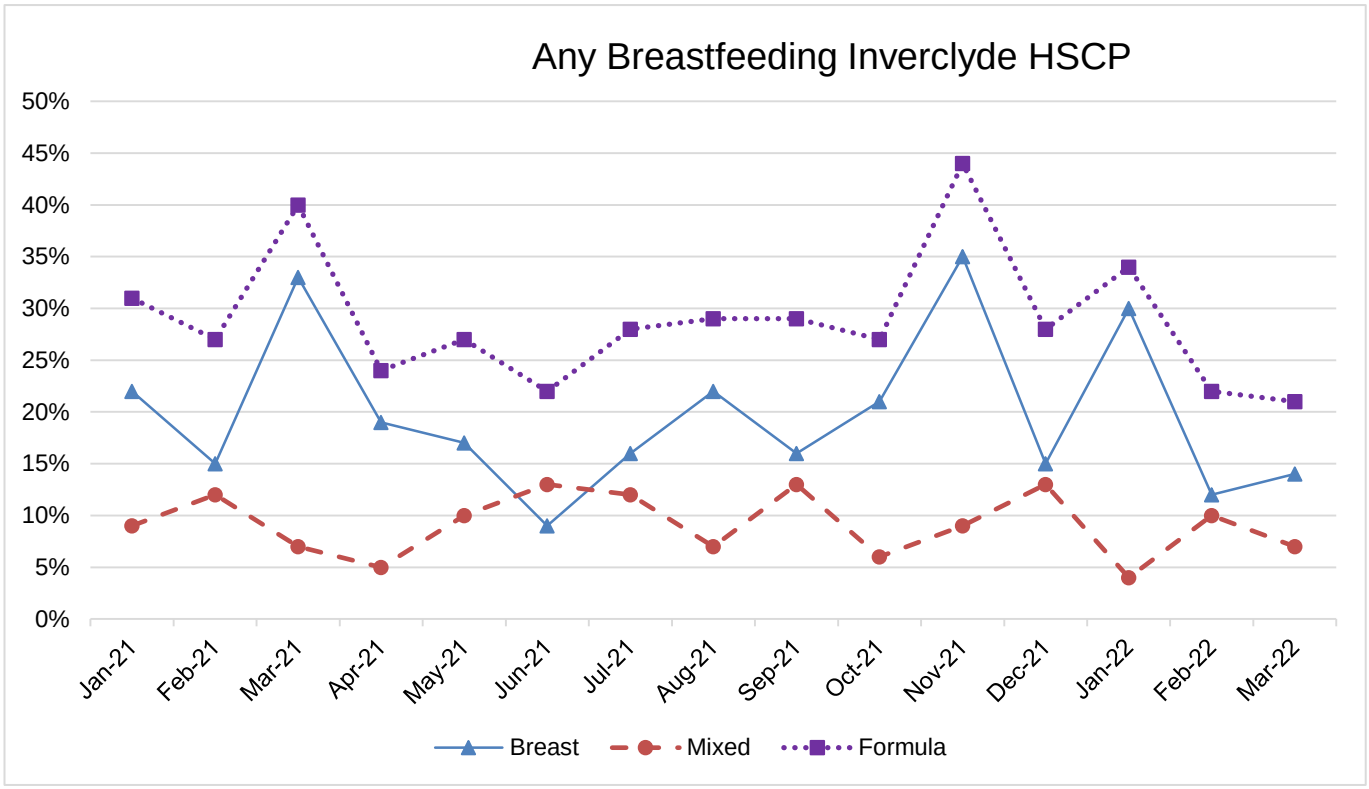
Childhood immunisations continue to be delivered by the centralised team in both Greenock and Port Glasgow locations. Throughout the Covid-19 pandemic we have continued to maintain a high level of attendance for our immunisation clinics. Any failed attendances are followed up by Health Visiting staff as supporting parents to attend immunisations remains a key focus, in particular for Measles, Mumps and Rubella.



Source: PHS (Public Health Scotland)

Infant Feeding and Breastfeeding

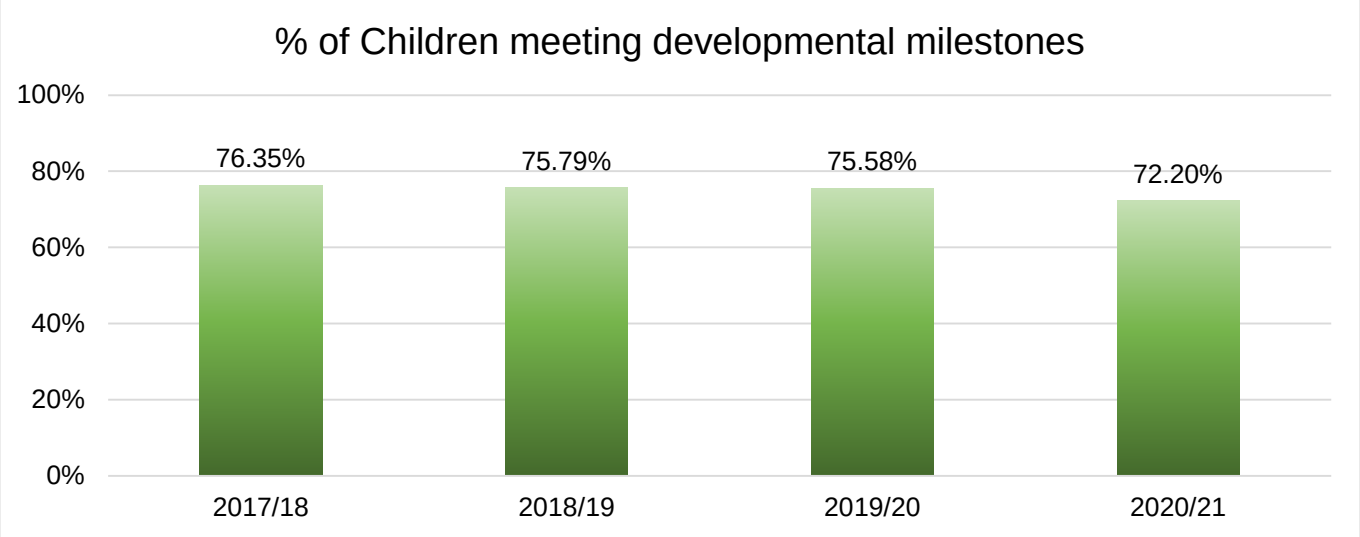
Promoting and protecting breastfeeding (BF) remains a public health priority for Inverclyde HSCP in line with the World Health Organisation and UNICEF Baby Friendly. However, despite BF being a priority, rates remain low compared to the rest of the Scotland with only 14% exclusively BF at 6 weeks in the last quarter January - March 2022. The Breastfeeding Program for Government (PfG) continues to support Inverclyde HSCP projects to help increase BF, particularly among the most disadvantaged in SIMD1, Family Nurse Partnership (FNP) and those with Special Needs in Pregnancy Service (SNIPS). The "In reach Service" in partnership with the midwives also offers intensive support to all breastfeeding mums at discharge from hospital. The mural in Nicolson Street by the artist "Smug" was recently promoted discussing the cultural difficulties with breastfeeding with local mums on the BBC News. The mural will be the basis for focus groups and work within schools and the community. As the Covid-19 pandemic recedes the breastfeeding group has recommenced and will now incorporate an antenatal workshop on breastfeeding on the first Tuesday of the month. Recruitment is also underway with Compassionate Inverclyde to recruit further volunteer 'New mum companions' to help mums post-delivery to support close and loving relationships and protecting breastfeeding. Our culture change work continues with the recruitment of local businesses who sign up to be welcoming of breastfeeding mums Breastfeeding Friendly Scotland (office.com), the local cafes which have signed up will be displayed on Parent Club Scotland Interactive map. The link below highlights work thus far Inverclyde HSCP Projects.



Source: PHS (Public Health Scotland)

27 – 30 month assessments

The Scottish Government target is 85% of children with no concerns on all 8 developmental outcomes. In 2016/17, there was a change to the domains assessed by health visitors at a child's 27-30 month review. The percentage of children meeting developmental milestones is part of the Local Government Benchmarking Framework. This national framework is designed to develop better measurement and comparable data across all council areas. The latest data for 2020/21 was published in April 2022 and shows that the percentage of children in Inverclyde meeting developmental milestones continues to be lower than the Scottish average.



Source: PHS (Public Health Scotland)

The Speech Language Therapy team have continued to work on new initiatives alongside colleagues in health visiting and education to support improvement in the developmental milestones. This piece of work is focussing on impacting change in the under 3 population in response to data gathered via the 27-30mth assessment. Joint pieces of work mirrored in both Health and Education are being carried out, in particular around upskilling parents and education staff at a universal level to support and nurture early language development.

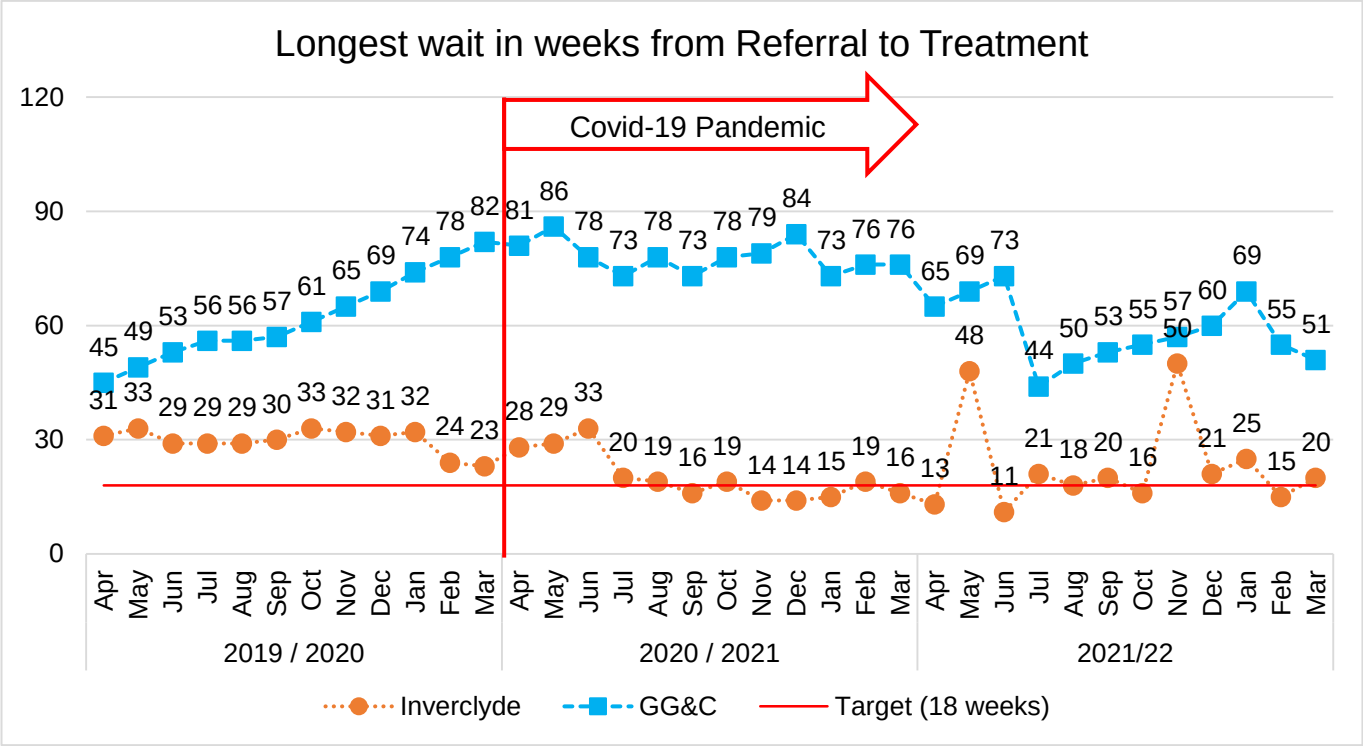
Specialist Children's Services

Throughout the Covid-19 recovery phase all services have continued to provide a high level of care utilising a variety of means and methods available, depending on restrictions, in order that the children and families of Inverclyde continue to experience excellent care and support.

Nurses within Specialist Community Paediatric Team Inverclyde have adapted their service delivery over the past two years while continuing to provide uninterrupted care to families within the locality. Covid-19 monies were secured to help with the disability waiting lists, which has helped greatly and the whole team continue to work cohesively.

Within Specialist Children's Services there has continued to be a commitment to adapting the Autistic Spectrum Disorder diagnostic service resulting in a significant reduction in waiting times for families. This drive has kept children and families at the forefront, having numerous consultations with young people to seek their views in order to impact change.

CAMHS (Child and Adolescent Mental Health Service)



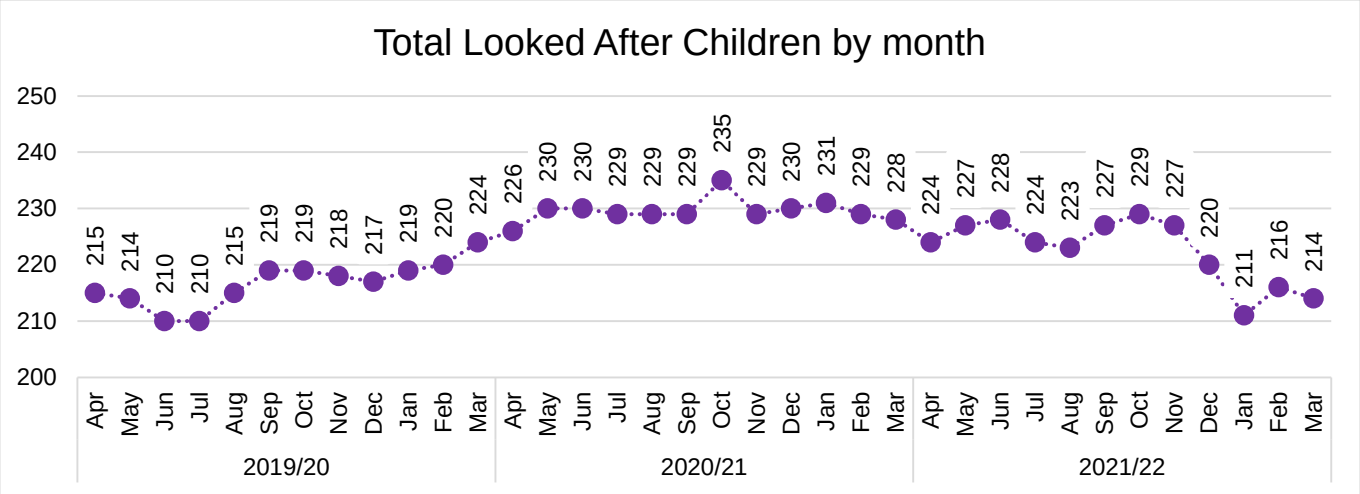
We have established a dedicated team to offer and deliver first appointments since October 2020 which is helping to reducing and maintain the referral to treatment time. Inverclyde CAMHS continue to meet the Referral to Treatment target of 18 weeks.We have seen a rise in urgent referrals with 30% of all new referrals being categorised as urgent with children and young people presenting as a risk to themselves in terms of their behaviours and mental health presentations (challenging behaviours, self-harm or suicidal behaviours, eating disorders, potential psychosis symptoms). All such referrals are responded to promptly and assessment of the risk and mental health carried out as soon as possible, within 24/48 hours of receipt of referral based on clinical need. This has also had a direct impact on Consultant Psychiatry time, as they often need Psychiatry assessment or medication intervention more quickly. As may be anticipated, this high volume of risky referrals, which often need allocated for further assessment and intervention immediately, does have a direct impact on waiting times for children and young people who have been assessed and added to the CAMHS waiting list for intervention, but do not need prioritised due to risk.

Despite the pressures on the service, we have continued to develop our staff with additional training in Cognitive Behavioural Therapy; CBT for eating disorders; family based treatment for eating disorders; Autism Diagnostic Observation Schedule assessment, allowing us to deliver a high standard of evidence based care. Our nursing team have set up a physical health monitoring clinic which has been extremely successful and reduces the need for physical monitoring to be done by GPs this monitoring system provides a more cohesive experience for children, young people and their families. A number of CAMHS staff are also central to the work being carried out with Skylark staff, Speech and Language Therapy, and Community

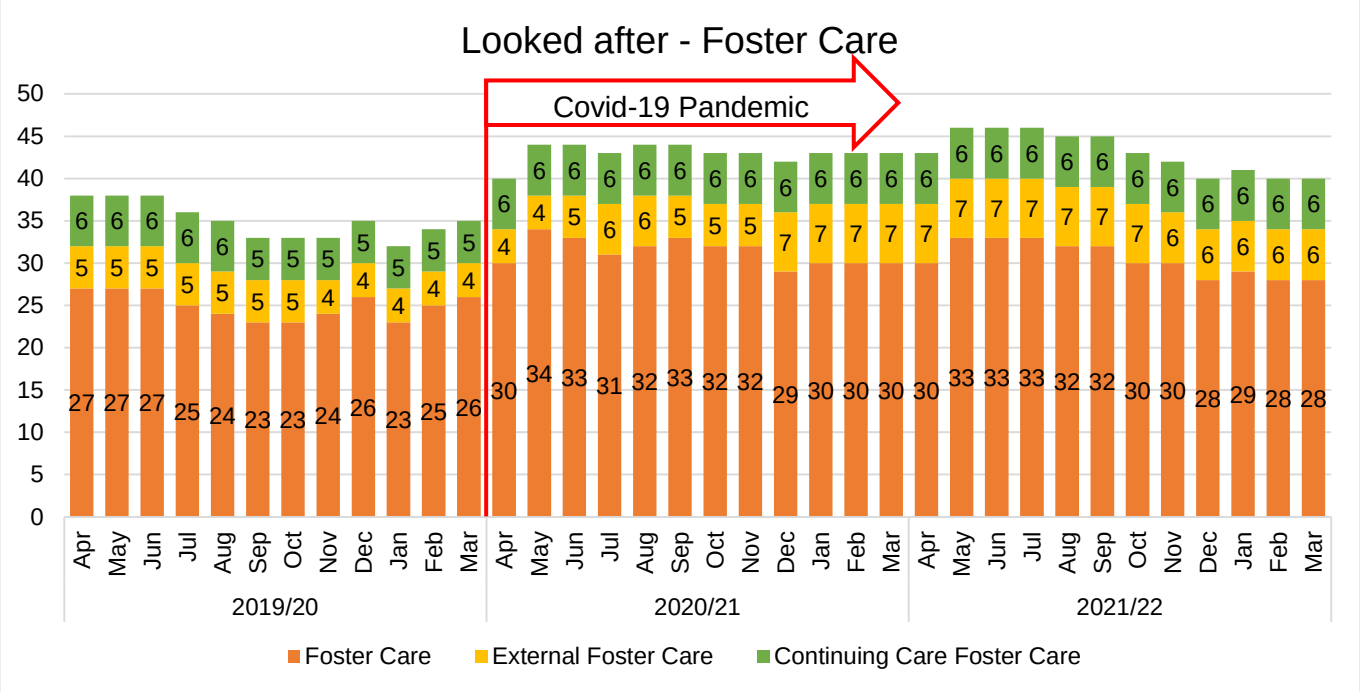
Paediatrics to develop and implement a new neurodevelopmental pathway for children and young people in Inverclyde.

Source: GG&C CIS (Central Information Centre)

Looked after Children



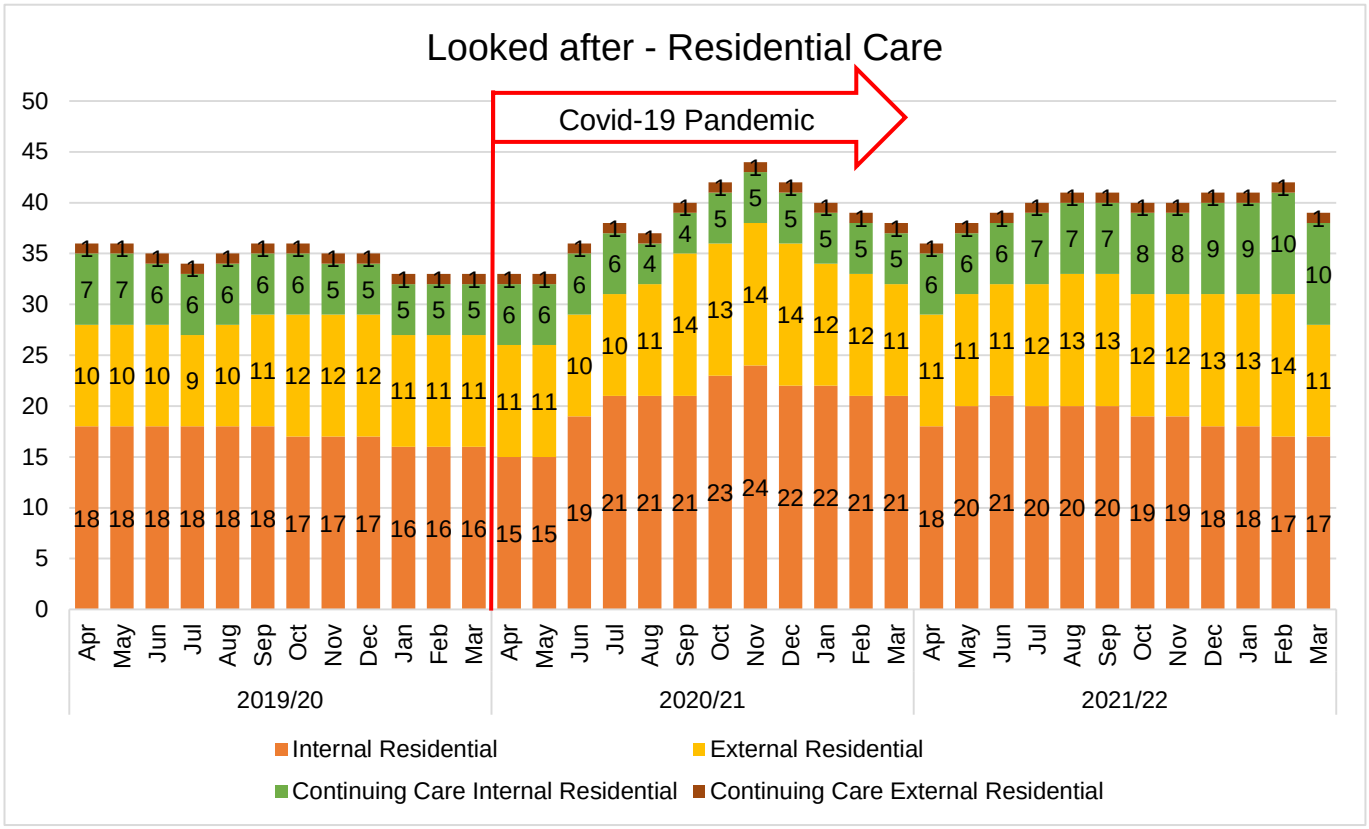
Source: Swift



Source: Swift

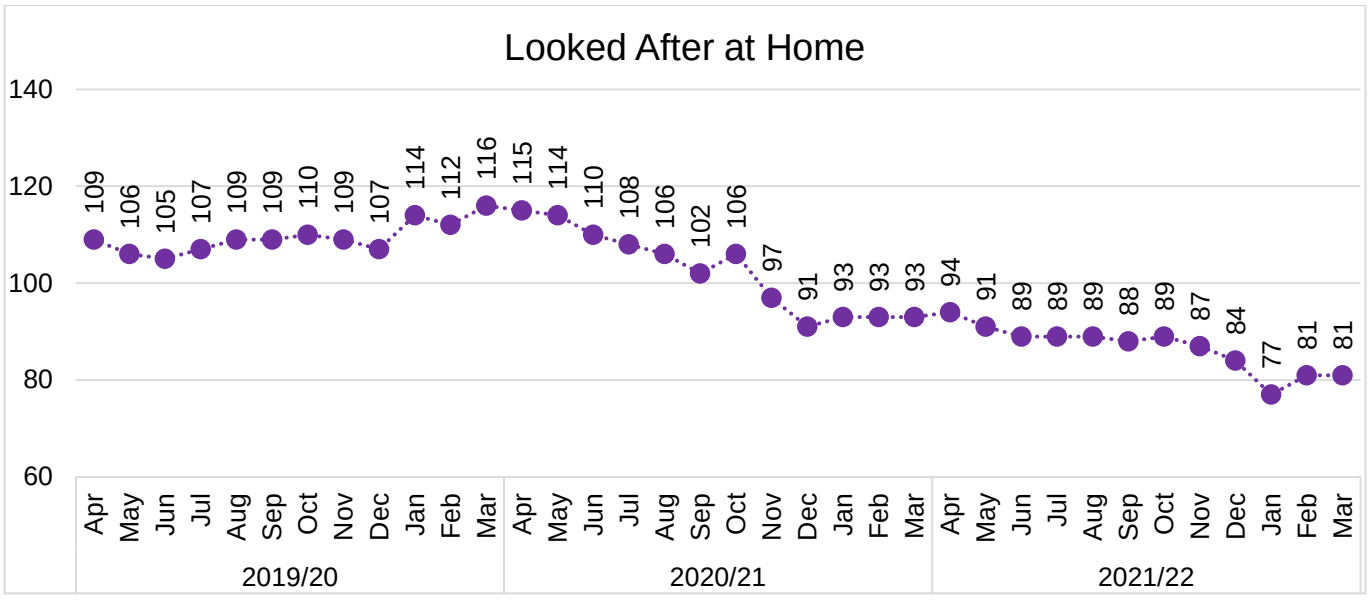
Foster Care placements have remained stable throughout the year and the majority of placements were with local carers. This included young people who remained with carers beyond their 16th birthday in continuing care placements and externally commissioned placements being long term placements for young people subject to permanence orders. The graph below details foster care placements and types.

There has not been considerable change in the number of looked after in Residential Care over the last 3 years. As with foster care, there are a number of young people who have remained in their placement beyond their 16th birthday. The graph below details the total number of young people split by residential care type.



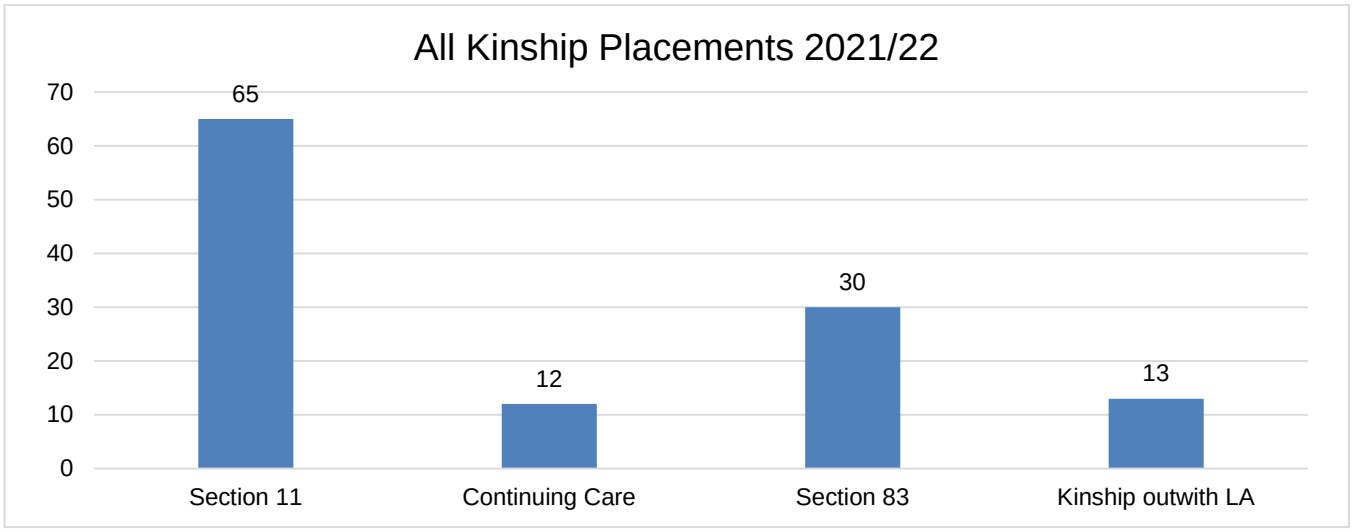
Source: Swift

The number of Looked after at Home figures have decreased recently, which reflect in the decrease of the total number of Looked After figures in the graph shown earlier.



Source: Swift

The graph below details Kinship Placement types with the highest number of young people being place on a Section 11 (residence order).

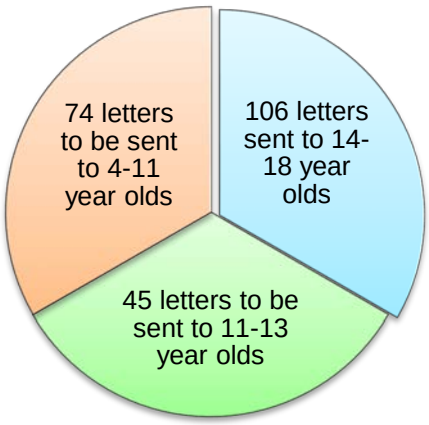


Source: Swift

I Promise

In the last quarter of 2021/22 we appointed a programme manager to our "I Promise" team. This is our response to the wide ranging system change and development that will be required over the next 10 years to realise the ambition of The Promise. Information gathering and initial developmental activities and consultation events have gathered pace since January 2022 and will continue throughout the year. I Promise is supported by 3rd sector partners locally.

106 letters have been distributed to Social Workers for young people who are currently subject to Compulsory Supervision Orders. We hope social workers will share these with young people in an effort to introduce the IPromise Team and encourage young people to meet in person or virtually to obtain their views in relation to their experience of what we do well and how as a service we can do better.



IPROMISE WORKFORCE ENGAGEMENTS

Voice

Listening to the workforce

183

colleagues from across the Inverclyde workforce who support our children and families have met to discuss what Inverclyde is doing well and what we need to do better.

The IPromise Team met with colleagues from a range of supports. Social workers, family nurses, home support, kinship workers, residential staff, education, and panel community to name a few.

Discussing The Promise and our local systems, practices, processes and culture Identifying where change is needed and what the workforce needs to thrive.

Identified themes for tests of change

- Family Time
- Family Group Decision Making
- Report Writing
- Language Matters
- Stigma
- Solution focused meetings
- Workforce support

Inverclyde Stop-Go Pledges

- Help me by helping my family
- Nothing about me without me
- Try to keep me where i am and support me for as long as needed
- Help people to understand me and my experiences
- Help me to understand what's happening and why

Big Action 3 - Together we will protect our population

We will reduce the risk of harm to everyone living in Inverclyde by delivering a robust public protection system with an emphasis on protecting the most vulnerable in our communities.

National Outcomes relating to this Big Action

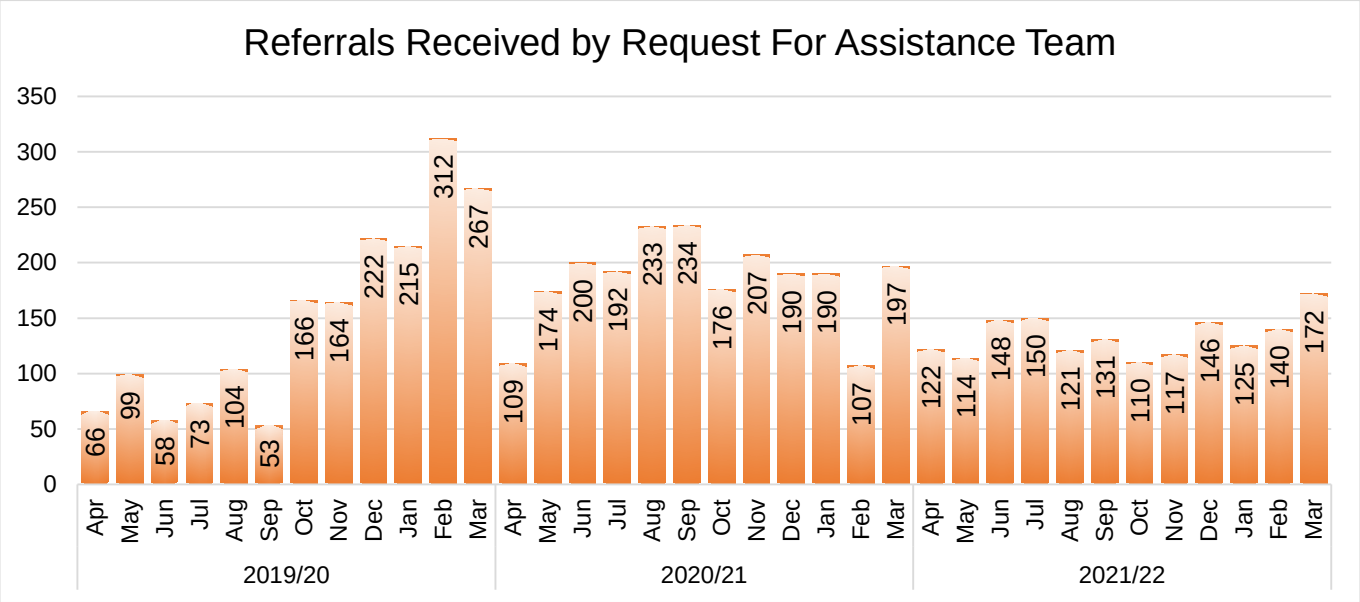
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
7	People using health and social care services are safe from harm
13	Community safety and public protection.
14	The reduction of reoffending.
15	Social inclusion to support desistance from offending.

Local Activity

Child Protection

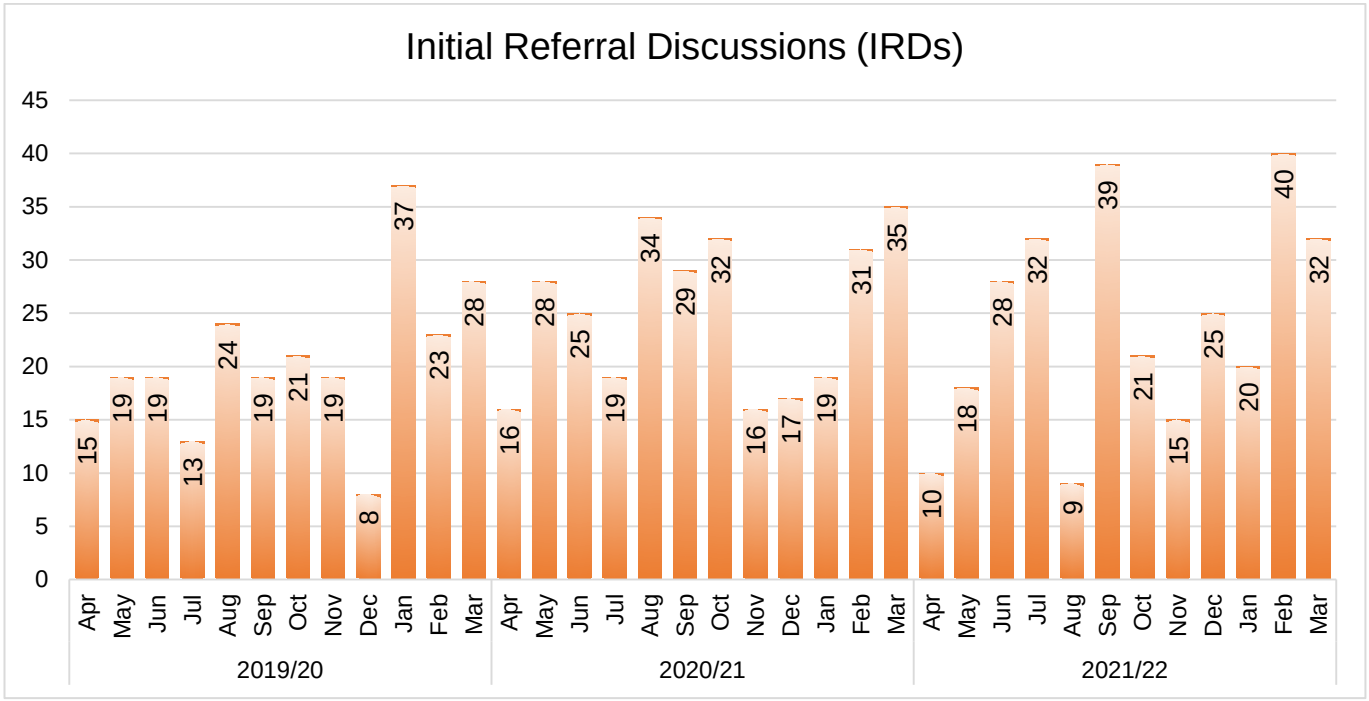
Initial referrals around Child Protection are made to the Request for Assistance Team (RFA). The chart below shows the referrals received by the RFA team for the last 3 years. Request for Assistance Referrals for 2021/22 have reduced and remained, on average, lowest since September 2020.

The graph below details referrals received for the last 3 years:



Source: Swift

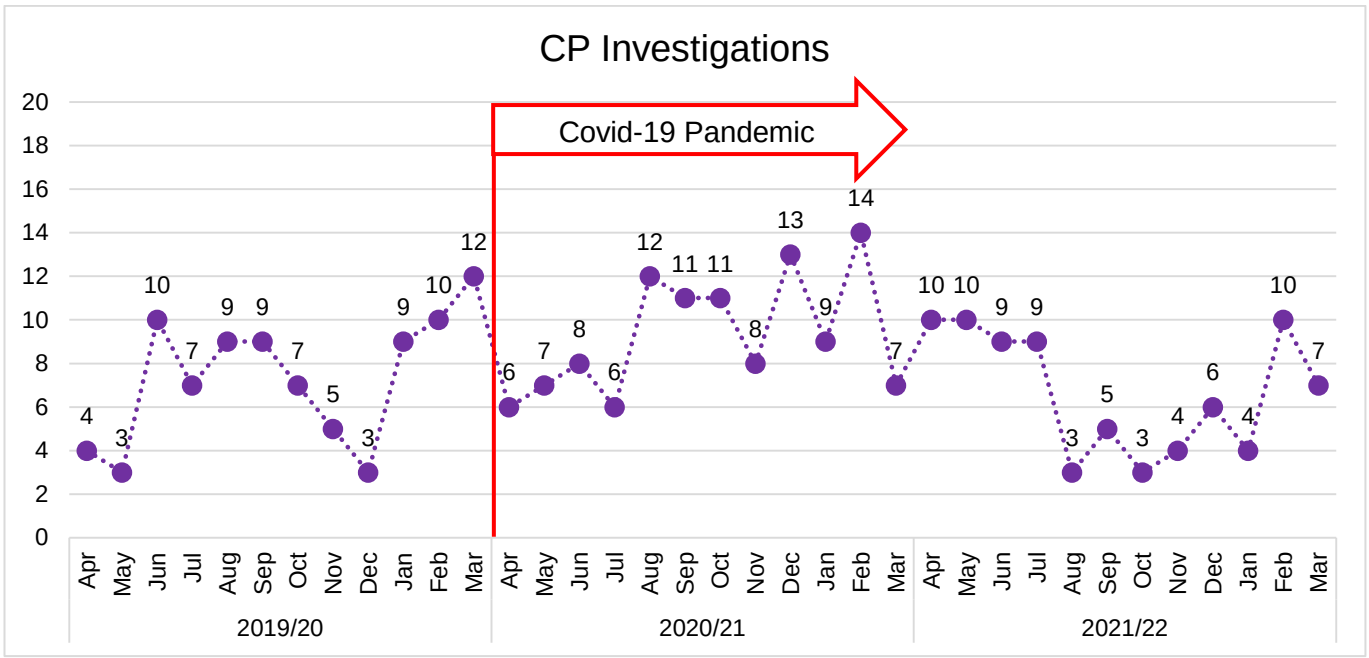
IRD's (Initial Referral Discussions)



Source: Swift

Child Protection Investigations

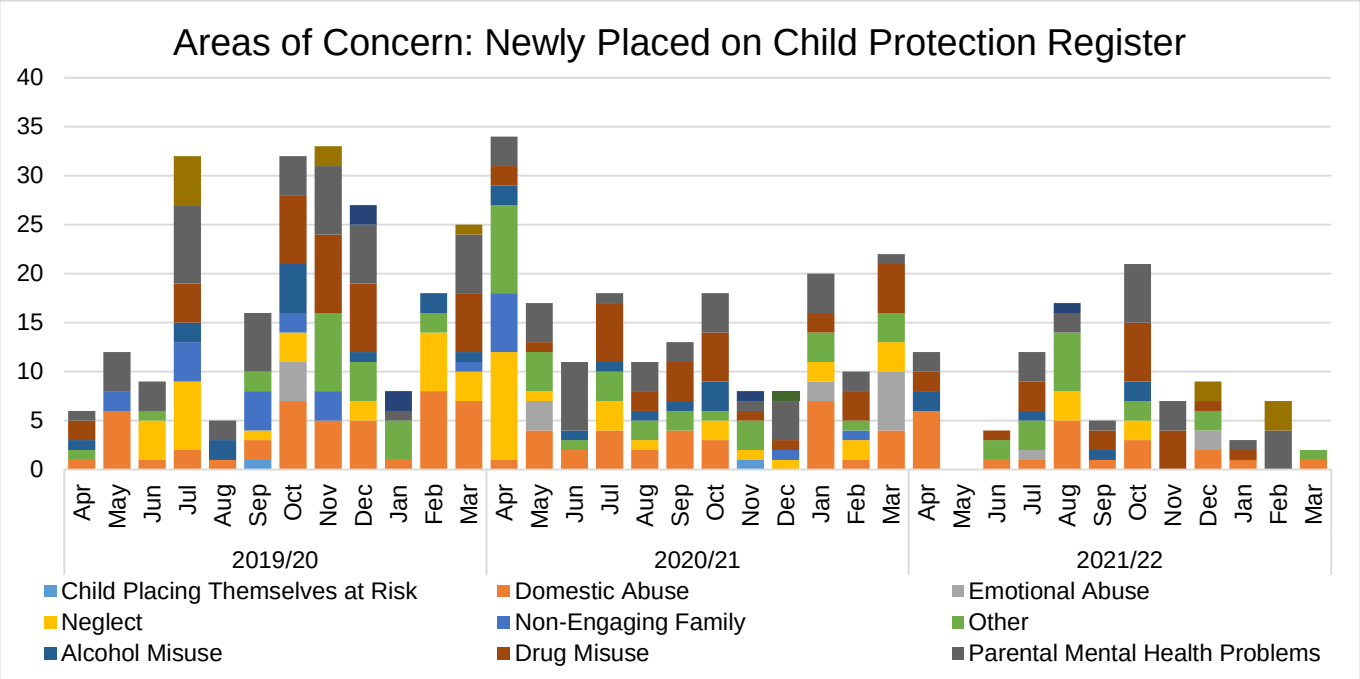
Where appropriate, an investigation is undertaken; the number of child protection investigations undertaken are shown in the chart below. Note: the figures below are Child Protection Investigations started within the month.



Source: Swift

Areas of concern

After an investigation a child may be placed on the child protection register; there are various reasons for this and sometimes multiple reasons are identified. The chart below highlights the main reasons for a child being added to the register.



Source: Swift

Scottish Child Interview Model – North Strathclyde Pilot

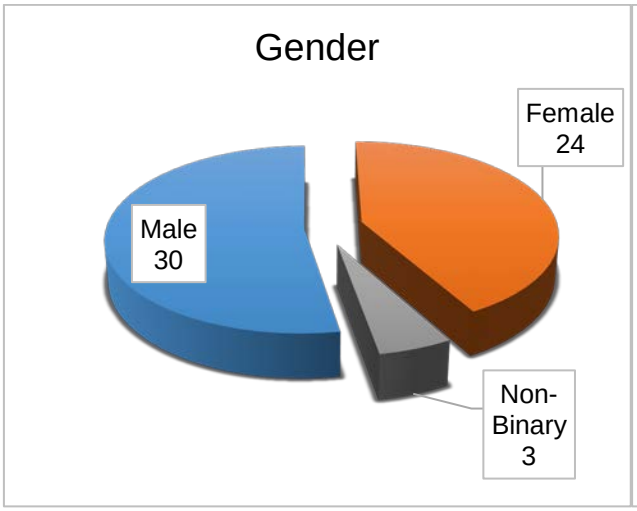
The North Strathclyde Project, using the Scottish Child Interview Model, is now completing its second operational year. This pilot was set up to be at the forefront of best practice when providing child-centred and trauma informed joint interviews within the judicial process for children and young people.

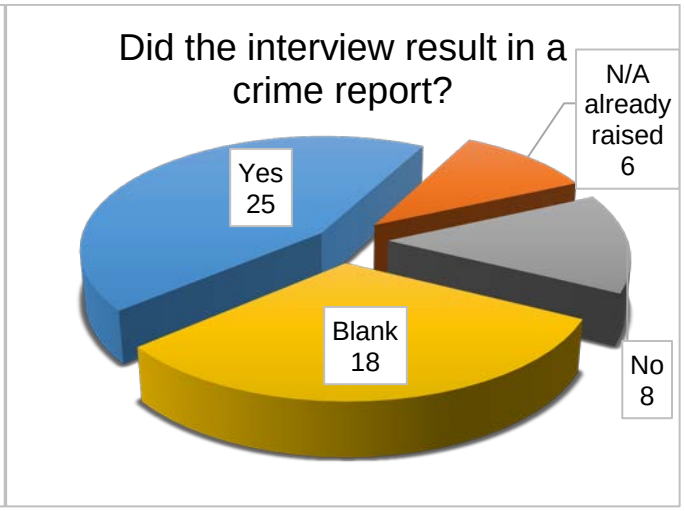
There continues to be close links between the 4 local authority areas, 2 police divisions and key stakeholders. The integrated team continues to influence best practice on the national forum with close links to the Barnahus Quality Standards. The next steps are towards the House for Healing and with Children's 1st building on the trauma informed and recovery support for those children and young people to provide a place and space that is child-centred.

As the North Strathclyde operation team is in its second year we continue to have rich data around the benefits of the model and the consistent approach to interviews being experienced by children and young people. We are seeking continuous improvement and learning from the evaluation work across stakeholders, including children and families.

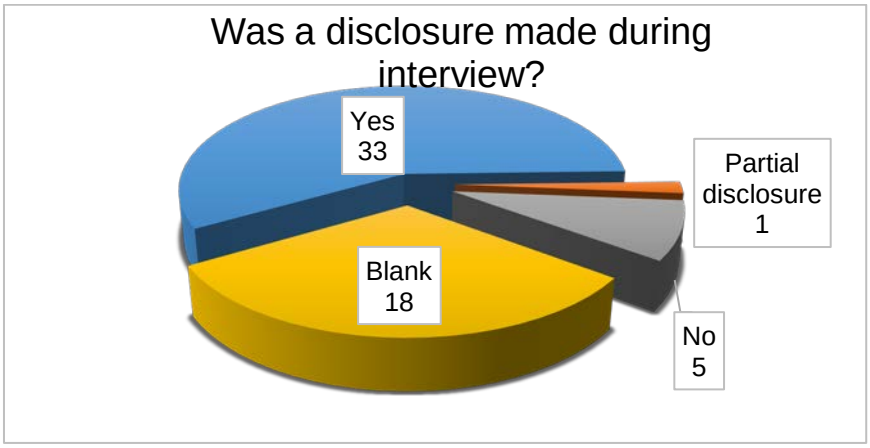
Children's 1st as the 3rd sector partner have also expanded their offer of therapeutic recovery workers, who can provide a continuation of support.

57 children were supported to attend a Joint Investigative Interview since August 2021, with ages ranging from 5-17, 60% of children were between the ages of 6-11.

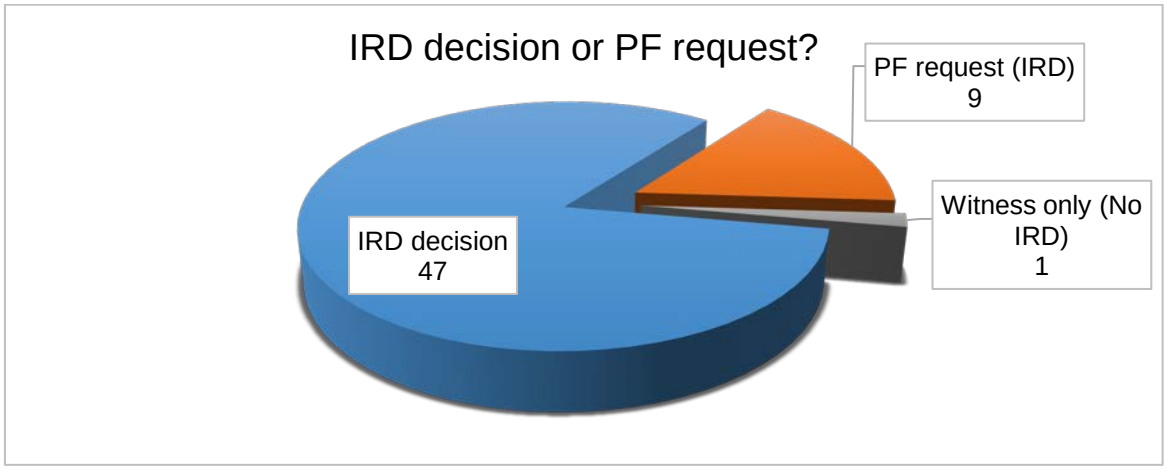




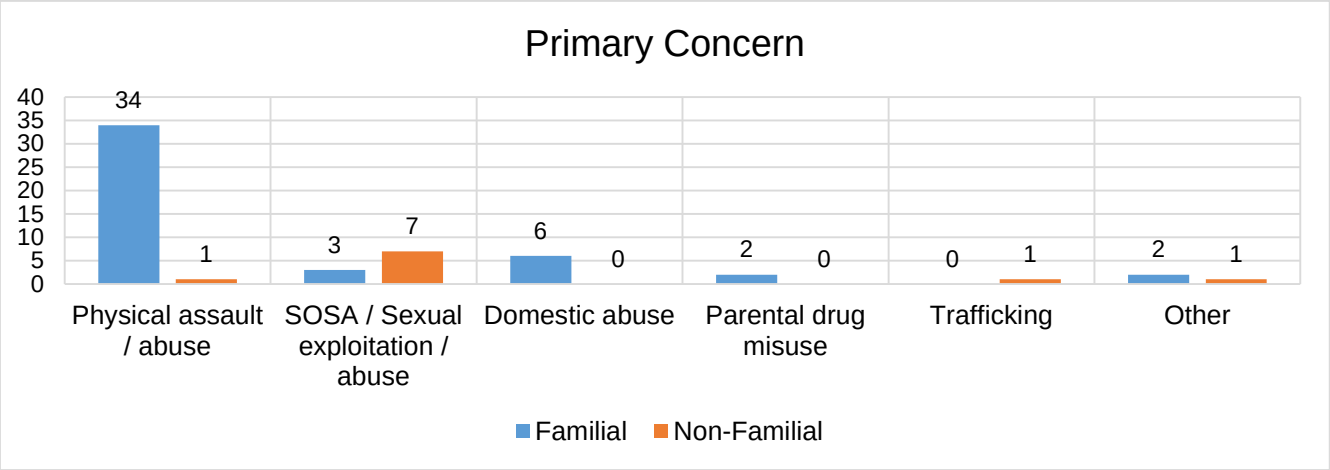
A total of 89% of interviews over the year resulted in a full or partial disclosure regarding the incident for which the child was participating in an interview.



Most Joint interviews have taken place following an IRD decision, the multi-agency meeting initiating Child Protection enquiries. Some interviews have been at the request of the Procurator Fiscal.



A significant number of referrals to the North Strathclyde partnership since August 2021 has been reflective of physical assault concerns, thereafter sexual offences and domestic abuse.



Protecting vulnerable adults

Adult Protection Inspection

In January 2021 the Care Inspectorate completed an adult protection inspection virtually which provided challenges for the inspection process in the midst of the pandemic.

Inverclyde was rated ‘good’ following this inspection. The Care Inspectorate raised that some adult protection risk assessments and chronologies were not on HSCP Adult Protection templates on Civica system. In addition evidence of application of the 3 point test in case notes and investigation reports was not explicit. This has now been addressed in terms of the implementation of the shared agency chronology and adult protection inquiry template on Civica System. The Inquiry template will improve the quality of evidencing the application of the 3 point test in case notes on Swift.

It was concluded that the partnerships key processes for adult support and protection were effective with areas of improvement. There were clear strengths supporting positive experiences and outcomes for adult at risk of harm, which collectively outweighed the areas of improvement.

Strengths

The partnership had taken positive steps to ensure there was improvements in the lives of adults subject to adult support and protection processes, and that they were safer because if the support and protection they received.

Effective communication, information sharing, collaboration and joint work were positive features of the partnership's response to adult support and protection work.

Staff from across the partnership were clear and confident about their responsibilities and protection roles.

Staff shared clear and well understood vision for adult support and protection.

There was a high degree of confidence amongst staff that strategic leaders, including the adult protection committee (APC) provided good leadership for adult support and protection work.

Priority areas for improvement

The partnership's practice standards and operating procedures need to be revised to ensure service managers apply a more consistent approach to adult support and protection chronology, risk assessment and protection planning work.

The partnership should review its key processes documentation and ensure it more accurately records the three-point test. The focus should be on screening inquiry, and investigation activity.

The partnership quality assurance performance framework should be further developed and more consistently applied to ensure a better understanding of results and the improvements required.

The chief officers group and adult protection committee should scrutinise quality assurance activity more robustly and ensure identified improvement work is carried out.

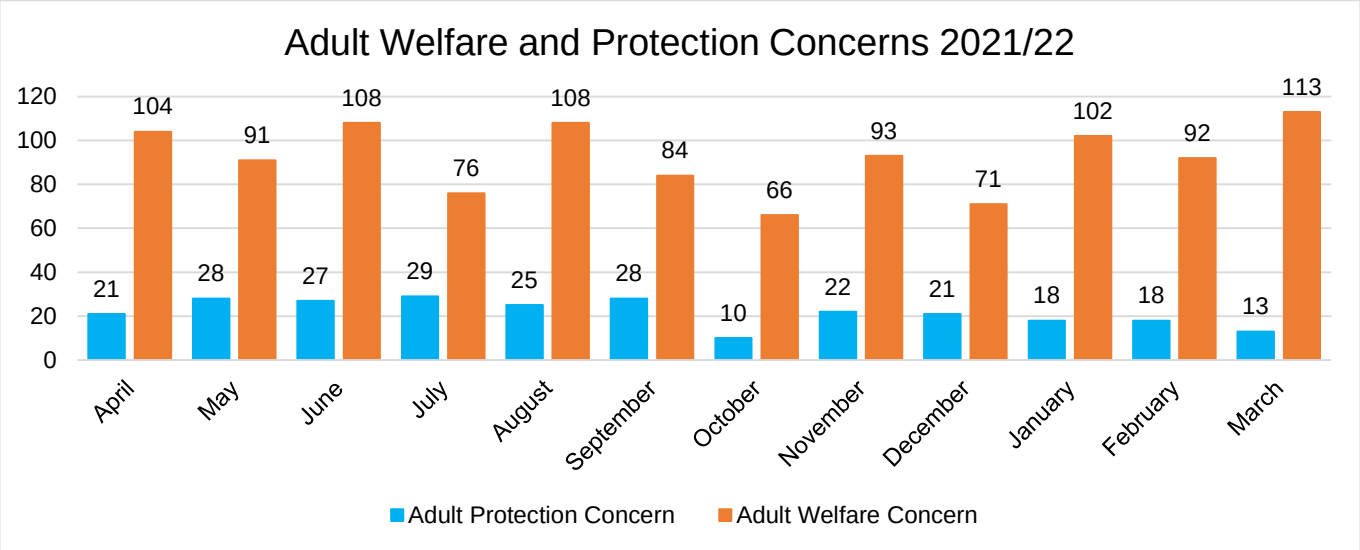
Adult Protection

For the financial year 2021/22 there were 260 adult protection referrals with the 5 year average being 222.2 a 17.46% increase. The numbers referred under the auspices of adult protection range from 9 to 29 per month.

The total number of adults referred under auspices of both adult protection and adult welfare has stabilised with a shift to more adults being referred under the auspices of adult protection.

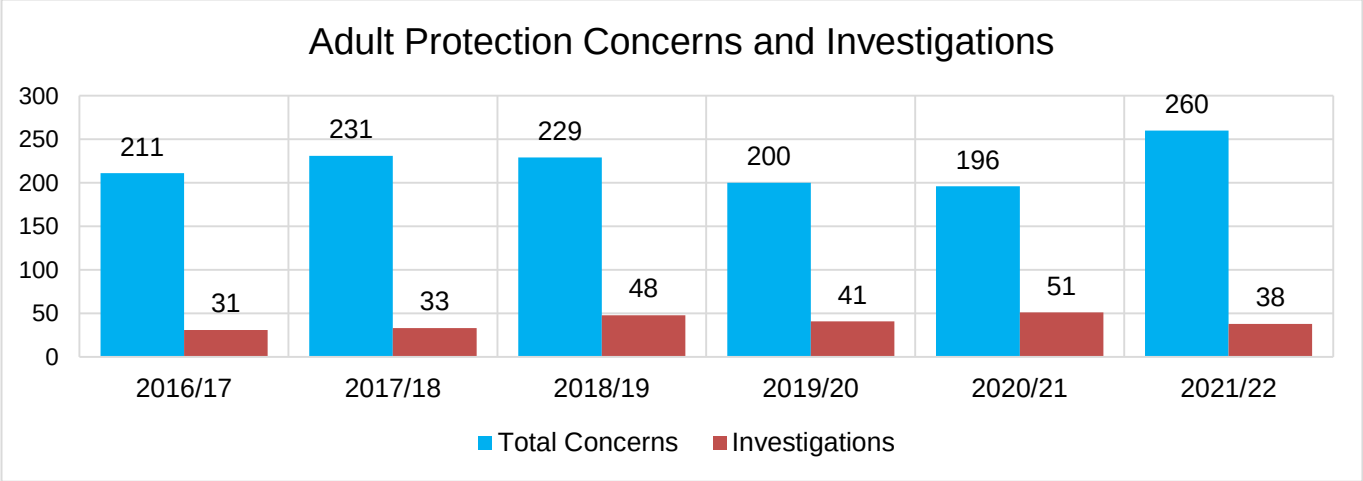
Changes to legislation, such as GDPR, and changes to systems; personnel; process and procedures; guidance; and training, all impact on considerations, including thresholds for referral. In addition a national or local focus on a particular type of harm or source of referral can also impact on the number of referrals made under the auspices of adult protection. Throughout the pandemic there is and has been a focus on adult protection and quality of care in care homes. For 2021/22 there is a 110% increase in the adult protection referrals made by care homes.

Existing good relationships have been built upon and work continues with local care homes to ensure they are supported by the HSCP. The emphasis has been on care homes sharing their adult protection concerns in order for appropriate advice, support and action to be determined and provided. The majority of referrals have not required to be progressed via the adult protection process.



Source: Swift

The numbers of investigations by financial year fluctuate. For last 5 years the number has ranged between 31 and 48 per annum. The average number of investigations carried out per annum over the last 5 years is 41.8. For financial year 2021/22 there have been 38 investigations and is within the per annum range.

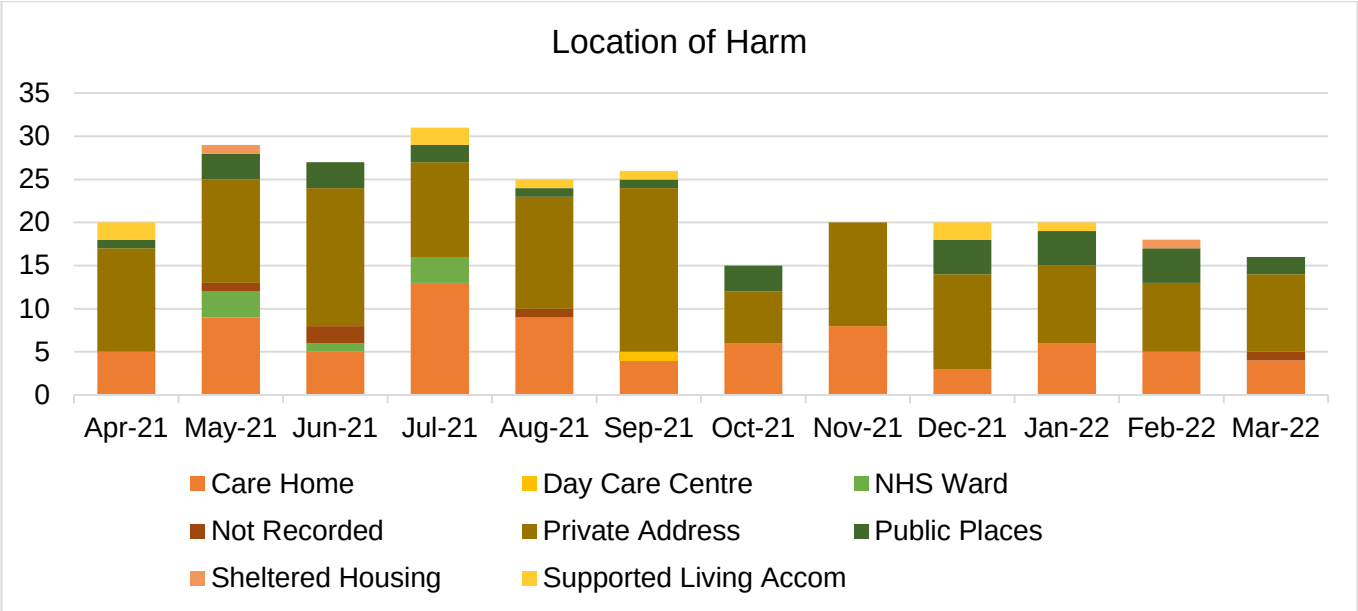


Source: Swift

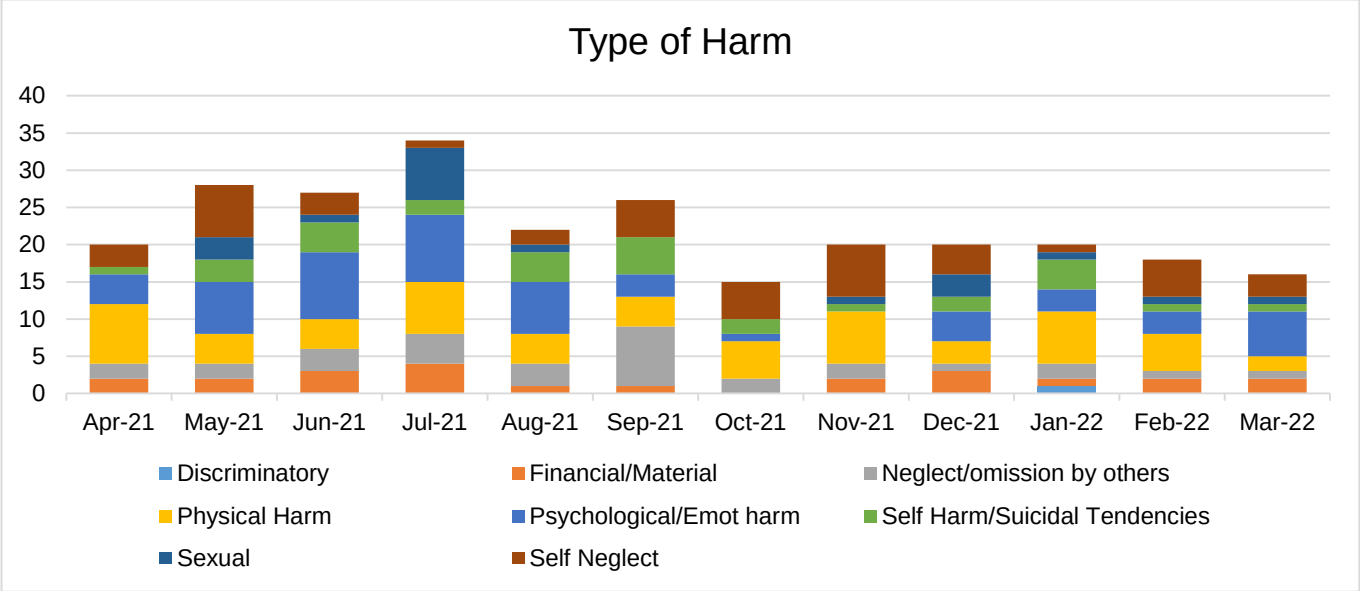
As in all previous years the most common location of harm is private address and from analysis, the greatest risk is from the people closest to them such as relatives (within and out with household), friends and current or former partners or spouses.

Only the principal category of harm can be reported for each investigation but it can be the case that more than one type of harm is applicable.

Since 2008 Physical and Financial Harm have been the highest category types reported with Psychological/Emotional Harm in most years being the third main category type. The impact of the pandemic is the most likely reason for the prevalence of this harm type. Police Scotland make the most referrals locally and nationally .There has been a 79.5% increase in referrals from Police Scotland in 2021/22 who are often responding to adults who are experiencing Psychological/Emotional Harm.



Source: Swift



Source: Swift

Most adults at risk of harm have comorbid conditions. The principle client categories recorded continue to remain unchanged over last 6 years:

- ✓ Alcohol Problems
- ✓ Dementing Illness
- ✓ Learning Disability
- ✓ Mental Health
- ✓ Physical Frailty
- ✓ Physical Disability

Criminal Justice Social Work Service

Inverclyde Community Justice Partnership

The Inverclyde Community Justice Partnership, chaired and hosted by Inverclyde Health and Social Care Partnership, continued to meet throughout 2021/2022 and was mainly focused on the progress of a new National Strategy for Community Justice and its impact on delivery within Inverclyde.

In order to better understand the impact stigma has on different groups in Inverclyde, the Community Justice Partnership led on a workshop at the Challenging Stigma Event 'Oor Bairns'. A number of participants had a rich knowledge in the community justice arena, providing a considerable insight into the stigma experienced by people involved with the justice system. Discussion centred on employability and the stigma that families also experience as a result of having a loved one in prison.

Community safety and public protection

The North Strathclyde MAPPA Unit is hosted by Inverclyde HSCP. It serves six Local Authorities, 3 Police Divisions and 2 Health Boards. The Unit organises MAPPA meetings for all level 2 and 3 individuals managed under the MAPPA arrangements. This brings together a number of staff from various services and agencies. The function of a MAPPA meeting is to create a Risk Management Plan to manage individuals who pose a risk of serious harm to their community These meetings are now hosted virtually and during 2022/23 the feasibility of moving to a hybrid model (where some agencies will have the option to attend in person) will be explored.

A key process in the management of individuals subject to MAPPA is the Environmental Risk Assessment (ERA) process. The purpose of the ERA is to identify any housing related risks associated with individuals living within the community or about to be released into the community. An individual can have more than one assessment completed, particularly where the focus is on identifying a manageable property following release from custody.

As part of the North Strathclyde MAPPA commitment to excellence a Case File Audit is conducted in each Local Authority area. This comprises of three cases reviewed twice yearly. All six Local Authorities were reviewed in 2021/2022 with 36 cases completed. No issues of concern were identified.

Strategic Needs and Strengths Assessment

Work has been undertaken during the reporting year to assist the Inverclyde Community Justice Partnership in the delivery of a Strategic Needs and Strengths Assessment to inform the

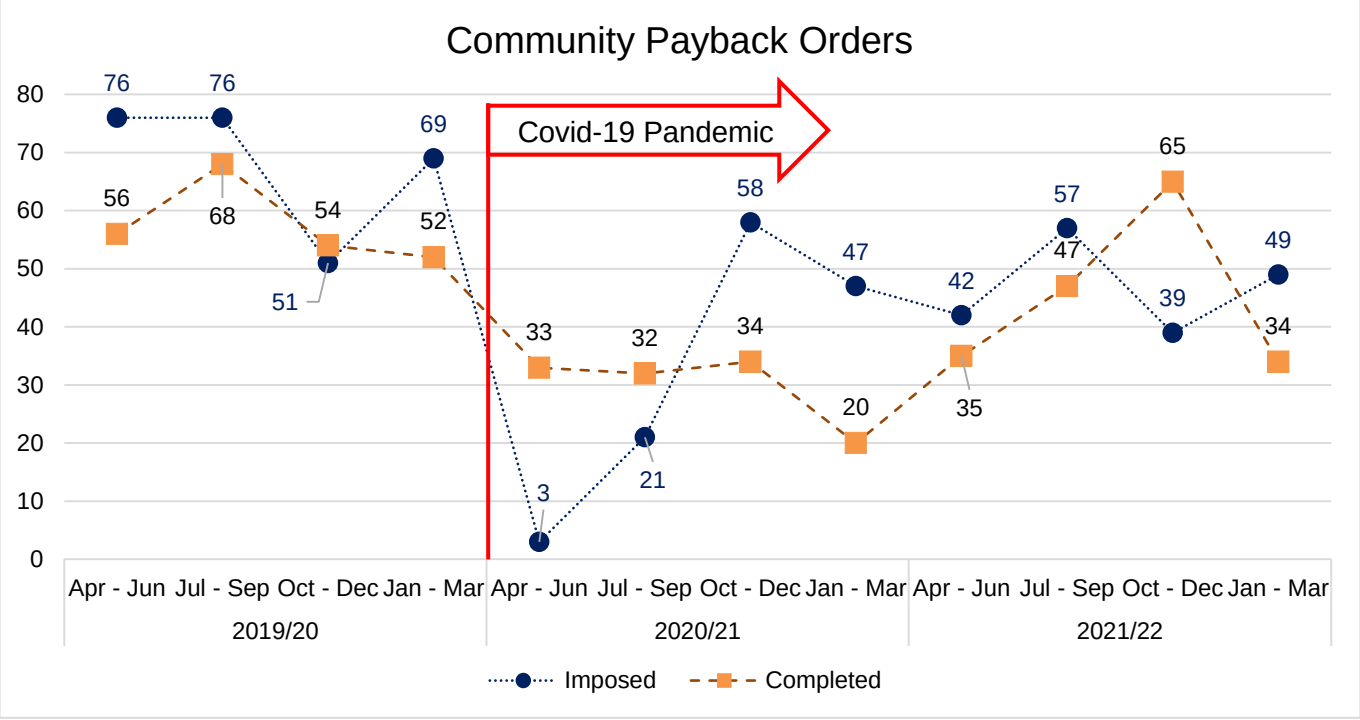
creation of an Inverclyde Community Justice Outcomes Improvement Plan (CJOIP) in April 2023. This document will pull together a range of data sets from nationally available data, to community planning priority action data, to aggregated data on specific needs/issues of Criminal Justice Social Work service users.

Early Action System Change- Women involved in the Criminal Justice System

Progress continued during 2021/2022 with regards to the Early Action System Change (Women involved in the Criminal Justice System). Phase one of the Project concluded in August 2021 with a Test of Change proposal which was informed by both women with lived/living experience of the Criminal Justice system and front line staff from both the statutory and third sectors with practical knowledge of supporting such women.

Community Based Sentencing Options

Effective community based sentencing options are essential in achieving the National Outcomes for Criminal Justice. Community Payback Orders (CPOs) were introduced in February 2011 and can consist of nine possible requirements, the most common of which is Unpaid Work and Supervision. These requirements can be made separately or combined into one CPO. In addition our community based Criminal Justice Social Work staff also supervise those released from custody on licence from Parole Board Scotland.



Source: Swift

Changes to legislation in 2022 introduced a tenth requirement; Restricted Movement Requirement. This can now be imposed at the point of initial sentencing where previously it was limited to individuals who were at risk of having their original community sentence breached. Preparatory work was undertaken during the reporting year by the Service in advance of its introduction across Scotland in May 2022.

Courts also have the option to place individuals on Structured Deferred Sentence (SDS), which is also provided by Criminal Justice Social Work. SDS aims to provide a structured intervention

for individuals upon conviction and prior to final sentencing. In so doing it can help individuals who have offended becoming further drawn into the justice system as well as address the underlying causes of their offending. This complements the range of credible community options available across Inverclyde and was introduced during the reporting year.

The case study below offers an example of how SDS has been used within Inverclyde to provide a person centred, proportionate response for an individual who was assessed as not requiring statutory supervision. This contributed to positive outcomes for the individual including improved overall wellbeing and a reduced risk of further offending.

B's story

Mr B was a mature individual who appeared before the Court as a first offender. He pled guilty to a domestic offence and a Criminal Justice Social Work Report was requested. The report writer assessed Mr B as being at low risk of further offending. Mr B exhibited appropriate victim empathy and, although he had been drunk at the time of the offence, did not appear to have significant issues with alcohol. It was identified that mental health issues, lack of confidence and social isolation were issues underlying the offence and the report writer recommended that these could be most appropriately dealt with by way of a structured deferred sentence (SDS).

The Court agreed to a SDS for an initial period of three months. Mr B met with his allocated Criminal Justice support worker weekly. It was recognised that he was an isolated individual lacking in confidence and the Criminal Justice support worker focused on developing an open and honest relationship with him.

Although alcohol was a factor in the offence, Mr B maintained that it was not a significant issue and was resistant to seeking specialist support in this area. As an alternative, he agreed to discuss his alcohol use with his allocated Criminal Justice support worker and for her to monitor his ongoing alcohol use.

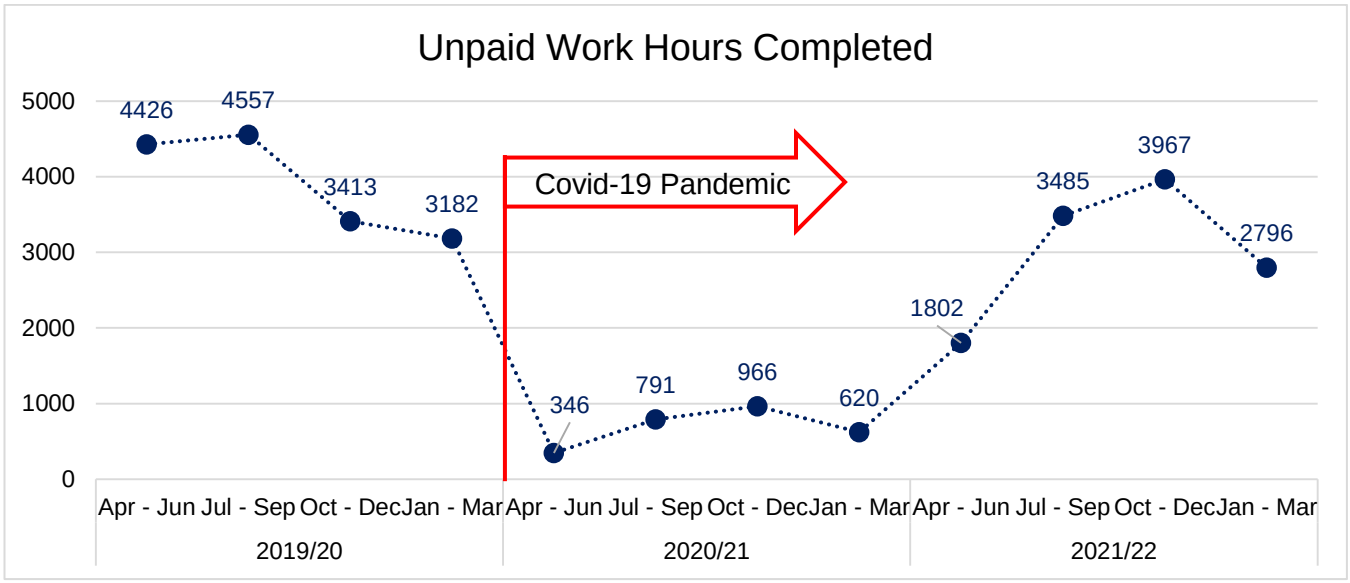
Mr B was supported to self-refer to mental health services, he was referred to a local counselling and therapy service and supported to attend a local community care forum.

By the end of the three month period, there was an overall improvement in Mr B's mood and mental health. He had been abstinent from alcohol throughout and intended to continue his engagement with the Community Care forum and mental health services (including the counselling and therapy service) voluntarily after completion of the SDS period, at which time a progress report was submitted to the Court. Mr B was nervous about attending Court for disposal, so his Criminal Justice support worker accompanied him.

The Sheriff considered the report from the Criminal Justice support worker and accepted that Mr B did not require further CJSW involvement and admonished him. Mr B went on to reconcile with his partner.

Unpaid Work

Throughout the reporting year our Unpaid Work Service had to work within a range of Covid-19 mitigation measures that have impacted on service delivery. A cautious approach was adopted to service recovery to ensure that in the event of any subsequent restrictions we had contingency plans to facilitate safe service delivery.



Source: Swift

The total number of hours of Unpaid Work completed in 2021/22 was 12,050, up 442% from last year (2,723) but still 22.6% below pre pandemic figure of 15,578 hours.

In May 2021 our outdoor projects resumed that had previously been assessed as being Covid-19 safe.

Initially the ratio of Unpaid Work supervisors to service users remained static at a maximum of 1:3, with only one project operating per day. However by the summer of 2021 the Service had begun to move forward from this with additional projects being opened up and our ratio of Unpaid Work supervisors to service users increasing where possible to our standard of 1:5.

Initial projects during spring and summer of the reporting period mirrored previous offers:

- ✓ Coves Reservoir Project – ongoing outdoor grounds work
- ✓ Devol Gardening Project – ongoing gardening project in conjunction with Inverclyde Shed
- ✓ Fitzgerald Centre Project – gardening, growing and other groundwork maintenance
- ✓ A local bowling club – repainting fences, gardening
- ✓ Walked Routes to School – many paths had become overgrown & slippery; cleared and cleaned.
- ✓ Vulnerable individuals – gardening etc.

The photos below highlight some of the work undertaken

Before			
After			

During the reporting year, the Service commissioned Action for Children (AfC) to provide Unpaid Work placements and other purposeful activity to young people aged 26 years and under. In addition to supporting these young people to complete their Unpaid Work hours the aim is to offer holistic support to help them with any barriers they are facing and in so doing help reduce further involvement with the justice system.

Additionally 35 industry specific qualifications were awarded in areas such as: Safety Awareness, Manual Handling, Use and Care of Hand Tools, Food Hygiene and Abrasive Wheels. Notably some young people completed more than 1 qualification. The rationale to these courses is to support our young people into employment opportunities across Inverclyde.

Unpaid Work Sub Group

Building on the work undertaken in 2020/2021 the Group has continued to support a variety of pieces of work during the reporting year including

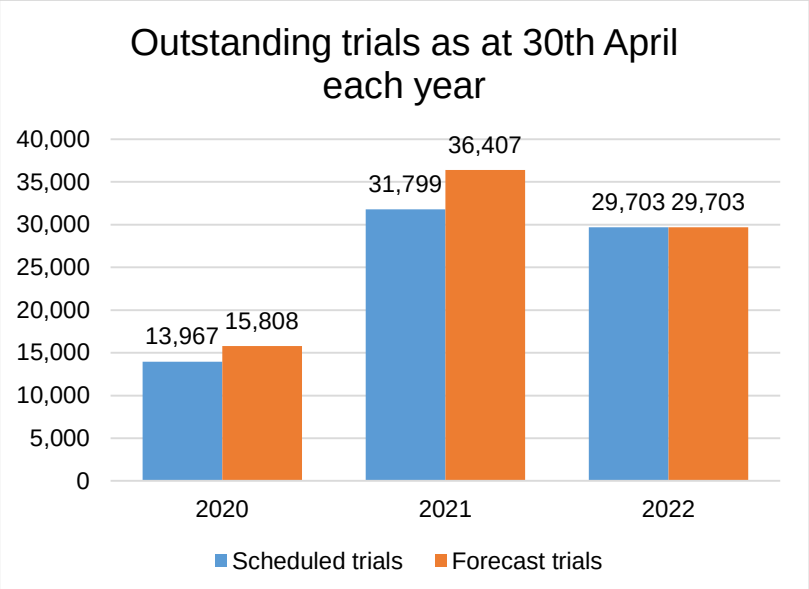
- ✓ Developed a referral pathway between Criminal Justice Social Work and Inverclyde Council Community Learning and Development (CLD)
- ✓ How Unpaid Work could support the diverse range of community groups and organisations across Inverclyde

Prison Based Social Work

Covid-19 has continued to impact on long term prisoners and their suitability for testing in the community in advance of their liberation. Acknowledging a need to have an offer for individuals, liaison across Inverclyde Prison based Social Work; Inverclyde community based Criminal Justice Social Work and staff from Scottish Prison Service, has ensured that individuals can travel to Inverclyde in advance of their liberation. This enables individuals to meet with their allocated community based Criminal Justice Social Worker who will also be able to facilitate connections with any service providers who will support them on

Justice Social Work Covid-19 recovery

The Service is aware that the Covid-19 pandemic still has a significant impact on Sheriff Court Business with the number of outstanding trials siting at nearly double the amount it was pre-pandemic. To provide context the trials scheduled against the forecast scheduled trials in April 2020, 2021 and 2022 is as follows



The above indicates that as the Courts continue to recover there is the potential for a knock on effect for Criminal Justice Social Work that could without careful planning overwhelm the Service which will also be on its own recovery journey. The ongoing support of the Inverclyde Community Justice Partnership will be critical to such planning, particularly in relation to the Unpaid Work Subgroup which could help to bolster capacity with regard to UPW placements and support transitions.

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

We will enable people to live as independently as possible & ensure people can live at home or in a homely setting including people who are experiencing homelessness, enhancing their quality of life by supporting independence for everyone

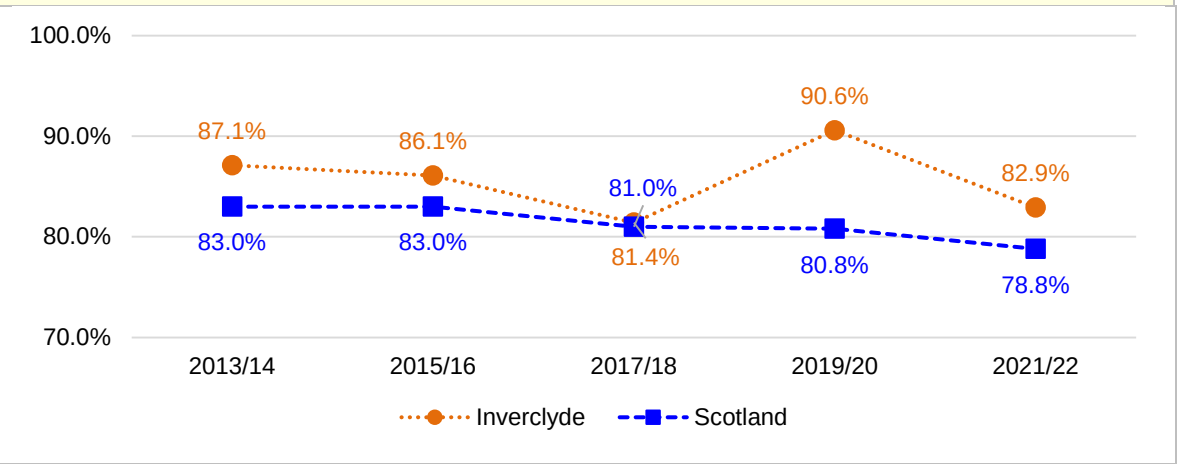
National Outcomes relating to this Big Action

1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
6	People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
7	People using health and social care services are safe from harm

National Integration Indicators

2

I was supported to live as independently as possible



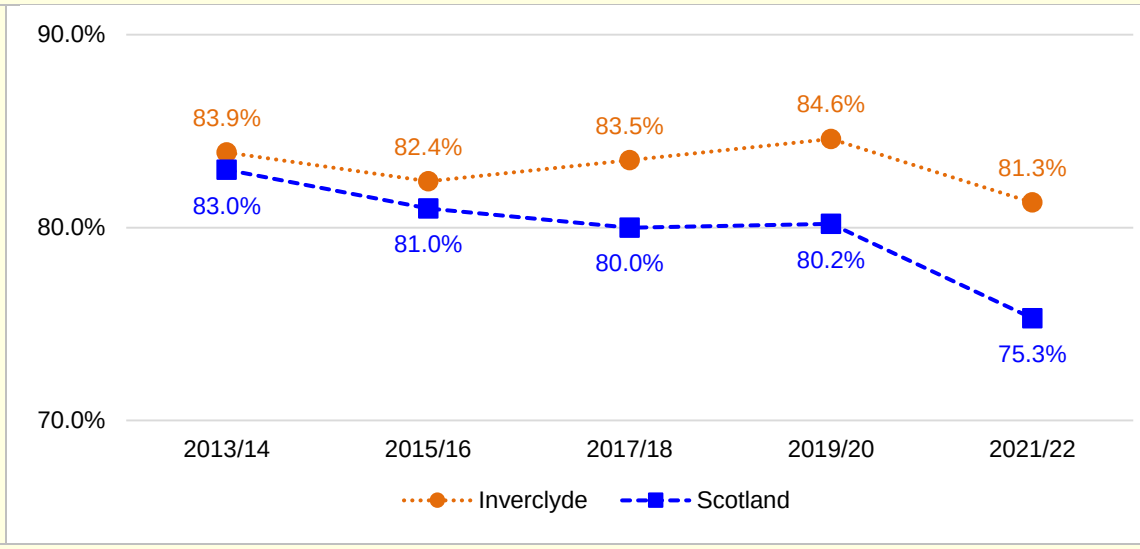
Our 2019/20 performance improved significantly with our Home 1st Reablement approach however the recruitment pressure within community has impacted on service levels.

Source: PHS

	2013/14	2015/16	2017/18	2019/20	2021/22
Total responses	184	195	147	284	152
Number agreed	160	168	120	257	126

5

Adults receiving any care or support who rated it as excellent or good



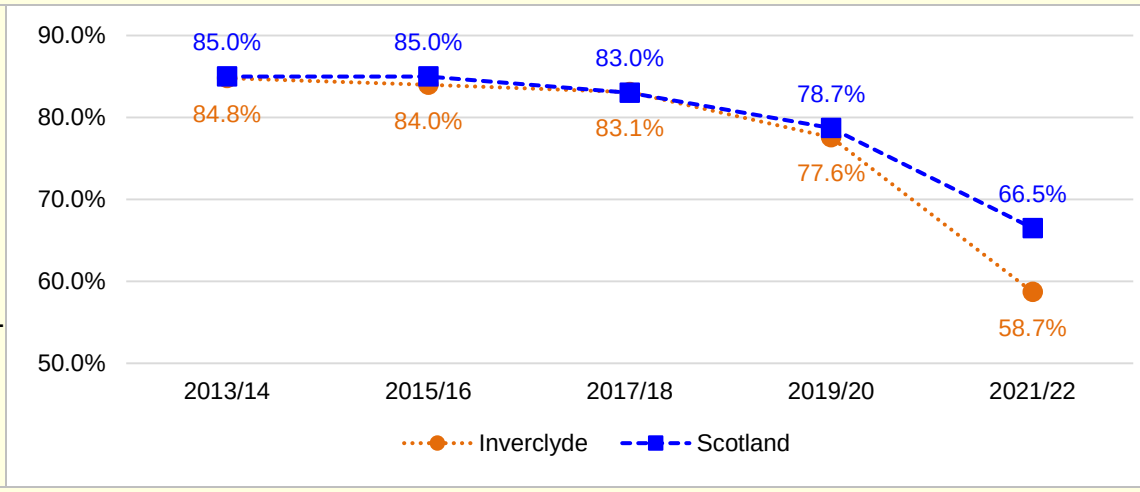
We have been able to maintain higher rankings than the national average however the impact of Covid-19 will have affected the quality of service.

Source: PHS

	2013/14	2015/16	2017/18	2019/20	2021/22
Total responses	204	214	154	306	169
Number agreed	171	176	129	259	137

6

Percentage of people with positive experience of the care provided by their GP practice



The overall positive experience of GP surgeries is down but this is a pattern replicated across Scotland and mostly relates to perceived access to the service and the impacts of Covid-19. The survey does show that the questions regarding the clinical care provided by doctors and nurses scoring remains high.

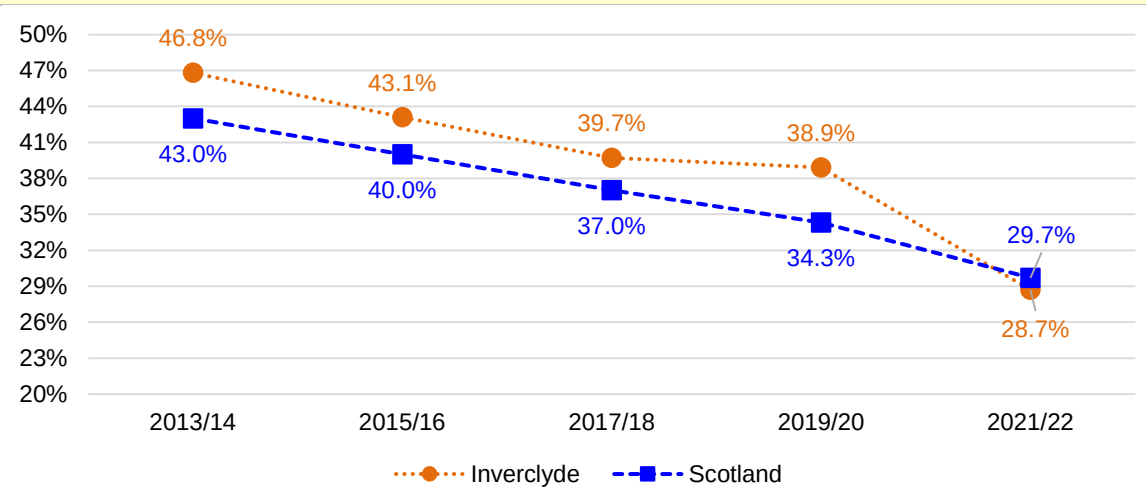
Source: PHS

	2013/14	2015/16	2017/18	2019/20	2021/22
Total responses	1661	1785	1698	2135	1468
Number agreed	1409	1499	1411	1657	862

8

I feel supported to continue caring

Higher figures = Better performance



The increase in support needs has impacted on service capacity to meet demand which has been exacerbated by the impact of Covid-19. Inverclyde HSCP recognises the importance of unpaid carers and will continue to support them.

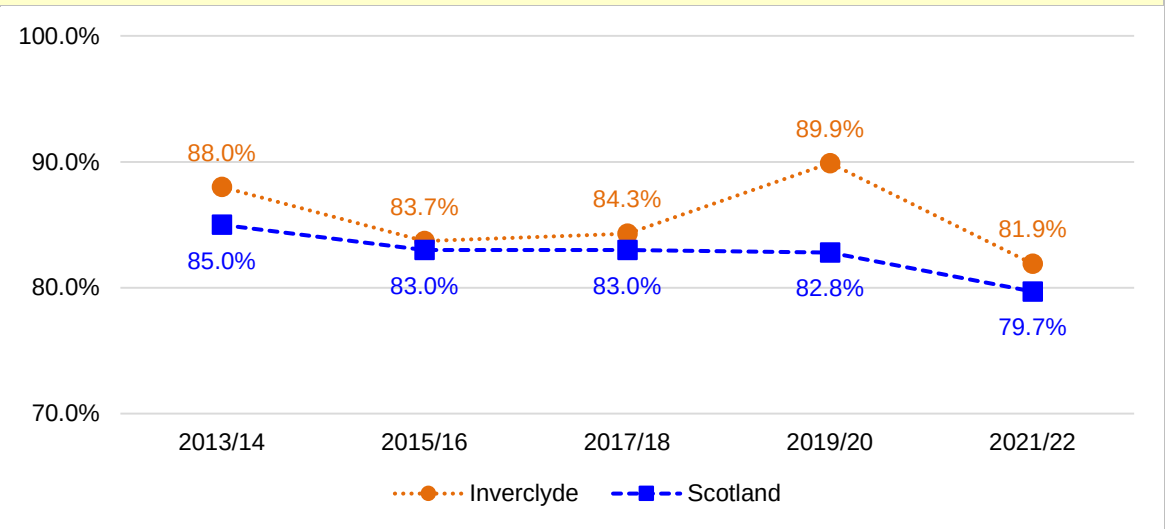
Source: PHS

	2013/14	2015/16	2017/18	2019/20	2021/22
Total responses	283	291	336	368	309
Number agreed	132	125	133	143	89

9

Adults supported at home who agreed they felt safe

Higher figures = Better performance



The impact nationally and locally of Covid-19 on services can be seen on how adults receiving support feel safe

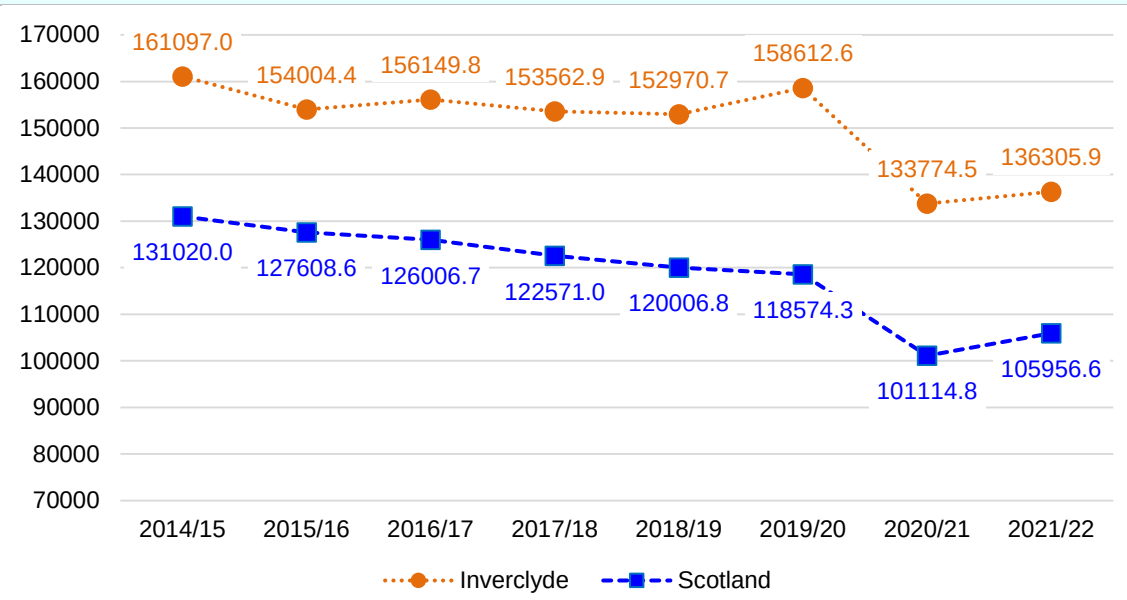
Source: PHS

	2013/14	2015/16	2017/18	2019/20	2021/22
Total responses	182	195	146	280	153
Number agreed	160	163	123	252	125

13

Emergency bed day rate (per 100,000 population)

Lower figures = Better performance



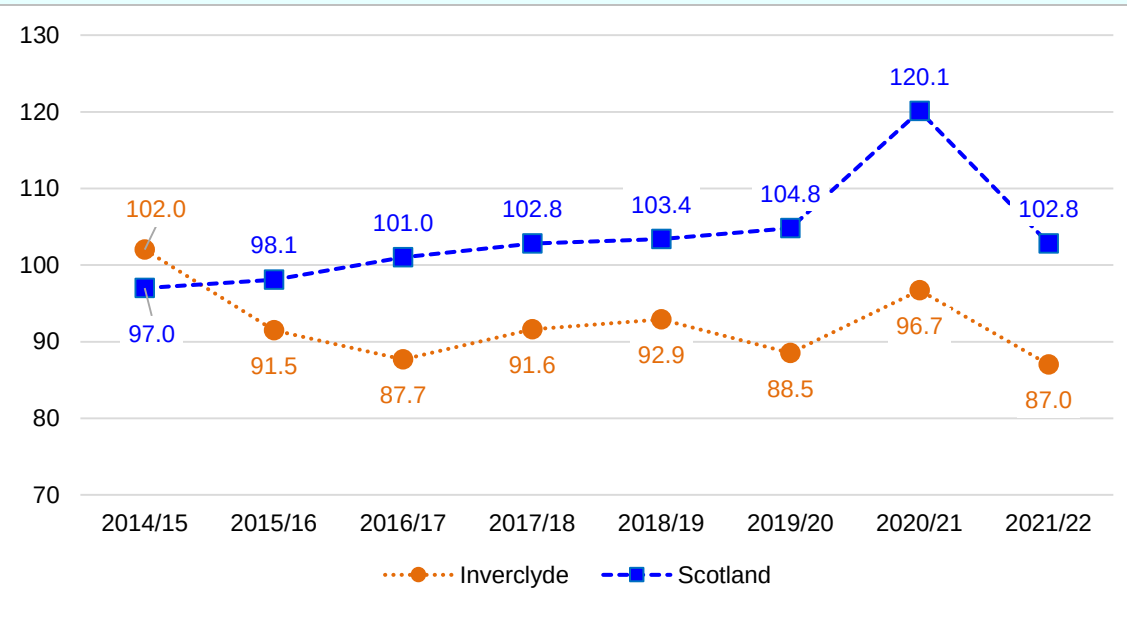
Local performance remained relatively static, however, a significant drop in the rate can be seen for 2020. Some of this will be due to our work in this area including targeting long term conditions and the impact of Covid 19.

*see note 1 Source: PHS

14

Readmission to hospital within 28 days (per 1,000 population)

Lower figures = Better performance



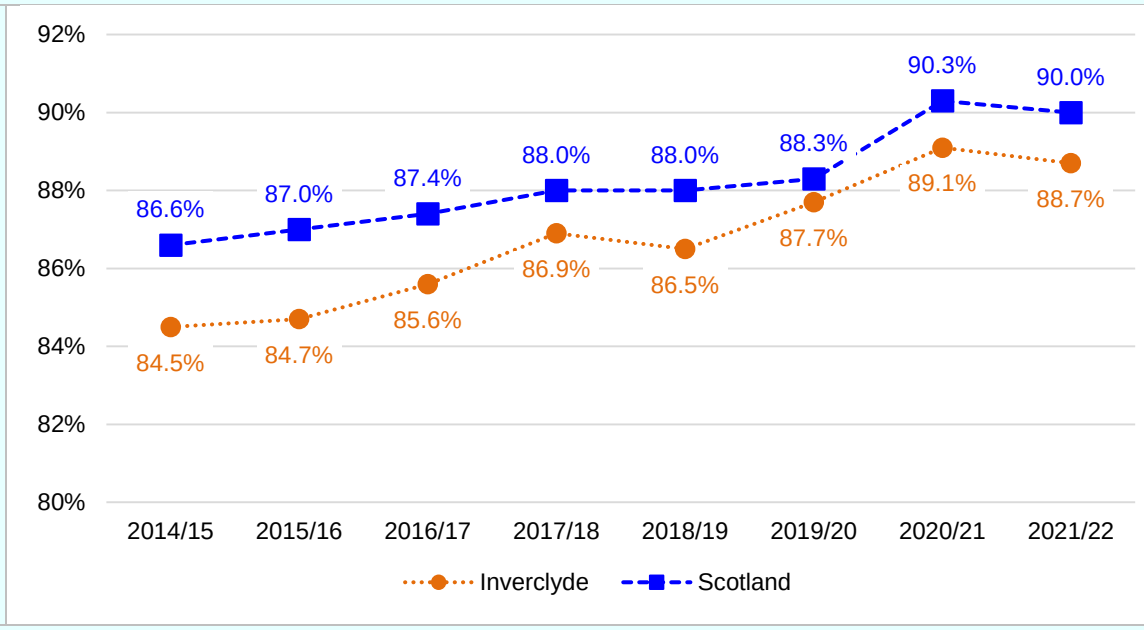
Inverclyde performance has improved and is better than the national picture. This is due to the Home 1st Approach and the intention to getting discharge right first time.

*see note 1 Source: PHS

15

Proportion of last 6 months of life spent at home or in a community setting

Higher figures = Better performance



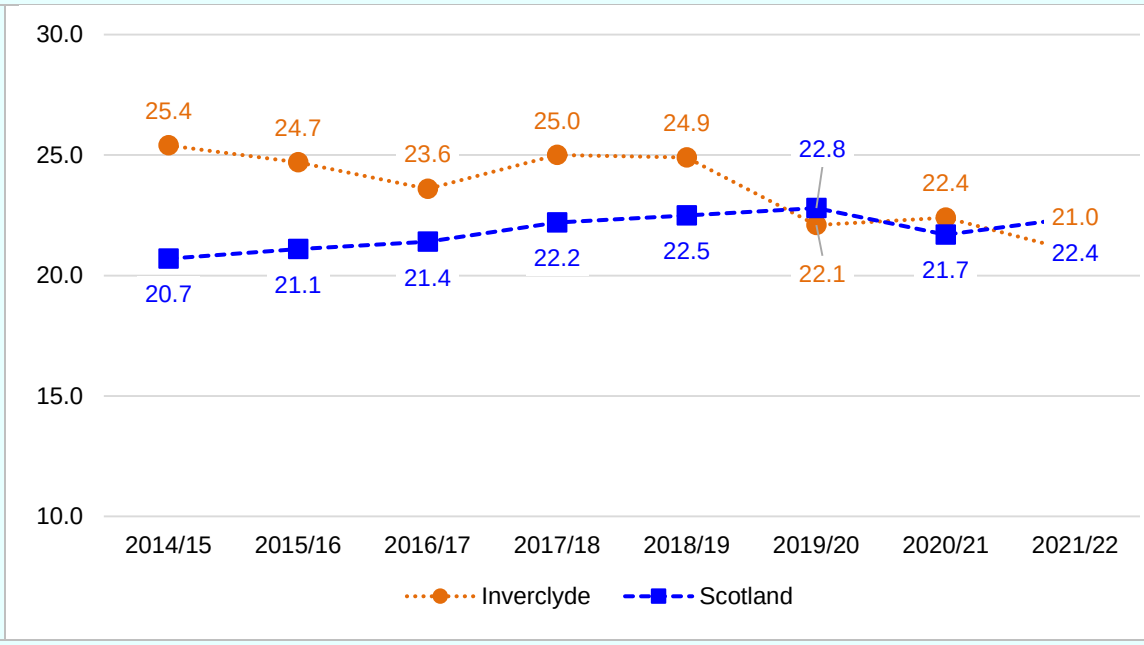
Local performance has continued to improve and we are now only slightly below the Scottish average.

*see note 1 Source: PHS

16

Falls rate per 1,000 population aged 65+

Lower figures = Better performance



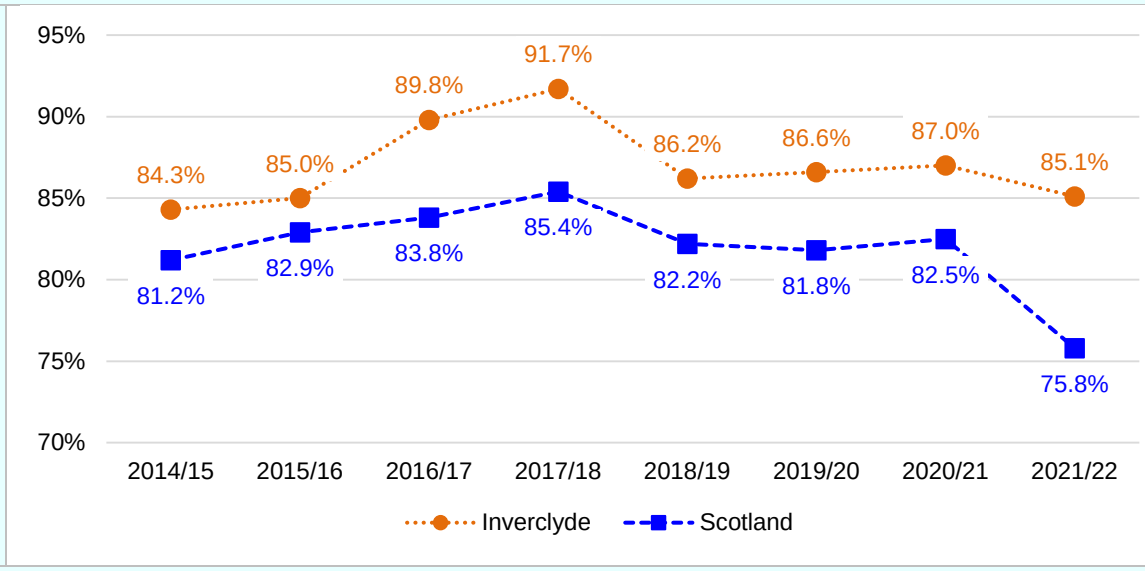
We saw some small improvements in reducing the rate of falls in our older population up to 2018/19. After introducing additional measures in 2019/20 we then saw a notable improvement.

*see note 1 Source: PHS

17

Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

Higher figures = Better performance



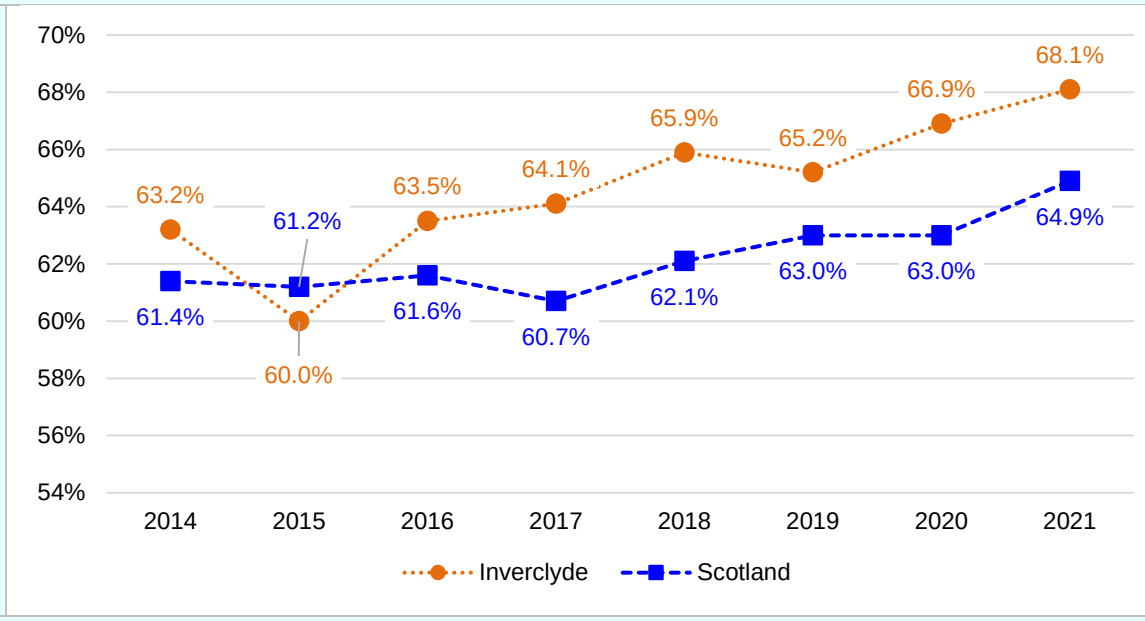
Even though our performance dropped from a high of 91.7%, we continue to do well and this reflects the strong partnership working between HSCP and our local care provider organisations.

Source: PHS

18

Percentage of adults with intensive care needs receiving care at home

Higher figures = Better performance



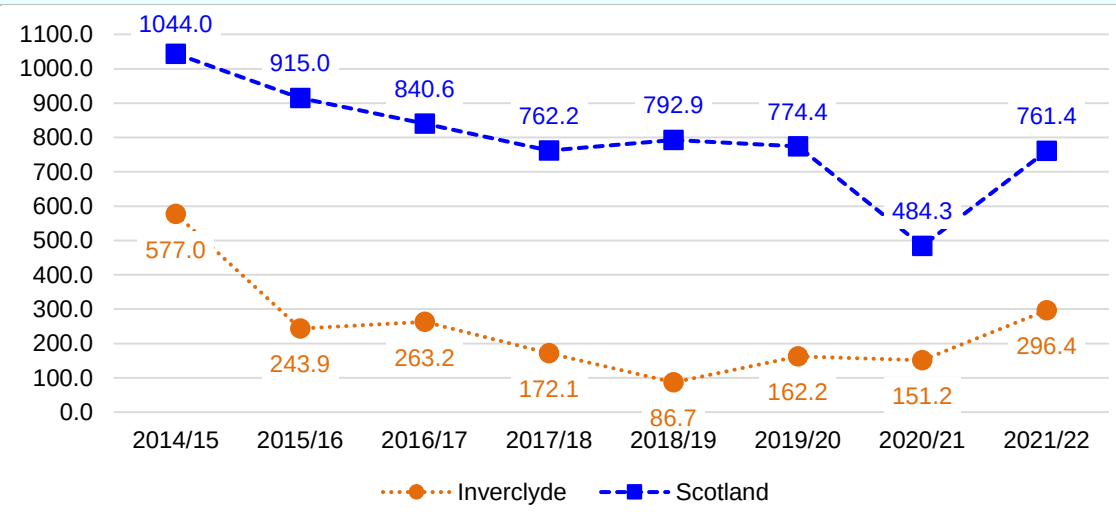
We have seen a sustained improvement in performance and we aim to further increase this.

Source: PHS

19

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

Lower figures = Better performance



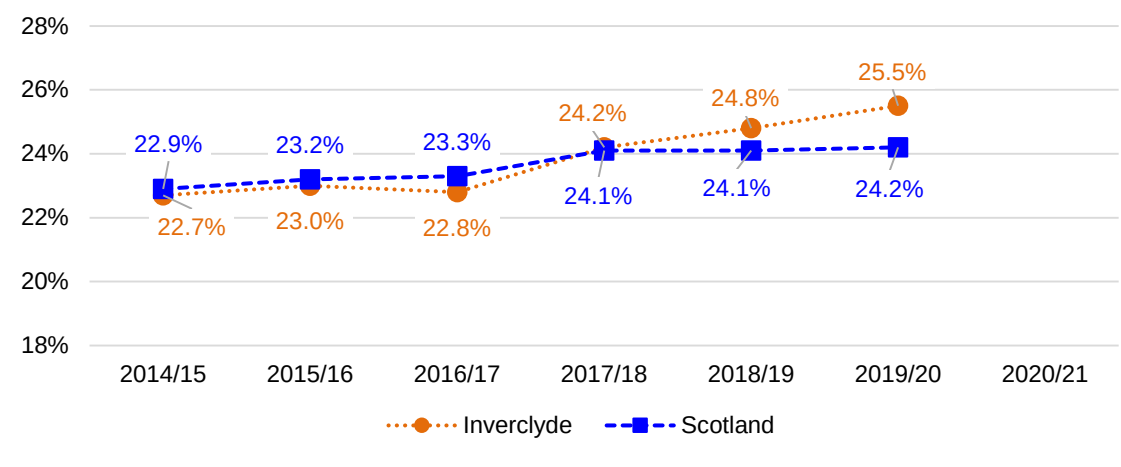
Inverclyde performance on delayed discharge is regularly the best in Scotland and significantly better than the Scottish average.

Source: PHS

20

Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency

Lower figures = Better performance



Performance has remained fairly consistent both locally & nationally with only minor changes over the last few years.

Source: PHS

PHS recommend that Integration Authorities do not report any time period for indicator 20 beyond 2019/20 within their 2021/22 APRs. NHS Boards were not able to provide detailed cost information for 2020/21 due to changes in service delivery during the pandemic.

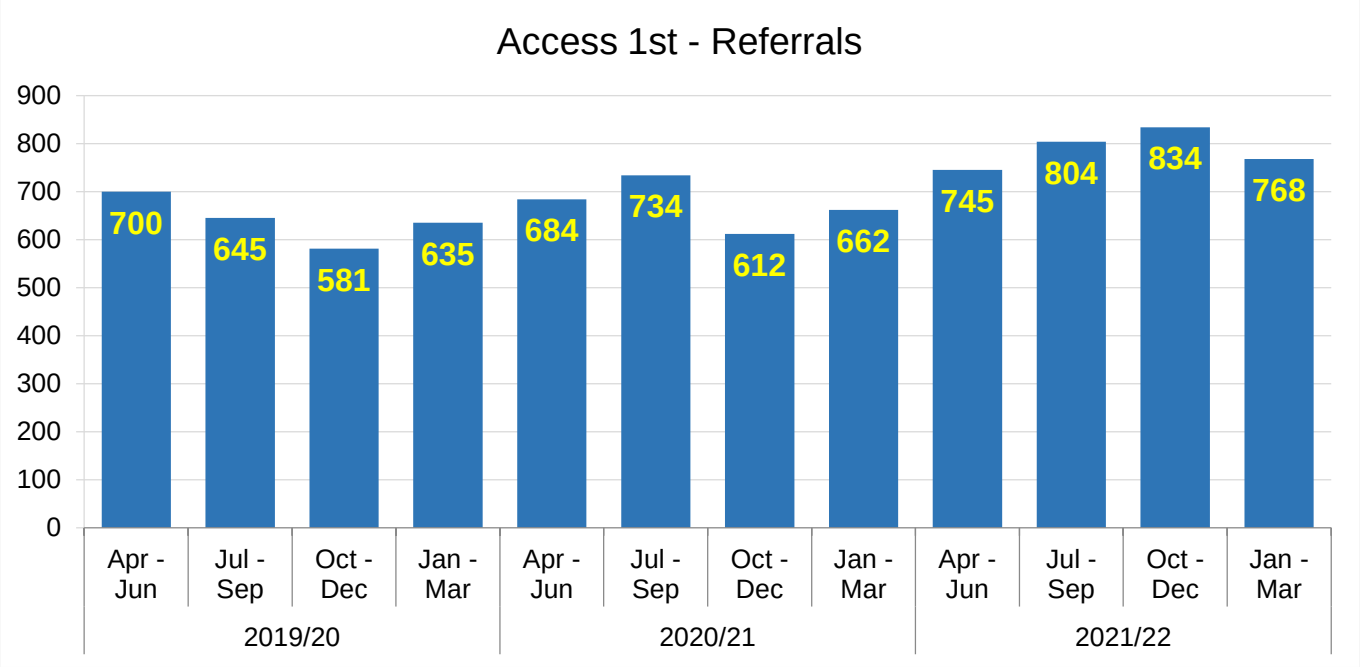
Note 1: Please note that the figures for 2021/22 are provisional and subject to change.

Local Activity

Access 1st

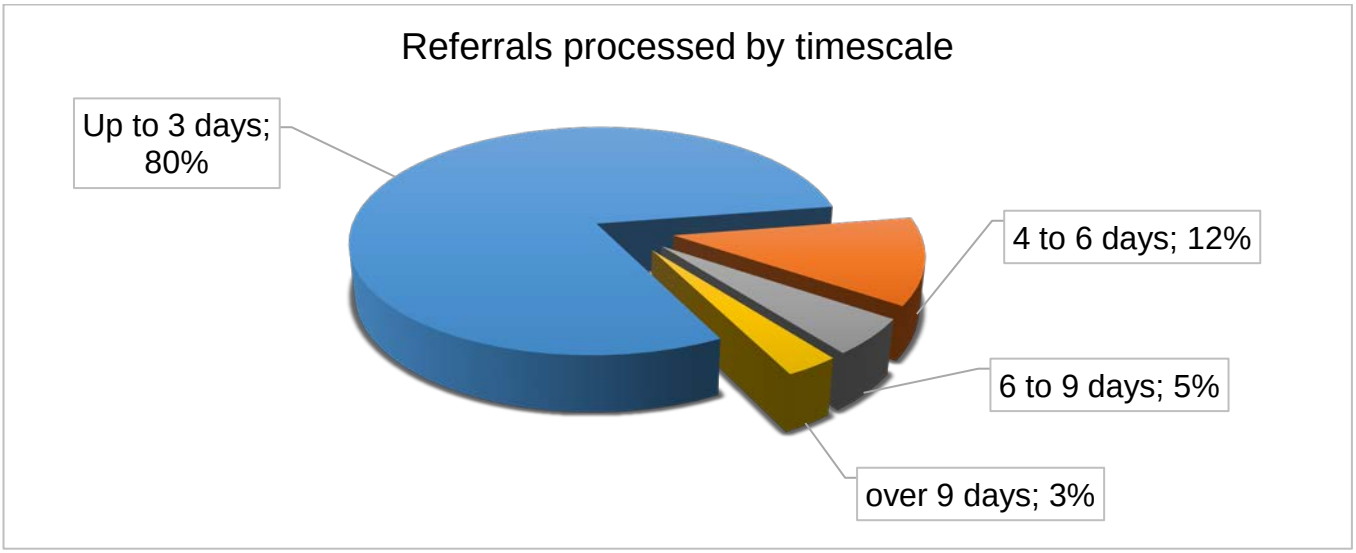
Since its implementation in January 2019, Access 1st has continued to deliver the single point of access to Inverclyde Health and Community Care Services.

In the 2021/22 reporting period Access 1st received 3151 referrals and key performance indicators were established to monitor the length of time taken for processing referrals.



Source: Swift

As the chart below indicates, the majority of the referrals received (80%) were processed within 3 days. However 3% of referrals took over 9 days to complete, these were predominately due to Access 1st being unable to contact the referrer or awaiting information from a service to enable a response.



Source: Swift

The Access 1st approach to screening and responding to new referrals, has reduced the operational demand on individual teams to better focus on more complex levels of need.

Home 1st

The established partnership with acute around Home 1st continued to deliver successful discharge planning during the pandemic. The established Discharge Hub at IRH ensured quality work continued with safe discharges reducing pressure on acute services and ensuring people were cared for in a safe environment of their choice.

Delayed discharges

Inverclyde HSCP has a recent history of good performance in terms of discharges from hospital in ensuring vulnerable adults and older people return to their own home or a home like setting. Across Scotland the Covid-19 pandemic had a huge impact on hospital discharge performance. Inverclyde maintained a high level of performance and was best performing partnership in terms of reducing Bed Days Lost for patients over 75 years of age.

Further information on unscheduled care is covered under the MSG section.

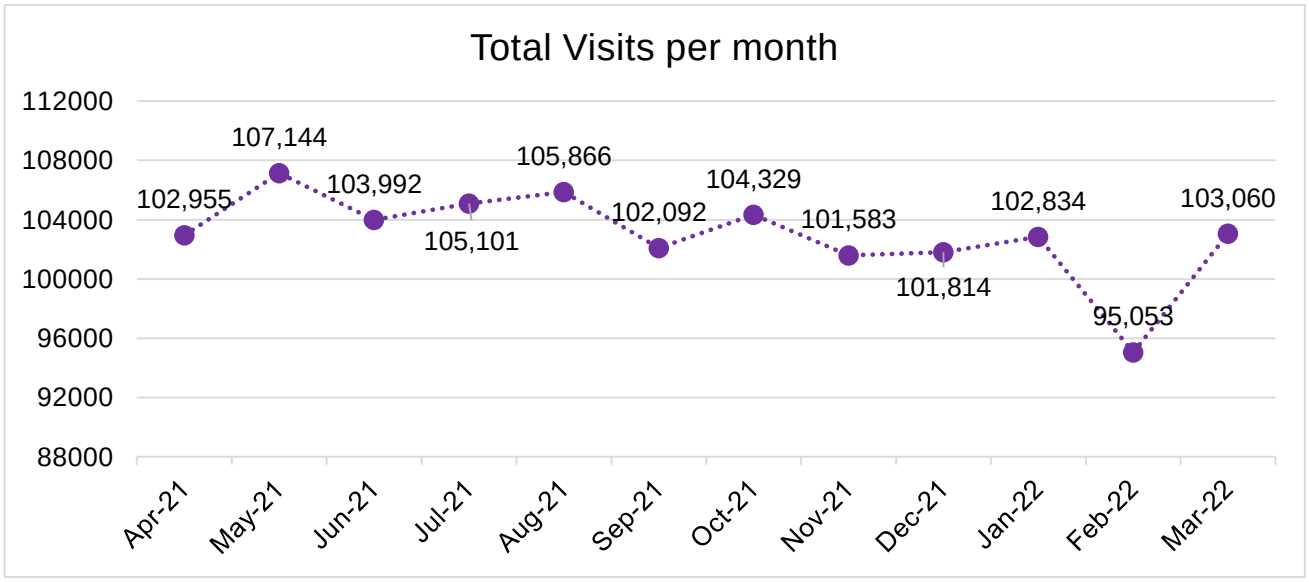
Our aim is to ensure every service user is seen by the right person at the right time and in the right place with an emphasis on being on seeing more people at home or in other community settings when it is safe and appropriate to do so. When hospital level care is required then we ensure that appropriate resources are available.

Our plans for improvement are focused on three main themes reflecting the patient pathway		
Prevention and early intervention with the aim of better support so people receive the care and treatment they need at or close to home and to avoid hospital admission where possible	Improving hospital discharge and better supporting people to transfer from acute care to appropriate support in the community.	Improving the primary and secondary care interface by providing GPs with better access to clinical advice and designing integrated patient pathways for specific conditions

Care and support at Home

Over the past 12 months, across both HSCP and commissioned services, have delivered 1,235,823 visits to 1971 service users in the community. The service continues to deliver on average 103,000 visits per calendar month. There remains a year on year increase in the

overall amount of visits being provided, with the HSCP now providing more visits by internal services than pre-pandemic.



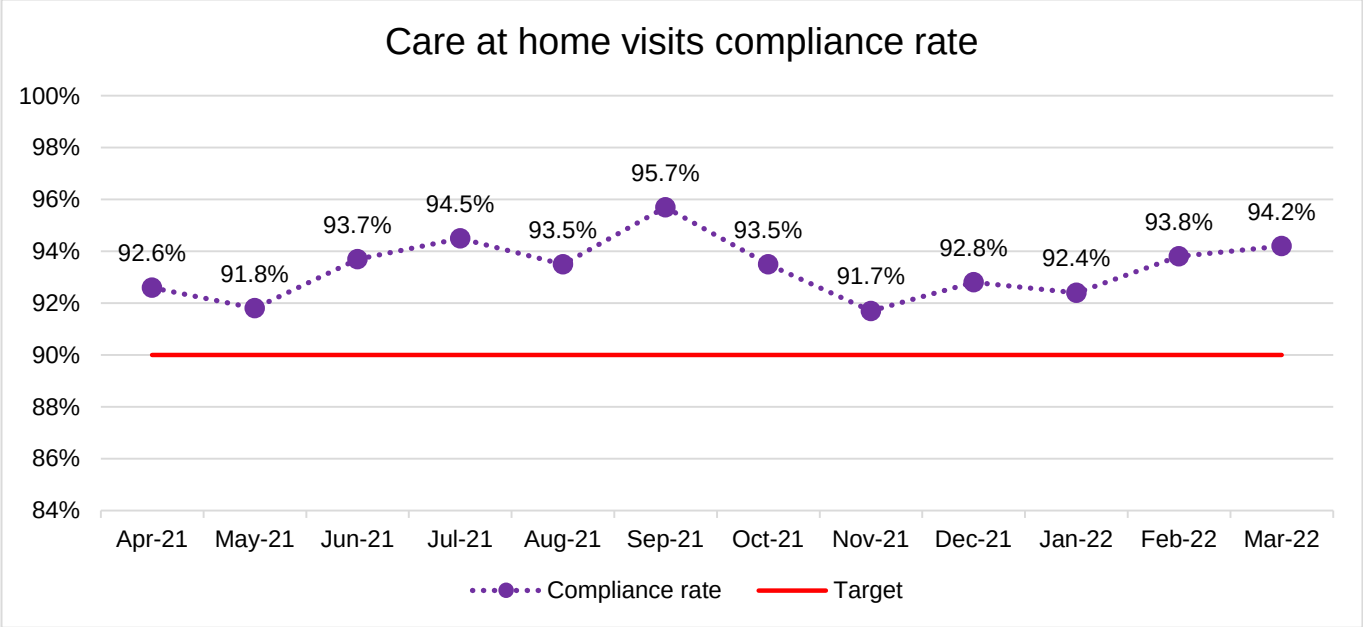
Source: CM2000

The service continues to monitor service delivery and working with our external partners, we ensure that we are continuing to deliver a high standard of care to our service user group in the community.

Through our Electronic Call Monitoring system (CM2000), we are able to ensure services is being planned and delivered in line with commissioned contracts. This system provides the essential information in relation to the monitoring and compliance of service delivered. This ensures that the level of service is accurate for each service user and can be adjusted dependent on assessed level of need.

Compliance / confirmation of Care at Home visits delivered – PI target is 90%

A key issue from service user feedback is ensuring staff are on time for visits. This graph shows the compliance of staff in logging in and out of a service users home, this gives us real time data to ensure that service users are receiving their service at the agreed time and allows us to monitor the punctuality and duration of visits. Nationally, Inverclyde continues to have the highest compliance.



Source: CM2000

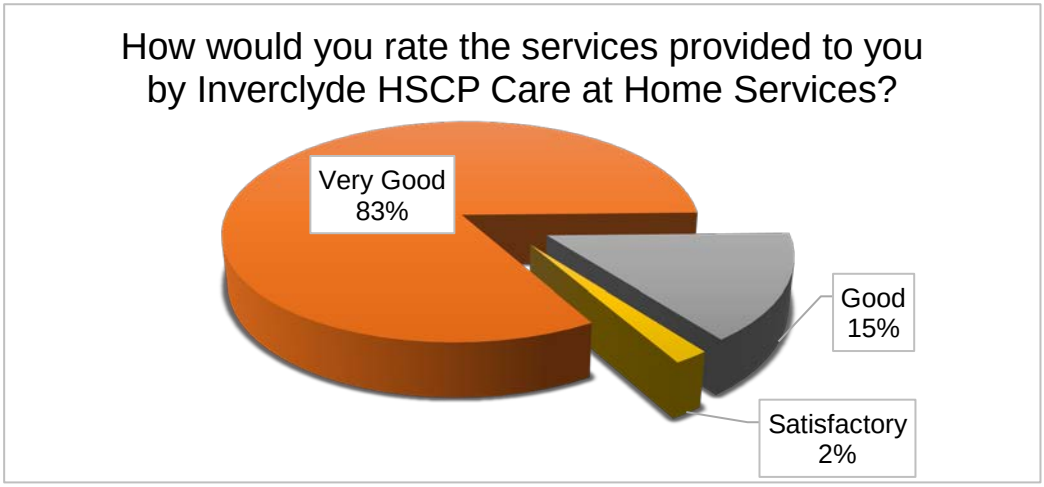
Care at Home were nominated and won the HSCP Staff award 2021, this was an amazing achievement for the team in recognition of the continued hard work throughout a very difficult and challenging year.

The service maintained regular quality assurance visits to ensure we achieved our performance indicators for service delivered, the key indicators for service users is around the quality of service, the punctuality of visits and the continuity of staff.

There continues to be a high level of satisfaction amongst our service users despite the challenges that the service has faced in the past 12 months. This reflects in the feedback forms completed by service users during our Quality Assurance visits.

Service User Satisfaction with overall service.

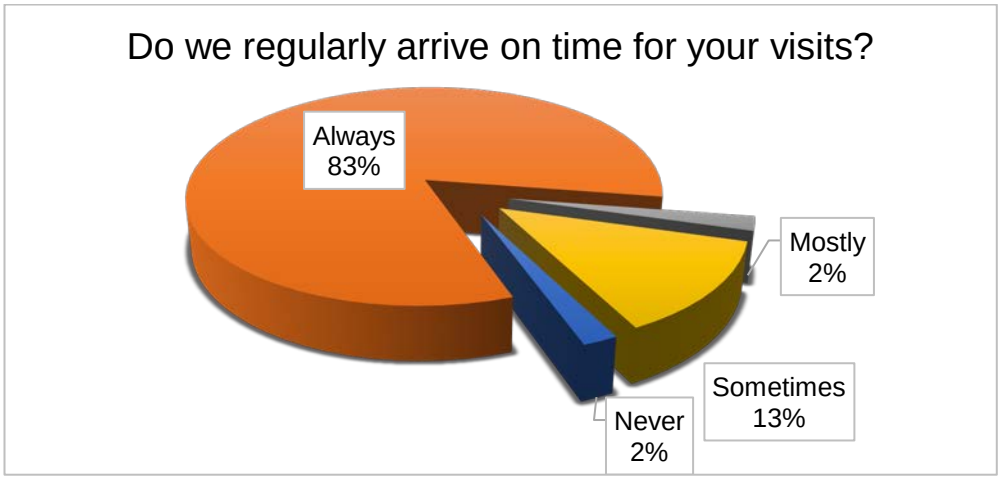
98% of service users rated us 'good' or 'very good' when rating the service we provided to them. Where less positive feedback is provided and was rated as satisfactory, analysis showed dissatisfaction around continuity of care being the reason. Service users reported that the changes to their regular home support workers was disconcerting.



Source: Service User Feedback Survey

Service User satisfaction around Punctuality of the service

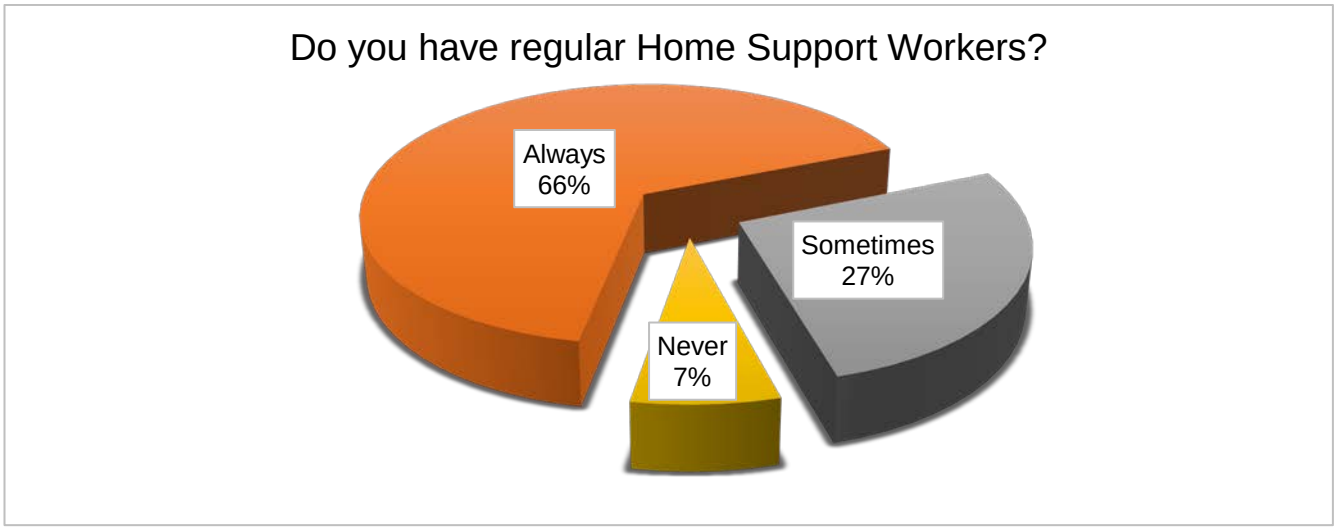
There is a slight drop from the previous years for visit punctuality however this was anticipated due to the level of adjustments required due to the continuing impact of Covid-19 related absence. A high standard was still maintained.



Source: Service User Feedback Survey

Service User Satisfaction around Continuity of Care

Similarly the impact of Covid-19 impacted the continuity of care although the service minimised this as much as possible. Overall service users recognised the additional challenges in the last year.



Source: Service User Feedback Survey

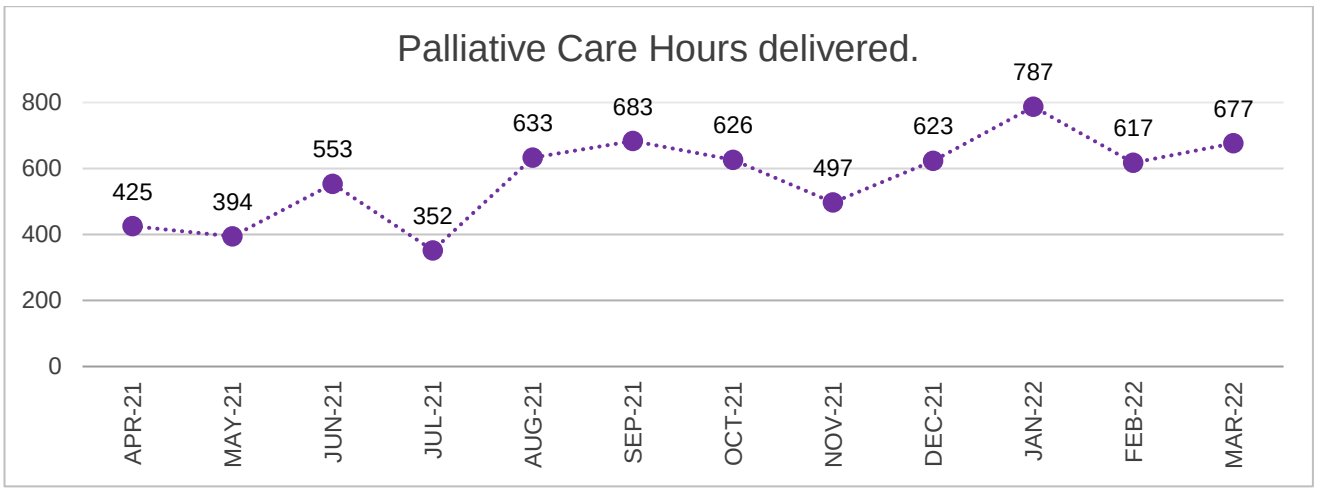
The Care & Support at Home Service has continued to provide a critical service to the community of Inverclyde during the pandemic. Similar to the national picture Care & Support at Home Services have been impacted by staff absence due to isolation requirements and vacancy management issues, however the service maintained critical support to the community.

Within Care and Support at Home recruitment continues to be the main pressure impacting on availability of service for both the HSCP and commissioned providers. The service is seeing a high turnover rate and an ageing staff group alongside the additional challenges in the last year has resulted in a significant loss of knowledge, skill and experience over the last year.

The service is now undergoing a review of Care & Support at Home Services which will initially report back in autumn 2022.

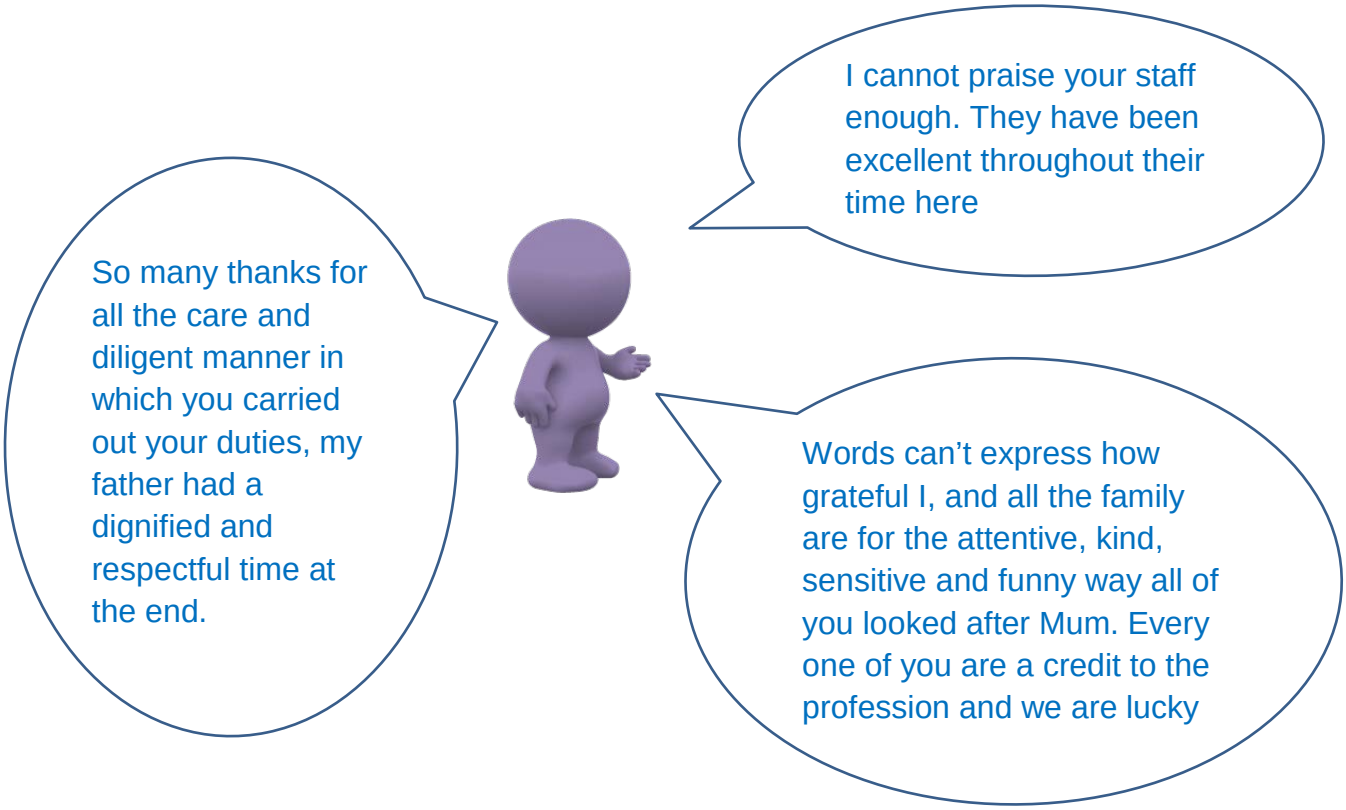
Palliative Care

We commenced a Palliative Care service in mid-2019, This service supports service users to remain in their own home at end of life. Over the past 12 months there has been an increase in referrals and use of the service for end of life care. This has resulted in a 37% increase of palliative hours delivered.



Source: CM2000

Feedback regarding the palliative team continues to be very positive from our service users and family members, comments below:



Hypertension – Florence (Flo)

Flo is provided to diagnose and monitor hypertension in the community – it combines the expertise of health care professionals with the convenience of remote monitoring. Flo enables patients to use a BP monitor to submit their blood pressure reading to their GP for review. This continues to support the reduction in face-to-face primary care appointments and makes it easier for people to understand their own condition and make lifestyle changes to allow them to maintain longer and healthier lives in self-managing and monitoring their health remotely.

Long Term Conditions – Home and Mobile Health Monitoring

The Service continues to support people with Chronic Obstructive Pulmonary Disease (COPD) in the community to better self-manage their condition. The service provides a home hub or an App for those who are confident in using this preferred method of communication. The service provides early intervention and anticipatory medication supported through community nursing thus hopefully avoiding potential hospital admissions.

Technology Enabled Care Services

Analogue to Digital

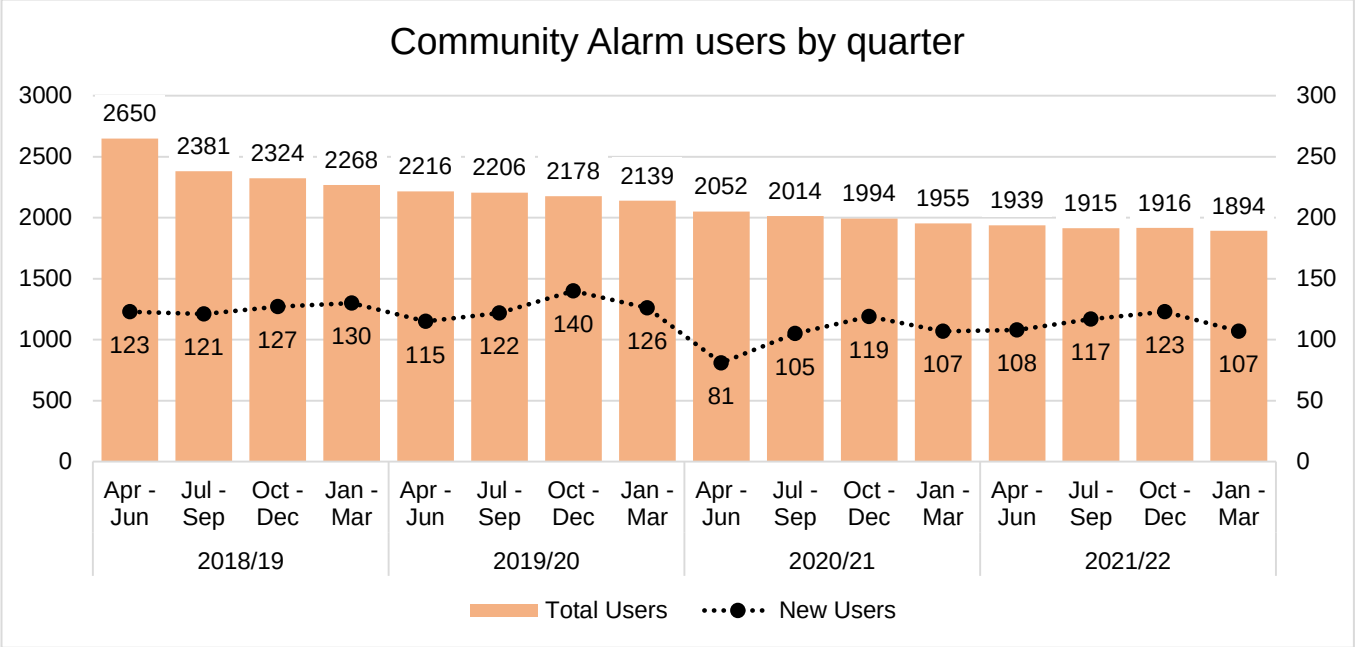
Inverclyde HSCP Technology Enabled Care have been reviewing the current Community Alarm equipment following an announcement by Ofcom that the analogue telephone network will be switched off in 2025 across the UK.

The change to a digital network will impact on the analogue community alarm/ telecare systems currently supplied to our 2000 Inverclyde service users. This will require all community alarms/telecare sensors to be replaced prior to the switch off date of 2025.

Inverclyde has evidenced the successful operation of digital alarm units connecting through to the alarm receiving centre. A replacement program has been commenced with the first 250 Units purchased.

2021-2022 continued to be a challenging year for all services due to the Covid-19 pandemic. As a service Technology Enabled Care continue to provide emergency response to our service users following activation of a community alarm, providing unscheduled visits 24 hours per day 365 days of the year.

Facilitating hospital discharges with urgent installation of alarm technology on a patients discharge remains a priority of Technology Enabled Care. Decreasing the potential need for hospital beds within the acute setting during a period of extreme pressure.



Source: Swift

In March 2021 the total number of service users was 1955, this figure reduced to 1894 by March 2022 (a reduction of 61). The number of new service users from April 2021 – March 2022 was 455 which is slightly higher than the previous 2 years. The drop in total service users can be attributed to the continuing impact of the Covid-19 pandemic across the service. Total withdrawals April 2020 – March 2021 were 507 compared to 531 in April 2021 – March 2022, a slight increase of 24.

Due to the current rise in the cost of living and significant increases in the cost of utility bills we are expecting to see a potential rise in withdrawal requests from our service users over 2022/23. We will be monitoring this closely over the coming year to ensure the safety of our service users.

Independent Living Services

Due to the demand on the service for increased urgent, same or next day response, which accounts for around 42% of referrals, the service has been redesigned to have a specific Urgent Hub model. This provides a multi-disciplinary team approach to supporting complex community situations to support people to remain safe and at home in the community.

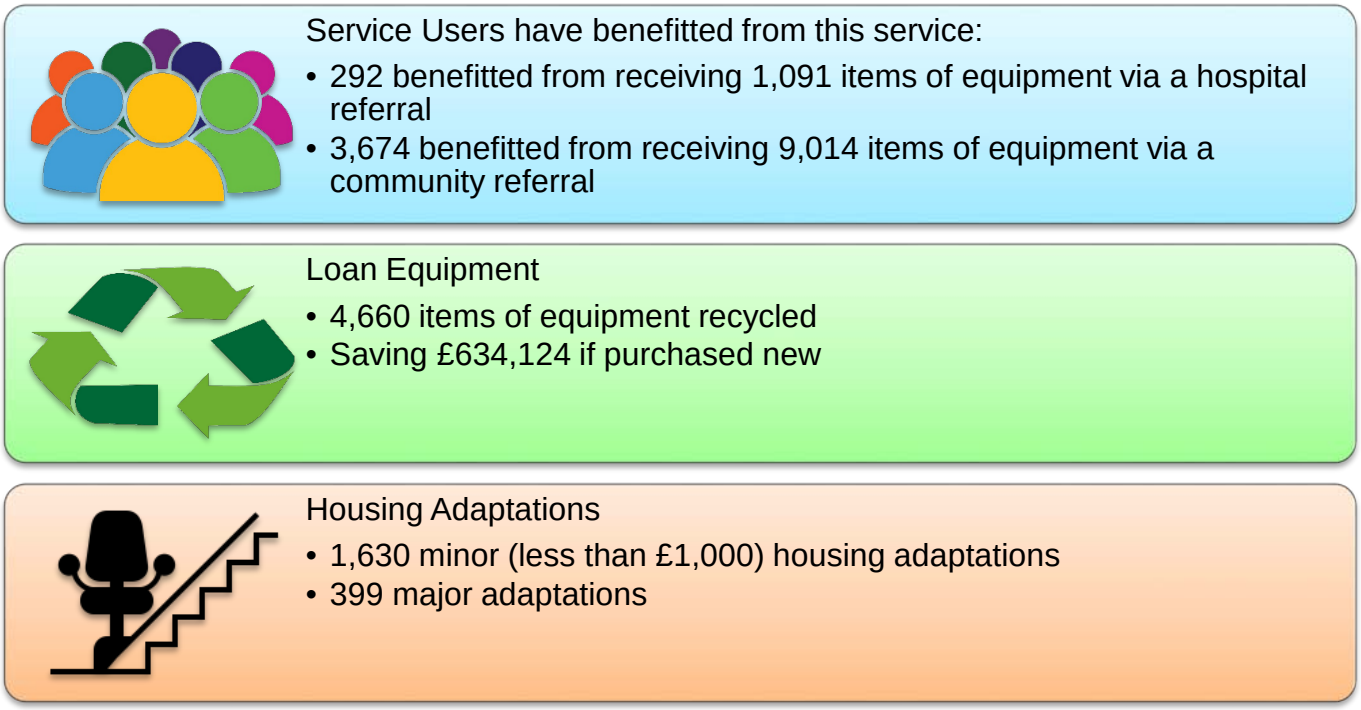
The duty service has been remodelled utilising telephone assessments and video consultation to provide a responsive service to non-complex enquiries.

The service continues to support care services with alternative tailored moving and handling solutions and in the last year have prevented the need for care provision by 351 care hours per week at initial assessment. Following review of current service users care provision reduced the need for care by 119 care hours per week.

A new equipment and adaptations management system has been designed with a plan to roll out along with assessment training to prospective professionals with a view to reduce waiting times and cross referrals for equipment and minor adaptations.

Equipment Loan Service / Adaptations

3966 Service users have benefitted from receiving 10105 pieces of equipment. The graph below shows the split between hospital referrals and community referrals.



Source: ELMS2

Referrals

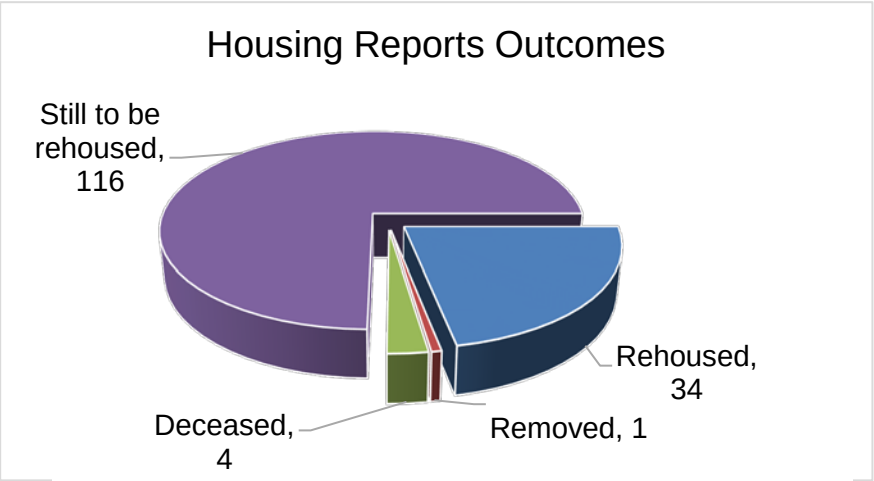
The Community Rehab and Enablement service have supported 2005 referrals in the last year, 3392 referrals have been processed within Community OT and Sensory Impairment and 1566 Blue Badges have been issued.

Prevention

The local falls pathway is currently being revitalised with close working partnerships including Inverclyde Leisure on the approach to falls and frailty.

Housing

155 Housing reports have been completed for people whose current home environment restricts their ability to live independently. Working closely with housing partners, around specialist housing provision 20 people who have complex housing needs, have moved to new build properties within the area in the last year.



Source: Centre for Independent Living

The service has identified around 20 homes that are local and accessible on the market for Registered Social Landlords to consider as part of the acquisitions programme for housing in Inverclyde.

Carers

Inverclyde HSCP works with partners across Inverclyde to support Carers and Young Carers. Our primary partner is Inverclyde Carers Centre (ICC) who offer practical support, advice and information, emotional support and support to access mainstream services, as well as having a strong and campaigning voice for our Carers in Inverclyde and nationally.

As with every other social care organisation the HSCP and ICC had to adapt and change how support was offered to our Carers taking account of the increased social isolation during the pandemic our Carers were experiencing with the reduction of face to face contact and peer support.

Infection control was a major aspect of protecting carers and the cared for and the HSCP worked to establish free access to PPE for this group as well as up-to-date information around vaccination which was communicated through the ICC.

The HSCP continued to support Carers and Young Carers throughout the pandemic by maintaining Carers support plans and providing short breaks away from the traditional residential / nursing care home respite, as due to the pandemic nursing home were closed quickly for infection control reasons. Due to the reduction in care options available, our carers and cared for person had to consider their options.

At 31st March 2022

2280 carers registered with the carers centre

116 carers newly registered since January

25 new Adult carers support plans completed since January

Carers self assessment

- 369 Carers completed in 2021/22
- 611 Carers completed in 2020/21 (this was part of the Carers Covid Vaccination Programme)

As we recover from the pandemic, service including the Carers Centre, are now fully open our carers can now directly access the carers centre and all face to face support in addition to direct access to short breaks through the Carers Centre as well as HSCP Short Breaks Bureau. The number of short breaks, respite, and alternatives to respite provided is detailed below.

Respite provided during 2021/22

Residential / Nursing		Learning Disability Residential Respite		Alternative / Short Break Respite
64 Service Users	975 nights	46 Service Users	712 nights	87 Service Users

Covid-19 Pandemic

Covid-19 / Influenza Vaccination

The primary care team have continued to work to deliver the national Covid-19 vaccination programme to our housebound individuals who are unable to attend a vaccination centre. This also includes our care home residents across Inverclyde. Inverclyde HSCP remains responsible for delivering the Covid-19 vaccination and any subsequent booster vaccinations to this cohort of patients. All necessary operating processes and governance structures are in place as required. A mixture of staff have been seconded from various services to deliver the vaccinations, including our District Nursing team and bank staff have been key in this local delivery model.

During the Covid-19 booster campaign, between September 2021 and January 2022, HSCP vaccinated 594 care home residents and 2173 housebound patients.

Mass vaccination clinics remained the responsibility of NHS Greater Glasgow and Clyde and they have continued to operate from large local community venues. HSCP have supported these clinics during periods of acceleration of the booster programme, where there were significant staffing pressures across the board.

Adult Flu Vaccination

The annual seasonal flu campaign usually starts end September / October and includes everyone over the age of 65 and anyone under 65 in at risk categories. Health and care staff also receive their flu vaccination, we are actively encouraging our care at home staff to get vaccinated.

GP practices historically delivered the flu vaccination programme, however last year's programme (2020/21) saw a mixture of practices and mass vaccination clinics delivering both the flu vaccine and the Covid-19 vaccine as it became available. This has prompted further changes to the delivery model. The flu campaign has also been extended to include those between 55 and 64, additional social care staff and household members of those in shielding groups. The extended flu campaign is set to continue in Scotland in 2022-2023.

Our nurses also administered the flu vaccine alongside the Covid-19 booster dose, to those housebound individuals and care homes. Historically, in care homes, the care home staff would administer the flu vaccine to their residents.

During the current 2021/22 influenza vaccine season, 31,582 adults (aged 18+) who reside in the Inverclyde HSCP have received the flu vaccine so far. There was also a pause of the flu campaign delivery during December 2020, as the Covid-19 booster programme accelerated at pace. This was to ensure as many people as possible could receive their Covid-19 booster dose by the end of 2021.

Primary Care Improvement Plan

In 2021 the Primary Care Improvement Plan (PCIP) Memorandum of Understanding (MoU) was refreshed to cover the period 2021-2023. The key aim remains of expanding and enhancing multidisciplinary teams working to help support the role of GPs as expert medical generalists to improve patient outcomes. The MoU Parties recognise that whilst a great deal has been achieved, there is however considerable development of services required to fully deliver the GP Contract Offer commitments originally intended to be delivered by April 2021. We have a number of MDTs supporting practices including:

Advanced Nurse Practitioner: There has been significant progress on the Primary Care Improvement Plan (PCIP) including the recruitment of 6.6 wte ANPs and an ANP Lead. Our ANP lead will continue to develop our response to urgent care through delivery of a home visiting model. The ANP will support GP practices in the response to Home Visits, this model continues to be reviewed in partnership with GPs and LMC and adapted as appropriate.

Community Treatment and Care Services (CTAC): All 13 GP Practices have access to all services with responsibility fully removed from practices, however there will be an expectation that phlebotomy will be available in practices during consultations where this is deemed urgent and appropriate. Our aim is to be more creative about CTAC delivery given the challenges facing accommodation. All Inverclyde practices will have access to CTACs and capacity will increase with the implementation of additional CTAC at Port Glasgow Health Centre (Lithgow Wing) to meet our demand. A standardised interventions list and core service specification for CTAC has been developed and is being used across GG&C.

Community Link Workers (CLW): All 13 practices have CLW input within their MDT and we have awarded a contract with 3rd sector CVS to host the service. Demand for CLW input has increased as a result of the Covid-19 pandemic and we will continue work in partnership with our 3rd sector colleagues to develop this service to respond to the needs of the local population.

Our local **Choose the Right Service** campaign compliments our Board wide, National 'Right Care, Right Place' campaign, in March 2022 this included the Right Care Right Place – Receptionist Campaign. The campaign aim was to create a greater understanding of the pivotal role receptionists play in signposting people to the right care for their specific healthcare needs. This campaign highlights the role of multi-disciplinary teams both within and external to the general practice, increasing patients understanding of alternative care pathways. Nationally it was acknowledged that there was a lack of awareness of the changing role of receptionists and their pivotal role in navigation of patients to the right health care expert. A national and local campaign ran together using various media platforms including TV, VOD, Digital, Social, Press and Radio channels during the month of March 2022. This was integral in changing the public perception of the receptionist and understanding their role in care navigation.

Our Primary Care teams worked together with our GP Practices in getting this message in to the public domain locally, it was an opportunity to remind our stakeholders of our Choose the Right Service and Right Care – Right Place. This will continue throughout 2022 and beyond.

Community Learning Disability Update

The Community Learning Disability Team provides services to over 300 people with a wide range of needs. The majority of people using the service experienced changes to their support packages due to Covid-19, with most social activities restricted. The Fitzgerald Centre was one of the first day services to open after the Covid-19 closures.

Learning Disability Day Services and staff in the community team maintained regular contact with service users and carers to ensure critical support was available. Feedback from carers and services users during this difficult period confirmed the importance of building-based Day services as one of the preferred options for some people with Learning Disability.

To ensure Inverclyde has a building base fit for the future, particularly for people with complex learning and physical disabilities, plans for building the new Learning Disability Hub have continued with plans now at the advanced design stage. These have been up-dated to achieve low carbon emission standards, and additional funding has been secured from the Derelict and Vacant Land Fund. The Project Board meets every three weeks and there has been a Communications and Engagement group facilitated by TAG to ensure that service users and carers are involved in the plans for the new Hub.

The CLDT participated in a Dementia project group over the past year to develop guidance for care homes on the needs of people with Learning Disability who may develop early dementia or require care home admission.

Services for adults with Autism have been subject to review, and a test of change around transition will soon be completed.

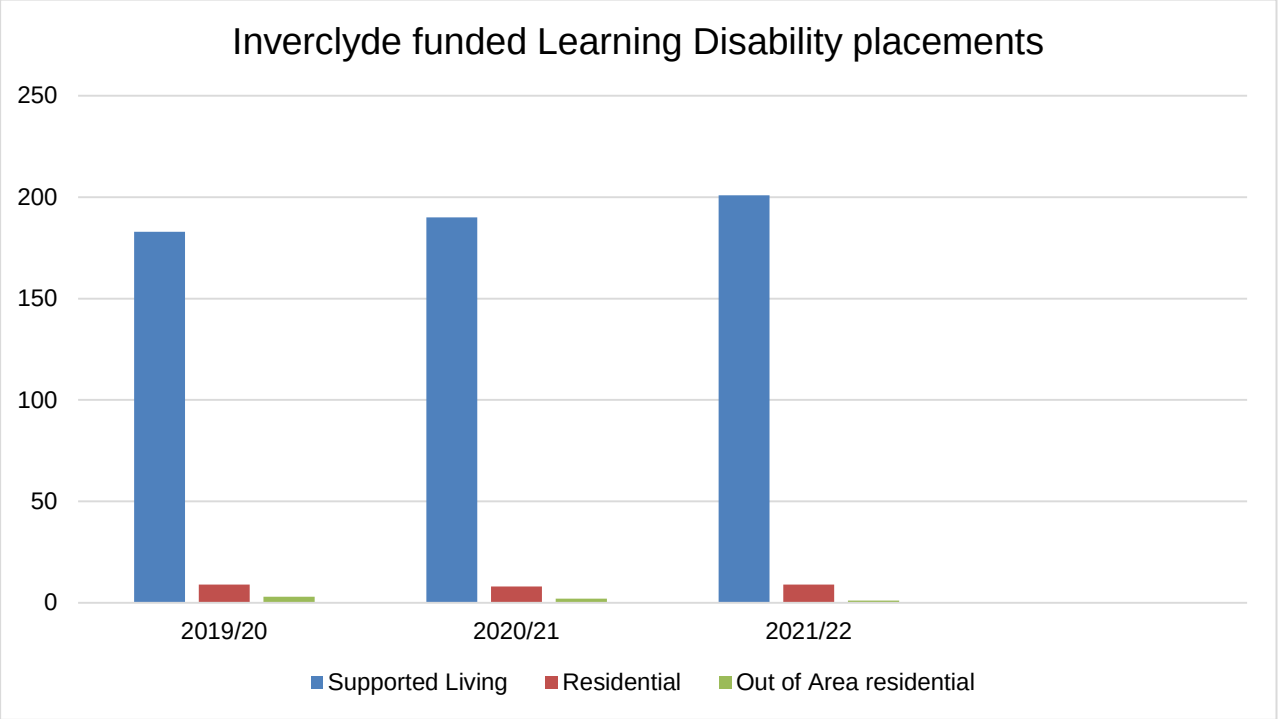
Our aspirations are to continue to build on the foundation work around supporting health promotion and activity in partnership with other agencies to reduce the demand on our services and focus some of our resources upstream in prevention.

The Maximising Independence agenda that is being adopted across Scotland is key to the way the service operates. Over the last year the demand for crisis work has increased and we have remodelled within the team to support this work.

A Quality Improvement approach has been developed, and the service are learning and upskilling staff in areas such as the use of CRAFT (Comparative Risk Assessment Framework and Tools) and Routine Sensitive Enquiries across the whole integrated team, and Positive Behaviour Support training (at post-graduate level) for 3 members of the team.

Redesign of Services and Learning Disability Hub

The CLDT has worked closely with RiverClyde Homes and Cloch to create more blocks of supported living on the core and cluster model and are keen to work with other housing providers to expand the number of specialist supported housing places for adults with learning disabilities in Inverclyde. There are currently only a small number of adults with learning disabilities placed out of area, with the number in external residential placements reduced to 1 person. Work has continued to reduce out-of-area placements, increase local Supported Living options and plan for young people leaving care and moving up to adult services.



Review of Learning Disability Night Services

The CLDT has continued to carry out reviews both in-person and through virtual platforms throughout the past year. Individuals with Sleepovers have been reviewed with the goal of reducing the number of individual night services, by connecting tenants in core-and-cluster developments or to night response services. Transformation Funds to cover some additional review officer time and Telecare costs have been agreed. New TEC systems have been installed in Lyle Street, Redholm and Station Road services to facilitate shared night services. While the review of night services is not yet complete, more than £100,000 of recurring savings has already been identified.

Service users and staff at Fitzgerald Centre walk for wellbeing

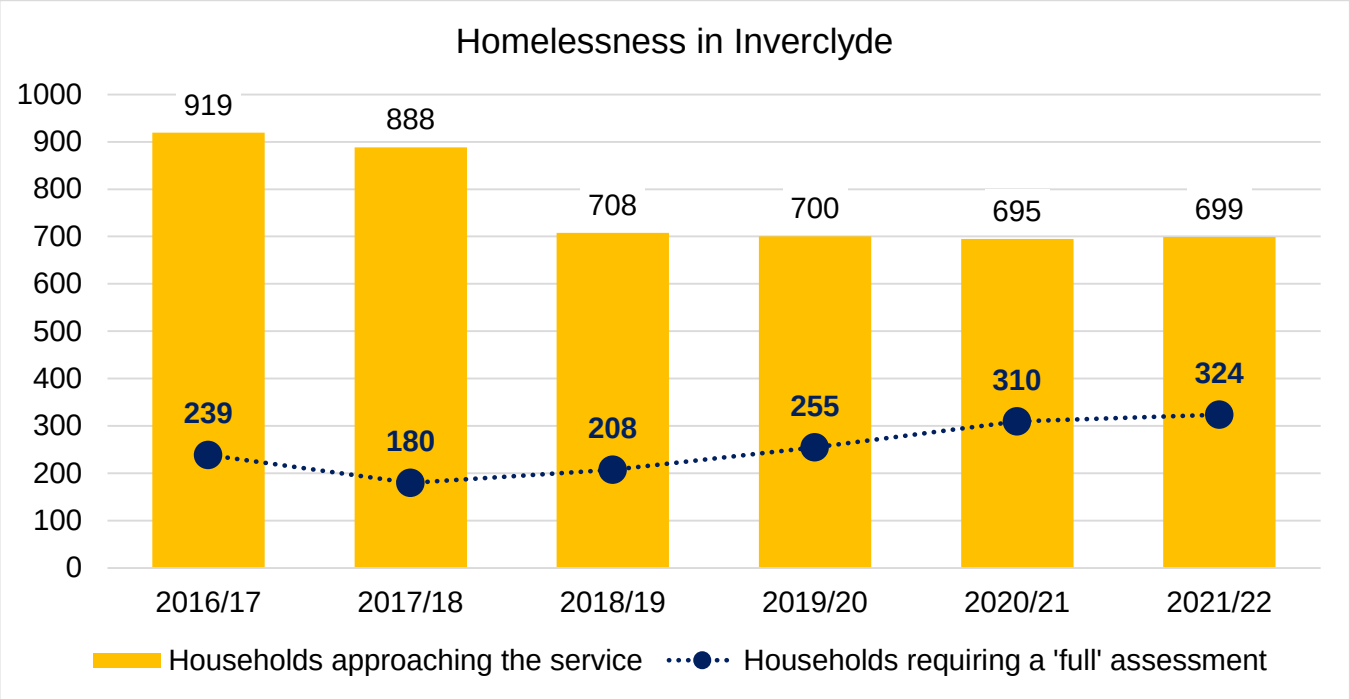
Due to the nature of support that the team provide they thought of alternative ways to improve their wellbeing. The team, and people that they support, virtually travelled to Japan to accomplish the Mount Fuji challenge. This took them on a 46-mile (74km) journey around the Fuji Five Lakes and up to the peak of Mount Fuji. Their combined steps and distance were calculated, including swimming, walking and carrying out physiotherapy exercises.

This is part of the art project that the service users have been working on which gave the team the inspiration for the challenge:

Below is a display that the team created in the main corridor to remind them of their achievement and the fun that they had during it.

Homelessness

The pandemic continues to impact on homelessness with 699 total presentations for 2021/22, of these 324 required a full assessment/temporary accommodation. These figures are in line with 2020/21 service activity.



Source: Swift

Full Homelessness Cases

Closed

- 358 in 2021/22
- up from 295 in 2020/21

Average case length

- 25.6 weeks in 2021/22
- Down from 32.4 weeks in 2020/21

Housing First remains a priority of the service to ensure that those with complex needs, are given the right support to obtain and sustain a tenancy. Ten people started (a permanent tenancy) on the Housing First model, with nine of these still open to Housing First support and an additional three more waiting to move into tenancies. This model will be expanded further throughout the coming year.

We have worked with our service users and the Registered Local Landlords to convert tenancies to become the permanent home for an individual or family who are in temporary accommodation, are settled and have made positive connections in that local community family.

Lost contact with people who have been assessed as homeless remains an issue. However this is steadily reducing from 12.4% of people losing contact with the service in the first quarter of the year reducing to 10.3% by March 2022.

A more detailed approach to homelessness prevention and increase in housing options approach led to prevention cases being open longer over the year. 659 prevention cases were closed in 2021/22 when compared with 823 prevention cases closed in the previous year. This has been due to more involved ongoing engagement with landlords (private & RSLs), Advice and Environmental Services, Legal Service Agency, ICIL etc. in order to ensure tenancy sustainment and maximising available housing options.

Tenant Grant Fund

Inverclyde received £93k from the Scottish Government to address Covid-19 related rent arrears. The Homeless Team have worked in collaboration with housing strategy, housing benefit and registered social landlords to identify those at risk of homelessness who meet the qualifying criteria.

At the end of March 2022 there were 45 live applications with arrears of just over £87k. Twenty nine cases have been processed for payment with £38k of grants being awarded. The full allocation will be awarded which will go some way to preventing homelessness for a number of tenants across Inverclyde.

Market Facilitation and Commissioning Plan 2019 to 2024

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

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

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

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

The restrictions during the Covid-19 pandemic has impacted the progress of the commissioning workplan. However, 57 contract awards were made from April 2021 to March 2022, and market facilitation background research and reviews have taken place in relation to the future contracting of Homecare, Daycare and Supported Living Services in Inverclyde.

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

We will promote early intervention, treatment & recovery from alcohol, drugs & tobacco & help prevent ill health, we will support those affected to become more involved in their local community.

National Outcomes relating to this Big Action

1	People are able to look after and improve their own health and wellbeing and live in good health for longer
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities

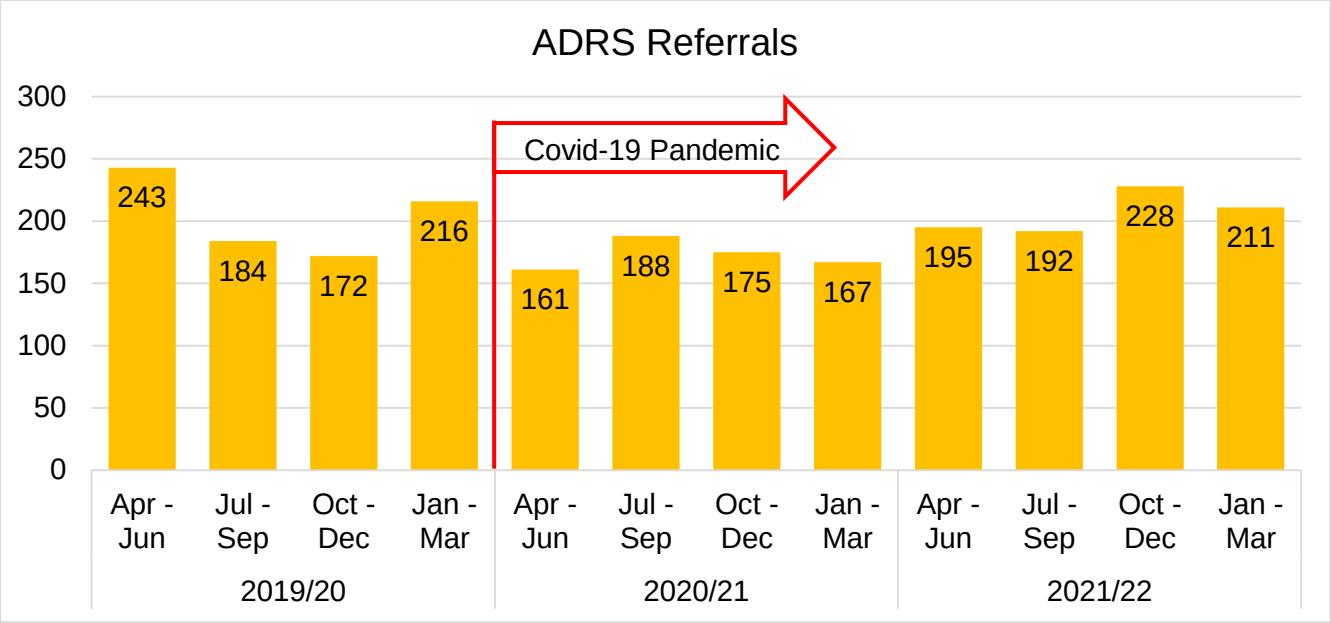
Local Activity

ADRS (Alcohol and Drug Recovery Service)

Our integrated service provides a range of care and treatment options to people affected by alcohol and drugs and who have complex needs.

The service had previously undergone a strategic review, with full implementation of the recommendations and service redesign initially on hold as a result of the pandemic. This has now been concluded and recruitment to the social care workforce of Alcohol and Drug Recovery Workers and Senior Alcohol and Drug Recovery Workers is in the final phase. Inverclyde ADRS also expanded the acute addiction liaison nurse team to provide additional reactive capacity through an assertive outreach approach for those hard to reach or engage who are most at risk of harm or overdose.

The Scottish Government also launched new Medication Assisted Treatment (MAT) Standards which are evidence based to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. The service is working with other ADP partners and other HSCP's across Greater Glasgow and Clyde to ensure full implementation locally.

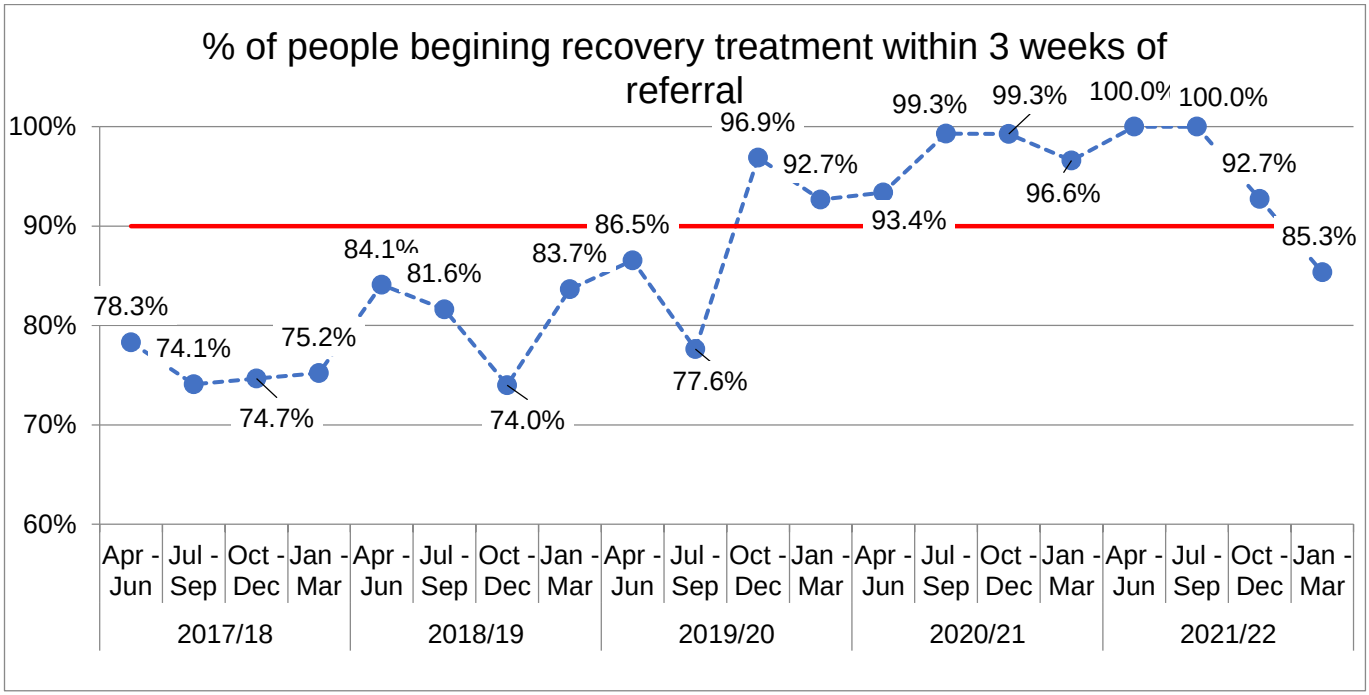


Source: SDMD (Scottish Drug Misuse Database) and DAISy (Drug and Alcohol Information System)

Beginning treatment

A national target has been set by the Scottish Government that states "90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery". Seeing people quickly gets them onto a journey of recovery sooner, thus leading to better outcomes.

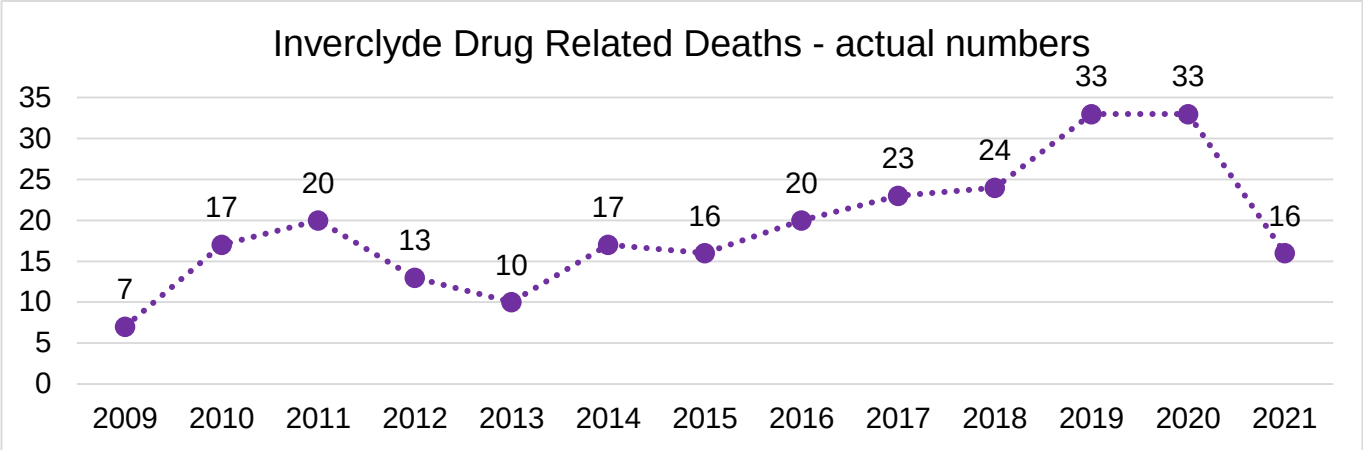
After some initial work to improve our position in 2019/20 for 2020/21, even with the impact of Covid-19 pandemic, we have been able to meet or exceed this target.



Source: SDMD (Scottish Drug Misuse Database) and DAISy (Drug & Alcohol Information System)

Drug related deaths

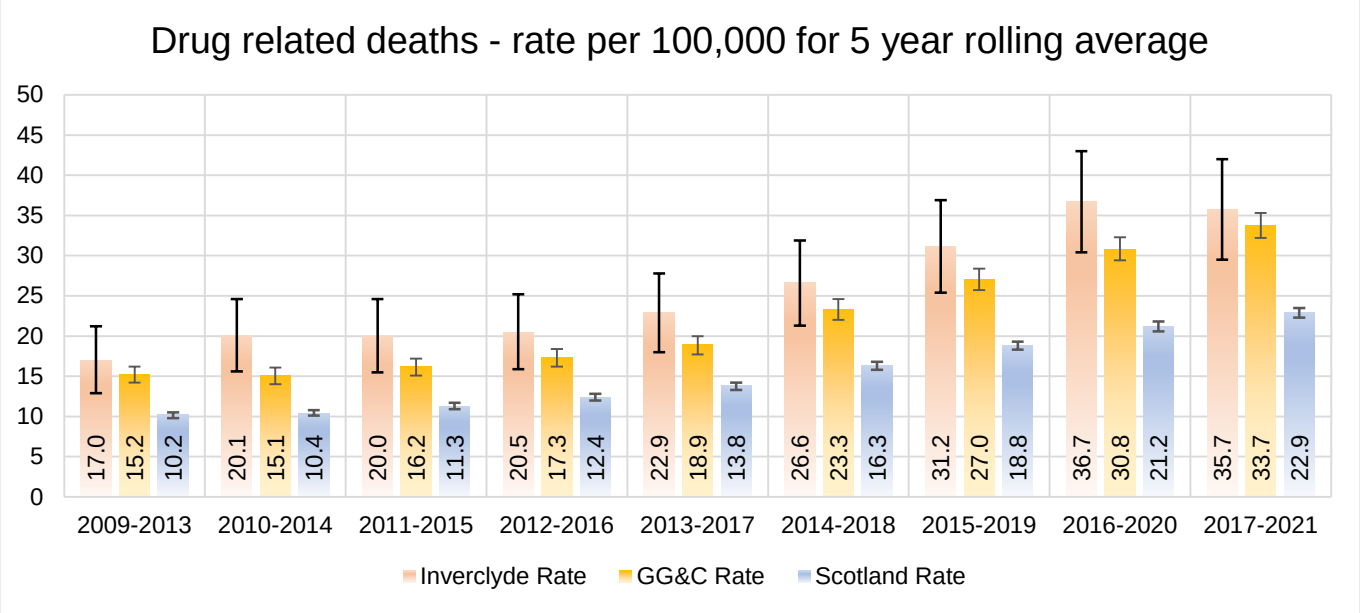
In 2021 there was a reduction in the number of drug-related deaths in Inverclyde from 33 in 2020 to 16. While this reduction is welcome, we still have a challenge to further reduce this number.



Source: NRS

Comparing our 5 year age-standardised rate for 2017-2021 Inverclyde remains the third highest in Scotland with only Glasgow city and Dundee city higher.

Local Authority Area	Age-standardised rate per 100,000 population
Dundee City	45.2
Glasgow City	44.4
Inverclyde	35.7



Source: NRS

Preventing Drug Related Deaths

In 2021, after adjusting for age, people in the most deprived areas were more than 15 times as likely to have a drug-related death as those in the least deprived areas (64.3 per 100,000 population compared with 4.2). This is an indication of the complex nature of drug-related deaths where factors like poverty and the impact of severe and multiple disadvantages including homelessness, mental health, and involvement in the justice system, as well as the impact of trauma, may increase the risk of a drug-related death.

Inverclyde Alcohol and Drug Partnership's (ADP) Drug Death Prevention Action Plan focuses on actions related to the national Drug Death Taskforce priorities:

- ✓ Targeted distribution of naloxone
- ✓ Immediate response pathway for non-fatal overdose
- ✓ Medication-Assisted Treatment
- ✓ Targeting the people most at risk
- ✓ Public Health Surveillance
- ✓ Equity of Support for People in the Criminal Justice System

Inverclyde ADP are in the process of refreshing the Drug Death Prevention Action Plan, taking the opportunity to capture the wide range of actions and additional funding. Partners recognise that these actions will take time before achieving the overall ambition of reducing the unacceptable number of drug related deaths in Inverclyde.

Over the last year good progress has been made in several key actions including:

- ✓ The inclusion of the 3rd sector to distribute Naloxone (through the Lord Advocate's decree during Covid-19)

- ✓ The development of the information sharing protocols with key partners to ensure assertive outreach within 48 hours to anyone who has had a non-fatal overdose
- ✓ Work to support those most at risk of harm into treatment and try to keep them established within treatment services via the ADRS Liaison Nursing Team who are working to improve pathways of care
- ✓ The reduction in waiting times into ADRS treatment services; the ongoing work to support service users onto appropriate doses of treatment; and the introduction of Buvidal (longer lasting injection) which, if clinically appropriate can be offered as a treatment
- ✓ The review of all drug deaths on a multiagency basis to determine any learning and improvements in practice
- ✓ The test of change of Care Navigators to work intensively with the most vulnerable service users known to Homelessness; ADRS and Criminal Justice

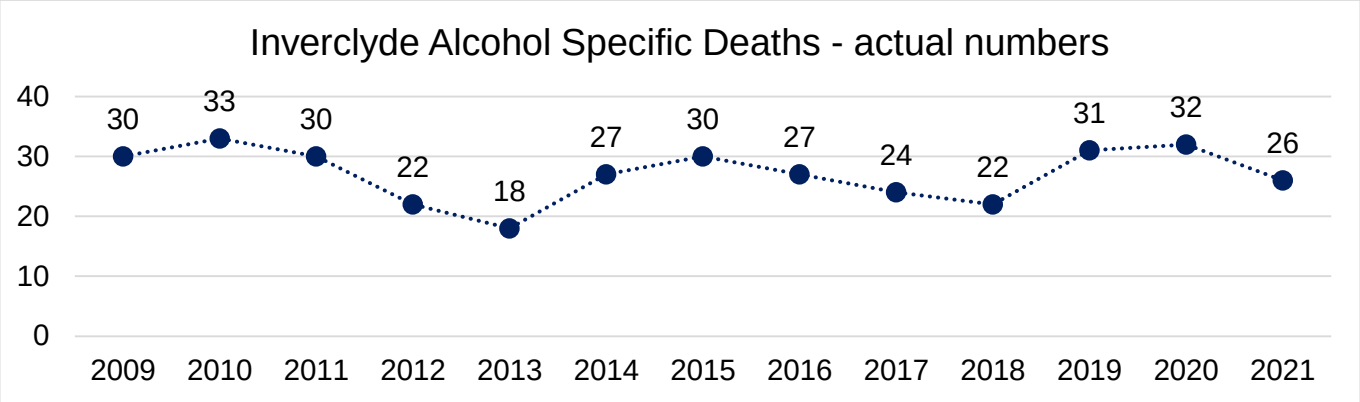
Analysis from the 2019 drug-related deaths in Inverclyde indicated that 30.3% of people were in police custody in the six months prior to their death. Inverclyde ADP has secured funding from the national Drug Death Task Force to employ Peer Navigators in Greenock Police Custody as a means of early help. This is a test of change with the potential to influence practice across Scotland, targeting a group of people who are at an increased risk of a drug-related death.

A key priority in Inverclyde's Anti-Poverty Strategy is utilising funding to undertake an employability pilot, targeting a cohort of 20-30 year old males who are unemployed with alcohol or drug dependencies. This pilot has initially targeted Greenock Town Centre followed by a second phase targeting Port Glasgow. This pilot recognises the challenges to overcome in relation to reducing poverty and increasing employment opportunities while tackling health inequalities.

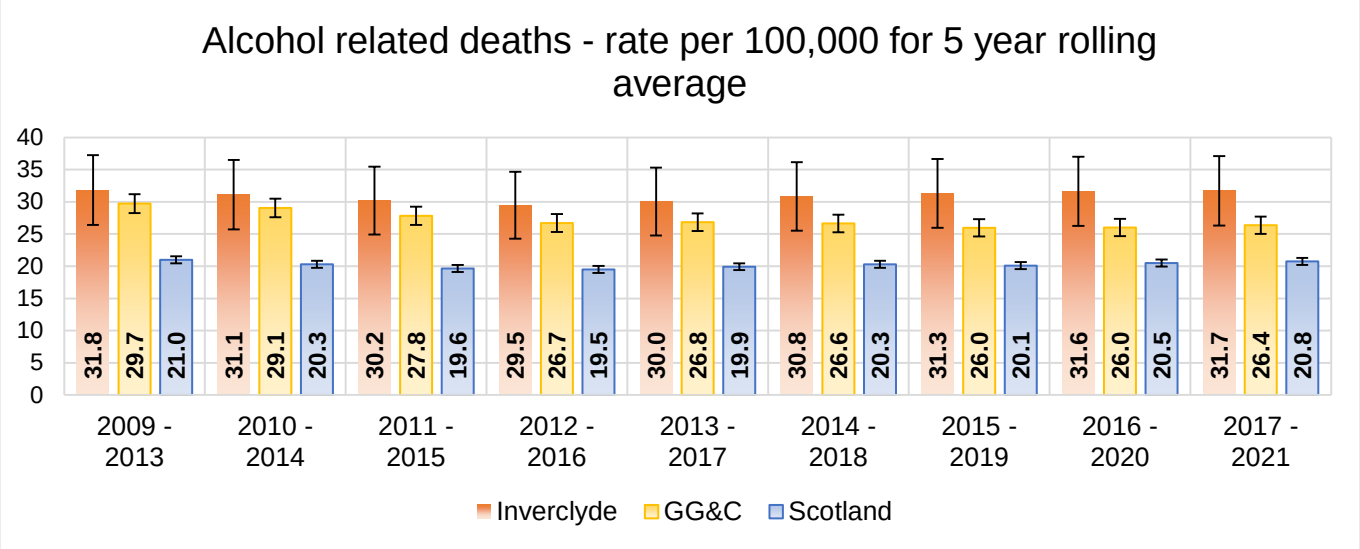
Other developments being progressed by Inverclyde ADP that may also help to prevent drug related deaths include more system wide changes, including developing a recovery community and where people are given hope that change is possible and people can and do recover. A key barrier is around stigma and Inverclyde ADP has developed a strategy and action plan to start to remove this barrier, titled "Being Accepted". Finally, Inverclyde ADP recognises the vital role residential rehabilitation can provide, but only where the scaffolding is in place to offer people the necessary support in preparation for this step as well as the support in the community following a residential placement. We are in the process of developing a clear pathway of support.

Alcohol Specific Deaths

In 2021 there were 26 recorded alcohol specific deaths in Inverclyde, down 6 from the 2020 figure of 32.



Source: NRS



Source: NRS

Preventing Alcohol Specific Deaths

NHS GG&C have undertaken an audit of alcohol specific deaths and Inverclyde was included in this cohort. Findings from this report are being presented to the Drug Related Death Monitoring Group with a view to develop an action plan to reduce alcohol specific deaths in Inverclyde.

In addition, Inverclyde HSCP are actively involved in providing responses with regards to applications made to the Inverclyde Licensing Board. The Alcohol and Drugs Partnership (ADP) is also supporting the refresh of our local Alcohol Profile. This will inform the Inverclyde Licensing Forum in considering issues of over-provision across Inverclyde and at a locality level.

Inverclyde ADP closely monitor the number of Alcohol Brief Interventions delivered locally and are in the process of exploring opportunities to expand this in wider settings. This will be included as an action to support the prevention of alcohol specific deaths.

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

We will build on our strengths. This will include our staff, our carers, our volunteers & people within our community, as well as our technology & digital capabilities

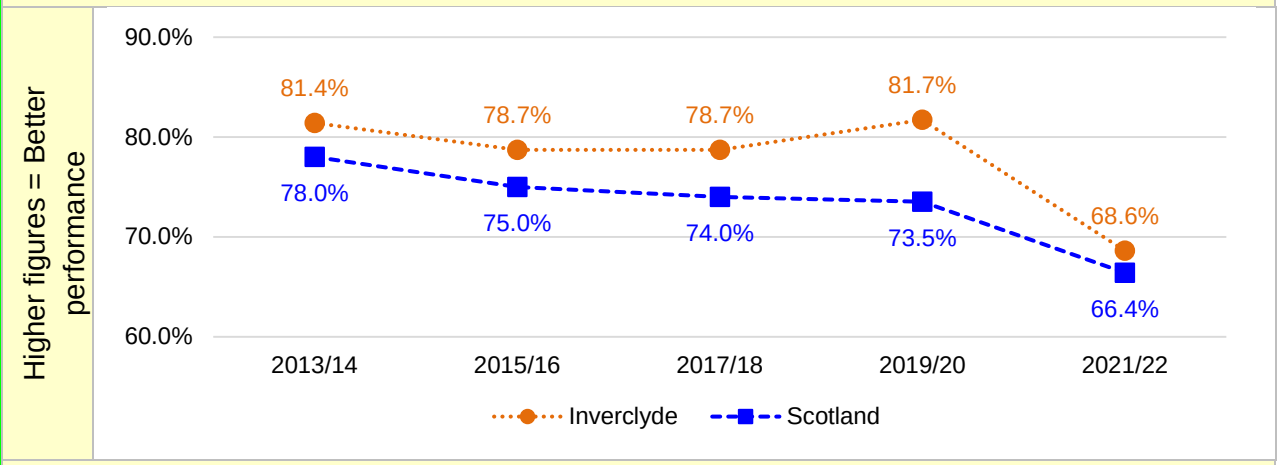
National Outcomes relating to this Big Action

1	People are able to look after and improve their own health and wellbeing and live in good health for longer
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
6	People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9	Resources are used effectively and efficiently in the provision of health and social care services

National Integration Indicators

4

My health, care or support services seemed to be well coordinated



Our performance remains fairly consistent and above the Scottish average. However, we are aiming to improve on this through our current care at home review.

Source: PHS

	2013/14	2015/16	2017/18	2019/20	2021/22
Total responses	184	197	146	274	146
Number agreed	150	155	115	224	100

Local Activity

Greenock Health and Care Centre

In May 2021 staff and services moved in to the new Greenock Health and Care Centre which was officially opened by the Cabinet Secretary for Health & Social Care on 20th October 2021. This was the culmination of several years of planning and development and offers a modern, spacious environment from which to deliver a range of health & care services that will benefit patients and staff alike. Firmly embedded within the community, facilities include a café and courtyard garden incorporating a memorial to our colleague Janice Graham, the first healthcare worker to die from Covid-19 in Scotland. A tranquil place of reflection this garden is also designed for use by the CAMHS team as an alternative place when working with young people.

A range of HSCP staff and GPs participated in online workshops which supported the development of a Primary Care Estate Strategy. Facilitated by Hub West and Higher Ground Healthcare Planning, the strategy offers short, medium & long term options for consideration and which will form the basis of future planning conversations.

Supporting Communities

Our excellent partnership working with our local communities and 3rd sector has continued. The Inverclyde Cares project Board was established with 3 key priorities for Inverclyde:

- ✓ To develop a whole system approach to Loss and Bereavement across Inverclyde
- ✓ Remembering Together, Covid-19 Memorial
- ✓ Challenging Stigma

The Bereavement work is well underway including the development of a project, No One Grieves Alone. The Covid-19 Memorial model is now finalised and the artist was recruited. This was a partnership between greenspace Scotland, CVS, HSCP and Inverclyde Council. CVS Inverclyde Resilience Network held a Challenge Stigma event in February 2022, to contribute to the work of Inverclyde Cares which promotes inclusive communities that support people to live active and fulfilling lives.

YourVoice supported the development of the Recovery Hub in Clyde Square which is now being utilised by different organisations to provide support and space for members of our Recovery community.

Our staff

Work Place Wellbeing Matters Plan

A 3 year plan was launched (2020 – 2023) to support the HSCP's organisational recovery and to ensure support for the mental health and wellbeing of the HSCPs staff remains a priority.

The overall aim of the plan is:

"Across Inverclyde we will deliver on integrated and collaborative approaches to support and sustain effective, resilient, and valued health and social care workforce"

The local Inverclyde implementation of this agenda has focused on a partnership working approach, in collaboration with our staff side representatives, 3rd sector and independent sector colleagues.

The work and initiatives carried out last year have been built on and support with health and wellbeing continues throughout the HSCP and throughout Inverclyde with our partners. Below is a summary of what was achieved since the last report:

Wellbeing Fund

A Wellbeing Fund has been established to support and promote health and wellbeing across the health and social care workforce. Staff and teams can apply for funds to support health and wellbeing initiatives. Staff teams have made the most of the fund by applying for various team activities e.g. team building outdoor events such as paddle boarding, kayaking, scavenger hunts, creating a safe outdoor fire and pizza making. Other teams have opted for indoor events such as team building through art, hatchet throwing, massage, spa days and wildlife identification team building outdoor events, team building indoor events, spa days, lunch and afternoon tea. Some of the teams have applied for funds to decorate and create a quiet, relaxing space for staff to go to and another team has applied to erect a garden of remembrance at their place of work.

- ✓ **Leisure Activities -** We have linked in with Inverclyde Leisure to provide closed fitness classes for Inverclyde Council employees.
- ✓ **Z-cards -** Currently in the process of having z-cards printed for HSCP staff which will have the details of important health and wellbeing contact numbers, both local and national.
- ✓ **Central Repository/Hub -** We have developed a Council wide wellbeing hub on the external website which is accessible to all staff (and the local community). The HSCP has a separate page which staff can access to find local and national health and wellbeing resources easily.
- ✓ **Monday Messages -** We continue to circulate information, on a 2-3 weekly basis, signposting local and national resources, training etc. to the entire staff team within HSCP and to our 3rd sector and independent sector colleagues.

- ✓ **Healthy Working Lives -** The annual assessment is on 'pause' whilst the national team focus on other priorities. The working group has started back up again and working hard to ensure that we meet the criteria to retain the Gold Award.
- ✓ **Wellbeing Events** - During Mental Health Awareness Week, 5 virtual wellbeing events were held: Stress Management; Wellbeing in Grief; Keeping Active at Work; Being Active at Work; and Managing Stress Mindfully. The events were offered out to all staff across the HSCP and the Council.
- ✓ **Mental Health Leadership and Mental health e-learning modules**

Winter Wellness Week

Inverclyde HSCP were awarded Winter Pressures money from Scottish Government for Health and Social Care (including 3rd and independent sectors) and Primary Care staff, advising that it should be used to support the wellbeing of these workforces.

We had our first 'in person' event where we were joined by lots of our local partner organisations.

Your Voice Inverclyde

Over 50 staff attended the event at various point during the day and the feedback was extremely positive – people found it fun, interesting and informative and, more importantly, they enjoyed the time out of their normal day-to-day to catch up, take a breath and have a cuppa!

In addition to all of the above, we teamed up with Inverclyde Leisure and TBR Health to offer free access to fitness classes, swim, sauna etc. during Winter Wellness Week – staff took up the opportunity to attend classes and take time to go for a swim either during or after work.

Compassionate Grit (focussing on taking the lead with mindset, motivation and goals)

Rig Arts Inverclyde hosted a wellbeing drawing workshop

Inverclyde Advice Services – delivered a session on financial wellbeing

Competition time with JD Gyms

Parklea Branching Out

Inverclyde HSCP will continue to implement and develop the staff wellbeing plan to ensure staff wellbeing is supported and improved

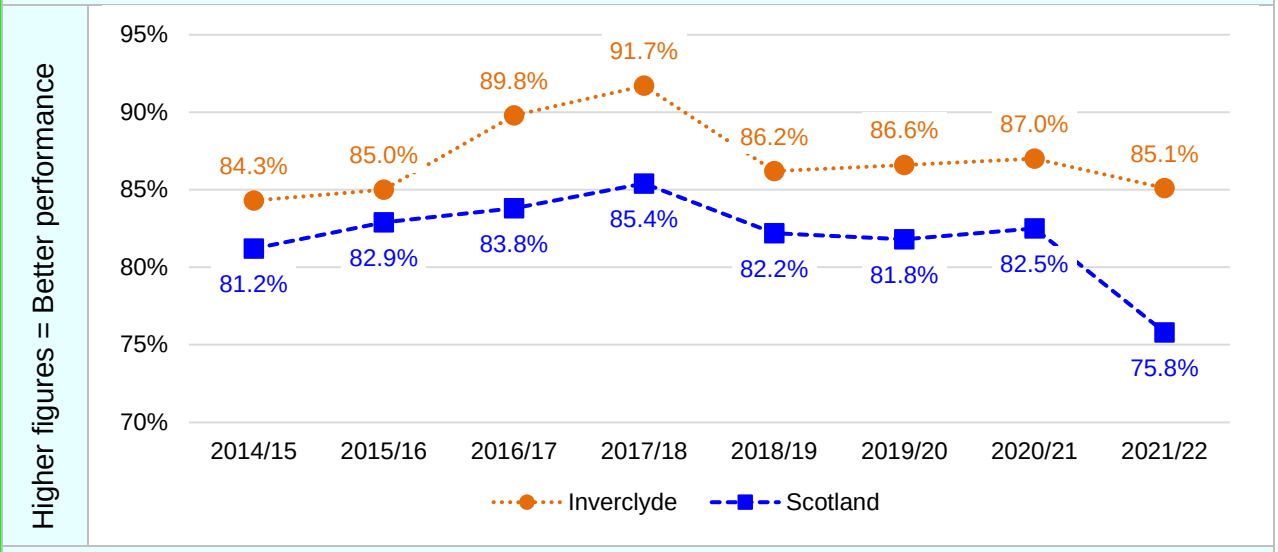
New Scots Integration Work

The New Scots refugee integration strategy 2018-2022 is built on partnership and collaboration, led by the Scottish Government, COSLA and the Scottish Refugee Council and sets out a vision for a welcoming Scotland where refugees and people seeking asylum are able to rebuild their lives from the day they arrive.

Inverclyde has continued to play its part in supporting refugee resettlement with many Afghan and Syrian refugees now firmly resettled and embedded within the local community. With the Ukrainian crisis we are now engaged with a number of Ukrainians who have been supported through the Homes for Ukraine scheme to come to Scotland. Throughout 2022/23 we expect our New Scots population to grow and look forwarding to supporting Inverclyde to embrace our new populations.

National Integration Indicators

17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections



Even though our performance dropped from a high of 91.7%, we continue to do well reflecting the strong partnership working between the HSCP and our local care provider organisations

Source: PHS

Care Inspectorate Activity

The total number of providers inspected during 2021/2022 was 27. These included inspections to Older People Care Homes, Care at Home providers and one Children and Family provider. Six providers where inspected on more than one occasion resulting in 35 inspections taking place.

Nine of the services inspected were Inverclyde Area services.

Eighteen of the services inspected were Out of Area services where Inverclyde HSCP have service user/resident placements.

Of the 27 services that were inspected during their initial visit:

- ✓ 3 services improved their grades.
- ✓ 15 services maintained their grades.
- ✓ 9 services grades decreased.

Of the 27 services that received an initial visit, 6 services then had a second follow up visit by the Care Inspectorate to review the requirements/areas of improvement that had been made on the initial visit. These 6 services initially had a decrease in their grades however on the follow up visit 2 services increased initial grades and 3 services maintained their initial grades.

One service had 3 inspections carried out with an initial decrease, however on the follow up visit grades were maintained and on the 3rd final visit the service increased their grades.

For the 9 inspections undertaken in the Inverclyde area:

One service increased their grades, 6 services maintained their grades and 2 services had a decrease in their grades.

For the services who received a decrease on their grades;

One changed from ‘Adequate’ to ‘Unsatisfactory’;

One changed from ‘Adequate’ to ‘Weak’

From the initial inspections the Care Inspectorate made 53 areas of improvement and 34 requirements.

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

Recommendations

The provider should ensure people's day-to-day activities are meaningful and accessible for everyone living in the home. This should involve all staff, reflect individual preferences, and include activities to maintain and enhance people's level of independence, skills and abilities.

To support residents' safety and wellbeing, the provider should ensure that all staff follow up to date guidance regarding infection prevention and control (IPC) procedures. This should include but is not limited to training in IPC practice and ensuring staff are aware of the correct IPC guidance and procedures.

Systems should be utilised to support the oversight and management of the service to support improvements. People using the service and the staff team should be given opportunity to share their views in how to improve the quality of the service.

To ensure a consistent approach to medication administration, protocols should be in place where medication is prescribed on an 'as required' basis, and the outcome of medication administered recorded to indicate its effectiveness.

Requirements

Provider must ensure that there are adequate processes in place to notify the Care Inspectorate of specific events, or changes within the service as per 'Records that all registered care services (except childminding) must keep and guidance on notification reporting'.

Provider must ensure that all staff are trained in Infection Prevention and Control measures in relation to Covid-19; (HSCS 3.14) taking account of 'Covid-19: Information and Guidance for Social, Community and Residential Care Settings (Excluding Adult and Older People Care Home settings) Version 1.8.'

Care Homes

Care Home Assurance Tool (CHAT) visits commenced across all NHSGGC partnerships in May 2020 in response to the impact of Covid-19. The visits set out with the aim to provide additional clinical input, support and guidance to care homes which were under extraordinary pressure. This work aligned to the Executive Nurse Directors responsibilities set out by Scottish Government in which they were to provide nursing leadership, professional oversight, implementation of infection prevention and control measures, use of PPE and quality of care within care homes.

Care homes across Inverclyde received assurance visits in 2021 from visiting teams made up of a group of up to four staff representing nursing, commissioning, social work with a Senior nurse leading the visit from the HSCP or Care Home Collaborative.

Additional supportive visits particularly during Covid-19 outbreaks were also undertaken. Good practice and improvements were identified during the assurance process, with care homes taking ownership of the actions required and working in collaboration with HSCP colleagues to achieve improvements.

The NHS GGC (Greater Glasgow and Clyde) agreed assurance tool which is utilised for the visits focuses on three main areas:

- ✓ Infection Prevention and Control (IPC)
- ✓ Resident Health and Care Needs
- ✓ Workforce, Leadership and Culture

Findings from the visits included -

- ✓ A very high level of compliance against the IPC criteria in the report
- ✓ Good practice evidenced in relation to resident health and care needs. Care homes felt homely and it was clear that staff were working to support a person centred approach
- ✓ Many staff reflected on how difficult it had been throughout the pandemic, particularly when there were resident deaths in the homes and when the residents were not able to receive visitors. Staff reported that they felt supported by their management teams and were happy in their roles.

CHAT reports for individual homes are all submitted to NHSGGC for analysis as part of the NHS Board wide assurance processes, and overarching themes and trends for GGC are pulled from this process which assists with the ongoing development of the CHC.

It should be noted that care assurance visits are just one part of the supportive framework around care homes and sit alongside HSCP day to day relationships with individual care homes, HSCP oversight Huddles and the Care Home Assurance Group. However, the CHAT outcomes give the opportunity to discuss with care homes areas of strength as well as key priorities for the next 12 months.

The Care Home Collaborative was established to work with and further support care homes during and in recovery from the Covid-19 pandemic. The Collaborative is based on the principle of bringing people together across the many different groups, organisations and professions who are already working alongside the care home sector and for those groups to work collaboratively towards a shared goal.

The overarching goal is in the spirit of learning, sharing and improving together to ensure the best possible lives for care home residents aligned to what matters to them.

The collaborative works in partnership with the homes and HSCP and can offer added expertise over a range of areas including (but not limited to) Infection Prevention and Control, person centeredness, food, fluid and nutrition, tissue viability, quality improvement, leadership and education. This expertise has been invaluable to homes during Covid-19 outbreaks in providing support and the team can work to support homes with any improvements identified as a result of the CHAT visits and to share good practice across the wider system.

Some examples of local good practice identified from CHAT visits includes –

The home is involved in many community projects such as Together with Music project which connects them with a local school to carry out various activities

There were lots of different areas within the home, for staff to provide meaningful activities that supported individual resident's needs i.e. the quiet lounge with busy bench for a resident who now has dementia, but used to like to work with tools

There is a private Facebook page for the home and families can see resident activities and their family member's participation in these online

One member of staff talked openly about spending time with individuals who walk with purpose, and that with time he has learnt how to engage with them and make them smile

The home is carrying out a North Coast 500 challenge at the moment and aim to "travel" a total of 500 miles collectively either walking or cycling. Residents are using pedalling machines and total distance being recorded. It has been noted that residents who had difficulties with mobility previously have improved due to participating in the challenge

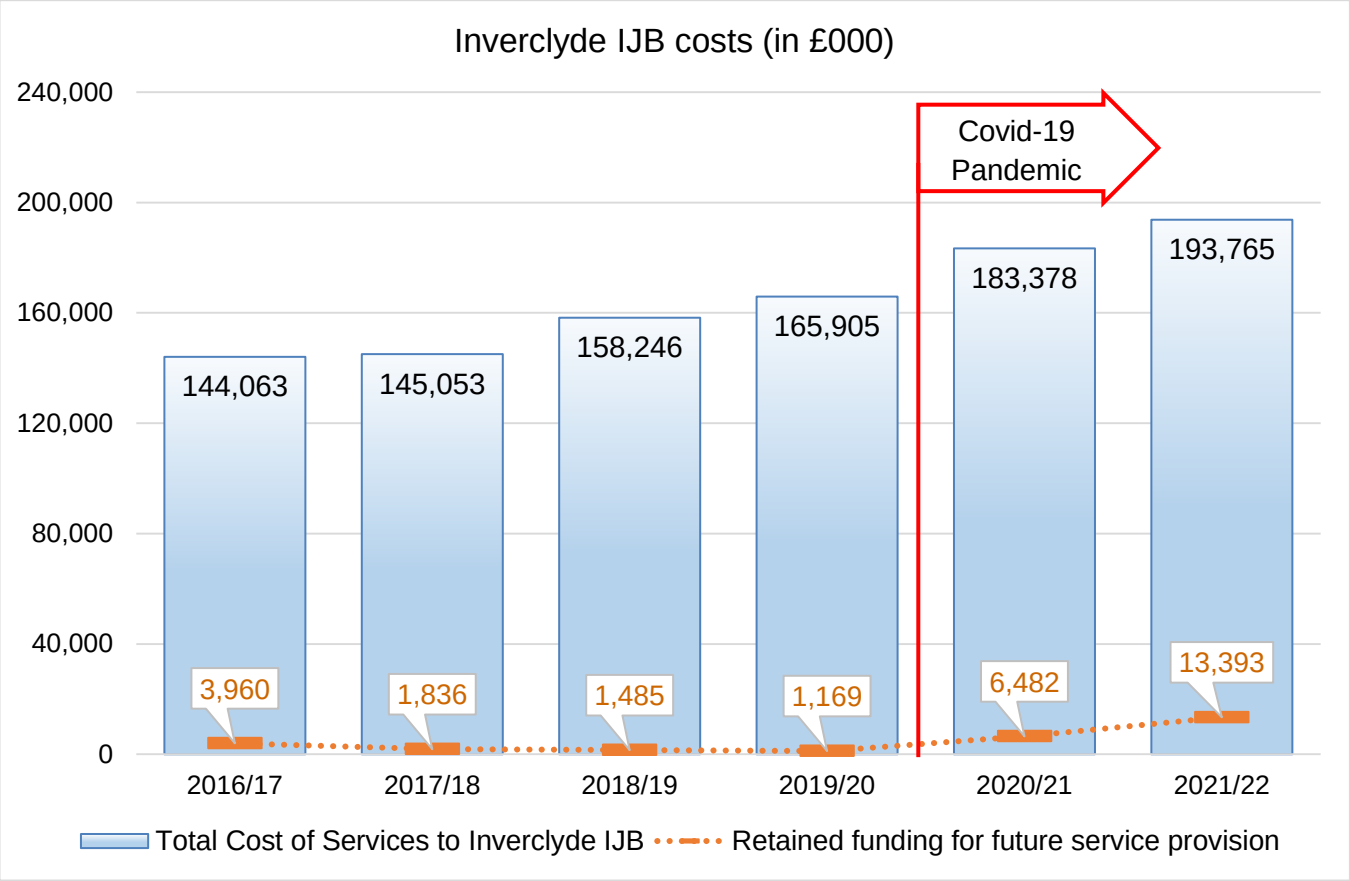
Section 3 – Finance

Inverclyde IJB Financial Summary by Service

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22* £000
Strategy and Support Services	2,591	2,416	2,111	2,133	1,881
Older Persons	26,867	27,020	28,407	30,383	31,015
Learning Disabilities	10,653	11,898	12,545	12,299	13,286
Mental Health – Communities	5,804	6,712	7,101	7,485	7,807
Mental Health – In Patients	9,338	8,729	9,737	10,607	10,689
Children and Families	12,986	13,738	14,114	14,711	16,571
Physical and Sensory	2,659	3,117	3,203	2,939	3,166
Addiction / Substance Misuse	3,389	3,464	3,181	3,826	3,807
Assessment and Care Management / Health and Community Care	7,772	8,258	9,981	10,789	13,055
Support / Management / Administration	3,807	4,174	4,339	450	2,840
Criminal Justice / Prison Service	(38)	26	49	148	85
Homelessness	967	791	1,043	1,173	1,240
Family Health Services	21,766	25,547	27,056	29,618	25,911
Prescribing	18,817	18,591	18,359	18,242	19,166
Covid-19 pandemic Funding				10,400	7,288
Change Fund	1,236	1,133	1,044	0	0
Cost of Services directly managed by Inverclyde IJB	**128,614**	**135,614**	**142,270**	**155,201**	**157,805**
Set aside	16,439	22,632	23,635	28,177	35,960
Total cost of Services to Inverclyde IJB	**145,053**	**158,246**	**165,905**	**183,378**	**193,765**
Taxation and non-specific grant income	(146,889)	(159,731)	(167,074)	(189,860)	(207,158)
Retained funding for future service provision	**1,836**	**1,485**	**1,169**	**6,482**	**13,393**

*at the time of publishing the 2021/22 figures were provisional and still to be approved by committee.

The IJB works with all partners to ensure that best value is delivered across all services. As part of this process the IJB undertakes a number of service reviews each year to seek opportunities for developing services, delivering service improvement and generating additional efficiencies.



Budgeted Expenditure vs Actual Expenditure per annum

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
Projected surplus / (deficit) at period 9	(1,426)	(897)	(37)	(690)	855
Actual surplus / (deficit)	1,836	1,485	1,169	6,482	13,393
Variance in Under/(Over) Spend	**3,262**	**2,382**	**1,206**	**7,172**	**12,538**

Explanation of variances

2017/18 - spend on Earmarked Reserves lower than anticipated coupled with a higher than anticipated overall underspend on services, mainly Social Care, as outlined in the Annual Accounts

2018/19 - higher than anticipated underspends on services, mainly Social Care, as outlined in the Annual Accounts

2019/20 - higher than anticipated underspends on services due to delayed spend on some projects funded through reserves, delay in filling vacancies and additional income received in year, as outlined in the Annual Accounts

2020/21 - variance is higher than anticipated, as a result of underspends on services due to Covid-19 pandemic and delays on some projects funded through reserves, delay in filling vacancies and additional funding for Covid-19 pandemic costs received in 2020/21, being carried forward to reserves for future years spend.

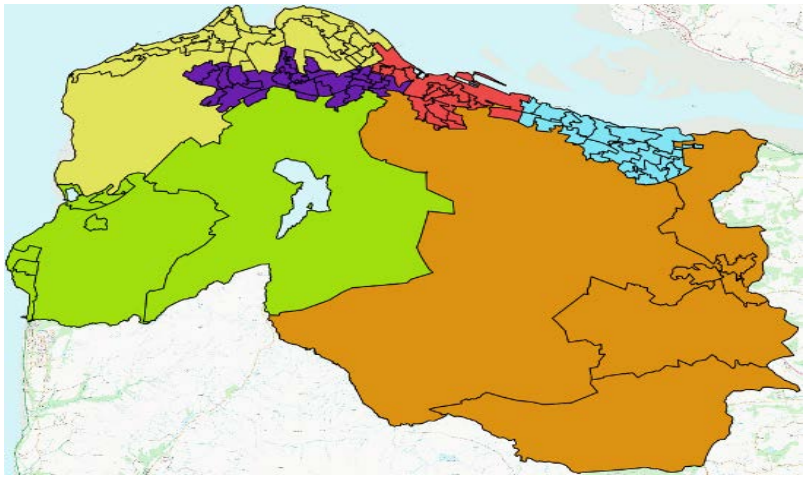
2021/22 – the main reasons for movement in the position since period 9 is additional Covid-19 funding from Scottish Government received to fund spend in 2022/23 of £8.130m, additional Winter Pressures funding of £1.135m, and funding for Primary Care Improvement, Mental Health Recovery and Renewal, Alcohol and Drug Partnership and a few smaller funds totalling £4.367m. These funds have all been earmarked for use in the next financial year.

Section 4 – Localities

A joint approach to locality planning had been adopted by Inverclyde Alliance, the area's Community Planning Partnership and Inverclyde Health and Social Care Partnership. It aimed to empower communities by strengthening their voices in decisions about public services. Locality planning is guided by two pieces of legislation:

- ✓ The Community Empowerment (Scotland) Act 2015 placed a requirement on community planning partnerships to produce locality plans for smaller areas of Inverclyde and work with communities to agree what the key priorities are that should be addressed in those locality plans.
- ✓ The Public Bodies (Joint Working) (Scotland) Act 2014 placed a requirement on Inverclyde's Health and Social Care Partnership (HSCP) to create at least two localities. The purpose of establishing localities for the HSCP is to provide an opportunity for communities and professionals such as GPs, social workers, pharmacists, and dentists to take an active role in and provide leadership for local planning of services.

Across Inverclyde, six localities were created that cover the whole of Inverclyde to ensure that every community has the opportunity to take part. The intention was that each locality would comprise of a Locality Planning Group (LPG) and a Communications and Engagement Group (CEG).



- ✓ Kilmacolm and Quarriers Village
- ✓ Port Glasgow
- ✓ Greenock East and Central
- ✓ Greenock West and Gourock
- ✓ Greenock South and South West
- ✓ Inverkip and Wemyss Bay

Impact of Covid-19

The joint approach between the HSCP and the wider community planning partnership to develop localities continued into 2021/22 albeit at a much slower pace due to the impact of Covid-19.

Throughout 2021/22 a review of the locality planning arrangements was undertaken Initial progress was made in establishing the groups which were led by different partners within the localities. Some communities were easier to engage than others and the Communication and Engagement Groups have all developed at different paces, with greater success in some localities than others. The Covid-19 pandemic impacted on the continued development with changes to service delivery and the shift to online meetings.

In terms of Locality Planning Groups, It was agreed that an incremental approach to establishing the six locality planning groups would be taken with two LPGs being developed in Port Glasgow and Inverkip and Wemyss bay localities. These areas were to be pilots and learning from these would help establish future LPG development. Both locality planning groups have now met and had very different approaches to how the meetings were run. The group meetings involved, in the main, community representatives from Communication and Engagement Groups with a few statutory partners.

Feedback following the meetings from the community has been that many people are keen to be involved in the communication and engagement groups however do not want to be involved in formal governance structures surrounding locality planning. In addition the differing roles of Community Councils and Locality Planning Groups has been the subject of discussion and the need for clarity as to their statutory status.

Feedback from partners included capacity concerns regarding the expected attendance at six Locality Planning Groups on a regular basis. In particular it has been difficult to involve health and social care professionals e.g. GP's; pharmacists etc. due to the work demands, and concerns raised as to the future requirement for their involvement in six LPGs.

The role of LPGs for IJBs is to ensure service planning and utilisation of resources at a local level, therefore with key professionals missing this would prove difficult.

Having piloted the Locality Planning Groups and discussed with a range of partners and community members, learning has emerged which has led to the realisation that one model may not be the best approach. Whilst this was a common sense approach, based on good rationale for a small locality areas such as Inverclyde, the concern is by pursing this approach it may not meet either set of legislation nor meet the needs of the Inverclyde community and partners.

Learning from the current model of locality planning across Inverclyde has concluded that it is not in the best interests of all partners to continue with this approach. A new model of continuing with the six Communication and Engagement Groups and the development of two Health and Social Care Locality Groups is seen as the way forward with plans to develop these groups throughout 2022.

Appendix 1 - National Outcomes

National Health and Wellbeing Outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including support to reduce any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

National Outcomes for Children

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

National Outcomes for Criminal Justice

13. Prevent and reduce further offending by reducing its underlying causes.
14. Safely and effectively manage those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all.

Glossary of abbreviations

A&E	Accident and Emergency department
AAU	Acute Assessment Unit
ADPM	Advanced Dementia Practice Model
ADRS	Alcohol and Drug Recovery Service
ADP	Alcohol and Drugs Partnership
APR	Annual Performance Report
AWI	Adults with Incapacity
BF	Breast Feeding
CHAT	Care Home Assurance Tool
CJSW	Criminal Justice Social Work
CLW	Community Link Worker
CPO	Community Payback Order
CTAC	Community Treatment and Care Services
DZ	Data Zone
ERA	Environmental Risk Assessment
GG&C	Greater Glasgow and Clyde Health Board
GP	General Practitioner
HEPMA	Hospital Electronic Prescribing and Medicines Administration
HSCP	Health and Social Care Partnership
HLE	Healthy Life Expectancy
IJB	Integration Joint Board
ICC	Inverclyde Carers Centre
IRD	Initial Referral Discussions
IPCU	Intensive Psychiatric Care Unit
LPG	Locality Planning Group
MAPPA	Multi-Agency Public Protection Arrangements

MAT	Medication Assisted Treatment
MHO	Mental Health Officer
MMR	Measles, Mumps and Rubella
MSG	Ministerial Steering Group
NHS	National Health Service
NRS	National Records for Scotland
PCIP	Primary Care Improvement Plan
PDS	Post Diagnostic Support
PHS	Public Health Scotland
RFA	Request for Assistance
RSL	Registered Social Landlord
SDS	Structured Deferred Sentence
SIMD	Scottish Index of Multiple Deprivation
SMR	Scottish Morbidity Record
SNIPS	Special Needs in Pregnancy Service
TEC	Technology Enabled Care

Inverclyde Health and Social Care Partnership

Hector McNeil House

Clyde Square

Greenock

PA15 1NB

INVERCLYDE HSCP Health and Social Care Partnership

NHS Greater Glasgow and Clyde

Inverclyde council