INVERCLYDE
HSCP
Health and Social Care Partnership

Inverclyde Health and Social Care Partnership

Annual Performance Report 2022-2023

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 ክቕርብ ይኽእል።

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

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

Inverclyde HSCP, Clyde Square, Greenock, PA15 1NB ☎ 01475 715365

Welcome to our seventh Annual Performance Report (APR) which reflects our progress at Inverclyde Health and Social Care Partnership (HSCP) over a challenging year. This is my first Annual Performance Report since joining the organisation in August 2022 as Chief Officer.

This Annual Report evidences that there is much to be proud of, however it also shows that the HSCP has many challenges ahead. As well as a growing older people's population and increasing levels of need in our population, against a backdrop of financial challenge, the pandemic exposed deep inequalities that have existed for too long, with the most severe impact on those communities who were already disadvantaged. This, combined with the onset of a cost-of-living crisis has left many of our citizens exposed to financial peril and vulnerable to mental and physical health issues.

Whilst the Covid-19 pandemic is now over, its lasting impacts continued into 2022/23. Interim governance structures developed in 2020/21 were continued into 2022/23 as we moved through the pandemic. Throughout this time the HSCP continued to work to put people at the centre of all that we do and ensured that essential services were delivered safely and effectively and in line with our Strategic Plan.

The Strategic Plan which had previously been reprioritised to focus on Covid-19 recovery was refreshed throughout 2022/23. The refreshed plan along with an Outcomes Framework to show progress against both our national and local indicators was formally approved at the March 2023 IJB.

Despite the challenges, we made a difference to thousands of lives in 2022-2023, and that is down to the resilience and dedication of health and social care staff and third sector colleagues and partners. Since joining Inverclyde HSCP, I have been struck by the care, compassion, and commitment I have witnessed provided by our staff to their patients, service users and our community. Excellent partnership working with the Third and independent sector is evident in the creativity and support provided within our community.

This Annual Performance Report 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 2022/23. We will continue to review performance and continue to develop our performance management arrangements with the aim of improving and scrutinising our performance to achieve better outcomes for our community.

The HSCP continues to be ambitious for our communities and this report highlights the positive outcomes the integration of health and social care services can have on individuals, families, and the wider community along with the input of those with lived experiences of our services.

It has been a privilege to lead the partnership throughout 2022/23 and I continue to be proud of the work we do in and across Inverclyde.

Kate Rocks

Chief Officer

Inverclyde HSCP

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SECTION 1: Introduction

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

This is the seventh report for Inverclyde Integration Joint Board (IJB) and in it we reflect on the last year (2022/23) and consider the progress made in delivering the actions set out in our Strategic Plan (2019-24); reflect on key service developments and innovation that has shone through; and review our performance against agreed National Integration Indicators (NII) 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 and local outcomes, and examples from across the HSCP services as 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 Locality Planning

Appendices - National Outcomes

Glossary - List of the abbreviations used in this report.

Overview of Inverclyde HSCP

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 new and 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.

Population

The latest population estimates for Inverclyde were published by National Records for Scotland (NRS) on 13 of July 2022, estimating for mid-year 2021.

Inverclyde has a total estimated population of 76,700, making up 1.4% of Scotland's total. The population has decreased over the last decade, with projections showing this will continue. The gender split is Inverclyde is one male to every 1.09 females, which is a higher proportion of females than Scotland has (1.05). 21.8% of Inverclyde's population is aged over 65 years, compared to 19.6% for Scotland. Over time this is expected to increase in Inverclyde, with the projected dependency ratio set to increase from 58.6% in 2023 to 72.6% in 2043, widening the gap to Scotland (NRS 2018-based population projections).

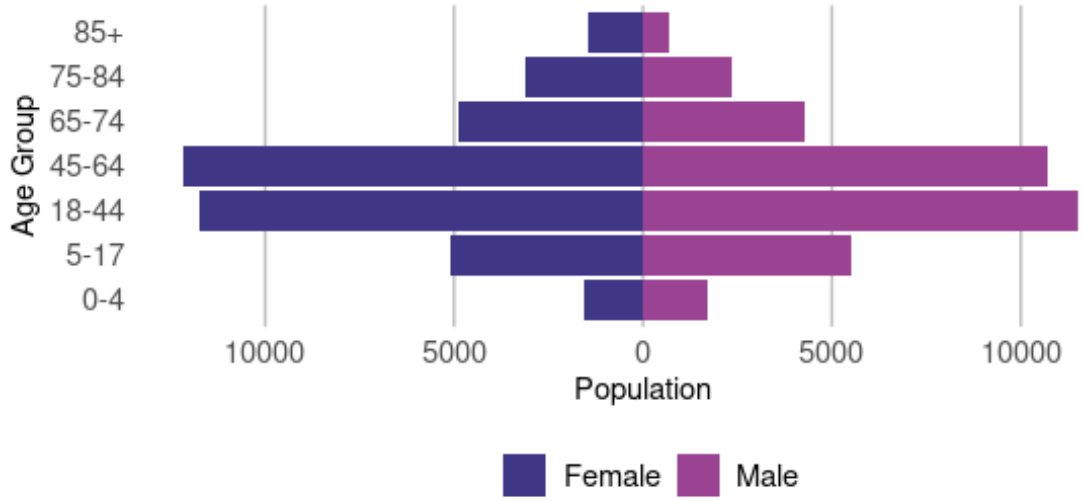
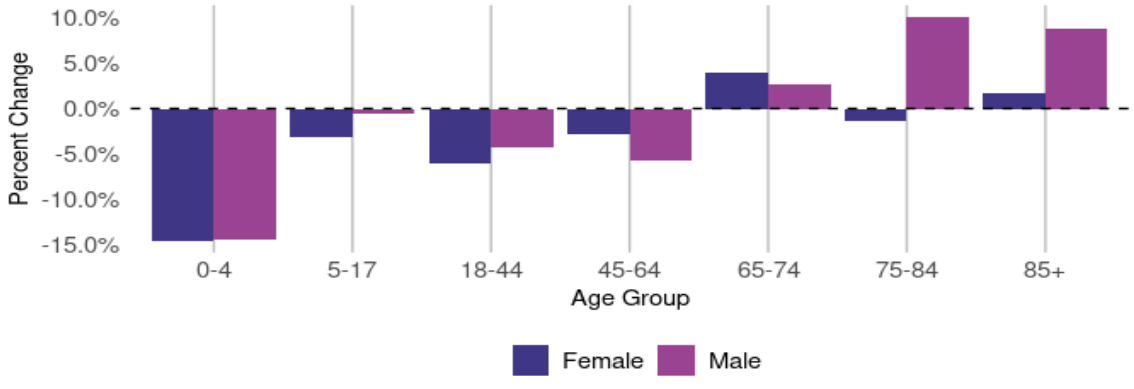


Figure 1: Population by age and sex

Figure 2 shows how the population structure has changed between 2016 and 2021.



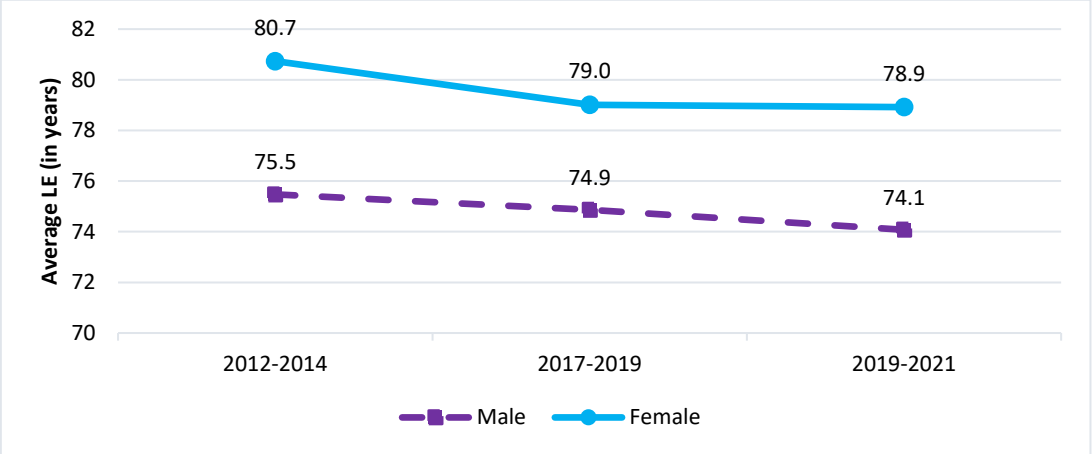
Source: National Records Scotland

Figure 2: Percent change in population structure from 2016 to 2021

Life Expectancy

In the latest period available from 2019 - 2021 (five-year aggregate), the average life expectancy in Inverclyde locality was 74.1 years of age for men, and 78.9 years of age for women. A 10-year time trend can be seen in Figure 5.

Figure 5: Average life expectancy in men and women over time for Inverclyde



Source: NRS Life Expectancy Estimates

Table 2 provides the average life expectancy for men and women in different areas for the latest period available.

Table 2: Average life expectancy in years for the latest time periods (2019 - 2021 aggregated years for the HSCP; 2018 - 2020 aggregated years for other areas).

Sex	Inverclyde	NHS Greater Glasgow and Clyde	Scotland
Female	78.9	79.5	80.8
Male	74.1	75.0	76.6

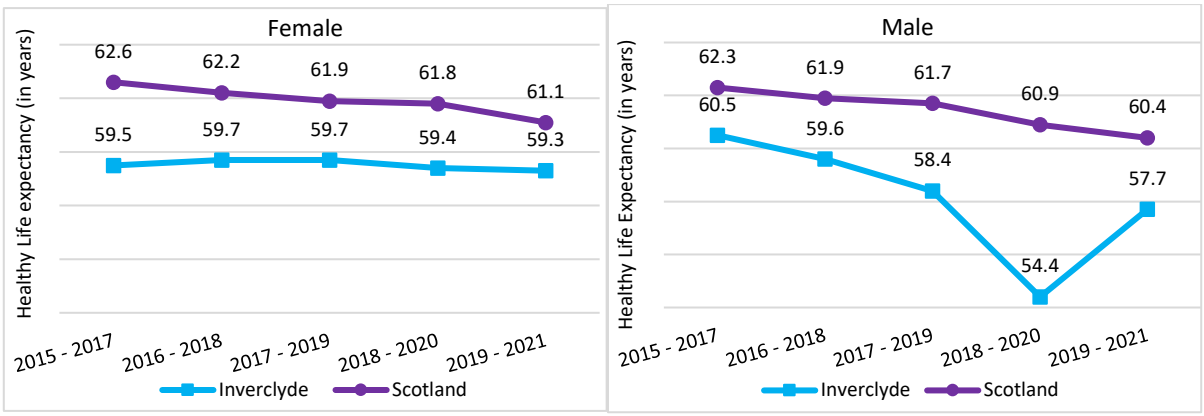
Source: NRS

As an organisation, we continue to aim to reduce both the gap to the national average in addition to the gap between males and females.

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).

Figure 6: Healthy Life Expectancy in men and women over time



As shown in Figure 6, NRS has estimated a decrease in the healthy life expectancy in Inverclyde and Scotland in recent years.

Healthy Life Expectancy (HLE) is an important measure to account for alongside life expectancy, 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 as these impact on the needs and demands of local health and care services.

Births

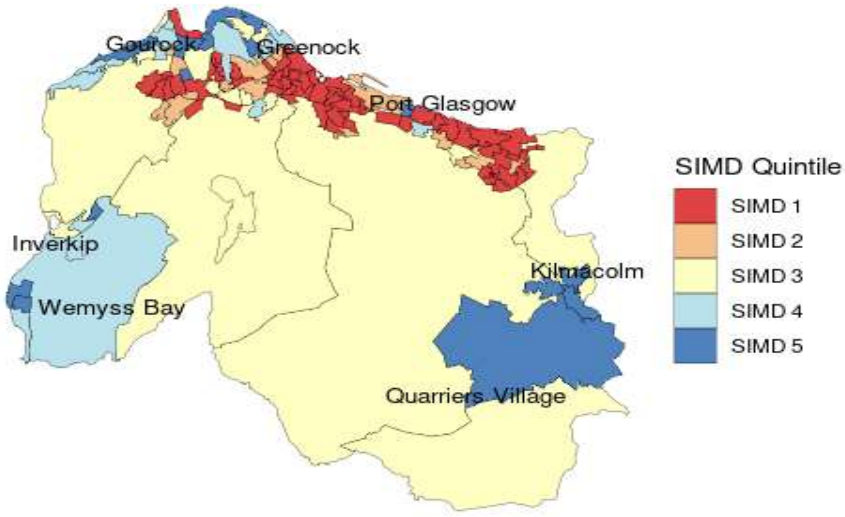
NRS state that the birth rate in Inverclyde has steadily decreased in the last decade, as it has across Scotland. Alongside this, between 2001 and 2021, the most common age group of mothers (at time of birth) changed from 30-35 to 25-29. The death rate in Inverclyde decreased slightly between 2020 and 2021, from 13.5 per 1,000 population to 13.4. This compares to a rate of 11.6 per 1,000 population for Scotland.

Deprivation

The following section explores the deprivation structure of Inverclyde through the Scottish Index of Multiple Deprivation (SIMD). The SIMD ranks all data zones in Scotland by several factors including Access, Crime, Education, Employment, Health, Housing and Income. Based on these ranks, each data zone is then given an overall deprivation rank, which is used to split data zones into Deprivation Quintiles (Quintile 1 being the most deprived, and Quintile 5 the least). The most recent SIMD ranking was carried out in 2020. This section mainly focuses on the SIMD 2020 classifications; however, the 2016 classifications are used to assess how deprivation has changed in Inverclyde when compared to the rest of Scotland.

Inverclyde has a relatively high proportion of its population living in the most deprived SIMD quintile (43.6%) and predictably, a smaller proportion in the least deprived SIMD quintile (14.8%). Comparing deprivation in 2016 and 2020 shows a polarising of the population towards most and least deprived quintiles, showing a heightened gap in deprivation compared to Scotland as a whole.

Figure: Map of Data Zones within Inverclyde coloured by SIMD (2020) quintiles



Source: Scottish Government, Public Health Scotland

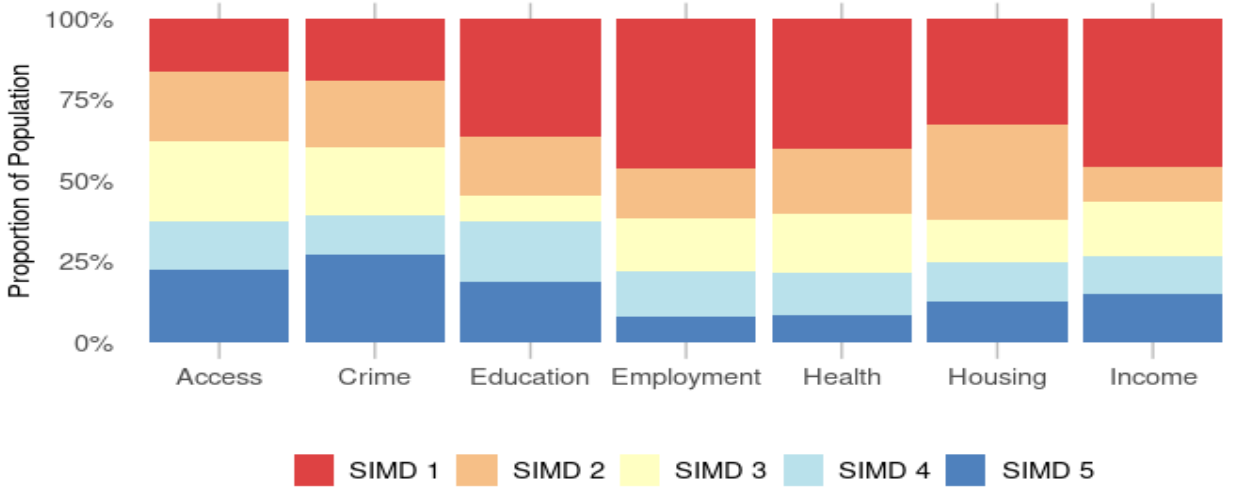
Table 1 details the percentage of the locality's 2016 population living in the 2016 SIMD Quintiles, the percentage of the 2021 population living in the 2020 SIMD Quintiles, and their difference for comparison. Figure 5 then breaks down SIMD by domain in Inverclyde.

Table 1: Percentage of the Inverclyde population living in the 2016 and 2020 SIMD Data zone Quintiles in 2016 and 2021 respectively.

Quintile	Percent of 2016 Population (SIMD 2016 Ranking)	Percent of 2021 Population (SIMD 2020 Ranking)	Difference
SIMD 1	42.3%	43.6%	1.3%
SIMD 2	12.9%	13.4%	0.5%
SIMD 3	15.6%	13.9%	-1.6%
SIMD 4	17.4%	14.3%	-3.1%
SIMD 5	11.8%	14.8%	2.9%

Source: Scottish Government, Public Health Scotland, National Records Scotland.

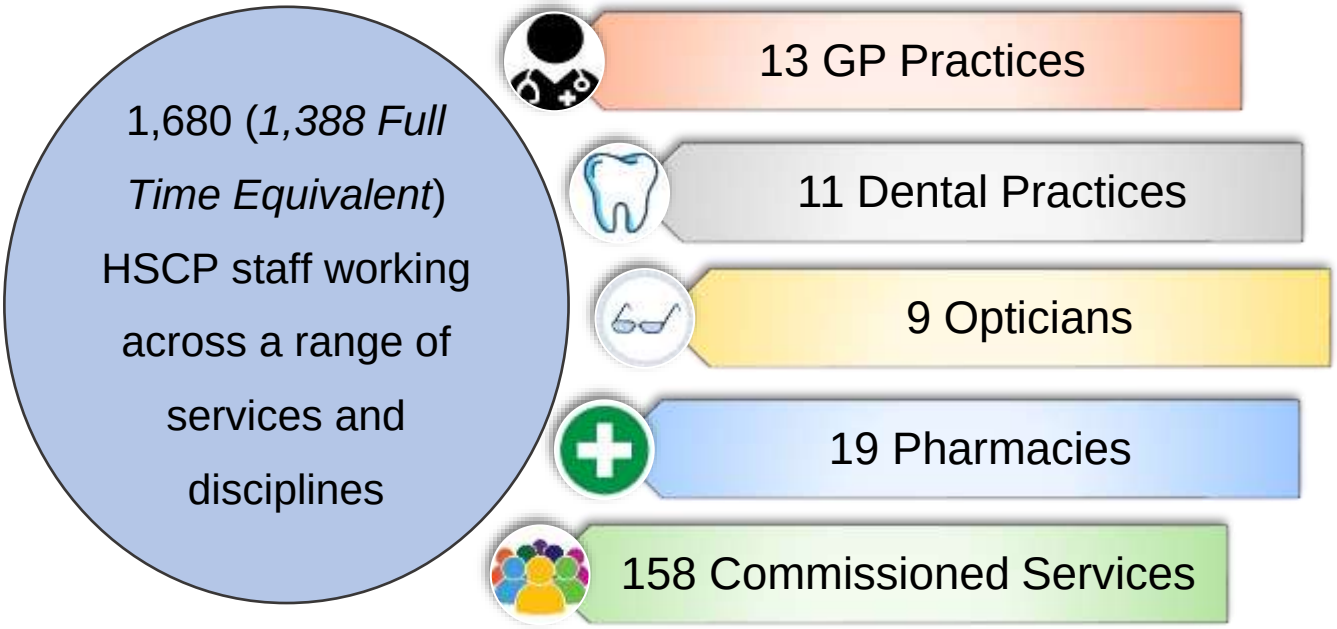
Figure 5: Proportion of the population that reside in each 2020 SIMD quintile by domain in 2021 broken down by SIMD domain.



Source: Scottish Government, Public Health Scotland, National Records Scotland

Our resources

The HSCP delivers an extensive range of services across primary care, health and social care and through several commissioned services.



Services Map

Inverclyde has a total of 13 GP Practices, 1 Emergency Department and 21 Care Homes (13 elderly care, 8 Other) – Care Inspectorate datastore (MDSF)

Strategic Vision

Inverclyde IJB set out through its five-year Strategic Plan (2019-24) and the Six Big Actions, our ambitions, and our vision. These reflected 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.

The five-year (2019-24) Inverclyde Strategic Plan set out the shared strategic priorities and ambitions for Inverclyde. This plan was refreshed throughout 2022/23 to reflect updated priorities and key deliverables for 2023/24. The refreshed plan has retained the Six Big Actions which link clearly with the nine National Outcomes for Scotland and the National Outcome Framework for Children, Young People and Community Justice.

This refreshed Strategic Plan and associated Implementation Plan and Performance Framework will lead the IJB forward for 2023/24 and plans are already underway for development of the next Strategic Plan for 2024/25 onwards.

The refreshed plan and associated documents can be accessed here Strategies, Policies and Plans - Inverclyde Council

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 Priority 6 Big Actions

Big Action 1: Reducing Inequalities by Building Stronger Communities and Improving Physical and Mental Health	Big Action 2: A Nurturing Inverclyde will give our Children and Young People the Best Start in Life	Big Action 3: Together we will Protect Our Population
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	Big Action 5: Together we will reduce the use of, and harm from alcohol, tobacco and drugs	Big Action 6: We will build on the strengths of our people and our community

SECTION 2: Performance

This section of the report will focus on our key performance within 2022/23 and will provide a range of national and local 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 and Families and Criminal Justice and again are all structured and reported using our Six Big Actions. Appendix 1 (page 65) shows all the National Outcomes.

This section contains information on

- the 23 National Integration Indicators (NII).
- the Ministerial Steering Group (MSG) Indicators.
- the Local Government Benchmarking Framework (LGBF).
- Inverclyde HSCP Local Performance Indicators.

The following scorecards have been collated to succinctly show how Inverclyde HSCP have performed against a variety of measures in the last year. This year's performance has been compared against previous years and against the rest of Scotland as a benchmark. The following table shows what's included in the scorecards and how to interpret the information.

Column	Description		
Indicator	Description of the measure being shown. Type of measure also shown (Total, %, Rate per 1,000 population)		
Rate	The most recent measure for Inverclyde HSCP (2022/23 or otherwise specified)		
Difference from Previous Year (%)	Percentage change in last year of recording.	●	Performance has improved since the previous year
		▲	Performance has stayed the same since the previous
		◆	Performance has declined since the previous year
Difference from Scottish Rate	Percentage difference from the most recent Scottish average.	●	Performance is better than the Scottish average
		▲	Performance is the same as the Scottish average
		◆	Performance is below the Scottish average
HSCP Rank	Ranks Inverclyde within the 31 HSCPs across Scotland. Rank 1 is the highest rate, Rank 31 is the lowest rate. The colour shows whether or not a high rank signals good performance or bad performance. NOTE: For the LGBF indicators - these are ranked 1 to 32 for the Local Authorities instead of 31 HSCPs. **Rank 1 for LGBF indicators signifies the best performing area, as per the LGBF website.**	●	Performance ranks in the top 16 HSCPs across Scotland
		▲	Performance ranks between 17 and 25 of the HSCPs
		◆	Performance ranks in the bottom 7 HSCPs across Scotland
5-year Trend	A spark-line chart showing the trend in Inverclyde in the past 5 years. The red dots represent the highest and lowest points		

Within each performance scorecard section, we have included an explanation as to where the data comes from and a short analysis of what the indicators tell us.

Within each Big Action Section, you will find examples of good practice and case studies to highlight the positive outcomes for our community.

National Integration Indicators

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:

1. Outcome indicators based on survey feedback- The Health and Care Experience survey (HACE) is sent to a random sample of patients who are registered with a GP practice in Scotland. Updated every two years - most recent data is 2021/22.

2. Data indicators- The primary source of data for these indicators are Scottish Morbidity Records (SMRs) which are nationally collected discharge-based hospital records. In accordance with recommendations made by Public Health Scotland (PHS) and communicated to all Health and Social Care Partnerships, the most recent reporting period available is calendar year 2022; this ensures that these indicators are based on the most complete and robust data currently available.

National Integration Indicators

Indicator Number	Indicator	Rate	Difference from Previous Year* (%)	Difference to Scottish Rate	HSCP Rank	5 Year Trend (spark line)	Notes	Most recent data
1	Percentage of adults able to look after their health very well or quite well	90%	0.2%	-0.8%	20		* Previous rate compared to was 2 years ago	2021/22
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	83%	-8%	4.1%	6		* Previous rate compared to was 2 years ago	2021/22
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	67%	-15%	-3.9%	22		* Previous rate compared to was 2 years ago	2021/22
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	69%	-13%	2.2%	12		* Previous rate compared to was 2 years ago	2021/22
5	Total % of adults receiving any care or support who rated it as excellent or good	81%	-3.3%	6%	6		* Previous rate compared to was 2 years ago	2021/22
6	Percentage of people with positive experience of the care provided by their GP practice	59%	-19%	-8%	27		* Previous rate compared to was 2 years ago	2021/22
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	80%	-3.2%	1.5%	10		* Previous rate compared to was 2 years ago	2021/22
8	Total combined percentage of carers who feel supported to continue in their caring role	29%	-10%	-1.0%	18		* Previous rate compared to was 2 years ago	2021/22
9	Percentage of adults supported at home who agreed they felt safe	82%	-8%	2.2%	10		* Previous rate compared to was 2 years ago	2021/22
11	Premature mortality rate for people under age 75 per 100,000 persons	509	-11%	9%	7			2021
12	Emergency admission rate (per 100,000 population) for adults (18+)	12,378	-6%	11%	12			2022
13	Emergency bed day rate (per 100,000 population) for adults (18+)	145,349	1.4%	28%	3			2022
14	Readmission to hospital within 28 days (per 1,000 population)	78	-14%	-23%	27			2022
15	Proportion of last 6 months of life spent at home or in a community setting	88%	-0.9%	-1.6%	30			2022
16	Falls rate per 1,000 population aged 65+	23	8%	5%	13			2022
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	80%	-4.6%	4.6%	10			2022/23
18	Percentage of adults with intensive care needs receiving care at home	68%	-1.8%	4.1%	10			2022
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (age 75+)	459.7	58%	-50%	26			2022/23
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	25%	1.6%	1.3%	8			2019/20

Summary:

- ✓ There are no updates to the Health and Care Experience (HACE) survey this year. This is usually updated every other year and the next update is due in May 2024. The results of the 2021/22 HACE survey show that Inverclyde performed above the Scottish average for the majority of the nine indicators. The percentage of people with a positive experience of the care provided by their GP practice was the only indicator ranked below the Scottish average.

- ✓ Despite ranking below average for premature mortality rate, emergency admission rate and emergency bed day rate, each have improved in Inverclyde over the past year. The rate of hospital readmissions (per 1,000 population) has also decreased since the previous year, with Inverclyde ranking above average.

- ✓ Inverclyde continues to perform below average in terms of the proportion of last 6 months of life spent at home or in a community setting, ranking 30th of the 31 HSCPs.

- ✓ The percentage of adults with intensive care needs receiving care at home continues to rank within the top 10 HSCPs in Scotland, despite a slight decrease in the last year.

- ✓ The number of days over 75-year-olds have spent in hospital when they are ready for discharge increased by 58% in the past year in Inverclyde. Despite this, Inverclyde still ranks above average.

Ministerial Steering Group (MSG) Indicators

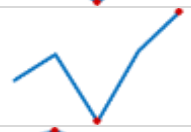
The MSG Performance indicators provide a focus on hospital-based performance within HSCP/IJB geographies specifically around Unscheduled Care such as Accident and Emergency attends, Emergency Admissions and Unplanned Bed Days (in hospital).

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 and Emergency), the individual's 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 three-month time lapse due to the collection and cleansing of the data.

Ministerial Steering Group (MSG) Indicators

Indicator Number	Indicator	Rate	Difference from Previous Year (%)	Difference from Scottish Rate	HSCP Rank	5 Year Trend	Notes	Most recent data
1	Emergency Admissions (18+)	7,350	-7%	10%	25		Rate per 1,000 population used for comparison to Scottish Rate. HSCP rank not standarised for population	2022
2a	Unplanned bed days - Acute (all ages)	79,545	7%	47%	22		Rate per 1,000 population used for comparison to Scottish Rate. HSCP rank not standarised for population	2022
2b	Unplanned bed days - Geriatric Long Stay (all ages)	153	23%	-93%	NA		Rate per 1,000 population used for comparison to Scottish Rate. HSCP rank not standarised for population. HSCP rank unavailable due to incomplete data in other areas.	2022
2c	Unplanned bed days - Mental Health (all ages)	17,136	-11%	25%	19		Rate per 1,000 population used for comparison to Scottish Rate. HSCP rank not standarised for population	2022
3a	A&E Attendance (all ages)	29,284	0.6%	45%	21		Rate per 1,000 population used for comparison to Scottish Rate. HSCP rank not standarised for population	2022/23
3b	A&E % Seen within 4 hrs	79%	-5%	10%	9			2022/23
4	Delayed Discharge bed days (Age 18+)	5,241	38%	-44%	26		Rate per 1,000 population used for comparison to Scottish Rate. HSCP rank not standarised for population	22/23
5	% of Last Six Months of Life by Setting (Community - all ages)	89%	-0.6%	-1.3%	24			21/22
5	% of Last Six Months of Life by Setting (Hospice / PCU - all ages)	0.4%	-34%	-0.02%	18			21/22
5	% of Last Six Months of Life by Setting (Community Hospital - all ages)	0%	-	-	NA		Ranking not appropriate: Large number of areas returning null value	21/22
5	% of Last Six Months of Life by Setting (Large Hospital - all ages)	11%	7%	2.8%	3			21/22
6	Balance of Care: % of pop in community or institutional settings (Home unsupported - 65+)	89%	-0.01%	-3.0%	30			21/22
6	Balance of Care: % of pop in community or institutional settings (Home supported - 65+)	6%	1.5%	2.2%	4			21/22
6	Balance of Care: % of pop in community or institutional settings (Care home - 65+)	3.2%	-4.7%	0.5%	3			21/22
6	Balance of Care: % of pop in community or institutional settings (Hospice / PCU - 65+)	0.01%	-23%	0.001%	NA		Ranking not appropriate: Large number of areas returning null value	21/22
6	Balance of Care: % of pop in community or institutional settings (Community hospital - 65+)	0.002%	-	-0.1%	NA		Ranking not appropriate: Large number of areas returning null value	21/22
6	Balance of Care: % of pop in community or institutional settings (Large hospital - 65+)	1.1%	7.6%	0.4%	3			21/22

Summary:

- ✓ There has been a reduction in the total number of emergency admissions in the latest year. Inverclyde has a higher rate (per 1,000 population) of emergency admissions compared to Scotland.

- ✓ There has been an increase in the number of unplanned hospital bed days for acute services and geriatric long stays (GLS) since the previous year but a reduction in the unplanned mental health (MH) bed days. Comparing to Scotland, Inverclyde has a higher rate of unplanned bed days for acute and MH services but a lower rate for GLS compared to Scotland.

- ✓ The number of A&E attendances in Inverclyde has increased in the last year. In addition, the proportion of patients seen within the 4-hour target also dropped by 5%. Inverclyde ranked in the top third of HSCP's in terms of meeting the A&E waiting times target.

- ✓ Delayed discharges from hospital have increased by 38% in Inverclyde in the past year. Despite this, Inverclyde is still performing well on this measure compared to the rest of Scotland with a rate 78% lower than the national average (rate of delayed discharges per 1,000 population).

- ✓ In terms of palliative care, the average proportion of patients last six months of life spent in large hospitals increased with the proportion spent in Hospice's/Primary Care Unit's (PCU) decreasing.

- ✓ There has been an increase in the proportion of over 65-year-olds being cared for in large hospitals. There has also been a 23% decrease in the proportion of over 65-year-olds being cared for in hospices/PCU's.

The Local Government Benchmarking Framework (LGBF)

The Local Government Benchmarking Framework (LGBF), published by the Improvement Service, is a high-level benchmarking tool which aims to develop better measurement and comparable data as a catalyst for improving services, targeting resources to areas of greatest impact and enhancing public accountability.

The framework provides high-level ‘can openers’ which are designed to focus questions on why variations in cost and performance are occurring between similar councils. The LGBF helps councils compare their performance against a suite of efficiency, output and outcome indicators that cover all areas of local government activity.

Several of the indicators are for services delivered by the HSCP (children and adult services) therefore included within this HSCP Annual Performance Report. Further detail on the indicators can be found at Benchmarking | Benchmarking (improvementservice.org.uk)

The Local Government Benchmarking Framework (LGBF)

Indicator Number	Indicator	Rate	Difference from Previous Year* (%)	Difference to Scottish Rate	Local Authority Rank	5 Year Trend (spark line)	Notes	Most recent data
CHN8a	The Gross Cost of "Children Looked After" in Residential Based Services per Child per Week	£ 4,938	50%	5%	22		Please see note in key regarding LA rankings	2021/22
CHN8b	The gross cost of "children looked after" in a community setting per child per week	£ 217	-7%	-46%	3			2021/22
CHN9	% of children being looked after in the community	87%	3.3%	-3.3%	21			2021/22
CHN17	Percentage of children meeting developmental milestones	74%	-2.9%	-8%	31			2021/22
CHN22	Percentage of child protection re-registrations within 18 months	10%	208%	2.4%	23			2021/22
CHN23	Percentage LAC with more than 1 placement in the last year (Aug-July)	10%	-36%	-6%	5			2021/22
CHN24	% of children living in poverty (after housing costs)	18%	-23%	2.6%	8			2020/21
SW01	Home care costs per hour for people aged 65 or over	£ 18.50	-47%	-36%	2			2021/22
SW02	Direct Payments + Managed Personalised Budgets spend on adults 18+ as a percentage of total social work spend on adults 18+	8%	61%	-0.6%	10			2021/22
SW03a	Percentage of people aged 65 or over with long-term care needs receiving personal care at home	67%	1.9%	5.4%	8			2021/22
SW04b	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	80%	-4%	1.5%	12		* Previous rate compared to was 2 years ago	2021/22
SW04c	Percentage of adults supported at home who agree that they are supported to live as independently as possible	83%	-9%	4.1%	7		* Previous rate compared to was 2 years ago	2021/22
SW04d	Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided	67%	-18%	-3.9%	25		* Previous rate compared to was 2 years ago	2021/22
SW04e	Percentage of carers who feel supported to continue in their caring role	29%	-26%	-1.0%	21		* Previous rate compared to was 2 years ago	2021/22
SW05	Residential costs per week per resident for people aged 65 or over	£ 548	4%	-25%	6			2021/22
SW06	Rate of readmission to hospital within 28 days per 1,000 discharges	93	-4%	-15%	8			2021/22
SW07	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	85%	-2.2%	9%	6			2021/22
SW08	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population (75+)	460	58%	-50%	7			2022/23

Summary:

- ✓ The gross cost of children in residential based services (per child per week) has increased since 2020/21. Despite this, the cost of placements in a community setting has decreased.

- ✓ The proportion of children reaching developmental milestones in Inverclyde is low when compared to the rest of Scotland, with less than three quarters of children reaching milestones in 2021/22. This can be partially attributed to the fact that 18% of children live in poverty Inverclyde, although this decreased since 2020/21.

- ✓ Inverclyde has a low home care cost for those aged 65+ compared the rest of Scotland. The cost per hour decreased in the past year.

- ✓ Fewer adults who are supported at home agree that they have a say in how their help, care and support was provided compared to the previous year. Inverclyde ranks below the Scottish average for this measure. Despite this, the proportion of care services graded good or better in Care Inspectorate Inspections ranks above the Scottish average.

Big Action Indicators

The six big actions were set out within the HSCP Strategic Plan (2019-24). As part of the refresh for 2023/24, a performance framework made up of local and national key indicators has been developed for each big action. As this is a new dataset, some data is not available for previous years, however going forward progress against performance will be monitored.

Big Actions - Strategic Plan Indicators (SPI)

Strategic Plan Indicator Number	Indicator	Rate	Difference from Previous Year* (%)	5 Year Trend (spark line)	Notes	Most recent data
SPI 1.1	Number of referrals to Primary Care Community Link Workers	1,533	11%		-	2022/23
SPI 1.2	Psychological Therapies: - Percentage of patients seen within 18 week RTT target	91%	0%		-	2022/23
SPI 1.3	Number of referrals to PDS (Post Diagnostic Support Dementia)	120	-32%		-	2022/23
SPI 1.4	Number of referrals to Distress Brief Interventions (DBI) programme	432	139%		-	2022/23
SPI 1.5	Number of new and returning service users to Advice Services	838	31%		-	2022/23
SPI 1.6	Number of cost of living support payments made (broken by SIMD area)	1=302 2=51 3=19 4=19 5=10 Total=401	-	-	No previous comparisons available (recording started in February 2023)	2022/23
SPI 2.1	Number of LAC medicals carried (access of 6 weeks referral to treatment)	-	-	-	No data available	-
SPI 2.2	Number of young people in receipt of continuing care	21	-5%		-	2022/23
SPI 2.3	Percentage of referral to treatment time target met for Children & Young People in Inverclyde, Children and Adolescent Mental Health Services (CAMHS)	98%	-0.7%		-	2022/23
SPI 2.4	Percentage of looked after children and young people who require to be cared away from home, who continue to reside in Inverclyde	75%	-8.0%		-	2022/23
SPI 2.5	Percentage of children vaccinated for MMR	96%	-1.0%		-	2022/23
SPI 2.6	Percentage of women breastfeeding in Inverclyde	23%	1.7%		-	2021/22
SPI 3.1	Number of referrals received by Children's Social Work that progress to a child protection investigation	82	2.5%		-	2022/23
SPI 3.2	Percentage of initial Child Protection Case Conferences held within 21 days from notification of concern	13%	-6%		-	2022/23
SPI 3.3	Number of Adult Protection Case Conferences that convert to an Adult Protection Plan	3	-50%		-	2022/23
SPI 3.4	Number of Adult Protection Investigations completed within 10 days of referral	9	-25%		-	2022/23
SPI 3.5	Number of staff and partner organisations trained in trauma informed practice	73	74%		2021/22 data was not recorded for the full year	2022/23
SPI 3.6	Number of unpaid work hours completed	10,674	-11%		-	2022/23
SPI 3.7	Percentage of Community Payback Orders (CPOs) successfully completed	71%	4.0%		-	2021/22
SPI 3.8	Percentage of Integrated case management (ICM) Case Conferences attended by community justice social workers for offenders in SPS custody	98%	-1.0%		-	2022/23
SPI 3.9	Percentage of MAPPA level 2 and 3 meetings convened within timescales (as specified in national guidance)	100%	0%	-	-	2022/23

Strategic Plan Indicator Number	Indicator	Rate	Difference from Previous Year* (%)	5 Year Trend (spark line)	Notes	Most recent data
SPI 4.1	Number of referrals for Early Intervention Support (Access 1st)	2,957	-6%		-	2022/23
SPI 4.2	Number of community alarm activations	244,306	180%		-	2022/23
SPI 4.3	Number of people self-directing their care through receiving direct payments and other forms of SDS	2995	-3%		-	2022/23
SPI 4.4	Percentage of adults with intensive care needs receiving care at home	68%	-1.8%		-	2021/22
SPI 4.5	Number of completed specialist housing reports	166	7.1%		-	2022/23
SPI 4.6	Number of new adult carer support plans completed	126	-		Data for 2021/22 unavailable	2022/23
SPI 4.7	Number of delayed discharge bed days 18+	5,241	38%		-	2022/23
SPI 4.8	Number of Anticipatory Care Plans (ACPs) completed	23	28%		-	2022/23
SPI 4.9	Number of advice enquiries that support and maintain tenancy sustainability	411	12%		-	2022/23
SPI 4.10	Number of housing 1st tenancies supported	6	20%		This figure shows the number in accommodation that entered tenancy that financial year	2022/23
SPI 4.11	Percentage reduction in external placement for adults with learning disabilities	increase 16% on baseline	24%		-	2022/23
SPI 5.1	Percentage of people beginning alcohol and drug recovery treatment within 3 weeks of referral	96%	-1%		-	2022/23
SPI 5.2	Number of people who started on MAT treatment within the reporting period	20	-		2022/23 first year of measure	2022/23
SPI 5.3	Current MAT Caseload, as at reporting date (Total number of people currently receiving MAT treatment)	629	-		2022/23 first year of measure	2022/23
SPI 5.4	Total number of people identified as being at high risk of drug-related harm who are assessed within reporting period	60	-		2022/23 first year of measure. Only Q4 data is available	2022/23
SPI 5.5	Number of people funded for residential rehabilitation	4	100%		-	-
SPI 5.6	Number of smokers supported to successfully stop smoking in most deprived SIMD data zones (20% most deprived)	5,057	1.6%		Data shown is for NHS Greater Glasgow & Clyde	2021/22
SPI 6.1	Number of wellbeing Activities promoted to staff	100+	-		Exact number not known	2022/23
SPI 6.2	Number of registered feedback reports on Care Opinion	10	-		2022/23 first year of measure	2022/23
SPI 6.3	Percentage of Staff Completing iMatter feedback	54%	0%		*in 2020 there wasn't a full iMatter questionnaire it was 'Everyone Matters Pulse Survey' due to the pandemic	2022/23
SPI 6.4	Percentage of HSCP complaints received and responded to within timescale	100%	23%		-	2022/23
SPI 6.5	Number of 3rd sector commissioned contracts	60	5.3%		-	2022/23
SPI 6.6	Percentage of adults able to look after their health very well or quite well	90%	0.2%		* Previous rate compared to was 2 years ago	2021/22

BIG ACTION 1 – REDUCING INEQUALITIES BY BUILDING STRONGER COMMUNITIES AND IMPROVING PHYSICAL AND MENTAL HEALTH

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.
5	Health and social care services contribute to reducing health inequalities.

Routes in to Supported Employment (RISE) Project

Routes in to Supported Employment (RISE) offers individualised support to young men aged 20-40, with a history of problematic substance misuse, residing in the most deprived areas of Inverclyde with the aim of moving them into employment. Individuals have a range of complex issues such as being in recovery, offending or homelessness and receive support from an Occupational Therapist and Support Workers to improve their skills and reduce the barriers to employment, education, or training.

During the first year the project developed to include:

- An increase in the age ranges from 20-40 years
- The addition of an Occupational Therapist to focus on the impact of trauma and substance use on daily activities and occupational performance.

RISE was a name chosen through engagement with our Inverclyde recovery community and supported by a small steering group representing statutory and third sector.

36 Men participated have participated with RISE.

22 individuals were engaging as of February 2023.

Employment outcomes range from in work to training.

Individuals experience a range of factors which impact their ability to engage with services and support including past trauma; current behaviours; offending; substance use; difficulty building and maintaining trusting relationships. Individualised support is offered, and this helps build hope and aspirations to improve wellbeing through meaningful employment. Outcome Star is the evidence-based tool used to support and measure change for individuals and shows progress made in stabilising the key aspects required before beginning to consider education, training, or employment aspiration. This is a unique approach to supporting recovery that focuses on the long-term benefit of employment in stabilising people's lifestyle and supporting their recovery. It is a whole system project which has the potential to change lives and the way recovery is viewed.

Routes in to Supported Employment (RISE)

A's story

"A's" view is that without the support of RISE, he would have given up and relapsed by this stage.

Instead, he feels focused, has increased self-awareness on his strengths and assets and for the first time has engaged productively with mental health services which he feels has enabled him to start recognising his potential. "A" reported that he has spent most of his life feeling disillusioned by his experience with statutory services but describes that RISE feels different because he feels valued within this system and there has been flexibility around his engagement.

"For the first time 'A' has engaged productively with mental health services".

A needed a lot of support and reassurance in the initial stages that engagement with the service would prove to be productive but since then "A" has attended most of his appointments and has given apologies if unable to attend.

Cost of Living

During 2022/23, the IJB agreed a proposal to create a Cost-of-Living Fund amounting to £0.430m, to be utilised to support residents of Inverclyde via the use of Section 12 and Section 22 legislation for a larger range of staff; grants via the third sector to community organisations; and distribution of warm boxes to those in need.

These funds are utilised to combat food and fuel poverty and to allow staff and organisations to support residents and service users in need due to the overall cost of living crisis. Spend of £0.165m was recorded in 2022/23, with the remaining funds earmarked for continuation of assistance during 2023/24 financial year.

- £0.430m Cost of Living Fund granted in 2022/23
- £0.165m spend recorded in 2022/23
- 401 Individuals and families supported.
- 284 supported families in SIMD areas 1-5

During 2022/23, 401 individuals and families were supported via the Section 12 and 22 process, a further 194 through grants to community organisations and 500 warm boxes were distributed over the winter period.

Community Mental Health Service

A particular aim of the Inverclyde HSCP Strategic Plan is to prioritise and develop key Mental Health Services that are critical to the sustained delivery and improvement of services, in support of reducing health inequalities, recognising the link between good physical and mental health and improving related health outcomes.

The Inverclyde Communities Mental Health and Wellbeing fund enabled the distribution of £244,609 in 2021/22 and £215,431 in 2022/23 to community organisations and third sector services in Inverclyde. The money has been used to fund projects that support mental health and wellbeing and help tackle the impact of social isolation, loneliness and the mental health inequalities made worse by the pandemic.

Mental health services continue to work closely with our local Distress Brief Intervention (DBI) providers, Scottish Association for Mental Health (SAMH), to facilitate the referral of individuals to the programme who require intensive support but do not require a clinical mental health service. Feedback about DBI has been overwhelmingly positive with both referrers and individuals referred to the service reporting good experiences. The DBI programme is one component of the mental health and wellbeing service landscape that aims to deliver the right help at the right time to individuals seeking support.

- 181 DBI referrals from Oct 2021-March 2022
- 432 DBI referrals 2022/2023 (full year)

Inverclyde HSCP's Community Mental Health Service continues to provide a range of evidence-based person-centred interventions. These range from short term low intensity psychological interventions provided by the Primary Care Mental Health Team (PCMHT) for people experiencing common mental health problems, to meeting the planned and unscheduled care needs of individuals experiencing severe and enduring mental health conditions. For the latter group of service users, the Adult and Older Persons Community Mental Health Teams (OPMHT) continues to provide a specialist multidisciplinary team approach to assessment, treatment and support. Additionally, the Community Response Service provides access to meet unscheduled care needs in collaboration with the centralised Mental Health Assessment Units (MHAU) and local teams.

Mental Health Inpatient Services

Our Mental Health Inpatient Service provides 24-hour care and treatment to adults and older adults who require an acute admission for assessment of their mental health, or longer-term admission to manage their complex care needs. Inverclyde has five mental health wards, with ninety inpatients beds in total across three separate units, all based on the Inverclyde Royal Hospital (IRH) site.

The NHS Greater Glasgow and Clyde Five Year Adult Mental Health Strategy has been refreshed and aims to continue its trajectory for 2018-2023, expanding on its original scope to take account of the range of services relevant to the wider complex of mental health services and the continuing impact of Covid-19, as services

- Five mental health wards
- Ninety inpatient beds

continue to remobilise to post pandemic state, or with refreshed focus on service delivery.

One of the key deliverables for local Mental Health services was to develop inpatient and community advanced clinical practice roles to sustain and improve service delivery. Since September 2022 there have been two trainee Advanced Nurse Practitioners (ANP) embedded within inpatient services. The trainees have been working alongside the multidisciplinary team locally as well as gaining experience and competence within other areas of clinical practice appropriate to the modules they are undertaking at master's level until 2024.

BIG ACTION 2 – A NURTURING INVERCLYDE WILL GIVE OUR CHILDREN AND YOUNG PEOPLE THE BEST START IN LIFE

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
7	People using health and social care services are safe from harm
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

I Promise

I Promise Team and Partnership Working

Our I Promise team and Virtual School Head Teacher have been travelling across Inverclyde's schools to share the work of The Promise and to focus on the five main education calls to action which include: no barriers to engagement in education; school improvement plans to ensure they are valuing and recognising the needs of theirs care experienced pupils; reducing formal and informal exclusions; positive destinations; and full participation in subjects and extracurricular activities.

The I Promise team has implemented and delivered on the findings of The Promise and developing the team. Two social work students have been part of the team at various times. In addition, our Children's Rights Officer is also part of I Promise team. The team have engaged with over **525** of our workforce and our stakeholders to deliver the findings of The Promise.

- 26 schools visited to share good work of The Promise
- Engaged with over 525 workforce and stakeholders.

"We must listen and respond", we listened and co-produced our wellbeing assessments with over 500 of our workforce and our children, young people and families. We created a working group and co-produced our new paperwork with our Proud2Care young people and our I Promise Modern Apprentice who have all provided great insight.

Children, Young People and Families have told us.

"We have too many people just coming into our lives and then they just leave coz it's their job and that's hard for us and that's why we need to limit people coming in and out of our lives".

Kinship – "good relationships with the kinship resource workers"
"Good supportive relationships come from the Peer Support opportunities available".

"Use an environment I am comfortable in; I prefer to have my meetings in my son's nursery. Hectors is too daunting".

"They need to appreciate that they are coming into your home. This is my safe space. I get anxious with people in my house. And if my house is not tidy, I get more stressed".

What's Next

- Listen and respond.
- Progress the 80+ calls to action within Plan 2021-24 with our partners.
- Create our engagement and participation strategy.
- Strive towards Peer support within our services.
- Continue to feedback to Children's Service Plan
- Promise Practitioner Forum
- Continue to offer digital app for hearing voices of our children and young people (Mind of My Own)
- Supporting tests of change and offer the right support at the right time.
- Networking/Conversation GIRFEC Cafes and continue to support with strategic elements requiring Promise input.

The Action for Children Inverclyde Wellbeing Service was commissioned by Inverclyde HSCP / Inverclyde Council to create a wellbeing service for children and young people aged 5 to 18. Staff provide a range of Direct, Preventative and Digital evidence-based solutions, which is delivered with the aim to:

- Increase understanding of emotional health needs
- Ensure active participation.
- Establish a platform for children and young people to support themselves and maintain good Emotional Health and Wellbeing
- Build positive emotional health and resilience in coping skills.
- Reduce referrals to specialist services.

One to one Counselling

- 216 young people aged P6 to S6 accessed school counselling during July 2022 to June 23
- Approx 60:40 split Female: Male
- Reasons for accessing support include anxiety; emotional /behavioural issues and low mood.
- 73 young people reported an improved outcome following support.

Throughout the last year the overall picture on improving children and young people's engagement with services is positive; there has been an increase in people accessing both counselling and support and wellbeing services. While the majority of those numbers have not recorded a positive outcome, the returns from Inverclyde's services recognise and have noted that a number of people who are currently continuing to access counselling and services have not completed an evaluation.

Community Mental Health and Wellbeing Support

In addition to this service, the Children and Young People's Community Mental Health and Wellbeing Supports and Services grant from the Scottish Government supports a range of service delivery across Inverclyde to support Children and YP emotional health and wellbeing. Programmes are delivered in partnership with 3rd sector organisations-Action for Children, Barnardo's and Kooth.

From July 2022-June 2023:

- 366 children and young people accessed the Emotional Distress Service delivered by all three organisations.
- 1273 attended the Positive Mental Health and Wellbeing Services which has included 819taking part in Bouncing Back sessions across all P7 classes in Inverclyde. Bouncing Back sessions are universal in scope and are not targeted at individuals, but presented to a whole class group as an early intervention,

Action for Children support a range of young people around:

- Building resilience and coping strategies (emotional regulation)
- Healthy and positive relationships, which extends to supporting relationships at home within families.
- Anxious thoughts and feelings

Support is currently ongoing and varies across the CYP and families in support taking place within school, including:

- Scheduled drop in groups
- Support for CYP as and when they feel they would benefit while attending school.
- Activities also take place out with school to build on social relationships in a less formal setting,
- Also involve support taking place within the family homes,
- Support extends to emotional support to the wider family to include and provide parents who are struggling with the challenges of supporting their child to fully engage with school.

Barnardo's have delivered two specific programmes:

Cygnet Programme

11 parents have successfully completed the Cygnet Programme. The Cygnet Programme is a targeted parenting support programme designed for parents of children and young people aged 8-18 who have a diagnosis of Autistic Spectrum Condition. The programme allows parents to develop their understanding of Autism and explore practical strategies and solutions to respond effectively to their child's needs and the more challenging aspects of their behaviours.

Thrive Peer Support Group

The thrive parent support group is a monthly support group for parents of children with a Neurodiverse condition, including ASC and ADHD. The group is not limited to parents in which their child has a diagnosis, and they can be going through the assessment process. This group has a core group of 9 parents and they can drop-in to the group as they require support. The group is a semi-structured group at the request of the parents who attend. They have expressed that some sessions they find it useful to have speakers giving advice on additional services, parenting advice, etc. However, they have expressed that they prefer most months without speakers because they find the peer support aspect of the sessions most useful and prefer some sessions in which they can simply share experiences and provide one another with emotional support. This is a forum in which they can provide one another with support and share the challenges in relation to their parents' roles.

Children's Health – Thrive under 5

Thrive under 5 (TU5) is a Scottish Government funded pilot programme in NHS Greater Glasgow and Clyde providing targeted support for young families in relation to food insecurity and child healthy weight. This programme seeks to address food poverty and food security as recognised barriers to providing affordable healthy food through a range of community organisations such as food pantries, community shops, flat pack meal providers, cooking equipment vouchers, community cooking and food growing programmes and community physical activity programmes.

- TU5 will be embedded into Inverclyde Food Network
- Health Improvement Senior post recruited
- Steering group has been set up and running with a wide range of organisations.
- Cooking Demos being delivered in local centres in Port Glasgow
- Cycling Hub being set up in Port Glasgow for families.

<u>Purpose of Project</u>

Pilot a whole system, community food-nurturing programme with families of pre-school children, combining action on food insecurity, healthy eating, and physical activity in Port Glasgow.

Whole Family Wellbeing Fund (WFWF)

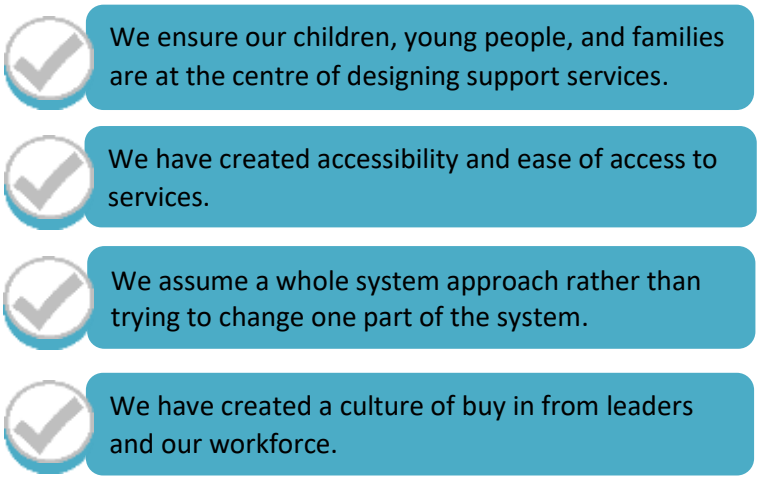
Inverclyde HSCP in collaboration with our partners from Education Services successfully bid for £907,000 of funding from the Scottish Government in the form of the Whole Family Wellbeing Fund. This was granted in late 2022 and is integrated into the work of our Children's Service Plan.

The Whole Family Wellbeing Fund (WFWF) will be utilised in Inverclyde to scale up our outreach service to delivery whole family support and design intensive services within Inverclyde for our children with complex needs to meet the aspirations of the Promise. The WFWF is still in development however will help drive the redesign of children's services for Inverclyde. Whole family support is about helping families to build on strengths and assets by improving capacity to provide care for their children that keeps them safe. We will provide strength-based services that are rooted in building on the foundations of the Promise.

The focus of our work is around:

- Children and Families to receive the right support at the right time from the right service.
- Increase and improve families' access to early help.
- Reduce unnecessary Social Work involvement.
- Supporting Interagency Referral Discussions (IRD) to ensure early identification and help.

To help ensure that the *'right support gets to the right people at the right time'* the operational structure has at its heart the use of evidence based. An operational structure has been drafted, involving staff in Inverclyde Health and Social Care Partnership (HSCP) and Inverclyde Educational Psychology Service (IEPS), which is in the final stages of development. This aims to both increase capacity and effectiveness of working at early intervention and intensive levels of need. In keeping with the demands of the logic model behind the Programme the ongoing development of the WFWF in Inverclyde will be non-siloed and will embrace coproduction both with service users and third sector partners



To ensure that therapeutic support is core to the programme a therapeutic intervention worker has been employed to work within the Hub structure. The therapeutic intervention worker is now receiving casework and there is evidence of impact for this workstream via the use of the Strengths and Difficulties Questionnaire. Three Throughcare Resources Workers have been recruited and a fourth worker will be recruited soon. This service will operate for seven days per week.

Through the WFWF there is a commitment to work with third sector partners. There is representation from Communities and Voluntary Sector Inverclyde (CVS) sit on the CSPP group. Several partners will be brought together to coproduce the early intervention approach. this includes Children 1st Homestart, Barnardo's, Action for Children and CVS. Furthermore, the Request for Assistance Team (HSCP) and Education Support Workers will be involved in ongoing discussions to ensure effective working and reduce duplication. Members of the team who will be

involved in supporting the Hubs are fully trained in trauma Informed practice and will link with the Trauma Informed Practice Lead to ensure consistency of practice across Inverclyde.

Wellbeing Service – Action for Children

B's Story – aged 12 – Wellbeing Transitions P7 - S1

"B" found the transition to high school extremely difficult. When I was introduced to "B," he was a non-attender, who's anxiety prevented him from walking through the school doors. The pressure that this put on the family created further stress. I met with "B" and his mum at the family home to see how our service could be of help.

I took "B" out for ice cream, we talked through his worries and how the service could work for him, advising that we could have individual time together as well as group time with three other boys in his year (that I also support). "B" was interested in both, so we planned for him to attend the group time the following week.

Throughout the next week "B" still found difficulty in attending school, I took him out for lunch to chat through his worries again. He mentioned that he did not like Fridays as he had PE and he found it stressful having to change in the middle of the day, therefore I was able to communicate this (with his permission) to his guidance teacher who then removed this obstacle from his timetable (temporarily). On return from lunch, I spoke to mum at length to relieve her worries about the situation and to reassure her that Action for Children would do everything possible to help ease this situation and use all the tools we have.

"Mum was pleased and relieved at the progress"

The following week "B" made it into the group time session where he joined two other boys in his year, afterwards he spent time in the student support room and remained in school for the rest of the day.

I spoke to mum who was pleased and relieved at the progress, she let me know that he enjoyed it and that he would like to continue with the group time as well as having individual time with me in school. He managed to go into school the next day too, however he had a setback when other pupils made fun of his attendance, swearing at him, and calling him names. This set back meant that the following week he could not go back through the school door again as his anxiety levels were extreme. I visited the family home that week and took "B" out for hot chocolate, we talked through his thoughts and feelings about group time and the event with the boys. We talked through strategies he could try, and he said he would give it another go. On return, I spoke to mum at length, I reassured her again that it was early days and that we would take baby steps building up "B's" confidence; she felt better.

"I'm going to attend the first two periods of school today".

The following week, I took "B" out for lunch to talk things through and build up our trusted relationship. He mentioned that he sits next to the boys who had been bullying him in his classes. I was able to communicate this (with permission) to the guidance teacher, who then made amendments in the classroom to suit. During this week, "B" made it into group time and even gave ideas for games next time (we played the card game snap and on the occasion that anyone got a snap we wrote in our notebooks something that we liked about ourselves….and then got a Haribo sweet). The following morning, I received a WhatsApp message from "B" telling me that he was going to attend the first two periods of school that day.

Over the following few months, "B's" attendance in school was a hit and miss, however he made it in for individual sessions and fortnightly group time with me and went on to attend weekly counselling sessions with Action for Children. He now attends school regularly and has been trying out a reduced timetable. Nevertheless, he currently presents as less anxious, has made new friends within school and I see him regularly with a smile on his face. He has just started his new S2 timetable and is open to going to more classes.

BIG ACTION 3 – TOGETHER WE WILL PROTECT OUR POPULATION

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.

Adult Protection

We continue to build on our partnership approach to our Adult Support and Protection (ASP) work across Inverclyde. Partnership staff effectively share information to identify and protect adults at risk of harm in ensuring our adults subject to ASP are safer because of the support they received. Police Scotland and our HSCP services effectively collaborated to keep adults at risk safe from harm and we successfully completed risk assessments and protection plans in a timely manner and of good quality, this is a true reflection of our multi-agency approach. Our staff reported they are confident in their role around keeping people safe, protected, and supported and that the quality of screening and triage work is very good, with referrals received and processed accurately and in a timely manner.

Following our 2021 Care Inspectorate inspection, we reviewed our key processes and documentation to ensure we more accurately recorded matters in relation to the three-point-test.
Chronology, risk assessment, protection planning tools and templates have been standardised to ensure a more consistent approach in supporting and informing our ASP investigations as second worker.

- 91% of adults at risk of harm who needed additional support received it.
- 94% of case conferences were rated good or better for quality.
- 93% of case conferences effectively determined actions to keep the adult safe.
- Police colleagues attended 57% of our case conferences with health colleagues attending 71% (when invited)
- 83% of staff concur that interventions for adults at risk of harm uphold the Act's principles of providing benefit and being the least restrictive option.

Following the implementation of process changes, feedback suggested that adults subject to adult support and protection, experienced a safer quality of life from the support they received and furthermore Adults at risk of harm felt supported and listened to in keeping them safe and protected during the ASP process.

Criminal Justice Integrated Case Management

Inverclyde Justice Social Work Services are active participant in the Integrated Case Management (ICM) process. The ICM process is co-ordinated by Scottish prison Service (SPS) and provides a multi-agency framework to plan and monitor the sentences of those serving long term custodial sentences and, crucially, provides an opportunity for planning for release to take place. Justice social workers based in the community team are invited to participate in the pre-release ICMs of all prisoners who will be managed on licence on release. This allows for plans to be made to support service users regarding housing; finance; health and other welfare issues in good time before their release. The pre-release is also significant to risk management as this is the forum where decisions are made regarding whether management under Multi Agency Public Protection Arrangements (MAPPA) is required.

Prison based social workers are also key participants in ICM meetings and our justice social workers, based at HMP Greenock, attend ICMs for all prisoners who will be released on licence regardless of whether they will live in the Inverclyde area on release. While they have less of a role in terms of enacting plans for release, they often take forward actions relating to managing/reducing risk of reoffending and can help to progress related needs issues while the individual remains in custody.

The ICM process, in its current format, was established in 2007 to support partner agencies to fulfil their responsibilities under the Management of Offenders etc (Scotland) Act 2005. However, the need for effective multi-agency planning and delivery to support public protection and reduce reoffending continues to be a key theme within the national policy context. The revised Scottish Government's National Strategy for Community Justice (2022) sets out 4 key aims. Important to the successful implementation of the ICM process is Aim 3, which states:

'Ensure that services are accessible and available to address the needs of individuals accused or convicted of an offence'.

Within Aim 3, priority actions 7 states:

'Enhance individuals' access to health and social care and continuity of care following release from prison by improving the sharing of information and partnership-working between relevant partners.

And 10:

'Enhance community integration and support by increasing and promoting greater use of voluntary throughcare and third sector services.

- 102 Integrated Case Management *Community Justice* cases attended in 2022/2023
- An increase of 9 cases from 2021/2022
- 113 Integrated Case Management *Prison Justice* cases attended in 2022/2023
- An increase of 11 cases from 2021/2022

The Inverclyde Community Justice Partnership will utilise this revised Strategy to inform the development of the new Inverclyde Community Justice Outcomes Improvement Plan, which will launch in 2024. The Partnership will seek to ensure this local Plan considers a range of improvement actions that will support the safe and effective re-integration from prison to the community of Inverclyde.

Throughout 2022/23 Inverclyde HSCP hosted an externally funded Early Action System Change Project – Women Involved in the Criminal Justice System. The Project Team co-produced system change with a group of women in Inverclyde involved in the Criminal Justice System. Two tests of change were completed to improve outcomes for women engaged with services; first, the commitment to HSCP and selected third sector partners (CVS and Your Voice) to develop trauma informed and responsive services and staff; second, a commitment to improving referral pathways into supportive community resources, making these more accessible and inclusive for women.

Following the completion of STILT, the Project Implementation Group, in collaboration with NHS Greater Glasgow and Clyde and NHS National Education for Scotland (NES), hosted a workshop in July 2022 towards the agreement of cascading training on trauma informed systems, services and practice to staff across the organisation and third sector partners. This event demonstrated commitment and consistency to Trauma Informed Practice by Leaders and Managers and was viewed as essential for the successful implementation of trauma informed systems and services; embedding and embodying Trauma Informed Principles of Trust, Choice, Empowerment, Safety and Collaboration should be the foundation of positive culture change.

This workshop concluded with a series of proposed recommendations for action across five broad themes; (1) action planning, (2) leadership, (3) staff recruitment and retention, (4) staff supervision and (5) wellbeing and lived experience.

- 73 staff across services have completed Scottish Trauma Informed Leadership Training (STILT)
- 38 of the 73 were HSCP staff and 35 from the Third sector.
- 17 staff members have completed Level three Trauma Enhanced Training (11 HSCP /6 third sector)
- 35 staff on waiting list for Level three Trauma Enhanced Training

To maintain the momentum around this agenda, an operational STILT Conference was hosted in September 2022 bringing together operational managers from HSCP Services (Criminal Justice, Children and Families, Homelessness, Alcohol and Drug Recovery Service), CVS Inverclyde and Your Voice Inverclyde. This conference supported those services in identifying actions in becoming trauma informed.

C's Story

"C" is subject to a Community Payback Order, which includes an Unpaid Work Requirement, for a serious violent offence. As part of the Unpaid Work Order and, as well as going out with "squads" to community-based projects, she was also referred into the Women in Justice Support Group (WJSG). This group is made up of women with lived experience of the Justice System or who are at risk of coming into the Justice System. Co-production is at the heart of the group and discussions and activities are driven by the women themselves. To date, the women have compiled an explanatory leaflet called "Attending Court" to explain Court processes to other women going through the Court system and are also currently looking at compiling guides involving what it means to be bailed for the preparation of a Justice Social Work Report and what it means to be subject to a Community Payback Order.

> *"I was so lucky to get a Community Payback Order, I was so worried I was getting jailed, I have family members in jail, it is not a great place for them. I had a bereavement around the time of my court case, and I was so scared, getting this Order really helped me".*

<u>Service Feedback</u>

"C" has been attending the Women in Justice Support Group (WJSG) since March 2022. She attends weekly and is an active participant in all group sessions and discussions. "C" has attended sessions focused on desistance from offending, emotional regulation, anger management, domestic abuse, addiction, and mental health. The Project Team take a strength-based approach with the women in the WJSG to help build self-confidence, resilience and coping capacities and our engagement with the women is based on the five principles of trauma-informed practice. "C" has been the mainstay of the WJSG and often leads discussions around pertinent issues raised by the women. She has spoken openly about her previous lifestyle and poor life choices and disclosed that her lifestyle was characterised by drug dealing, drug-taking, and associating with a negative peer-group, resulting in her involvement in the Justice System. Through her participation in the WJSG, it is evident to the Project staff that "C" has changed her perspective, has grown in confidence, has built resilience and a strong coping capacity and now feels empowered to take her life forward in a non-offending way.

> *"This is weird, I know the Order is still punishment, but I look forward to a Tuesday when I am with the project staff, those two have really helped me and all the girls with our confidence. No one is judged in the group…it is hard to explain but people talk to us about the future, or we discuss issues in our own lives, and they (Project staff) listen to us, I know girls have said they have never felt like that before when on an Order"*

<u>*What has the person achieved?*</u>

"C" was put forward for local volunteering, training, and employment opportunities. Through a third sector organisation, a volunteering placement was found for her in a local gardening initiative. Feedback from the volunteering co-ordinator was very positive and focused on "C's" ability to use her initiative and her skill set within this environment.

"Look, I know I have not done much in the last few years so working with them (the project staff)) has been big for me. They have encouraged me to try stuff I never thought of before. Take the outdoor work we do, I enjoy the graft and said to the project staff I would love to do more when I finish my order, next thing we are discussing volunteering stuff and I'm up there (community food growing place) helping, then I'm put forward for a course in gardening stuff. Now I am looking for a job, which would be massive for me".

This then led to her being supported to apply for further study in the horticulture field, which could potentially lead to her achieving a recognised qualification. From this trajectory, "C" has the opportunity to apply for employment within a local initiative, which supports people within the Police custody setting and is developing and enhancing her interview skills and writing her CV to strengthen her application.

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

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
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

Care at Home Redesign

Following the pressures and challenges the service experienced over the last three years to meet demands, Care at Home considered ways to make improvements on several aspects of the service. We recognised that it was vital that a reablement approach was embedded with all services to provide a quality service, best value, and maximise the individual's independence. These developments involved consultation with Your Voice, discussions with our staff, our people, and our wider stakeholders.

With significant effort from the home care team and our Allied Health Professional (AHP) colleagues we were able to re-organise our staff teams, our new approach includes reablement staff working alongside our longer-term staff to share their good practice, experience, and knowledge of the reablement ethos. This re-design enabled the service to improve on continuity of care as we reduced the number of staff in each area and the geographical areas covered by staff, this has seen a reduction in travel distance and time for staff. Early feedback has been positive with staff commenting *"they don't feel as stressed at work"*. Staff consultation events identified that the cost of living is an area of concern for staff particularly fuel costs and through the re-design we have seen a significant decrease in the number of miles claimed which ultimately results in staff not having to pay up front for petrol and wait for reimbursement, this reduction in the number of hours for travel time is creating some resource internally to help meet the demands

<u>Analogue to Digital (A2D) Inverclyde Technology Enabled Care (TEC)</u>

Technology Enabled Care (TEC) is part of the Care at Home review currently on going. Ofcom announced that the current analogue telephone network providing the current telephone systems will be switched off in

"Inverclyde has achieved a Silver Accreditation from the Local Government Digital Office with the aim of Gold Accreditation June 2023".

2025 across the UK. The system will be replaced with a Digital network which all telephones will require to operate over.

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

To address the essential transformation to a digital service Inverclyde TEC, Renfrewshire TEC, and Bield Response (BR24) collaborated a small three-month test of change funded by Local Government Digital Office. The test of change evaluated new Digital alarm units using two manufacturers and successfully evidenced the successful operation of our digital alarm units through to the alarm receiving centre.

- 75% of people rated the service as a 10 'excellent'.
- 18.8% of people rated the service as a 9 'very good'.
- 80% of people were 'very satisfied' with Digital at Home
- Of 1860 connections – 33% are digital (aim 100% Jan 25)

Care at Home

D's Story

I am a 60-year-old male. I was discharged from hospital following admission with a stroke. I was referred to the Reablement service for support once daily with personal care, grooming and dressing. My partner supports with meals, and I am independent with my medication.

Once at home I was visited by the Occupational Therapist Assistant, and we agreed that my goal was for me to complete as much of the tasks as I could and to only receive support where I struggled as regaining independence where possible was what mattered to me.

> ***"**This service is outstanding for me and my partner and has enhanced my daily living. The commitment to help me regain independence was evident in every interaction".*

I worked well with all staff, particularly Rosemary and Mary; they always encouraged me to participate to achieve my goal to wash independently. I use a shower chair and long-handled sponge and now they only assist me with the areas that I am unable to reach due to my weakness. I was also provided with a sock aid and a shoehorn, and this has enabled me to put on my socks and shoes independently.

This service is outstanding for me and my partner and has enhanced my daily living. The commitment to help me regain independence was evident in every interaction.

NHS Greater Glasgow and Clyde Board alongside HSCP Chief Officers adapted to Scottish Government requirements for assurance through refinement of the governance structure for Urgent and Unscheduled Care, whilst staying true to the three key themes of the Delivery Plan.

- **Early intervention and prevention** of admission to hospital to better support people in the community.
- **Improving hospital discharge** and better supporting people to transfer from acute care to community supports; and,
- **Improving the primary / secondary care interface** jointly with acute to better manage patient care in the most appropriate setting.

Early intervention and prevention of admission to hospital and Community Focussed Integrated Care

Work continues, on a wide range of approaches on frailty and falls across the HSCP. The Rockwood Frailty tool is being utilised across our adult services, utilising the data from this we have developed a Frailty Matrix across our HSCP and partner services. We continue to build on our proactive falls assessments, training for carers and walking aid reviews in our Care homes as well as replacement walking aid ferrules being available at local libraries and continue to pilot falls prevention training in one of our local care homes for staff.

We have redesigned and invested in our services to ensure we have a multi-disciplinary same/next day response for people who are at high risk of admission to hospital. This includes:

- Emergency Department pathways to home from hospital AHP's, Rehabilitation Service and District Nursing.
- Development of an Urgent Hub
- Emergency Department pathways to home from hospital
- Enhanced Social Work Duty Service
- Same day equipment provision
- Step up beds.

We implemented a multidisciplinary planning meeting to plan better outcomes for people with complex and fragile health conditions and as part of the winter planning resources, we extended our Allied Health Professional (AHP) service till 7:00 p.m. We have plans to go live with weekend cover at the end of May 2023. With this good work and the process of receiving referrals from Scottish Ambulance Service (SAS) through the Flow Navigation hub (to reduce conveyance to hospital) alongside the work off our Community Alarm responders reduces the risk of admission to hospital.

Learning Disability (LD) Hub

Inverclyde HSCP continues to develop the new Learning Disability (LD) Hub. Concept and spatial designs were completed at the beginning of 2023 with detailed design to be completed by June 2023.

Consultation and engagement with our people, parents and carers, staff and other stakeholders has proven successful and continues, the consultant and engagement process will ensure the design meets the brief, aspirations and the needs of our people who will use the HUB in the future.

"I'm sure I am speaking for many when I say I am delighted with the progress of the new LD Hub which will deliver modern, suitable surroundings to support adults and young people with LD" - Alan Cowan, Chair of the IJB (Greenock Telegraph 20th March 2023)

The Learning Disability and Autism Strategies priority areas remain focussed on improved health and well-being, closing the health inequalities gap, reducing harm, and maximising people's independence through an enablement model. Other areas of focus have improved Transitions into adulthood for 16-25-year-olds by increasing employment, training and volunteering options, people reaching their potential and feeling valued and included.

Out with the HUB building, work continued with community groups and third sector organisations to ensure opportunities for people in their own local community are accessible and inclusive. One example of partnership working is our HSCP LD Team are working with Parklea Branching out in developing a new employability programme for people with LD and autistic young people and as they develop their own £1.5m community HUB providing more accessible, community-based options.

Inverclyde HSCP Learning Disabilities and Children and Families teams with input from Education have worked in partnership with the Association for Real Change (ARC) Scotland to take part in a national trial of Principles of Good Transitions.

The HSCP facilitated an event for parents of senior phase pupils with Additional Support Needs at the Beacon in January 2023; a workshop for parents to understand the Transitions process and a chance to meet with Organisations that provide post-school options.

- 35 parents attended our workshop.
- Six schools across Inverclyde were involved.
- 19 Organisations attended the event.

The implementation of our Primary Care Improvement Plan (PCIP) has enabled GP practices to support patients in alternative settings, this is built on a multidisciplinary team model underpinned by seven key principles: safe, person-centred, equitable, outcome focussed, effective, sustainable, affordable and value for money.

"We have achieved a workforce of 46 wte multidisciplinary professionals, who now support General Practice under the direction of Primary Care Transformation and PCIP"

Over the course of implementation, we have reflected on lessons learned and adjusted our plan accordingly. This has included the implementation of a skill mixed workforce, which has provided opportunities for efficiencies, and built greater resilience in services.

CTAC Statistics – Reporting Period April 2022 – March 2023 Across Greenock, Gourock and Port Glasgow Treatment Rooms

- 31,547 appointments issued by CTAC (28,872 attended)
- 5863 cancelled appointments, 323 Did Not Attend (DNA)
- 29,738 procedures carried out (bloods most requested procedure = 11,632)
- 17,600 electronic referrals from GP to CTAC

Our priorities continued to focus on advancing and accelerating our multidisciplinary models of care across Community Treatment and Care (CTAC), Pharmacotherapy, Vaccination Transformation followed by Urgent Care.

The creation and implementation of CTAC services provides the opportunity to transfer activity in General Practice including minor injuries, chronic disease monitoring and other services suitable for delivery within a community setting. The move towards alignment of current Treatment Room services under the rebranding of Community Treatment and Care.

Our community link workers (CLW) model continues to be a valued asset. Although much of the CLW role is 'unseen' they are actively in the community providing support to patients, often with complex issues, to remove barriers and to link with resources and services to improve their overall wellbeing. We have seen a significant demand on our services, due to a variety of factors including asylum and New Scot population requiring a greater level of input and support, the ongoing cost of living crisis and of course the fuel poverty and food poverty challenges.

"Community link workers are now firmly embedded across 13 GP practices which has enabled relationships to grow, both with partners and with our people".

Care Homes and Care Home Assurance Tool (CHAT)

Care Home Assurance Tool (CHAT) visits commenced across all NHS Greater Glasgow and Clyde partnerships in May 2020 in response to the impact of Covid-19. The visits set out to provide additional clinical input, support, and guidance to care homes which were under extraordinary pressure. This work also 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. Good practice and improvements have been identified during the assurance process, with care homes taking ownership of the actions required and working in collaboration with HSCP colleagues to achieve improvements. Emerging themes are shared at the Collaborative Care Home Support Team (CCHST) meetings and through local governance processes.

"Every section (of the care plan) includes service user comments and staff comments. This highlights the residents are included, respected, responsive care and support, wellbeing and compassion is being provided by service.

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 CCHST and the Care Home Assurance Group. CHAT outcomes all the opportunity to discuss, with care homes, their areas of strength as well as their key priorities. NHS Greater Glasgow and Clyde and the Care Home Collaborative (CHC) Team see all individual home reports, support ongoing improvements and work with our care homes to provide training packages where required.

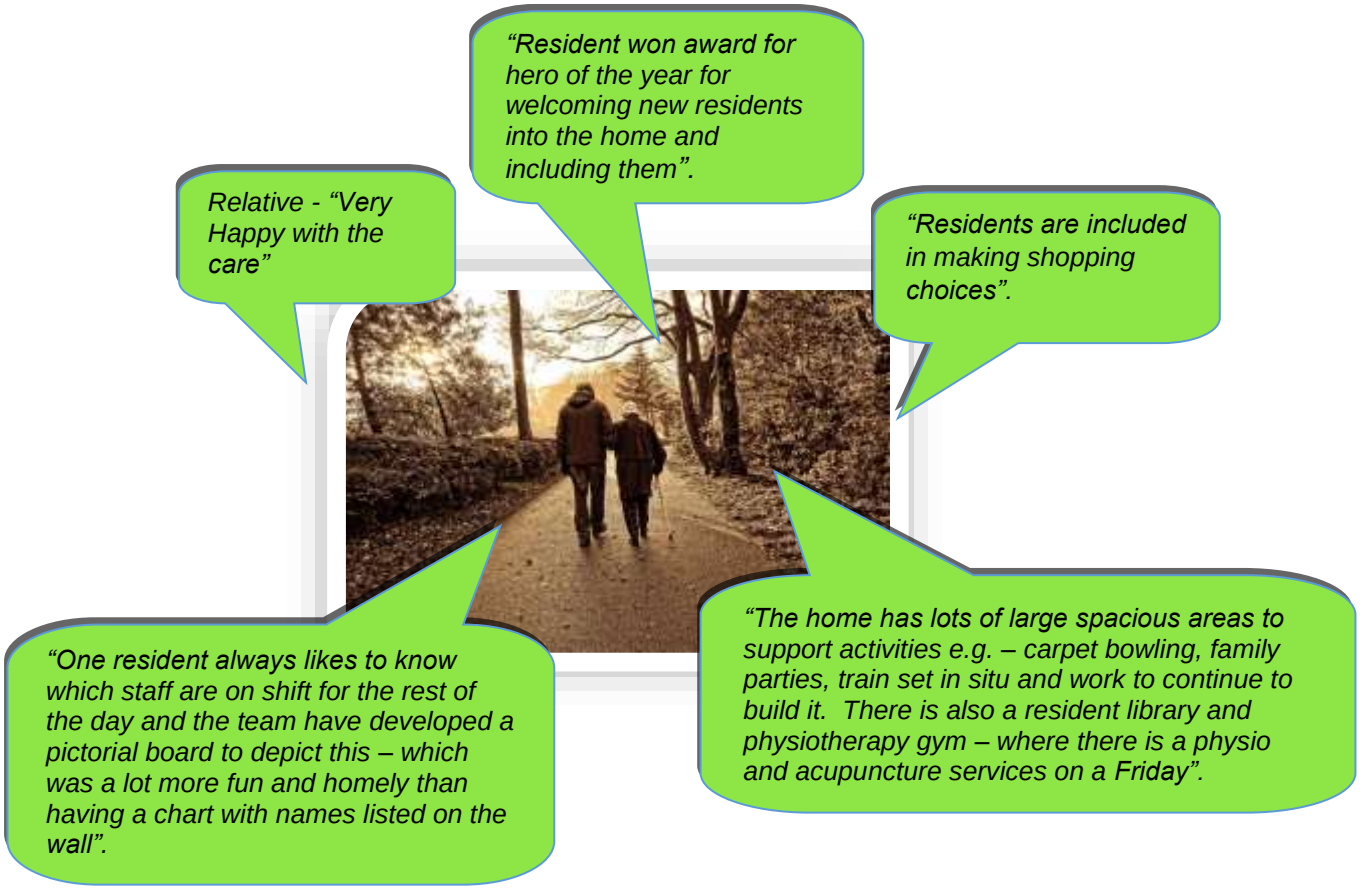
"The home has a weekly "Takeaway night" on a Saturday and residents can order from anywhere, staff will happily drive to several different restaurants to collect food as required to accommodate choice".

Each CHAT visit where improvements are identified, has led to a specific action plan for that home and these action plans will be discussed and monitored regularly with the homes to ensure that any required support is identified and provided. CHAT visits will continue to be held on a six-monthly basis, or more frequently if there is an identified need for a specific home.

Scottish Ballet

Scottish Ballet have developed a one-to-one digital resource package for those living with neurological conditions for use in bed or Chair. The CHC is working in partnership with Scottish Ballet to facilitate delivery, formal evaluation and support bringing together meaningful activity, movement and *"What Matters to you"* conversations in line with the Collaborative's Person-centred care. This work is being piloted in Inverclyde with three homes – Campbell Snowdon, Newark and Larkfield, and has involved participation from staff, residents and in some cases family members.

These examples, lifted directly from the reports, provide examples of good practice, high quality care and a person-centred approach to care.



"M's" Story

"M" is a 62-year-old man who lives with his wife "R", she is 68. "R" has a long history of depression; she has diabetes, and a diagnosis of Dementia. "R's" mobility is very poor, and she has a history of falls.

"M" works fulltime for the NHS and has no family in Scotland to support him. When I started working with this couple a lot attention was focused on "R's" needs. "M" was so stressed and anxious at this time, he advised that if "R" didn't go into long term care, he would need to leave his job. I supported "M" in completing an Adult Carers Support Plan and was able to identify that "M" had been experiencing severe stomach pain due to the stress of his caring role. This pain got worse when "R" was experiencing falls, or her dementia symptoms were worse. In addition to this "M" had started to experience panic attacks and was prescribed anti-depressant medication by his GP.

During the assessment process "M" advised that his caring role has impacted on their marriage. "M" no longer feels like he is "R's" husband. He describes himself as her carer now and any intimacy they had is gone in favour of caring tasks.

"M's" family all live in Cornwall and due to "R's" illness, they were no longer able to travel there which was impacting on the support "M" received from family members. "M" now enjoys respite breaks which allow him to visit his family in Cornwall. This has been an amazing source of support and strength for "M". He is now managing his caring role very well and he remains in full time employment.

In using the same Care home for respite "M" is now familiar with the staff and the routines and feels more comfortable leaving "R". This has had a very positive effect on "M". He is now managing his caring role very well; he maintains full time employment and when he feels he needs a break he is reassured that he knows this is a phone call away.

Housing First / Redesign of Homelessness Services

Objective three of the Inverclyde Rapid Rehousing Transition Plan is to: Implement a Housing First model which enables excluded service users to achieve housing sustainment. Since the implementation of a team of internal Rapid Rehousing Support Workers in November 2022, Inverclyde HSCP has achieved the successful scaling up of the model by increasing the number of individuals receiving Housing First support from nine in October 2022 to 50 in March 2023. This represents an increase of over 500%, indicating that the service now has a much larger scope for providing Housing First pathways without the restrictions on availability of local commissioned supports.

Consideration for the housing first pathway came from identification of beneficiaries with the following history - homeless/long history of repeat homelessness/tenancy failures, experience of trauma/abuse, ongoing addictions and/or mental health issues and experience of institutional care or imprisonment. Referral routes are open to a range of partners including homeless service, addiction and mental health services, community/criminal justice, family and children's teams and third sector partners.

The service additionally focused on cases facing or experiencing long term homelessness – all persons experiencing long term homelessness were automatically referred to the in-house support team while the Assessment and Support Officers concentrated on households approaching long term homelessness to prevent this. This resulted in a reduction of 21% from Q3 to Q4 when this focused approach commenced.

Engagement with those with lived experience is improving in relation to how we deliver our services – collaboration with Your Voice has resulted in an engagement session with a group of homeless or previously homeless households to discuss some areas of suggested improvement within the service and communicate to the group the changes the service was making. Since this session, Your Voice have continued to provide representation on the Communication and Engagement subgroup and continue to deliver valuable feedback from the group, this includes sense checking outgoing communications i.e., general information leaflets, giving their perceptions on stigmatising language etc. Resident interviews have also taken place to reveal perceptions on their journey through the service.

- 88% indicated that they were satisfied or very satisfied with the service received from staff.
- 76% of accommodation provided was a hostel with 24% in a temporary furnished flat.
- 30% of respondents did not receive any kind of welcome pack upon entering the service.
- 82% of our people confirmed Accommodation staff were 'approachable' and 71% 'helpful'.

The service undertook a survey with residents to gauge their satisfaction levels with the accommodation and service provided.

A total of 17 surveys have been collected so far, 13 of which were collected from the Inverclyde Centre (54% of residents) and 4 from service users in our temporary furnished flats (TFF). Although a direct comparison cannot be made, satisfaction levels amongst those in the TFFs appears to be higher than those in the Inverclyde Centre

J's Story

"J" had been living with a family member following the abandonment of his own tenancy but had been asked to leave. This man was known to local mental health services and regularly misused alcohol and substances, in addition "J" also had physical health issues for which he received treatment. Having spent time in the hostel setting, the individual was observed to have problems around door keeping therefore the service facilitated the move to a temporary furnished flat in the community to remove him from a setting that was viewed to be detrimental to him.

"**Never had that help, it made me nervous to begin with**".

"J" met the criteria for Housing First and was assisted by the in-house Rapid Rehousing Support Team following their initiation in November 2022. The team assisted him with budgeting and attending GP appointments and community support groups which he would be unlikely to attend on his own due to his mental health and struggles with anxiety, particularly in group settings.

"Forever grateful"

"The service saw something in me that I didn't see in myself. I would do it all over again. It helped me find myself, gave safety, security, advice".

"J" signed for a Scottish Secure Tenancy for a local housing association in February 2023 and the Resettlement Support Workers assisted him to access a starter pack provided by a local charity and a Community Care Grant.

As part of the tenancy agreement an Occupational Therapy referral was completed for adaptations in his new tenancy to incorporate a shower which was required in relation to the man's physical health.

"J" is now happy in a secure tenancy and continues to receive the wrap around support provided by the Rapid Rehousing Support Workers at seven hours per week.

"Rapid Rehousing Support Workers were "someone to phone when I needed with no judgement" and John confirmed having this help made a noticeable difference".

(33-YEAR-OLD MAN, GREENOCK)

BIG ACTION 5 – TOGETHER WE WILL REDUCE THE USE OF, AND HARM FROM ALCOHOL, TOBACCO AND DRUGS

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
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
7	People using health and social care services are safe from harm

Residential Rehabilitation

In the past year Inverclyde Drugs Alcohol and Drug Partnership (ADP) have worked proactively to improve referral and uptake of residential rehabilitation places. Within Inverclyde there are two residential rehabilitation facilities, both run by Jericho House, one for females the other for males. The ADP have block funded two places between November 2022 to March 2023.

In the past year the ADP have funded four people in residential placements throughout Scotland. The ADP have also developed a residential rehabilitation pathway with support provided by Turning Point Scotland and Inverclyde ADRS which will include a nurse, lead practitioner and administration.

- The ADP funded two places for Jericho House
- Turning Point Scotland Commissioned for residential rehab.
- The ADP have funded four people in residential placements.

It is anticipated that the commissioning of this service will greatly improve access and referral to residential rehabilitation making the process more equitable across the Inverclyde area.

Figures for residential rehab over the years

2018-19	2019-20	2020-21	2021-22	2022-23
1	2	2	2	4

The Medication Assisted Treatment (MAT) Standards for Scotland were published in May 2021 to ensure consistent delivery of safe, accessible high-quality care and treatment for people experiencing harm as the result of drug use regardless of where they live. MAT is the term for use of medication such as opioids, together with any psychological and social support.

The 10 standards adopt a rights-based approach, ensuring individuals have choice in their treatment and are empowered to access the right support for where they are in their recovery journey.

Although it has been challenging to achieve full roll out for MAT 1-5 by April 2023, Inverclyde ADP has achieved green status for MAT 2 and 5, with provisional green for MAT 1, 3 and 4. This demonstrates full implementation of the standard, with some refining of the experiential evidence gathering required to evidence full-service user/patient benefit for 1, 3 and 4. For MAT 6-10, full implementation is required to be achieved by April 2024.

	MAT STANDARD	**RAGB STATUS AT MARCH 2023**
1	All people accessing services have the option to start MAT from same day of presentation	Provisional Green
2	All people make an informed choice on what medication to use for MAT and the most appropriate dose.	Green
3	All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.	Provisional Green
4	All people can access evidence-based harm reduction at the point of MAT delivery.	Provisional Green
5	All people receive support to remain in treatment for as long as requested	Green
6	The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychological interventions (tier 2); and supports individuals to grow social networks.	Amber
7	All people have the option of MAT shared with Primary Care	Amber
8	All people have access to independent advocacy and support for housing, welfare, and income needs	Amber
9	All people with co-occurring drg use and mental health difficulties can receive mental health care at the point of MAT delivery	Provisional Amber
10	All people receive trauma informed care.	Provisional Amber

Inverclyde ADRS has an assertive, opt out approach with education provided to individuals including information about overdose symptoms, training, and supply of Naloxone. All staff have completed training in a range of harm reduction interventions including emergency supply of Naloxone which is available within the service. We continue to provide access to safe, clean injecting equipment provision (IEP) within the service and our nursing staff provide wound care, assessment and treatment of risks associated with injection and poly drug use.

We host Inverclyde and Renfrewshire Hepatitis C service which is a nurse led service to provide a seamless pathway for diagnosis, treatment and follow up of Hepatitis C in line with clinical guidelines.

We have a long-established good joint working with all community pharmacies. NHS board wide guidance allows for community pharmacies to inform the service if individuals do not attend for OST prescriptions. This has allowed us to promptly respond and re-engage the individual with further support and maintain them. Based on the level of risk to the individual there may be circumstances where ADRS will opt to deliver OST to an individual in their own home.

Inverclyde Addiction Liaison Outreach Service

X's story

"X" phoned ADRS Duty to request Opiate Substitute Treatment (OST). He had not been open to services but had previously been known to the service 16 years ago with a history of poly drug and intravenous drug use. "X" advised he had taken an overdose of heroin by injection the day previous and no longer wished to use illicit drugs. He had advised Duty staff that he planned to attend a residential rehab placement in two days' time and was requesting prescribed OST for the two days as to avoid using illicit drugs. "X" was referred to Addiction Liaison due to the rehabilitation involvement and recent overdose.

"X" advised he was an active member within the recovery community and had been for around 14 years".

"X" reported a lapse to opiate use following a period of ill health when he was prescribed co-codamol. Non prescribed co-codamol use increased over time with the occasional use of heroin. Reporting a non-fatal overdose, the previous day when using heroin. Naloxone was administered to bring him round. He did not attend hospital. He admitted to himself that he needed help and arranged for admission to residential rehab, borrowing money he was unable to afford. He phoned ADRS duty requesting OST prior to attending rehab.

Medical staff discussed the case and offered a same day appointment for assessment of suitability of OST. The appointment was arranged and facilitated by Addiction Liaison Nurse. "X" was fully assessed, and all risks where discussed. Based on the risks discussed and medical advice, patient opted for a period of treatment. He had informed rehab that he no longer wished to uptake the placement at this time and instead chose to engage with ADRS for a period of treatment and support. Patient was prescribed same day OST in line with MAT 1 and daily attendance at community pharmacy arranged. Oral Buprenorphine was agreed as a form of OST initially with a view to switching to long active injectable Buprenorphine (Buvidal)

Outcome:
OST was successfully initiated and titrated to an appropriate dose for stability and with other beneficial effects. "X" reported experiencing reduced anxiety and physical presentation improved. After engagement and treatment, the patient was successfully allocated an addiction keyworker within ADRS to continue assessments, reviews, and ongoing care planning. "X" currently remains active to service.

BIG ACTION 6 – WE WILL BUILD ON THE STRENGHTS OF OUR PEOPLE AND OUR COMMUNITY

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
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
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

Care Opinion

Care Opinion has been used by the people of Inverclyde to provide feedback to NHS Scotland services. The Health and Social Care Partnership agreed to subscribe to the Care Opinion platform in June 2022.

The HSCP for 2022 – 2023 had ten stories published and responded to. The trend for early 2023 is showing steady but slow progress. There is a Care Opinion Implementation Group chaired by the Chief Nurse to oversee progress and there is work ongoing to assist staff in the active promotion of Care Opinion for the HSCP. There has been an increase in stories, and this is a good indicator of the impact of local promotion.

The programme boards of Compassionate Inverclyde and Inverclyde Cares merged in 2021 to help Inverclyde recover from the pandemic in the most effective way. Inverclyde Cares created a strategic network of organisations from the third, public and private sectors underpinned by values of kindness, compassion and equality. Inverclyde Cares has three core principles: engaging communities, connecting people and building neighbourly and kind communities.

1. No One Grieves Alone

- Winning poster presentation at NES Annual Bereavement conference.
- 11 Organisations achieved their Bereavement Charter Mark and Bronze Kindness Award.
- Three organisations almost completed the Bereavement Charter.
- Two Inverclyde Bereavement Network Meetings held.
- More than 100 people in total have had bereavement training.
- Working in collaboration with Culture Creative we will host the first annual *"No One Grieves Alone"* Creative Arts event at the Beacon.
- Developing a Pet Bereavement Programme Pilot.

2. Kindness Awards

We launched our Kindness Awards event at the Beacon on 13th November 2022. It has proven to be a huge success and we hope to roll this out across secondary schools in 2023. Early discussions have been positive.

- 33 Kindness awards from January – March 2023
- 165 Individual Kindness awards to date
- 11 Bronze awards to date
- 1 Silver Award to CVS Inverclyde

3. Covid-19 Memorial: Remembering together

Phase 1 is complete with first draft of report submitted and discussed with steering committee and Phase 2 will begin in June 2023.

- 17 Bereavement Charter Meetings
- 3 Covid-19 Memorial Meetings
- 9 Kindness Awards Meeting
- 37 other network meetings i.e., Inequalities, volunteers

Inverclyde Cares engagement and planning meetings attended January – March 2023

New to Scotland

The team have continued to support those new to Scotland including those arriving from Ukraine and those claiming asylum either in dispersed accommodation or within local hotels. The team works very closely with other statutory and third sector partners to provide a warm welcome to Inverclyde and to support individuals and families to become integrated as part of the local community. Of note, in the past year, is the development of the Asylum Community Health Team who provide individuals with twice weekly support including individual health assessments, support to access wider health services and signposting to other community support.

In response to the ongoing conflict in Ukraine, the Scottish Government has participated in the Homes for Ukraine Scheme and the Ukrainian Super Sponsor Scheme (Warm Scottish Welcome). There are currently 143 Ukrainians residing with host families or in temporary accommodation across Inverclyde. 39 individuals have returned to Ukraine.

Since 2014 Inverclyde has participated in several refugee resettlement schemes and currently supports:

- 17 Afghan families – 85 individuals (under two Afghan schemes)
- 32 Syrian families- 138 individuals (under the Syrian Vulnerable Persons Resettlement Scheme)
- 7 Sudanese families- 25 individuals (under the Vulnerable Children's Scheme)

Maximising Independence

Maximising Independence commenced in November 2022 with the appointment of a Project Manager. A high-level project plan was agreed in March 2023 following a period of scoping, and engagement with services, organisations and the public across Inverclyde.

The purpose of Maximising Independence is twofold:

- working together, enable people in Inverclyde to age well, build resilience and maintain their independence.
- prevent, delay, or reduce people's reliance on traditional health and care services.

Maximising Independence focuses on preventative approaches, proactive, earlier intervention and supporting self-management of health and wellbeing. The initiative will build on previous and current preventative work in Inverclyde, link with related developments and have a strong emphasis on cross-sector collaboration.

A range of work streams are emerging, with two core projects currently planned – 'Making Early Contact Count' proof of concept project, and the creation of Inverclyde Supporting Self-Management community of practice. A measurement framework will monitor the impact of Maximising Independence on individuals, and across the health and care system.

ICIL Staff

The team at Inverclyde Centre for Independent Living (ICIL) has been innovative in developing ways to support and look after staff wellbeing, which in turn has a positive impact on service delivery.

The Team at ICIL had been split into two teams because of the pandemic, as well as having several members of staff working from home and the feeling of cohesion and of being one united team was lost. Throughout the pandemic the frontline team have worked tirelessly to support the residents of Inverclyde. They continued to assess at home and, where possible with limited resources, provided a service to ensure people with disabilities can stay at home. The team have also supported their home care colleagues to ensure that they are able to carry out their jobs. The admin team have worked tirelessly implementing new process and systems, supporting the staff to adapt to working from home during this period while ensuring that we are still able to assist the most vulnerable service users.

> ***"**This has created a real sense of teamwork, team bonding and benefitted staff in their overall mental health and wellbeing**".***

Unfortunately, the team also lost several co-workers and co-workers have lost family members/friends. However, the team have pulled together to deliver a different but equally efficient service and have worked hard to look after their health and wellbeing.

'Before'

They have created a space within the office which is away from the main area as a time out/supervision space in one of their disused office spaces. The room has been painted and rearranged with new soft furnishings and lighting to create an area where staff can go to either have supervision or to take time out if they are having a difficult day. It is also an area where staff feel comfortable to relax during their lunch break; or to share any issues that they may have in a safe environment. They were in touch with West College Scotland to plan days where they were able to offer massages/beauty therapies during lunch breaks – this in turn benefited the local student community.

They have weekly mindfulness sessions that are taken by two members of staff on a rotational basis. This has been a great success with staff, who are feeling the benefits of having this practice available to them on a weekly basis. As is well documented, the benefits of mindfulness not only include reducing stress, but it can also help with better sleep., improving focus and be more forgiving towards yourself and others. The ripple of effect of this will be positive for the service users that the team support.

In addition, they created an outside space/garden of reflection for staff. Work has been completed on the grounds and was carried out by staff themselves, liaison with colleagues in Criminal Justice, specifically unpaid work scheme, to help transform the overgrown space and plant a tree and have picnic benches where staff can sit. Staff also grew plants in the office and at home in preparation. Work on the project was carried out by a local business and staff themselves did a lot of the hard work.

'After'

The team have worked together and encouraged each other to take time out for their own health and wellbeing, creating a space to support this.

This has created a real sense of teamwork/team bonding and benefitted staff in their overall mental health and wellbeing. The Mindfulness sessions allow time and space for staff to look after themselves in a safe and comfortable environment. The outside space offers a place of reflection/quiet and to enjoy a break outdoors. All of this allows staff to provide a better-quality service.

"These projects have created a real buzz and enthusiasm amongst the staff team".

Charlotte's Story

Please meet Charlotte More a hairdresser from Halo, hairstylists in Gourock. Charlotte was nominated by one of her clients for Inverclyde's Kindness Award:

"I would like to nominate my hairdresser for a kindness award. She exemplifies kindness in our community.

Following a recent cancer diagnosis, I am currently going through chemotherapy treatment. A significant side effect has been my hair loss.

When I advised my hairdresser, she was so caring. We were able to discuss my preparation for hair loss. My hairdresser sent me flowers at Christmas and then sent flowers for my mum.

When my hair subsequently fell out, I contacted her to ask if she would mind shaving the rest of my hair. She not only agreed but opened her salon on her day off to do this.

"I think Charlotte exemplifies kindness in our community".

She has been so caring and understanding and doing everything she can to help at a really difficult time.

I would like to remain anonymous, but if Charlotte agrees, it would be good to publicise the award. Charlotte demonstrates what the kindness award is all about".

Anon

Care Inspectorate Activity

The total number of external commissioned providers inspected during 2022/2023 was seventy-seven. These included inspections to Older People Care Homes, Care at Home providers, Supported Living providers and Children and Family providers. Eight providers were inspected on more than one occasion resulting in eighty-seven inspections taking place.

Of the 77 services that were inspected during their initial visit:

- 26 of the services inspected were Inverclyde Area Services.
- 51 of the services inspected were of out of area services (where the HSCP have service user/resident placements)
- 19 services improved their grades.
- 33 services maintained their grades.
- 25 services grades decreased.
- 8 of the 77 services had a second follow up visit to review the requirements/areas of improvement.
- Initially those 8 services had a decrease in their grades however 6 services increased grades on further visits.

Two services had three inspections carried out with an initial decrease. Of these:

- 1 service increased their grades on their second visit and maintained those grades on their third visit.
- 1 service further decreased their grade in one area on their second visit and decreased further in areas on third visit.

For the 26 inspections undertaken in the **Inverclyde Area**:

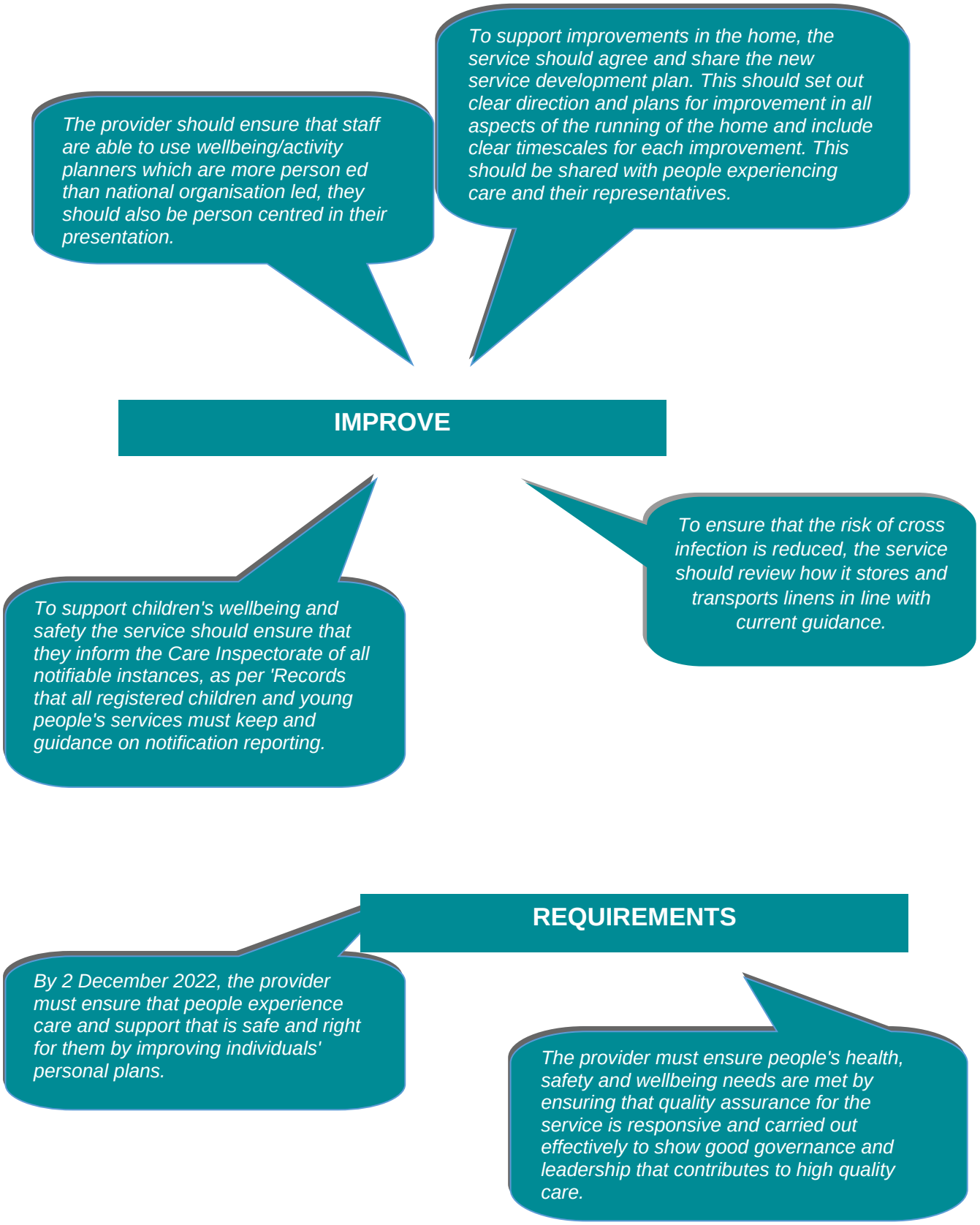
- 3 services increased their grades.
- 12 services maintained their grades.
- 11 services had a decrease in their grades.

Of the eleven services who received a decrease on their grades.

- 2 changed from ‘Very Good’ to ‘Weak’.
- 2 changed from ‘Good’ to ‘Weak’.
- 2 changed from ‘Adequate’ to ‘Weak’.
- 1 changed from ‘Excellent’ to ‘Good’.
- 1 changed from ‘Good’ to ‘Adequate’.
- 3 changed from ‘Very Good’ to ‘Good’.

From the initial inspections in Inverclyde the Care Inspectorate made 69 areas of improvement and 41 requirements made.

These are a sample of the areas of development, improvement and requirements made by the Care Inspectorate



In terms of our Childrens Houses, three were inspected during 2022/23. All were inspected specifically under “How well do we support children and young people's rights and wellbeing?”

The three houses decreased their grades from six to four which is graded 'good' meaning that there were important strengths with some areas for improvement. This decrease has been mirrored nationally with homes Scotland wide experiencing lower grades recovering from the Covid 19 pandemic.

The service is committed to continuous improvement and development and managers have taken forward improvements around older young people with challenging and complex needs. Older young people who are eligible for continued care are now allocated a continued care support worker to support skills for independent living.

In addition, a Child's Planning and Improvement Officer has been allocated to each of the 3 children's houses in Inverclyde to support regular reviews to take place to progress young people's plans towards greater independence.

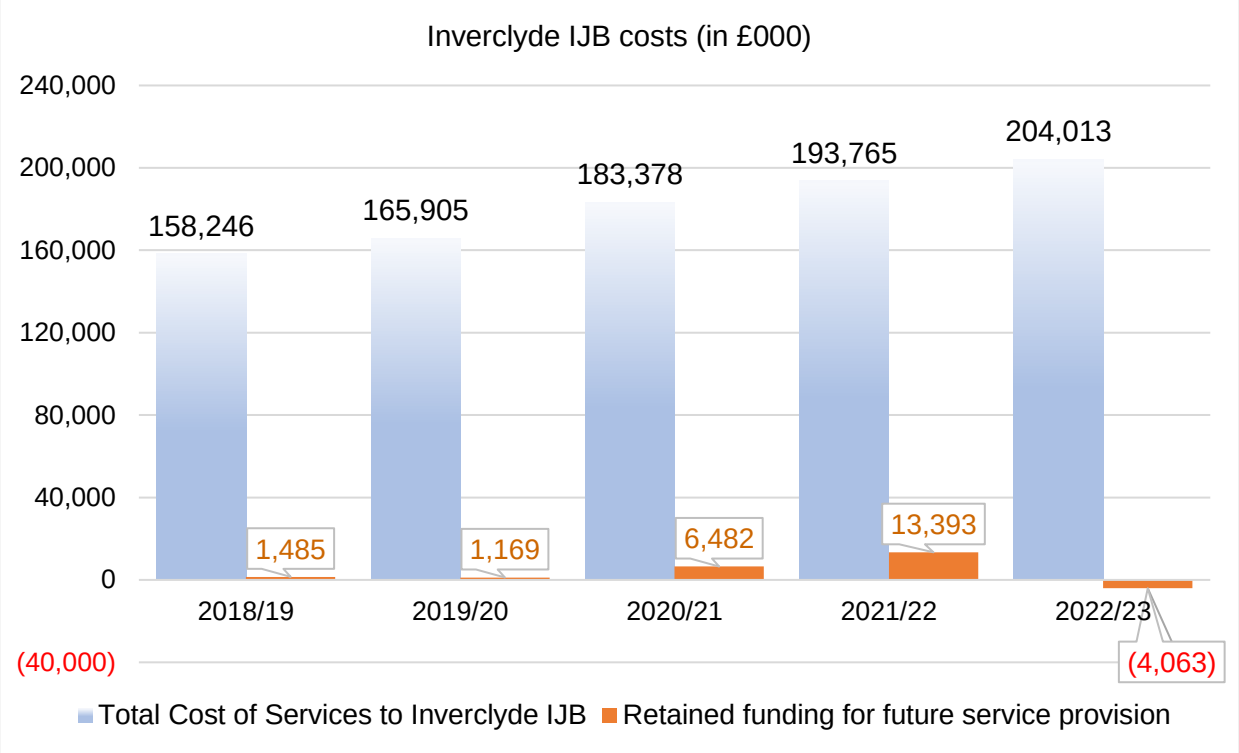
SECTION 3: Finance

Inverclyde IJB Financial Summary by Service

	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23* £000
Strategy and Support Services	2,416	2,111	2,133	1,881	1,751
Older Persons	27,020	28,407	30,383	31,015	34,482
Learning Disabilities	11,898	12,545	12,299	13,286	14,427
Mental Health – Communities	6,712	7,101	7,485	7,807	7,292
Mental Health – In Patients	8,729	9,737	10,607	10,689	11,844
Children and Families	13,738	14,114	14,711	16,571	17,152
Physical and Sensory	3,117	3,203	2,939	3,166	3,498
Addiction / Substance Misuse	3,464	3,181	3,826	3,807	4,146
Assessment and Care Management / Health and Community Care	8,258	9,981	10,789	13,055	12,604
Support / Management / Administration	4,174	4,339	450	2,840	7,938
Criminal Justice / Prison Service	26	49	148	85	39
Homelessness	791	1,043	1,173	1,240	1,516
Family Health Services	25,547	27,056	29,618	25,911	27,331
Prescribing	18,591	18,359	18,242	19,166	20,569
Covid-19 pandemic Funding			10,400	7,288	3,388
Change Fund	1,133	1,044	0	0	
Cost of Services directly managed by Inverclyde IJB	**135,614**	**142,270**	**155,201**	**157,805**	**167,977**
Set aside	22,632	23,635	28,177	35,960	36,036
Total cost of Services to Inverclyde IJB	**158,246**	**165,905**	**183,378**	**193,765**	**204,013**
Taxation and non-specific grant income	(159,731)	(167,074)	(189,860)	(207,158)	(199,950)
Retained (deficit) funding for future service provision	**1,485**	**1,169**	**6,482**	**13,393**	**(4,063)**

****At the time of publishing the 2022/23 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 services reviews each year to seek opportunities for developing services, delivering service improvement and generating additional efficiencies.



Budgeted Expenditure vs Actual Expenditure per annum

	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000
Projected surplus / (deficit) at period 9 (22/23 – Period 11)	(897)	(37)	(690)	855	(6,302)
Actual surplus / (deficit)	1,485	1,169	6,482	13,393	(4,063)
Variance in Under/(Over) Spend	**2,382**	**1,206**	**7,172**	**12,538**	**2,239**

Explanation of variances

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.

2022/23 – the last reported position to IJB was Period 11 which showed a projected deficit of (£6.302m). The year-end position shows an overall deficit on provision of services of (£4.063m), being a favourable movement of £2.239m before year end. This movement related mainly to movements in care package costs offset by an under recovery in homelessness arrears income, and in relation to new and additional reserves created to earmark underspends for use in future years, the most significant being Cost of Living Funds, refugee funds, Children's residential placements and pay contingency.

SECTION 4: Localities and Locality Planning

Localities - What Is It About?

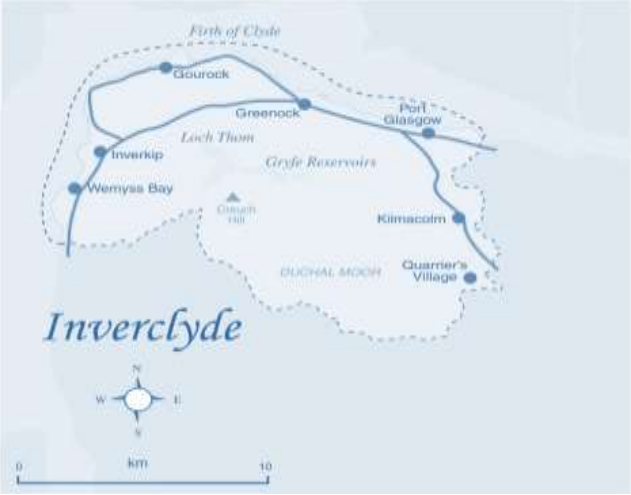
Inverclyde HSCP Locality Groups are established in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014, the Act puts in place the legislative framework to integrate health and social care services in Scotland. Section 29(3) (a) of the Act noted above requires each integration Authority to establish at least two localities within its area.

The HSCP is currently developing and building on our two Locality Planning groups (East and West) to support the understanding, planning and delivery of our HSCP services around communities within these localities.

Where are the East and West Localities?

The **East Locality** is defined as including the towns and villages of:

- Kilmacolm and Quarriers Village
- Port Glasgow
- Greenock East and Central (boundary Bakers Brae)



The **West Locality** is defined as including the towns and villages of:

- Greenock West and Gourock
- Greenock South and Southwest
- Inverkip and Wemyss Bay

Locality planning groups: 2022-23 update

Due to operational pressures and changes to our Senior Management Team Structure the establishment of both localities was delayed. The HSCP is in the process of a launch of our Localities with renewed vigour and fresh leadership, with closer links between localities and a wide range of our stakeholders including our Community Planning colleagues, Community Councils, Advisory Networks, Voluntary and Third Sector colleagues.

Locality Planning Groups will establish themselves with a future focus on what matters to our community. Early discussions identified some priority future focus issues, and we look forward to working with our stakeholders and partners in influencing change.

Participation and Engagement

Arrangements to determine what will be put in place to ensure full engagement and participation in the future will be outlined. There is an exciting opportunity for our Localities to be involved in the overarching consultation of our new Strategic Plan and our Equalities Outcomes.

A representative from the HSCP Locality Groups will represent the interests of their locality at the Strategic Planning Group (SPG).

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
ARC	Association for Real Change
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
DNA	Did Not Attend
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
MHAU	Mental Health Assessment Units
MHO	Mental Health Officer
MMR	Measles, Mumps and Rubella
MSG	Ministerial Steering Group
NHS	National Health Service
NRS	National Records for Scotland
OPMHT	Older Peoples Mental Health Team
OST	Opiate Substitute Treatment
PCIP	Primary Care Improvement Plan
PCMHT	Primary Care Mental Health Team
PDS	Post Diagnostic Support
PHS	Public Health Scotland
RFA	Request for Assistance
RSL	Registered Social Landlord
SAS	Scottish Ambulance Service
SDS	Self-Directed Support
SIMD	Scottish Index of Multiple Deprivation
SMR	Scottish Morbidity Record
SNIPS	Special Needs in Pregnancy Service
SPG	Strategic Planning Group
TEC	Technology Enabled Care
TU5	Thrive under 5

Inverclyde Health and Social Care Partnership (HSCP)

Hector McNeil House

Clyde Square

Greenock

PA15 1NB

INVERCLYDE HSCP Health and Social Care Partnership

NHS Greater Glasgow and Clyde

Inverclyde council