Inverclyde council

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 8

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

1.0 PURPOSE

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

2.0 SUMMARY

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

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

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

3.0 RECOMMENDATION

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

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

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

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

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

4.3 The National Steering Group proposed that:

- One year investment plans will provide the details of delivery arrangements for the short term change agenda. These will form the required older people's Change Fund Plans for 2013/14.
- Detailed 3 year implementation plans relating to the care group Strategic Commissioning Plans; will be detailed rolling three year planning documents refreshed on an annual basis;
- Partnership Commissioning Strategies and Strategic Commissioning Plans should be of 10 year time-frame reviewed and refreshed regularly consistent with related local planning cycles;

4.4 As per national guidance, Inverclyde CHCP developed the Joint Strategic Plan for Older People 2013-2023 in partnership with Inverclyde Carers Council, CVS Inverclyde, Your Voice, Scottish Care and Inverclyde Carers Centre in Spring 2013. A subsequent period of public engagement followed, facilitated by Your Voice.

The Joint Improvement Team reviewed all Partnerships' Joint Commissioning Plans in March/ April and together with our local public feedback; this has informed the final version presented here.

4.5 The Joint Commissioning Plan evidences the current position of health and social care for older adults in Inverclyde through a Joint Strategic Needs Analysis and outlines our commitments, illustrating the changes we will make to achieve the desired outcomes for older people living in Inverclyde. The delivery plan (p.17) shows our approach over the short (1 year), medium (1-3 years) and long term (3-10 years).

5.0 PROPOSALS

5.1 The ten year Joint Strategic Commissioning Plan continues to be implemented and governed subject to the arrangements outlined on p9 of the plan.

5.2 The Reshaping care for Older People Executive Group will be responsible for ensuring the plan is reviewed and updated as required and remains sensitive to current requirements throughout its ten year life.

6.0 IMPLICATIONS

6.1 Legal: None

6.2 Finance: None

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

6.3 Equalities:

The Joint Strategic Commissioning Plan will be subject to an NHSGG&C Equality Impact Assessment commencing in December 2013.

6.4 Repopulation: None

7.0 CONSULTATION

7.1 During the period (21st February 2013 – 18th March 2013) Your Voice Inverclyde organised and engaged with 21 Focus Groups, 268 older people, including 81 carers/ex-carers, were involved in the groups. The information gathered forms part of the appendix.

8.0 LIST OF BACKGROUND PAPERS

8.1 Joint Strategic Commissioning Plan for Older People 2013 - 2023

JOINT STRATEGIC COMMISSIONING PLAN FOR OLDER PEOPLE

2013 – 2023

INVERCLYDE PARTNERSHIP

W O R K I N G D R A F T
21.11.13

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1 OUR JOINT STRATEGIC COMMISSIONING PLAN

1.1 Introduction

The Inverclyde Joint Commissioning Plan for Older People 2013-2023 covers care and support services to older people over 65 years of age, which are delivered by the following partners, working closely with older people, carers, carers organisations and local communities:-

Inverclyde Community Health and Care Partnership
NHS Greater Glasgow and Clyde, including Primary and Secondary Care
Inverclyde Council
Third sector
Independent sector providers
Housing Providers

Our new plan outlines the partnership's vision for the next ten years. It explains how we will improve outcomes for older people and the approaches we are taking, including significant changes we will make to the ways in which we deliver care and support working with older people in Inverclyde.

The plan sets out a high level vision and future direction, along with specific areas for action and change, to show how we will work in partnership to develop new models of care and support to reshape services and improve outcome for older people, their families and carers. The plan is intended to reflect the CHCP's role as an ***assessor, purchaser, provider and safeguarder*** in relation to older people, and is designed to support business planning amongst our provider partners in the voluntary, community and independent sectors. The plan is also intended to stimulate creative, collaborative service planning and service delivery across organisational and sectoral boundaries, and to signal to existing and future providers of support potential service changes.

We intend to develop an older people specific elements of our Single Outcome Agreement to facilitate this through Community Planning.

This plan is also set in the context that the CHCP seeks through commissioning and strategic planning over the next 10 years to focus on delivering services that support ***involvement, empowerment, enablement*** **and** ***recovery*** for all citizens of Inverclyde, within the context of the Nurturing Inverclyde Agenda; where all citizens and communities can be ***Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible,*** *and* ***Included,*** *as demonstrated in the picture below:-*

The plan has been developed within a challenging and ever-changing context where public services are facing financial constraints while demand for services is increasing.

Major policy changes are also in development that will reshape services for older people, including the integration of health and social care services and the introduction of legislation to support Self-Directed Support and the delivery of more personalised services. These changes are described in more detail throughout this document.

The CHCP is still a relatively new and young organisation. It is our intention, with partners, that we commit to looking afresh at our business and at the ways in which we support our older people. We aim not to be bound by traditional views of services or need, or by what has gone before, but to be inspirational and develop services that will be flexible and adaptable to change over time to meet the needs of people who use them, and their carers, strongly guided by the views and aspirations of local people as our key partners in improving services and delivering on outcomes.

We recognise that to deliver on our aspirations will require determined and committed leadership from all partners, and are confident that this approach is already evidenced by our achievements to date.

The aim of the document is to clearly signpost our direction of travel, providing a guide for partners to craft new ways of working to deliver on our shared ambitions.

Signatories

Robert Calderwood: ……..
(Chief Executive, NHS GG&C)

John Mundell: ……..
(Chief Executive, Inverclyde Council)

Gloria McLaughlin: ……..
(Depute CEO, Scottish Care)

Ann Walsh ……..
(Chair, CVS Inverclyde)

Nell McFadden MBE ……..
(Chair, Your Voice – Inverclyde Community Care Forum)

Ann Price ……..
(Chair - Inverclyde Carers Centre Board)

Irene Pollard ……..
(Chair - Inverclyde Carers Council)

1.2 Governance/Planning Arrangements

There is a long and fruitful history of partnership and cross sector working in Inverclyde. This plan will strengthen and deepen such partnerships, through Community Planning and the achievement of the Inverclyde Single Outcome Agreement.

As is the case with our Reshaping Care for Older People Programme, this plan is a product of the partnership between Inverclyde CHCP, NHS Greater Glasgow and Clyde, Inverclyde Council, Scottish Care and local independent sector providers, CVS Inverclyde, the local Third Sector, Your Voice – Inverclyde Community Care Forum, Inverclyde Carers Council and Inverclyde Carers Centre. The partnership is underpinned by continuous and deepening engagement and involvement of local people, service users and carers, through means such as the Inverclyde CHCP People Involvement Advisory Network, Inverclyde Carers Network, Inverclyde Elderly Forum and the Hillend Service Users Group

It is planned that there will be ongoing engagement with social care providers, community and third sector organisations and local housing associations and housing providers.

This will ensure a consensus on direction of travel, facilitating an environment of trust through transparency and a sense of ownership through the mutual recognition of the presenting challenges and opportunities, informing the development of shared solutions.

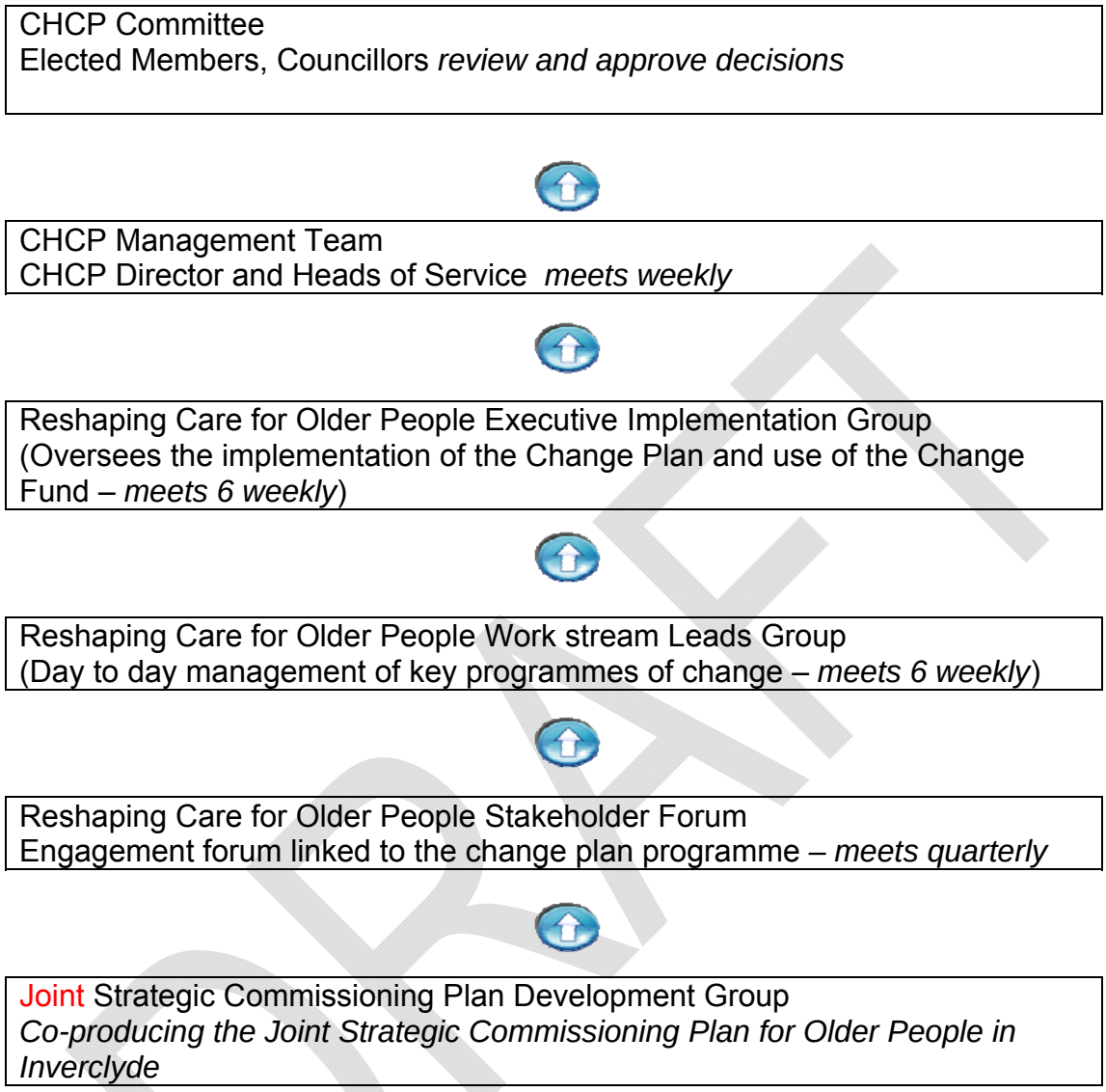
The governance of this plan will be through the partnership's Reshaping Care for Older People Programme Executive Implementation Group, underpinned by our Reshaping Care for Older People Programme Stakeholders Forum.

Statement of Governance

The graphic below is a statement of the decision making process in the CHCP related to Reshaping Care for Older People, and related agendas such as strategic joint commissioning.

Figure 1:

Governance of the Reshaping Care for Older People in Inverclyde



Statement of Roles and Responsibilities of Each Partner

The roles and responsibilities of each partner are set out below:-

Inverclyde CHCP takes the lead role in strategic commissioning. On behalf of NHS Greater Glasgow & Clyde and Inverclyde Council the CHCP combines the interests of community health and social care. The CHCP provides a co-ordinating function and supports the partners in developing the strategic document by facilitating the process and mechanism of engagement around strategic joint commissioning and service change development.

The independent sector via Scottish Care is engaged in all joint strategic commissioning development through membership of the various groups depicted in the governance diagram (below). The CHCP also facilitates regular provider forum sessions to engage with independent sector provider organisations.

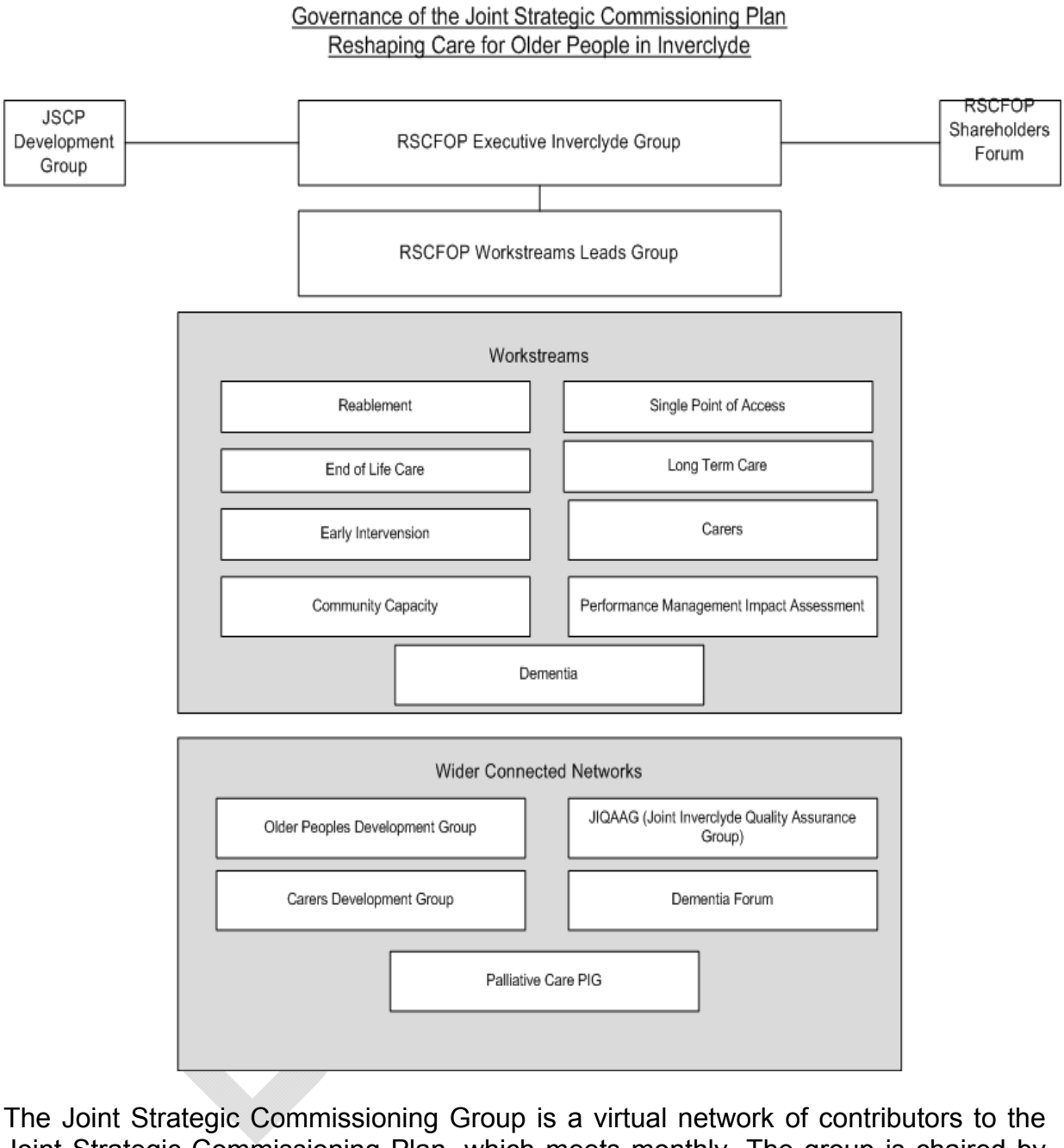
The local Third Sector is represented in the governance structures by the involvement of CVS Inverclyde/Inverclyde Third Sector Forum (I3SF). The Third Sector are partners in all aspects of the RCOP agenda, with a particular role in relation to community capacity building and co-production.

Services users, patients and the public are key equal partners and their engagement is facilitated via the CHCP and our people involvement partners Your Voice - Inverclyde Care Community Forum, though the Inverclyde People Involvement Network and CHCP Advisory Group, including the Inverclyde Elderly Forum.

Carers are equal partners in care, with a right to a voice in care planning, review and in relation to the development, planning and commissioning of services. Inverclyde Carers Council and Inverclyde Carers Centre Board are signatures to the plan and undertake regular engagement with carers in the Inverclyde Carers Network and represent their interests via the reshaping Care for Older People Stakeholders Forum. The core element of our Carers Strategy 2012-2015 have been used to inform the Joint Commissioning Plan to further ensure commissioning intentions are concurrent with the needs and aspirations of carers.

Figure 2:

Governance of the Joint Strategic Commissioning Plan



The Joint Strategic Commissioning Group is a virtual network of contributors to the Joint Strategic Commissioning Plan, which meets monthly. The group is chaired by the CHCP Head of Health and Community/Primary Care and has representation from a range of clients and sectors.

Regular communication is undertaken as part of the development work to engage views and opinions and this takes many forms including participating in existing forums.

Links with other Local Plans

This Joint Strategic Commissioning Plan has been developed through ongoing consultation with providers, users, carers and other interested parties predominantly linked to the Reshaping Care for Older People Change Plan, and will be an ongoing process.

This has enabled effective links with local planning activities, as well as maintaining a profile of its progress via the established governance frameworks supporting the Reshaping Care for Older People programme since 2011.

From a wider NHS GGC perspective, Inverclyde has an established representation on the NHSGGC Ageing Population Group, which facilitates linkages with the key themes of the NHS Local Delivery Plan, as well as emerging developments with the Clinical Services Review.

The intentions of this Joint Strategic Commissioning Plan are consistent with the aspirations of the Inverclyde Single Outcome Agreement and the CHCP Directorate Improvement and Development Plan, as well as the CHCP's Overarching Strategic Commissioning Plan which is in development.

Timescale of Plan

The submission of this plan sits within the Change Fund submission timetable, where a mid-year progress update was reported to the Joint Improvement Team (JIT) in September 2012, submission of the JIT reporting template on 28 February 2013, and publication of the draft Joint Strategic Commissioning Plan in February 2013. Subsequent review of the plan following public consultation has led to publication in November 2013.

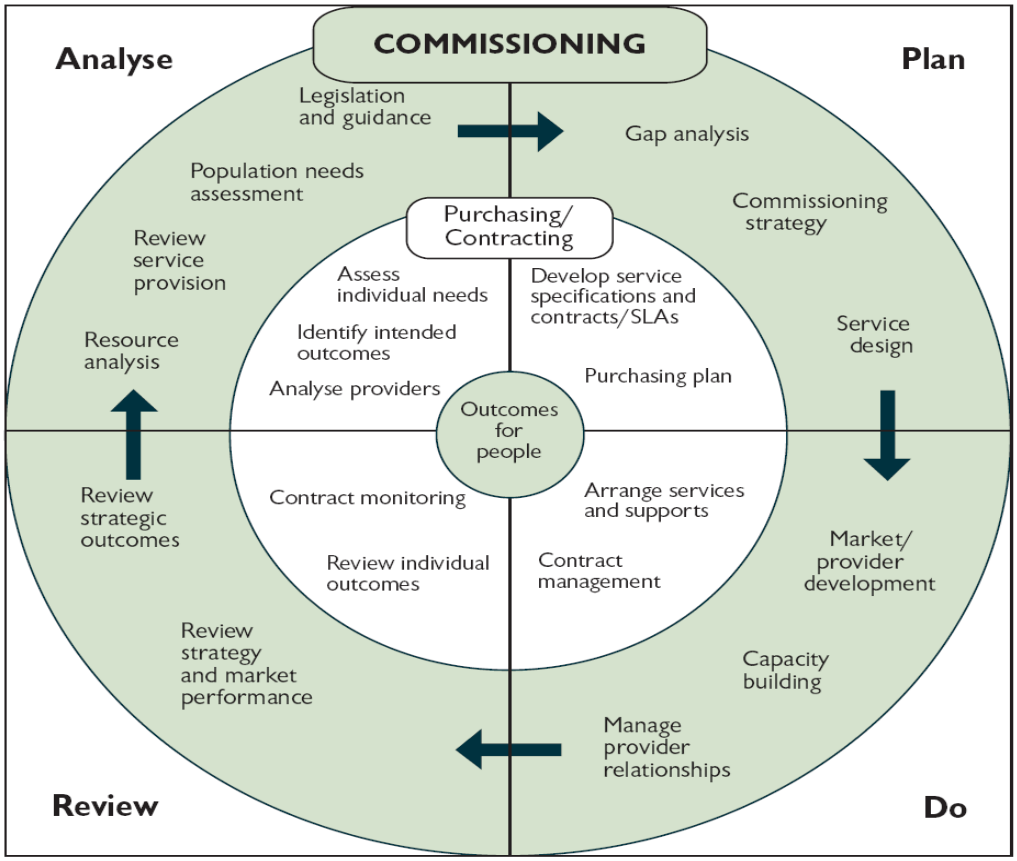
The Inverclyde Joint Strategic Commissioning Plan for Older People is a 10 year vision of services for older people, which includes short term targets for change and the detail of which will inform our 2013/14 spend against the Older People's Change Fund.

We recognise that whilst planning for 10 years, the plan initially focuses on the next 2 to 3 years, and will continue to adapt and evolve as both service change and demographic change impacts.

Commissioning Approach - Stages

The Inverclyde Partnership is committed to the Social Work Inspection Agency Commissioning Model, depicted in the diagram below. Commissioning will take place via working through the 4 recognised stages: Analysis, Planning, Doing and Reviewing, and will focus on outcomes for our older people acknowledging that Joint Commissioning "*is a complex strategic activity combining traditional disciplines of strategic planning, service design, procurement, internal service planning and performance management, and applying these disciplines in a new multi-agency environment. Joint commissioning is not simply about contracting between purchasers and providers, but concerns a whole range of ways in which services are developed and secured, including grants, service agreements, voluntary and community contributions and co-production*".

Figure 3:



1.3 Commissioning Approach – the market

Demand is expected to rise as a result of significant demographic change in the population of Inverclyde. Complexity is also increasing. This will have a substantial bearing on the care market, which has demonstrated vulnerabilities in the last twelve months, particularly in respect of independent care home providers.

The market will need to diversify the products and services offered to better meet the changing needs, expectations and outcomes of older people in Inverclyde and to develop in line with changing commissioning intentions and processes of purchasers.

A particular driver for this need for change will be the increase in use of self-directed support options by older people in realising their personal outcomes. Individual control over the delivery of personal outcomes will become a mainstream approach and people will choose from a range of self-directed support options instead of or in addition to statutory provision. We discuss this issue in more detail further on in this plan.

The range and flexibility of supports and services will need to grow to meet these changes while maintaining the highest quality of standards and value for money. In particular, there will be a shift in the model of care with an enhanced focus on rehabilitation and reablement. Prevention and early intervention will also be a focus

with a significant effort to ensure that community capacity building is encouraged and the use of community assets is maximised.

Models of housing provision will similarly need to reflect people's requirement for care and support which is delivered at home or in a homely setting. Commissioners and providers will be required to work together in partnership to develop approaches and service models to meet changing needs and expectations. At the same time quality assurance and monitoring arrangements will change to ensure that the effective delivery of desired personal outcomes for people is paramount regardless of the specific method of delivery chosen.

Overall public finance will reduce relatively over the course of the Joint Strategic Commissioning Plan and it is expected that a range of resources, personal and public, will be drawn upon in delivering care and support.

This Joint Strategic Commissioning Plan recognises the position of the public sector in working in partnership to lead and support diversification through engagement via provider fora to shape provision to deliver on the outcomes Inverclyde residents want to achieve. It also recognises the role to be played by Inverclyde residents, encouraging and maximising opportunities for individuals to take responsibility, for example, in the self management of care.

2 OUR VISION AND COMMITMENTS

2.1 Our Commitment to Older People Living in Inverclyde

Our commitment to Older People living in Inverclyde, as set out in the ICHCP Older People's Strategy, is that they should:-

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

The belief that most people, including those with complex care needs, can and would prefer to be supported in their own homes underpins this commitment. This is a local view expressed recurrently in our conversations with older people and their carers.

Key Outcomes

The following key outcomes for Inverclyde's Older People will result from our commitment:

1. Older people are supported to be as independent as possible
2. Older people can determine how to live their lives and what support they want, should they require it
3. Older people contribute to their communities and public life
4. Older people are protected from harm and neglect and feel safe at home and in their communities.
5. People with dementia, and their carers, receive the treatment, care and support following diagnosis that enables them to live as well as possible regardless of setting.

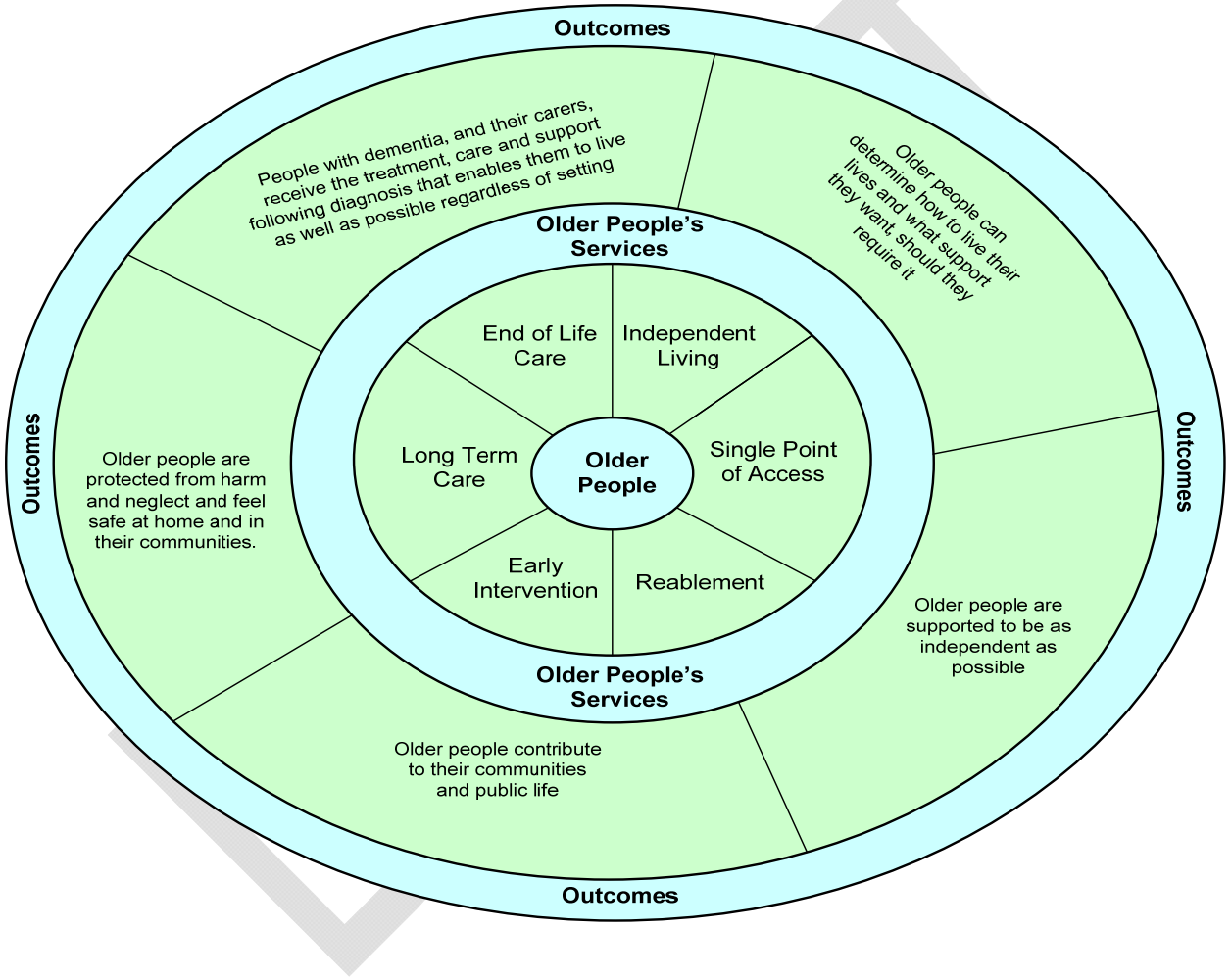
The outcomes above are aligned to the continuum for older people's services in Inverclyde, as per the Older People's outcome wheel on page 14.

The continuum forms the basis of our key strategic drive to reshape care for older people and underpins our vision for older people's services, and our commissioning intentions as set out in this plan.

We are committed to looking afresh at how we enable and empower older people and their carers to take charge of their health and abilities to ensure that our older population experience the best possible quality of life and sense of wellbeing. Central to our ambition is the drive to optimise independence for older people, in their own homes whenever possible, and when this is not possible, then in a homely setting.

Figure 4:

Older People's Services Outcome



3 ENGAGEMENT

Engagement with local people, particularly older people and their carers, has been central to the development of our Commissioning Plan for Older People's Services. We have well established vehicles for engaging with local people which we have drawn on and seek to further develop over the lifetime of this plan, working with our local voluntary sector engagement partners such as Your Voice (Inverclyde Community care Forum) and the Inverclyde Carers Centre.

During the period (21st February 2013 – 18th March 2013) Your Voice Inverclyde organised and engaged with **21** Focus Groups, **268** older people, including **81** carers/ex-carers, were involved in the groups.

All group members watched the NHS Ayrshire & Arran 'Reshaping Care for Older People' DVD to set the scene. Your Voice staff distributed copies of the draft Joint Strategic Commissioning Plan for Older People, provided an overview and referred to the 'Our Challenges and Intentions' section of the plan. Members then took part in a conversation and gave feedback around the following agreed questions:

- What do you think are the most important areas for action?
- What would help you to be more independent or involved in your community?
- What would assist you as carers (if relevant) to continue your caring role?
- What practical assistance could we work together to develop to achieve the aims discussed in the DVD and in the Joint Strategic Commissioning Plan?

Group members also took home a copy of the working draft and questionnaire to read over and feedback at their leisure. Individual feedback forms which were returned were been incorporated into the feedback analysis.

Through this process we gathered a wealth of intelligence, including ideas for action, which we have used to scope and refine our intentions. In some cases, such as in relation to the development of care and support at home and reducing social isolation, the feedback from local people helped us to clarify what our direction of travel should be and reinforced our aspirations.

We undertook a high level analysis of the feedback received in relation to each question asked. Responses have been themed as far as possible and particular responses of note were highlighted to particular service areas who could take action. Different themes emerged for each question and were not exhaustive or all encompassing. Rather, they were used to highlight key areas for action going forward.

Through our joint work with our engagement partners the local statutory sector will continue to involve local people in reviewing, developing and assessing the impact of services, and the changes we make.

4 OUR CHALLENGES AND INTENTIONS

Development of the Commissioning Plan has naturally led to a reconsideration of the many issues and challenges raised within it, and generated debate as to our priorities as we move forward in commissioning and procuring services over the next 3 and 10 years. We recognise that whilst planning for 10 years, the Plan initially focuses on the next 2 to 3 years, and will continue to adapt and evolve as both service change and demographic change impacts.

The development of the Inverclyde Joint Strategic Commissioning Plan for Older People has benefited significantly from engagement undertaken with local older people, their carers, professionals and other stakeholders. This engagement has shaped the development of a comprehensive and focussed Delivery Plan. To date the range of interventions progressed under the auspices of the Change Fund in Inverclyde have delivered a range of positive outcomes for our population. However, in developing our Delivery Plan we will achieve clarity and transparency in understanding the results of our interventions by;

- Undertaking a strategic needs analysis
- Carrying out contribution analysis and where necessary utilising a service improvement evaluation framework
- Reviewing practice and service models
- Employing Options Appraisals
- Measuring impact against our agreed joint performance framework

We face continued challenge, in common with other health and social care organisations, in relation to reducing bed occupancy related to delayed discharge. Our performance in reducing bed days in the hospital setting, not only in relation to Delayed Discharges but also for over 65s and over 75s generally, has improved at a greater rate than elsewhere within NHS Greater Glasgow and Clyde. However, in moving forward we must further focus on this key area of performance to achieve both the targets in relation to Delayed Discharges and the reduction in length of stay assumed in the acute bed model.

Currently in Inverclyde there are 20 Frail Elderly Continuing Care beds, with recent censuses showing that there is potential to reduce this number. However, there are still a number of patients who are fit for discharge being cared for in these beds. Similarly, in Frail Elderly Rehabilitation and Assessment beds in Inverclyde the average length of stay is 23 days, higher than in many other areas, and almost 50% greater than the future bed model target of 15.4 days.

Delivery of any reduction of these beds is dependent on reduced length of stay for patients, including the length of time awaiting discharge and the successful service redesign of community health and social care services as we further embed integration.

We have set out our intentions in relation to addressing key challenges in the delivery plan component of this document.

4.1 Delivery Plan 2013-2023

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
INDEPENDENT LIVING					
Housing					
There is disparate and inconsistent provision of housing for older people, with particular impact in areas of deprivation.	Accurately identify and have a plan to respond to future requirements for older people; numbers, type and location of housing	Identify a project lead within existing resources to scope and review the current situation and develop models for the future.	Develop closer working with the Council's Strategic Housing Team and housing associations to develop a shared vision of housing for older people.	Review pathways and processes to ensure availability of appropriate accommodation at times of need/ transition. Scope provision of new build/ develop existing stock.	We will have a stock of housing appropriate to different levels of need and disability. There will be clear process to address supply and demand.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Self Directed Support					
There is limited uptake of direct payments amongst people over 65 and there will be a focus on offering self directed support from April 2014.	Services will be developed & adapted to facilitate flexible and person led delivery of care and support, in order to meet personal outcomes.	Review current systems of support and advice to ensure fit for purpose	Raise awareness of new legislation and develop systems which can enable self directed support.	Promote self directed support for all those newly assessed and subsequently review existing service recipients. Demonstrate satisfaction and improved quality of life through use of an outcomes approach	People are empowered to make decisions about their own care and hold their own budgets should they choose to.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
EARLY INTERVENTIONS					
Day Care					
There is a range of traditional long term day care options following historic provision patterns. There is a decline in the demand for traditional long term care models, realign funding to reinvest in areas of new demand.	There will be a reablement and rehabilitative goal centred approach. Day care will be integrated in the community and supported by continued capacity building to facilitate moving on.	Scope current provision and identify future service models and develop a new service model. We will disinvest in care home beds by 5% over the next year and a further 5% over the next 3 years.	Undertake a rounded evaluation of provision, centred on the views of users and providers' perspectives.	Develop, engage and consult on a revised model of day service provision, encompassing health and social care. Commission and implement revised service models. We will re-invest and shift resources where appropriate.	We will have a broader range of day opportunities appropriate to the needs of service users delivered by a variety of providers. We will be able to evidence the benefit to short and long term health and social care outcomes of the revised model.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Long Term Conditions					
There is a range of uncoordinated work across services in relation to long term conditions, and a lack of clarity in respect of impact on access to services.	Provide individualised multi-disciplinary, multi-agency support for individuals with long term conditions and their families/carers.	Scope current provision and identify future service models to embed consistent approach and communication across services. We will deliver this via more effective use of existing resources and existing staffing models.	Review the NHSGG&C Supported Self Care Framework to ensure individuals are skilled to self care and monitor own condition for as long as possible or with minimal intervention.	Reablement and Rehabilitation Services will support individuals to recover from exacerbations of their condition and wherever possible to return to their previous level of function. Demonstrate satisfaction and improved quality of life through the use of outcomes and redesigned service provision.	Individuals will be part of the planning process and contribute to managing their own condition and planning for their future needs.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Anticipatory Care Planning					
There is a range of uncoordinated work across services, and a lack of appreciation of the benefits to be realised through effective anticipatory care planning.	The philosophy of anticipatory care will be embedded across multi-disciplinary teams and partners highlighting service users of particular vulnerability. Individuals are supported to make choices and plan for future care needs.	Identify Anticipatory Care Lead and develop action plan with steering group involving all partners.	Scope the range of individuals who would benefit from an ACP and identify the most appropriate lead professional. Implement an ACP pathway and design processes which will support effective information sharing across all partners. Continue to utilise the skills of the carers centre in emergency planning for carers.	Train and empower staff to initiate discussion around future care needs such as Power of Attorney. Evaluate implementation to consolidate effective anticipatory care planning for all. Monitor individual outcomes associated with Anticipatory Care Plans; reduction in exacerbations, admissions, use of additional support services.	All individuals who would benefit from an ACP will have one in place and have been involved in the planning where appropriate. The ACP and other relevant information is shared in a timely and secure fashion to ensure that planned interventions can be delivered. There will be a reduction in unplanned admissions to hospital and use of A&E which is attributed to the ACP approach.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Falls					
There are gaps in the data and knowledge in respect of who falls and what happens to them following a fall. The support and care for people who have fallen, whether injured or not, is not always consistent.	Robust data is available to inform planning and intervention. There is a robust pathway in place for someone who has experienced or who is at risk of a fall. Falls and hospital admissions linked to falls are prevented.	Work with acute services and SAS, community alarms service to identify the data and improve communication and pathways. Identify a lead to co-ordinate this work.	Establish a baseline position and scope the current pathways. Identify future potential pathways and methods of information sharing.	Implement a pathway with SAS, rehabilitation teams, telecare and reablement which supports individuals who do not need to be conveyed to hospital. Implement a pathway between telecare and rehabilitation for individuals experiencing multiple falls. Undertake baseline training of staff in all sectors. Undertake proactive work with people who are at risk of	There will be clear pathways for 1. Individuals at risk of falls 2. Individuals who fall but are uninjured 3. Individuals who fall and sustain an injury 4. Individuals who experience multiple falls We will reduce the amount of people attending A&E following a fall. We will reduce the amount of people suffering an injury as a result of a fall.

				falls to mitigate that risk. Address the recording of falls related presentations at A&E.	

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
SINGLE POINT OF ACCESS					
There are multiple access points to services	More effective signposting and easier access to services provided by all partners including the Third Sector	Identify the range and scope of services to be included in a Single Point of Access model. Consider support staff and IT needed to administer single point of access	Add immediately appropriate services to the existing single point of access. This change is cost neutral and will involve some workforce change	Review user experience of the changes to service to inform longer term planning. Undertake options appraisal to determine further extension of Single Point of Access within Health & Community Care Services. Establish the long term vision for the CHCP as a whole.	There will be a Single Point of Access to all Health & Community Care Services.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
REABLEMENT AND CARE AT HOME					
We have introduced a reablement service to facilitate optimum independence and decrease reliance on long term homecare services	Reablement as an approach is embedded across multi disciplinary teams and across our community supported and complemented by the development of community resources	Ensure current information management systems provide appropriate data to inform decision making processes	£684,000 from the 2013/14 Change Fund is being used to fund development in care at home and the development of reablement. Continue to embed a reablement approach across all services with a particular focus on dementia services.	Consider future development of service and pathways with an emphasis on bringing reablement, occupational therapy and rehabilitation closer together. To consider the benefit of reviewing all existing clients using an enablement approach Increase external provision of care to maximise available budget	More people will be enabled to remain independent for longer or to require a reduced level of social care support following a period of reablement. All care at home services either commissioned or in house will retain the reablement approach and maintain independence in the long term with clients.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
LONG TERM CARE					
Care Home Provision					
There is reducing demand for care home placement as the range of community services develops, resulting in vacancies in funded beds.	There will be 10% fewer local authority funded care home beds by 2016/17. The resource released from this reduction will have transferred to services to support people in their own homes	We will engage with care home providers and others to scope the potential for alternative models of providing care via care homes on a non residential basis, such as step up/step down day-care and/or a different model of residential care.	£20,000 from the 2013/14 change fund is being used to fund a Scottish Care Development Worker to facilitate engagement with the care home sector, particularly in respect of maintaining a stable and vibrant local care home sector. We will disinvest from care home beds and through options appraisals we will identify potential areas for reinvestment.	We will further disinvest from care home beds and evaluate the alternative models of care that have been put in place to inform future commissioning.	Sustain the reduced level of care home admissions as demographic changes become more pressing. People with more complex needs will be cared for at home rather than in long term care.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
Hospital Continuing Care					
There is a recurring under-occupancy of frail elderly continuing care beds at IRH of 50%, with the remainder being used to accommodate delayed discharge patients undergoing the assessment process.	The delayed discharge target of no patient being delayed is hospital by more than 4 weeks by April 2013, and by 2 weeks by April 2015 will be achieved. The resource currently spent on hospital continuing care beds, can be considered for reinvestment in preventative and home based care.	Review the delayed discharge processes to reduce delays in the assessment process and facilitate faster transition.	£42,000 2 social work posts from 2013/14 allocation of Change Fund to facilitate the assessment process. This is complemented by £96,000 AHP capacity from the 2013/14 Change Fund allocation. Quantify the impact on bed days of reducing delayed discharges.	To revisit the balance of care in terms of local need for continuing care beds and explore further the options for appropriate resource transfer.	Sustain a 0 delayed discharged target particularly as demographic changes become more pressing.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
END OF LIFE CARE					
There are well established palliative care services, requiring further effort to ensure seamless provision.	We need to reduce time spent in hospital in last 12 months of life, supporting people's wishes as to place of death	Establish and implement further expertise, choice and rapid access to appropriate services required for end of life care	£59,000 from Change Fund to support GP Facilitator, Practice Development and Clinical Nurse Specialists Implement work plan in response to scoping exercise.	Progress actions from scoping exercise, including setting targets for Gold Standards Framework, Liverpool Care Pathway, SPAR, and Advanced Care Planning Evaluate impact and identify gaps	Inverclyde is recognised as a Compassionate Community. Individuals are supported to die in the place of their choice.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
COMMUNITY CAPACITY BUILDING					
Community and voluntary sector supports and resources are not used to their optimum benefit to augment statutory services, and support people.	People can access a range of supports in their own community that meet needs and support inclusion, empowerment, involvement and recovery.	Invest time and resources in working across the statutory third sector to build the capacity of communities, groups and individuals to help themselves. Re-energise a culture across all services and sectors of seeking to make best use of community and individual resource based on an asset model, in harmony with interventional based approaches	£100,000 from our 2013/14 change fund has been allocated to supporting community capacity building projects to strengthen the involvement of community and third sector organisations and their work in relation to older people. Scope the range of needs and desires of local people in terms of community based provision and partnerships with the statutory sector.	Promote where possible the opportunity for involving local people and groups in delivery of services, in partnership with the statutory sector.	Commissioning services will enhance the local third sector and empower communities to sustain themselves and support their members, through delivery of services in a co-production model.

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
CARERS					
There is inconsistency of approach across services & client groups, supporting carers to be equal partners in care	Carers are recognised as equal partners in care across all settings and across all care groups Carers are fully supported to undertake their caring role	Implement the actions from the carers strategy 2012/15. Increase the number of carers assessments undertaken	£97,000 from 13/14 change fund has been allocated to Inverclyde Carers Centre to deliver hidden older carers, carers and hospital discharge project and carers emergency and long term planning project. Begin to implement the Equal Partners in Care (EPiC) principles.	Scope the opportunities to mainstream the work being undertaken in year 1 by redesigning the core work of key services Ensure carers are aware of the opportunities provided to them by Self Directed Support in improving the care that can be provided	Carers can fully participate in the planning and evaluation of care for the person they care for. We have process which allow us to learn from the experience of carers

Where are we now	Where do we want to be	How will we get there	Short Term 12 months (April 2013 – March 2014)	Medium Term 1 - 3 years (April 2013 – March 2016)	Long Term 3 - 10 years (April 2016 – March 2023)
DEMENTIA					
Currently implementing the redesign of Older People's Mental Health	Provide early intervention and post diagnostic support to service users and carers	We will work closely with partners to improve care pathways and to improve support for people diagnosed with dementia	We will use £35,000 of the 2013/14 Change Fund to deliver post diagnostic support to people with dementia	Introduce a tiered approach reflecting levels of need. We will implement Promoting Excellence to improve the way our staff work with people with dementia, their families and carers.	Inverclyde will be a dementia friendly community.

5 JOINT STRATEGIC NEEDS ASSESSMENT AND PERFORMANCE SUMMARY

5.1 Current Profile

Inverclyde is one of the smallest local authorities within Scotland, and is comprised of towns of Greenock, Gourock, Port Glasgow, Inverkip, Weymss Bay and the villages of Kilmacolm and Quarriers. Inverclyde has a very small ethnic minority population with less than 1% of its residents coming from an ethnic minority background.

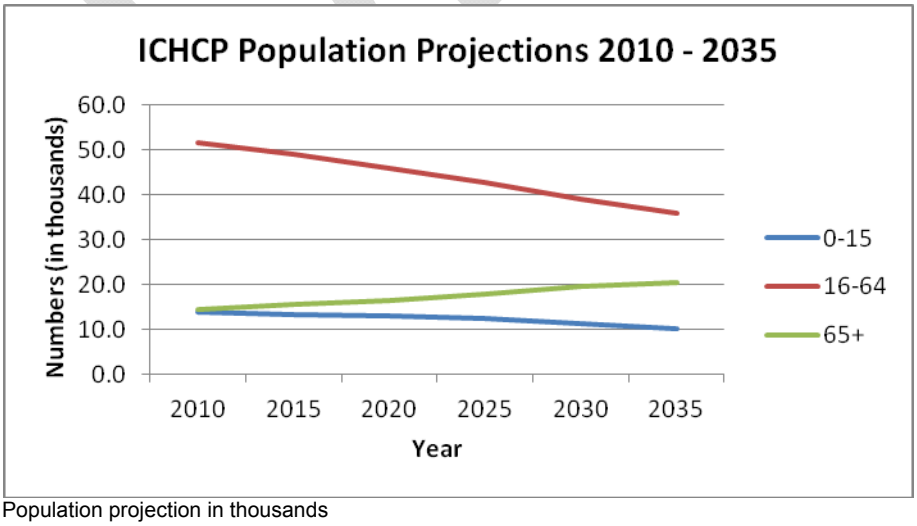
Inverclyde's mid-year population estimate for 2012 was 80,860 people[1]. The number of young persons aged 0-15 years of age was 13,403, for the age group 16-64 years of age the number of people was 52,076 and 15,201 people are in the 65 and over age bracket with 7,003 of these people being aged 75 and over.

5.2 Projections

Inverclyde's 65 and over population is set to rise significantly over the next 22 years according to the latest figures published by the NRS (National Records of Scotland, formerly named the General Register Office for Scotland).

Overall, Inverclyde's population is falling year on year, with people in the age bracket of under 65 continuing to decrease as time moves on, this is in stark contrast to our older population (65+) which is projected to rise from 14400 (approx.) in 2010 to 20500 (approx.) by 2035, a rise of 70%.

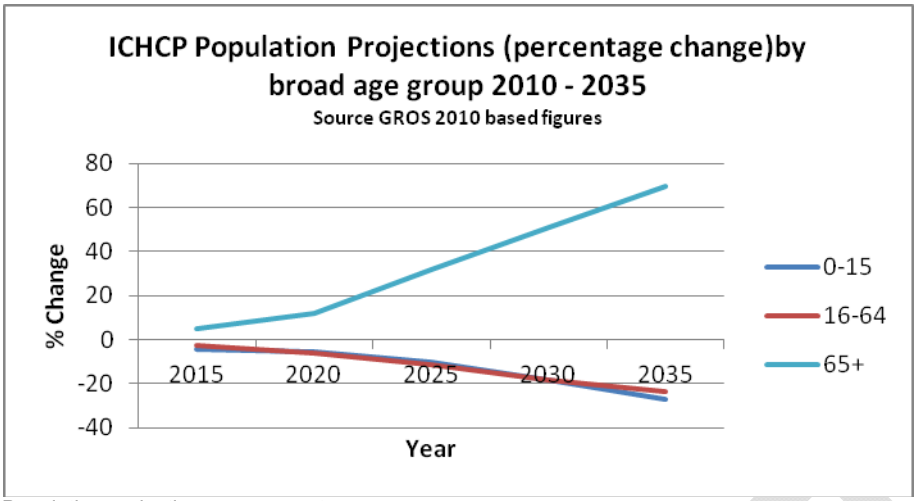
The first chart shows the population age brackets in actual numbers (thousands). This demonstrates the trend of the total number of people under 65 falling steadily while people over 65 steadily rising. The second chart shows a more pronounced picture when the data is analysed as a percentage change in the population.



Population projection in thousands

[1] http://www.gro-scotland.gov.uk/statistics/theme/population/estimates/mid-year/2012/list-of-tables.html

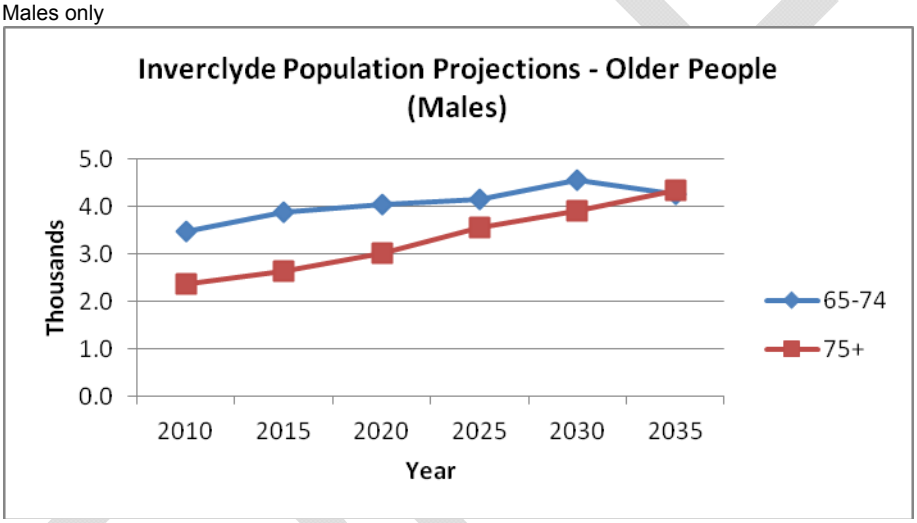
Source NRS



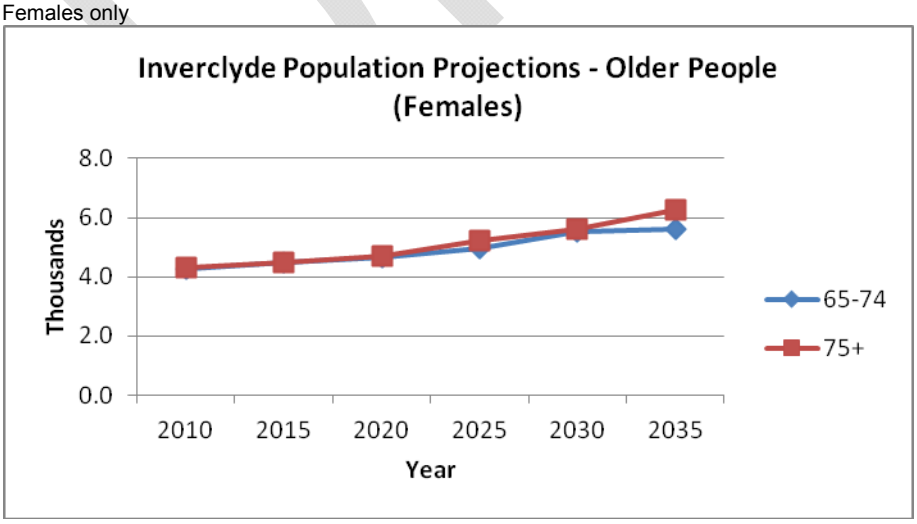
Population projection as a percentage
Source NRS

The following charts show the gender split projections for the same period and also show the additional grouping of those people aged 75+. These charts clearly show a sharper increase in the 75+ age group.

Males only



Females only



5.3 Deprivation

Another consideration that has to be taken into account is the level of deprivation and health inequalities.

Inverclyde has a total of 325 datazones. Most of these datazones are found in the most deprived deciles according to the key findings from the Scottish Index of Multiple Deprivation (SIMD) 2012.

This is an increase since 2004 and to demonstrate the significance of this, Inverclyde had 6 datazones in the 5% most deprived areas, and 36 in the 15% most deprived in the year 2004.

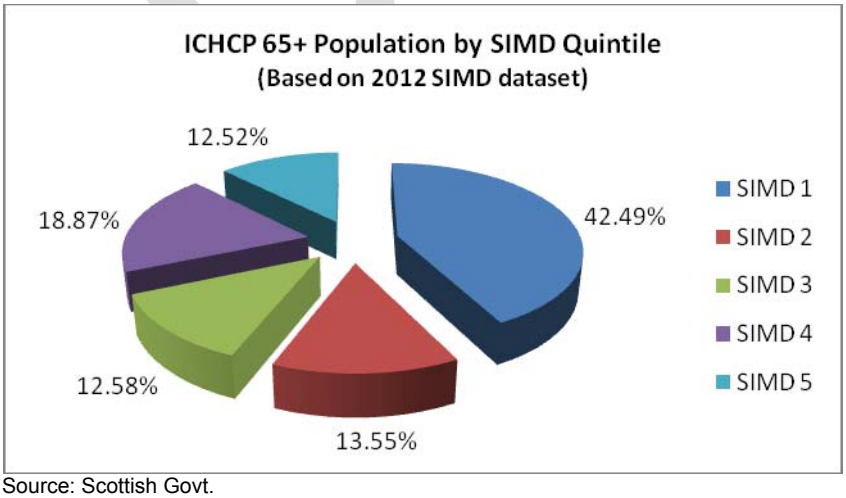
Number of Inverclyde datazones in deprived areas		
Year	**5% Most Deprived Areas**	**15% Most Deprived Areas**
2012	14	44
2004	6	36

Source: Scottish Govt.

The majority of older people residing within Inverclyde are resident in the most deprived quintile (SIMD1) which has a major impact on their health and care needs. Based on the 2012 mid-year estimates from National Records of Scotland (NRS) and from the 2012 SIMD data set, 6,137 of Inverclyde 65+ persons were living within SIMD 1 areas (the most deprived quintile), that accounts for 42.5% of the entire elderly population in Inverclyde. Therefore, it is clearly evident that there will be significantly more pressure on local health and social care services as the elderly population continues to grow.

	SIMD Quintile	Population	% of total
▲	SIMD 1	6137	42.49%
Most Deprived	SIMD 2	1957	13.55%
	SIMD 3	1817	12.58%
Least Deprived	SIMD 4	2726	18.87%
▼	SIMD 5	1808	12.52%

Source: Scottish Govt.



Source: Scottish Govt.

5.4 Life Expectancy

Inverclyde's Life Expectancy (LE)[2] rates are below the Scottish Average. For males at birth the Scottish average is 75.85, the figure for Inverclyde is 72.98. For females at birth the Scottish average is 80.43, in Inverclyde the figure is 79.15.

This may be attributed to a combination of deprivation levels and high prevalence of long term conditions. Conditions associated with smoking for example have a prevalence rate of 26.63 per hundred patients within Inverclyde.

If we examine the LE rates at age 65 for Inverclyde, the area has the second lowest LE for males out of the 32 local authorities with only Glasgow City having a lower rate. In relation to females, Inverclyde sits in 24th position of the 32 local authorities. In terms of Healthy Life Expectancy (HLE)[3], Inverclyde again sits only above the Glasgow City CHP for the male population. The HLE for Inverclyde males is 62.4. For females the HLE is 68.7, fairing marginally better than North and South Lanarkshire, West Dunbartonshire and again, the Glasgow City CHP area.

5.5 Dementia

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

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

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

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

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

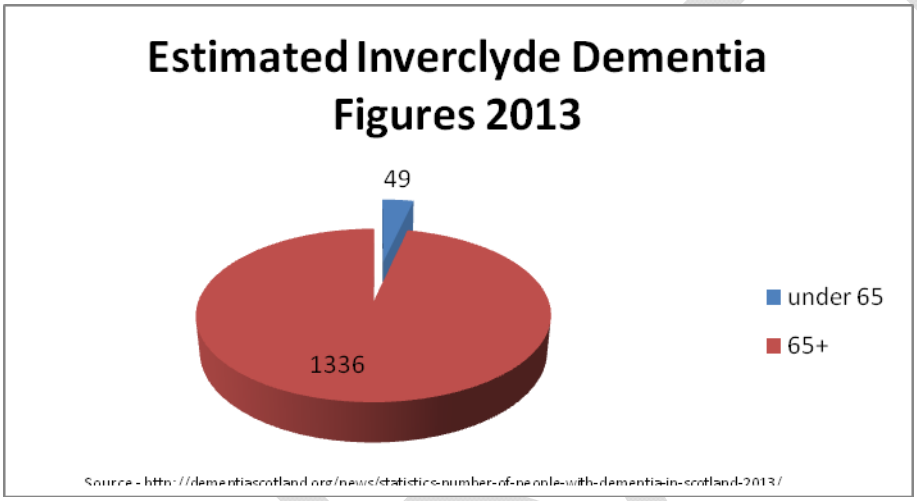
In 2012 the Scottish Government made a commitment to guarantee that people receiving a diagnosis of dementia will be offered a minimum of one year post diagnostic support:

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

[2] LE Data Source – NRS 2008-2010 Life Expectancy tables
[3] SCOTpho report 1999-2003

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

According to the Scottish Government's Dementia Strategy[4], the number of people suffering from dementia will double over the next 25 years. This estimates numbers of people with a dementia in Inverclyde in 2013 is 1385, 1336 of these people are aged 65 and over with the remaining 49 being under 65 (based on the EuRoCoDe and prevalence rates, see chart below). Based on this it is estimated that by 2037 this number will be approximately 2770. It should be noted however, that prevalence rates may change as time progresses and as such the projections will change in accordance with the rates of prevalence.

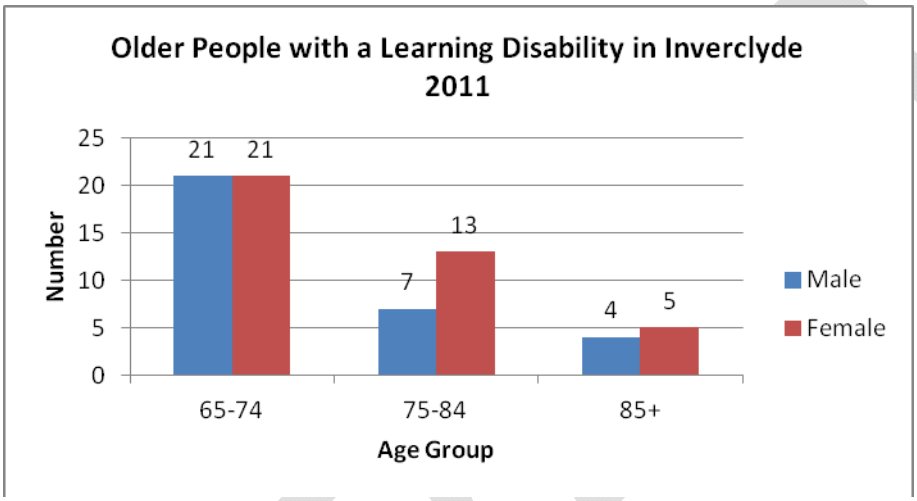


[4] http://www.scotland.gov.uk/Publications/2010/09/10151751/6

5.6 Learning Disabilities

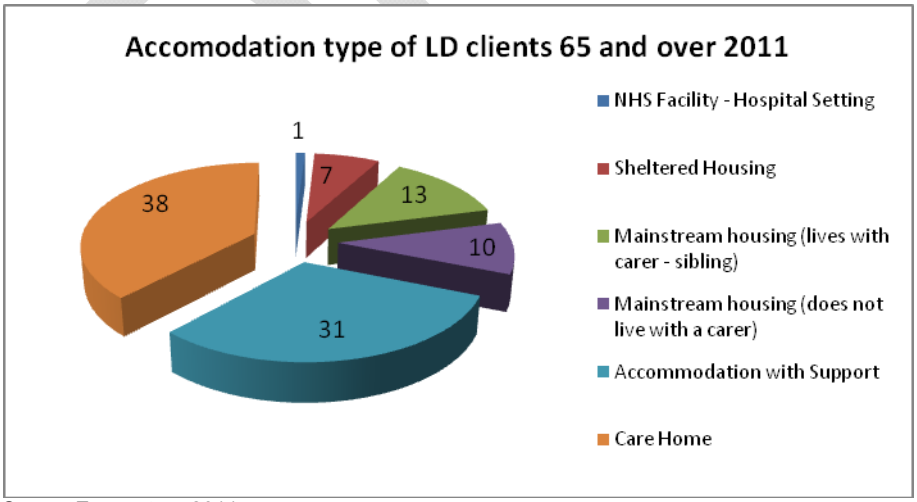
In 2011, there were 577 people in the Inverclyde locality with a diagnosed learning disability. (Approximately 8.8 adults per 1000 population, a rise 0.1 per 1000 in 2010). Of these 71 were aged 65 or over.

With advances in healthcare and treatments, people with a learning disability are expected to live longer. People with LD are more likely to develop dementia and in addition, about 50% of people who have Downs Syndrome and live to age 60 are likely to develop Alzheimer's. This implies that our learning disability service will come under increasing pressure in years to come.



Source Esay return 2011

The graph below demonstrates where people with a learning disability reside. The rise in the Learning disability population described above is anticipated to have an impact on this picture.



Source Esay return 2011

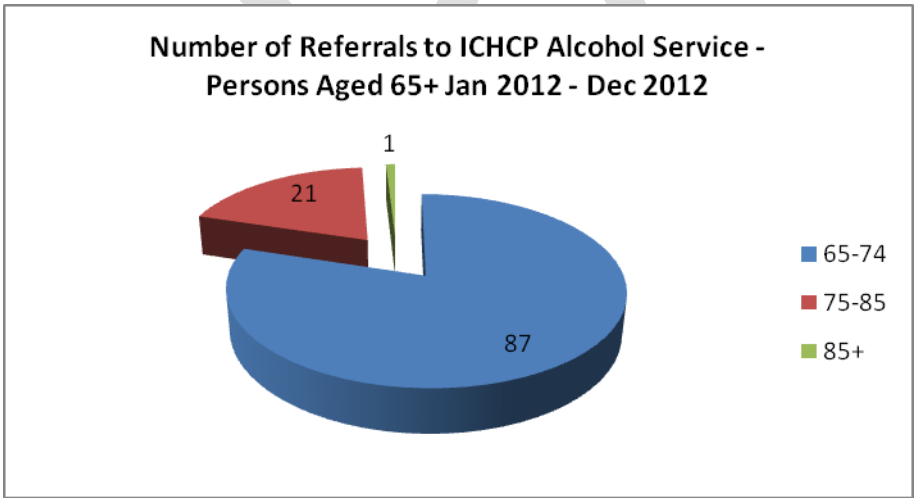
5.7 Alcohol Misuse

Alcohol misuse has been a historic problem within Inverclyde and continues to be a problem with large numbers of people affected directly and indirectly by alcohol misuse. Alcohol can have long term effects on an individual's health including conditions affecting the liver and also causing Alcohol Related Brain Damage and Korsakoff's syndrome. The Inverclyde Alcohol and Drugs Strategy[5] contains further information which supplements this section.

In 2005, the alcohol related death rate in Inverclyde was 44.7 per 100,000, the third lowest in the Greater Glasgow & Clyde NHS board area, since then however, Inverclyde has been consistently one of the worst areas for alcohol related deaths. In 2009 and 2010, for example Inverclyde had the highest rate of alcohol deaths, and in 2007, 2008 and 2011 it was the second highest in the board area.

Greater Glasgow and Clyde have set local targets for alcohol related admissions to hospital. The target for Inverclyde was 12.0 for every 1000 people. Rates of admission to hospital for alcohol related conditions in Inverclyde were consistently breaching the target until September 2012 which was 11.4 per 1000, a drop of 1.9 per 1000 on the previous month's figure. Inverclyde has recently been meeting its targets for lowering rates of admission for alcohol related conditions but more work needs to be done to ensure the downward trend continues.

During the period Jan 2012 – Dec 2012, a total of 109 older people were referred to ICHCP's Alcohol Service, the breakdown of the age groups of these referrals can be seen below.

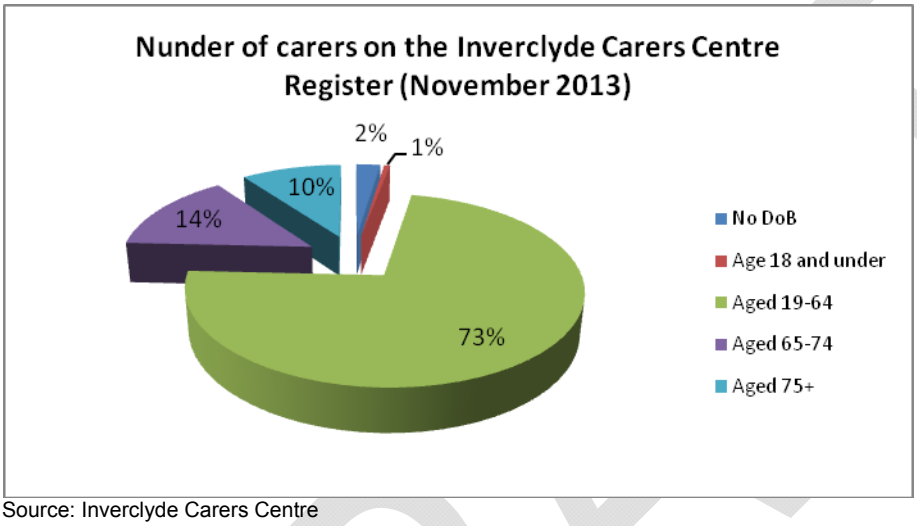


5 http://library.nhsggc.org.uk/mediaAssets/CHP%20Inverclyde/Development%20Plan%20Update%202011%2012%20Final%20Draft.pdf

5.8 Carers

According to the Scottish Governments Carer's Strategy, around 1 in 8 people will at some point in their life become a carer. On that premise, we can estimate that there around 9892 carers[6] in Inverclyde. As Inverclyde's age profile suggest that we have an ageing population, we can assume that the number of carers in Inverclyde will grow significantly in the near future.

Inverclyde Carers Centre has provided the CHCP with the age profile of the carers within Inverclyde, which can be seen below.



Source: Inverclyde Carers Centre

If we examine the data relating to long-term activity-limiting health problems in Inverclyde taken from the 2011 census data we can see that of our population, 12.5% felt that they were limited a lot by a limiting long term health condition, which is 2.6% higher than the overall Scottish figure. 11.3% of Inverclyde's population said that they were limited a little by a limiting long term health condition. This has a direct impact on the level of care a person may need, and in many cases this care falls to a relative of friend who is classed as an unpaid carer. The table below shows the levels of unpaid care in Inverclyde and in Scotland as a whole.

	Inverclyde		Scotland	
Description	**Percentage**	**Number**	**Percentage**	**Number**
Provision of unpaid care				
All people	100.0%	81,485	100.0%	5,295,403
Not providing care	89.9%	73,233	90.7%	4,803,172
Providing 1 to 19 hours of care a week	5.1%	4,120	5.2%	273,333
Providing 20 to 34 hours of care a week	1.0%	849	0.9%	46,315
Providing 35 to 49 hours of care a week	0.9%	721	0.8%	40,501
Providing 50 or more hours of care a week	3.1%	2,562	2.5%	132,082

Source: Scotland's Census 2011

[6] http://www.scotland.gov.uk/Publications/2010/07/23153304/30

Inverclyde GPs have a Carers Register, in which they keep a record of which of their patients is considered to be a carer. The figure for people registered in 2012/13 on the GP Carers Register was 1299 people, which is approximately 13% of our estimate of the total number of carers. In addition Inverclyde Carer's Centre also has a register, of which they have number of carers at 2181, which although much higher that the GP register is still only around 20% of our estimate.
Work is required on an on going basis around raising awareness and encouraging people to register as carers within Inverclyde, to reduce levels of hidden caring.

5.9 Care Homes

Inverclyde has a total of 15 care homes. 11 of these establishments are Nursing Care homes, with 4 being Residential only. Within the Nursing Care Homes there are a total of 622 beds, and 114 beds within the Residential Homes.[7]

The average age of people resident within care homes as at September 2013 was 84 years of age, and the average length of stay in the 15 care homes was 2.81 years, this is slightly above the national average of 2.4 years.

Between April 2012 and Sept 2013 there were, on average, approximately 17 new admissions to care homes per month. For the same period the total number of new admissions to care homes was 307, with 56% being referred from Hospital and 44% from the community. Nationally, 50% of admissions to care homes are from the hospital setting.

In addition to funded places, the CHCP access the remaining available places for short breaks/respite if and when required.

5.10 Care at Home Services

Inverclyde is currently undergoing a service redesign of its Care at Home service, including the implementation of the new CM2000 monitoring and scheduling system. The service currently has two operating models; Mainstream Care and Support and Re-ablement.

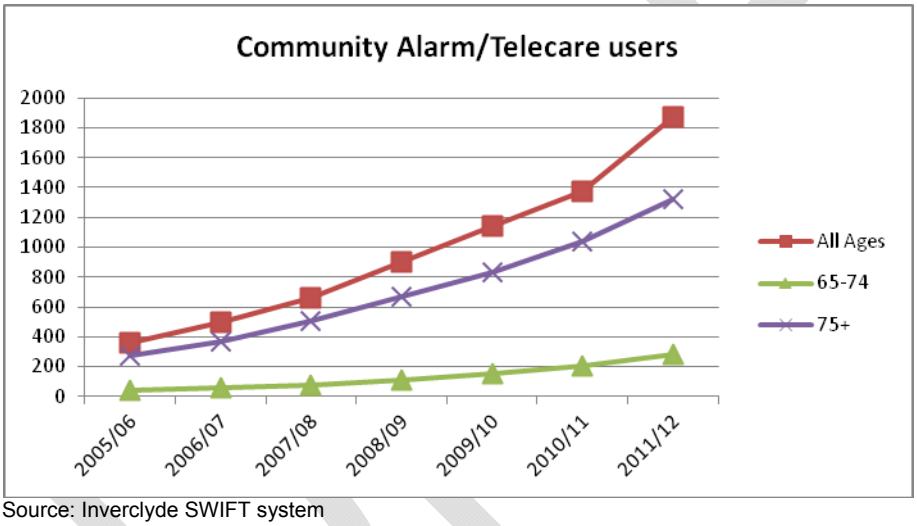
Mainstream Care and Support at Home caters for people with longer term domiciliary care needs (personal and social care). Re-ablement is a service intended to help people regain independence after a period of hospitalisation or recovery from some other major event such as long term illness.

In 2005, Care at Home provided a service for a total of 1032 65+ services users[8]. The latest 2013 figure is 1217[9]. The rate per 1000 population has been rapidly growing for the last few years; In 2010/11 the rate per 1000 was 77.4, as at August 2013 the figure stands at 83.9, an 8.39% increase in a 3 year period. As the number of service users and the complexity of their needs increases, then number of hours required from the service is likely to increase.

[7] Local Care Home data
[8] Data from Scottish Neighbourhood Survey
[9] Latest Home Care data CM2000

Inverclyde CHCP is currently uses both internal and external service providers. In May 2013, Inverclyde CHCP provided 70.79% of Care and support at Home services. External providers (independent, voluntary and also direct payments for home care) provided 29.3% of Care and support at Home services. In recent months this balance has continued to shift in favour of external provision; as at August 2013, the CHCP provided 59.5%% of home care services and 40.5% was provided by the external providers. In terms of percentage increase, external services were providing 8.3% more of the home care services during the reporting period.
Care at Home services also manages local Community Alarm/Telecare provision. This service provides emergency response to people living independently in their own homes. The equipment installed gives reassurance to these vulnerable people, knowing that at a touch of a button they can get support and assistance when it is needed.

The chart below[10] shows the increase of users of telecare services since 2005. The chart demonstrates the sharp rise in people age 75+ using this service. Telecare services enable people to live independently and facilitate prevention of hospital admission.



Source: Inverclyde SWIFT system

5.11 Secondary Care Services

Secondary Care services in Inverclyde are provided by Inverclyde Royal Hospital, delivering a local district general hospital service, and the adjoining Larkfield Unit which delivers continuing care, rehabilitation and day hospital services for older people.

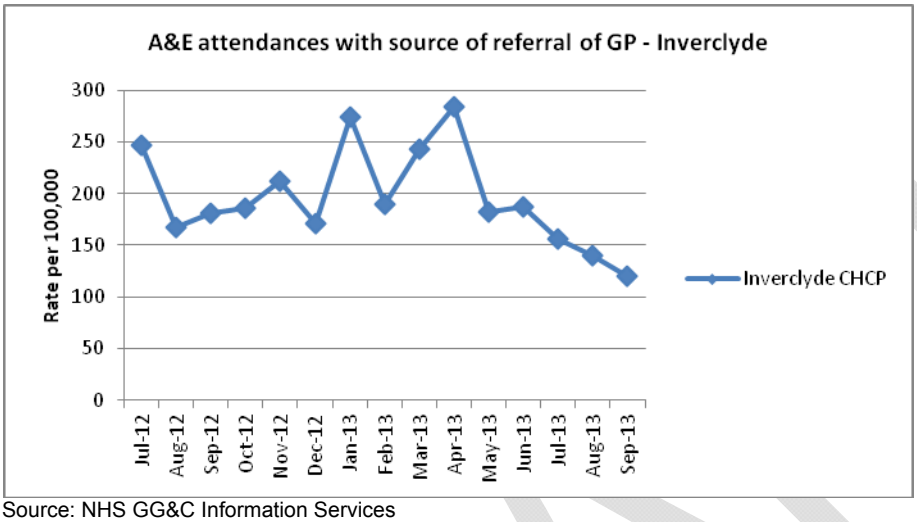
In relation to A&E attendances, the Scottish Government has a HEAT target around A&E services.

> "To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14."

[10] Inverclyde SWIFT system

Inverclyde CHCP has the second highest rate of attendance consistently in the GG&C board area, second only to Glasgow South. It should be noted however that the rate of attendance is decreasing but at a very slow rate. In the period July 2011 to June 2012, the rate of attendance per 100,000 was 3148. The latest figure for the period October 2012 to September 2013 was 2988 per 100,000.

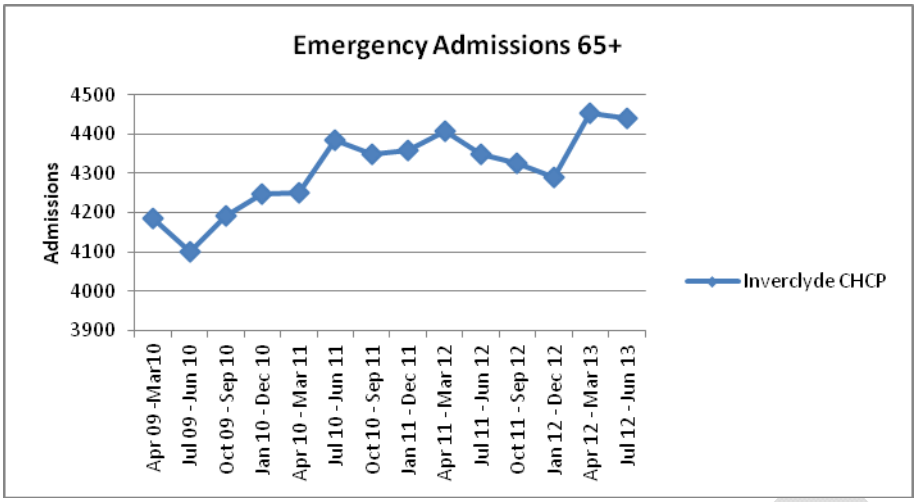
A&E attendances with a referral from a GP have decreased from 247 in July 2012 to 120 in September 2013. The GP referral trend during this period is a downward one overall; however there are spikes in the trend over the winter months as shown in the chart below.

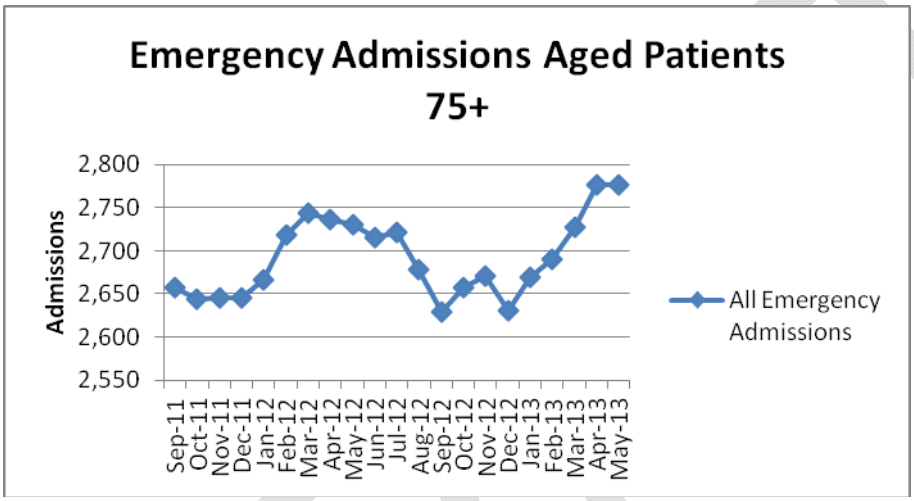


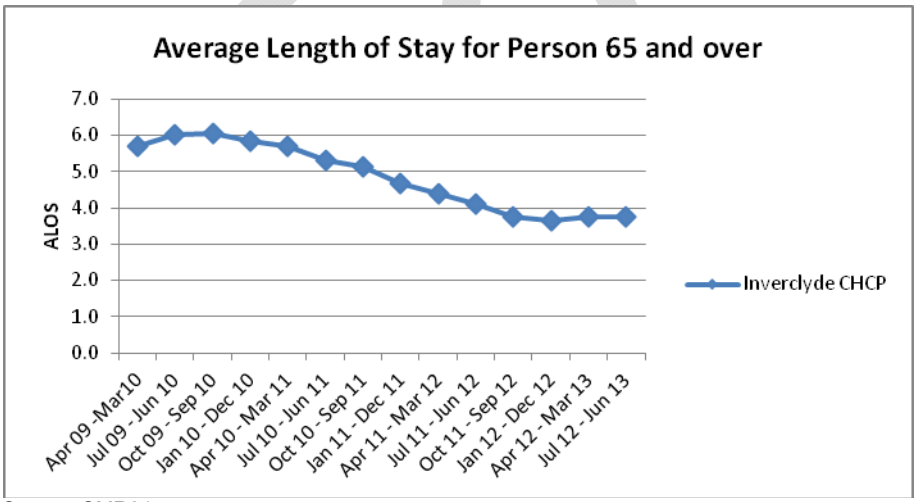
Source: NHS GG&C Information Services

One of the key strategic drivers of Reshaping Care for Older People is to reduce the need for emergency hospital care. This requires NHS Boards to work to achieve agreed reductions in emergency inpatient bed day rates for people aged 75 and over between 2009/10 and 201/12 through improved partnership working between the acute, primary and community care sectors. From March 2012 the target is to reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population by at least 12% between 2009/10 and 2014/15.

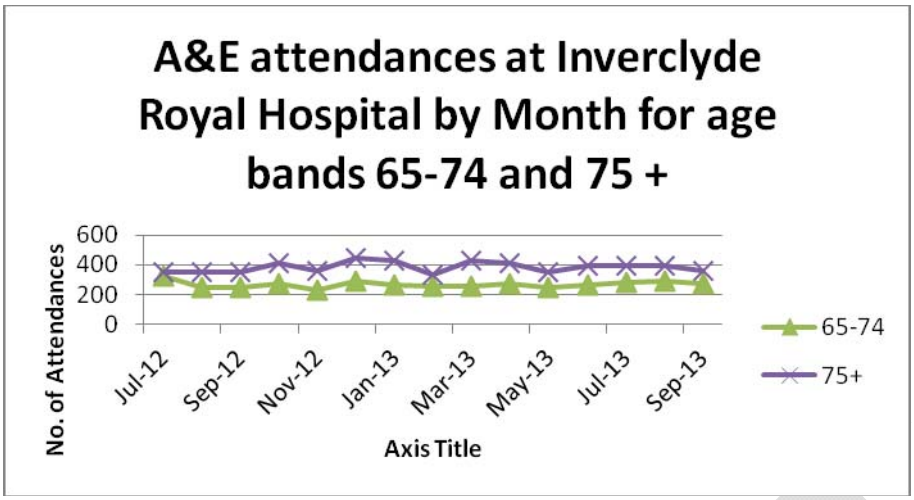
In terms of emergency admissions for people aged 65 and over, Inverclyde is showing an upward trend in the rate of admissions since March 2010. With regard to lengths of stay, the opposite is true. This demonstrates that although admissions are rising the patients are staying within the hospital for a shorter length of time. See charts below.



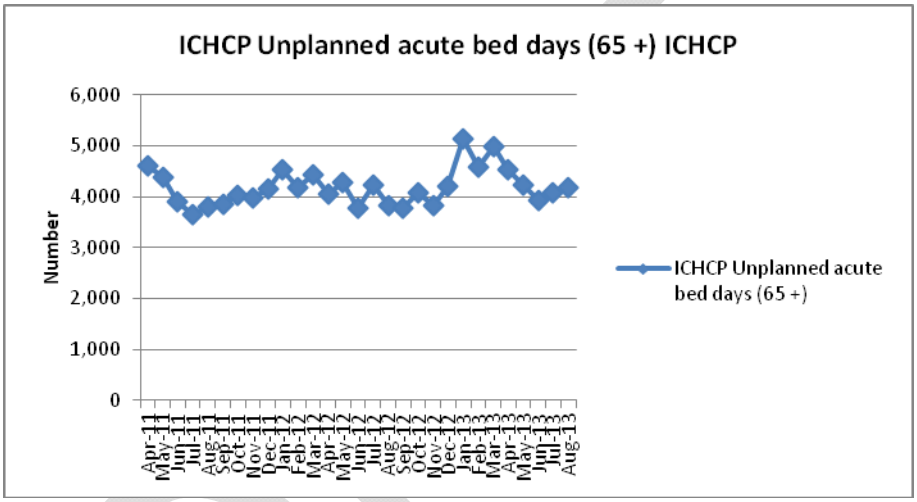


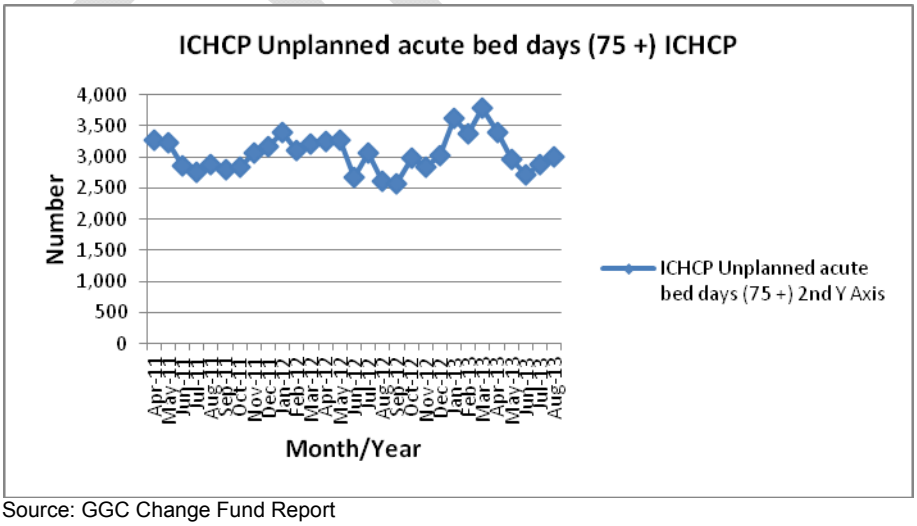


Source: SMR01

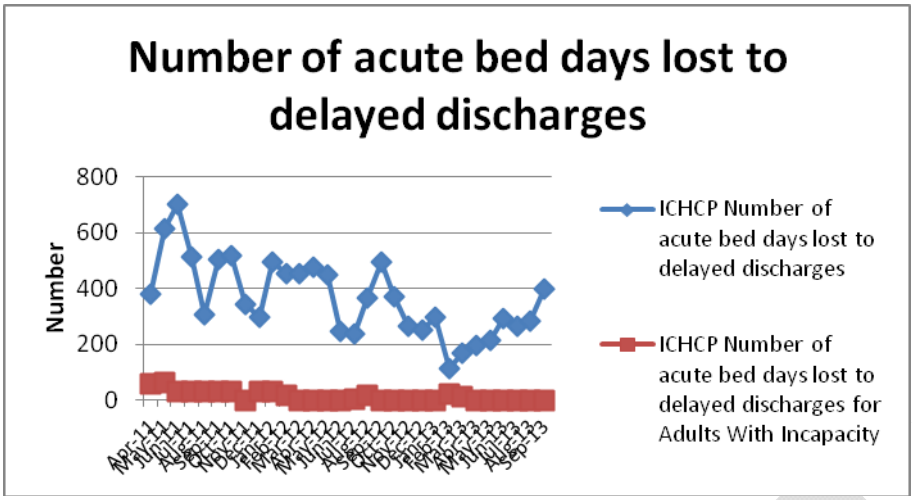


Unplanned Bed Days for Inverclyde residents 65+ and 75+ currently show no overall trend and remain fairly static only rising during the winter months, reflecting natural seasonal variation.





Source: GGC Change Fund Report



Source: NHS GG&C Information Services

Funding from Change Plan resources has provided additional social work assessment capacity within the hospital to provide flexibility at times of demand. However, recent experience and performance has demonstrated that this remains a risk for the partnership. Moving forward, with the Delayed Discharge target reducing to 4 weeks in April 2013 and 2 weeks in April 2015, we have committed to revisiting all processes supporting the Delayed Discharge pathway, with the aim of further streamlining.

In Inverclyde we have seen a significant and sustained reduction in unplanned acute bed days for both over 65s and over 75s. However, in common with other areas, we are experiencing a small rise in over 65s emergency admissions. Therefore, admissions are more frequent but of a shorter duration. This reflects our view that in terms of efforts to date we can see significant improvements from the range of interventions we have developed to support and facilitate effective discharge, with further work on going to consolidate efforts to prevent admission. In common with many of our earlier service changes this poses a challenge as it is difficult to demonstrate cause and effect, i.e. where should we concentrate our efforts to have the greatest impact. This challenge is compounded by the need to secure partnership commitment to anticipatory and preventative measures which are largely untested and lack evidence to support their introduction. However, given the progress to date in reducing bed days in Inverclyde, we are confident that the partnership can and will achieve progress in avoiding hospital admissions and sustaining older people at home.

Inverclyde CHCP regularly meets the 4 week delayed discharge target and as a partnership, we are committed to achieving the HEAT targets and contributing to the NHS GG&C overall achievement of the targets

5.12 Palliative and End of Life Care

Palliative and end of life care in Inverclyde is supported by many CHCP services and partner organisations.

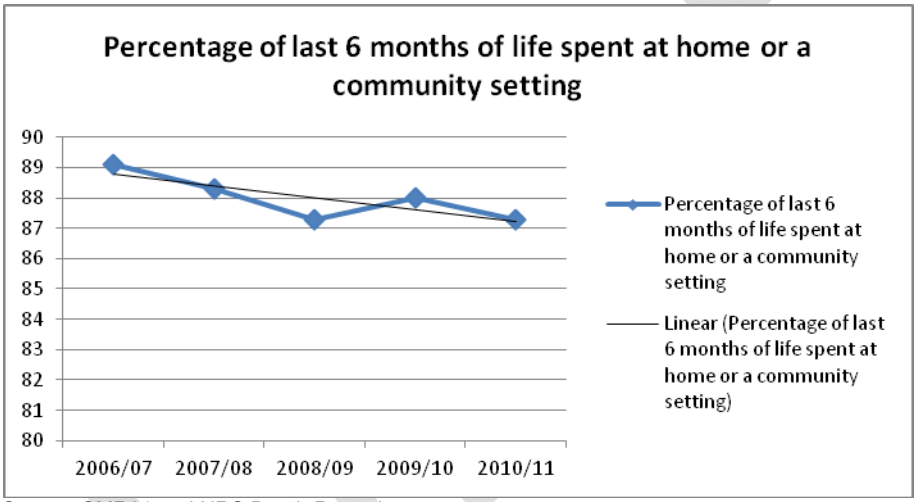
The CHCP services include all 16 GP Practices and approximately 93 Community Nurses. These services can be at any one time supporting around 37 palliative and

end of life patients and their families. Over a year this can amount to around 400 people.

The Liverpool Care Pathway was implemented in all 16 Practices in Inverclyde between 2009 and 2011, and is used by all GPs and community nurses to provide palliative and end of life care, although this is currently under review nationally. The LCP is also in care home and secondary care settings.

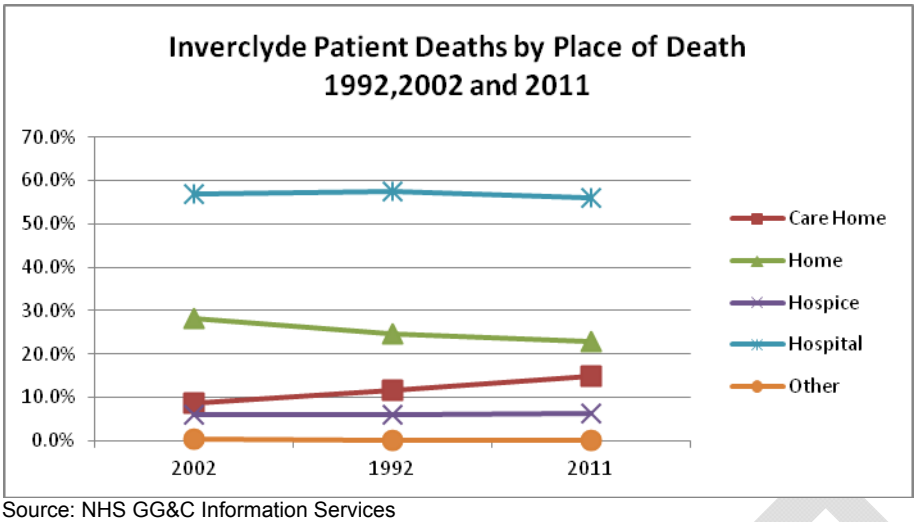
In addition to the services provided by the CHCP, the Marie Cure Nursing Service provides an overnight service supporting approximately 8 patients per month with an average of 27 visits for each of the patients.
Ardgowan Hospice provides specialist day support, drop in clinics and has 8 inpatient beds and can support over 700 people per year. The hospice also employs palliative nurse specialists who work in the community complementing the other CHCP and Marie Curie services.

One of the main aims of palliative and end of life care in Inverclyde is to allow people to be cared for and die in their own home, this being the preferred option for most patients. Since 2006/07 however, the percentage of patients spending their last 6 months of life at home has been gradually decreasing as shown in the chart below.



Source: SMR01 and NRS Death Records

In terms of deaths, there is large difference between the number of deaths in a hospital and deaths in a community based setting (such as home, care home of hospice). In 1992 the difference as a percentage between hospital deaths and community deaths was hospital 57.05% and community 42.95%. In 2011 the hospital percentage was 56.06% and community 43.94%. (see chart below) Although the gap has narrowed slightly, there is long way to go before the aim of allowing people to be cared for and die in the community is met. A more determined effort is required to achieve this goal.



Source: NHS GG&C Information Services

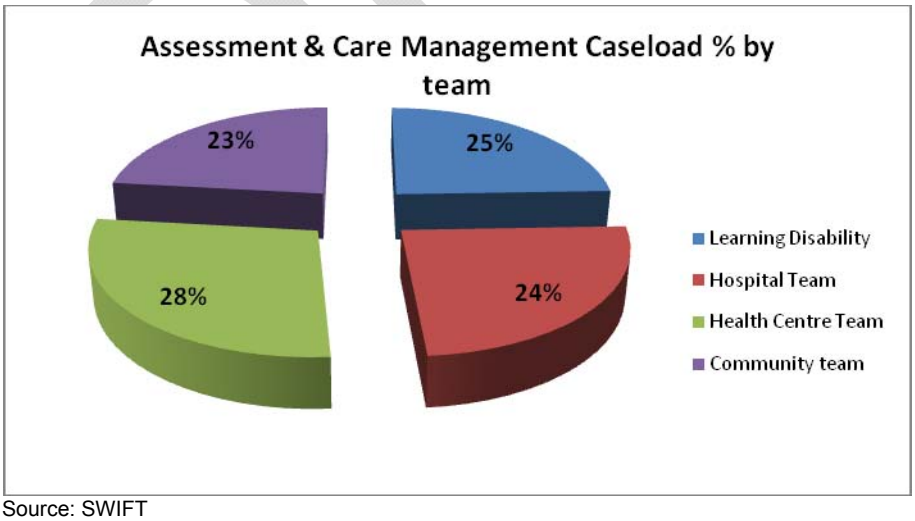
5.13 Assessment & Care Management

Inverclyde residents who require community care services need to be assessed by our Assessment and Care management service.

The 4 dedicated teams assessment and care management teams are:

- Learning Disabilities team
- Hospital Team
- Health Centre's Team
- Community Team

A recent analysis has shown that in terms of caseload weighting, all the teams have a reasonably even split at the present time, with the service supporting a total of 1055 individuals on average.

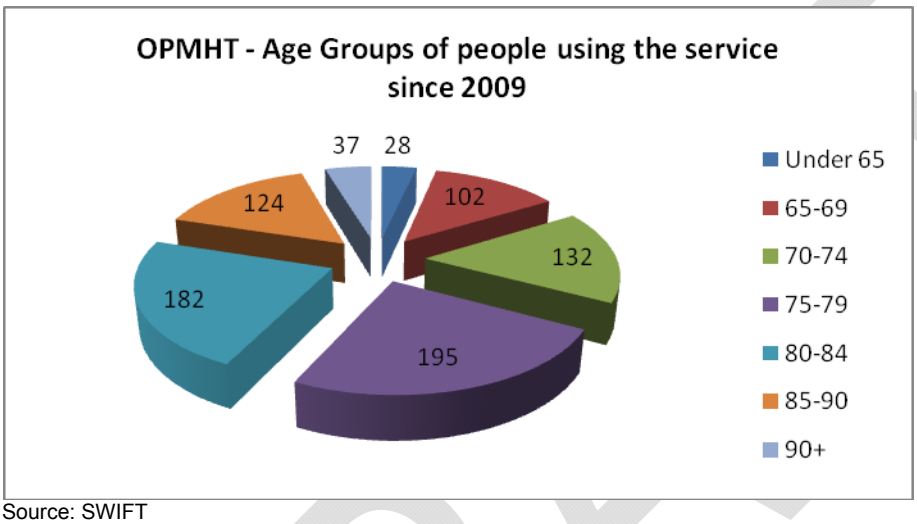


Source: SWIFT

5.14 OPMH

The Older Peoples Mental Health Team (OPMHT) in Inverclyde provides mental health care for people over the age of 65 with a functional mental illness, including dementia. The objective of the OPMHT is to manage people with these conditions within their own home or the community. The team also assists older people returning home from hospital.

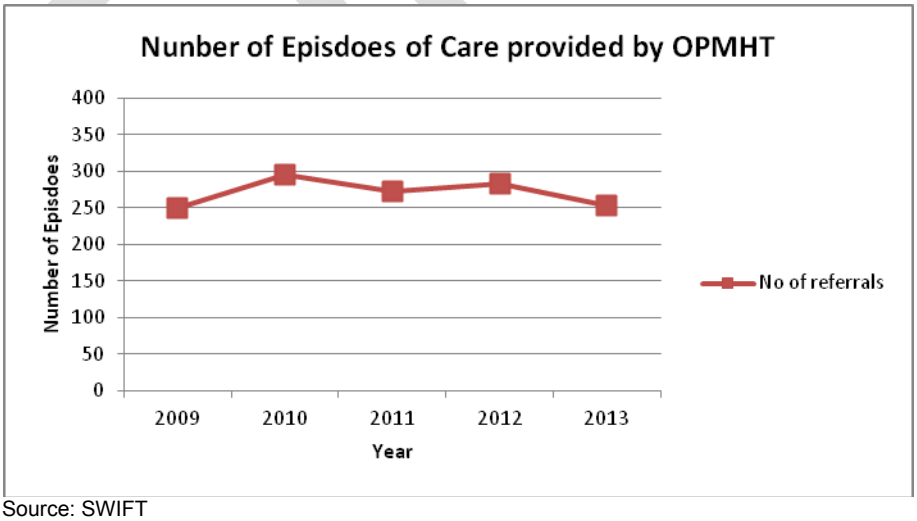
Since 2009 the team has provided approximately 1,300 episodes of care to 800 people. The breakdowns of the age groups are shown below.



Source: SWIFT

The small number of people under 65 may be explained by early onset of dementia in people with a learning disability or people with Down's syndrome.

Episodes of care provided by the service have remained fairly constant since 2009 with no overall trend.



Source: SWIFT

5.15 Equipment & Adaptations

The need of Inverclyde's residents for specialist medical and social care equipment is provided through the Joint Equipment Store. The store provides equipment for those people who have been assessed by suitably qualified staff to have a requirement for specialist equipment to enable them to remain on their own homes to support the level of care that they require.

In the period 1st November 2012 to 31st October 2013, a total of 2,186 people requested and were given equipment, which consisted of 3,387 orders. Further analysis shows this amounted to 6,615 pieces of equipment.

The store issues a wide variety of equipment to different CHCP services including Community Nursing, Occupational Therapy and Physiotherapy. The breakdown of types of equipment loaned in this period can be seen in the table below.

All Equipment Loaned over the Period 01/11/12 – 31/10/2013	
Type of Equipment	**Number of items**
Bariatric	16
Bathing	1181
Beds & associated Equipment	1482
Moving and Handling Equipment	748
Paediatric	3
Pressure Care	745
Seating	676
Small Aids	656
Toileting	1108
Grand Total	***6615***

Unsurprisingly, approximately 48% of these loans were to residents living in the most deprived areas of Inverclyde (SIMD 1 quintile).

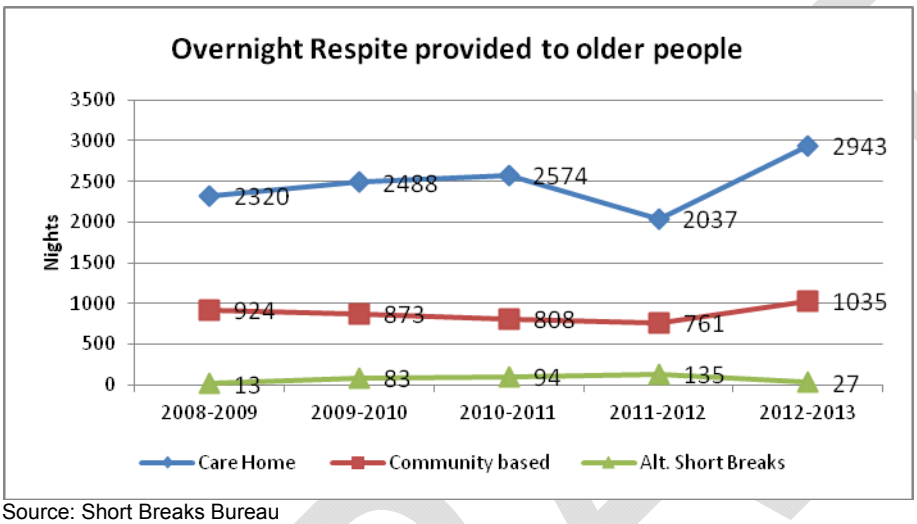
People in care homes may also have equipment loaned to them. In this same reporting period (01/11/12 – 31/10/2013) only 0.73% of all loans were to people residing in care homes.

There have been approximately 500 adaptations to people homes since Apr 2013. The number of adaptions can greatly vary from month to month, for example in April 2013 there were 24 adaptions within that month. Whilst in June there were 169 adaptations. More work needs to be done to understand the trends within the adaptations service.

5.16 Respite Care/Short Breaks

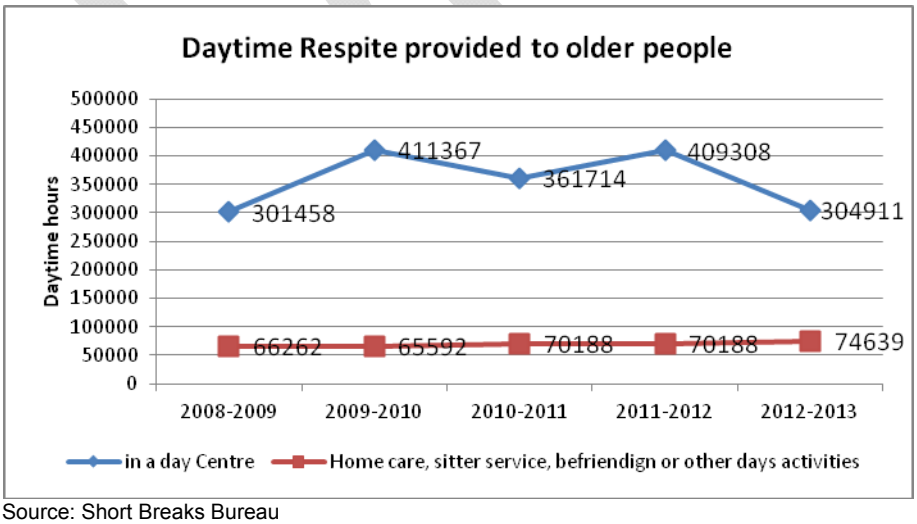
It has been consistently highlighted that carers benefit greatly from Respite/Short breaks from their caring role, enabling them to enjoy a quality of life away from their caring responsibilities and enable them to perform their caring role more effectively.

In Inverclyde, the total number of overnight respites provided to older people aged 65 and over has increased from 2902 in 2011/12 to 4005 in 2012/13. This is due to a high level of demand for respite provision in a care home setting due to complexity, the ageing population and responding to carer's needs.



Source: Short Breaks Bureau

For daytime hours, older people aged 65 and over has seen a decrease in 2012/13. In 2011/12 the total number of daytime hours provided was 479,496, in 2012/13 this shrank to 377,550 hours, a decrease of 97,777 hours. The reason for this decrease is due to a number of factors including an increase in demand and complexity which has had an impact on the services ability to provide domiciliary respite via Care and Support at Home.



Source: Short Breaks Bureau

The Inverclyde Short Breaks Strategy sets out the vision Inverclyde CHCP has in terms of providing breaks for individuals of all ages and developing the type of breaks on offer to produce better outcomes for individuals and their carers. The strategy will support the development of more creative types of breaks, away from the more traditional residential respite.

The Short Breaks Bureau acts a broker in arranging short breaks for individuals and their carers or family members. The Bureau aims to match the needs and preferences of service users to a variety of options on offer including city breaks, hotels and caravans. Many older people have begun to make use of the Louden Trust which offers financial assistance to older people and their carers to enable them to have a holiday and can be arranged through the Bureau. In addition, community based facilities such as Hillend Respite Unit and Rowan Gardens Sheltered Housing are popular options for older people, as indeed is care at home in the form of sitting services.

5.17 Sheltered Housing

Sheltered housing is housing designed particularly for older people with the aim to help make their lives easier and to enable them to remain relatively independent. Community Alarm / Telecare, is for the most part, a main feature of such complexes and most also include a communal social area. It is also common for sheltered housing to have a warden.

Inverclyde currently has 20 Sheltered Housing complexes. These complexes comprise of 3 types of property:

- Bedsit – Bed/Sitting room (single occupancy)
- Single Flats – one bedroom
- Double – larger than single occupancy (but not necessarily 2 bedroom)

Inverclyde Council account for 35% (7) of the complexes, consisting of 1 bedsit, 22 single flats and 1 double.

The remaining 65% is provided by private organisations or housing associations that provide the service to the CHCP, the breakdown of which is shown in the table below.

		Accommodation Type			
Provider	Name of Accommodation	Bedsits	Single flats	Double	Total
Inverclyde Council	Monkton Place	1	22	1	**24**
Inverclyde Council	John Gault House	6	48	10	**64**
Inverclyde Council	Riverside Gardens	16	12	0	**28**
Inverclyde Council	Glebe Court	17	8	0	**25**
Inverclyde Council	Broadstone Gardens	1	31	5	**37**
Inverclyde Council	Seafield House	0	21	4	**25**
Inverclyde Council	Stewart House	0	21	6	**27**
Cloch Housing	Elliott Court	2	20	0	**22**
Margaret Blackwood	Macclehose Court	20	0	0	**20**
Bield HA	Carwood Court	43	0	23	**66**
Bield HA	Jamaica Court	0	14	15	**29**
Bield HA	Crosshill Gardens	0	26	16	**42**
Bield HA	Rowan Gardens	10	0	0	**10**
Bield HA	Armadale Court	0	17	16	**33**
Abbeyfield Society	Abbeyfield Ardgowan Sq	6	0	0	**6**
Abbeyfield Society	Abbeyfield Esplanade	7	0	0	**7**
Trust HA	East Kirk Court	0	18	12	**30**
Trust HA	St Margaret Court	0	8	19	**27**
Greenock Medical Aid Society	Bagatelle	0	10	18	**28**
Little Sisters Of The Poor	Holy Rosary Residence,	0	20	0	**20**
TOTALS		**129**	**296**	**145**	**570**

There are also 3 private Sheltered Housing complexes, who operate out with CHCP services, and provide only a private service. 2 of these are in Kilmacolm and the other is in Gourock.

6 PLANNING CONTEXT

6.1 Local & National Policy

We are operating in a plethora of national policy and guidance, informing local policy and practice.

National Policy:

- Public Bodies (Joint working) Bill 2013
- Better Outcomes for Older People
- Changing Lives
- All our futures: Planning for a Scotland with an Aging Population (2007)
- Shifting the Balance of Care
- Community Care Outcomes Framework
- NHS HEAT Targets
- National Dementia Strategy and Standards for Dementia Care
- National Carers Strategy
- NHS Scotland Quality Strategy 2010
- National Older People's Housing Strategy
- Reshaping Care for Older People: A Programme for Change 2011-21
- Reshaping Care for Older People: 'Getting On' 2013
- Self-Directed Support
- Living and Dying Well
- 2020 Vision

Local Policy:

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

Key Strategic Drivers:

- Reablement
- Creating mutual health and social care services

- Rehabilitation Framework
- Self Directed Support and Personalisation
- Outcomes focussed assessment, care and support planning
- Telecare and Telehealth
- Community Capacity Building/ Community Development
- Co-production – working together with users and carers to develop services and supports

6.2 Integration

Since the creation in October 2010 of the integrated Community Health and Care Partnership, we have been working to embed the ethos of integration across all levels of the organisation. In particular, we are keen to ensure the benefits of integration are maximised at an operational level, ensuring that patients, service users and carers experience as seamless a transition as possible when their needs span traditional organisational boundaries.

Recognising that we need to actively manage and develop the integration process, we are engaging in several pilots to inform this process. In spring 2013 we participated in a pilot inspection by the Care Inspectorate to examine the level of organisational integration in relation to Older People's Services. The outcome of this inspection was very positive, with good feedback about the quality and impact of our services and endorsement of our intended direction of travel.

In addition, Inverclyde CHCP is piloting an NHS GG&C model to create a shared approach to shaping demand and design for hospital services between Acute Services and primary/ community services. The model is based on:-

- a transparency of baseline activity, including age, disease and service information and cost of acute services for each partnership;
- analysis of how that baseline varies from population norms; results from differential primary care performance; might be reshaped by community health, social and primary care changes;
- defined whole system changes required to be delivered through joint plans to enable acute services to deliver quality and efficiency targets and focus on essential activity. Examples could include reducing delayed discharge or shifting place of death.
- a means of agreeing collective action to manage demand with the essential buy in of GPs.
- a joint planning process to deliver a three year change plan which will reshape the baseline;
- the joint planning process to have a core component of collective shared priorities but also the potential for each partnerships joint plan to reflect local issues and priorities; and focuses upon hospitals delivering only the care for which hospital is essential

6.3 Reshaping Care for Older People

In common with partnerships across Scotland, Inverclyde CHCP's approach to Reshaping Care for Older People is integral to many aspects of our working as a partnership. It has provided a framework for our revised governance arrangements, with the additional resources provided by the Change Fund proving to be pivotal in facilitating transition through a range of service redesigns. As we continue to address demographic and funding pressures, the principles of Reshaping Care for Older People will underpin how we plan and deliver care in Inverclyde. The pathway

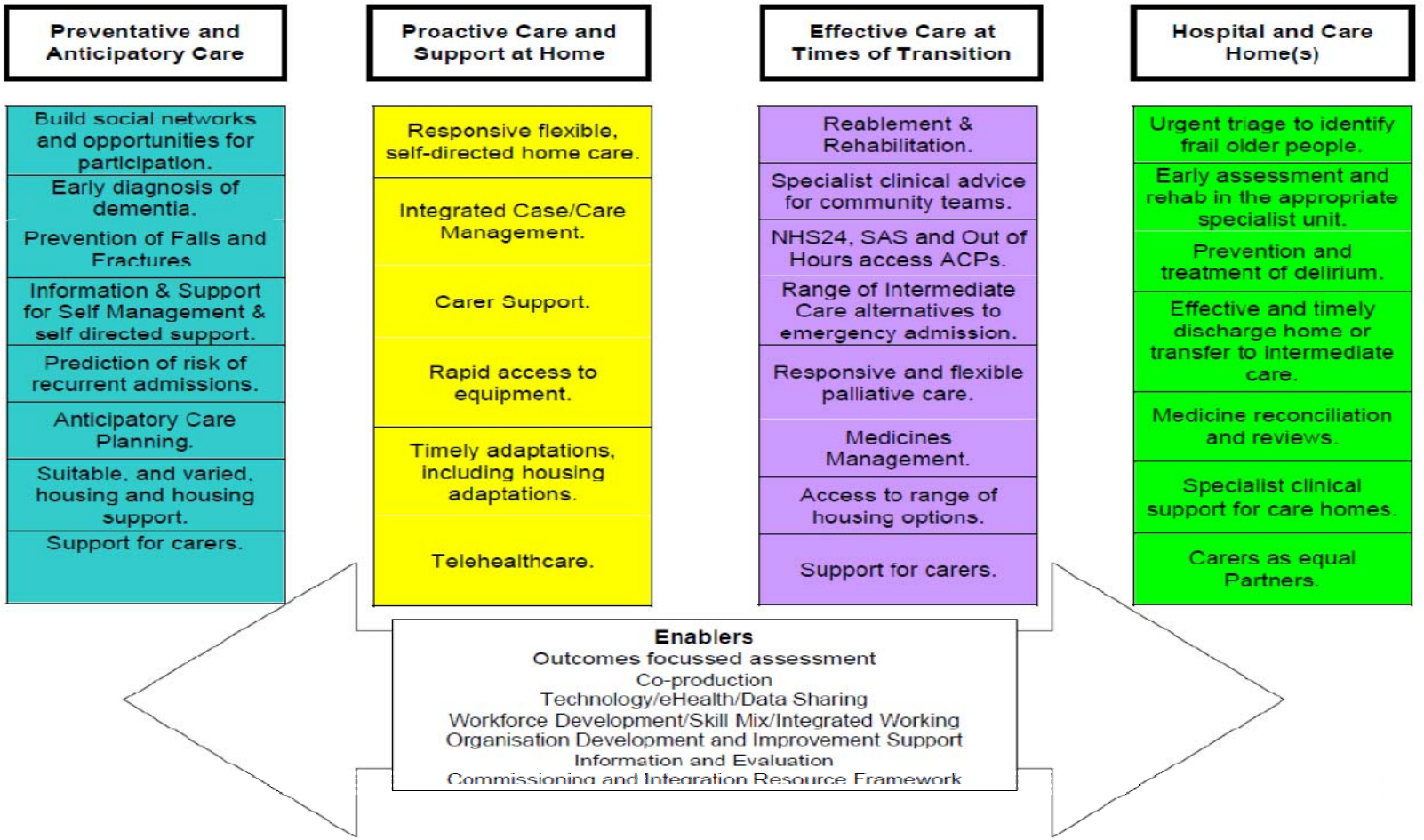
diagram on page 57 (Figure 5) demonstrates the range of services for older people, and where they sit within the Reshaping Care for Older People pathway.

Shifting the balance of care has been a priority for many years in moving from large institutional based provision to more appropriate community or home based settings. However, it continues to have resonance in achieving the other core policy drivers. The term shifting the balance of care also refers to the shift we want to make in terms of using more external provision of services rather than in-house services supported by, for example, the increased use of modern technology like telecare. Shifting the balance will require significant redesign of services, looking at how we use resources like day centres and day-care; intermediate care (bridging between hospital care and transition back to independent living at home), and reablement services.

Inverclyde CHCP's focus and performance upon the Delayed Discharges targets has been apparent for some years and is underpinned by our commitment that it is in everyone's best interest to spend as short a time as possible in hospital, returning to an appropriate, safe care setting upon discharge.

Figure 5:

Reshaping Care Pathway

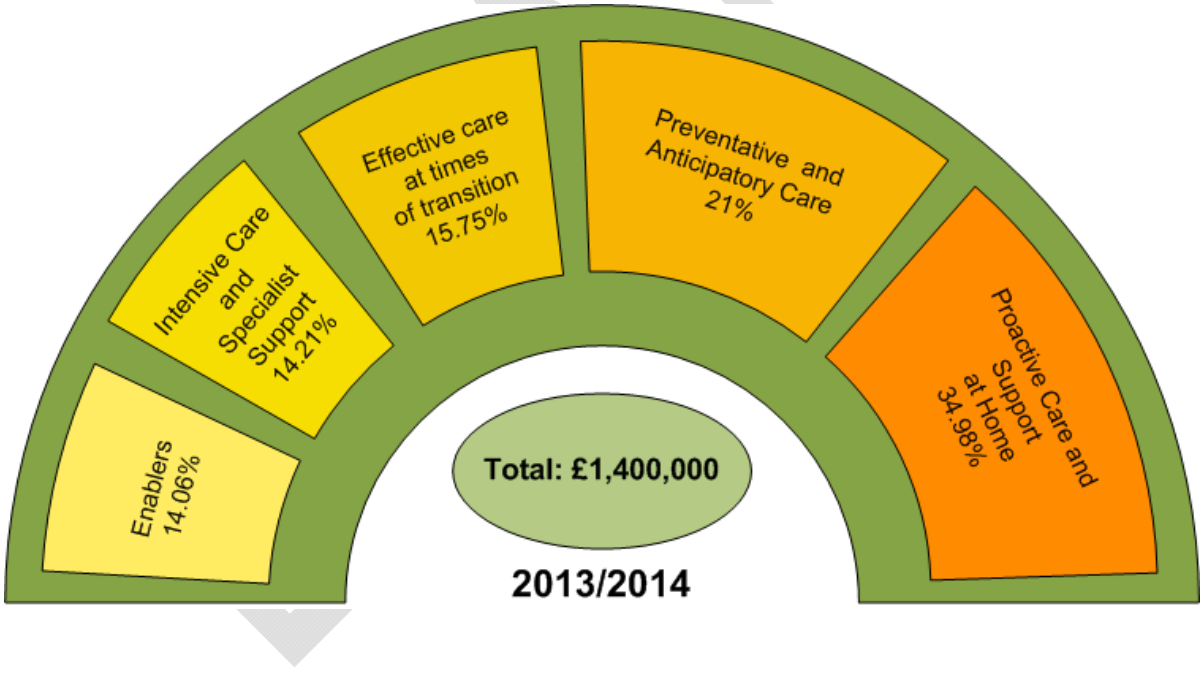


The recent refresh document *Reshaping Care for Older People 'Getting On' (2013)* acknowledges that nationally, much has changed, but that there is still much to do. Whilst outcomes and measures for success may continue to change, the actions and ambitions laid out in 2011 remain just as relevant:

> 'Older people are valued as an asset, their voices are heard And they are supported to enjoy full and positive lives in their own home or in a homely setting.'

We are investing now to reduce the cost of future ill health with a strategic shift towards prevention, promoting health, wellbeing and independence. This shift is clearly visible year on year in our change fund investment streams and will remain our focus. The percentage of funding against each pillar for 2013 - 2014 is shown below.

Figure 6:



6.4 Person centred approach

The definition of outcome is the impact of end results of interventions and/or services on a person's life "Outcomes focused services and support therefore aim to achieve the aspirations, goals and priorities identified by (assessment)" (Glendinning et al 2006).

Improving outcomes for service users is at the forefront of social care service, and increasingly community health services too, but social care and health providers have often struggled to measure and evidence improved outcomes in any meaningful way. Evidence of improvement can be obvious at an individual level but the 'soft' information that often demonstrates improved outcomes can be difficult to aggregate. This makes it difficult for service providers to be confident, at a strategic level, that our service inputs are delivering what they need to on a population wide basis.

Single Shared Assessment Procedures in Inverclyde CHCP have been updated to reflect the Community Care Outcomes Framework, and the SHANARRI wellbeing outcomes to help us reflect more easily what outcomes have been achieved individually and collective as a result of our collective efforts with service users, patients and carers. The Community Care Outcomes link to the Scottish Government National Outcomes which are:-

- Improved health
- Improved well being
- Improved social inclusion
- Improved independence and responsibility

Assessment, care planning and review lie at the heart of identifying and improving outcomes for people using community care services/support and their carers. The Talking Points Approach to outcomes which we aim to implement fully builds on research conducted over many years by the Social Policy Research Unit at York University and further research by members of the Talking Points team at the University of Glasgow (Petch et al).

By engaging with a range of services and community supports such as formal health and social work services, housing, voluntary organisations, community's own infrastructures, the person's own strengths and personal resources etc outcomes can be achieved. This collaborative and assets based approach underpins our Joint Strategic Commissioning Plan.

Personalisation of services was an explicit goal of 'Changing Lives', and is intended to put the person at the centre of decision-making about services and supports they receive. It is also intended to promote the development of personal and community capacity to reduce dependence on services. Again this is core to our Joint Strategic Commissioning Plan approach.
This will be through engaging with a range of services and community supports such as formal health and social work services, housing, voluntary organisations,

community's own infrastructures, the person's own strengths and personal resources etc. This approach underpins our Joint Strategic Commissioning Plan.

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6.5 Self Directed Support

The National Strategy for Self Directed Support (SDS) in Scotland was launched in November 2010. This 10 year strategy aims to set out and drive a cultural shift around the delivery of support that views people as equal citizens with rights and responsibilities, rather than passive recipients of services.

The strategy has 26 recommendations but the main themes are linked into the cultural shift of moving from needs led assessment to supporting a person to think about what they want to achieve and to support them to plan for this.

The Social Care (Self-Directed Support)(Scotland) Act 2013 received Royal Assent in January 2013. Draft regulations and guidance were published for consultation in April 2013 and are currently in draft form.

With the implementation of the SDS Act and the move to the personalisation agenda care provision is changing. We are now moving away from thinking "what services do we need to provide to ensure a persons needs are met "to be in a position of supporting the person to think about what they want to achieve (their outcomes) and to help them plan how to manage this.

Section 1 of the act places a duty on local authorities to have regard to certain principles in carrying out it's functions under the Act and apply to the local authorities' social welfare responsibilities (the provision of care and support) to both adults and children. These principles are related to:

- Involvement - giving the person as much involvement in the assessment of their social care needs and the planning of their support as they want
- Informed choice – providing reasonable assistance to assist someone to express their own views about the choices available to them and make an informed decision about their preferred choice
- Collaboration - authorities are required to collaborate with a person in both the assessment of their needs and the provision of support or services following the assessment

The act also provides a discretionary power to authorities in order that they can provide support to carers following a carer's assessment under section 12AA of the 68 Act or section 24 of the 1995 Act (section 3)

The Act places a duty on local authorities offer four options to individuals they assess as needing care and support under:

- section 12A of the Social Work (Scotland) Act 1968 (the 1968 Act)
- section 3 of this Act (support for adult carers)
- section 24 of the Children (Scotland) Act 1995 (the 1995 Act)
-

The four options are:

- Option 1 – the person receives a direct payment to purchase their own support
- Option 2 – the person chooses the support who they want to provide their support and the local authority makes the arrangements on their behalf and pays the provider
- Option 3 – the local authority chooses the support and commissions the service on behalf of the person
- Option 4 – is a combination of options 1 to 3.

To be ready to deliver this part of the strategy:

- We need a system that can allocate funding to individuals which ensures equality, fairness and is transparent and which can meet the assessed needs
- We need an assessment tool which captures the information needed for the resource allocation as well as associated policies and guidance
- We need a training programme in place to support staff with all aspects of SDS and it's delivery
- We need good communication / relationships with providers, 3rd sector and the community to ensure that everyone understands and has the capacity to deliver on SDS and Personalisation
- We need to ensure that we can monitor packages and can quickly access the information required for all statutory returns

To facilitate this there is a team in place who are working with the established steering group to oversee the processes required to be ready for April 2014 and beyond. There are also work streams in place who will take forward particular aspects of the required tasks. These are:

- Finance and Resource Allocation
- Assessment Policy and Procedures
- Learning and Development
- Communication, Partners and Providers
- Reporting and Infrastructure

Self-directed support will give older people and their carers increased choice and control over the care and support provided, therefore this plan will have to be developed with the required flexibility to respond to any future, and indeed ongoing, changes in markets or demand.

6.6 Welfare Reform

The UK Government is currently introducing a wide range of changes to the social security benefit system under the Welfare Reform Act 2012 and the Pensions Act 2011. In common with most other areas in Scotland, it is anticipated that these reforms will have a significant impact on the local economy, local people, and local services which we need to be aware of and responsive to. While not all of the planned changes will affect older people a number will impact directly, such as proposed changes to pensions and housing benefit and we are quantifying the likely increase in pensioner poverty and financial exclusion amongst older people. It is also anticipated that a number of the reforms planned which are anticipated to directly affect working age people, such as changes to unemployment benefit and disability benefit, will compound as these people get older. It is also anticipated that there are likely changes to the ways in which services are funded in the longer term, as a result of welfare reform and of the financial context in the UK economy generally.

The partnership is supported by work being undertaken in the statutory and voluntary sector to respond to the challenges of welfare reform and seeks to deliver services which as responsive to the needs of individuals, as their context changes, particularly in terms of financial exclusion and/or anxiety around such issues.

6.7 Carers

In 2010 the Scottish Government, in partnership with COSLA, launched a new Carers strategy for Scotland covering the period 2010-2015. “Caring Together” builds on progress made since the Care 21 report and sets out a shared vision of society where:

- Carers are recognised and valued as equal partners in care
- Carers are supported and empowered to manage their caring responsibilities with confidence and in good health and to have a life of their own outside of caring
- Carers are fully engaged as participants in the planning and development of their own personalised, high- quality, flexible support and are not shoe-horned into unsuitable support. The same principle applies to carers' involvement in the services provided to those for whom they care
- Carers are not disadvantaged, or discriminated against, by virtue of being a carer.

The Scottish Government required all partnerships in Scotland to develop initiatives as part of their Reshaping Care for Older People which support the carers of older people to maintain their caring role which is crucial to supporting older people to live as long as possible in their own homes and communities. Inverclyde’s response to this has been underpinned by our own local Carers and Young Carers Strategy 2012 – 20015, which was co-produced with carers and has been recognised nationally as an example of best practice.

There are an estimated 8000 carers in Inverclyde. 2181 are currently registered with the Carers Centre. 529 of this number are carers aged 65+ with 218 of these carers being aged 75+. More than half of the registered carers, 1386 are looking after someone over the age of 65.

We have in place a Carers Development Group to oversee the implementation of the Carers Strategy, and an advisory group to drive our carers projects linked to the Reshaping Care for Older People agenda. Both groups are inclusive in membership and provide strategic leadership on carers issues.

Specific investment to support unpaid carers relates to:-

- Supported hospital discharge – we have a carers support worker from our carers centre co-located in the local acute hospital to work alongside NHS staff to support carers before and at the time of discharge of their loved one.
- Emergency and Long Term Planning – a worker is in place to support older carers to consider longer term and contingency planning for their loved one should their needs change or an emergency arise.
- Befriending – facilitating partnerships between former carers and current carers to help promote natural supportive friendships based on common experiences and understandings.
- Carers Information Packs – we have continued to publish carers information packs for distribution to carers to increase awareness and information.
- The introduction of initiatives which support more personalised and flexible access to respite services through the publication of our new Short Breaks Strategy
- New approaches to carers and financial inclusion are being developed through our local Financial Inclusion Partnerships, with tailored intervention from advice workers to carers.
- Devolved budgets for Short Breaks to Inverclyde Carers Centre, which enable carers to have short breaks together or arrange for sitting services around their needs.
- Emotional support for carers at the Carers Centre through Counselling and Stress Management sessions
- Training opportunities for carers in relation to long term conditions and self improvement opportunities.

Inverclyde CHCP is fully committed to supporting carers and to delivering on the expectation that carers should be equal partners in care. To this end, we were successful in being chosen as a pilot area for the implementation of Equal Partners in Care (EPiC). EPIC is a joint project between NES and SSSC to implement the workforce education and learning elements of the Carers Strategy by linking three core principles to the current range of health and social care policies For the six months to March 2014, there will be a focus on embedding the Level 1 ‘Carer Aware’ and level 2 ‘Caring Together’ principles of EPiC within existing and planned training and development across the organisation.

Our Change Fund plan recognises the commitment of carers and the huge contribution they make to how services and support are currently delivered and how they will evolve in future.

An engagement session took place in December 2012 with our local Carers Network focussed on carers and commissioning. From this event we know that:-

- Carers wish to be acknowledged and listened to as partners
- Carers wish to be fully involved in the planning and reviewing of individual care packages for their loved ones.
- Carers wish to be fully involved in hospital discharge planning
- Carers welcome the opportunity to be fully involved in the coproduction and monitoring of the Inverclyde Carers Strategy
- Carers welcome the opportunity to be able to influence and shape the future direction of services and support.
- Carers would welcome the introduction of SDS.

We are committed to building continuously on the strong partnerships between the CHCP and Inverclyde Carers Centre and Carers Council to ensure that carers have a strong voice in commissioning, and continue to develop their role as equal partners in the delivery of care and support.

6.8 Care Homes

In Inverclyde Residential and Nursing Home care is provided through a range of independent sector providers. There are 16 homes varying from small family run homes to larger purpose-built homes.

The Care Homes are supported by a range of Primary Care Services including District Nursing, General Practitioners and a range of Allied Health Professionals.

Between 1 December 2012 and 31 May 2013 GPs were invited to undertake a comprehensive review of their patients who resided in care homes. This review covered topics which are considered important when providing healthcare and anticipating future health or care needs for this particular group *(AWI, POA/guardianship, history of falls, DNACPR status, ACP, pharmacy review, palliative care).*

Practices visited all current care home patients and any new patients who were admitted to a care home and registered with the practice between 01 December 2012 and 31 March 2013. Not all GPs participated in the project and consequently not all patients were visited. A total of 458 forms were returned for analysis.

Feedback from GPs and Care Home staff reported positive outcomes in terms of raising awareness of the importance of the various aspects of anticipatory care amongst GPs, care home staff as well as care home residents and their relatives. Those residents who were visited will have benefited from an extensive review of their current and future care. Additionally, GPs and care home staff have indicated that they are now more likely to review other patients and have an increased understanding of the importance of carrying out such reviews.

Data on A&E and acute admissions will continue to be collected and analysed as it becomes available with a view to establishing if the project has affected admission patterns from care homes.

Anecdotally, there has been a perception that admissions to hospital from Care Homes have been a source of concern, both in terms of frequency of admission and reason for admission. However, an audit of emergency admissions to Acute hospital services has refuted this perception, with admissions being in proportion and appropriate. However, it has recently been reported that admissions to EMI Inpatient facilities from Care Homes has been rising, and we have agreed to further work with Care Homes to improve our understanding of the reasons for this and develop joint approaches to address this.

Recently we have reviewed the range of performance measures relating to Care Homes and some interesting changes in patterns of activity are emerging, most notably:-

- that age on admission to Care Home is increasing;
- that length of stay is reducing;
- that for the first time we are seeing demand for Care Home places reduce.

This last point is reinforced by a rise in demand for more comprehensive homecare packages to maintain people at home, avoiding Care Home admission, leading us to conclude that an options appraisal is required to explore this key area further to establish where we could disinvest in Care Home places and reinvest in alternative provision of care.

A task force review "Reshaping Residential Care for Older People" is currently underway and due to report back to the Scottish Government and COSLA by the end of the year. This report will shape a strategy on future provision of residential care. Consultation, would then be required with recommendations being implemented later in 2014. Emerging themes from the review are:

- A long term 20 – 30 year perspective is required
- Attention must be paid to the personalisation agenda
- Workforce flexibility is crucial
- A range of approaches to future commissioning are required.

6.9 Homecare/Reablement

The Homecare service in Inverclyde is available to people living at home in the community, whether living alone or as a family member. The service is provided to a wide range of people including frail older people, people with physical or sensory impairments, people with learning disabilities, people with mental health problems and other vulnerable groups.

The key aim of the service is to enable people to live as normal and independent a life as possible in their own home. Services include personal care which is available

free of charge to people aged over 65 years and non personal care services which are chargeable in line with the Council's Charging Policy.

An independent review of our Homecare services was commissioned in 2011 for a number of reasons:-

- Changes to the demographic profile with an increasing percentage of older people in conjunction with a reduction in people of caring age;

- The apparent increased costs and increased demands upon the service;

- Issues raised by the Care Commission inspection process in terms of the unmanageable span of control for managers of the service;

- The desire expressed by Inverclyde's older people to live independently at home for as long as possible, supported by services which were flexible to accommodate changing needs.

Key recommendations from the review which have been progressed in the last 12 months include:-

- The modernisation of rotas to meet service demands ;

- Investment in technology to facilitate mobile working, electronic monitoring and electronic scheduling;

- Restructuring of management to reduce the span of control, enhance day to day operations, improve leadership of teams whilst improving assessment/care management review functions;

- Development of the local mixed economy; and

- The development of a reablement model of care supported by Occupational Therapy staff.

The Reablement Homecare service was introduced in October 2011 in the East area of the CHCP. Funding from the Change Plan has supported the developmental stage of this major redesign. In common with many other areas of Scotland, Inverclyde has embraced the philosophy of reablement and cultural change that it brings, for both service users and staff.

Reablement builds upon the principle of homecare to support independence, taking it to the further stage of maximising the opportunity for longer term independence through more comprehensive assessment and supported interventions at an early stage.

Learning from our experience of the implementation of reablement in the East, from the beginning of June 2012, the reablement service rolled out to the 2 other geographical areas within Inverclyde, West and Central, supported by discrete

reablement teams. Across the teams, we are now beginning to see some consistency in demand and outcomes for service users:-

- Around 10% of services stopping as a result of readmission to hospital, although retain the option of accessing the service again upon discharge;

- Around 25 - 30% of service users achieving independence following the process of reablement;

- Between 50 - 60% of service users moving to mainstream homecare services, however, reducing their hourly input by an average of 30%.

However, with the changes in Homecare and Reablement it is apparent that we are a complex, evolving environment.
The services we provide need to be sensitive to the scale and pace of change, both in terms of demand and in how we can flex delivery of services to meet this. The financial climate in which we are operating adds to this complexity, making the challenge not only to deliver a high quality and responsive service but one which is also efficient, cost-effective and affordable.

To inform our future plans for procurement, we are in the process of reviewing the implementation and planning assumptions which have informed our recent changes in both Homecare and Reablement, with the aim of integrating this level of scrutiny to our routine performance management of services. Further consideration is required to determine the extent of the shift in the balance of care between internal and external provision of this service, particularly following the Council budget-setting process.

6.10 Building capacity in our communities

Inverclyde has long been characterised by progressive community development, and by a strong and resilient voluntary and community sector presence.

We aim through this Joint Strategic Commissioning Plan to build on this tradition and reinvigorate the community based approach to supporting our local older people.

In the times of financial stringency we currently face, positive opportunities for more collaborative and dynamic forms of service delivery are required, as referenced by organisations such as The Health and Social Care Alliance in their initial scoping report on the Older People's Change Fund.

Enhancing the role of the Third Sector, this creates an opportunity for better partnership working; both across sectors and with service users and their informal support networks. We are committed to working with Community Planning partners to develop, agree and implement a third sector development strategy to develop organisations, volunteering, social enterprise, partnership and external funding.

Community services are understood to include contributions by both communities (informal) and organisations (structured). These contributions are mostly resourced through a combination of contracted services, grant funding, donations and volunteering.

The spectrum of community services is very broad and includes:-

- Social transport
- Support to adopt and maintain a healthy lifestyle
- Social activities & day care
- Peer support & befriending
- Advocacy
- Maintenance / handyperson services
- Advice & Information
- Shopmobility and other support to access shopping
- Digital inclusion
- Intergenerational activity

These types of services are rarely a statutory requirement. However evidence, such as that produced by the London School of Economics in their paper "Building Community Capacity - Making an Economic Case" (http://www.thinklocalactpersonal.org.uk/_library/BCC/Making_an_economic_case_doc.pdf) demonstrates that the investment in preventative spend has a significant cost saving for public sector health and care services, whilst also improving quality of life for older people.

Community Capacity Building

Community capacity building is a key element of the long term national strategy to support individuals, families and communities to increase the level of support provided to people within and by their own communities.
An investment in capacity building allows development of greater long term capacity for people to be supported within their own community.

As part of the overall agenda to shift the balance of care towards preventative supports and promote independent living, Inverclyde CHCP is actively working with the third sector and other partners to develop community capacity. We work collaboratively particularly with our third sector partners and through the Inverclyde Alliance Community Engagement and Capacity Building Network (CECBN) to provide advice, guidance and other support to individuals, communities and organisations to develop resources and services which can support people to live safely and independently within their communities without the need for ongoing intervention from health and social care services.

Inverclyde's Reshaping Care for Older People Programme partners have taken a whole systems approach to rolling out the Reshaping Care for Older People agenda, particularly in relation to linking more traditional operational services with community capacity building opportunities. Partners include Inverclyde Community Health &

Care Partnership, CVS Inverclyde, Scottish Care, Your Voice Inverclyde and local carers organisations.

Volunteering

We recognise the significant impact that volunteering has on the provision of services, as well as the greater impact that it could have with further development. Volunteering is not viewed as a cheaper way of delivering services; but instead as a way of improving the quality of the experience received by service users. Volunteering by older people themselves also has a positive impact on their physical and mental health and wellbeing, social connections and quality of life.

The proportion of people in Inverclyde who volunteer is recognised as being below the national average which creates significant challenges for both third and public sector organisations that do, or seek to, involve volunteers. This strategy recognises the need to raise the profile of volunteering, create exciting and relevant opportunities to volunteer and to ensure that volunteering is an enjoyable and rewarding experience.

Partnership with third sector providers

As stated above, there is a strong Inverclyde community ethos of working together and a long tradition of working in partnership across the statutory and third sector; particularly in relation to jointly developing innovative community based services. We seek to build upon this and use the Joint Strategic Commissioning Plan to explore further opportunities for communities to deliver services themselves through working in partnership with agencies and public bodies.
We recognise the value that the third sector brings to service delivery and wish to encourage more third sector organisations to take a 'social enterprise' approach; by entering into contracts with statutory agencies for the delivery of services and by identifying opportunities created through the use of Self-Directed Support.

To ensure that contracts with third sector organisations remain innovative, effective and outcome-driven we will investigate and pilot a Public Social Partnership approach to service design; providing opportunities for service users, communities and third sector organisations to be involved at an early stage of development and creating strong partnerships that allow for creativity and flexibility; rather than traditional commissioner/provider roles.

We will use the national experience of CEiS and Social Value Lab; alongside the knowledge of local partners (such as CVS Inverclyde); to progress a number of pilot Public Social Partnerships. These will begin with local "innovation" sessions to identify where third sector organisations can identify new ways of working. Alongside these our local providers forum are already active in bringing forward new models of service delivery fit for the future.

In addition to improved commissioning outcomes these innovations will create a stronger environment of partnership between the third and statutory sector provision. This will improve understanding and confidence across sectors, increase quality referrals to all services and strengthen the capacity of the third sector to

attract external funding into local services that align with the agreed priorities of the partners.

COMMUNITY CAPACITY BUILDING PROJECTS

A number of projects were funded through the Community Capacity Workstream of the Reshaping Care for Older People Programme in 2012/2013 including, Contact the Elderly, Good Neighbourhood and Social Transport Service, Handyman Service, Financial Fitness, Care and Repair and the Cook School Project. The aim of supporting these projects was to assist local voluntary organisations to develop their capacity to support older people to continue living in their own homes and feel more connected with their community. Our engagement partners Your Voice highlighted these projects through the local People Involvement network and referred local people for support as appropriate.

To underline our commitment to community capacity building, £100, 000 has been allocated to another six projects during 2013/ 2014. Using an innovative approach, applications were assessed by a small group against the Reshaping Care for Older People outcomes and subsequent funding awarded. This group included an older carer, a member of the CHCP Older People's Advisory Group, a representative of CVS and the CHCP Key Partnerships Lead. Not all those awarded funding were third sector organisations but nevertheless demonstrated how they would support older people to build their own capacity and support within the community.

Muirshiel Rapid Response Handyman Service:

Initially funded during 2012/13, this service is aimed at older people over 65, who require assistance with odd jobs in their own homes in an emergency situation, to avoid them having to be admitted to care or hospital. The project can also assist with decorating, removing furniture and small jobs to allow people to be discharged from hospital into a comfortable environment. Funding for 2013/14 will allow the service to use the skills of a graduate placement to explore new opportunities, be more enterprising and enhance existing services.

Circles Advocacy:

Circles Advocacy in Inverclyde (formerly Inverclyde Advocacy) is providing advocacy support for Older People over 65 whether that be within a care home setting; hospital or living at home. Support will enable people to live as independently as possible including support to access Self Directed Support.

Inverclyde Council - Community Learning & Development:

Wider Opportunities in Inverclyde (WOOPI) project started in September 2009 and is funded for 5 years from the Big Lottery's Investing in Communities Programme. WOOPI provides a range of programmes designed to improve the physical, mental health and well being of Inverclyde residents who are 55+. WOOPI also aims to break down intergenerational barriers and cultural perceptions with a focus on skill sharing and generations working and learning together. As lottery funding declines, the focus will be on the development of the capacity building aspects of the model

and towards older people who are 65+ and more vulnerable whilst still maintaining an early intervention approach.

Inverclyde Radio:

Inverclyde Radio is an internet based radio station with whom we will work in partnership to develop oral audio delivery of information about our services and those of partner organisations, agencies and third sector contributors. Relevant information and advice will be provided during promotional weeks such as carers week & falls awareness week.

Action on Hearing Loss:

Hear to help service will provide a drop in service for hearing aid maintenance, advice, support and signposting those who have hearing impairments.

Royal Voluntary Service

An outcomes based programme will enhance community transport, support assisted shopping, personal emergency planning and offer support during times of bad weather.

Keeping Active In Later Life:

Inverclyde's Keeping Active in Later Life Project is run by Your Voice Inverclyde Community Care Forum and works in partnership with Inverclyde Community Health & Care Partnership (CHCP) along with various voluntary/community organisations and private providers. Whilst not in receipt of change fund monies, this project is a positive example of enabling older people to remain living at home and to enhance their quality of life

The project aims to provide practical and emotional support to address social isolation and assist older peoples independence to remain at home. By facilitating access to flexible services that promote independence in partnership with Inverclyde Community Health & Care Partnership, it enables older people to shape and develop sustainable services to meet local need.

Working with older people to design a programme of support that highlights the importance of prevention and social inclusion, it encourages self management of long term conditions and/or disabilities, which fits with the peer support model. The project assists and stimulates a network of self help and peer support to build capacity and enable more able older people, through community buddies, to assist those less able to participate and get involved in their everyday life. It also co-ordinates a partnership approach to promote older peoples well being and prevent them slipping into risk situations.

Support will promote: the reablement model of care; recovery/rehabilitation; health & wellbeing; social engagement and improved social/community connections, leading to greater independence, inclusion and enable older people to remain living at home and enhance their quality of life. Key to the success of this project is the point of

referral for individuals. Recently we have routinely referred to this project as service users complete their period of reablement, and are monitoring the impact and benefits realised through this approach.

6.11 Co-production

Co-production, defined as "delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours". Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change" (NEF, 2011), and is seen as key to meeting the challenge of delivering social care and health services in these difficult times.

In co-designing services we will increasingly use co-production as the default method of service delivery. Managers and staff across sectors will be trained, supported and encouraged to use co-production, asset based & personal outcome approaches to working with clients; recognising the skills and capabilities of people.

7 CARE CONTEXT

7.1 Dementia and Mental Health Interface with Change Fund: 2013-2014

Currently Inverclyde CHCP is engaged in implementing the Modernising Mental Health Services Strategy. This work includes the redesign of Older Peoples Mental Health Services and is based on the development of care pathways, including the dementia care pathway. The work in this area includes addressing the interface with wider community care services, older people's services and the acute sector; priority of the partnership and includes:-

- an existing Dementia Care Pathway action plan, updated to reflect Scotland's National Dementia Strategy 2010, and incorporating Standards of Care for Dementia in Scotland 2011;
- use of the Dementia ICP to inform service elements required and redesign of existing service provision;
- use of service improvement techniques within redesign work groups, including engagement with the Mental Health collaborative;
- the piloting of different approaches to supporting people with dementia at home within the local Telecare development work;
- pilot approaches with the third sector in respect of early interventions to support people with dementia and their carers;
- a robust partnership approach with GP's locally to improve early diagnosis, and post diagnosis support.
- Development of specialist support to non dementia inpatient services to improve quality of care and ensure appropriate care is provided.

Within Older Peoples Mental Health services the future model for service delivery has been developed and current work is focused on the detail of this in operational processes to enable implementation. The model is based on a tiered approach to interventions matched to need, with functions identified as below, and cross referenced to the Reshaping Care pathway:

Tier 1: Primary Care: Preventative and Anticipatory Care; Proactive Care and Support at Home Pathway links.

- To enable single point of access to mental health services, with initial determination of level of need in context of the pathways applied by the GP.
- Provide diagnostic service either by the GP or in conjunction with Consultant;
- Provide treatment and support to GP prescribing and medication review;
- Post diagnostic support for people receiving a diagnosis of Dementia;
- Access to psychological interventions for people with functional illness presentations;
- Enabling access to wider support services at home and within the community, e.g. day activities, home care;
- Elective access to second tier mental health services when need indicates.

The focus within primary care mental health services is on a timed programme of intervention for people with functional illness presentations of Depression; Anxiety; Adjustment Disorders; and identification and assessment of people with Dementia and post diagnosis support.

Tier 2: Secondary health services, and specialist mental health teams.
Proactive Care and Support at Home, and Effective Care at Times of Transition, Hospital and Care Homes Pathway links.
Access to the mental health service for those with complex needs arising from Dementia; Psychosis; and more complex or enduring functional illness presentations may include:-

- fast track assessment for people within the community requiring assessment by the mental health service;
- supplementary mental health interventions within existing care arrangements in the community;
- fast track assessment to support care within other settings, i.e. General Hospital inpatient service; Care Homes;
- routine liaison to support care within other settings;
- Care management of people requiring ongoing mental health service intervention due to complexity of mental health needs.

The priority work is currently focused on the implementation of fast track assessment and Liaison services and during 2012 further work to enable implementation of the Primary Care elements of service will be taken forward.

7.2 Palliative Care

Inverclyde CHCP has an explicitly stated commitment to working across agencies and in partnership with voluntary organisations to establish expertise, choice and rapid access to services required for End of Life care.

With relatively high levels of people with cancer and higher than the Scottish average levels of people with non-malignant life-limiting illnesses such as chronic lung disease, the palliative care needs of the Inverclyde population are significant.

The CHCP has a close working relationship with Ardgowan Hospice and are collaborating in progressing work to develop Inverclyde as a compassionate community.

From Change Plan resources we have invested in a number of Palliative Care initiatives, including:-

- An additional Acute based palliative care Clinical Nurse Specialist;
- A community based palliative care Clinical Nurse Specialist
- A community based Practice Development Nurse;
- GP funded sessions to facilitate the introduction of the Macmillan Gold Standards Framework and support primary care palliative care
- A programme of palliative care training for care and support and home staff
- An independent scoping project of palliative care services and pathways.

The independent palliative care scoping exercise reported at the end of March 2013 and has informed the three years workplan of the Inverclyde Palliative and End of Life Care Planning are Implementation Group, and include analysis of the impact and benefits gained from the range of investments and service changes.

The overall aim of the scoping work was to map current palliative care provision and identify those services/areas that are working well and those areas where attention, development or improvement may be beneficial, particularly around transition between services.

There have been 3 key elements of the work undertaken to date:-

Firstly, to elicit and analyse demographic epidemiological and service related data;

Secondly, to determine the palliative care services available and elicit the views of health and social care professionals as to the services that are working well and those that require attention and/or development;

Thirdly, to elicit the views of patients and carers as to the palliative care services that they experience as being beneficial and those they feel may benefit from attention.

It may in some ways appear to be counter intuitive to set targets in relation to palliative care. However, we are keen to evidence the impact of our interventions and, following the scoping exercise, will be setting targets in relation to:-

- the use of Gold Standards Framework in GP Practices;
- the use of the Liverpool Care Pathway in all appropriate care settings;
- the use of Supportive and Palliative Action Register (SPAR) in Care Homes and NHS Continuing Care;
- the use of Advanced Care Planning;
- activity, both qualitative and quantitative, in relation to preferred place of care and preferred place of death.

The completed scooping project and the revised action plan of the local Palliative and End of Life Care Planning and Implementation Group resultant from that work, has ensured that out efforts in relation to improving and developing services in this arena are evidence based and informed by the views and aspirations of key stakeholders.

Key areas of effort we will focus on in relation to palliative and end of life care in this plan are in relation to transitions between mainstream community service and specialist supports and transition between secondary care and care/support at home for people who wish to die in their own home should their prognosis and clinical needs permit this.

7.3 Intermediate Care

In Inverclyde we have developed a range of services under the auspices of Intermediate Care, providing a network of interventions with the key strategic aim of reducing unnecessary admissions to hospital, supporting timely discharge, maximising opportunities for greater independence and reducing the demand for admission to Care Homes.

Fast Track Assessment

We have a well established Fast Track Assessment service provided in the Acute setting. This enables same or next day assessments to be accessed from primary care, resulting in both a medical and gerontology nurse specialist opinion with clear results demonstrating a reduction in hospital admissions. We are developing pathways which will include fast track assessment, for example when someone is frequently falling at home.

Rehabilitation and Enablement Team

Established in May 2011, by combining community and previously hospital based multi-disciplinary AHP services, the Inverclyde RES team provide a comprehensive service for those who require rehabilitation services to be delivered on a domiciliary basis.

Progress has been made in reviewing previous referral criteria, ensuring that the combination and co-location of pre-existing teams facilitates closer working and economies of scale from a relatively small pool of Allied Health Professionals. The Gerontology Nurse Specialist is now part of RES bringing the additional nursing skills to the multi- disciplinary approach.

Single Point of Access

The co-location of the RES team at the Inverclyde Centre for Independent Living, and natural union arising from this, was opportunistic in creating the beginnings of an SPOA for a number of services and teams. All service provided from the Inverclyde Centre for Independent Living are now available via the SPOA and a joint triaging system is now in operation across the services. We will continue to consider how to build upon this, adding further teams incrementally and in line with the overall desire of the organisation. We consider this to be a key opportunity to improve appropriate access to services whilst maximising the efficiency of existing limited resources. The change fund has allowed additional resource to develop administrative processes and will also contribute to IT solutions should these be required going forward.

Telehealthcare

Complementing the emergency response service for community alarms in Inverclyde, which provides a 24 hour, 7 days per week service to almost 2,000 service users, we have developed a range of telehealthcare services. This aims to use a range of monitoring and assistive technology devices to support vulnerable older people to live independently and remain safe within their own homes. Equipment includes:-

- Door contact monitors
- Smoke/heat detectors
- Natural gas/CO monitors
- Bed exit monitors
- Flood detectors
- Epilepsy bed monitors
- Falls detectors

Anticipatory Care Planning

Within our services a number of initiatives are developing, reflecting the principles of Anticipatory Care Planning, including within District Nursing services and through the GP review of Care Home residents. We have an identified ACP Lead supported by a local steering group and the group is currently using Scottish Patients at Risk of Readmission and Admission (SPARRA) data to establish who would most benefit from an ACP and beginning to use a model of implementation. The steering group will monitor the work and review effectiveness of our plans and interventions, including our ability to maintain individuals in their own home and wherever appropriate avoid unnecessary hospital admissions.

Interface Pharmacy

Recognising that medication is by far the most common form of medical intervention, as a partnership, and utilising Change Fund resources, a number of initiatives have been progressed in interface pharmacy:-

- Four out of five people aged over 75 years take a prescription medicine and 36% are taking four or more. However, we also know that up to 50% of drugs are not taken as prescribed, many drugs in common use can cause problems and that adverse reactions to medicines are implicated in 5 – 17% of hospital admissions.
- Pharmacist medication review by pharmacists currently working within the CHCP has shown improvements in prescribing by altering medication choice and formulation, discontinuing therapy no longer required or in response to adverse drug reactions, providing patient education, improving monitoring of medicines, addressing concordance issues and improving cost effectiveness.
- Currently 1.0 WTE CHCP Interface Pharmacist (50% Delayed Discharge/ 50% PPSU funding) provides medication review for older people and pharmaceutical advice and support at IRH Day Hospital and across the primary/secondary care interface.
- During 2012, we also had a pharmacy technician in post who November 2012 received the Scottish Pharmacy Award for Innovations in Prescribing Quality and Efficiency.
- We have again utilised change fund money to provide pharmacy technician support with a particular emphasis on working with our reablement and care at home services

Key Objectives and Areas of Work:-

1. To reduce avoidable medication-related issues in primary care.
1. To reduce emergency hospital admissions and readmissions for avoidable medication-related issues.
1. To undertake pharmacist medication reviews with elderly patients on polypharmacy and/or high risk medication.
1. To reduce avoidable readmissions by undertaking medicines reconciliation as soon as possible post discharge.
1. To report on pharmacy interventions.
1. To review medicine reconciliation on discharge.
1. To support elderly patients to manage their medicines in their own home.

This service has developed a range of positive interventions which we are now consolidating into mainstream services. It is also timely that following our successful project, within their contract GPs are now reviewing their most vulnerable patients with regard to polypharmacy.

<u>Potential Further Areas of Development in Intermediate Care</u>:-

Intermediate Care Beds

We continue to consider use of intermediate beds and have identified a number of potential options such as within a residential setting or the use of a flat within

sheltered housing. Given the proposed changes to Care Home provision, we intend to explore further the use of the released capacity to provide options of both Step Up and Step Down care for consideration.

8 FINANCIAL FRAMEWORK

8.1 How we use our resources

In this section we describe the NHS and Social Work resources used to support older people's services in Inverclyde.

This analysis remains at an early stage, pre-integration, and in order to get a complete picture of resources allocated to support older people in Inverclyde we plan to add in third and independent sector resources, as well as other partnership services such as housing and leisure.

For NHS, resources the 2013/14 budget was set in line with the Greater Glasgow & Clyde Health Board's financial plan. Work is ongoing to identify efficiency savings for 2014/15 and 2015/16.

For Inverclyde Council the 2013/16 Social Work budget was as part of the Council's three year budget on 14 February 2013 and this identified the resources for 2013/14 along with the following two financial years. This included decisions on both Social Work specific pressure and savings proposals along with the impact on Social Work from Council wide decisions.

Inverclyde CHCP has an annual revenue budget of £120 million of which £37 million relates to GP services and prescribing costs, the remaining £83 million is the operational CHCP budget with £48 million of this relating to Older People.

Below we highlight the current 2013/14 operational budgets for Older Peoples Services for health and social work, and data from the integrated resource framework based on 2011/12 which provides useful benchmarking information.

Operational Budget – Health

The operational budget for the NHS is summarised in **table 1** and highlights the main service components of the **Health** budget.

Table 1 – Operational Budget Health

	£'000
Health & Community Care	4,209
Change Fund	1,403
Mental Health Services	5,593
Resource Transfer & Delayed Discharge	2,393
Total	13,598

Within the Health & Community Care budget £2.8m relates to Nursing, including District Nursing Services and £0.4m is for Rehabilitation.

Within Mental Health services £1.1m is spent on Community Services with £3.8m on Inpatient Services.

A detailed breakdown of the Change Fund activity is included at annex 2.

In addition, to the resources above the costs of Family Health Services (GP services) and GP Prescribing need to be included to identify the full NHS resources allocated to older people. The costs of these services that relate to Older People, as identified in the Integrated Resources Framework, is shown at table 2;

Table 2 – GP Services and Prescribing Costs

	£'000
Family Health Services	3,204
GP Prescribing	6,824
Total	10,028

A full breakdown of the Integrated Resource Framework for Inverclyde is included at annex 1 for information.

The total notional Health budget for Older People is shown at table 3;

Table 3 – Total Notional Budget Health

	£'000
Health Operational Budgets	13,598
Family Health Services and GP Prescribing Costs	10,028
Total	23,626

Operational Budget – Social Work

The following information at table 4 highlights the main elements of the Social Work budget for 2013/14 totalling £24m.

Table 4 – Operational Budget Social Work Services

	£'000
Purchased Nursing & Residential Care	10,720
Purchased Homecare	2,289
Homecare Service	6,127
Other Services	4,997
Total	24,133

Within Other Services £1.8m is spent on Assessment and Support, £0.4m on Community Alarms with £1m on Daycare and Meals.

Within social work budgets there is no requirement for notional budgets to be added. However a significant proportion of Change Fund resources are deployed through Social Work.

Change Fund

To assist Partnerships in reshaping care the Scottish Government allocated Change Fund resources in 2010/11 for a four year period. The total resources available through the Change Fund in are outlined in **table 5** below and table 6 shows the current year spend across the five care pathways.

Table 5 – Inverclyde Change Fund allocation 2011/12-2014/15

	£'000
2011/12	1,228
2012/13	1,400
2013/14	1,403
2014/15 (anticipated)	1,200
Total Inverclyde Change Fund	5,231

Table 6 – Inverclyde Change Fund allocation 2013/14 by Pathway

	£'000
Preventative & Anticipatory Care	295
Proactive Care & Support at Home	491
Effective Care at Time of Transition	221
Hospital & Care Homes	199
Enablers	197
Total Inverclyde Change Fund 2012/13	1,403

Table 7 – Inverclyde Change Fund allocation 2013/14 by Service Area

	£'000
Acute	154
CHCP - Health	154
CHCP - Council	800
Community Capacity Health	56
Community Capacity Council	239
Total Inverclyde Change Fund 2012/13	1,403

In addition to the funding above a further £396,000 will be spent on projects funded from 2012/13 slippage. A supporting list of projects and allocated resources is at annex 2.

Integrated Resource Framework

The integrated resource framework is an exercise to map the totality of resources across health and social care consumed by different patient groups or users of the service. The latest figures from the integrated resource framework show that in 2011/12 people aged over 65 in Inverclyde consumed a total resource of £83m. This has been broken down in the different service areas as shown below.

Table 7 – Integrated Resource Framework Summary 2011/12

	£'000
Hospital based services	**41,139**
Health community services	**7,370**
Family health services (GPs, prescribing etc.)	**10,028**
Local authority social care services (1)	**24,133**
TOTAL	**82,670**

(1) Not available from 2011/12 IRF data so taken from Table 4

A break down of what is included in hospital based services is included in **annex 1** and table 8 below gives a summarised analysis, showing that of the hospital based services totalling £41m that £18m or 45%, is used on emergency admissions to hospital services. This is activity that by its definition is not planned but nevertheless results in a hospital stay.

The largest health community resource is prescribing, totalling nearly £7m in 2011/12. GP and other family health services make up the next highest total at £3m, followed by district nursing at just over £1m. Other community services account for a small proportion of the overall resource use.

Local authority social care resources include almost £11m spent on care homes (accommodation based services) and £8.4m on home care. Other totals include £3m on case work, equipment, adaptations, meals and services to carers. Just over £1m is spent on day care services and delivery of meals.

Table 8 – Integrated Resource Framework Hospital Based Services 2011/12

	£'000	%
Unplanned Admissions	18,331	45%
Planned Admissions including Day Cases	9,457	23%
Mental Health	5,319	13%
Geriatric Long Stay (being reviewed)	449	1%
Outpatients	7,582	18%
Total	41,138	

Summary

In summary we can conclude that the annual base budget for health is **£23.6m** (comprising £13.6m operational budget and £10m notional allocation of Family Health Services and GP Prescribing costs) and for Social Work is **£24.1m** providing a combined total of **£47.7m**. This **£47.7m** is the overall total resource devoted to health and social work services for older people in Inverclyde for the financial year 2013/14.

9 HOUSING

The *National Housing Strategy for Older People* clearly defines expected outcomes and recommends clear strategic leadership which extends partnership working beyond the public sector. Information and advice is key to older people being empowered to make choices and have access to appropriate housing and support. This support may take the form of practical help such as Care and Repair and Telecare or information such as welfare rights and benefits advice. Taking a wider supportive perspective, community capacity building and co-production will enable older people to avoid social isolation and live more independently particularly when living alone.

Better use of existing housing alongside new, affordable and sustainable housing is imperative and the national strategy encourages new models of housing whilst ensuring proper use of adaptations, adapted houses and selection of suitable properties to meet individual needs.

The Inverclyde Local Housing Strategy 2011-2016 sets out a number of strategic outcomes:-

- Inverclyde residents have access to a range of suitable housing options including housing for particular needs and housing purpose-built or adapted to meet the needs of older people.
- Inverclyde residents are able to make best use of their housing. This includes provision of equipment and adaptations together with appropriate care and support services delivered direct to people in their own homes and communities.
- Inverclyde residents receive appropriate support when they experience changes to their housing needs including information and advice services and help with finding suitable alternative accommodation where necessary.

The current economic climate produces challenges to providing purpose-built housing for older people and, as such, alternative and innovative funding schemes are being pursued for new build affordable housing. This will require further discussion and strategic planning in the context of future requirements for older people.

10 WORKFORCE

Our workforce, across all sectors, is key to the achievement of the aims of this Plan. Only through the continued development of our workforce, and continued support of informal carers and the community, will be able to ensure that we can respond to the challenges facing us in meeting the changing needs of our population.

The 'workforce', in its broadest sense, supporting older people and their carers is vast. In some cases there are specific groups of professionals in all sectors who specialist in supporting, caring for and treating older people. In the main, however, older people are supported via mainstream services.

As part of modernising and reviewing services for older people we are undertaking significant workforce analysis and workforce planning. The analysis of the workforce is underpinned by the work of national bodies that are supporting new approaches to service delivery and workforce development. These include:

- the Joint Commissioning Approach recommended by the National Joint Improvement Team. (Joint Strategic Commissioning Learning and Development Framework November 2012).
- the NHS Education for Scotland strategic framework and will incorporate the findings of the refreshed framework for 2014 to 2019 when it is published.
- Institute for research and Innovation in Social Services

It is intended that workforce development and planning will be a core feature for the lifetime of the Plan, and not a one off event. To determine the local workforce supporting older people and the roles in which they are engaged we need to understand how people are working and practicing and to help people develop to deliver optimum services and supports.

The NHSGG&C Clinical Services Review underpins that we need to support our workforce to meet future changes.

- All our services depend on having the right number of appropriately trained staff in place. Failure to plan for this could lead to services being unsustainable or facing crises.

- All professions are under pressure so we cannot just think about substitution of roles, but need to look at how services can be delivered better by teams working across professions and agencies.

Through this Joint Commissioning Plan we plan to carry out a learning and development needs analysis of the Older Peoples Workforce, across the statutory, independent and 3rd sector, in order to identify the skills and knowledge gaps which require to be addressed to embed the Joint Commissioning Plan.

Detailed analysis of the learning and development needs of the Older People's workforce is well underway. This will provide a foundation for developing the workforce in a flexible way. It is recognised that practitioners are currently operating in a climate of substantial service redesign, organisational practice changes and ongoing service demands. Nevertheless a number of learning and development initiatives are underway. These are designed to support the workforce in the new ways of working that will be required under the Joint Commissioning Plan such as:

1. Outcomes
2. Self Directed Support
3. Dementia Strategy
4. Leadership
   - and governance
   - and reflective practice
5. Statutory Training
6. Reablement
7. Assessment and Support Planning
8. Risk Assessment and Risk Enablement
9. Protection
10. Co-production/ Joint Commissioning
11. Culture Change and Community
12. Learning Resources

Appendices:

1. Financial Information
2. Change Fund Allocation by Project
3. Housing Contribution Template

Appendix 1

Integrated Resource Framework Extract 2011/12 Inverclyde

Mapping Section	Inverclyde (CHP: S03000018)		
	All ages	65 +	75+
a) Hospital *(SFRs 5.3 - 5.9)*			
Inpatient - Non elective (Acute+MH+GLS)	**£40,058,074**	£23,268,670	£15,587,693
Inpatient - Elective (Acute+MH+GLS)	**£15,110,617**	£7,292,872	£3,649,705
Inpatient - Acute non elective [2a]	***£30,627,116***	*£18,331,022*	*£12,820,104*
Inpatient - Acute elective [2a]	***£14,112,080***	*£6,462,606*	*£3,064,373*
Inpatient - Acute day cases [2a]	**£7,774,688**	£2,994,474	£1,416,145
Inpatient - Mental Health non elective [2b]	***£8,982,241***	*£4,488,932*	*£2,381,762*
Inpatient - Mental Health elective [2b]	***£998,536***	*£830,266*	*£585,331*
Inpatient - Geriatric Long Stay non elective [2c]	***£448,717***	*£448,717*	*£385,826*
Inpatient - Geriatric Long Stay elective [2c]	**-**	-	-
Inpatient - Maternity inpatients [2d]	**£1,800,435**	-	-
Inpatient - Maternity day cases [2d]	**£1,069,930**	-	-
Inpatient - Special Care Baby Unit [3]			
Outpatients - Accident & Emergency [4]	**£2,789,172**	£567,100	£327,264
Outpatients - Consultant - New [5]	**£3,781,183**	£1,015,764	£498,328
Outpatients - Consultant - Return [5]	**£6,171,990**	£1,723,421	£878,085
Outpatients - Nurse led clinics [6]	**£1,951,488**	£806,484	£506,071
Outpatients - AHP [7]	**£7,127,159**	£1,961,445	£985,607
Day patients [8]	**£3,078,832**	£1,509,209	£1,002,975
(a) Hospital Total	**£90,713,568**	**£41,139,439**	**£24,851,873**
b) Community *(SFR 8.3)* [9,10]			
District Nursing	**£1,556,282**	£1,189,714	£883,536
Health Visiting	**£1,168,499**	£76,938	£55,167
Midwifery	**£468,319**	£18	£9
Child Health	**£1,748,795**	-	-
Specialist Nursing	**£841,153**	£264,090	£131,210
Clinical Psychology	**£281,154**	£88,272	£43,857
Community Mental Health Teams	**£4,517,555**	£1,718,810	£916,750
Community Learning Difficulties Team	**£763,081**	£58,626	£13,939
Addiction Services	**£1,373,520**	£223,630	£63,314
Family Planning	**£763,345**	-	-
AHP - Physiotherapy	**£429,900**	£134,972	£67,059
AHP - Occupational Therapy	**£38,375**	£12,048	£5,986

AHP - Chiropody	**£372,261**	£116,876	£58,068
AHP - Dietetics	**£213,938**	£67,168	£33,372
AHP - Speech Therapy	**£240,027**	£75,359	£37,441
Laboratory - Direct Access/FHS Practitioners	**£1,356,053**	£425,749	£211,528
GP Out of Hours	**£854,363**	£268,237	£133,271
Community Dentistry	**£453,503**	£46,262	£33,912
Incontinence Services	**£327,016**	£327,016	£152,290
Home Dialysis	**£75,223**	-	-
Breast Screening	**£406,012**	£85,019	-
Health Promotion	**£1,151,260**	£211,039	£98,280
Other (please specify)	**£6,306,270**	£1,979,927	£983,705
b) Community Total	**£25,705,904**	**£7,369,769**	**£3,922,693**
c) Family Health Services *(SFR 8.4 / Note 5)*			
GMS - Global sum [11]	**£5,860,749**	£1,637,888	£859,252
GMS - Enhanced services [11]	**£1,486,872**	£415,532	£217,992
GMS - QOF [11]	**£2,151,571**	£601,294	£315,445
GMS - IT, Premises, etc [11]	**£1,965,405**	£549,267	£288,150
Pharmaceutical services - GP prescribing [12]	**£16,974,896**	£6,824,023	£3,572,202
Pharmaceutical services - Other	**excluded**		
General Dental Services	**excluded**		
General Ophthalmic Services	**excluded**		
c) FHS - GMS and GP prescribing total	**£28,439,494**	**£10,028,003**	**£5,253,041**
d) Sub-contracting total *(SFR 24)* [13]			
e) Total Mapped Expenditure (a+b+c)	**£144,858,966**	**£58,537,212**	**£34,027,607**

Appendix 2

Change Fund 2012/13 Allocation by Project

Total Funding £1.8m being £1.4m 2013/14 allocation and £0.4m slippage from 2012/13)

ACUTE - HEALTH	**£'000**
Stroke Out Reach Team	53
AHP weekend working	83
Palliative Care CNS 0.5wte	25
Practice Development Nurse	43
Total	**204**

CHCP HEALTH	**£'000**
Change Fund Lead/ Project Work	46
Rehabilitation - physio and triage of referrals, along with implementation of electronic referrals (SPOA)	50
Pharmacy Technician	35
Impact Analyst	37
Total	**168**

CHCP COUNCIL	**£'000**
Change Fund Lead / Project Work	71
2 Social Work posts to speed discharge process.	34
Reablement lead	39
Reablement Seniors 3 Senior home support workers for reablement teams	70
Reablement Workers	300
Admin support for pilot reablement team	57
Full time OT and 2 OTAs	91
Home care assessment and reviewing post	55
Homecare Pilot Extension Monitoring Officer	25
Telecare project extension and equipment	100
Business Support Manager	39
OTA -Community Alarms	22
Dementia Post	38
To provide capacity in Older Persons Mental Health Team to develop Dementia Strategy	35
Step down beds, bridging funding for 2 EMI beds	47
Administration and support	26
Total	**1,049**

COMMUNITY CAPACITY HEALTH	**£'000**
Practice Development Nurse	43
Administration and support	21
End of Life Care GP Facilitator	11
Total	**75**

COMMUNITY CAPACITY COUNCIL	£'000
Supporting Voluntary Sector Community Groups - bidding process	100
Carers Support	127
Housing with Support & Care	50
Scottish Care - Development Worker	23
Total	**300**

Appendix 3

HOUSING CONTRIBUTION TEMPLATE

This template should be completed jointly by appropriate lead officers from local authority housing and the health and social care partnership. Once completed the template should be incorporated as a discrete element within the Joint Strategic Commissioning Plan for Older People.

It should be signed off as part of the overall Joint Strategic Commissioning Plan for Older People by the signatories to that overall plan **and the Chief Housing Officer**.

Theme	Detail
Outcomes relevant to the housing contribution (*Note1)*	The following Inverclyde Alliance Single Outcome Agreement (SOA) priorities are relevant to the housing contribution: **SOA1** - Inverclyde's population is stable with a good balance of socio-economic groups **SOA2** - Communities are stronger, responsible and more able to identify, articulate and take action on their needs and aspirations to bring about an improvement in the quality of community life **SOA4 -** The health of local people is improved, combating health inequality and promoting healthy lifestyles **SOA7** - Inverclyde is a place where people want to live now whilst at the same time safeguarding the environment for future generations **SOA8** – Our public services are of high quality, continually improving, efficient and responsive to local people's needs The following manifesto commitments are also applicable to the housing contribution: **MHC11** – Lobby the Scottish Government for additional funding to provide new affordable housing for local people **MHC14** – Build on our existing partnership with Health, through the CHCP, to ensure that this integrated community service will enhance the health and social wellbeing of our communities

	The Inverclyde Local Housing Strategy 2011-2016 (the LHS) also contains strategic outcomes that are of relevance to the housing contribution: **Outcome 1** – Inverclyde residents have access to a range of suitable housing options. This outcome includes housing for particular needs and housing purpose built or adapted to meet the needs of older and disabled people. Representative groups and organisations were fully consulted on the development of this outcome. This included participating in the options appraisal process, scoring and weighting of priorities and developing an action plan. **Outcome 2** – Inverclyde residents are able to make best use of their housing. This outcome includes the provision of equipment and adaptations together with appropriate care and support services delivered direct to people in their own homes and communities. **Outcome 4** – Inverclyde residents receive appropriate support when they experience changes to their housing needs. In addition to the assistance noted above, this outcome includes information and advice services and help with finding suitable alternative accommodation, where necessary.
Strategic direction of travel and proposed investment changes within the draft Joint Strategic Commissioning Plan for Older People *(Note 2)*	Inverclyde Council has a duty to meet housing need and demand and as part of the LHS development, the council fully engaged in a joint process with the seven other local authorities in the Glasgow and the Clyde Valley Strategic Development Plan area to produce a regional Housing Need and Demand Assessment (HNDA). The HNDA includes an assessment of the needs of older and disabled people together with those affected by limiting long-term illness. The Inverclyde LHS is the overarching strategic plan for housing, initially over a five-year period but also looking forward over the next ten to twenty years. Housing Supply Targets are included in the LHS to address demand and need identified through the HNDA process. These targets cover all tenures as there is a high level of private ownership in the council area and the needs of owners and tenants have to be included in future provision. Allowing people to maintain independence throughout their lifetime remains a high

	priority for the council and housing developers. The LHS and the associated Strategic Housing Investment Plan (SHIP) set out our investment priorities and how we aim to develop the right products in both the social and the private housing markets. All new houses for social rent are built to varying needs standards and we are encouraging private builders to adopt the same standards to "future proof" the new homes that they build. The amount of Affordable Housing Supply Programme funding to Registered Social Landlords (RSLs) has reduced considerably and this has resulted in a complete re-prioritisation of investment in new affordable housing. The LHS also states how the council will continue to invest in Care & Repair services to assist private owners and private tenants to make the best use of their homes. The Council's Scheme of Assistance provides mandatory grants of up to 80% of the overall cost for adaptations in the private sector. These works are funded though the council's Private Sector Housing Grant which is under continuous review as the demand for assistance outstrips resources and this impacts on the level of adaptations being carried out.
The housing contribution – investment already planned on the basis of the LHS (and if appropriate the LA Housing Business Plan for its own stock) (*Note 3)*	Inverclyde Council transferred all of its housing stock to two locally-based RSLs in December 2007 and all affordable social rented housing is now provided by RSLs. The council is however the Strategic Housing Authority and we work in partnership with local and national RSLs to address the shortfall in affordable housing and in housing for particular needs identified in the HNDA. The SOA priorities and the LHS strategic outcomes noted above have been translated into Action Plans and some of the key actions are as follows: • RSL partners are working to achieve the Scottish Housing Quality Standard by 2015 (this includes providing equipment and adaptations, where appropriate, to allow tenants to make best use of their homes) • The Strategic Housing Investment Plan (SHIP) is updated annually in line with the LHS strategic outcomes and Scottish Government funding availability

	• The council will continue to work in partnership with RSLs and developers to provide homes suited to the needs of older people, including those with disabilities • The council will continue to work with RSLs and developers to provide New Scheme Shared Equity (NSSE) options for older people who prefer to remain as owners rather than tenants • The Strategic Housing Team will work with RSLs and CHCP services to prioritise access to housing for community care groups based on level of risk and nature of need • Support the promotion and wider use of telecare/telehealth to enable older people to remain in their own homes • Widely promote and financially support the Inverclyde Care & Repair Scheme • Develop an evidence base which quantifies the need for specialist amenity or adapted housing to meet the SOA priorities and LHS strategic outcomes • Develop a database of specially adapted properties and ensure there is a good match of households to homes in the allocations system
Likely future impact of plan upon housing resources (*Note 4)*	The provision of housing purpose built to meet the needs of older people will be more costly than mainstream housing. Building more houses designed for older people with particular needs will therefore have an impact on the overall number of new affordable homes that can be constructed. Costs of new house building have been driven down substantially due to the economic climate and subsidy levels have been reduced accordingly. Although there is some scope to alter benchmark subsidy levels to reflect the additional costs of housing for particular needs, it will be difficult to include housing of this type in local development programmes due to ongoing budget constraints. The provision of additional housing advice, information and support for older people is being pursued through a Housing Options Guide in partnership with RSLs and through the development of a housing “one stop shop” incorporating a wide range of housing and service providers. The current level of resources per year, is as follows: • Adaptations to private sector properties - £950,000 • Adaptations to RSL properties – £300,000

	• Care & Repair - £257,000
Process for integrating the housing contribution to the Joint Strategic Commissioning Plan for Older People in future *(Note 5)*	The Change Fund Programme Board includes a representative from the Strategic Housing Team who has been involved in the development of the JSCPOP by attending planning and development meetings with Health and CHCP staff. The Strategic Housing Team is also represented on the Housing & Accommodation Sub Group involving RSLs and accommodation and service providers. Private Sector Housing Grant funding and Affordable Housing Supply Programme funding will continue to be used to support the outcomes of the JSCPOP, as far as possible. Discussion of how to achieve better outcomes across Health, CHCP, and housing services is ongoing through the Housing & Accommodation Sub Group.
Outline and understanding of shared data sources , and gaps to be addressed *(Note 6)*	As previously noted, the LHS includes a two-tier HNDA encompassing the Glasgow and the Clyde Valley Strategic Development Plan Authority area (eight local authorities, including Glasgow City) and information for the Inverclyde Council area. Estimates of need and demand for affordable and private housing have been calculated up to 2025. Gathering information on future needs of older people has mostly been carried out at a regional level and work needs to be dome to provide information at a local, Inverclyde level. This secondary housing needs assessment requires to be carried out in partnership with Health, CHCP, RSLs and the Strategic Housing Team (see note 7). The Strategic Housing Team has produced a Housing Trend Monitoring Report that will form a useful starting point for further research and analysis of the housing scene in Inverclyde and of market segments including the needs of older people.
Key challenges going forward *(Note 7)*	• The secondary HNDA involving the need and demand for housing suitable for older / disabled people has to be completed to inform future investment decisions (LHS/SHIP/SLP) • Alternative and innovative funding schemes are being pursued in response to reduced Scottish Government funding for new build affordable housing and reductions in overall subsidy levels • The case for maintaining levels of Private Sector

	Housing Grant (no longer ring-fenced) has to be made in order to meet ongoing demand • The housing contribution to future Change Fund proposals needs to be discussed further and incorporated into strategic planning • Existing good relationships with social and private sector housing providers have to be further developed in the light of reduced funding and Welfare Reform changes • The demographic profile of the Inverclyde Council area clearly shows that the housing needs of older people will become more acute over time and more effective planning is required to address these needs at this challenging time for both public and private finance

Note 1: This should reflect those health and social care measures, including outcomes that are considered most likely to be impacted by the housing contribution. They should include national and local measures, as detailed in the JSC Plan for Older People

Note 2: This should describe the proposed overall shift in the balance of care and outline the key service re-design proposals in the JSC Plan for Older People that are intended to deliver this shift

Note 3: This should detail those aspects of the current LHS that contribute to delivery of the JSC Plan for Older People focusing on change in service delivery to support health and social care outcomes, and should also reference the local authority's investment plans for its own stock where appropriate.

Note 4: This should outline the potential impact that the plan is likely to have on housing resources, both services and bricks and mortar, going forward

Note 5: This should explain local proposals for ensuring that the housing contribution is clearly articulated and how a stronger housing perspective will be incorporated into future JSC processes and plans

Note 6: This should describe the data sources that have been used by both health and social care and housing in compiling the JSC Plan for Older People and the Local Housing Strategy and identify any currently apparent gaps in the data that, were they to be addressed, would better support joint working between the sectors

Note 7: This should highlight any particular issues regarding housings' contribution that have emerged from discussions relating to the completion of this HCS and/or any other related processes