**SOUTH LANARKSHIRE COMMUNITY PLANNING PARTNERSHIP**

**PARTNERSHIP IMPROVEMENT PLAN**

**2017-2020**

**Health and Social Care Partnership**

**VISION**

*To improve the quality of life for all in South Lanarkshire by ensuring equal access to opportunities and to services that meet people's needs*

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**South Lanarkshire Health and Social Care PIP**

1. **Poverty, Deprivation and Inequality**

In recognition of the importance of good health and wellbeing both individually and within communities, Health and Social Care has been a key pillar of Community Planning in South Lanarkshire over the last 10 years.

The strategic environment for Health and Social Care has undergone significant change over recent years, mainly resulting from the impact of the Public Bodies (Joint Working) (Scotland) Act 2014, whereby elements of Health and Social Care were required to integrate from the viewpoint of strategic planning and operational delivery. As a result, Health and Social Care is now coordinated through the South Lanarkshire Integration Joint Board (IJB), whose membership includes representation from:

* South Lanarkshire Council;
* NHS Lanarkshire;
* Independent Sector;
* Voluntary Sector;
* Carers;
* Public Partnership Forum; and
* Trade Unions.

Collectively, and under the direction of the IJB, the South Lanarkshire Health and Social Care Partnership (SLHSCP) worked with partners in localities to agree a vision as detailed below in our Statement of Ambition.

Poverty deprivation and inequality are often the underlying determinants of whether people are healthy or not. This is determined by their social and economic circumstances and wider environment. Factors such as where we live, genetics, income, education, gender, social networks and access to health care services, all have considerable impacts on health and can also contribute to health inequality.

The context of people’s lives determine their health and lifestyle choices. Individuals are unlikely to be able to directly control many of the determinants of health and this contributes to health inequality. Material factors such as poverty, as well as social, cultural and environmental factors impact on lifestyle behaviours, such as smoking, addiction or poor diet. The Partnership in collaboration with Community Planning Partners and the wider community will focus our efforts on preventing the wider environmental influences and taking action to mitigate individual effects.

The Partnership is committed to the delivery of preventative and anticipatory care interventions, in order to optimise wellbeing and the potential to reduce unnecessary demand on our Health and Social Care System. We work to improve the determinants of good health e.g. mental wellbeing, positive parenting and mitigate the determinants of poor health e.g. poverty and alcohol abuse.

1. **Statement of Ambition**

The Health and Social Care Partnership has an agreed vision and Statement of Ambition, which was formalised in 2015 following establishment of the Partnership. This vision statement “working together to improve health and wellbeing **in** the community – **with** the community” reflects the Partnership’s commitment to fully involve and work with communities to improve their health and wellbeing.

1. **Extent and Nature of Issues**

One of the fundamental issues arising from the Strategic Needs Assessment was the increased demand on services arising from increasing demographic pressures as a result of an ageing population. In analysing the impact of this through the needs assessment in more detail, it became apparent that this factor was contributing to a number of other issues which the needs assessment highlighted as follows:

* Increased hospital and residential care activity;
* Increasing numbers of people living with 1 or more long term conditions;
* Rising levels of dementia prevalence;
* Increased vulnerability, particularly in relation to capacity and protection planning;
* Growing number of carers and the requirement to support an increased number of them to maintain their caring role;
* Housing options for older people;
* Poverty levels in households where there were children and young people; and
* Lifestyle issues, such as significant increases in levels of obesity and substance misuse.

The Health and Social Care contribution to developing our priorities has been informed and developed from the extensive consultation and participation activity which we undertook as part of developing our Strategic Commissioning Plan 2016-19. Over the course of 2015 and early part of 2016, we undertook locality based consultation events. This involved a programme of 3 events in each of the four localities or 12 in total. This was also supplemented by direct engagement with other organisations who requested that we come and discuss the plan and the priorities with them, for example, Carers Groups and also older people as facilitated by Seniors Together. In terms of coverage and direct engagement, approximately 900 stakeholders took part in the locality based half day events. Supplementing this, we also received 44 written responses to the draft Strategic Commissioning Plan, which helped (in addition to the events) to shape 10 key themes that stakeholders agreed we should focus our efforts on.

1. **Priorities**

As set out above, the consultation process led to wide discussion and in turn agreement was reached to prioritise and focus resources of the SLHSCP on the following:

* Statutory/core work;
* Early intervention/prevention and health improvement;
* Carers support;
* Models of self–care and self–management;
* Seven day services;
* Intermediate care and reducing reliance on hospital and residential care;
* Suitable and sustainable housing;
* Single points of contact;
* Mental Health and Wellbeing; and
* Enablers to support better integrated working.

As a result the Strategic Commissioning Plan reflects a set of actions and measures which have been prioritised to set the direction of travel for the SLHSCP in meeting the demands highlighted from the Strategic Needs Assessment, consultation priorities and the 9 National Health and Wellbeing Outcomes.

As part of developing the Strategic Commissioning Plan 2016–19, the SLHSCP undertook significant work to understand what the priorities should be for Health and Social Care. Specifically, two wide ranging pieces of work were completed to shape this as follows:

* a Strategic Needs Assessment at a partnership level and within each of the four localities of Rutherglen/Cambuslang; Hamilton/Blantyre; Clydesdale; and

East Kilbride;

* A number of consultation sessions with partners and members of the public regarding how the Partnership should prioritise its activities in tackling the major themes arising from the needs assessment (see section 3); and
* The 9 National Health and Wellbeing Outcomes and how the SLHSCP works with other partners to achieve these.

To this end and taking cognisance of the above, our Strategic Commissioning Plan and Community Planning contribution directly reflects these priorities and how the Partnership will focus its energy on these areas.  From a performance and planning perspective, this is what we will report against in terms of measuring progress and impact.

1. **Partnership Outcomes**

Whilst the Partnership recognises that the Strategic Commissioning Plan 2016-19 will provide focus on all of the above, the Health and Social Care Partnership in a wider Community Planning context intends to work with partners to prioritise the following areas in relation to the Community Plan:

1. Individuals, families and communities are empowered to take preventative action to support positive health and wellbeing with a focus on communities and groups whose health outcomes are poorest;
2. Shifting the balance of care from hospital and residential settings to community based alternatives; and
3. Carers and in particular those on low incomes are fully supported to access financial advice and information and practical wellbeing support.

**PIP – Health and Care**

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| **Priority Outcome 1: Individuals families and communities are empowered to take preventative action to support positive health and wellbeing with a focus on communities and groups whose health outcomes are poorest** |
| **Rationale:** If we are going to improve our population’s health and reduce local health inequalities and reduce demand on our services, it is of paramount importance that we work with communities, partners and staff to deliver initiatives that prevent ill health, and intervene early and avoid the escalation of need unnecessarily. This will also require working with people to support them to care for themselves with a view to maximising resources that are under considerable pressure. **Context:** South Lanarkshire wide population health is generally on a par with Scotland but when we drill down to smaller geographical levels, the health inequalities can be significant. However, we know that poverty is one of the most significant contributors to health inequalities. **Life Expectancy**Life expectancy at birth in the most 15% deprived areas for men is 71.1 years and this is 6.6 years less than those born in the rest of South Lanarkshire or 77.7 years. No matter where men are born they are expected to have shorter lives than women. **Life Expectancy – Male** - 71.1 years in the most deprived area against 77.7 years in the least deprived**Life Expectancy – Female** - 77.6 years in the most deprived area against 81.2 years in the least deprived**Long Term Conditions (LTC)**Based on current projections, we know that people with one or more long term condition is projected to increase. For example:**People with One Long Term Condition*** 7,565 people aged 65-74 had one LTC in 2011/12 rising to 8,062 in 2013/14 or by 6.5%
* 5,324 people aged 75-84 had one LTC in 2011/12 rising to 5,569 in 2013/14 or by 4.6%
* 1,710 people aged 85+ had one LTC in 2011/12 rising to 1,755 in 2013/14 or by 2.6%

 **People with Three Long Term Conditions*** 1,403 people aged 65-74 had three LTCs in 2011/12 rising to 1,460 in 2013/14 or by 4.1%
* 1,597 people aged 75-84 had three LTC in 2011/12 rising to 1,805 in 2013/14 or by 13%
* 749 people aged 85+ had three LTC in 2011/12 rising to 876 in 2013/14 or by 17%

Within this, the long term conditions with the most significant prevalence and projected increases are as follows:* People with Coronary Heart disease is projected to increase by 11.3% between 2016 and 2021
* The number of people affected by stroke is projected to increase by 9.2% between 2016 and 2021
* The number of people with diabetes is projected to increase by 5.2% between 2016 and 2021
* The number of people with a physical disability is projected to increase by 5.1% between 2016 and 2021

**Mental Health, Learning Disability, Substance Misuse and Smoking**Equally, the prevalence of mental health, substance misuse and smoking is more pronounced in more deprived areas, thus impacting on overall health and wellbeing outcomes as the following data shows:* In 2014, the number of working age adults who had a mental health/learning disability in South Lanarkshire was 15,180 or 15.6% of the adult population. This is quite a bit higher than the Scottish average of 12.2%
* **Prescriptions for anxiety, depression etc** - 10% in the most deprived area against 8% in the least deprived
* **Smoking rates for mothers to be –** 28.5% in the most deprived area against 5.6% in the least deprived
* **Alcohol and drugs** – in excess of 1,500 referrals are managed annually through the Lanarkshire Alcohol and Drugs Service for South Lanarkshire, with over 400 individuals being directly supported at any one time

**Obesity**Obesity in South Lanarkshire is a significant issue, with over 65% of the population being overweight or obese. Projections tell us that 40% of the adult population will be obese by 2035. Obesity is associated with the development of a range of illnesses, including diabetes, coronary heart disease and cancer.**High Resource Users of Services**Health costs associated with high resource users of services have been analysed by the Partnership and from this we know that 7,858 individuals consumed £157m or 50% of the total health expenditure in South Lanarkshire. This data has been further analysed to provide a profile of the types of services being accessed, with a further more detailed analysis scheduled to be undertaken on the top 25% of the 7,858 individuals. **Drivers:** It is well known that health inequalities have a clear link to life chances and overall health and wellbeing. The above data highlights that overall potential demand for health and social care services will continue to increase unless the overall health of the population improves. In addition to demand being a driver, there are a number of national strategies which require to be taken account of and all link into this agenda as follows:* The Public Bodies (Joint Working) (Scotland) Act 2014
* Health Inequalities in Scotland – Audit Scotland 2012
* A Route Map to the 2020 Vision for Health and Social Care 2011
* Mental Health Strategy for Scotland 2012-15
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| **We will measure progress towards this priority outcome with reference to the following indicators and targets** |
| **Indicator(s) and Source** | **Baseline** | **Latest figures reported** | **Short Term Target (1 year)** | **Medium Term Target (3yr)** | **Long Term Target****(10yr)** |
| **Increase** the life expectancy levels in the 15% most deprived areas of South Lanarkshire to be comparable with South Lanarkshire Average (Female)**Source: nrscotland** |  (2015) 81.2 South Lanarkshire Average |  (2014/16)77.2 | Reduce the Gap towards South Lanarkshire Figure (78.1) | Reduce the Gap towards South Lanarkshire Figure (79.1) | Reduce the Gap towards South Lanarkshire Figure (81.2) |
| **Increase** the life expectancy levels in the 15% most deprived areas of South Lanarkshire to be comparable with South Lanarkshire Average (Male)**Source: nrscotland** |  (2015) 77.7 South Lanarkshire Average |  (2014/16)71.9 | Reduce the Gap towards South Lanarkshire Figure (71.6) | Reduce the Gap towards South Lanarkshire Figure (72.1) | Reduce the Gap towards South Lanarkshire Figure (77.7) |
| **Reduce** the rate of pregnant mothers in the 15% most deprived areas who smoke during their pregnancy**Source: scotpho** |  (2014) 16.5% South Lanarkshire Average |  (2015)28.0%  | Reduce the Gap by 1% towards South Lanarkshire Figure  | Reduce the Gap by 1% towards South Lanarkshire Figure  | Close Gap to South Lanarkshire Average (12%) |
| **Monitor** the percentage of people who have 2 to 4 long term conditions**Source: NEXUS** |  (2016/17)35.7%South Lanarkshire Average36.9%Scottish Average |  (2016/17)35.7  | Maintain below the Scottish Average (36.9%) | Maintain below the Scottish Average  | Maintain below the Scottish Average  |

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| **We will measure progress towards this priority outcome with reference to the following indicators and targets** |
| **Indicator(s) and Source** | **Baseline** | **Latest figures reported** | **Short Term Target (1 year)** | **Medium Term Target (3yr)** | **Long Term Target****(10yr)** |
| **Reduce** the proportion of the population being prescribed drugs for anxiety, depression or psychosis**Source: NEXUS**  | (2016/17)21.4% South Lanarkshire Average18.5% Scottish Average  |  (2016/17)21.4%  | Reduce by 0.5% | Reduce by 0.5% | Reduce to Scottish Average  |
| **Maintain** the percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery**Source: SW Resource Plan** |  (2016/17)100% |  (2017/18)94.2% | Maintain | Maintain | Maintain |
| **Maintain** the number of those newly diagnosed with Dementia who will have a minimum of one year’s post diagnostic support**Source: South HSCP CE Quarterly Report** |  (March 2017)441  |  (2017/18)535 | Maintain | Maintain | Maintain |
| **Maintain** percentage of adults able to look after their health very well or quite well**Source: Core Indicators** |  (2015/16) 94% South Lanarkshire Average94% Scottish Average |  (2015/16)94%  | Maintain at Baseline (Scottish Average) | Maintain at Baseline (Scottish Average) | Maintain at Baseline (Scottish Average) |

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| **We will take the following actions to achieve the outcome above** |
| **Change Required** | **Action to achieve change (including outcome measures and targets)** | **Timescale** | **Responsibility** | **Poverty focus** |
| Empowering communities to improve their own health and wellbeing | Through locality planning, work with communities to develop solution focused interventions which are sustainable and owned by communities | 2017/18 Onwards | Nurse Director | 1, 5 |
| Grow capacity in the Third Sector to ensure that people are supported to improve their health and wellbeing | 2018/19 | Head of Health Promotion and Chief Executive of VASLan | 1, 5 |
| Develop the necessary locality planning arrangements to support better integrated working across Health and Social Care Services and other partners in localities | 2017/18 Onwards | Heads of Health and Social Care | 1, 5 |
| Develop a population based Mental Health Improvement Action Plan for South Lanarkshire in line with the new Mental Health Strategy | 2018/19 | Nurse Director | 1, 5 |
| Shifting the focus from reactive interventions to early intervention and prevention programmes | Support the expansion of the Get Walking Lanarkshire Programme | 2018/19 | Head of Health Promotion | 5 |
| Support the ambitions of the Greenspace Partnership | 2018/19 | Head of Health Promotion | 5 |
| Review the scope of and uptake of preventative health and wellbeing services by deprived communities and vulnerable groups for example Weigh to Go; Stop Smoking; health screening etc | 2018/19 | Head of Health Promotion | 5 |
| Develop an anticipatory care programme to provide health checks for vulnerable people | 2018/19 | Head of Health Promotion | 5 |
| Pilot the Primary Care Physical Activity Prescription Intervention and subject to evaluation, extend the coverage of this across localities | 2018/19 | Head of Health Promotion/ SLLC | 5 |
| Improved financial wellbeing of low income families and vulnerable service users | Deliver a programme of activity to mitigate against the negative health consequences of financial insecurity due to poverty and welfare reform | 2018/19 | Head of Health Promotion | 1, 5 |
| Develop and deliver the scaling up of existing financial wellbeing partnership activity. Will require consideration of target groups; resources; delivery partners | 2018/19 | Head of Health Promotion | 1, 5 |
| Develop and deliver associated training/awareness raising activity to embed consideration of financial wellbeing in Health and Care Services | 2018/19 | Head of Health Promotion | 1, 5 |
| More people are able to look after and improve their own health and wellbeing through self-care and self-management  | Identify associated improvement actions, including consideration of how community facilities and integrated approaches can be used to improve accessibility and uptake | 2018/19 | Head of Health Promotion | 5 |
| Develop Telehealth and Telecare approaches and community awareness and take up of these in the most deprived areas and across vulnerable groups | 2018/19 | Head of Health and Social Care | 5 |
| Continue to deliver evidence based, robust partnership health intervention initiatives in line with the population need, ensuring access for all | 2018/19 | Head of Health Promotion | 5 |
| Better coordinated and seamless services for people affected by substance misuse | Implement a fully integrated model of substance misuse based on a single system management and operational delivery | 2018/19 | Head of Children and Justice | 5 |

1. **Family focused inclusion strategy 5 Tackling health inequalities**
2. **Supporting employment/childcare 6 Supporting safeguarding measures**
3. **Improving housing quality 7 Improving local environment**
4. **Supporting education, skills, development – young people**

**PIP – Health and Care**

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| **Priority Outcome 2: Shifting the balance of care from hospital and residential settings to community based alternatives** |
| **Rationale:** Whilst there will always be a requirement for bed based forms of care provided away from a person’s home, one of the national priorities is to shift the balance of care to provide more care in the community and within people’s homes. This very much underpins what users and carers of services have told us is their preference. In addition to this, the resources associated with bed based care is significant and does not always support the person to achieve their desired outcomes. Developing and extending the range of options that people can access in terms of how they are supported will be a key aspect of the transformational change required, with the aim being to bring about a sustainable model of care for the future. Our strategic needs assessment data provides context for this.**Context:****Accident and Emergency Demand**In 2014/15, Accident and Emergency attendances for the South Lanarkshire Health and Social Care Partnership were 323.3 per 1,000 population, which is significantly higher than the national average of 278.6 per 1,000 population. From a locality perspective, there are also challenges for the Partnership, in that there is significant variation across the four localities as highlighted by the following equivalent information:

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| **Locality** | **A&E Attendances per 1,000 population 2014/15** |
| Clydesdale | 245.0 |
| Rutherglen/Cambuslang | 397.1 |
| Hamilton/Blantyre | 318.6 |
| East Kilbride | 333.6 |

It is important to understand the relationship between A&E activity and emergency admissions, given that the A&E Department represents the hospital front door. From a conversion perspective, the SLHSCP is also higher than the Scottish average, with 27.6% of A&E attendances resulting in a hospital admission compared with a Scottish average of 26.7% for 2014/15. Forecasts for A&E attendances project an overall increase of 14% for the 65+ population and 32% for the 85+ population over 2014/15 to 2020/21.**Emergency Admissions** Similar trend information for emergency admissions is observed in a SLHSCP context. In 2014/15, a rate of 109.1 per 1,000 population was reported, compared with a Scottish average of 104.4. The variation across localities is less pronounced, with all localities (except Clydesdale) being above the Scottish average as follows:

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| **Locality** | **Emergency Admission per 1,000 population 2014/15** |
| Clydesdale | 100.9 |
| Rutherglen/Cambuslang | 106.3 |
| Hamilton/Blantyre | 114 |
| East Kilbride | 110.8 |

 It is not only the current position which places a demand on services, if everything remains equal and demographic growth continues in line with the projected increases, then our own forecasts for emergency admissions are projected to increase by 19% for the 65+ population and 39% for the 85+ population over the period 2014/15 to 2020/21.**Discharge Planning Demand**The knock on effect of the above is the correlation between emergency admissions and discharge planning. The SLHSCP can discharge anywhere between 200-250 people per month from hospital with an associated care package. Referrals to the Hospital HUB for supported discharge are on average 83 per week or 372 per month. However, within this, there are people who can be delayed in hospital whilst awaiting a care package. Increased admissions on a week by week basis will more often than not result in increased requests for health and social care community supports, for example home care and residential care. Again our needs assessment data indicates that demand in this area is growing and we also know that the average hospital home care package is on average 2.5 hours more than the equivalent community based package. Therefore, shifting the balance of care is a better option in managing resources.**Residential and Nursing Care**Current demand for residential and nursing care has resulted in the Partnership having to fund an additional 5 new places over and above the existing 50 new places allocated per month. In terms of the current placements, there are at any time, approximately 2,200 people in residential and nursing care. **Drivers:** Demand on services and national policy remain the key drivers. The Health and Social Care Delivery Plan objectives for 2016 includes focus on reducing accident and emergency attendances, emergency admissions, unscheduled bed days, delayed discharges, end of life care, balance of spend across hospital/residential and community. In addition to this, the Integration Joint Board (IJB) issued 6 additional directions to South Lanarkshire Council and Lanarkshire NHS Board focusing on care at home, reviewing and redesigning existing care pathways in the community, locality planning, Primary Care Transformation, the Emergency Care Pathway and Local Outcome Improvement Plans. |

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| **We will measure progress towards this priority outcome with reference to the following indicators and targets** |
| **Indicator(s) and Source** | **Baseline** | **Latest figures reported** | **Short Term Target (1 year)** | **Medium Term Target (3yr)** | **Long Term Target****(10yr)** |
| **Reduce** Accident and Emergency Department attendances per 1,000 population (65+)**Source: ISD List Team** |  (2016/17)418.1 South Lanarkshire Average319.0 Scottish Average |  (2017/18)278 per 1,000 | Maintain | Reduce | Achieve Scottish Average |
| **Reduce** conversion of Accident and Emergency attendances to admissions **Source: ISD List Team** |  (2016/17) 28% South Lanarkshire Average25% Scottish Average |  (2017/18)29%  | Reduce by 1% | Achieve Scottish Average  | Maintain Scottish Average |
| **Reduce** the Emergency Admission rate per 100,000 population **Source: Core Indicators** |  (2016/17) 13,867 South Lanarkshire Average12,265Scottish Average |  (2017/18)12,430 | Maintain | Reduce | Achieve Scottish Average |

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| **Reduce** the number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (75+)**Source: Core Indicators** |  (2016/17)1,341 South Lanarkshire Average842 Scottish Average |  (2017/18)1,246 | Reduce | Reduce | Achieve Scottish Average |
| **Maintain** the percentage of people who spend their last 6 months in a community setting **Source: Core Indicators** |  (2016/17)87% South Lanarkshire Average87%Scottish Average |  (2017/18)87%  | Maintain in line with Scottish Average  | Maintain in linewith ScottishAverage  | Maintain in line with Scottish Average |
| **Reduce** number of people in residential care as a percentage of the overall adult population**Source: IMPROVe** |  (Jan 2018)3.8%  |  (March 2018)3.3%  | Reduce to 3.6% | Reduce to 3.3% | Reduce to 3% |
| **Increase** the number of people successfully completing a reablement episode **Source: IMPROVe** |  (2016/17)1,425  |  (2017/18)1,456 | Maintain | Increase | Increase |

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| **We will take the following actions to achieve the outcome above** |
| **Change Required** | **Action to achieve change** **(including outcome measures and targets)** | **Timescale** | **Responsibility** | **Poverty focus** |
| Reduce dependency on acute hospital beds to support transition to community based alternatives | Dedicate the use of up to 8 beds within Stonehouse Hospital to support cases where delays result from Adults with Incapacity Guardianship Orders (AWI) being progressed  | 2017/18  | Director of Acute Services and Head of Commissioning and Performance | 5 |
| Through bed modelling, consider the future use of all hospital beds and potential alternatives to these. In the Hairmyres catchment area, this would initially concentrate on the in-scope beds | 2017/18 | Director of Acute Services and Head of Commissioning and Performance | 5 |
| Reducing demand at Hospital Front Door | Introduce re-direction policies with an associated public campaign focused on reducing the number of unnecessary A&E attendances and the alternatives to this | Commencing from October 2017 | Director of Acute Services/Director of Health and Social Care/Communications Manager | 5 |
| Discharge Planning | Reduce the number of referrals for social care assistance to support discharge from hospital to be more in keeping with the national average | 2017/18 | Director of Acute Services | 5 |
| Review the current Discharge HUB arrangements and consider other delivery options, for example locality based models | 2017/18 | Heads of Health and Social Care | 5 |
| Implement Discharge to Assess Model across the South Lanarkshire Partnership | 2017/18 | Heads of Health and Social Care | 5 |
| Build Anticipatory Care Planning into the Core Assessment process to strengthen outcomes based planning | 2017/18 | Heads of Health and Social Care | 5 |
| Introduce Estimated Date of Discharge across all ward areas | 2017/18 | Director of Acute Services | 5 |
| Increase market capacity and options for home care provision arising from new contractual arrangements | 2017/18 | Heads of Health and Social Care andHead of Commissioning and Performance | 5 |
| Undertake evaluation of the 22 Local Authority Intermediate Care Beds and agree next steps following this evaluation | 2017/18 | Head of Commissioning and Performance | 5 |
| Avoiding unnecessary hospital admissions | As part of reviewing existing pathways and models of care, consider the development of increased locality based provision of previously hospital based services - including extended Hospital at Home/Integrated Community Support Team (ICST)/Advanced Nurse Practitioners (ANPs) | 2017/18 | Heads of Health and Social Careand Director of Acute Services | 5 |
| Undertake targeted work to better understand how we manage potentially preventable admissions (PPAs) | 2017/18 | Head of Commissioning and Performance | 5 |
| More people are able to look after and improve their own health and wellbeing and maximise their independence | Work with VASLan to support the continued development of the locator tool to provide alternatives to traditional forms of care and support | 2017/18 | Head of Commissioning and Performance and Chief Executive, VASLan | 5 |
| Support people to maximise their independence through the delivery of a reablement approach across all localities | 2017/18 | Heads of Health and Social Care | 5 |
| Continue to deliver the Care at Home Medicines Management Project to include all care at home providers across the four localities | 2017/18 | Heads of Health and Social Care | 5 |
| We will develop Telehealth and Telecare approaches in partnership with housing which will support people to live safely and independently in their own homes | 2017/18 | Heads of Health and Social Care | 5 |
| Monitor the Self Directed Support options that service users and carers are selecting as part of directing their own health and care | 2017/18 | Head of Commissioning and Performance | 5 |

1. **Family focused inclusion strategy 5 Tackling health inequalities**
2. **Supporting employment/childcare 6 Supporting safeguarding measures**
3. **Improving housing quality 7 Improving local environment**
4. **Supporting education, skills, development – young people**

**PIP – Health and Care**

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| **Priority Outcome 3: Carers and in particular those on low incomes are fully supported to access financial advice, information and practical wellbeing support** |
| **Rationale:** In South Lanarkshire and across Scotland, carers provide a significant input to looking after their family members and friends. Without carers, the demands on an already pressurised health and social care system would increase dramatically, to the extent that existing resources would in no way meet these demands. Therefore, it is of paramount importance that the contribution of carers is not only recognised, but is valued and supported. Consequently, as a Partnership, we need to work with carers to ensure that the support we offer them enables them to continue in their caring role and that whatever we do has a long term impact and is sustainable. **Context:** It is estimated that across Scotland, 12% of the population provide care on a regular basis to family members and friends. However, it is often debated that this figure could be significantly understating the actual numbers, given that many people who provide care to family members and friends do not regard themselves as a carer. In a local context, South Lanarkshire has the following characteristics in relation to the carers profile:* 14% of adults or 28,335 people provide care on a regular basis
* Of these 38% provide this continuously
* 51% of carers are aged 60+ indicating that similar to a rising older person’s population, the profile of carers is also one of an ageing profile
* Very few carers have formal emergency plans, in circumstances where they may become unwell and cannot continue their caring role. Most rely on other family members and friends or indeed Social Care Services
* Carers repeatedly highlight the main issues for them as being the financial impact of caring, short breaks and the requirement of support to help them maintain their own health and wellbeing
* As at the last Health and Social Care Experience Survey in 2015/16, 42% of carers felt supported in their caring role. This figure was a drop in the previous reported figure of 47% in 2013/14.

**Drivers:** Carers (Scotland) Act 2016 and national and local recognition of the value and partnership that we have with carers. Increased statutory duties and requirement to produce a Carers Strategy for the Partnership. |

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| **We will measure progress towards this priority outcome with reference to the following indicators and targets** |
| **Indicator(s) and Source** | **Baseline** | **Latest figures reported** | **Short Term Target (1 year)** | **Medium Term Target (3yr)** | **Long Term Target****(10yr)** |
| **Increase** the number of new carers identified and supported each year through the Third Sector**Source: Carers Report** | (2017)2,845  |  (2018)3,460 | Maintain | Increase | Increase |
| Monitor the number of people providing 20 to 49 hours of care per week**Source: NRS (Nexus)** |  (2011)5,785  |  (2011)5,785  | Monitor for Contextual Purposes | Monitor for Contextual Purposes | Monitor for Contextual Purposes |
| Monitor the number of people providing 50+ hours of care per week**Source: NRS (Nexus)** |  (2011)9,030  |  (2011)9,030  | Monitor for Contextual Purposes | Monitor for Contextual Purposes | Monitor for Contextual Purposes |
| **Maintain** the percentage of carers who feel supported to continue in their caring role**Source: SG Core Indicators** |  (2015/16)42%South Lanarkshire Average41% Scottish Average  |  (2015/16)42%  | Maintain at Scottish Average  | Maintain above Scottish Average | Maintain above Scottish Average |
| Monitor the number of new carers supported by dedicated Welfare Rights Officers **Source: Social Work Resource Plan** |  (2016/17)1,010  |  (2017/18)963 | Monitor for Contextual Purposes | Monitor for Contextual Purposes | Monitor for Contextual Purposes |

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| **We will take the following actions to achieve the outcome above** |
| **Change Required** | **Action to achieve change (including outcome measures and targets)** | **Timescale** | **Responsibility** | **Poverty focus** |
| Reform support to carers in line with the requirements of the Carers Act (2016) | Implement the duties contained within the Carers Act (2016), with particular regard to carer eligibility, short breaks and the Carer Enablement Plans | 2018 | Head of Commissioning and Performance | 1, 5 |
| Participate as national pilot site to develop a new Strategy for Carers 2018-21 utilising £10k national funding | 2018/19 | Head of Commissioning and Performance | 1, 5 |
| Utilise South Lanarkshire Partnership share of Scottish Government £2m allocation to strengthen carers support across the four localities | 2017/18 | Head of Commissioning and Performance | 1, 5 |
| As part of the Carer Enablement Plans, develop a suite of indicators which measures carers health and wellbeing  | 2018/19 | Head of Commissioning and Performance | 1, 5 |
| Improve support for carers with regards to financial wellbeing and ensure systems are in place to identify those carers who require financial support | Provide dedicated financial wellbeing support to carers | Ongoing | Head of Commissioning and Performance | 1, 5 |

1. **Family focused inclusion strategy 5 Tackling health inequalities**
2. **Supporting employment/childcare 6 Supporting safeguarding measures**
3. **Improving housing quality 7 Improving local environment**
4. **Supporting education, skills, development – young people**