South Lanarkshire
Partnership
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Progress Report

Health and Social Care Partnership PIP

Quarter 4 - 2018-19

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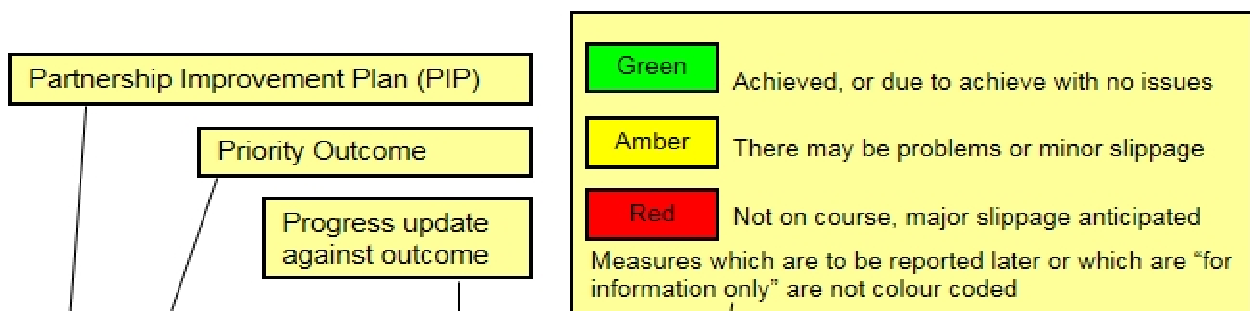
How to use this performance report

This performance report is intended to be both informative and easy to use. The guide below is designed to help you get the most out of the report and to answer the most common questions you might have.

Measure Status – are we on course to achieve?
The "traffic light" codes are:



Community Planning Partnership - Partnership Improvement Plans Health and Social Care Partnership PIP

Priority Outcome 2: Shifting the balance of care from hospital and residential settings to community based alternatives

Change Required	Indicator / Action	Comments	Status	Baseline	LATEST Data	LATEST Period	TARGETS Short (1 yr)	TARGETS Med (3 yr)	TARGETS Long (10 yr)
	Monitor the Self Directed Support options that service users and carers are selecting as part of directing their own health and care	Self-directed Support comprises of four funding options. At 31 March 2018, 380 people were in receipt of Option 1 (Direct Payment). This compares to 357 in the previous quarter. There were 64 service-users using Option 2 (an Individual Service Fund) compared to 55 in the previous quarter. Option 3 relates to council arranged services and Option 4 allows for a mixture of funding options. Option 3 remains the preferred option for service users in South Lanarkshire and reflects the national position.	Green						

Priority Outcome 3: Carers and in particular those on low incomes are fully supported to access financial advice, information and practical wellbeing support

Change Required	Indicator / Action	Comments	Status	Baseline	LATEST Data	LATEST Period	TARGETS Short (1 yr)	TARGETS Med (3 yr)	TARGETS Long (10 yr)
Outcome Indicators	Increase the number of new carers identified and supported each year through the Third Sector	In 2018 the number of new carers identified has increased to 3,460. There has been a significant increase in the Hamilton/Blantyre area, this could be attributed to outreac[h] collaborative activities and presentations within the localit[y] resulting in new carers accessing our services. Overall there is a 17% increase compared to 2017 figures. Each Quarter Lanarkshire Carers Centre provide a detailed service profile report capturing new carers, carers no longer requiring support, and overall numbers of carers on their carers register.	Green	2017 2,845	3,460	2018	Maintain	Increase	Increase
	Monitor the number of people providing 20 to 49 hours of care per week	There were 5,785 people providing 20 to 49 hours of care per week. As we know this figure could be significantly higher as people who provide care to family members and friends do not always regard themselves as carers.	Contextual	2011 5,785	5,785	2011	Monitor for Contextual Purposes	Monitor for Contextual Purposes	Monitor for Contextual Purposes
	Monitor the number of people providing 50+ hours of care per week	There were 9,030 people providing 50+ hours of care per week. As we know this figure could be significantly higher as people who provide care to family members and friends do not always regard themselves as carers.	Contextual	2011 9,030	9,030	2011	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	At March 2016, 42% of Carers felt they were supported to continue in their caring role. South Lanarkshire is sitting above the Scottish Average of 41%.	Green	2015-16 42% South Lanarkshire Average 41% Scottish Average	42%	2015 -2016	Maintain at Scottish Average	Maintain above Scottish Average	Maintain above Scottish Average
	Monitor the number of new carers supported by dedicated Welfare Rights Officers	Even though for 2017-18 we have shown a slight decrease (4.65%) on the baseline figure for 2016-2017, we have increased significantly the amount of backdated benefits claimed from £191,800 (2016-17) to £208,581 (2017-18). This is a very positive outcome for the Carers who have been represented.	Contextual	2016-17 1,010	963	2017 -2018	Monitor for Contextual Purposes	Monitor for Contextual Purposes	Monitor for Contextual Purposes

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Summary - number of measures green, amber, red, contextual and to be reported later under each Priority

Priority Outcome	Status					Total
	Green	Amber	Red	Contextual	To be reported later	
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	8	0	0	0	0	8
Priority Outcome 2: Shifting the balance of care from hospital and residential settings to community based alternatives	4	0	0	0	3	7
Priority Outcome 3: Carers and in particular those on low incomes are fully supported to access financial advice, information and practical wellbeing support	4	0	1	0	0	5
Total	**16**	**0**	**1**	**0**	**3**	**20**

Summary - number of interventions green, amber, red and to be reported later under each Priority

Priority Interventions	Status				Total
	Green	Amber	Red	To be Reported Later	
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	16	0	0	0	16
Priority Outcome 2: Shifting the balance of care from hospital and residential settings to community based alternatives	17	0	0	0	17
Priority Outcome 3: Carers and in particular those on low incomes are fully supported to access financial advice, information and practical wellbeing support	5	0	0	0	5
Total	**38**	**0**	**0**	**0**	**38**

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

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
Outcome Indicators	Increase the life expectancy levels in the 15% most deprived areas of South Lanarkshire to be comparable with South Lanarkshire Average (Female)	Life expectancy figures have decreased to 77.2% in the 15% most deprived areas of South Lanarkshire. This is in keeping with South Lanarkshire as a whole and the Scottish Average, as recently life expectancy figures have decreased for the first time ever to 80.7% for females, which slightly reduces the gap.	Green	2015 81.2 South Lanarkshire Average	77.2	2014 -2016	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)	Life expectancy figures have increased to 71.9% in the 15% most deprived areas of South Lanarkshire. This means that the gap is reducing, as South Lanarkshire life expectancy for males as a whole have decreased for the first time since 2002-2004 to 76.8%, which slightly reduces the gap.	Green	2015 77.7 South Lanarkshire Average	71.9	2014 -2016	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	In 2017-18 the rate of pregnant mother who smoke in the 15% most deprived areas was 27.4%. This is a slight decrease on the previous year's figure of 28%. The trend shows that we are continuing to reduce the gap on pregnant mothers who smoke in the most deprived areas.	Green	2014 16.5% South Lanarkshire Average	28.0%	2016-17	Reduce the Gap by 1% towards South Lanarkshire Figure	Close the Gap to South Lanarkshire Average (12%)
	Monitor the percentage of people who have 2 to 4 long term conditions	35.7% of the South Lanarkshire population had 2 to 4 long term conditions in 2016-17. As part of the Health and Social Care agenda we need to improve our population's health and reduce local health inequalities to reduce demand on our services. Some of the highest long term conditions in South Lanarkshire include anxiety/depression, COPD/asthma, hypertension, chronic pain and Gastro-Oesophageal Reflux. We are working with communities, partners and staff to deliver initiatives that prevent ill health to enable people to support and care for themselves.	Green	2016-17 35.7% South Lanarkshire Average 36.9% Scottish Average	35.7%	2016-17	Maintain below the Scottish Average	Maintain below the Scottish Average
	Reduce the proportion of the population being prescribed drugs for anxiety, depression or psychosis	The latest figures we have for this are for 2016-17, where 21.4% of the population within South Lanarkshire were prescribed drugs for anxiety, depression or psychosis. The Physical Activity Programme has been successfully rolled out to all four localities as an alternative to medicine. Referral reasons to this programme include, Mental Health, Obesity, Musculoskeletal and general fitness.	Green	2016-17 21.4% South Lanarkshire Average 18.5% Scottish Average	21.4%	2016 -2017	Reduce by 0.5%	Reduce to Scottish Average

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

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Maintain the percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	There were 571 referrals for drug/alcohol treatment in 2018-19 across South Lanarkshire. Only 93% of these referrals started treatment within 3 weeks of the referral. There has been recent changes in the structure of substance misuse teams and new systems working which may have impacted on performance. This will be monitored by senior managers. The national target which the South Lanarkshire Alcohol and Drug Partnership (ADP) are required to report quarterly to the Scottish Government is that 90% of referrals to alcohol and drug service are seen within three weeks of referral.	Green	2016-17 90%	93.0%	2018-19	Maintain	Maintain
	Maintain the number of those newly diagnosed with Dementia who will have a minimum of one year's post diagnostic support	In 2018-19 577 people with a new diagnosis of dementia were offered one year's post diagnostic support. This compares with 535 people in 2017-18 and importantly shows a commitment to meeting growing demand in this area of service delivery.	Green	March 2017 441	577	2018-19	Maintain	Maintain
	Maintain percentage of adults able to look after their health very well or quite well	In 2017-18, 92% of adults were able to look after their health very well or quite well. This is slightly lower than 2016-17, however, the Scottish Average has also dipped to 93%.	Green	2015-16 94% South Lanarkshire Average 94% Scottish Average	92.0%	2017-18	Maintain at Baseline (Scottish Average)	Maintain at Baseline (Scottish Average)
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	Draft locality plans are in the process of being finalised for all four localities. The plans focus on two key aspects 1. the delivery of South Lanarkshire wide priorities detailed in the Strategic Commissioning Plan; and 2. addressing issues unique to the locality as identified through the consultation process with local communities.	Green	---	---	---	---	---
	Grow capacity in the Third Sector to ensure that people are supported to improve their health and wellbeing	Through the ongoing delivery and development of the Integrated Care Fund, funded provision National Health and Wellbeing Outcomes (NHWO) 1,2,5 and 6 are being assessed with 95% of the funded project contributing toward NHWO 1 which is based on how people are able to look after and improve their own health and wellbeing. Project monitoring is being reported through a contribution analysis approach based on a matrix of activities and indicators.	Green	---	---	---	---	---

Priority Outcome 1: Individuals families and communities are empowered to take preventative action to support positive health and wellbeing wit a focus on communities and groups whose health outcomes are poorest

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Develop the necessary locality planning arrangements to support better integrated working across Health and Social Care Services and other partners in localities	Locality planning and governance arrangements continue to be developed. At present all localities have a core management team led by the integrated Health and Social Care Manager and the more formalised Locality Planning Group comprising of all local partners and chaired by an Integration Joint Board voting member. Further work is being done to look at the next steps with regards to the relationship between localities and what is centrally directed.	Green	---	---	---	---	---
	Develop a population based Mental Health Improvement Action Plan for South Lanarkshire in line with the new Mental Health Strategy	A new Lanarkshire wide Mental Health Strategy is currently in the process of being developed by a wide range of stakeholders including members of the public. The first iteration of this plan was presented to the South Lanarkshire Integration Joint Board (IJB) in April 2019 with a view to bringing the final strategy to the June IJB for sign off. Following this, an Implementation Plan will support the delivery of a number of actions to improve the mental health and wellbeing of communities and individuals within South Lanarkshire.	Green	---	---	---	---	---
Shifting the focus from reactive interventions to early intervention and prevention programmes	Support the expansion of the Get Walking Lanarkshire Programme	The Get Walking Lanarkshire is a pan Lan programme, and the figures below are for South Lanarkshire (SL) only: Get Walking Lanarkshire now offers 19 community walks and 7 closed walks for specific target groups. The walks are led by 71 (mainly volunteer) walk leaders. In the past year (January–December 2018) the project attracted 262 (whole of Lanarkshire) new walkers; 31 new walk leaders were trained; 6 new walks were set up; and the walks attracted 7,996 walkers cumulatively. The project continues to support Dementia Friendly and Macmillan Friendly walks. The first dedicated wheelchair and mobility scooter friendly health walk was set up in partnership with Older and Active in East Kilbride. In addition a Big Fit Walk was organised to raise awareness among people with long term health conditions about the benefits of gentle walking. Partnership work with the Green Health Partnership led to 1 mile walking routes being mapped from 6 SL leisure centres to be used as part of Weigh to Go classes.	Green	---	---	---	---	---

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

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Support the ambitions of the Greenspace Partnership	The Green Health Partnership has identified over 150 outdoor opportunities in South Lanarkshire such as community gardening, volunteering, walking and are now available on a number of promotional platforms such as the Greenspace portal, Locator, Scotland's Service Directory and Well Connected. Usage of the greenspace portal has tripled with 304 new users accessing the site in January 2019 in comparison to 100 in January 2018. More than 30 green health volunteering opportunities have now been registered with VASLan. 3 existing referral pathways (South Lanarkshire Leisure physical activity prescription, Well Connected and Weigh to Go) have been enhanced with the introduction of green health activities as a formal option. 4 community hospital gardening sessions are available in Kirklands, Douglas, Cleland, Coathill hospitals; 76 patients and volunteers have engaged with sessions from February to December 2018. Over 200 Health and Social Care staff in South Lanarkshire have received a presentation and information on the Green Health Partnership and opportunities to connect people with nature in their communities. East Kilbride Hunter Health and Community Centre is a good example of involving volunteer Wayfinders to signpost people to community health walks and other outdoor opportunities. A current analysis of SIMD 1 and 2 areas and poor quality greenspace has identified improvement work required for Strutherhill and Fairhill areas.	Green	---	---	---	---	---
	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	There is continuous monitoring and review of the uptake and reach in the deprived areas to ensure that uptake of programmes is at an acceptable level. All of the programmes such as Weigh to Go and the Physical Activity Prescription Programme monitor SIMD data zone, the outcomes for the participants and regularly consider new recruitment and retention approaches. Through the work in the Neighbourhood Planning areas we are again reviewing and developing approaches and supports that will engage people in the deprived areas in the services, with proposals in place to consider new and different services and more local venues for some programmes. The Keep Well Anticipatory Health Screenings are targeted at very specific groups such as the homeless, carers, people involved with the justice system and Gypsy Travellers.	Green	---	---	---	---	---

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

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Develop an anticipatory care programme to provide health checks for vulnerable people	Keep Well continues to identify our most vulnerable populations who face inequalities in health because of their lifestyle, culture or disabilities. The populations include homeless, Gypsy Travellers, offenders, those misusing substances, people from black minority ethnic (BME) populations as well as carers and people from the deaf and deaf blind community. We offer a holistic health check that focuses on reducing cardio-vascular risk and provide lifestyle advice to support the individual to improve their health and well-being. Many of our most vulnerable clients require to be case managed by our nurses who support the client to access and engage with mainstream services. We also provide Health and Well-being Workshops for offenders and some of our BME groups. 396 people had a health check where 27% were found to have a clinical risk that required a referral to their GP Practice for further investigation. 425 referrals were made to services that support health behaviour change. 176 were required to be case managed due to their complexity. In addition we carried out an improvement project to measure health and well-being outcomes for carers who were supported through case management. 100% of carers reported an improvement on discharge from the programme.	Green	---	---	---	---	---
	Pilot the Primary Care Physical Activity Prescription Intervention and subject to evaluation, extend the coverage of this across localities	Coverage of the Primary Care Physical Activity Prescription Intervention has now been rolled out across all 4 localities of South Lanarkshire. There is an evaluation underway and details of this will be available when complete.	Green	---	---	---	---	---

Priority Outcome 1: Individuals families and communities are empowered to take preventative action to support positive health and wellbeing wit a focus on communities and groups whose health outcomes are poorest

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
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	A Financial Inclusion Plan is in place and actions have been delivered on time and within budget. The plan responds to the national NHS Welfare Reform Outcomes Focussed Plan (March 2018). This includes action on staff and public awareness raising and communication activity, pathways into welfare advice from health settings and partnership activity in support of the multi-agency financial inclusion work locally. Progress on the plan is reported to a number of sources including South Lanarkshire Community Planning Partnership, South Lanarkshire Strategic Commissioning Plan, Community Plan and the national Welfare Reform Health and Employability Group. Six welfare advice hubs within community health settings were delivered by Hamilton and Rutherglen CABs in Hamilton, Blantyre, Larkhall, Carluke, Douglas and Rutherglen. In Rutherglen from Q1 to mid-March Q4, 105 people were supported and 252 enquiries were received. This led to a collective financial gain in this period of £158,815. In the remaining sites, Advice Services delivered by Hamilton CAB during this period supported 345 people with 1562 different issues. 83% of issues were social security related; 4% housing and 4% debt; 3% financial and charity support with 2/3 of these food bank referrals. A gain of £647,800 of financial inclusion was achieved. Of the people given advice, 259 out of 345 people state they have a disability; 205 unable to work due to ill-health/disability; 206 describe their disability as limiting daily life 'a lot'.	Green	---	---	---	---	---

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

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Develop and deliver the scaling up of existing financial wellbeing partnership activity. Will require consideration of target groups; resources; delivery partners	The financial well-being improvement work has now been scaled up across South Lanarkshire Health Visiting (HV) Teams and combined with Midwifery Services. A routine enquiry approach has been adopted by HV and Midwives to raise the issue of money worries with clients at all assessment contact points in Health Visiting and at 2 key contact points in Maternity Services. A reporting system is being developed to record routine enquiry contacts to allow the system process to be tracked. In the reporting period April 2018-February 2019 there were 845 referrals from Midwives and HV to the Telephone Advice Lines, a 37% increase from the previous year, with 79% of families engaging with the service. Highlights of note have been the participation of Money Matters Advice Services in the national campaign videos on the NHS Education Scotland website and the project reaching the finals of the Quality Improvement Awards. Overall there has been an identified financial outcome gain of £95,995.00 in a sample of 20 families. In April 2018-January 2019 the target groups reach demonstrates 14.6% of referrals where the parent has a disability, 8.7% where the child had a disability 43.5% Loan parents, 5.2% 3 or more children, 22% children under one 22% and 22.9% where parents were under 25.	Green	---	---	---	---	---
	Develop and deliver associated training/awareness raising activity to embed consideration of financial wellbeing in Health and Care Services	As a response to gaps identified through our partnership continuous improvement process, a learning set was developed with Money Matters Advice Service, the Tackling Poverty Team, Health Visiting and Health Improvement who co-delivered child poverty and financial wellbeing sessions to all ten Health Visiting Teams (122 participants) and three quarters of the locality Social Work Teams. The process of revising a communication plan for financial inclusion is underway and a stakeholder planning session was held to inform this plan. Use of the Money Worries App is promoted to staff through communication activity and campaigns such as Stick Your Labels and Challenge Poverty Week.	Green	---	---	---	---	---
More people are able to look after and improve their own health and wellbeing through self-care and	Identify associated improvement actions, including consideration of how community facilities and integrated approaches can be used to improve accessibility and uptake	We now have colocation of South Lanarkshire Leisure and Culture staff within the Hunter Health Centre and Lockart Hospital which is providing accessibility to health intervention pathways.	Green	---	---	---	---	---

Priority Outcome 1: Individuals families and communities are empowered to take preventative action to support positive health and wellbeing wit a focus on communities and groups whose health outcomes are poorest

Change Required	Indicator / Action	Comments	Status	Baseline	LATEST Data	LATEST Period	TARGETS Med (3 yr)	TARGETS Long (10 yr)
self-management	Develop Telehealth and Telecare approaches and community awareness and take up of these in the most deprived areas and across vulnerable groups	There has been a significant increase in the use of Flo text monitoring (Blood Pressure) in South Lanarkshire. Around 80 GPs have now signed up to this and there has been a particular increase within the rural and deprived areas. From April 2019 this will be scaled up and extended to difficult to reach groups. Video Conferencing (VC) use has been extended to 'Attend Anywhere' for Out of Hours, Integrated Community Support Team (ICST) staff and South Lanarkshire Social Work staff. This has also been set up to help with the redesign of care facilities allowing staff to liaise with service users families who live outwith the UK.	Green	---	---	---	---	---
	Continue to deliver evidence based, robust partnership health intervention initiatives in line with the population need, ensuring access for all	A number of programmes across a range of issues and delivered with a range of partners are in place. The recent publication of the National Public Health priorities for Scotland includes further evidence and guidance on activity and programmes and we have considered our local work against this and will continue to review in light of new information.	Green	---	---	---	---	---
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	There is one integrated team leader in place for each of the four localities in South Lanarkshire. All four team leaders are managing both health and social care staff. A supervision process is in place and this has been signed off by the Social Work Governance Committee. All referrals are being screened by the Team Leader and allocated according to who is best placed within the team to take them forward. A performance management framework has been agreed with the Integrated joint Board and the Alcohol and Drug Partnership. Recent evidence from a client survey would indicate that progress is being made in a number of areas, however further progress is required on ensuring family inclusive practice, recovery plans are available to staff and access to independent advocacy services. A training needs analysis has been completed, training delivered and appraisals completed end of March 2019 for all staff. Public protection elements of the service have also been strengthened, with bespoke training planned on adult and child protection. It has also been agreed to appoint an operational manager for the service to ensure consistency of social work practice. As this is the first service in South Lanarkshire to become integrated there remains a number of HR and IT issues to resolve. One team are now co-located, with plans this year to co-locate another.	Green	---	---	---	---	---

Priority Outcome 2: Shifting the balance of care from hospital and residential settings to community based alternatives

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
Outcome Indicators	Reduce Accident and Emergency Department attendances per 1,000 population (65+)	To be updated as soon as figures are available.	Report Later	2016-17 418.1 South Lanarkshire Average 319.0 Scottish Average	------		Reduce	Achieve Scottish Average
	Reduce conversion of Accident and Emergency attendances to admissions	To be updated as soon as figures are available.	Report Later	2016-17 28% South Lanarkshire Average 25% Scottish Average	------		Achieve Scottish Average	Maintain Scottish Average
	Reduce the Emergency Admission rate per 100,000 population	To be updated as soon as figures are available	Report Later	2016-17 13,867 South Lanarkshire Average 12,265 Scottish Average	------		Reduce	Achieve Scottish Average
	Reduce the number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (75+)	Since 2016-17 performance continues to improve in this area. Discharges for people aged 75+ are 1,042 per 1,000 population in comparison to 1,118 in 2017-18.	Green	2016-17 1,341 South Lanarkshire Average 842 Scottish Average	1,042		Reduce	Achieve Scottish Average
	Maintain the percentage of people who spend their last 6 months in a community setting	89% of people in South Lanarkshire are spending the last six months of life in the community, which shows that people are being cared for at home or closer to home with a planned approach to end of life care resulting in less time in an acute hospital setting. This is consistently in line with the Scottish Average.	Green	2016-17 87% South Lanarkshire Average 87% Scottish Average	89.0%	March 2019	Maintain in line with Scottish Average	Maintain in line with Scottish Average
	Reduce number of people in residential care as a percentage of the overall adult population	At March 2019, 3.2% of the overall adult population were in residential care. This shows that South Lanarkshire Health and Social Care Partnership continue to support choices which are community focused and less reliant on institutional and acute interventions.	Green	Jan 2018 3.8%	3.2%	April 2019	Reduce to 3.3%	Reduce to 3%
	Increase the number of people successfully completing a reablement episode	During the year 2018-19, 1,775 episodes of reablement were successfully completed by South Lanarkshire residents, this is an increase on the previous year of 1,456. This continues to demonstrate that service users are being supported to maximise their independence.	Green	2016-17 1,425	1,775	2018-19	Increase	Increase

Priority Outcome 2: Shifting the balance of care from hospital and residential settings to community based alternatives

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
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	8 beds within Stonehouse Hospital have been dedicated to and are currently being used to support where Adults with Incapacity Guardianship Orders (AWI) are being progressed. This change was implemented last year.	Green	---	---	---	---	---
	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	Work continues to implement shifting the balance of care in line with the aspirations of the Strategic Commissioning Plan. The disinvestment in 30 off-site beds in Udston Hospital and the redesignation of Lockhart Community Hospital are examples of this ambition being realised. In particular, a proportion of the resources attached to these beds have been reinvested in community based supports such as home care and district nursing.	Green	---	---	---	---	---
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	Re-direction at the front door is in place through frailty assessments and redirection. Work has also began within GP practices (1 in East Kilbride and 1 in Rutherglen) to complete frailty assessment and prevent admission / step up. This pilot is called community response team and is working together as a multi disciplinary team (which includes Hospital at Home, Social Work, Home Care and intermediate care beds) working together to prevent admission.	Green	---	---	---	---	---
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	Over the years 2017-18 and 2018-19 the weekly average number of new home care hours requested by the hospital increased by 10% or 55 hours weekly, this figure fluctuates on a week by week basis. This is an improvement on last years figures of 31.5% or 130.56 hours. There is recognition from the Health and Social Care Partnership that further changes in the way we deliver services will need to be progressed as current levels of demand are continuing to increase. This will involve being more ambitious and creative with future models of delivery.	Green	---	---	---	---	---
	Review the current Discharge HUB arrangements and consider other delivery options, for example locality based models	Currently the 'discharge to assess' process is in place in both Wishaw and Hairmyres. This is progressing well and links to intermediate care and supporting your independence have been established. Additional staff from OT within both NHS and SLC are also assisting. The pathway is also being supported using technology enabled care.	Green	---	---	---	---	---

Priority Outcome 2: Shifting the balance of care from hospital and residential settings to community based alternatives

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Implement Discharge to Assess Model across the South Lanarkshire Partnership	A 'Discharge to Assess' process has been put in place in both Wishaw and Hairmyres Hospital , however this process is dependent on home care availability. Currently there is a recruitment drive underway to create capacity for rapid response to support discharge to assess. Pathway for community has been put in place. This is linked to intermediate care/Supporting your Independence. Work around this is currently being progressed with additional staff from OT within both NHS and SLC assisting. The pathway is also being supported using technology enabled care.	Green	---	---	---	---	---
	Build Anticipatory Care Planning into the Core Assessment process to strengthen outcomes based planning	Anticipatory Care Plans (ACPs) are discussed with patients/service users in the context of the overall assessment process. Having an ACP is not mandatory and it is very much at the discretion of the service user/patient. The model followed for this is the nationally approved toolkit and in circumstances where the service user/patient has chosen to have an ACP, this has been a useful communication tool of the person's preferences.	Green	---	---	---	---	---
	Introduce Estimated Date of Discharge across all ward areas	Estimated Date of Discharge (EDD) is now in place across all wards in the three acute hospitals. In Monklands this has formed part of the daily capacity meeting to guide towards ward discharge planning and overall hospital capacity. This further enhancement is now being rolled out to Hairmyres and Wishaw to improve the process within these hospitals. Each of the sites have robust dynamic discharge improvement groups focussing on structured discharge processes that meet with individual patient's needs.	Green	---	---	---	---	---
	Increase market capacity and options for home care provision arising from new contractual arrangements	This has been completed with 22 home care providers now part of contractual arrangements. This has increased choice and flexibility in the market to supplement the resources already provided through the in-house home care service.	Green	---	---	---	---	---
	Undertake evaluation of the 22 Local Authority Intermediate Care Beds and agree next steps following this evaluation	An evaluation of the 22 intermediate care beds was completed in 2017/18. The outcome of this evaluation demonstrated that there was a real value in formalising transitional care beds as a mainline option to support people to return home. In excess of 50% of the 80 people who were part of the evaluation were successfully supported to return home. This learning has formed a key strand of the modernisation activity being progressed by the Partnership in relation to future provision within Council care homes.	Green	---	---	---	---	---

Priority Outcome 2: Shifting the balance of care from hospital and residential settings to community based alternatives

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
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)	Additional monies have been invested on a recurring basis to increase the number of community nursing staff and allied health professionals to create the capacity to further embed the ICST approach across the Health and Social Care Partnership. It is also anticipated that the test of change undertaken in East Kilbride in respect of the IV therapies pathway (enablement, avoiding admission and length of hospital stay) will also be expanded across localities as required.	Green	---	---	---	---	---
	Undertake targeted work to better understand how we manage potentially preventable admissions (PPAs)	The project work at the moment being undertaken is: COPD pathways; Intravenous (IV) therapy pathways; Palliative care end of life; falls prevention; frailty work. The pilot multi disciplinary Community Response Team will assist with potentially preventable admissions.	Green	---	---	---	---	---
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	Work continues around the future development of the 'Locator', a communications group is in place and links to Scotland's Service Directory (at a local level) are in the process of being established. Discussions with Pharmacies are planned to take place with a view to using 'Locator', additional work includes identifying other 'Community Access Points' that would allow 'Locator' to be accessed.	Green	---	---	---	---	---
	Support people to maximise their independence through the delivery of a reablement approach across all localities	Reablement interventions are considered for all home care referrals across the four localities. Successfully completed interventions demonstrate that service users can achieve a level of independence which on average results in them being 30% less dependent on home care services. However, the suitability of a referral for Supporting Your Independence (SYI) can vary due to the nature of the persons need, for example, if there are a higher number of people who are at an end of life stage or require palliative care and would not be suitable for SYI.	Green	---	---	---	---	---

Priority Outcome 2: Shifting the balance of care from hospital and residential settings to community based alternatives

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Continue to deliver the Care at Home Medicines Management Project to include all care at home providers across the four localities	The project has been a success with home care visits being planned around service users daily medication requirements. Further scoping work is now being undertaken to look at the frequency of daily medications and consider alternative medication to reduce the number of doses required each day. There has also been some further work being scoped out within acute sites where community pharmacists are working with ward staff looking at the frequency of doses the patient requires in preparation for their discharge home. This in turn will have an impact on potentially reducing the number of home care visits required for service users in scope and in doing so allow investment of home care hours into other areas.	Green	---	---	---	---	---
	We will develop Telehealth and Telecare approaches in partnership with housing which will support people to live safely and independently in their own homes	We are progressing Assistive Technology within the development of the new care facility in Blantyre. Agreement has been given for telehealth project manager to lead in this development.	Green	---	---	---	---	---
	Monitor the Self Directed Support options that service users and carers are selecting as part of directing their own health and care	During the year 2018-19 there were 2,707 people directing their own support. Self-directed Support comprises of four funding options. Option 1 – Direct Payment – 451 Option 2 – Individual Service Fund – 53 Option 3 – Council arranged services – 2203 Option 4 – Allows for a mixture of funding options Option 3 still remains the preferred option for service users in South Lanarkshire and also reflects the national position.	Green	---	---	---	---	---

Priority Outcome 3: Carers and in particular those on low incomes are fully supported to access financial advice, information and practical wellbeing support

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
Outcome Indicators	Increase the number of new carers identified and supported each year through the Third Sector	The 4,011 figure reflects information gathered from Lanarkshire Carers Centre only. We now have carer figures, combining reports from both Lanarkshire Carers Centre and South Lanarkshire Carers Network which reports 6,006. However, at this stage, we are unable to ascertain how many of these carers use more than one service.	Green	2017 2,845	4,011	2019	Increase	Increase

Priority Outcome 3: Carers and in particular those on low incomes are fully supported to access financial advice, information and practical wellbeing support

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Monitor the number of people providing 20 to 49 hours of care per week	The data we have is reported from the 2011 Census data. However, we are now in the process of gathering more local data through our Planning Support for Carers and should be able to give a more accurate account at our next update. From the local data gathered from Lanarkshire Carers Centre reports 3,844 people who have reported the number of care hours they provide. In this group a total of 692 carers provide 20 to 49 hours per week. This equates to 17% of the total 4011 carers who engage with this service. The 2019 Carers Survey asked 306 people, the care hours reported were 29% of respondents (online survey). We know these figures could be significantly higher as people who provide care to family members and friends do not always regard themselves as carers.	Green	2011 5,785	5,785	2011	Monitor for Contextual Purposes	Monitor for Contextual Purposes
	Monitor the number of people providing 50+ hours of care per week	The data we have is reported from the 2011 Census data. However, as above, we are now in the process of gathering more local data through our Planning Support for Carers and should be able to give a more accurate account at our next update. However, local data gathered from Lanarkshire Carers Centre reports 3,844 people who have reported care hours. In this group a total of 3029 carers provide 50+ care hours per week. This equates to 79% of the total number of carers who engage with this service. The 2019 carers survey asked 306 people, the care hours reported were 55% of respondents. (online survey) Similarly, we know these figures could be significantly higher as people who provide care to family members and friends do not always regard themselves as carers.	Green	2011 9,030	9,030	2011	Monitor for Contextual Purposes	Monitor for Contextual Purposes

Priority Outcome 3: Carers and in particular those on low incomes are fully supported to access financial advice, information and practical wellbeing support

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Maintain the percentage of carers who feel supported to continue in their caring role	On a national level 32% of carers feel they are supported to continue in their caring role. The Scottish Average has now dipped to 37%. It is not possible to give a true reflection of this across the range of services as different organisations report satisfaction levels against their own services only. The Health and Social Care Partnership undertook a recent survey where 306 (not associated with any individual organisation) carers responded to a question 'Do you think the range of services currently offered meet the needs of carer in South Lanarkshire'. 12% said fully meets and 59% partly meets. We also asked carers to respond to 'I feel my needs are met' where 33% strongly agreed or agreed.	Red	2015-16 42% South Lanarkshire Average 41% Scottish Average	32%	March 2019	Maintain above Scottish Average	Maintain above Scottish Average
	Monitor the number of new carers supported by dedicated Welfare Rights Officers	Our partners organisations work to promote the Welfare Rights Service with referrals being made from the dedicated carer organisations. 132 referrals were made between April 2018 and December 2018. The total number of new carers supported by dedicated Welfare Rights Officers from 1 April 2018 to 31 March 2019 is 1,057.	Green	2016-17 1,010	1,057	2018-19	Monitor for Contextual Purposes	Monitor for Contextual Purposes
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	1. The local eligibility criteria has been published to include a full suite of indicators for both adult and young carers. Consultation with carers through a series of focus groups was completed during February and March 2018. A total of 218 carers were engaged in the process. 2. The Health and Social Care Partnership's Short Breaks Services Statement has been published to include guidance for carers as to how to access a short break aligned to eligible and non eligible needs. A survey was undertaken with 179 respondents answering a broad range of questions. A range of respitality, day care, respite and creative breaks are available in South Lanarkshire. 3. Carer enablement plans have now been developed (see below) following the national framework guidance.	Green	---	---	---	---	---
	Participate as national pilot site to develop a new Strategy for Carers 2018-21 utilising £10k national funding	Developing our refreshed Carers Strategy at the same time as bringing on stream the duties of the act was over ambitious. Lessons learned have paved the way for the development of the Carers Strategy which now sits with the other duties of the Act and are nearing conclusion. The Draft 2019 2022 Carers Strategy was launched at a Carers Conference on 29 March 2019.	Green	---	---	---	---	---

Priority Outcome 3: Carers and in particular those on low incomes are fully supported to access financial advice, information and practical wellbeing support

Change Required	Indicator / Action	Comments	Status	Baseline	--- LATEST Data	Period	---- TARGETS ---- Med (3 yr)	Long (10 yr)
	Utilise South Lanarkshire Partnership share of Scottish Government £2m allocation to strengthen carers support across the four localities	A report was presented to the Integrated Joint Board in June 2018, which identified additional financial resource to be invested in Carer Support in an additional two localities to ensure cover across all areas. Lanarkshire Carers Centre has now recruited to all posts with Carer Support staff linked to all our localities.	Green	---	---	---	---	---
	As part of the Carer Enablement Plans, develop a suite of indicators which measures carers health and wellbeing	The Health and Social Care Partnership has developed carer enablement plans following the national framework guidelines placed against low/moderate/substantial/critical risk/impact. Health and Wellbeing Adult Carer indicators within the categories: Health and Wellbeing, Relationships, Living Environment, Employment and Training, Finance, Life Balance and Future Planning. Health and Wellbeing Young Carer indicators within the categories: Safe, Healthy, Achieving, Nurtured, Active, Responsible and Included.	Green	---	---	---	---	---
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	A Money Matters (MM) Advice Service remains in situ in South Lanarkshire with a team of four dedicated carer welfare rights officers, one based in each locality. A strong culture of welfare rights referrals exists amongst our commissioned organisations with specific links on the local authority website carers pages and welfare rights information published across the suite of HSCP carer documents. Financial questions are embedded in the Adult Carer Support Plan and Young Carers Support Plan to ensure carers who need financial support are signposted not just to MM team but additionally to trusts, bursaries and grants.	Green	---	---	---	---	---