North Lanarkshire Council
Report

Adult Care and Social Work Committee

Does this report require to be approved? ☐ Yes ☒ No

Ref MD/CR **Date** 18/02/25

Strategic Commissioning Plan 2023-26 and Programme of Work Update

From Morag Dendy, Chief Officer (Planning, Performance and Quality Assurance)

E-mail dendym@northlan.gov.uk **Telephone**

Executive Summary

The report provides Committee with a mid-cycle update on the implementation of the Strategic Commissioning Plan 2023-26 and its associated Programme of Work.

Each item within the Programme of Work is included in the appendix with a summary position on its current status and a RAG assessment.

Recommendations

It is recommended that the Adult Care and Social Work Committee:

(1) Acknowledge the current status of the Programme of Work, as contained within Appendix 1 of this report.

The Plan for North Lanarkshire

Priority	Improve the health and wellbeing of our communities
Ambition statement	(12) Ensure our residents are able to achieve, maintain, and recover their independence through appropriate supports at home and in their communities
Programme of Work	Resilient People

1. Background

1.1 The Integration Joint Board approved the final version of the Strategic Commissioning Plan 2023-2026 at its meeting on 22 March 2023, setting out how the Health & Social Care Partnerships plans and delivers services for North Lanarkshire over the medium term and how these arrangements help to contribute towards achieving the national health and wellbeing outcomes.

1.2 Subsequently, a more detailed Programme of Work was approved by the Board at its meeting on 27 September 2023, setting out in more detail the programmes and activities intended to help transform the health and social care system.

2. Report

2.1 The Integration Joint Board and Adult Care and Social Work Committee have been kept informed of progress for each of the items within the Programme of Work, with specific reports considered by either the Board or the Committee since September 2023.

2.2 Now that we have reached the mid-point of our planning cycle, this report has been compiled to take stock of progress and achievements to date across the entirety of the Programme of Work (PoW). Each of the PoW items are included in Appendix 1 with a summary of the current position and a Red/Amber/Green status assessment.

2.3 As previously reported, the partnership has been adopting a learning as management strategy (also known as Human Learning System) approach, working with partners from Healthcare Improvement Scotland to make learning and experimentation the key force driving our work. This approach to learning has been promoted across the range of programmes and redesign activity as part of this overall Programme of Work.

2.4 A key element of our learning approach has been the development of a Whole System Enabling Approach, often referred to as Back to Basics, which is helping us systematically understand and consider how all parts of the Health & Social Care system interact and influence each other. This approach is referred to throughout the report and is central to our efforts in supporting people to thrive by providing targeted services that are tailored to reflect their diverse needs. Keeping people central to the decisions that affect them helps us plan actions that support positive outcomes for those who access our services. By adopting a “sticky person” approach, which is to identify a lead person not only to assess need but to engage others to ensure the right response where needed, rather than pass on, we can safeguard against long waits, by waiting well and getting to the right response quickly.

2.5 The overall ambition of our Programme of Work and of our Whole System Enabling Approach is to have a system that is streamlined, supports fewer repeat actions and touch points/onward referrals for people and makes best use of resources by using them in a more effective and productive way. This will ensure that not only are we offering people the right support, at the right time and so increasing their quality of life, we are also increasing the quality of experience for staff in work satisfaction. To achieve this across the whole system, each locality will be responsible for their local population, which means decisions will be made closer to people. This approach will help support

robust connections across all local stakeholders to Locality Planning Groups (LPGs), Local Outcome Improvement Plans (LOIPs) and Community Boards (CBs).

2.6 This report offers a mid-cycle stock-take of the partnership's progress against the commitments made in its Programme of Work. Significant progress has been made and is recognised within the appendix attached to this report. Further work will continue over the next eighteen months to ensure momentum is sustained and key milestones continue to be delivered.

3. Supporting documentation

3.1 Appendix 1 – Programme of Work Status Update (October 2024)

Morag Dendy
Chief Officer (Planning, Performance and Quality Assurance)

4. Impacts

4.1	**Public Sector Equality Duty and Fairer Scotland Duty** Does the report contain information that has an impact as a result of the Public Sector Equality Duty and/or Fairer Scotland Duty? Yes ☐ No ☒ If Yes, please provide a brief summary of the impact? If Yes, has an assessment been carried out and published on the council's website? https://www.northlanarkshire.gov.uk/your-community/equalities/equality-and-fairer-scotland-duty-impact-assessments Yes ☐ No ☐
4.2	**Financial impact** Does the report contain any financial impacts? Yes ☐ No ☒ If Yes, have all relevant financial impacts been discussed and agreed with Finance? Yes ☐ No ☐ If Yes, please provide a brief summary of the impact?
4.3	**HR policy impact** Does the report contain any HR policy or procedure impacts? Yes ☐ No ☒ If Yes, have all relevant HR impacts been discussed and agreed with People Resources? Yes ☐ No ☐ If Yes, please provide a brief summary of the impact?
4.4	**Legal impact** Does the report contain any legal impacts (such as general legal matters, statutory considerations (including employment law considerations), or new legislation)? Yes ☐ No ☒ If Yes, have all relevant legal impacts been discussed and agreed with Legal and Democratic? Yes ☐ No ☐ If Yes, please provide a brief summary of the impact?
4.5	**Data protection impact** Does the report / project / practice contain or involve the processing of personal data? Yes ☒ No ☐ If Yes, is the processing of this personal data likely to result in a high risk to the data subject? Yes ☐ No ☒ If Yes, has a Data Protection Impact Assessment (DPIA) been carried out and e-mailed to dataprotection@northlan.gov.uk Yes ☒ No ☐
4.6	**Technology / Digital impact** Does the report contain information that has an impact on either technology, digital transformation, service redesign / business change processes, data management, or connectivity / broadband / Wi-Fi? Yes ☐ No ☒ If Yes, please provide a brief summary of the impact?

	Where the impact identifies a requirement for significant technology change, has an assessment been carried out (or is scheduled to be carried out) by the Enterprise Architecture Governance Group (EAGG)? Yes ☐ No ☐
4.7	**Environmental / Carbon impact** Does the report / project / practice contain information that has an impact on any environmental or carbon matters? Yes ☐ No ☐ If Yes, please provide a brief summary of the impact?
4.8	**Communications impact** Does the report contain any information that has an impact on the council's communications activities? Yes ☐ No ☒ If Yes, please provide a brief summary of the impact?
4.9	**Risk impact** Is there a risk impact? Yes ☐ No ☒ If Yes, please provide a brief summary of the key risks and potential impacts, highlighting where the risk(s) are assessed and recorded (e.g. Corporate or Service or Project Risk Registers), and how they are managed?
4.10	**Armed Forces Covenant Duty** Does the report require to take due regard of the Armed Forces Covenant Duty (i.e. does it relate to healthcare, housing, or education services for in-Service or ex-Service personnel, or their families, or widow(er)s)? Yes ☐ No ☒ If Yes, please provide a brief summary of the provision which has been made to ensure there has been appropriate consideration of the particular needs of the Armed Forces community to make sure that they do not face disadvantage compared to other citizens in the provision of public services.
4.11	**Children's rights and wellbeing impact** Does the report contain any information regarding any council activity, service delivery, policy, or plan that has an impact on children and young people up to the age of 18, or on a specific group of these? Yes ☐ No ☒ If Yes, please provide a brief summary of the impact and the provision that has been made to ensure there has been appropriate consideration of the relevant Articles from the United Nations Convention on the Rights of the Child (UNCRC). If Yes, has a Children's Rights and Wellbeing Impact Assessment (CRWIA) been carried out? Yes ☐ No ☐

Appendix 1 – Programme of Work Status Update (October 2024)

1. Getting It Right For Everyone (GIRFE)	
The GIRFE Pathfinder is working with staff in localities to take forward the learning from the co-design process and progress the prototypes ensuring these are deployed and embedded within the Whole System Enabling Approach (Back to Basics). The North Lanarkshire Pathfinder will focus on the following prototypes during the next phase of testing: • **My plan** – a means by which people can record their own information and share with agencies when required. The aim of **My plan** is to remove any need for people to retell their stories and their circumstances multiple times. This includes living well, ageing well and dying well. • Work is ongoing to embed the GIRFE principles across a variety of approaches that deliver preventative and early intervention approaches and activities. The aim is to improve access to appropriate supports and services by ensuring there are good conversations with people and their families from the first point of contact. Through an enabling approach, we will embed multidisciplinary teams (**My team**) around the person and their plan. • Our approach to improving the co-ordination of people's support involves a sticky person as a trusted point of contact who supports people with the coordination of their plan and appointments as an integrated member of a multi-disciplinary team, including when someone receives support from a variety of teams. Areas for further development and design include determining how the sticky person for each person is allocated and how the role might be undertaken by a family member or other non-professional. • Clarity of vision for a community hub involves principles which will support the development of Hubs ensuring they reflect local needs and where people can connect with public services and with local people involved in both service delivery and decision making. The Council has an approved set of hub guiding principles so the we are building upon active work being undertaken in Newmains and St	

Brigid's Community Hub, Riverbank and Chryston community hubs. Further development of this prototype includes identifying what community supports and services can be delivered through the hub, in reach and outreach, as well as the development of performance indicators to determine the impact of support on the health and well-being of the communities they serve. • **Dementia practice** - Additionally, we have agreed to consider staff competencies in supporting people with dementia post diagnosis. We understand that families can sometimes have extended wait on supports and this can be a challenging time so can we consider 'waiting well'. We will work with staff across Home Support and Integrated Day Services in gathering data re training/development and competencies and whether this meets expectations as required in the Dementia Strategy. • **GIRFEC to GIRFE (Moving On**) - Working with our Education and Families colleagues to consider this important transition stage in a young person's life. In what way can this transition be seamless with the right support at the right time. As outlined earlier we require to consider what the prototypes mean in real time. There has been extensive engagement and communication across the HSCP regarding the need for the workforce to get back to basics, have meaningful conversations with people about what is important to them.	
2. Frailty Strategy	
The Lanarkshire Strategy for Preventing and Managing Frailty 2023 – 2028 was approved in November 2023. The implementation of the strategy is ongoing with a particular focus on the establishment of frailty networks, which commenced in November 2023 with the aim of providing a collaboration between the multi-disciplinary teams on our acute sites and the partnerships who have experience in frailty work. This has led to richly informed conversations which has been at the forefront of driving realistic and patient-centred change for the people living in North Lanarkshire. With continued engagement with both North and South Health and Social Care Partnerships, including GP localities, District Nurses and Third Sector organisations, there has been an understanding on how staff work with frailty patients and the challenges around this. It has also ensured more joint working between acute and community teams.	

3. Home Support Redesign	
The Home Support Redesign programme continues to focus on the following key elements: ***Assessment and Planning*** The development of an integrated approach through the establishment of Home Assessment Team working closely with Reablement and Integrated Rehabilitation Team builds on the work to deliver discharge to assess and same day response. This aligns the home support workforce with locality health and social work teams and will provide a range of resources to facilitate assessment and planning. By adopting this approach, it will ensure that when someone needs longer term support it is based on thorough assessment and support planning. This will be for people whose needs are more complex, including end of life care, within their own home. Following assessment and support planning, individuals will have the option of NLC home support delivered by the Living Well Service. Supported people can consider how their support is delivered through the 4 options as outlined in the self-directed support legislation. At the point of review, options will be discussed including individual budgets or direct payments which can be used flexibly to meet identified outcomes. The home support workforce in North Lanarkshire, provides essential support and care to individuals, carers and families. The Living Well Service will continue to provide care and support to individuals who require longer term, planned support. Due to the changing demographics and complexity of individuals requiring support, the workforce will be able to provide a responsive, flexible approach to those with fluctuating needs. The workforce establishment and structure need to be finalised to allow for the model to be fully operational. This work will be ongoing with business partners and trade unions. ***Workforce*** The recruitment of staff to assessment and planning has been prioritised to support the operational model. The service has invested in dedicated staff to support learning and development through training, including	

refresher cycles, and investment in workforce development to provide high quality care. An overall training plan has been created and has been made available to managers within the service. The plan ensures key activity is progressed including monitoring mandatory training for Home Support Workers as well as highlighting registration requirements for all staff to deliver quality driven service offering flexibility and focused on service user outcomes.

Dynamic Scheduling
The tool will improve consistency, reduce missed visits, and incorporate travel time accurately. For the first time, the service will be able to monitor care delivery in real-time and monitor quality indicators such as punctuality, continuity and service duration. The tool will demonstrate how person-centred support improves quality of life and measures the effectiveness of care delivered.

Engagement
An important aspect in the review of the service model was to involve both staff and individuals who use the service by offering opportunities for them to shape the service by active participation. Consultation with the workforce and stakeholders was undertaken through a series of events including face to face meetings across all locality areas and surveys to capture views and experiences of the current and future model. During each consultation event operational issues were captured and addressed which included 'You Said, We Listened'.

The engagement with supported people and their cares/ families highlighted recurring themes and included the need for continuity of care with consistency of carers and timing of visits however many reported that carers were respectful and courteous.

Following consultation with the workforce and stakeholders, benchmarking was undertaken with eight local authorities including Renfrewshire, East Dunbartonshire, South Lanarkshire, Inverclyde, Falkirk, Fife and Glasgow to gain a more in-depth knowledge and understanding of other Health and Social Care Partnerships, how they operate and manage Care at Home and Home Support provisions. This included gathering data across key areas of service delivery including preventing hospital admissions, facilitating hospital discharge, managing demand, cost and system.

The information collated has allowed the service to identify best practice and useful learning from others to develop a structure for the Home Support Workforce. A workforce plan is being finalised. ***Improving Quality*** The proposed changes will ultimately ensure people have a high quality, safe and compassionate care and support, which is sustainable and maintained across all localities	
4. Carers Strategy	
The partnership's new Carers Strategy 2024-27 was approved and published in May 2024 and the approach continues to be based on the principles of the Carers (Scotland) Act 2016 and Self-Directed Support (Scotland) Act 2013, promoting a whole system approach that enables people to have more choice and control in their lives. The development of the Carers Strategy gave us the opportunity to undertake extensive engagement and participation activity with carers and supported people. This has resulted in a carer led and carer informed strategy, co-produced with carers and carer organisations locally. The sense of "joint ownership" that has emerged is something that carers, carer organisations and UHSCNL can be proud of. The aspiration is to offer a sustainable and innovative means to achieve the outcomes that carers, as well as supported people, identify as being important to them. Through these initiatives, carers can lead full and meaningful lives, and ensures that people can engage in, participate in, and contribute to the local economy and wider society, should that be their choice. The wider approach also encompasses the principles of Getting it Right for Everyone (GIRFE) and Community Wealth Building. Carers, carer focused organisations and University Health and Social Care North Lanarkshire (UHSCNL) have, over time, developed a very robust carer support infrastructure, and our Carers Strategy 2024-2027 seeks to utilise this to best effect.	
5. Care Home Assurance Team	
In 2021-22, My Health, My Care, My Home (Healthcare Framework) was co-produced by Scottish Government and stakeholders from across health and social care with the aim of improving outcomes for	

adults living in care homes across Scotland. The document was centred around six core elements, and underpinned by two key enablers, which were felt to be crucial in helping the sector to implement its vision. It also makes several recommendations to reduce the inequalities facing people living in care homes. To ensure a collaborative approach with implementation of the Healthcare Framework an engagement session took place in April 23 with all key stakeholders including care home staff, care home managers, care home providers, Care Inspectorate, Scottish Care, Health, Social Work and Social Care Staff. Subsequently, a Project Plan was developed and agreed with key stakeholders and Short LifeWorking Groups (SLWGs) were established covering all six core elements: ***Nurturing Environment*** The collaborative visit programme has shifted from “doing to” to “doing with” and new initiatives such as the MDT and Hand Hygiene Improvement projects have been built using a collaborative approach. There have been improvements in encouraging and listening to feedback. An example of this has been in working together to address the needs of care home staff training, which resulted in the development of the recently completed 6-month training programme. The newly appointed Practice Development Educator for care homes is currently engaging with staff to collaboratively develop the next programme based on the care homes identified needs and the HSCP’s priorities. This includes enabling routes for care home staff to access planned NHS training has begun. ***Multi-Disciplinary Team (MDT)*** We work collaboratively with the care home staff, assisting with care planning and introducing ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). The team have now joined up with Social Work to attend the residents’ 4–6-week review in the care home. ***Prevention*** The application of Infection Prevention Control (IPC) standards in care homes is well supported. The dedicated IPC team is available for advice, education and guidance. The MDT approach will support the contents of care plans to be reflective of the individuals care needs taking into account health needs, which is often a role that carers complete. The support from CHL will therefore ensure the best start for residents entering care homes ensuring a more comprehensive proactive, preventative approach.	

Appendix 1 – Programme of Work Status Update (October 2024)

1. Getting It Right For Everyone (GIRFE)	
The GIRFE Pathfinder is working with staff in localities to take forward the learning from the co-design process and progress the prototypes ensuring these are deployed and embedded within the Whole System Enabling Approach (Back to Basics). The North Lanarkshire Pathfinder will focus on the following prototypes during the next phase of testing: • **My plan** – a means by which people can record their own information and share with agencies when required. The aim of **My plan** is to remove any need for people to retell their stories and their circumstances multiple times. This includes living well, ageing well and dying well. • Work is ongoing to embed the GIRFE principles across a variety of approaches that deliver preventative and early intervention approaches and activities. The aim is to improve access to appropriate supports and services by ensuring there are good conversations with people and their families from the first point of contact. Through an enabling approach, we will embed multidisciplinary teams (**My team**) around the person and their plan. • Our approach to improving the co-ordination of people's support involves a sticky person as a trusted point of contact who supports people with the coordination of their plan and appointments as an integrated member of a multi-disciplinary team, including when someone receives support from a variety of teams. Areas for further development and design include determining how the sticky person for each person is allocated and how the role might be undertaken by a family member or other non-professional. • Clarity of vision for a community hub involves principles which will support the development of Hubs ensuring they reflect local needs and where people can connect with public services and with local people involved in both service delivery and decision making. The Council has an approved set of hub guiding principles so the we are building upon active work being undertaken in Newmains and St	

Brigid's Community Hub, Riverbank and Chryston community hubs. Further development of this prototype includes identifying what community supports and services can be delivered through the hub, in reach and outreach, as well as the development of performance indicators to determine the impact of support on the health and well-being of the communities they serve. • **Dementia practice** - Additionally, we have agreed to consider staff competencies in supporting people with dementia post diagnosis. We understand that families can sometimes have extended wait on supports and this can be a challenging time so can we consider 'waiting well'. We will work with staff across Home Support and Integrated Day Services in gathering data re training/development and competencies and whether this meets expectations as required in the Dementia Strategy. • **GIRFEC to GIRFE (Moving On**) - Working with our Education and Families colleagues to consider this important transition stage in a young person's life. In what way can this transition be seamless with the right support at the right time. As outlined earlier we require to consider what the prototypes mean in real time. There has been extensive engagement and communication across the HSCP regarding the need for the workforce to get back to basics, have meaningful conversations with people about what is important to them.	
2. Frailty Strategy	
The Lanarkshire Strategy for Preventing and Managing Frailty 2023 – 2028 was approved in November 2023. The implementation of the strategy is ongoing with a particular focus on the establishment of frailty networks, which commenced in November 2023 with the aim of providing a collaboration between the multi-disciplinary teams on our acute sites and the partnerships who have experience in frailty work. This has led to richly informed conversations which has been at the forefront of driving realistic and patient-centred change for the people living in North Lanarkshire. With continued engagement with both North and South Health and Social Care Partnerships, including GP localities, District Nurses and Third Sector organisations, there has been an understanding on how staff work with frailty patients and the challenges around this. It has also ensured more joint working between acute and community teams.	

refresher cycles, and investment in workforce development to provide high quality care. An overall training plan has been created and has been made available to managers within the service. The plan ensures key activity is progressed including monitoring mandatory training for Home Support Workers as well as highlighting registration requirements for all staff to deliver quality driven service offering flexibility and focused on service user outcomes.

Dynamic Scheduling
The tool will improve consistency, reduce missed visits, and incorporate travel time accurately. For the first time, the service will be able to monitor care delivery in real-time and monitor quality indicators such as punctuality, continuity and service duration. The tool will demonstrate how person-centred support improves quality of life and measures the effectiveness of care delivered.

Engagement
An important aspect in the review of the service model was to involve both staff and individuals who use the service by offering opportunities for them to shape the service by active participation. Consultation with the workforce and stakeholders was undertaken through a series of events including face to face meetings across all locality areas and surveys to capture views and experiences of the current and future model. During each consultation event operational issues were captured and addressed which included 'You Said, We Listened'.

The engagement with supported people and their cares/ families highlighted recurring themes and included the need for continuity of care with consistency of carers and timing of visits however many reported that carers were respectful and courteous.

Following consultation with the workforce and stakeholders, benchmarking was undertaken with eight local authorities including Renfrewshire, East Dunbartonshire, South Lanarkshire, Inverclyde, Falkirk, Fife and Glasgow to gain a more in-depth knowledge and understanding of other Health and Social Care Partnerships, how they operate and manage Care at Home and Home Support provisions. This included gathering data across key areas of service delivery including preventing hospital admissions, facilitating hospital discharge, managing demand, cost and system.

The information collated has allowed the service to identify best practice and useful learning from others to develop a structure for the Home Support Workforce. A workforce plan is being finalised. ***Improving Quality*** The proposed changes will ultimately ensure people have a high quality, safe and compassionate care and support, which is sustainable and maintained across all localities	
4. Carers Strategy	
The partnership's new Carers Strategy 2024-27 was approved and published in May 2024 and the approach continues to be based on the principles of the Carers (Scotland) Act 2016 and Self-Directed Support (Scotland) Act 2013, promoting a whole system approach that enables people to have more choice and control in their lives. The development of the Carers Strategy gave us the opportunity to undertake extensive engagement and participation activity with carers and supported people. This has resulted in a carer led and carer informed strategy, co-produced with carers and carer organisations locally. The sense of "joint ownership" that has emerged is something that carers, carer organisations and UHSCNL can be proud of. The aspiration is to offer a sustainable and innovative means to achieve the outcomes that carers, as well as supported people, identify as being important to them. Through these initiatives, carers can lead full and meaningful lives, and ensures that people can engage in, participate in, and contribute to the local economy and wider society, should that be their choice. The wider approach also encompasses the principles of Getting it Right for Everyone (GIRFE) and Community Wealth Building. Carers, carer focused organisations and University Health and Social Care North Lanarkshire (UHSCNL) have, over time, developed a very robust carer support infrastructure, and our Carers Strategy 2024-2027 seeks to utilise this to best effect.	
5. Care Home Assurance Team	
In 2021-22, My Health, My Care, My Home (Healthcare Framework) was co-produced by Scottish Government and stakeholders from across health and social care with the aim of improving outcomes for	

adults living in care homes across Scotland. The document was centred around six core elements, and underpinned by two key enablers, which were felt to be crucial in helping the sector to implement its vision. It also makes several recommendations to reduce the inequalities facing people living in care homes. To ensure a collaborative approach with implementation of the Healthcare Framework an engagement session took place in April 23 with all key stakeholders including care home staff, care home managers, care home providers, Care Inspectorate, Scottish Care, Health, Social Work and Social Care Staff. Subsequently, a Project Plan was developed and agreed with key stakeholders and Short LifeWorking Groups (SLWGs) were established covering all six core elements: ***Nurturing Environment*** The collaborative visit programme has shifted from “doing to” to “doing with” and new initiatives such as the MDT and Hand Hygiene Improvement projects have been built using a collaborative approach. There have been improvements in encouraging and listening to feedback. An example of this has been in working together to address the needs of care home staff training, which resulted in the development of the recently completed 6-month training programme. The newly appointed Practice Development Educator for care homes is currently engaging with staff to collaboratively develop the next programme based on the care homes identified needs and the HSCP’s priorities. This includes enabling routes for care home staff to access planned NHS training has begun. ***Multi-Disciplinary Team (MDT)*** We work collaboratively with the care home staff, assisting with care planning and introducing ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). The team have now joined up with Social Work to attend the residents’ 4–6-week review in the care home. ***Prevention*** The application of Infection Prevention Control (IPC) standards in care homes is well supported. The dedicated IPC team is available for advice, education and guidance. The MDT approach will support the contents of care plans to be reflective of the individuals care needs taking into account health needs, which is often a role that carers complete. The support from CHL will therefore ensure the best start for residents entering care homes ensuring a more comprehensive proactive, preventative approach.	

Anticipatory and Future Care Planning There is a need to raise awareness of ACP's and to provide education and training for care home staff. A training package is currently being developed by palliative care consultants and the Care Home Practice Development Educator ***Palliative and End of Life Care*** We promote various tools to aid residents' palliative and end of life care needs and provide training to support their use. ***Urgent and Emergency Care*** The Flow Navigation Centre (FNC) appropriately refer care home residents to Hospital at Home from 09:00hrs- 17:00hrs. This approach has successfully supported care home residents to remain in the care homes. These hours will be extended over the next few months.	
6. Hospital @ Home	
During 2023, a rapid review of the Hospital at Home service was undertaken, taking into account the immediate plans for expansion and the future vision for Hospital at Home in line with Scotland's national strategy Horizon 1 (complete) • Extended operating hours to include evening and weekend working • Enhanced interfaces between community nursing, hospital based specialities and more understanding of capabilities across the system. Increased reporting of agreed KPIs • Increased professional to professional advice via consultant connect • Captured learning from Heart Failure Test of Change to inform speciality developments across the service • Explored Flow Navigation Centre being the single point of access for escalation and deescalation Horizon 2 (complete) • Refocused service to admission avoidance • Clearly defined step down criteria for complex cases	

Anticipatory and Future Care Planning There is a need to raise awareness of ACP's and to provide education and training for care home staff. A training package is currently being developed by palliative care consultants and the Care Home Practice Development Educator ***Palliative and End of Life Care*** We promote various tools to aid residents' palliative and end of life care needs and provide training to support their use. ***Urgent and Emergency Care*** The Flow Navigation Centre (FNC) appropriately refer care home residents to Hospital at Home from 09:00hrs- 17:00hrs. This approach has successfully supported care home residents to remain in the care homes. These hours will be extended over the next few months.	
6. Hospital @ Home	
During 2023, a rapid review of the Hospital at Home service was undertaken, taking into account the immediate plans for expansion and the future vision for Hospital at Home in line with Scotland's national strategy Horizon 1 (complete) • Extended operating hours to include evening and weekend working • Enhanced interfaces between community nursing, hospital based specialities and more understanding of capabilities across the system. Increased reporting of agreed KPIs • Increased professional to professional advice via consultant connect • Captured learning from Heart Failure Test of Change to inform speciality developments across the service • Explored Flow Navigation Centre being the single point of access for escalation and deescalation Horizon 2 (complete) • Refocused service to admission avoidance • Clearly defined step down criteria for complex cases	

• Move from medical delivered model to a medical oversight model • Rapid access to diagnostics • Developed and implemented recommendations from Heart Failure learning Horizon 3 – to be implemented by March 2025 • Finalise workforce model for service • Connect Hospital at Home to locality teams (urgent response and nursing) • Agree model for multiple Responsible Medical Officers when the service expands into other specialties • Clarify system wide governance arrangements • Ensure a de-escalation and escalation framework is in place • ANPs undertaking differential diagnosis	
7. Home Assessment Team (HAT)	
The Home Assessment Teams are operational in all localities and are fully embedded within the enabling approaches developed in each locality. ***Service Model*** • Standard Operating Procedure agreed and in place. • Workshops held to map pathways, review and agree pan-Lanarkshire referral criteria with all key stakeholders including transfers of care into reablement, mainstream/longer term home support and integrated rehabilitation services. • HAT staff accommodation secured in university hospitals and community. • Induction programme established. ***Data and measurement*** • Data spreadsheet developed to record activity and enable monitoring of performance and outcomes. This continues to be revised according to activity and developments. ***Recruitment***	

- Recruitment to HAT ongoing to build capacity across all localities. The pressures within the system regarding workforce are widely acknowledged and adjustments continue to be made to skill-mix.
- Several recruitment campaigns have been progressed across health and social care to recruit across the team including Home Support, Physiotherapy and Occupational Therapy staff.
- It is the intention for existing staff to be able to work flexibly across sectors as required to meet demands.
- Interim operational management of HAT has been delegated to two Locality Social Work Managers, aligned to the 2 hospital sites of University Hospitals Monklands and Wishaw, and an NHS Service Manager, working closely with the discharge arrangements and the hospital social work teams. This will be rolled out across the six localities.
- Strategic management is also undergoing a review to ensure integration into the new GIRFE/Enabling Approach arrangements.

As HAT has developed, further synergies have been identified with other key programmes of work to improve our prevention and early intervention response. This includes Getting It Right for Everyone (GIRFE), the Frailty Strategy, Home Support Refresh, the Whole System Enabling approach and the Operation FLOW Optimal Discharge Planning Target Operating Model.

The interface with other parts of a person's journey is critical. Whilst some individuals will not require any statutory support, there will be those who would benefit from further intervention. Therefore, while we ensure FLOW through the acute hospital sites, this is also required within community settings and timely access to reablement, and rehabilitation will be critical to enable people to maximise their potential and ensure that they receive the support that is right for them.

Weekly meetings have been established between relevant staff in HAT, Home Support, Reablement and Integrated Rehabilitation Teams to facilitate effective communication regarding individual service users and reablement activity and subsequent goal setting supported by a standard operating procedure. Taking a Whole System Enabling Approach, each locality is developing a multi-disciplinary enabling approach to ensure an effective and timely response that taps into community resources, where appropriate, through our recently appointed third sector community connectors.

8. Self Directed Support Transformation	
A learning and development plan is in place to support new and existing practitioners, team leaders and seniors, managers and wider stakeholders. Practitioners, people who have support arrangement in place, family carers, independent sector providers and third and voluntary sector providers are also actively involved in the delivery of more formal training as well as in the ongoing refresh of the plan Work is ongoing with colleagues involved in the delivery of both local authority and independent sector care at home services to increase choice and control through individualising arrangements and planning with people to meet changing needs flexibly and responsively, understanding the focus on frailty. In keeping with a place-based approach to empowering localities and facilitating decision making closest to the person, changes to the authorisation of individual budgets within an enabling approach to localities has been introduced. This approach has increased the speed of decision making, empowered practitioners and leaders, and increased the creativity and flexibility that underpins self directed support.	
9. Community Alarm Service	
The plan for North Lanarkshire Council's community alarm service is to transition to a new digital service, this will ensure that the Alarm Receiving Centre (ARC) is fully digitised and will meet the digital requirements of our service while minimising the risks to analogue failures as the decommissioning of these old analogue lines progress. This will allow the Partnership to adopt a new Digital Solution that will meet future requirements and can be customised to our specific operational requirements. This work has included 13 other local authorities to ensure that a robust and secure solution can be found. At the time of writing several local authorities have successfully transitioned over to the new digital ARC that will be supported by Chubb and Sky Response. The transition to digital has required the service to review all alarm devices that are in place within homes in the community and sheltered house residences and replace these current analogue devices with digital ready alarm devices. There will also be a requirement for digitally enabled peripherals such as falls detectors, door contacts etc, to be thoroughly tested to ensure that they are compatible with the new digital	

alarm receiving centre and alarm device. The ability to connect existing interconnected fire/smoke detectors via the digital alarm is currently not available. The Scottish Government are working with manufacturers on solutions to connect these devices to remove the need for multiple detectors to be in the same room. The service has already changed around 3000 analogue alarms to a Hybrid digital ready unit which do not use the analogue telephone line, with a further 1000 planned to be exchanged by November 2024. The service also issued a questionnaire seeking service users feedback on the Community Alarm service, 124 questionnaires were returned. The findings of the questionnaire were that service users were satisfied with the service provided and that staff were helpful, polite and treated people with dignity and respect. The service recently held an awareness day for Health and Social Care staff, stakeholders and third sector organisations over a 2-day period to provide more information and insight into the Community Alarm Service and how the service operates and functions. Several focus groups were held with community alarm staff over a number of weeks in late 2023, each focus group was provided with an open platform to share their feedback, views, knowledge, and insight into the community alarm service. The feedback was grouped into themes and further analysed to identify several important issues. Overall staff were incredibly positive about their roles/responsibilities and proud of the impact that their service had on individuals needing support from the community alarm service. The service recognises that the staffing resource has not been reviewed within the community alarm service since its inception, however given the service growth as well as prioritising the move from an analogue to digital solution as well as the introduction of new digital technology it is evident that a review of the staffing structure is required.	
10. Community Nursing Review	
The new Vision & Model for Community Nursing was launched in October 2024. ***Caseload Complexity***	

New complexity descriptors have been developed using a collaborative approach with the community nursing teams. All staff have received training to ensure a consistent approach to measuring complexity of patients within caseloads. These are now used on a daily basis to describe workload demand and support safe staffing. An audit tool was created to review the overall complexity of caseloads which will be used to aid the fair distribution caseloads and support a review of skill mix within the community nursing teams. Practice Assessors have been allocated to each locality to support the teams. They are working with District Nurses and trainee District Nurses to support improvements in caseload management **Care Management & Referral Criteria** A collaborative approach to managing patients with complex care needs is being currently taken with nurses working as part of a wider multidisciplinary team in localities. This approach ensures that everyone works together and can quickly respond to complex often unscheduled demand for services. In line with our strategy for preventing and managing frailty, frailty scoring is being introduced to community nursing assessments. Identifying frailty at an early stage will enable staff to plan and coordinate care, support wellbeing and optimise independence. We are also reviewing future care planning and will work in conjunction with GP's to ensure we proactively plan and coordinate care using realistic medicine principals to achieve the aims of Healthy Ageing and Living Our Best Lives in Lanarkshire. A Community Nursing Referral Centre (CNRC) was established in February 2024 and now takes calls for Wishaw, Motherwell, Airdrie and Bellshill. The other two localities are currently recruiting call handling staff to join the CNRC and hope to be in all localities by November 2024. **Roles, Responsibilities and Training** An internal District Nursing trainee pathway was developed and has been successfully supporting the training and registration of staff. A review of this training pathway took place to ensure it reflects the new Nursing Midwifery Allied Health Professional (NMAHP) Competency Framework and Queens Nurse Institute Scotland (QNIS) standards. Concerns around a gap in leadership is being addressed by encouraging Team Leaders to attend Leadership and Quality Improvement courses.	

11. Alcohol & Drugs Partnership Strategy	
A programme of extensive and competitive commissioning activities took place via the North Lanarkshire Alcohol & Drugs Partnership (ADP) in 2023, with five key services tendered to support the delivery of the National Mission Priorities, including: • Early intervention, prevention and education – awarded to Landed • Individual Placement Support – awarded to SAMH • Adult and Whole Family Support service – awarded to Phoenix Futures • Recovery Community Development – awarded to Recovery Scotland • Crisis, overdose response and assertive outreach service – awarded to Turning Point Scotland North Lanarkshire ADP Board made the decision to commit to three year funding for all new and continuing services from 2023 onwards. This recognised feedback from stakeholders citing challenges faced with previous year on year funding arrangements that impacted on staff recruitment and retention, longer term planning and service stability. A number of test of change projects have been funded/initiated via NLADP, including: • Arrest referral pathways via Police custody centres • Contextual safeguarding for children and young people • Alcohol and Drug Solutions Courts, and; • Extended Youth Work Provision and Diversionary Activities via Community Learning and Development (CL&D). ***Drug Death Prevention*** Work to refine drug death prevention efforts in 2023 included a full review of the Drugs Death Prevention Group (DDPG) operational workstreams with a full membership update and work plan now in place. ***Reducing Alcohol Harms*** The Reducing Alcohol Harms group has been meeting for the last 18 months and is a multi-agency group with broad representation from the ADP partners. There is a detailed work-plan linked to the RAHG that cuts across whole population measures and targeted local interventions from Licensing, Alcohol Brief Interventions, Health Needs Assessment, education and training and work to target higher risk groups.	

Residential Rehabilitation
An extensive programme of work was led by the ADP support team and the Scottish Recovery Consortium to offer training and support to staff to ensure residential rehab is available to anyone who wishes to be assessed. Residential rehab is now offered more consistently as part of the treatment and care offer in North Lanarkshire

Whole Family support
NLADP continues to invest in family support linked to the decisions reached via the Whole Family Approach sub-group, led by the national holistic framework, local evidence of need and linked to ADP strategic objectives.

MAT Standards
North Lanarkshire is on track to meet all MAT standards with the exception of MAT 7. This is due to constraints linked to delivery of MAT across Primary Care. North Lanarkshire is not unique in this. MAT 7 limitation have been acknowledged by the Scottish Government and Public Health Scotland as a national barrier with the majority of ADP areas unable to deliver on this standard. A great deal of work has gone into achieving the standards across the whole system, this has been acknowledged by Public Health Scotland and the Scottish Government.

12. Prisoner Healthcare

The Adult Health Services Unit (AHSU), in collaboration with Scottish Prison Service (SPS), and on-site staff, successfully undertook a Service Model Review to implement an improved Prisoner Healthcare service to the population of HMP Shotts. This included stabilised staffing models, improved staff training plans, and improved patient centred care for all patients, in particular those with identified existing health needs. Originally commissioned in January 2022, the review covered the following 8 standards:

- Standard 1: Effective Management of Resources & Staff Governance
- Standard 2 Primary Care & chronic disease Management
- Standard 3: Mental Health & Addictions

• Standard 4: Medicines Management • Standard 5: Infection Prevention and Control • Standard 6: Person Centred Health and Care • Standard 7: End of Life Care • Standard 8 : Deteriorating Patient The action plan produced from the review made 31 recommendations, all of which are now complete and signed off. A scheduled Healthcare Improvement Scotland inspection took place in May 2022. Several recommendation sfor improvement were categorised under Standard 9: Health and Wellbeing: The prison takes all reasonable steps to ensure the health and wellbeing of all prisoners. The AHSU management team worked well in collaboration with the prisoner healthcare team, and SPS to ensure these actions were addressed in a timeously manner. The team met with HIS a further twice between the initial inspection and August 2023 to review the progress made. In September 2023, HIS officially signed off the plan as complete with no further review required until the scheduled inspection in 2027. Commendations were made at the efforts made to address the recruitment, retention, and overall staffing issue in the prison. Currently, 20 of the 22 recommendations are 100% complete, with the remaining two actions ongoing as part of a pharmacy review.	
13. Mental Health & Wellbeing Strategy	
The success of the Lanarkshire's Mental Health and Wellbeing Strategy, 2019-2024 is the result of co-production, ongoing engagement, robust planning, trusted collaboration and joint implementation of a system-wide approach to mental health and wellbeing in Lanarkshire, with all partners considered equal. The key achievements of the 2019-24 Strategy have been reported to the Board in a separate report. Given the close alignment between the 2019-2024 Lanarkshire and 2023 national strategies, the Integration Joint Board agreed at its Liaison Session on 8th November 2023, agreed with the proposal that, rather than produce a new Lanarkshire Strategy, partners should work together to develop a Lanarkshire	

Delivery Plan. The Lanarkshire delivery plan will be aligned to the strategic actions set out in the national Delivery Plan, and link clearly to local strategies and plans including both Health and Social Care Partnership Strategic Commissioning Plans, NHS Lanarkshire's Our Health Together strategy, Children's Services Plans, the Plan for North Lanarkshire Community Plans and Local Outcome Improvement Plans. Since then, work has been undertaken to: • Establish a sustainability plan to identify any outstanding priorities and actions from 2019-2024 strategy to be carried forward into the new Lanarkshire Delivery Plan; • Assemble a final report on the work carried out over the 2019-2024 Mental Health and Wellbeing Strategy, a Review report of the MHWS 2019-2024 for sharing and publication; • Carry out a self-assessment of where we are in Lanarkshire in relation to the strategic actions set out in the National Mental Health and Wellbeing Delivery Plan; • Engage with stakeholders both at Lanarkshire-wide, including a self-assessment workshop with all stakeholders, presentations and discussion at Lanarkshire Links Quarterly meetings and locality level, via the Community Boards in North Lanarkshire, to identify any further priorities and actions for the Lanarkshire Delivery Plan; • Prepare a draft Lanarkshire MHW Delivery Plan for adoption by the Integration Joint Board, subject to the endorsement of South Lanarkshire IJB, Community Planning Partnerships, North and South Lanarkshire Councils and the Lanarkshire NHS Board; • Propose future governance and leadership for the implementation of the MHW Delivery Plan – set a draft plan and Terms of Reference for Lanarkshire MHW Delivery Board • Stand down current Mental Health and Wellbeing Strategy Board, Executive Group and associated workstreams and close the 2019-2024 programme of work;	
14. Speech & Language Therapy	
The Speech and Language Service Improvement Group was established in 2023 and undertook a scoping exercise with a view to developing a new service model. As a result, areas of priority were agreed, and work streams established: ***Waiting List*** This work is progressing well in a testing phase following • review and standardisation of the processes that support patient pathway and inform digital plan.	

• Agreeing, refining and developing core clinical offerings at Universal, Targeted and Specialist level. • Ensuring workforce have the confidence, resources and knowledge to deliver the core service model ***Digital*** Previously, the service had no digital footprint. Trakcare has been implemented since September 2024 and the service is at an early stage of being able to gather evidence from the robust data it can provide. However, early indicators are that this will provide necessary evidence to better understand recording of interventions, where barriers or bottlenecks can occur in pathway. ***Communications and Engagement*** Colleagues within the service had already well-established social media platforms and information and education via YouTube that was used to support children and young people and their parents and carers. Support has been provided to extend SLT website to include adult services. This will coordinate all SLT information to one defined space. Members of group are also contributing to development of an app that will support children and families who are supported by local health visitor colleagues. ***HR and Workforce*** A review of all posts across the service has been undertaken. Focus of future work is on continued development of relationship with higher education. This will support opportunities for students in training as well as provide development for opportunities for career development of both unregistered and registered roles. ***Administration and Accommodation*** This work is at an early stage and will be appropriately informed by evidence now available due to implementation of Trakcare.	
15. CAMHS	
There have been 6 work streams within the Programme. These have all either been fully completed or are well progressed to a business as usual model of operational delivery:	

Neurodevelopmental Service All neurodevelopmental requests for assistance are now channelled via the established Neurodevelopmental Service. This combined three previous waiting lists (CAMHS, NDS and Paediatrics) and provided transparency of referral pathway, consistency of response and quality assurance of assessment. This is a highly skilled workforce and maximum efficiencies within resource are assured. Time limited commission of an external provider has provided additional capacity that facilitated assessments of young people before they graduated to adult service referral routes. Demand for assessment continues to exceed capacity. This has been highlighted nationally and is common across all health board areas. It is advised that national work will influence next steps with neurodevelopmental services. ***Choices & Partnership Approach (CAPA)*** This new model of patient management has been operational since May, 2023. It can now provide robust data capable of assuring planning of service capacity and informing trajectories over a longer time period. ***HR & Workforce*** A full review of workforce in line with CAMHS and NDS specifications was undertaken and professional and support staff gaps addressed. ***Communication and Engagement*** An Engagement Officer role has established a process that facilitates consultation with children, young people and their families. This provides assurance that the child's voice is represented in our strategic planning and individual care planning. A website has been established and design of CAMHS and NDS logos were undertaken in partnership with New College Lanarkshire and decided by public vote. ***eHealth*** Trakcare build completed to facilitate delivery of CAPA Model. Electronic case record now in place across whole service. ***Capital/Strategic Planning*** Large scale refurbishment delivered in South Lanarkshire. Work ongoing across 3 sites in North Lanarkshire to deliver same.	

The objectives initially set by Programme Board have been realised and have now progressed to a stage of sustainability of performance and quality assurance that is aligned with national specification. The performance trajectory is positive. 73.91% against an RTT of 90% was delivered in July 2024. Objective analysis by Public Health Scotland colleagues has assured that full delivery of 90% RTT should be realised by October 2024. This is reliant on continuance of funding aligned to a workforce that is responsible for delivery of trajectory. Additional modelling is taking place to provide assurance of patient review list care provision. Whilst not a government recorded or formally reported target, it is a good indicator of patient experience and shifts balance of care from responsive crisis management to planned intervention. Additionally, we continue to work with West of Scotland colleagues to deliver a standard of care provision capable of managing care locally and consistently to facilitate equity with other health board areas. This has included expansion of our unscheduled CAMHS (UCAMHS) model. It has combined the expertise of CAMHS Duty Team, Intensive Treatment Team and Nurse Team. Hours of service delivery will be further expanded in October. This additional capacity and expertise will support avoidance of admission care planning, support safe hospital discharge and manage risk appropriate to environment. The UCAMHS response model is available to all children and young people on both CAMHS and NDS lists who experience deterioration in mental health whilst waiting to be seen or awaiting specific treatment. This service is also open, by referral, to any child or young person previously unknown who has presented with an acute deterioration in mental health with aligned escalation of risk	
16. Paediatrics Review	
In order to deliver the Paediatrics Review programme, five working groups were established: • Communications and Engagement • Accommodation • Transition and Interfaces • eHealth (now Digital) • HR and Workforce • Regional and National Links	

All are at various stages of progress and have been prioritised according to acuity of clinical challenges that have arisen. Additionally, a sixth group has been established to ensure the modernisation plan is aligned with current financial challenges and potential for saving realisation as well as transformational change.

A 3 Horizon approach was taken to prioritisation and phasing of work to be planned and delivered:

Horizon 1
• Nursing Care Assurance
• Review of Continence Services

Horizon 1 work is progressing well. The nursing care assurance work has been led by the Associate Director of Nursing and been supported by NHS Lanarkshire Quality Improvement Team. The standards agreed have been inclusive of contributions made by nurse colleagues who work within paediatric in-patient environment and of community based nurses who support specialist care for children within a clinic, their home and/or school environment(s).

The Review of Continence Service has been led by Clinical Lead for Community Paediatrics. This has been more challenging to progress due to clinical demands on colleagues involved, changes within continence aligned workforce and assurance work identified that required address prior to full commencement of work. Despite these challenges, a literature review has been undertaken and review of current service model undertaken with a plan to test new model soon.

We expect further projects to be undertaken subject to availability of clinical staff. Further examples of work already being considered is the development of a supported palliative care pathway and review of current acute pharmacy colleague support and its interface with primary care. Prioritisation of work to be undertaken in future will be informed by release of capacity of colleagues who are completing initial Horizon 1 work and colleagues who can be released from clinical activity.

Horizon 2
• Sustainability of medical rota

This Horizon 2 focus of work emerged quickly as a clinical risk due to unsustainability of Tier 1 and 2 medical rotas that require to be in place to ensure safe function of in-patient care. Tier 1 is junior trainee doctors who provide the foundation of medical intervention within ward. Tier 2 trainees are higher trainee doctors who are working towards becoming a consultant within paediatrics. This is an important trainee rota to fill as it provides a pathway for interested trainees to return in the future as consultants. If numbers are not coming through and/or they do 5 not have a good trainee experience whilst with us, it will have a negative impact on long term recruitment of these specialist colleagues to Lanarkshire. Tier 3 is our consultant level rota. All rotas are inextricably linked and cannot be separated without negative impact on wider system, and at times on individuals. This fragility of rota is due to a culmination of factors which include less availability of trainees being provided by deanery and increasing numbers of trainees who want to work less than full time. This has resulted at times, in increased pressures resulting in use of locums and of requests generated to consultants to act down into senior trainee roles. This negatively impacts on planned community care assessment and review and places an additional burden of stress on an already tired workforce. Due to level of risk identified, additional support was approved by Core management team. Additionally, our Medical Director continues to have dialogue with deanery to assure that we are receiving an equitable offer of trainees. Horizon 3 • New clinical model Clinical capacity will need to be realised from completion of ongoing Horizon work to facilitate taking forward this larger piece of work. Meantime, informal discussions have commenced between nursing and medical colleagues with their respective professional leads. Health and well-being of colleagues during times of significant change have been recognised as a potential barrier and risk to further progression of work. Organisational development colleagues are supporting professional leadership and operational management to appropriately support staff throughout and beyond this programme of work by involving them in “stay conversations” which can also contribute and inform to modernisation plans.	

The pace of transformational change has been slowed by limited capacity of clinicians to commit time to service improvement work. This is due to clinical demand, which can be variable throughout seasons of year. This will be factored into plans for spring and summer 2025 that will aim to progress work towards delivery of new clinical model, Horizon 3.	
17. Community Solutions	
The Community Solutions Strategy and Investment Plan 2022-25 was approved in 2022 and continues to deliver a range of programmes activities within the third sector, supported by a range of programme evaluation and accountability arrangements. During 2023/24, VANL managed the provision of funding awards to Community and Voluntary Sector (CVS) organisations to deliver services to local people on a range of priority issues: • Anticipatory Care Support • Befriending Support • Carer Breather Fund - Phase Two • Children, Young People and Families Mental Health and Wellbeing Fund - Phase Four • Community Mental Health and Wellbeing Fund - Phase Two • Community Transport • Hospital Discharge Support A future review of funding arrangements will explore the following areas and develop updated investment proposals, which will improve health, wellbeing, and inclusion, whilst reducing demand on public services: • Our Community Connectors' pilot scheme • Continuation of our effective support for people discharged from hospital provided by the CVS. • Support for unpaid carers – especially short breaks from caring • Strengthening CVS support for physical activity given the significant benefits to health that can be achieved through physical activity and the potential for the CVS to provide further support. • Strengthening volunteer driver support for people attending health and social care appointments, to support access and inclusion more cost-effectively.	

• Review of anticipatory care and befriending will be supported through a separate complementary process Achievements to note from 2023 and 2024 include: The focal point of the Improving Lives Initiative is a pilot of Community Connectors using the "three conversations" approach to assist people in crisis to help them find support from community and voluntary groups and, if appropriate, refer them to sources of support from the public sector. This includes people with a diagnosis of cancer. Ten connector posts are funded for two years and are employed by North Lanarkshire Disability Forum, which has considerable relevant experience having previously employed advisors to assist people with self-directed support for over six years with national funding. Capacity Building • Carers' capacity building – North Lanarkshire Carers Together supporting empowerment and engagement of carers • Community & Voluntary Sector Capacity Building – VANL supporting the provision of specialist guidance to CVS organisations that assist children, young people and families. • Volunteering capacity building – VANL continue to promote volunteering within health and social care support roles and liaise with volunteer-involving organisations to improve their volunteer management and support	
18. Digital Technology & Systems	
The digital system transformation activity taking place across the partnership is considerable and the key projects such as Mosaic (the new social work case management system) and Dynamic Scheduling Tool are critical phases and will go Live before the end of this financial year. Each of the project teams continue to work with all stakeholders, including Senior Managers, front line staff and integrated teams across the partnership, to ensure a smooth transition as each product goes live and to ensure the benefits outlined above are realised.	

Implementing these systems presents not just a shift from legacy systems, some of which are end of life, but also a cultural shift in using digital platforms which allow the service to function differently. The ability to access and generate accurate and real time information to support practitioners, the ability for supported people to access their own data and the enhanced data quality and integration offered by these products will continue to support the service in enhancing staff's digital skills across a range of settings. As part of the review of the oversight groups for the programme of work, a new Digital & Technology Group has been established for the partnership and will be tasked with pursuing a range of programmes and projects which will introduce and embed a range of new digital systems, technology and equipment across a range of health and care settings. An important part of this work will be ensuring appropriate alignment with the digital developments already in progress within the other programmes of work highlighted in the report, e.g. CAMHS, Mental Health & Wellbeing Delivery Plan, etc.	
19. Engagement & Participation Strategy	
Over recent months a focused effort has been directed towards refreshing the Engagement & Participation Strategy that will serve as the foundation across all areas of our work. The final version of the Engagement & Participation Strategy 2024-27 was approved in May 2024. In the development of the Strategy, we actively engaged with stakeholders; representatives of community-based organisations, supported people, carers, and staff teams. Learning from these sessions has highlighted what is considered good engagement and participation and provided confirmation that the refreshed strategy should: • Be short and user friendly. • Be an overarching strategy that can guide communication and action planning across all areas of services and supports. • Build from the current strategy, including what we have learned and what people have told us. There has been good progress to increase the resource and capacity across community-based organisations to strengthen the voice of supported people, including those harder to reach e.g. BAME, LGBTQI+ and those in more rural communities.	

We recognise the importance in ensuring that engagement and participation is meaningful and not tokenistic, so the principles of engagement and participation are now included in the Staff Induction programme, both as written information and as a direct input to programme for new social work and social care practitioners.

A wide range of stakeholders have been actively engaged in the development of the Strategy through consultation and direct involvement. Promotion to implement the Strategy will be a shared responsibility and will include awareness raising and the development of practical tools to support:

- An evidence base on how people experience services and how their experience shapes and improves future development of services and supports.
- The voice of supported people in our communities
- Increased capacity for early intervention and prevention.
- Two-way communication and a strengthened feedback loop back to decision makers
- Increased feedback and the role of lived experience in improvement of services and supports.
- Increased connections with supported people and communities that are harder to engage with.
- Increased awareness about what is important to supported people and their communities.

The refresh of our Locality Planning Group arrangements and alignment with the Locality Planning Teams and Community Boards is underway. Once finalised, this will provide sector, locality, and thematic forums, which can be influenced and shaped through engagement and participation with our Communities, Carers and Supported People.

20. Academic Partnerships

In the past year, there has been a significant development in the strategic academic collaborations within the Lanarkshire system. With NHS Lanarkshire updating its Service Level Agreements with the University of Strathclyde, Glasgow Caledonian University and University of West of Scotland, work was also undertaken to develop strategic Memorandums of Understanding (MoUs) with both Councils.

Through these developments, MoUs have now been agreed with Glasgow Caledonian and both Councils, with the two Health and Social Care Partnerships now granted University Status with GCU. Work continues

to develop this approach with the other two Universities as we continue to develop our strategic academic approach. Overall, significant progress continues to be made across the NHS Lanarkshire and the Health and Social Care Partnerships in academic collaboration with partner universities. There has been an expansion not only in the volume of collaborative work undertaken but also in the complexity of projects and in the increasing diversity of links between NHSL and multiple departments and individuals across our strategic partnerships. There is a mutual desire to explore many more projects and areas of innovation that often require short notice decision making associated with modest sums of fixed term investments, though there has also been significant external funding identified over the year. More recently, the University of Strathclyde has signed Memorandums of Understanding with both Lanarkshire councils – consolidating the formal, multi-agency collaboration and continuing to develop the relationships and opportunities for the HSCP and local authorities.	
21. Care Academy	
The Care Academy is a collaborative initiative between NHS Lanarkshire, North Lanarkshire Council and South Lanarkshire Council. The Academy is authorised to work with partners such as local councils, education departments, colleges, universities, the independent sector and third-sector organisations to attract and recruit staff to the health and social care workforce. Four workstreams have been established: Workstream 1 – Attraction, recruitment, retention and wellbeing Developing recruitment strategies to attract prospective candidates to the sector. Engaging and focusing on employee safety, well-being motivation to enhance employee retention. Workstream 2 – Pathways to care for young people Strengthening the reach and impact into the health and social care sector through a vocational education model, aiming to grow a future talent pipeline.	

Workstream 3 – Adult pathways to care Improving prospects for working-age adults entering the health and social care sector, addressing poverty, and inequality, attracting passive candidates, and facilitating career change opportunities Workstream 4 – Funding and procurement Continually review and assess current and upcoming funding streams and identify potential gaps and opportunities. Explore the potential of community benefits opportunities. It was agreed at the most recent Board meeting to put this workstream on hold until the others are all well established.	

	Incomplete and unlikely to be delivered against agreed timescales – remedial action required.
	Incomplete and but within acceptable thresholds.
	Complete or on-track for completion against agreed timescales