COMMUNITY SOLUTIONS
Building Community Capacity and Carer Support

Community Solutions Annual Report

1 April 2019 – 31 March 2020

10th April 2020

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Introduction

Community Solutions (previously Community Capacity Building and Carer Support) is Health and Social Care North Lanarkshire's Community and Voluntary Sector (CVS) delivery branch. Through the Community Solutions Strategy, "Softening the Lines", - the CVS's contribution is co-ordinated, robustly monitored and works to the regional logic model based on a series of programme outcomes. The Community Solutions work is based on co-production (which includes co-commissioning at a community level); giving people choice and control and building compassionate communities through connections and capacity building of local supports.

Using eleven project hosts to guide best practice (e.g. in physical activity; healthy eating; anticipatory planning; transport etc) and 6 locality host organisations to ensure a truly community led approach, a devolved budget of £1.14 million from HSCNL together with a number of additional funds totaling £1,390,000 is directly invested in organisations and community groups (budget for 19/20 attached as Appendix 1) with countless others receiving support from other means such as capacity building, training and organizational and volunteer support.

Investment ranges from micro-investment (£300-£5000) and matched funds, to strategic investment in projects of up to £75,000. Our programme approach ensures that all activity links to Partnership outcomes and that best value is achieved. Additionally, the programme is able to use its budget to leverage a significant, although variable, amount of additional funding and in-kind contributions. In 2019/2020 a conservative estimate of additional income leveraged totaled £743,383 (detailed in Appendix 2). This excludes the new funding generated in 19/20 for implementation from 20/21 onwards of £627,887, which will be increased as the year progresses.

Our approach has been recognised nationally and internationally as a model of best practice to achieve outcomes for citizens and get best value from the CVS. This report details the activity and outcomes for the year 2019/2020.

Background

It is widely recognised that prevention is a key component of managing future demand in terms of health and social care. It is also recognised that the health and wellbeing of the population can be negatively impacted upon by issues such as lack of physical activity, poor nutrition, poverty and inequality. Evidence about the negative impacts on physical and mental health of isolation and loneliness has also been increasing.

The Community Solutions programme and the associated 5-year strategy focus on supporting the prevention agenda. The programme is built around a personal outcomes-based approach which looks at the individuals, their strengths and seeks to improve lives by reconnecting people with their own networks, communities and community assets. This approach also recognises the key contribution of carers and the importance of supporting them in their role and improving their personal outcomes.

By having the overarching aims of preventing isolation and loneliness and addressing inequalities; by moving away from defining people by age or condition; by reconnecting people with their communities; and by looking at innovative approaches which support people to be more active and to have a better diet, we can significantly improve the health and wellbeing of the population. This approach builds more inclusive, cohesive and resilient communities thereby reducing future reliance on statutory agencies and services.

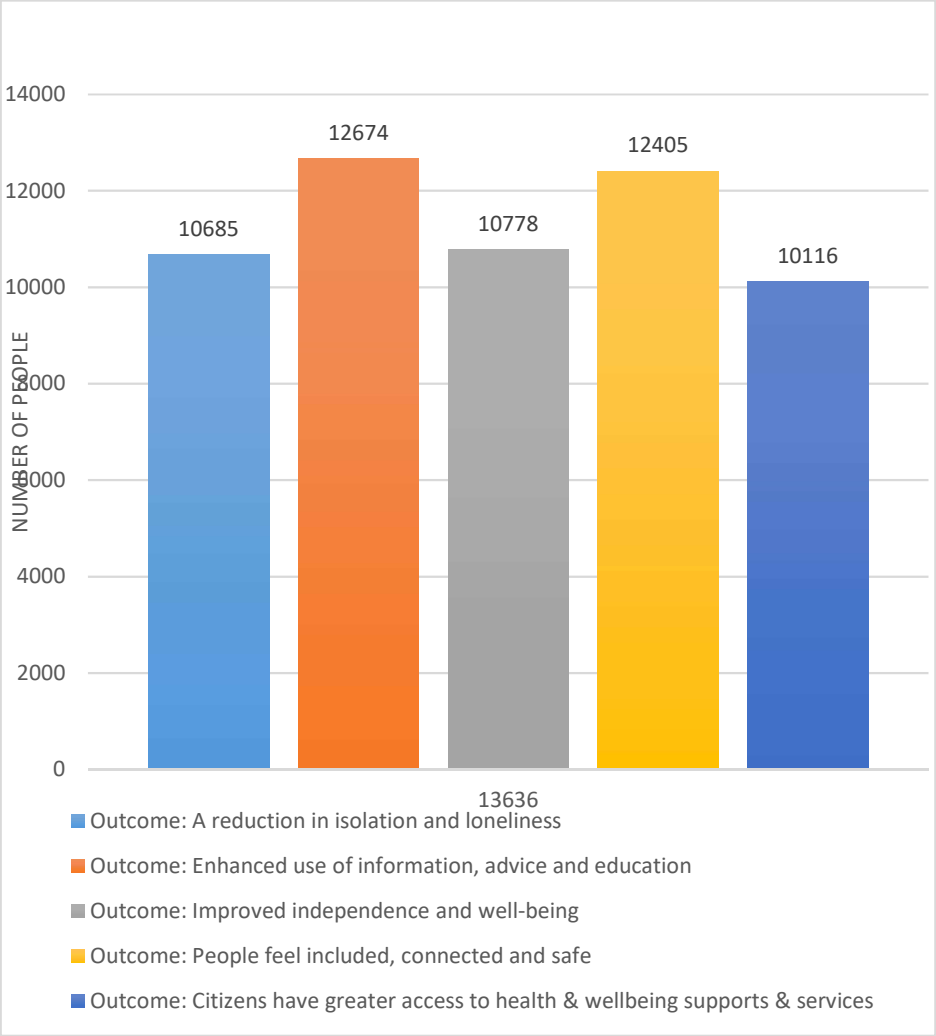
Programme outcomes

The following are the programme outcomes for adults, carers, and children and families achieved from 1 April 2019 – 31 March 2020. Please note that owing to a delay in funding to the Home visiting and Befriending organisations, associated projects only reported on six months of activity.

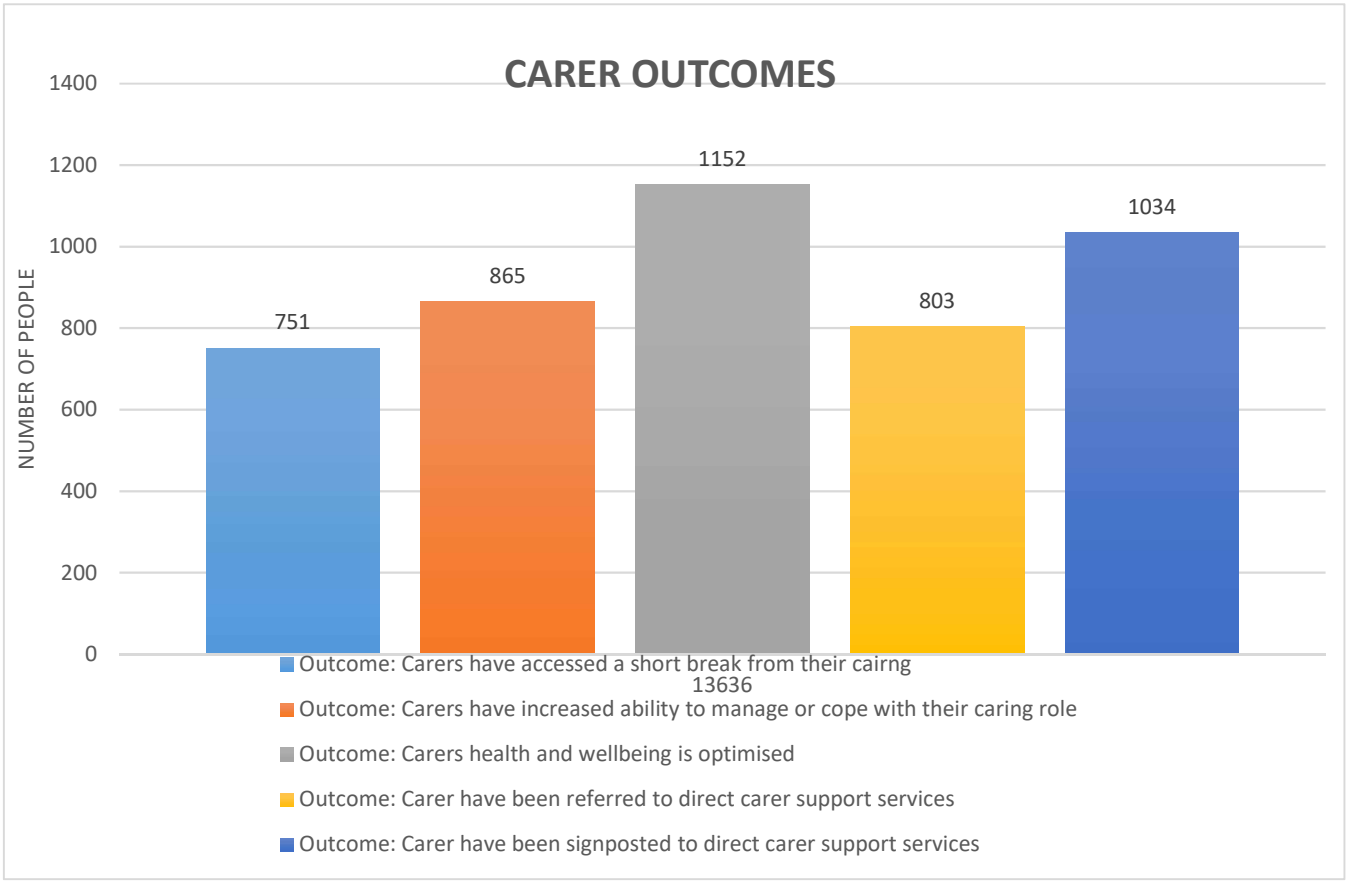
Additionally, we do not collate impact questionnaires from the community transport journeys as we feel it would be invasive in many cases for the drivers to request information of this nature on a journey. Therefore, the assumed outcome data from community transport has, as in the last four years, been excluded but represents significant output as well as significant investment.

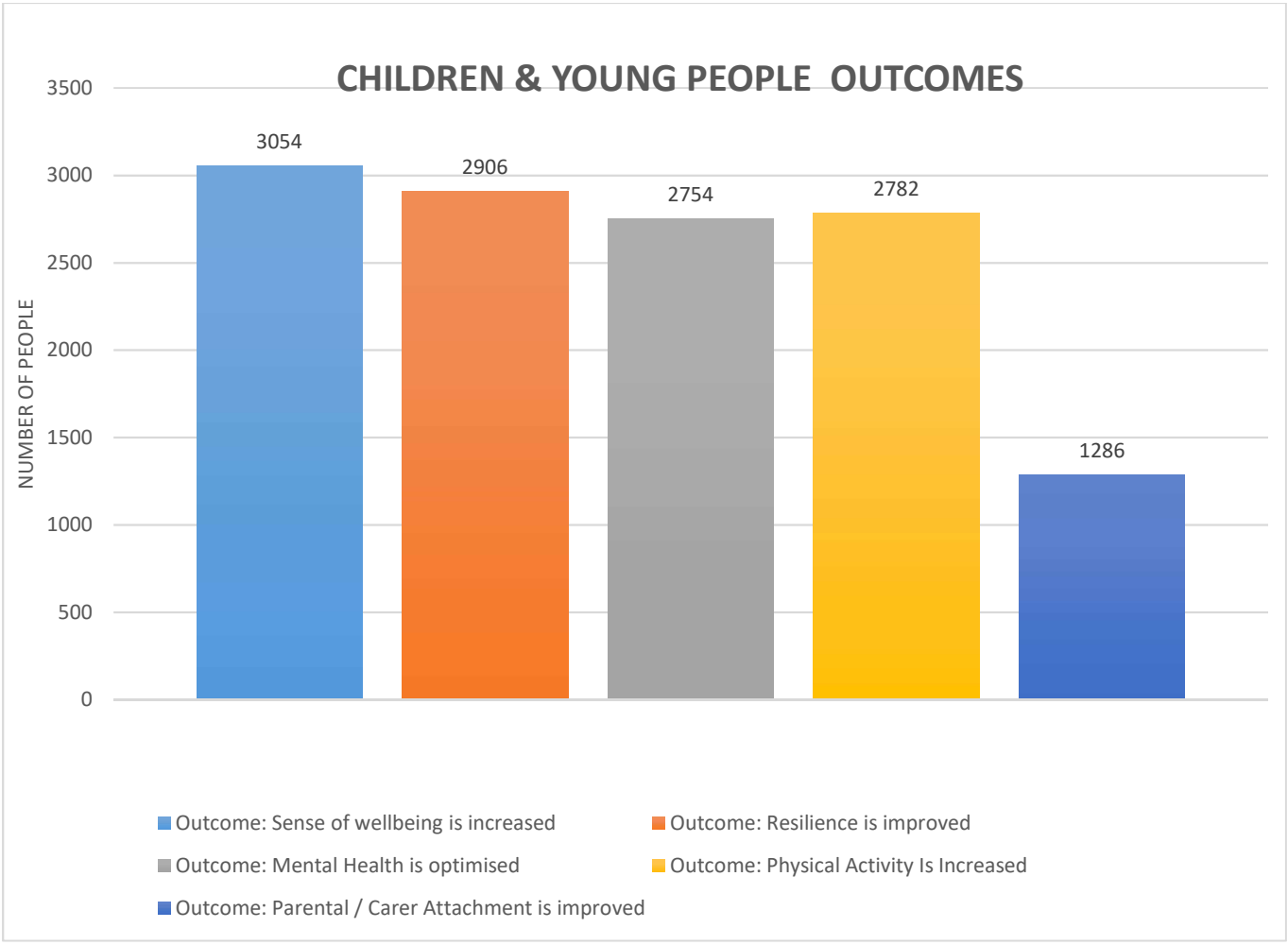
Please also note that since the inception of the Community Solutions, how and what we report has been reviewed year on year to try to ensure the data is as robust as possible whilst remaining proportionate. This review has been enhanced in year to include the engaging of a Senior Research, Information and Evaluation Officer who has worked with key stakeholders and will offer a revised monitoring framework going forward. It is hoped that this will include cost avoidance data and impact on High Resource Users.

The projects from which the outcomes were achieved are noted in Appendix 3.



Outcomes for carers are noted below. These show a significant drop both on last year but also on a historic target of 50% impact on carers which was removed in 19/20. This should be addressed by Community Solutions funded organisations and is already being addressed through the new investment in Carer Conversation for 20/21 (detailed under Carer Update) as well as the work of the sub groups of the Carer Support Network.




CHILDREN & YOUNG PEOPLE OUTCOMES
NUMBER OF PEOPLE
3500
3000
2500
2000
1500
1000
500
0
3054
2906
2754
2782
1286
Outcome: Sense of wellbeing is increased
Outcome: Resilience is improved
Outcome: Mental Health is optimised
Outcome: Physical Activity Is Increased
Outcome: Parental / Carer Attachment is improved

Locality partnership development programme updates

The Locality Partnership Development Programme (LPDP) and associated Locality Activity Fund (LAF), a £30,000 delegated budget to each locality consortium for co-production, remains the foundation of the Community Solutions programme ensuring that community capacity building, taking an assets-based approach continues to the driving force behind the strategic direction of the Community Solutions work.

Key successes from the locality activity fund investments are noted below and a full list of the groups and organisations invested can be found as Appendix 5.

Locator

Awareness of what is available is often one of the biggest issues for community members and health and social care professionals and therefore Community Solutions staff continue to build the Locator tool. In the year from April 2019 to March 2020 key statistics in relation to Locator use:-

- 8,907 unique users generated
- 42,784 page views
- On average users will spend 2 minutes 35 seconds per site visit
- 40% of all site users browsed more than one page on each visit
- two highest search categories were social group and parent and toddler groups.

Airdrie

Airdrie locality have funded 19 different locality activity projects with an average investment of £1578 and a projected reach of 3821. Despite 7 projects funded in 19/20 being yet to start, the locality has been able to demonstrate outcomes of 122 reports of reduced isolation and loneliness and 584 reports of children and families with an increased sense of wellbeing.

Projects have included, Diamonds in the Community and Time For Us both having a focus on children and young people who live in poverty and are isolated. Another five projects funded during quarter 4 had a focus on children and young people including boulder climbing in Plains to growing veg in the centre of and Airdrie car park.

The new Community Fridge Project is an innovation of the newly created Airdrie Poverty Action Group (APAG) that sees a large number of partners attending due to the high levels of poverty within Airdrie and the villages. Members include CLD, VANL, NHS, Airdrie food bank, clothes bank, Diamonds in the Community and NL leisure. This group will be having a development day in late March and are also looking at becoming a constituted group so they can access funding through the Big Lottery. Currently the Community Fridge project will be delivering in Whinhall which is an area where the consortium host has held a few events. However there are no ongoing community groups within the area. With the resurrection of Whinhall Action Group this project will be overseen by this community group with support from the consortium and APAG and will also look at housing a fridge at St Margaret's School. The area identified is near the bus stop as many children go home to an empty fridge an no dinner. The Airdrie Craft Group will be building a casing for the fridge as this needs to be outside and not locked in a school or community centre, where access is limited.

Bellshill

Bellshill locality have funded 12 projects in year with an average investment of £2,500 per project. Reporting on 31 funded projects to include those which had been funded last year and continue to deliver, Bellhsill have a projected reach of 1107 people. In year, Bellshill locality host used their Befriending investment to generate an additional £324,887 over five years from a Big Lottery Award demonstrating the impact of the HSCNL investment.

Working in partnership with wider consortium members, Bellshill Neighbourhood identified six individuals within their group who could benefit from developing their cooking skills and nutrition education. The areas focused on in the course were food hygiene and safety, as both had been highlighted as key areas to cover, as well as food labels. Currently no course evaluation exists but there are some comments passed on from the Neighbourhood Network community living workers throughout the course.

> *When I spoke to participant A yesterday, she said it was great and she was desperate to tell her key worker, she told me all about the macaroni cheese especially*
>
> *One of the members contacted me last night to say they had just ate their meal they made and loved it, you're a hit!*
>
> *They are all loving the course, I think it's been very beneficial so far.*
>
> *I think the hand washing activity was really useful, particularly now that it's so important to wash your hands at the moment*

glow bug hand washing activity

The Bellshill Locality joint development event took place on 3 October with the theme of 'Communications'. Approximately 60 representatives from statutory, private and third sector colleagues attended. Representatives from LAF funded organisations were also invited to participate and showcase their work and other local partners attended to share information on their areas of work with the attendees, eg Police, NHS, Paths for All, NL Disability Forum, Orbiston Neighbourhood Centre, Bellshill West Parish church, Voices of Experience Forum and others. - There were 4 main themes explored in 4 workshops:

- Locality profile – comparing new and old;
- Communicating effectively;
- What's missing within communication in Bellshill;
- Scotpho data website and MLE website demo.

Positive Growing with VIP

J is a young boy in kinship care, who has witnessed and experienced domestic violence from two parents who are drug dependant. On attending VIP at beginning he was very disruptive, screaming, hitting other young people and being very aggressive. J is now attending over two evenings and has calmed down, he is willing to take part in group activities and has made new friends within the group.

On discussion with his social worker, they have commented that J is now listening and able to communicate better at sessions with them and that his teachers and head teachers have said his concentration has increased and his ability to share and willingness to take part in activities has improved and this is down to VIP.

Coatbridge

Community Solutions Coatbridge has funded a total of 14 projects through the Locality Activity Fund throughout the year. These projects have covered a wide variety of initiatives, working with all ages, to meet key health and social care outcomes across the locality. To date, there has been a total of 554 participants taking part in LAF funded projects within the Coatbridge locality this year. 177 participants noted that they felt a reduction in loneliness/isolation as a result of participating in a LAF funded project. 194 people said their participation in a LAF funded project has helped them feel more connected with their community. Carers also remain a key focus in relation to this funding - 84 carers have felt they are more able to manage their caring role as a result of being part of a LAF funded project and 242 of our locality's children and young people reported that they felt an increased sense of wellbeing through participating in LAF funded programmes.

Jelly Bean

Coatbridge have funded Jelly Bean which has had an enormous impact on *Daniel* and his family. *Daniel* is a 7-year boy whose family is living on a low income. *Daniel* began attending sessions roughly a year ago. His family had advised that Daniel could find new people and situations very difficult to cope with and that this could, in turn, trigger him to exhibit challenging behaviour. Since joining Jelly Bean he is becoming much better at dealing with new and unfamiliar situations. *Daniel's* mother has also reported that this has been mirrored at home and that he appears to be happier and more settled He is also becoming much better at dealing with new and unfamiliar situations.

His regular attendance at Jelly Bean has also enabled his mother to continue working. Its continued running during the refurbishment of the Centre, made possible by this funding, continues to impact Daniel and the other children and families who use the service, in a positive way.

Coatbridge have also funded AVP (detailed as case study 3 in Appendix 6) which has made lifechanging impact on the individuals who take part.

> *Great, I feel so much better and the course made me realise a lot of things about myself and others. I honestly feel like the course has saved my life and I think everyone should do it.*
>
> *The main things I got from the course is that it made me see how my behaviour was affecting other people and that it helped me understand why people act in certain ways.*
>
> *There were loads of lightbulb moments throughout that made me see things clearer and feel more positive about myself, life and the future.*

Cumbernauld and the North

Cumbernauld Locality funded 20 different locality activity projects at an average investment of £1,500 per project. Owing to a variety of factors including staffing changes, many of the projects have been unable to report in year resulting in a low outcome return. However, this should be rectified in early 20/21.

Highlights from the year included “Sheila’s Sheds”, where one participant stated that she had always wanted to do woodwork but, in her day, ‘*girls weren’t allowed to do woodwork at school, it was only the boys. Girls had to do domestic science.*’ Participants thoroughly enjoy attending and have been making educational toys to donate to children and young people with additional needs.

Additionally, in quarter 2, the consortium funded the North Family Summer Programme 2019 which was a well attended programme with 83 people (51 children and 32 adults) attending 8 trips to family friendly venues which were tailored to meet the needs of children and families with additional support needs.

> *gave me time to interact with other parents who have kids with special needs*
>
> *all members of the team who led the group were brilliant and my kids thoroughly enjoyed themselves. Thanks for organising these trips*

Motherwell

The Motherwell consortium have funded 15 groups with an average spend of £2000 from which they have generated 770 reports of reduced isolation and loneliness and 294 reports of carers having a short break from their caring role. With a renewed focus on children, young people and families, in particular the mental health and wellbeing of this cohort, they also have 951 reports of children, young people and families having increased sense of wellbeing.

To everyone at The Motherwell Consortium.

Thank you so much for granting our charity funds through your Locality Activity Programme.

In October we celebrated our first birthday and in one year we have grown so quickly and helped so many people, thanks to the kindness of people like you.

Recent fundraising and donations that we have recieved have allowed us to open a Chat Cafe in Newmains Community Centre, add a new Bake & Banter activity at the hub and add another counsellor to our staff. We are also in the process of starting up a Women's only Fitness and Well-being Club, a Chat Cafe in Forgewood and a Kids Mental Health Hub.

We know many charities applied for funding, so we are very grateful that you supported us.

Thank you so much from everyone at You Are My Sunshine Charity (YAMS).

Rhonda Jones, Chair

YAMS exists to make mental health support more local and accessible to communities. They have been working in Newarthill since their inception, however following contact from local people in the Forgewood area where there have been an increase in suicide rates recently the consortium has worked with them to look at building their capacity in terms of volunteer recruitment and development and linking them with other mental health support organisations to provide similar services in the Forgewood area. These would include activities such as exercise groups, peer support groups and linking in with existing counselling provision in the Forgewood area.

Reach Lanarkshire Autism have also identified a number of families from the south of north Lanarkshire (Bellshill, Motherwell, Wishaw) who are unable to access Autism Support for their children because of the issue of transport and also established that when their children are older (teens, young adults) there is limited support opportunity. So, Reach will develop a Motherwell based activity group for teens/young adults with autism, an initiative that has been supported by a few Community Solutions Locality Consortia.

X was very withdrawn and seemed anxious when he joined the Teen group (Reach). The first few weeks it took a lot of encouragement from his parent to get him out the car and come into the venue. X would scream and become very agitated once he entered, he would not allow his parent to be out of his sight, wouldn't interact with staff or his peers and they would need to leave after 15 mins or so. It was also visible that his parent was becoming very stressed during these episodes.

He received positive prompting and lots of reassurance from staff until he seemed to settle and adjust to his surroundings. X is nonverbal but we were able to identify from close observation of his body language that he seemed to enjoy helping staff to set up activities for the group. X seemed to enjoy having ownership of the responsibility and now makes it his task each time he attends.

The difference in X confidence is brilliant, he is beginning to socialise with his peers and has now allowed his mum to sit with the other parents / carers in an adjoining room. His parent stated that he pulled her jacket and gestured her to go away to sit with the other parents. She also mentioned that she has now taken him to other activities to try, something she had always been too anxious to do on her own.

Intergenerational work continues to be a focus for the Motherwell Consortium. Two local primary schools Muirhouse Primary and St Brendan's are now engaging weekly with the local lunch club within the Isa Money Centre in Motherwell. This activity is being supported by Befriend Motherwell and to date has not required any LAF resource but consortium support to make the connections with the schools and lunch club. This culminated in attendance from the local school at the befriend Motherwell Christmas lunch.

Wishaw

The Wishaw Consortium invested in 16 projects in 19/20 with an average investment of £1,875 in a wide range of projects the impacts or which are demonstrated below. Additionally, the consortium host used £29,000 from Community Solutions Befriending investment as match funding to support their Big Lottery Befriending proposal which has secured a further £305,000 into North Lanarkshire.

This will support the growth of their mentoring project which J attends (see below).

J (32) was referred into the mentoring program from Routes to work and had never had paid employment having been a carer to his father his whole life. On the loss of his father, he was put on Universal credit and obliged to seek employment. He presented as (and believed) he had a learning disability although never had any assessment or diagnosis nor received any community support before.

J was matched with a Befriender initially to socialise J in his local area and to help him develop aspirations. After the initial 4 weeks with the Mentor J revealed that he couldn't read or write well nor understood a computer. He was good at gaming and had developed effective evasive techniques to disguise the fact that he couldn't read but also that he would love to be a confident reader. Unfortunately, there were no basic literacy classes happening in the locality which suited J but through the mentoring volunteers, the consortium were able to find a retired teacher who offered to 'tutor' J until a suitable class was identified.

It transpired that J 's confidence in learning had been stifled at some point in his life and that he did understand more reading than he believed himself. This boosted his confidence in learning and increased his self worth . Within a matter of weeks J was confident enough in asking to tackle reading on the computer.

J is now linked to Lead Scotland for computer sessions and has created a 'picture' aspiration of attending college to do panel beating and mechanics with a view to gaining employment and a better life for himself. Meantime, he has joined the local men's shed and attends frequently, now confident enough to take the lead in welcoming new members and plans to join a local motor sport club as a volunteer to get some experience in working with cars and work related responsibilities.

The Consortium also funded the ever-growing Shotts bike revival which, aside from a visit from the Cabinet Secretary for Communities to make a smoothie from a bike, also has an attendee P.

P (67) has suffered from isolation due to having suffered a stroke 8 years ago which left him with limited use of his right-hand side. Having previously been a very active man this has led to a decline in his mental health due to loneliness and '*feeling like a spare part'* to use his own words. He attended the Shotts revival event where he was able to "cycle" by using the wheelchair transporter bike (his chair attached to the adapted bike) and he felt the freedom of being on a bike.

On the day P progressed onto the side by side tandem piloted by a ride leader and '*felt the best I've felt in years! When are you bringing the bikes again?*' This has led P to now take more interest in his physiotherapy exercises so to be fitter when spring comes around.

Thematic project updates

Anticipatory Care Planning

The Preventative Advocacy Lead Officer (PALO) continues to work across the six localities building strong links with the statutory, private and voluntary sectors in efforts to build capacity for all care groups and carers; ensuring that their quality of life is enhanced within local communities. This is being achieved by carrying out a programme of outreach work; this includes 1:1 advocacy support, information stands, surgeries, talks/presentations.

Throughout the final quarter, work has continued in promoting Anticipatory Care Planning (ACP) along with further methods of future planning. In addition to promoting ACPs, the PALO continues to support individuals to complete same.

A working relationship with Caldervale High School has continued and during the final quarter, two training sessions were provided to young people aged between 13 and 16. In addition to this we have also provided information stands at two events aimed at pupils and their parents. These events allowed us to target people of varying backgrounds ensuring that information relating to ACPs and future planning were disseminated appropriately.

Preventative Advocacy & Future Planning Reach

21 Preventative Advocacy Sessions

238 Attendees

21 Information Stands on Future Planning

878 Attendees

28 Future Planning Surgeries

93 Attendees

Work with Sheltered Housing Complexes continues and has expanded to include private organisations, recently providing a training session to residents within a Bield Sheltered Housing Complex. Moving into a new year of work it is anticipated that work will continue with the private sector of Sheltered Housing by organising appropriate training sessions with Bield, Trust and Hanover Housing. The PALO continued to work in partnership with St Andrews Hospice providing training sessions to the Outpatient Department. These sessions were delivered to the Wellbeing Groups and this will continue into the upcoming year of work with further dates scheduled.

Community Alarms

In year, 382 visits have been made with 774 being contacted resulting in 335 signposts.

This work will become critical as home care and the way in which community alarms are reviewed and evolved. In 20/21, for the first time, the Community Alarms funding will be managed through the Community Solutions structure though they have always linked closely.

Community Food

In year, 117 courses have been delivered with 433 participants. The types of courses are wide, varied and needs led as is evident from the examples below ranging from people who were recovering from throat cancer (through Maggie's Centre); children and young people with additional support needs and their families; and those in sheltered housing as well as those with specific health conditions e.g. diabetes, prediabetes etc. This illustrates the co-ordinated and strategic approach driven at locality level requiring expert delivery services.

A four-week course was offered at Willowbank High which offers day support to young people who have social, emotional or behavioural needs. This course had 2 families attend (6 participants overall), as well as one pupil who attended on his own in the final week. This course was facilitated in partnership with a home/school partnership worker after she identified a need to try and engage families at the school with cooking.

Topics that were covered included the Eatwell Guide, how to increase vegetable intake, eating well for less and free sugars. Some feedback from these sessions:-

I enjoyed making pancakes and playing games

I enjoyed everyone's company

Amazing

I enjoyed everybody's company and winning the balloon challenge

I enjoyed the activities and games and cooking

Additionally, two 1.5 hour training sessions were facilitated with 7 members of staff who regularly work with people living at Meadowside Gardens and Broomfield Gardens sheltered housing. The training covered three modules:-

- eating for health and wellbeing;
- nutritional and health needs of older people; and
- supporting older people to eat well.

Participant scores of "how confident are you in supporting older people to eat well" increased from 6.3 to 8.1 between pre and post training (where 0 = not confident at all and 10 = most confident).

This was followed by a food demonstration with 13 individuals from Meadowside Gardens and Broomfield Gardens sheltered housing. All of the individuals had long term conditions such as T2DM, high blood pressure or high cholesterol, which is why the resources that were used were chosen. The recipe was also from Diabetes UK so that it would be suitable for all the individuals. Everyone who attended said that they enjoyed the curry and that the resources were useful.

Airdrie (Maggie's Centre)

Background: Participant A had been diagnosed with stomach cancer and has undergone a gastrectomy (surgical removal of a part or the whole of the stomach). Post treatment, the recommendations were to eat, little and often however high protein and fat meals to ensure they met their energy requirements. Participant A is now off supplement drinks because she is managing to maintain her bodyweight and is eating more regular due to the support of the NHS, Maggie's and LCFHP nutrition inputs.

Session 1: I am struggling with nutrition and meal ideas as I've been doing weight watchers for years but because of cancer, I have had a lot of my stomach removed so I've to have a high energy diet (high protein and fats but small meals now). At weight watchers it was the opposite, I feel my thoughts around food have been conditioned for many years which is hard to change. I know that I'm losing weight and need to start adding fats to my meals however, I just can't handle the thought of adding cream to food.

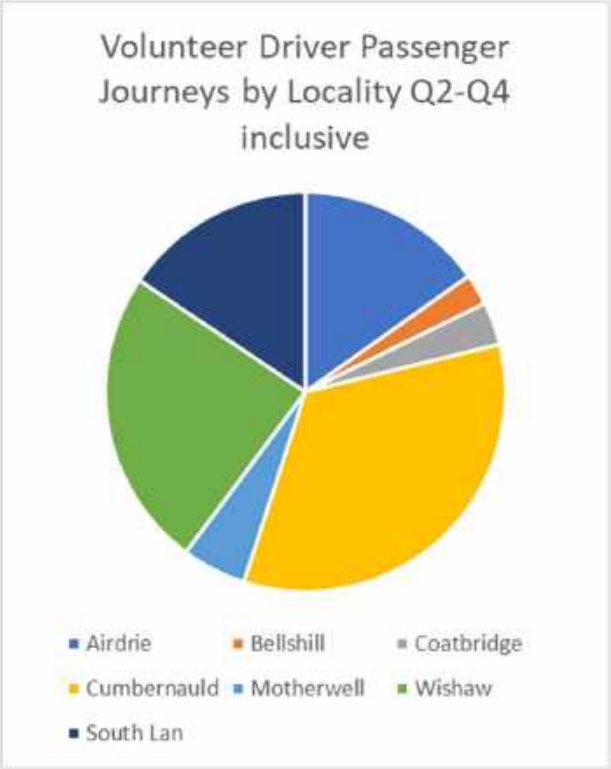
End of Course: Another great session learned another recipe that really suits my needs and how to tailor meals to my taste. I loved the black pudding and cheese and tomato muffins. The classes have really given me motivation to cook again and eat healthier and to support me to eat enough post gastronomy. I feel these classes have really been beneficial in my recovery. I'm pleased to say, I feel the benefits of eating more nutritious meals as I feel better and have more energy.

Community Transport

Community Transport continues to be a key pillar for Community Solutions delivering a staggering number of outputs and journeys utilising well-supported, well-trained volunteers to do this.

Key outputs:

- 19, 160 Passenger Journeys
- 15, 001 Mini Bus Journeys
- 3348 Volunteer Driver Journeys
- 4292 Volunteer Hours



Linking closely to partners in Health and Social Care North Lanarkshire (HSCNL), including but not exclusively the NHS Lanarkshire Hub pilot, Getting Better Together Shotts as the Community Solutions Lead organisation also bring an additional resource totaling £54,500 to the Programme from Strathclyde Passenger Transport with £22,500 for a much needed wheelchair accessible vehicle and £32,000 in additional funding.

October 2019 saw the highest ever usage of volunteer driver with over 300 journeys made.

In January and February 2020 there was a 37% increase in comparison to the same time period in 2019. Community Solutions made an additional investment in Community Transport Volunteer Drivers to support the service due to these increases.

At time of writing (April 2020), the impact of Covid-19 highlighted further the need for an enhanced community transport service with NHS Lanarkshire hub transport provided by Getting Better Together with demand doubling since 23 March 2020.

Through the Strategic Commissioning Plan, Community Solutions have submitted a Community Transport to Health Programme of Work which commits to working with our partners and linking to the Achieving Excellence initiative to ensure that this need is met.

Cost Avoidance

Whilst the work of the Monitoring Framework is ongoing, the following rationale is being applied to address cost avoidance estimates for volunteer drivers.

Volunteer Drivers carried out 3348 passenger journeys in 2019/20 – that equates to 1674 passengers taken to and from the hospital.

It is reasonable to assume that due to the age and mobility difficulties that most passengers would not be able to attend their appointment without the assistance and level of service offered by their volunteer driver, ie picked up at home address, correctly assisted to vehicle, escorted to and from Hospital department, correctly assisted to vehicle and taken home then assisted to their front door if required.

On the basis that 50% did not attend appointments	837 people
DNA (did not appear) cost (NHS Lanarkshire figure)	£135
Cost avoidance for NHS Lanarkshire (837 x £135)	£112,995
Cost of funding Community Transport project	£72,000
Total cost avoidance	**£50,995**

High Health Gain Individuals

The High Health Gain Individuals test of change saw delay in start-up owing to a delay in funding. In quarter two, an event was held in the Health and Wellness Hub where four of the participants of the Health and Social Care North Lanarkshire (HSCNL) High Resource User (HRU) Programme attended. One individual engaged with the volunteer development programme. Following this low return from the HRU Cohort (HSCNL Working Group), more focused work took place with individuals out with this cohort resulting in three high health gain individuals engaging.

Whilst this is a low quantitative return, the impact on individuals concerned is high and the cost-saving, which Community Solutions cannot currently reliably establish, can be assumed from the nature of the high health cohort. This will be explored as the Monitoring, Evaluation and Learning Framework evolves.

One individual was attending social work once a month, psychologist once a month and Occupational Therapist once a month. After six months of supported volunteering, she has been discharged from all three and does not self-medicate anymore with alcohol. Although she still suffers chronic pain all over her body she takes Diazepam 5mg if and when needed & sleeping tablets if really needed. Since volunteering her tolerance of being around people and new surroundings has increased so much that she is now doing two hubs per week. She is also leading on the garden project at the office with planting flowers and looking after them. She has informed the hub that she is ready for more responsibility and therefore it has been agreed she will become a Hub Co-ordinator from April 2020.

Whilst the investment from Community Solutions for this project has ceased, High Health Gain Individuals remain a key priority in the strategy and engagement of this cohort should continue to be explored including:-

- With the specific HRU HSCNL Working Group Cohort;
- With other individuals out with this cohort who have high usage of variety of services;
- How to quantify the reduction of use in services as a result of community and voluntary sector supports.

Homevisiting and Befriending

9 Community and Voluntary Sector organisations have been funded through a consortium approach to deliver Home Visiting and Befriending services. This coordinated approach allowed an increase in quality service delivery to meet differing needs across North Lanarkshire. This included support to those from 0-2 years, family support, mentoring for young people, support for local adults and coverage of rural areas.

Home visiting and befriending

- 1572 Telephone wellbeing checks
- 153 Telephone Befriending Matches
- 322 Group Befriending Sessions
- 62 Referrals to other services
- 334 Signposts to other services
- 81 Volunteers recruited and matched
- £548,055 match funding

Community Solutions funded organisations to the value of £179,545 with confirmed match funding of £548,055 demonstrating a more than doubling of the HSCNL investment. Additionally, in 19/20, using Community Solutions funding as future match, GBT Shotts were successful in securing Big Lottery funding of £305,000 over two years and Orbiston Neighbourhood Centre similarly were successful in securing £324,887 over five years.

Parents are offered support to develop attachment with their children through Homestart using evidence based approaches (Video Interactive Guidance)

The impact that befriending is having through our collaborative approach ensures that lives are being changed for all members of our community as is demonstrable from the snippets below:

> *It's been nice for me to be able to spend some time with her (volunteer). I go to college during the week and usually look after my dad at weekends, so to go a walk or grab a coffee and tell someone about how things are going really takes my mind off things.*
>
> (Young Carer (18) Volunteering Matters)

> *My befriender and I have already been out for a walk and we have more things planned. My days don't seem quite so long now, thank you*
>
> (Cumbernauld Action for Care of the Elderly Participant)

> *I never use to go out until I came here, you can get cabin fever if you don't go out*
>
> (Young Mum Homestart)

Hospital Discharge / Discharge to Assess Test of Change

In total the service has supported or provided information to 120 people. The service made 61 direct referrals on behalf and patients and their carers to a range of community supports which are provided by localities, thematic projects and the wider community.

In November 2019 we commenced the test of change to expand the service to support referrals from the Community Rehabilitation Teams and the Discharge to Assess (D2A) model. In the final quarter the service has made contact and supported 39 patients and carers as a result of a referral via D2A or the community rehab teams. From the 61 direct referrals made in March 2020, 35 of these were made as a result of this referral pathway. In total we have supported 56 individuals and made 48 referrals since November 19.

Key statistics

- 67% of enquiries were for people over the age of 65
- 28% described themselves or the cared for as living with a mental health issue (47% Dementia Diagnosis)
- 67% described themselves or the cared for as living with a long-term health condition
- 36% of people described themselves or the cared for as feeling lonely and isolated

The service continues to identify hidden carers, provide information and make direct referrals for carer support with 27 carers given some level of support in quarter and a further 58 being signposted.

The Carer Coordinator post at University Hospital Monklands is still to be filled and meanwhile the community liaison service continues to pick up referrals to support carers directly during the discharge process. At present the numbers received do not impact negatively on the service and the support provided at this time leads to ongoing referrals to the community.

> *I was looking forward to getting home but now I realise how isolated I am now that I am not in the company of others in the ward.*

Since retiring through ill health I have really been wanting to occupy my time. Volunteering locally was a great suggestion.

The volunteer driver transport to my appointments is a massive relief as I do not have to leave my husband for as long as I would, if I had to use public transport.

Physical Activity

In year, there has been a 7% increase to just under 50% of people being referred to Active Health who have subsequently opted to take out the offer of an additional three month membership at a reduced rate. This shows that people are remaining physically active up to five months after the initial engagement.

Specific work has been driven to support people and their families affected by cancer. The range and depth of this work has been at both strategic level: looking at patients journey from diagnosis to a return to community based activity; discussion about the steps to embed the current physical activity programmes for people with cancer in the Active Health programme; and at a practical level, delivering workshops to Breast Cancer Care Charity groups, the local metastatic breast cancer group and groups at Maggie's Centre. The information and support services developed by the Macmillan in Lanarkshire Project team has a far reach and is contributing significantly to reducing the sense of isolation, anxiety and frustration individuals feel when dealing with a cancer diagnosis.

The whole programme which is funded through £40,000 co-ordination fee combined with funding via NHS Lanarkshire Active Health investment (£181,064) and Macmillan (£33,000) has increased reports of reduced isolation and loneliness up to 7451 and has the following comments:

I feel that coming to this class has helped me a great deal with my physiotherapy I am standing a lot more and I am gaining a lot more strength. I feel if it wasn't for my class being available I wouldn't be feeling as great in recovery as I do. I am doing movements with my arms and legs. This class is BRILLIANT.

Strength and Balance NM female (34)

I have attended since I had my stroke. The exercises initially helped me regain my mobility and have since given me the strength to maintain a fair degree of stability when walking. Being a group of people of similar age and who also find movement a challenge has proved to be a great help and incentive to improve together and share our problems.

WH male (85)

Shopmobility

Since July 2019, there have been a total of 67 new registrations across both sites demonstrating a 23.6% increase on the same handover from Town Centre Activities Limited (TCA) and exceeding the set target of 60. Health and Wellness Hub have also received funding from NLC Business Transformation Fund for 50% costs towards 4 new scooters and 8 staff to be trained in a "Chair based Exercise" programme.

Other income streams to cover the remaining 50% costs totalling £4,400 are still being pursued. As well as the £75,000 investment in Shopmobility from TCS, Community Solutions supplemented the investment with £6,104 to ensure a smooth and effective transition.

As Shopmobility begins to evolve into a more holistic service through the Health and Wellness Hub, it's value cannot be underestimated as is demonstrated by the testimonials below:

> *I have been a member of Shopmobility for almost 10 years I rely and depend on the service for doing my shopping and for important doctor's appointments. All the staff are extremely helpful and without the service I would be so lost.*
>
> *If Shopmobility wasn't here it would take all my independence away making me house bound. I would lose my confidence, as I wouldn't get out. I wouldn't be able to get about the shops because I struggle to walk. It gets me out to mix with folk. People rely on Shopmobility, which includes me!*
>
> *This service is a godsend; I would be lost without it.*

Volunteer Development

Over the year, through Community Solutions and Voluntary Action North Lanarkshire (VANL) core funding, 440 volunteers have been recruited and matched. 95 have been trained. The anticipated number of people trained is lower than expected but will be revisited as the Volunteering ambition in the SCP is explored with a focus on creating and matching volunteer opportunities (largely the focus on the vol development work currently). This will be led through the Volunteering Network.

Volunteers matched offer value to the communities for which they volunteer but also enhance their own skills, self-esteem and wellbeing.

As part of the development of the Monitoring, Evluation and Learning Framework, there is an ambition to move toward capturing the impact of the volunteers in a more strategic way which would include volunteer hours (as is counted in Community Transport already); numbers of volunteers (as is counted in befriending) to give us the full impact and allow a cost saving to attributed to this key cohort of our communities.

V, has a hearing impairment was looking for a long time to engage with the local organisations. After contacting VANL she has been instantly referred to Ponies Help Children and Coatbridge CAB, where she can now use her skills and meet new people.

L, who has been referred by her Job Coach from NLC Supported Employment was working as machinist, however her workplace which was a supported environment ended in January and she was looking for something meaningful to do. L has ASN but this hasn't stopped her from volunteering and she is now volunteering with St. Andrew's charity shop in Airdrie, where she is working in a well-structured routine working environment.

Training session at Job Centre Plus Motherwell

Training session for Kilsyth Carers

Strategic updates

Carer Support

The Carer Support Network (CSN) works with key partners to support the implementation of the Carers Act, ensuring that Carers' Rights are understood and promoted through the CVS. This includes the right for carers to:-

- be involved in hospital discharge processes;
- have an Adult Carer Support Plan; and
- have access to a support budget where there are identified eligible needs.

Through the key strategic role of North Lanarkshire Carers Together, the CSN is represented on the HSCNL Carer Strategy Implementation Group which has recently revised its membership and Terms of Reference. The Community Solutions programme manager is also a member of that group. The new North Lanarkshire Strategy for Carers 2019-23 has been approved and recognises the key role that Community Solutions programme plays in supporting carers at a local level.

As per the outcome report above, positive outcomes for carers has decreased in year and is falls far short of the historic ambition of 50% impact on carers. A sub group of the CSN is working to explore the reasons for this which are multi-faceted and may include:

- Funding having to spread to more people (e.g. children and families);
- Increased partnership working with direct carer organisations, NLCT, LCC and Young Carers Project;
- Carers benefitting from and accessing support via the programme but not identifying as a carer (as has often been a challenge);
- Carers needs more embedded in developments as a result of EPiC training;
- Organisations not having the tools to either record or facilitate carer engagement

The CSN has had a key role working with Equals Advocacy in the exploration and development of a carer engagement tool to be used across Community Solutions and the wider CVS. It is hoped that this tool will both support engagement, where it is not happening, but also allow us to capture the work that is taking place.

Additionally, in line with HSCNL's ambition to drive more CVS investment through the Community Solutions structure, previous Carer Strategy Implementation Group funding is now being driven through Community Solutions. Now, following a series of engagement events in late 2019, the five previously funded organisations (Enable Rascal, Parkinson's Support Group Motherwell, Parkinson's Support Group Lanarkshire, Watch Us Grow and the Haven) were supported via engaging with the Community Solutions Strategy. This has allowed an additional £90,000 funding in direct carer support for non-carer specific organisations for 20/21 which the CSN will support (alongside organisational and capacity building support from VANL).

The carer engagement tool together with additional strategic investment and the work of the CSN sub group should see a significant rise in carer outcomes in 20/21.

Children, Families and Young People

The Children, Young People and Families (CYP&F) Strategy has now been finalised and approval from the Governance sub group to proceed with Community Solutions supporting its

implementation has been confirmed. As per the strategy, the CYP&F Development Officer will support the NL community and voluntary sector to work more effectively together and with statutory partners, supported by the Children, Young People and Families Network, to help children, young people and families thrive and achieve their potential. The focus of the strategy and this delivery programme is on improving

- quality of life;
- physical, mental and social wellbeing;
- advancing children's rights; and
- tackling inequality.

Support for vulnerable and at-risk children, young people and families is prioritised including those affected by:

- poverty
- abuse, neglect and violence
- chronic and life-limiting conditions
- learning difficulties and neurological challenges
- mental health issues
- caring responsibilities (young carers)

The work set out in the strategy and workplan, which has been developed and will be delivered and evaluated in accordance with the "Getting it Right for Every Child" framework and linked "SHANARRI" goals (Safe, Healthy, Nurtured, Achieving, Nurtured, Active, Respected, Responsible and Included) and will facilitate improved support and services for children, young people and families including:-

- promotion of supportive and caring relationships, including parenting support;
- support for healthy development and learning through play, children's and youth groups, arts activities, sport;
- promotion of healthy living – including diet, physical activity, social connections, preventing substance misuse;
- action to prevent child poverty and to support those affected by poverty through employability support and welfare advice;
- support for those experiencing difficulties or in crisis through food banks, refuges, therapeutic support, social care.

Additionally, work continues on engaging the CVS in supporting NL's ambitions on breastfeeding as well as in Q3, VANL beginning the host role for the Autism development officer who aims to support those waiting for a CAMHS referral to access additional supports through the very uncertain waiting time.

IMPROVEMENT UPDATE

In March 2019, the Improvement Service supported Community Solutions in a review. This was the first of its kind for a community and voluntary sector organisation and the purpose was to consider how stakeholders felt that the Community Solutions had been performing in terms of the following areas:-

- Community Engagement and Participation
- Strategic Planning
- Focus on Outcomes
- Leadership and Relationships
- Governance
- Use of Resources
- Performance Management
- Reporting Impact

Key strengths were identified as being:

- Strategic Planning (including a clear sense of direction and clear plans on how we will meet our ambitions. This is against a backdrop of short term funding.)
- Meeting Outcomes (taking a personal outcomes approach and enabling people to live healthier more independent lives in their community maximising their individual and social capital)
- Impact
- Partnership working (achieving more together than would have been if working in isolation demonstrating the efficacy of the strategic approach)

The following three key areas were identified as areas for improvement:

Communications and Branding

The programme was rebranded in Quarter 1. The brand has already gained traction and is becoming recognisable. Work is continuing on a CVS website for North Lanarkshire, Community Solutions will be included as a key section. Communications through HSCNL new Communications Officer will be a priority now that the officer is in post.

Use of Data

Community Solutions have employed a Research, Evaluation and Information Officer to guide the development of an improved Monitoring, Evaluation and Learning Framework for the Community Solutions Programme. This will strengthen the collection and use of data to measure progress, demonstrate impact, inform decision making and enhance learning for improvement in line with HSCNL's emerging priorities.

Key areas of focus include:-

- capturing demographic data on programme beneficiaries particularly in relation to addressing inequalities;
- outcomes measurement at project and programme level; and

- calculating cost avoidance.

Funding Arrangements (especially in short-term funding and disproportionate process)

A development plan focusing on longer term funding arrangements and realignment of existing partnership funding through the programme has been drafted and will be taken forward from December 2019 with key members of HSCNL Senior Leadership Team. In the meantime, the governance arrangements within the programme have been reviewed to reduce duplication and prevent unnecessary delay whilst maintaining a robust, partnership approach to decision making with co-production at its heart.

NEXT STEPS

With the outbreak of Covid-19 and the declaration of a global pandemic, Community Solutions and it's funded and partner organisations have mobilised to become a key contributor to the co-ordinated North Lanarkshire response to help our communities remain as safe and as physically and emotionally well as possible.

At time of writing, this mobilisation has involved Community Solutions funded organisations adapting their delivery models quickly and in response to need including:-

- Community Food support, including NL-wide and local food support planning and co-ordination; food purchase and storage; food preparation and delivery;
- Befriending services changing to deliver telephone befriending or 'Zoom' group chats;
- Wellbeing support services changing to deliver foods, medicines and other essential items to vulnerable individuals including people in the shielding category until 16 June;
- Transport engaging driving staff and volunteers in moving key items both for NHSL, the Community Assistance Centres (CACs) and the wider community and voluntary sector;
- Community Solutions locality host organisations becoming the key locality anchor organisations, linking to the CACs and co-ordination of service response;
- VANL development staff:-
    - strengthening their locality roles and becoming key C19 Locality Link Officers working with Community Solutions Anchors, wider community and voluntary sector in each locality and key statutory locality officers;
    - managing referrals from the NLC Helpline for people in the shielding category to local community and voluntary groups to provide support;
    - supporting faster matching of volunteers to C19 support roles.

The impact of C19 will reach far beyond the newly implemented lockdown period with longer-term challenges around mental health and poverty, including food poverty. The Community Solutions programme, will continue to be informed by communities, local people and work in partnership with HSCNL to ensure that the programme remains flexible and responsive to any emerging need.

In addition to our C19 response, Community Solutions remains committed to building on the following strategic priorities and programmes of work:-

- Continued effective delivery of support to vulnerable groups and communities to improve their wellbeing and strengthen equality through Community Solutions funded anchor organisations, locality development programmes and thematic issues such as carers, children, young people and families, food, self-directed support, transport to health;
- Prevention and early action; facilitation of further system redesign and strategic investment with community and voluntary sector contribution at its foundation and informed by commissioned evidence review
- Compassionate Lanarkshire; integration of the values and approaches into Community Solutions
- Social Prescribing; facilitating further development of effective social prescribing approaches in NL involving the community and voluntary sector and primary care, informed by the findings of the NL Social Prescribing Scoping Study

- Volunteering; strengthening recruitment, matching and support for volunteers in health and social care roles
- Monitoring, Evaluation and Learning (MEL); enhanced approaches across Community Solutions funded organisations and the wider community and voluntary sector to demonstrate outcomes and effectiveness and support ongoing improvements informed by the new MEL framework developed during 2019-20.

APPENDIX 1: Budget

Community Solutions 19/20 Closed Budget

Closed Budget Community Solutions 2019/2020		
HSCNL 19.20		**£1,141,000**
Non 19.20 HSCNL Source		
Shopmobility	NLC SLA	£75,000
SiRD	Inspiring Scotland	£74,475
Ring Fenced Carry Forward	Ring Fenced MIS / HRU	£62,000
Soc Prescribing Scoping	NHSL	£30,000
Underspend 18.19		
Dementia	Alt Scot	£6,577
LAF	L&L; L&L; WA	£5,431
Total Budget		£1,394,483
Expenditure		
C&F Network	VANL	£27,319
Volunteer Training	VANL	£37,846
Promoting / Enabling Healthy Eating	LCFHP	£40,000
Anticipatory Care / Individual Planning	Equals Advocacy	£40,000
Promoting / Enabling Physical Activity	NL Leisure Trust	£40,000
Carer Network	NLCT	£40,000
Community Transport	GBT	£72,000
Hospital Discharge	GBT	£77,500
Programme Facilitation	VANL	£80,000
LPDP	VANL/NLCT/GBT/GNT/ONC/CAC E	£300,000
LAF	Multiple	£180,000
HV&BF	Multiple	£169,545
HV&BF Support	VANL	£10,000
Event	VANL	Cancelled due to C19
D2A Test	GBT	£12,000
MIS	VANL	£30,000
High Resource Users	Health and Wellness Hub (HWH)	£32,000
Locator Development	VANL	£11,000
SiRD	Equals Advocacy with NLDF	£70,477
Social Prescribing	VANL	£30,000
Shopmobility	HWH	£75,000
Extension Vol Drivers	GBT	£5,900
Extension Shopmobility	HWH	£6,104
Total Spend		**£1,386,691**
Ring Fenced Balance	**SiRD**	**£3,998**
Balance		**£3,794**

APPENDIX 2: Additional Generated Income

Project	Source	Amount	CCB&CS 'Match' Amount if relevant	Brief Description
Food	Eat well, age well	£ 5,000	Sessions from CCB&CS	Training for staff and volunteers / Nutrition courses for older people
Food	Toolkit printing and materials (attainment funding)	£ 38,500	Core investment in LCFHP	Research and production/printing of the Toolkit
Food	Texture diet course and cooking (Macmillan)	£ 7,000	Sessions from CCB&CS	Planning and costs to sessions
Food	YMCA climate change funding	£ 4,240		
Food	Oral health – community challenge fund	£ 21,500		Promotion of oral health messages in all LCFHP sessions
Physical Activity	Macmillan	£ 33,000		Strategic and operational support to PA and those with cancer
Transport	Scottish Passenger Transport	£ 32,000		Support co-ordination of CT
Transport	SPT vehicle	£ 22,500		Wheelchair accessible vehicle
HV&BF	Various Match for Consortium Proposal	£ 548,055	£ 169,545.00	Various befriending - adult locality; mentoring; young carers; young vulnerable families
Bellshill	National Lottery Community Fund	£ 1,269	Previously funded through CS	Befriending grant previously LAF funded
Bellshill	Corra Foundation	£ 1,200		Befriending Support
WMF	Cycle Scotland	£ 2,400	£ 2,716.00	
WMF	Retirement Integration Ticket Sales	£ 1,800	£ 500.00	
WMF	Salsburgh Mens Shed participatory Budget	£ 20,000	£ 640.00	
Coatbridge	Room Hire Safety Zone	£ 4,919		
		£ 743,383		

The following funding was also included in the reporting.
Physical Activity Active Health from NHSL - £181,064

APPENDIX 3: Outcomes by Project

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: A reduction in isolation and loneliness	**Total**	**Total**	**Total**	**Total**
Shop mobility				**2807**
Community Alarms	**3**	**12**	**21**	**21**
Advocacy	**26**	**48**	**68**	**89**
Home Visiting & Befriending			**406**	**455**
Community Food	**36**	**46**	**74**	**176**
Community Transport	**4008**	**8222**	**14869**	
Hospital Discharge	**66**	**125**	**185**	**238**
Physical Activity	**2026**	**4262**	**5936**	**7451**
Volunteer Development	**87**	**185**	**290**	**406**
High Health Gain	**4**	**4**	**6**	**8**
Locality Activity Programme	**20**	**732**		**1708**
Total	**6276**	**13636**	**21855**	**10552**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Enhanced use of information, advice and education	Total	Total	Total	Total
Shop Mobility				
Community Alarms	**106**	**207**	**289**	**349**
Advocacy	**26**	**48**	**68**	**89**
Home Visiting & Befriending			**304**	**323**
Community Food	**36**	**46**	**74**	**176**
Hospital Discharge	**66**	**125**	**185**	**238**
Physical Activity	**2026**	**4262**	**5936**	**7451**
Volunteer Development	**87**	**185**	**290**	**548**
High Health Gain	**4**	**4**	**6**	**8**
Locality Activity Programme	**20**	**726**		**3399**
Total	**2371**	**5603**	**7152**	**12581**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Improved independence and well-being	**Total**	**Total**	**Total**	**Total**
Shop Mobility				**2807**
Community Alarms	**89**	**157**	**235**	**295**
Advocacy	**26**	**48**	**68**	**89**
Home Visiting & Befriending			**354**	**399**
Community Food	**36**	**46**	**74**	**176**
Hospital Discharge	**66**	**125**	**185**	**238**
Physical Activity	**2026**	**4262**	**5936**	**7451**
Volunteer Development	**99**	**242**	**370**	**475**
High Health Gain	**4**	**4**	**6**	**8**
Locality Activity Programme	**20**	**696**		**1466**
Total	**2366**	**5580**	**7228**	**10597**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: People feel included, connected and safe	Total	Total	Total	Total
Shop Mobility				
Community Alarms	**5**	**17**	**29**	**40**
Advocacy	**26**	**48**	**68**	**89**
Home Visiting & Befriending			**389**	**436**
Community Food	**36**	**46**	**74**	**176**
Hospital Discharge	**64**	**123**	**176**	**217**
Physical Activity	**2026**	**4262**	**5936**	**7451**
Volunteer Development	**138**	**257**	**397**	**528**
High Health Gain	**4**	**4**	**6**	**8**
Locality Activity Programme	**20**	**655**		**3284**
Total	**2319**	**5412**	**7075**	**12229**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Citizens have greater access to health & wellbeing supports & services	**Total**	**Total**	**Total**	**Total**
Shop Mobility				**2807**
Community Alarms	**11**	**23**	**28**	**34**
Advocacy	**26**	**48**	**68**	**89**
Home Visiting & Befriending			**363**	**396**
Community Food	**36**	**46**	**74**	**176**
Hospital Discharge	**66**	**122**	**185**	**230**
Physical Activity	**2026**	**4262**	**5936**	**7451**
Volunteer Development	**138**	**257**	**397**	**528**
High Health Gain	**4**	**4**	**6**	**8**
Locality Activity Programme	**20**	**45**		**1006**
Total	**2327**	**4807**	**7057**	**9918**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Carers have accessed a short break from their caring	**Total**	**Total**	**Total**	**Total**
Shop Mobility				
Community Alarms	0	0	0	0
Advocacy	0	0	0	0
Home Visiting & Befriending			92	104
Community Food	19	33	42	45
Hospital Discharge	5	14	18	20
Physical Activity				
Volunteer Development	3	10	14	18
High Health Gain	2	2	3	4
Locality Activity Programme	4	453		560
Total	**33**	**512**	**169**	**751**

Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20

Outcome: Carers have increased ability to manage or cope with their caring role	Total	Total	Total	Total
Shop Mobility				
Community Alarms	11	23	28	34
Advocacy	7	14	19	25
Home Visiting & Befriending			82	95
Community Food	19	33	42	45
Hospital Discharge	36	71	95	117
Dementia Support				
Physical Activity				
Volunteer Development	4	12	16	21
High Health Gain				
Locality Activity Programme	4	528		474
Total	**81**	**681**	**282**	**811**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Carers health and wellbeing is optimised	**Total**	**Total**	**Total**	**Total**
Shop Mobility				
Community Alarms	100	180	263	331
Advocacy	7	14	19	25
Home Visiting & Befriending			81	103
Community Food	19	33	42	45
Hospital Discharge	36	71	94	116
Community Transport				
Physical Activity				
Volunteer Development	4	12	16	21
High Health Gain				
Locality Activity Programme	4	510		494
Total	**170**	**820**	**515**	**1135**

Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20

Outcome: Carer have been referred to direct carer support services	Total	Total	Total	Total
Shop Mobility				
Community Alarms	100	180	263	331
Advocacy	0	0	19	25
Home Visiting & Befriending			33	42
Community Food	19	33	42	45
Hospital Discharge	36	71	94	116
Community Transport				
Physical Activity				
Volunteer Development	4	12	16	21
High Health Gain				
Locality Activity Programme	4	305		223
Total	**163**	**601**	**467**	**803**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Carer have been signposted to direct carer support services	Total	Total	Total	Total
Shop Mobility				
Community Alarms	36	74	83	105
Advocacy	7	14	19	25
Home Visiting & Befriending			92	104
Community Food	19	33	42	45
Hospital Discharge	56	104	157	215
Community Transport				
Physical Activity				
Volunteer Development	1	8	11	
High Health Gain				
Locality Activity Programme	4	445		519
Total	**123**	**678**	**404**	**1013**

Outcomes for Children and Young People

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Sense of wellbeing is increased	**Total**	**Total**	**Total**	**Total**
Community Alarms				
Advocacy	15	15	15	15
Home Visiting & Befriending				
Carer Support				
Community Based Palliative Care				
Community Food	54	198	201	212
Hospital Discharge				
Community Transport				
Dementia Support				
Physical Activity	32	323	457	482
Volunteer Development				
High Health Gain				
Locality Activity Programme		420		2171
Total	**101**	**956**	**673**	**2880**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Mental Health is optimised	**Total**	**Total**	**Total**	**Total**
Community Alarms				
Advocacy	15	15	15	15
Home visiting and befriending				
Carer Support				
Community Based Palliative Care				
Community Food	54		201	204
Hospital Discharge				
Community Transport				
Dementia Support				
Physical Activity	32	323	457	482
Volunteer Development				
High Health Gain				
Locality Activity Programme		319		1888
Total	**101**	**657**	**673**	**2589**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20

Outcome: Parental / Carer Attachment is improved	Total	Total	Total	Total
Community Alarms				
Home visiting and befriending				
Advocacy	0	0	0	0
Carer Support				
Community Based Palliative Care				
Community Food	7		34	40
Hospital Discharge				
Community Transport				
Dementia Support				
Physical Activity	32	323	457	482
Volunteer Development				
High Health Gain				
Locality Activity Programme		27		622
Total	**39**	**350**	**491**	**1144**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Resilience is improved	Total	Total	Total	Total
Community Alarms				
Home visiting and befriending				
Advocacy	15	15	15	15
Carer Support				
Community Based Palliative Care				
Community Food	54		201	204
Community Liaison				
Community Transport				
Dementia Support				
Physical Activity	32	323	457	482
Volunteer Development				
High Health Gain				
Locality Activity Programme		319		2019
Total	**101**	**657**	**673**	**2720**

	Apr - Jun 19	Apr - Sep 19	Apr - Dec 19	Apr - Mar 20
Outcome: Physical Activity Is Increased	Total	Total	Total	Total

Community Alarms				
Home visiting and befriending				
Advocacy	15	15	15	15
Carer Support				
Community Based Palliative Care				
Community Food	54		201	207
Community Liaison				
Community Transport				
Dementia Support				
Physical Activity	32	323	457	482
Volunteer Development				
High Health Gain				
Locality Activity Programme		292		2004
Total	**101**	**630**	**673**	**2708**

APPENDIX 4: Outputs by Project

Theme	Outputs*	Target QTR1	Actual QTR1	Target QTR2	Actual QTR2	Target QTR 3	Actual QTR 3	Target QTR 4	Actual QTR 4
Advocacy	Number of new referrals	15	26	30	48	45	68	60	89
Advocacy	Case load worked with in quarter (incl referrals from previous quarter not closed)	25	26	25	27	25	26	25	25
Advocacy	Preventative Advocacy Awareness Training Sessions	6	9	12	11	18	15	24	21
Advocacy	Number of people attending training sessions	60	82	120	101	180	113	240	238
Advocacy	Future Planning Surgeries Held	6	13	12	22	18	28	24	28
Advocacy	Number of people attending surgeries	20	42	40	63	60	93	80	93
Advocacy	Self Management / Future Planning Information Stands Hosted	6	10	12	13	18	16	24	21
Advocacy	No of people attending stands	75	73	150	136	225	420	300	878
Home Visiting & Befriending	Telephone Wellbeing Checks						184	123	209
Home Visiting & Befriending	Telephone Befriending Matches						5	61	5
Home Visiting & Befriending	Group Befriending						91	141	93
Home Visiting & Befriending	One to One Befriending						63	133	77
Home Visiting & Befriending	One to One Connections/Connectors						10	25	20
Home Visiting & Befriending	Referrals to Other Services						14	40	20
Home Visiting & Befriending	Sign posts to Other Services						93	117	117

Theme	Outputs*	Target QTR1	Actual QTR1	Target QTR2	Actual QTR2	Target QTR 3	Actual QTR 3	Target QTR 4	Actual QTR 4
Home Visiting & Befriending	Volunteers Recruited						33	69	56
Home Visiting & Befriending	Volunteers Matched						40	75	52
Home Visiting & Befriending	Volunteers Trained						50	79	60
Home Visiting & Befriending	Connected Community Formed						0	5	0
Home Visiting & Befriending	Peer Relationship Established						9	14	9
Children & Families	Strengthening of Children & families network (membership)	2	2	1	1	1	2	2	2
Children & Families	Mapping service & input into locator								
Children & Families	Meet with CLPG 3rd Sector reps on a regular basis	1	0						
Children & Families	Embed access to Child Protection Training into core training delivered.	25	25	25	25	25	30	25	22
Children & Families	Co coordinate improvement work & develop appropriate Tests of change	2	0			2	2	1	1
Children & Families	Sleep Scotland Parent Workshop	1	1	1	1	0	0	2	2
Children & Families	Work with colleagues on breast feeding action group to increase rates								
Community Food	Locality Healthy Eating Sessions (Tailored to Locality) @ 16 sessions per six localities over the year (96 sessions in total)	24	25	48	50	72	77	96	117
Community Food	Locality Participants (targets based on 8 people attending each course lasting 4-8 weeks long). Food demos can include a higher number.	32	185*	64	237	96	300	128	433
Community Food	Healthy Eating Champions								

Theme	Outputs*	Target QTR1	Actual QTR1	Target QTR2	Actual QTR2	Target QTR 3	Actual QTR 3	Target QTR 4	Actual QTR 4
Community Food	Recruited and/or in training	4	4*	8	4*	16	4*	24	4
Community Food	Trained and Delivering	24**	2		2		2		2
Community Transport	Specifying passenger journeys as a target does not illustrate the breadth or quality of work carried out by GBT CT.	0	4276	0	8805	0	15156		19160
Community Transport	GBT Minibus services	0	3463	0	6795	0	11953		15001
Community Transport	Volunteer Driver Service inc Hospice and MAF	0	812	0	1694	0	2600		3348
Community Transport	NHSL/GBT/CTG Transport Hub Pilot	0	268	0	583	0	870		1078
Community Alarms	Number of Visits/Reviews		106		207		289		382
Community Alarms	Number of Clients Contacted		157		378		553		774
Community Alarms	Number of direct referrals made for support		2		7		10		13
Community Alarms	Number of Clients/Carers Signposted		106		207		243		335
Community Alarms	Number of Direct Referrals made for Carers		0		1		1		1
Community Alarms	Number of Amendments to records		122		262		357		475
Hospital Discharge	Number of people supported for Information Received by the HDSP	145	163	290	288	435	440	580	560
Hospital Discharge	Numbers of referrals made by HDSP for Community Based Support	75	95	150	201	225	298	300	359
Hospital Discharge	Number of Carers Signposted for support by the HDSP	70	56	140	104	210	157	280	215
Hospital Discharge	Number of Carers referred for support or supported by the HDSP	25	27	50	75	75	104	100	114
Physical Activity	Increase in the number of people being referred to the Specialist Health Class Programme	1250	353	1250	742	1250		1250	1576
Physical Activity	Increase in the number of people being referred to the General Active Health programme	3000	1549	3000	3132	3000		3000	5460

Theme	Outputs*	Target QTR1	Actual QTR1	Target QTR2	Actual QTR2	Target QTR 3	Actual QTR 3	Target QTR 4	Actual QTR 4
Physical Activity	Increase in the number of people being referred to the Weigh to Go Programme	500	76	500	152	500		500	478
Physical Activity	Increase in number of people being referred to the Move More Programme	150	25	150	105	150		150	269
Physical Activity	Increase in numbers of teenagers accessing the Get Active Teens programme	100	32	100	131	100		100	202
VANL Shop Mobility	Registered Members				396		414		422
VANL Shop Mobility	New registrations across both sites				41		59		67
VANL Shop Mobility	Service user Engagements - Coatbridge				1358		2660		3162
VANL Shop Mobility	Service user Engagements - Motherwell				700		1480		1921
VANL Shop Mobility	Total number of Users - Coatbridge				651		1301		1666
VANL Shop Mobility	Total number of Users - Motherwell				409		850		1141
Volunteer Development	Volunteers recruited and matched	100	103	200	219	300	354	400	440
Volunteer Development	Volunteers trained in MLE / Locator	84	16	168	54	252	69	336	95
Volunteer Development	Awareness Raising	42	38	84	42	126	42	168	42
Volunteer Development	MLE / Locator Training Sessions	12	5	24	11	36	14	42	18
Volunteer Development	Volunteers trained in development	42	0	84	52	126	54	147	66
Volunteer Development	Volunteer Training Sessions for Development	6	0	12	7	18	22	24	23
Volunteer Development	Community Champions recruited	0	0	6	0	9	0	12	0
Volunteer Development	Community Champions Co-Development Sessions	1	0	2	0	3	0	4	0

Theme	**Outputs***	Target QTR1	Actual QTR1	Target QTR2	Actual QTR2	Target QTR 3	Actual QTR 3	Target QTR 4	Actual QTR 4
Volunteer Development	Community Connections Platform Maintained	1	1	1	1	1	1	1	1
Volunteer Development	Third Sector accessing multi-agency training sessions	30	0	60	0	90	0	120	0
Volunteer Development	Promotion of multi-agency training sessions	1	0	2	0	3	0	4	0
Volunteer Development	Volunteer Friendly Accreditations	0	0	6	0	6	0	12	6 TBC
Volunteer Development	Volunteer Friendly Re-Accreditations	N/A	N/A	N/A	N/A	N/A	N/A	12	6 TBC
Volunteer Development	Organisations supported	42	69	168	158	252	216	336	267
High Health Gain	High Health Gain Individuals engaged	4	4	4	1	3	1	4	0
High Health Gain	Personal Outcomes Framework engaged	4	0	4	1	3	1	4	0
High Health Gain	Reduction in presentations to services	4	0	4	0	3	0	4	0
High Health Gain	Reductions in medications	4	0	4	0	3	0	4	0
High Health Gain	Outputs for Other Services								
High Health Gain	High Health Gain Individuals engaged	4	1	4	2	3	2	4	3
High Health Gain	Personal Outcomes Framework engaged	4	1	4	2	3	2	4	3
High Health Gain	Reduction in presentations to services	4	1	4	2	3	2	4	3
High Health Gain	Reductions in medications	4	1	4	2	3	2	4	3

APPENDIX 5: Locality Partnership Development Programme Locality Activity Fund Spend

Locality	Name of Organisation	Award
Airdrie	Airdrie Adult Leaners Forum - TFU	3,245.00
Airdrie	Community Futures - Plains Climbing Boulder	600
Airdrie	North Lanarkshire Disability Access Panel	500
Airdrie	NHs Mental Health (Getting Ahead of Postnatal Depression)	2,238.00
Airdrie	Voice of Experience - Back to the future over 65 event	1,008.80
Airdrie	Diamonds in the Community - Physical Activities Summer Camps	2,000.00
Airdrie	Pitter Potter - Pitter Potter Gardening Group	2,091.00
Airdrie	REAL Women - Real Change	1,540.00
Airdrie	Airdrie Community School Uniform Bank - Preloved Uniform	2,000.00
Airdrie	Diamonds in the Community - Physical Activities Summer Camps (2nd application)	2,000.00
Airdrie	Craft Skill Swap Group	1,500.00
Airdrie	The Advisory Group - Sit Tall Stand Strong	500
Airdrie	Mavisbank School - Sensory Art Family Project	1,890.00
Airdrie	St Andrew's Hospice - Hand Massage	1,736.95
Airdrie	Friends of Airdrie & Coatbridge Islamic Centre	1,500.00
Airdrie	HOPE for Autism - Reducing Isolation for Autistic Adults	1,425.00
Airdrie	PlayPeace - Including All: Active Evenings	2,856.00
Airdrie	Airdrie Craft Group - Community Fridge Cabinet Build	869.25
Airdrie	Whinhall Action Group	500
Subtotal		**30,000.00**
Bellshill	Orbiston YMCA - Lets Relax	1,574.00
Bellshill	SA	500
Bellshill	REACH Lanarkshire Autism - REACH Bellshill Youth & Teen Groups	528
Bellshill	LCFHP - Community Food	1,720.00
Bellshill	Bellshill & Mossend YMCA - Y-health and Wellbeing	3,640.00
Bellshill	Generations Garden @ Lawmuir School	738
Bellshill	Tannochside Community Garden	1,000.00
Bellshill	Solihull: Understanding for your Child	1,600.00
Bellshill	Motive8	7,800.00
Bellshill	REACH Lanarkshire Youth & Teens Groups)	4,052.00
Bellshill	Bellshill & Mossend YMCA - Y-health and Wellbeing	3,610.00
Bellshill	Utheo Ltd - ONC Activity Programme	3,238.00
Subtotal		**30,000.00**
Cumbernauld/North	Chryston Parish Church - The Hub	5,000.00
Cumbernauld/North	CL & D - North Family Summer Programme 2019	1,500.00
Cumbernauld/North	Kilsyth Civic Week - Tea dance	1,200.00
Cumbernauld/North	Gartcosh Lunch/Activity Group	670
Cumbernauld/North	CACE/North Locality Consortium Information Day	1,000.00
Cumbernauld/North	CACE Shelia Shed	1,623.00

Locality	Name of Organisation	Award
Cumbernauld/North	Auchinloch Community Group	670
Cumbernauld/North	Kilsyth Methodist Lunch Club	500
Cumbernauld/North	North Lanarkshire Disability Access Panel	500
Cumbernauld/North	CACE - Relaxed Mind & Body	2,250.00
Cumbernauld/North	CACE - Relaxed Mind & Body in Moodiesburn	1,370.00
Cumbernauld/North	CACE - North Locality Activity Library	700
Cumbernauld/North	Muirhead & District Senior Forum = Christmas Celebration Dancing Activity Fun Lunch	940
Cumbernauld/North	Cornerstone House Centre - Community Film Project	3,950.00
Cumbernauld/North	NHS Lanarkshire - Clyde United Football Team	928
Cumbernauld/North	Strathcarron Community Project - Community Building Project	1,500.00
Cumbernauld/North	NACPP - Bicycle Kit Security for School Children	940
Cumbernauld/North	Carbrain and Hillcrest Community Council	2,680.00
Cumbernauld/North	Westfield Friendship Club - Kilsyth	114
Cumbernauld/North	Cumbernauld Young Mums & Mums2B Group	1,965.00
Subtotal		**30,000.00**
Coatbridge	Coatbridge Men's Shed	1,110.00
Coatbridge	Glenboig Development Trust - SCP Gardening Project	3,345.60
Coatbridge	Parent Action for Safe Play - PASP Football Group	1,356.00
Coatbridge	LCFHP - Community Food	1,870.00
Coatbridge	Pentland Parent/Carers - Community Information Event	350
Coatbridge	Upbeat - Confidence Building Music Workshops	2,000.00
Coatbridge	Parkrun - Drumpellier Junior 2K Event	3,000.00
Coatbridge	REACH Autism Lanarkshire - Coatbridge Youth & Teen groups	4,160.00
Coatbridge	Kirkshaws Neighbourhood Centre - Aspire to Inspire	4,780.00
Coatbridge	North Lanarkshire Disability Access Panel	500
Coatbridge	Coatbridge Kinship Carers - Next Steps	420
Coatbridge	The Health & Wellness Hub - Coatbridge Shopmobility Wellbeing Project	4,500.00
Coatbridge	The Safety Zone - The Wednesday Group	2,108.40
Coatbridge	The Peoples Pantry - Getting Started	500
Subtotal		**30,000.00**
Motherwell	CL&D Muir Street Young Carers	2,000.00
Motherwell	Community Action Newharthill - Summer Programme	1,024.00
Motherwell	Lanarkshire Deaf Club - Gym Classes	2,000.00
Motherwell	LCFHP - Community Food - Muir street young Carers	1,795.00
Motherwell	NLCT & CL& D - Community Connections	3,936.00
Motherwell	North Lanarkshire Disability Access Panel - Motherwell	500
Motherwell	Parkinson's Self Help Group (Motherwell)	1,440.00
Motherwell	Health & Wellness Hub	1,520.00
Motherwell	Brannock HS - Brannock HS Inter-generational Project	2,000.00
Motherwell	Motherwell CLD Team - Support to young People Project	1,900.00
Motherwell	REACH Autism Lanarkshire - Motherwell Youth & Teen groups	4,095.00
Motherwell	PlayPeace - Including All	2,856.00

Locality	Name of Organisation	Award
Motherwell	You Are My Sunshine	2,992.50
Motherwell	GlenCairn PS = Glencairn Health Project	
Motherwell	Forgewood Housing Cooperative - kitchen upgrade	1,441.50
Motherwell	Motherwell CLD Team - Support to young People Project	500
Subtotal		**30,000.00**
Wishaw - Shotts	LCFHP - Community Food	1,720.00
Wishaw - Shotts	bra	607
Wishaw - Shotts	Getting Better Together - Newmains	607
Wishaw - Shotts	Getting Better Together - Shotts	1,502.00
Wishaw - Shotts	Shotts EU Congregation Church - Wednesday Community Lunch Club	
Wishaw - Shotts	REACH Autism Lanarkshire - Shotts Youth & Teen groups	4,840.00
Wishaw - Shotts	Lanarkshire carers Centre - WMF Consortium Carers & Service User Event	1,414.00
Wishaw - Shotts	ST Thomas' Women's group - SHIFT	1,180.00
Wishaw - Shotts	Mornay Way & Nithsdale Retirement Integration - Joseph Duffy	500
Wishaw - Shotts	GBT - Fortissat Youth Form	500
Wishaw - Shotts	Fool ON - mental health Support & Recovery through Performing Arts	3,117.00
Wishaw - Shotts	GBT - Walking Football	500
Wishaw - Shotts	Harthill Cancer Support Group	870
Wishaw - Shotts	Made4u in ML2	1,993.75
Wishaw - Shotts	GBT - Cycles for All	8,770.00
Wishaw - Shotts	GBT - Green Health Consortium Project	1,239.25
Wishaw - Shotts	Salsburgh Community Council - Salsburgh Men's Shed start up support	640
Subtotal		**30,000.00**

Appendix 6 Case Studies.

Name of Project	**Community Liaison Officer/Hospital Discharge Project**
Date of Submission	19/03/20

Primary Contact	**Mark Slorance**
Email	mark@voef.org.uk
Telephone #	07715093069

1. Summary

Please summarise the case study in one paragraph of no more than 100 words.

The Community Liaison Officer (CLO) received a referral from an occupational therapist who is part of the rehabilitation team in January. The referral was for a gentleman (Mr J) aged 79 years who lives alone in the Wishaw area. Mr J has a range of health conditions and there was concern that he was becoming increasingly socially isolated. The CLO contacted Mr J and visited Mr J in his home to discuss community supports. This resulted in referrals being made on the Mr J's behalf to Getting Better Together (GBT) Swift befriending service and also to GBT Volunteer Driver Programme.

What was the issue you were addressing or working on?

The main issues which were identified by the CLO during a phone call with Mr J and home visit with were social isolation and low mood. Mr J lived alone, had no children and main contact was via his sister who visited when she could although she herself was an older adult. Other main contact was with homecare staff who visited twice daily and a friendly neighbour who assisted Mr J with shopping.

Mr J had a previous stroke and heart replacement surgery which affected his mobility and also resulted in minor speech difficulties. Mr J no longer had confidence leaving his home independently and required a level of assistance to do so. This was reducing Mr J's opportunities for social contact and resulting in Mr J mostly leaving his home for medical appointments. Mr J had some medical appointments planned in the future and was concerned about transport getting to and from these. Mr J was mobile for short distances using Zimmer/walker and it was identified by the CLO that he would benefit from assistance to get his walker down a few step at the entrance to his home and reassurance when out. Due to the location of his home to the road, there was a significant distance for Mr J to walk to get to the road which it difficult for Mr J get to any transport without assistance/reassurance. This made it difficult for Mr J to access community transport options such as the MyBus service and attend any local groups independently.

Social isolation and underlying health conditions were contributing to Mr J experiencing low mood. Mr J enjoyed social company and it was hoped that by increasing this this would have a positive impact on Mr J's mood. Mr J had tried a

peer based telephone befriending service in the past but did not feel this worked for him due to being unable to disclose any personal details due to confidentiality issues.

What did the project do?

(Remember to include how the older person or carer was involved and consulted (asset approach); how Personal Outcomes were met; Intervention(s), organisations involved)

The CLO phoned Mr J to introduce himself and to ask Mr J if he would like a home visit to discuss available community supports. The CLO visited Mr J in his home and provided Mr J with an information pack which included information about a range of potential supports within the local area. The information provided and discussions covered a range of different support areas including community transport, advocacy library at home services, befriending services, mental health supports and local activity groups some of which could assist with transport. CLO also included information about local carer support organisations for Mr J's Sister and neighbour

The CLO discussed with Mr J his current situation, any difficulties that he had and what was important to him. During discussions the CLO removed any information that was either of no interest or was unsuitable for Mr J's current situation.

What was important for Mr J was to increase social opportunities. This could be either within the home or ideally, if possible, to go out for a coffee or to try a local group. As Mr J would not feel confident to walk from his home to the road independently if would be difficult for him to access MyBus service for transport to local groups. The CLO advised that the main options were befriending services and the groups that can assist with transport such as Reengage service which facilitate Sunday lunch groups.

As Mr J did have some mobility, the CLO advised that it would be beneficial to explore whether local befriending service could support Mr J's mobility to access the local community and local groups. Mr J granted consent for a referral to be submitted to Getting Better Together SWIFT service which was then submitted to GBT following the home visit. Mr J had difficulty attending medical appointments independently so the CLO provided information about the Volunteer Driver programme and consent was obtained to make a referral on Mr J's behalf to request assistance with transport for medical related appointments.

Potential supports to help Mr J with his difficulties with low mood were explored and Mr J was provided with information about these. These included Lanarkshire Links, Well- Informed and Expeerience Counts. The CLO checked with Mr J if he felt he required input from the local Community Mental Health Team but Mr J did not feel that this was required. Instead Mr J informed that it would be helpful if he had access to some telephone support if he was

concerned about his mental health. The CLO provided information about the Well-Informed service but agreed with Mr J that he would post out further information about Breathing Space and Samaritans following the home visit. Before the end of the visit the CLO copied down the contact number for Breathing Space for Mr J and left this with him. Following the home visit the CLO posted the relevant telephone support leaflets including Breath Space as requested.

Mr J enjoyed music and had a CD collection so the CLO provided information about the library at home service. The CLO explained that they can also deliver music as well as books. The CLO also advised that as Mr J is unable to access local community independently home based computer tuition may be possible via Lead Scotland North Lanarkshire's service but Mr J did not wish to access this.

The CLO informed Mr J that there is support services available which might be of interest to both his sister and neighbour. CLO asked Mr J if he wished the CLO to contact his Sister/neighbour but Mr J said he would prefer to ask Sister/neighbour to look at the information folder rather than CLO making contact.

What were the outcomes/benefits or otherwise?
(What happened and what was gained or lost from this? When were the benefits realised? Would you do anything differently? What is/was your timeline?)

The anticipated outcomes are that Mr J will be matched with a volunteer befriender which will increase social contact. Depending on their assessment of Mr J's mobility, it is hoped that Mr J will be able to assisted to access local community and linked in with local groups if possible. If transport and assistance can be provided to assist Mr J to attend local group then it is hoped that this will provide an opportunity for Mr J to meet new friends and contacts. It is anticipated that this increased social contact will have a positive impact on Mr J's mood and help reduce periods of low mood.

It is anticipated that Mr J will benefit from assistance to attend medical related appointments with the Volunteer Driver Programme for some of his forthcoming medical appointments. The information provided is a resource that Mr J could use in future. This includes phone numbers that can be contacted if there is a crisis. The CLO established a point of contact with Mr J and he could contact him with concerns and enquiries about another available supports. Although there was no direct contact with Mr J's sister and neighbour they should now be aware of available carer support and can contact the CLO if they wish. In addition to this, Mr J's family will be aware that Mr J will be supported by volunteer befriender and volunteer driver.

The main area the CLO would like to do differently if dealing with this enquiry again would be to have this direct contact with family and neighbour. The service is equally aimed at supporting people and their carers.

The enquiry was received in 31st January and initial contact was made by the CLO on 31st January. The home visit was on 6th February and the last referral was submitted on 11th February. Letter to confirm referral made and additional requested information was posted on the 21st February

Name of Project	Equals Advocacy Partnership
Date of Submission	20/3/20

Primary Contact	Brenda Vincent
Email	brenda@equalsadvocacy.org.uk
Telephone	01698 327772

2. Summary

Please summarise the case study in one paragraph of no more than 100 words.

The client is living with a diagnosis of dementia alongside a life-limiting respiratory condition. The client wished to plan for their future and in particular end of life care so that any stress and anxiety they were experiencing could be alleviated as much as possible.

3. What was the issue you were addressing or working on?

Future planning and self-management.

What did the project do?

(Remember to include how the older person or carer was involved and consulted (asset approach); how Personal Outcomes were met; Intervention(s), organisations involved)

The advocate met with the client and discussed with them appropriate methods of advanced care planning. The client and advocate discussed the client's wishes and specifically what anxieties they had concerning the future.

The client was clear that they wished to remain in control of their life as much as possible therefore wanted to ensure that if their condition(s) progressed to a point whereby they could not communicate their wishes that their past views would still be heard. The advocate ensured that the client had appropriate written information about Advanced Directive's (Living Will), Anticipatory Care Plans, Power of Attorney, Advanced Statements and Named Person. Following a discussion regarding this, the client stated that they had already established a Power of Attorney however would like to complete an Anticipatory Care Plan along with updating their Advanced Statement, establishing a Named Person and obtaining further information about Advanced Directives.

The advocate supported the client to complete a comprehensive Anticipatory Care Plan, ensuring that the client's views were communicated, the client was clear in their definition of what they felt was a "want" or a "need" therefore the client was supported to ensure that this was communicated clearly throughout the Anticipatory Care Plan.

The client was also provided with relevant and up to date information from the Mental Welfare Commission regarding Named Person and Advanced Statements. The client was then supported to update their Advanced Statement and was provided with appropriate written information concerning Named Person's.

The client requested that they be provided with information relating to lawyers in their local area that specialise in Advanced Directives. The advocate supported the client to utilise the Law Society for Scotland's website to locate appropriate lawyers and contact same, each lawyer provided a verbal quote that was then passed on to the client for their information and future use.

The client also expressed during the Anticipatory Care Planning process that they wished to avoid and/or limit hospital admissions as they felt overall hospital admissions had a negative impact on their health in general. The advocate supported the client by contacting the Hospital at Home Team to obtain accurate information in relation to referrals to same and what service would be provided if required. The client made aware of the information given by the Hospital at Home Team and is aware of how to access this service during periods of ill health.

During the Anticipatory Care Planning process, the client also expressed that they are experiencing fatigue relating to their respiratory condition and are aware of a change in their strength and balance. The client stated that both issues were at an early stage however would like to have information on how to manage same. The advocate contacted St Andrew's Hospice and is currently in the process of referring the client to the Fatigue Management classes along with the Strength and Balance classes that they provide.

4. What were the outcomes/benefits or otherwise?

(What happened and what was gained or lost from this? When were the benefits realised? Would you do anything differently? What is/was your timeline?)

The client experienced a reduction in stress and anxiety, was provided relevant information that would ensure the client could continue to self-manage their conditions. The client has also experienced an increase in independence and responsibility with regards to their health.

Coatbridge Consortium Case Study

AVP ran three 16-hour practical workshops in the Coatbridge area entitled "Building Better Relationships." These workshops helped participants improve their problem solving, communication and conflict resolution skills through learning a range of skills and tools that will lead to a reduction in violence in many forms, from physical, verbal and self-harm. AVP held two level 1 workshops, one level 2 workshop and offered free places for all from the Coatbridge area to train as facilitators. The workshops ran from January to December 2019. The majority of referrals for the programme came from Mental Health and Addictions Teams.

Through participation in the AVP workshops participants from Coatbridge had a reduction in isolation and loneliness through understanding, learning and demonstrating the skills required to communicate more effectively with friends, family and other community members. Participants also developed the skills to handle conflict and end the cycle of violence, (both physical and verbal) benefitting themselves, their families and the wider community.

The AVP programme is an excellent example of a programme which the Coatbridge Consortium has helped to establish within the locality through LAF funding over the past three years. The programme, which usually has a cost attached for participants, previously operated in Glasgow and Edinburgh only. The LAF funding provided has enabled AVP to provide free workshops within the Coatbridge locality, allowing the programme to go from strength to strength. As it moves into its fourth year, it has now managed to become self-sustaining, securing funding from a new source for the 2019/20 round of workshops.

The feedback from the workshops was excellent and feedback from one of the telephone evaluations has been included as part of this case study.

1. **What lead you decide to take part in the Workshop?**

   "Referral from the Coatbridge mental health team. They gave me a leaflet and I went along as the course was free and I had a lot of issues in my personal life and I knew I needed help."

2. **What were your feelings before the workshop happened?**

   "I was feeling angry, isolated and very anxious beforehand and had a lot of resentment and anger towards my ex-wife. I was very irrational and over reacted to simple situations in life."

3. **How do you feel now about having taken part?**

   "Great, I feel so much better and the course made me realise a lot of things about myself and others. I honestly feel like the course has saved my life and I think everyone should do it.

   The main things I got from the course is that it made me see how my behaviour was affecting other people and that it helped me understand why people act in certain ways.

   There were loads of lightbulb moments throughout that made me see things clearer and feel more positive about myself, life and the future."

4. **What are the main things you remember about the workshop?**

   "How to communicate my feelings better and to understand how other people are feeling, seeing the other side of the story. Anger iceberg, tree of violence, volcano and the "I" messages where the main things I remember."

5. **What, if anything you have learnt about yourself or about conflict during this workshop?**

   "I learnt how much of a dark place that I was in and how irrational I was being. I pretty much had zero chance of dealing with conflict and couldn't communicate properly anymore. The course has made me realise what I was doing and has given me the opportunity to change and I now feel I have the tools to deal with conflict more easily and be more confident. The course has taught me to expect the best and not the worst."

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