council to commission support services - from LAMH - A memory clinic is held at Udston (Hamilton) and there Lanarkshire area. The Newberry Rooney dementia centre in Hamilton has given added Research is continuing in close conjunction with the out of Hours service to delivered via community pharmacies. Alternative sites to the traditional Primary care emergency centres helps increase capacity of the service and screening packs which are available at dementia centres in the South Lanarkshire area. The University and University of Edinburgh also crosses both Community Care Assessment Tool, Pain tools. Three year programme of staff training across all care settings using the Liverpool Care Pathway - for the last five days of life.

NHS Lanarkshire has been developing an ACP that includes a clinical component. Working with the patient and their families to look out for symptoms that may indicate a change in their condition and providing guidance on what action to take should this occur. This may reduce the number of people in Care Homes who attend A&E. Integrated Care Management Teams and other community health, mental health, learning disabilities, physical disabilities and social work. Meds can also work to change people's lives. Telecare and Assistive Technology is being developed, delivered in both local authorities Lanarkshire has been developed, delivered in both local authorities. The Clyde valley Community planning partnership relatively new is currently looking at the possibility of areas for joint services nothing concrete but clearly something for the future. This covers the autonomy to those aspects of care that may disable them. Each service user will go through a (max) 6 week assessment period and if the service is still required, this will be provided by another source or provider. The care plan will have an action plan that will be reviewed every 6 months and highlight areas where re-enrolment can be achieved. The action plan will have an input from a multi-disciplinary source. This is practice is being phased into 2006, 2007 and 2008. Telecare is now in use within the NHS Lanarkshire area. The Newberry Rooney dementia centre in Hamilton has given added capacity for specialist day care as well as dedicated training facilities and expertise for staff working with dementia carers.

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emergencies. This will allow patients to remain at home should they wish.

- **Integrated Care Management** in alcohol and drug services is being implemented across NHS Lanarkshire.

  This approach enables the provision of the best care and support for people with complex health and social care needs in their own homes. Integrated care management encourages good quality practice that supports holistic assessments and user and carer participation, and the key to better outcomes and the first step in developing appropriate care and support plans.

- **South Lanarkshire** Number of targets relating to the shift in care from residential and institutional settings to home settings:
  - The number of older people receiving intensive home care will be 35% of all people receiving long term care – this has been exceeded (figure 35.5%) at end of quarter 1, 2009.
  - Maintain at 71% the number of older people whose service starts within 5 working days of their community care assessment being completed – this was exceeded in 2009 with 81.95% of people’s service starting within 5 days of their community assessment being completed.
  - The South Lanarkshire Children's Health and Social Care Protocol Group has overseen a range of work for conditions such as stroke, delirium, dementia drug prescribing, UTIs and the GP contract. This latter issue has resulted in a project which has seen agreements between local care homes and GP surgeries to provide a Locally Enhanced Service to all care homes. By March 2009 all care homes in South Lanarkshire have implemented across NHSL. This approach enables the provision of the best care and support for people with complex health and social care needs in their own homes.

- **North Lanarkshire** Integrated Addiction Services. 6 locally-based integrated (Health and Social Work) teams meeting the needs of people with complex alcohol and drug problems.

- Single management structure in place with locally based managers and one overall NL Service manager reporting to NL Partnership Board for Addictions.

- **Living and Dying Well** Delivery Plan is a joint health and social care document including identification of needs, collaborative care planning and co-ordination of care and may prevent avoidable hospital admissions.

- **Self Management Programmes** can enable people to manage their care better and avoid the need to attend A&E as often. A range of Self Management Programmes are being developed and piloted to enable people living with a long term condition to manage their condition on a daily basis in a way which supports their daily life/work. Some programmes are condition specific while others are generic. Programmes include COPD, Diabetes, Stroke, Children and Young People, and Chronic Pain.

- **Considerable work has been undertaken by South Lanarkshire Social Work Services** to promote Falls awareness and prevention in residential and care settings.

  As part of this an information leaflet has been developed in consultation with local service users and this will be presented at a conference in September 2009.

- **Keep Well Programme is well established in CPN North and is proving very successful in engaging people in early detection of health issues and early intervention where health/social issues exist**.

- **GP Care Homes contract that will improve primary care support to people in care homes leading to reduced presentations at A&E from care home residents**.

- **NLC development of intermediate care including assessment and rehabilitation in care homes which is a joint initiative enabling older people to move from hospital to assessment and rehabilitation placements as alternative to permanent [and sometimes premature] move to care home**.

- **Community Older People’s Team, Cambuslang and Rutherglen. An integrated team that brings together health and social care and education and training and health supports to young carers**.

- **UPAD funding is agreed at a joint Committee chaired by Health** has been up and running to manage this process. New Alcohol funding has been the main focus of last year and this years spending plans with significant investment in place.

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<th>Integrated Care Management</th>
<th>Services and allows for closer working across each of the disciplines.</th>
<th>Primary Care Continence Services. All patients presenting with symptoms of urinary incontinence are triaged through continence service prior to acceptance by secondary care.</th>
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<td>incorporates a multiagency approach with regular discussions at multi-disciplinary team meetings within GP practices or other settings, enable health and social care practitioners to reassess individual care plans, address any gaps, and make more effective/efficient use of the local team and services.</td>
<td>Integrated health and social care service working across acute and community services providing the opportunity for service users to be offered rehabilitation in a more homely environment and supporting discharge back to the community. This service prevents hospital admission by taking referrals from GPs and Early Supported Discharge and supports early discharge taking referrals from acute.</td>
<td>SLOW STREAM REHABILITATION WITHIN PARKSPRINGS CARE HOME (NHS BEDS). Intermediate Care Beds. Integrated health and social care service providing 10 slow-stream rehab beds allowing clients extended rehab to support discharge home.</td>
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- Integrated Services – Wishaw General – Motherwell/Wishaw/Clydesdale Locality
- ASSESSMENT AND REHABILITATION BEDS WITHIN LESLIE HOUSE (6 BEDS) AND BELLHAVEN HOUSE (4 BEDS). Local authority care homes Intermediate Care Beds
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