AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date: 4 November 2019**
Report By:	**Louise Long** **Corporate Director (Chief Officer)** **Inverclyde Health & Social Care Partnership**	**Report No: IJB/73/2019/DG**
Contact Officer:	**Deborah Gillespie** **Head of Mental Health, Homelessness and Addictions**	**Contact No: 01475 715284**
Subject:	**Mental Health Strategy and Improvement Programmes**	

1.0 PURPOSE

1.1 The purpose of this report is to provide an update on developments to take forward the mental health strategy within Inverclyde, and to present the Mental Health Strategic Needs Assessment.

2.0 SUMMARY

2.1 The HSCP has convened a multi-agency Inverclyde Mental Health Programme Board (IMHPB) which has oversight of the range of work streams and provides a local context for delivery of both the NHSGG&C and national mental health strategies.

2.2 The range of improvements is significant requiring partnership working across the system and includes primary and secondary care, third sector, and public involvement, Police Scotland, Community Planning and the Alliance Board.

2.3 In order to inform the focus of work, a strategic needs assessment has been developed and is included as an appendix 1.

2.4 Inverclyde was chosen to work in partnership with Health Improvement Scotland and Alzheimer Scotland as the Dementia Care Co-ordination Site. This is the subject of a separate report.

2.5 The programme of work is supported by investment from Action 15 funding from the Scottish Government, detailed at Appendix 2.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to:

(1) Note progress in delivery of mental health improvement in Inverclyde.

(2) Note the content and key evidence within the Mental Health Strategic Needs Assessment.

(3) Agree to commission a review of Mental Health Officers model of service delivery.

(4) Agree the investment of Action 15 funding as detailed in Appendix 2.

5) Agree a further updated report detailing the outcome of the peer recovery model will be presented to a future IJB

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 Delivering improvement in mental health services is taking place within a complex landscape with direction provided by a number of strategies/ policies:

- Action 15 Implementation Plan (National Mental Health Strategy 2017-2027).
- Primary Care Improvement Plan- Primary Care Mental Health.
- NHSGG&C Adult Mental Health Strategy.
- Children & Young People's local development work- Mental Health task force.
- NHSGG&C Older People's Mental Health Strategy development.
- Review of Inverclyde Addictions Services.

Within Inverclyde HSCP the Inverclyde Mental Health Programme Board (IMHPB) has been established to oversee these programmes. This reports to the Integration Joint Board and met for the first time in March 2019.

4.2 The role and remit of the Inverclyde Mental Health Programme Board (IMHPB) is:

- To promote, support and facilitate active participation of all relevant stakeholders in the range of mental health improvement programmes in Inverclyde including the appropriate service user groups. This will include ensuring capacity is built within service user groups.

- To ensure that progress against the individual implementation and improvement plans is sustained.

- To work collaboratively to help ensure that work streams/ aligned programmes connect strategically.

- To have oversight of financial resources, making recommendations on use of resources if and when required.

- To agree any key messages for communication about changes occurring as part of the overall improvement programmes.

This group meets quarterly and is chaired by the Chief Officer Inverclyde HSCP.

4.3.1 **Key Messages from Mental Health Strategic Needs Assessment**

An early action of the IMHPB was to commission a detailed strategic needs assessment which was completed in July 2019 and will continue to be updated as additional data becomes available. In particular, the inclusion of data on health and wellbeing of young people when the report from the survey in schools becomes available later in the year.

4.3.2 Deprivation is a major factor in health inequalities and mental wellbeing. There are also national inequalities in mental and physical health care including access and associated resources.

- Only 1 in 3 people who would benefit from treatment for a mental illness currently receive it, on current estimates.
- People with life-long mental illness are likely to die 15-20 years prematurely because of physical ill-health.
  People with a mental health problem are more likely than others to wait longer than 4 hours in an Emergency Department.

4.3.3 Drawing on a range of local health information and service delivery data, the following is key evidence required to be used to inform the planning and delivery of services:

- Positive perceptions of mental and emotional wellbeing are highest in the age

groups 16-24 and 65-74 and lowest in the age groups 55-64 and 75+.

- Social isolation and loneliness have a significant impact on mental health with people in all age groups reporting feeling lonely in the last 2 weeks, this being most apparent in those aged 16-24 and 75+.
- The number of patients with a serious mental illness is highest in the central GP cluster and is increasing in all clusters (East and West).
- The number of patients with newly diagnosed depression continues to increase and is slightly higher in West GP cluster than East and Central.
- Rates of serious mental illness and depression are higher in Inverclyde than Scotland and NHSGG&C.
- Rates of Dementia are higher than Scotland and NHSG&C however rates of hospital stay for these patients have more than halved since 2013/14.
- Referrals to CAMHS following the increasing trend across Scotland however waiting times in Inverclyde remain lower than in NHSGG&C and Scotland.
- Inverclyde central GP cluster has 2 ½ times the rate of alcohol related admissions than West cluster.
- Drug related hospital stays within Inverclyde Central Locality are the highest in Scotland.
- 25.8% decrease in probable suicides in Inverclyde between 2004-2018.
- 73.5% of probable suicides between 2011- 2017 were male.
- Upward trend in referrals for people in crisis with an even split between male and female however 65% of referrals are from the 16-44 age category.
- 30% increase in volume of mental health related police incidents since 2017 with the highest rate of incidents in Greenock town centre datazone.
- Referrals to both the Primary Care and Older People's Mental Health Teams are increasing.
- Stress and mental health amongst the highest reasons for referral to Community Link Workers based in GP practices.
- Range of social/ peer support connections made by Community Connectors improving physical and mental health and wellbeing.

4.4 **Work streams**

The range of work required in response to both local need and to address the expectations from the range of policies and strategies detailed in 4.1 is being taken forward through a number of work streams, reporting to the Programme Board. These are detailed below, with information about the current areas of focus and progress to date.

4.4.1 **Prevention and Primary Care**

Improving support within primary care is explicit both within the Primary Care Improvement Plan and the national strategy with funding allocated in both streams. A workshop was held in June 2019 which explored current data and challenges in supporting mental wellbeing, distress and recovery in primary care. Key areas in which to test changes were identified as:

- Explore the development of multi-function hubs (distress & recovery).
- Embed Distress Brief Interventions (DBI).
- Development of Peer Support work.
- Navigator role for crisis/ attendance at Emergency Department.
- Impact of trauma training framework in practice.

4.4.2 **Community Services**

A review of the Community Mental Health Team operational processes is underway to identify opportunities to improve efficiency and effectiveness within the service, promoting the principles of easy access in and out of service, and the right level of intervention at the right time. This is informed by the Efficient and Effective Community Team workstream of the NHSGG&C five year strategy. Phase 1 process mapping,

demand and capacity will be complete by the end of October. Phase 2 will concentrate on interface and pathway arrangements.

An action plan supporting sustainability of the Mental Health Officer (MHO) service has been produced in response to pressures arising from increased demand and reduced capacity within the MHO service provision. Immediate action includes refocusing of the team with agency backfill support, along with a temporary transfer to the full time MHO service of a staff member from within the HSCP. MHO availability via agencies on the Scotland Excel Framework is being explored.

A further action is overall review of the Mental Health Officer service being commissioned to scope service demand, capacity and activity. National and local priorities will inform outputs including agreement on the preferred model for sustainable service delivery and opportunities to improve efficiency and effectiveness within the service. The commissioning is expected to be complete by the end of October 2019 with the review process commencing thereafter.

4.4.3 **Distress & Unscheduled Care**

An NHSGG&C wide Multi-Agency Distress Collaborative reported earlier in 2019, key recommendations were that HSCPs should consider:

- Alternative responses to distress.
- Consolidation and further development of existing practice around Repeat Presentations to Emergency Departments.
- Increase distress response training to multi-agency groups.

Engagement is underway with the national lead for Distress Brief Interventions (DBI). DBI is about offering timely *Connected Compassionate Support* to those in distress. Based on our exploration of commissioning and delivering this service, a proposal is to be written outlining the case for implementation in Inverclyde.

A training needs analysis will be undertaken around distress, suicide prevention and trauma informed practice to understand the current landscape and formulate an approach which encompasses all partner agencies. Approaches to addressing unscheduled care including the navigator role will be the subject of a separate report.

A critical element of unscheduled care is requirement for acute admissions. The general landscape will be shifting to further improve the community focus and capacity for unscheduled care. Whilst there continues to be local provision for acute admissions the national issue of shortage of Psychiatrists could impact on the service in the future. This is both in terms of Consultant provision and consequent impact for adequate supervision of the medical training programme.

4.4.4 **Recovery**

A recovery strategy is in development which will include approaches across Mental Health, Alcohol and Drugs and link with reablement approaches. Consultation with service users and carers has been key to establishing our approaches with events being held in 2016 and 2018. Reflecting on the outcomes of these events we will:

- Continue to build on partnership working with all individuals and groups, communities and services.
- Support people to develop the skills they need to work effectively together.
- Support staff to learn skills in co-production and to skill up service users and carers so that they can participate in an informed and confident way.
- Continue to support carers by recognising their specific needs and their expertise.
- Promote the creation of Recovery Standards across Inverclyde that evaluate how effectively services support social inclusion, equality, financial inclusion and mental health recovery.

- Promote peer led approaches to support and recovery.

The Recovery workstream of the NHSGG&C Mental Health five year strategy specifically supports the promotion of a recovery ethos within all commissioned and directly provided services and the development of:

- Recovery colleges.
- Peer support worker model.
- Provision of training/ awareness of recovery orientated services for staff, patients and carers.
- Pilot of a recovery planning tool to promote realistic medicine.
- Recovery conversation cafes/ activities.

Inverclyde is a pilot site for the employment of peer support workers within our mental health teams. This is a test of change and will explore the role that peer support can have in supporting people during admission to hospital, facilitating timely discharges, and engagement with recovery-focused community support. These posts are currently being recruited to and appropriate applicants have now been shortlisted for interview.

4.4.5 The implementation of the elements of the programme of work is supported by investment from Action 15 funding from the national Mental Health Strategy 2017-2027, and this includes investment in GG&C wide developments in relation to unscheduled care and recovery, the details of which are within the attached Appendix 2. The scope and range of the work programme is extensive and requires additional support to implementation, and this investment includes provision for a programme manager on a fixed term basis.

5.0 CONCLUSION

5.1 A work plan is being developed to take forward these areas of work, ensuring coherence and interface with work across the HSCP including the Alcohol and Drug Service review outcome, Community Justice Plan and the Children and Young People's Mental Health Tier 2 service development.

6.0 IMPLICATIONS

6.1 FINANCE

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

6.2 There are no specific legal implications arising from this report.

HUMAN RESOURCES

6.3 There are no specific human resources implications arising from this report.

EQUALITIES

6.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required. Individual change programmes will have Equality Impact Assessments undertaken.

6.4.2 How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	Positive - Increase access to mental health support and interventions.
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	Positive – increase access to mental health support and interventions
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	Positive – continuing involvement in service development
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	Positive – training of staff across HSCP services and wider agencies to ensure all are aware of their values and beliefs to ensure non-discrimination.
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

6.5 There are no clinical or care governance implications arising from this report.

6.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	The programme will ensure service users and the wider community have access to a wider range of support including peer support and self management programmes.

People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	The programme will continue to develop a recovery oriented approach to ensuring people with mental health needs can enjoy a positive quality of life.
Health and social care services contribute to reducing health inequalities.	None
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	Identifying and responding to carers mental health needs will impact on enabling the caring role.
People using health and social care services are safe from harm.	Development of responses to distress and unscheduled care will support management of people experiencing mental health crises at risk of harm.
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Staff are engaged with development of new and improved approaches within evidence based practice.
Resources are used effectively in the provision of health and social care services.	The focus of work to enhance and support prevention, early intervention and self-management will enable best use of resources targeted to need.

7.0 DIRECTIONS

7.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	X

8.0 CONSULTATION

8.1 There is representation from Your Voice and the Mental Health Reference Group on IMHPB. Service user involvement has also been included in various projects/ tests of change such as Multi-Agency Distress Collaborative and Recovery and as such forms part of plans for delivery of services.

9.0 BACKGROUND PAPERS

9.1 Appendix 1- Inverclyde HSCP Mental Health Strategic Needs Assessment.

APPENDIX 1

MENTAL HEALTH & WELLBEING

HEALTH NEEDS ASSESSMENT

SEPTEMBER 2019

Introduction

Deprivation is a major factor in health inequalities:

- There is a social gradient in health – the lower a person's social position, the worse his or her health
- Health inequalities result from social inequalities[1]

A little over 40% of the population of Inverclyde (33,500 people) are in the top 20% most deprived data zones in Scotland. 22,000 people in Greenock Central Locality live in an area considered one of the worst for health deprivation in Scotland. This is not to say that every one of those individuals is health deprived but that the overall area that they live in is. Healthy Life Expectancy (years lived in a 'healthy' state) is lower than that for Scotland and overall Life Expectancy in Inverclyde is lower for both males and females than for Scotland. Despite recent increases in Inverclyde, a gap between those in the different localities of Inverclyde remains. Men and women in Kilmacolm central will live longer than those in Greenock Central (male = 14 years, women = 15 years).

There are also inequalities in mental and physical health care including access and associated resources.

- Only 1 in 3 people who would benefit from treatment for a mental illness currently receive it, on current estimates.
- People with life-long mental illness are likely to die 15-20 years prematurely because of physical ill-health.
- People with a mental health problem are more likely than others to wait longer than 4 hours in an Emergency Department[2]

The following needs assessment considers data from a variety of sources and highlights the impact of local socio-economic circumstances on mental health and wellbeing within Inverclyde.

[1] Fair Society, Healthy Lives (The Marmot Review) 2010
[2] Mental Health Strategy 2017 – 2027 Scottish Government

Mental Health & Wellbeing

Wellbeing is linked to mental health in that it attempts to measure how happy and content people are in their everyday lives. Self-reported views of health and wellbeing are shown in Figure 1[3]. There are evident gaps between those living in the most deprived areas and those in the rest of Inverclyde.

Figure 1 Self- Reported Views of Health

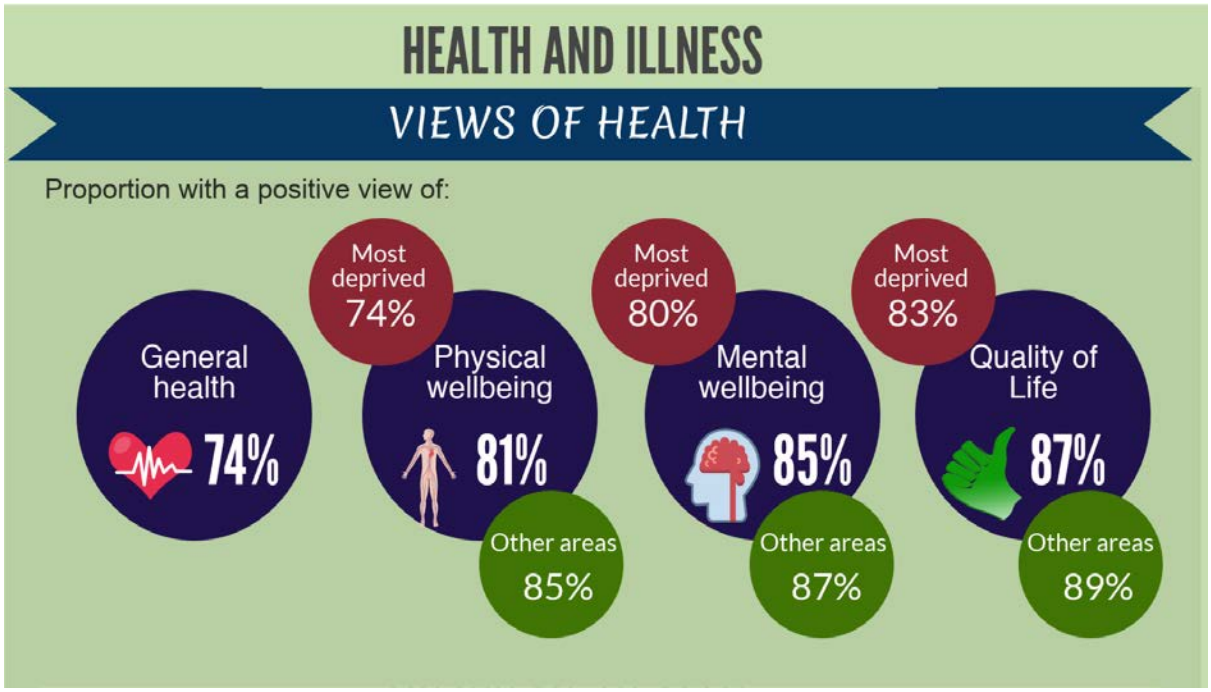


Figure 2 and 3 show the views of wellbeing by age and by deprivation. Positive perceptions of mental and emotional wellbeing are highest in the age groups 16-24 and 65-74 and lowest in the age groups 55-64 and 75+. Overall quality of life however is highest for those aged 16-24 and 25-34 and lowest in the most deprived 15% of the population.

[3] Inverclyde HSCP health and wellbeing survey 2018

Figure 2 Positive Perception of Mental and Emotional Wellbeing by Age

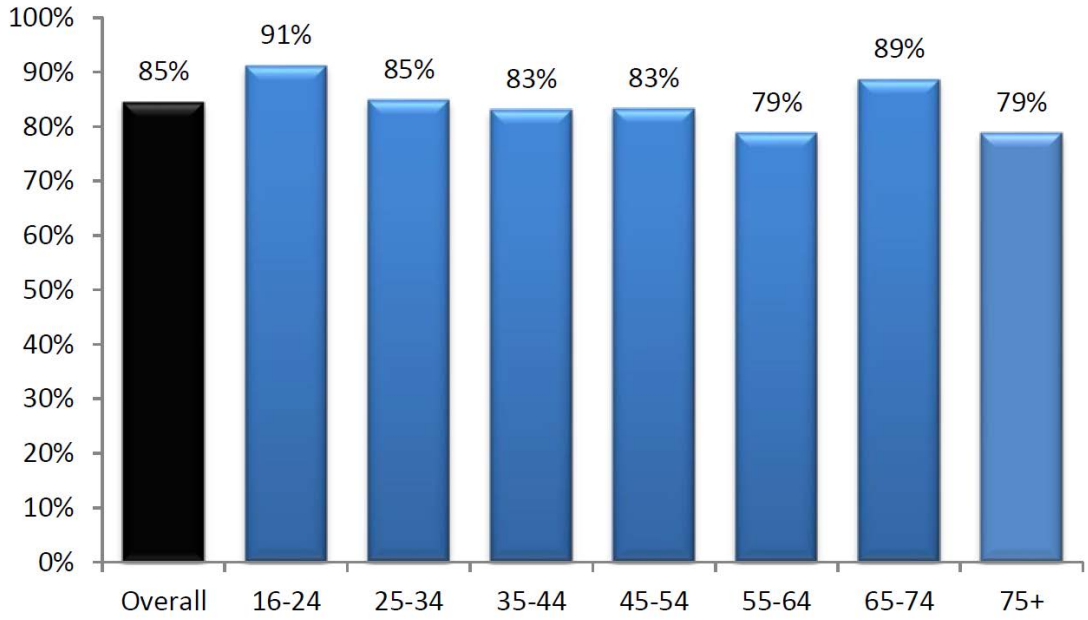
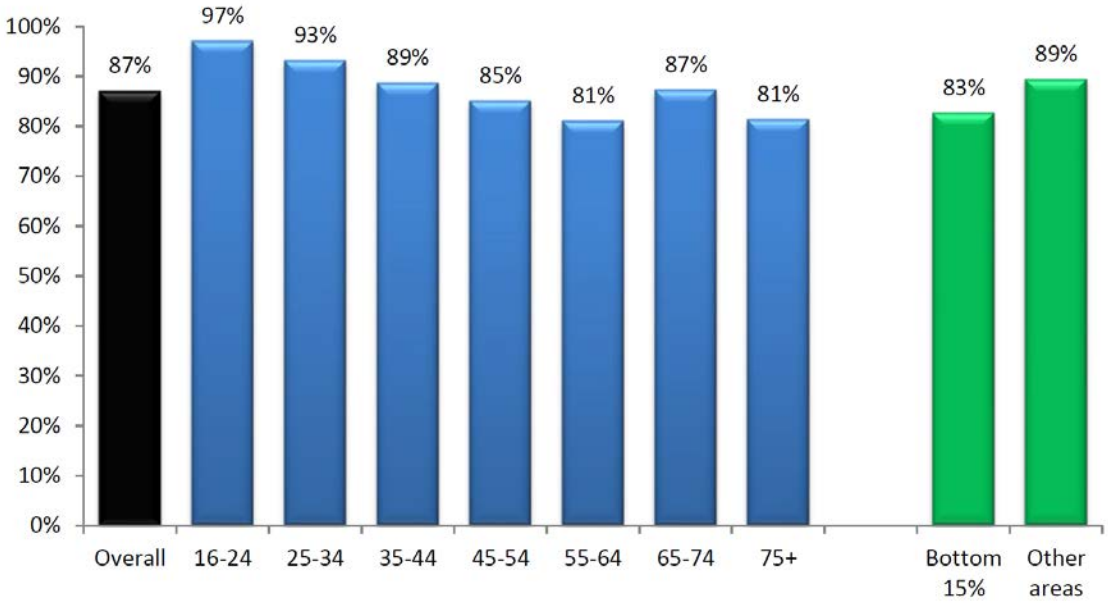
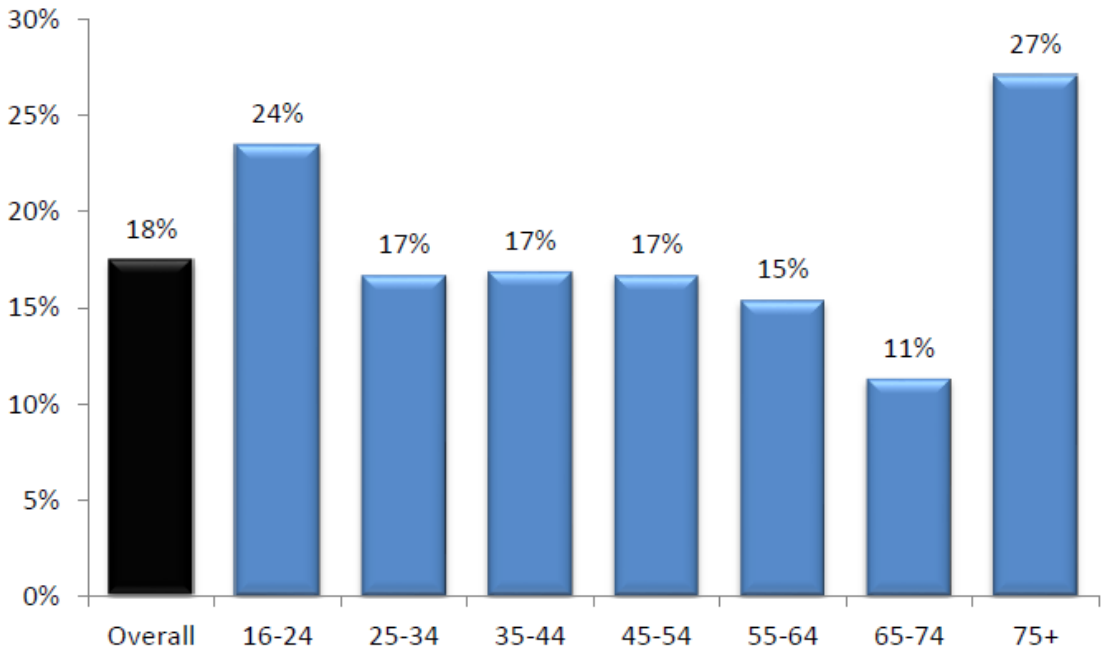


Figure 3 Positive Perception of Quality of Life by Age and Deprivation



It is acknowledged that social isolation and loneliness can affect anyone at all ages and stages of life. There is increasing recognition of social isolation and loneliness as major public health issues that can have a significant impact on a person's physical and mental health. The Inverclyde Health & Wellbeing Survey shows that 9% of our population feel socially isolated from family and friends and that there were people in all age groups who described feeling lonely some of the time in the previous 2 weeks (Figure 4). This was most apparent in the age groups 16-24 (24%) and 75+ (27%). Older people are more likely to live alone and therefore be at risk of social isolation. In contrast those in the older age groups are more likely to report a sense of belonging to their local area.

Figure 4 Proportion who had felt lonely at least some of the time in the last 2 weeks



Prevalence

Prevalence information on mental health conditions is available from primary care data sources. This information is based on the historic Quality & Outcomes Framework (QOF) data which measured achievement for practices against a range of evidence-based indicators, with points and payments awarded according to the level of achievement. This data is presented as GP Cluster information- East, Central and West clusters (Appendix 1).

The tables below show the number of patients in each cluster that were on the disease register for specific diseases from 2015/16 to 2017/18.

Figure 5 - Number of patients on the mental health disease register 2015/16 – 2017/18

Mental Health	2015/16	2016/17	2017/18
Inverclyde East	267	257	280
Inverclyde Central	279	280	412
Inverclyde West	341	339	346
Inverclyde HSCP	887	876	1038

Source: PCI dashboards, ISD Scotland

The mental health definition only includes patients with serious mental illness, defined as schizophrenia, bipolar affective disorder or other psychoses.

The number of patients on the mental health disease register in Inverclyde increased between 2016/17 and 2017/18 by 18%. The majority of this was the result of an increase in Inverclyde Central. During this time there was a practice merger in Inverclyde Central and it *may be that practice records were reviewed and updated after the merger, meaning more patients were identified.*

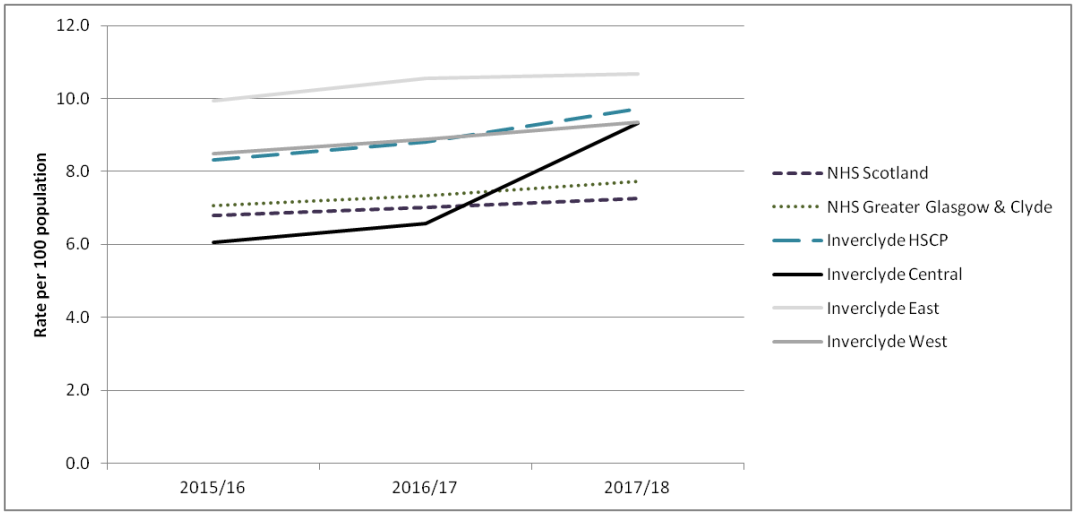
Depression statistics are based on newly diagnosed cases of depression:

Figure 6 - Number of patients on depression disease register 2015/16 – 2017/18

Depression	2015/16	2016/17	2017/18
Inverclyde East	2,214	2,324	2,513
Inverclyde Central	1,112	1,193	2,649
Inverclyde West	2,472	2,597	2,729
Inverclyde HSCP	5,798	6,114	7,891

Source: PCI dashboards, ISD Scotland

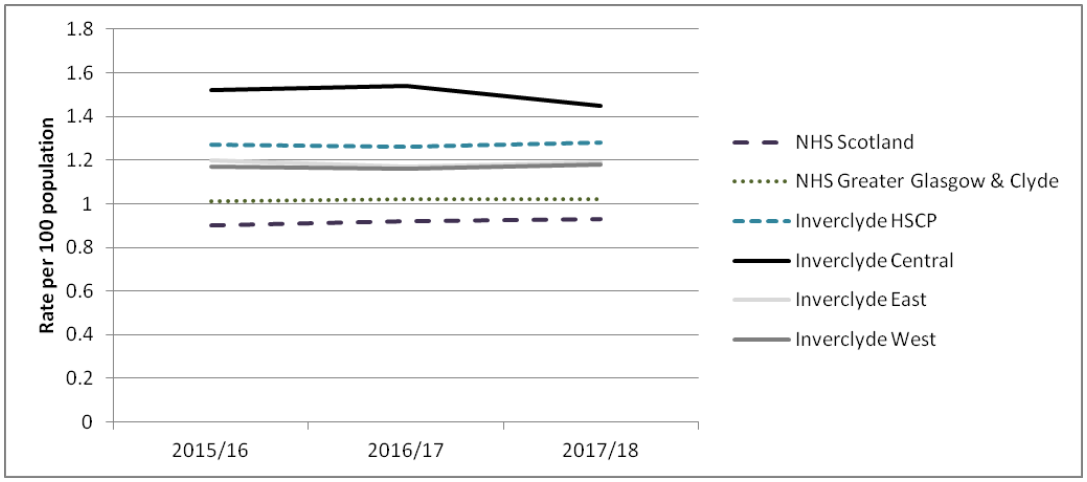
Figure 7 - Rate of depression per 100 population



Source: PCI dashboards, ISD Scotland

The number of patients with a depression diagnosis had increased in each of the last three financial years although there has been more than a doubling of cases in Inverclyde Central between 2016/17 and 2017/18 (again this may be due to the previously mentioned practice merger). Overall, newly diagnosed depression cases increased by 30% in Inverclyde during those years. Increases in depression cases are to be expected due, in part, to the cumulative nature of this register.

Figure 8 - Rate of mental health patients per 100 population



Source: PCI dashboards, ISD Scotland

Burden of disease

Burden of disease is a measurement designed to take into account how death and ill health are affected by a number of disease and injury risk factors. Burden of disease studies use a single composite measure which combines the years lost because of early death (years of life lost - YLL) and years lost because people are living in less than ideal health (years lived with disability - YLD). The measure used to describe the overall burden of disease is called the disability-adjusted life year (DALY).

Figure 9 below shows the rate of mental health DALYs. The rate in Inverclyde is higher than both NHS GG&C and Scotland for all three disease types meaning the burden is greater.

Figure 9 – Mental health diseases DALY rates per 100,000 population

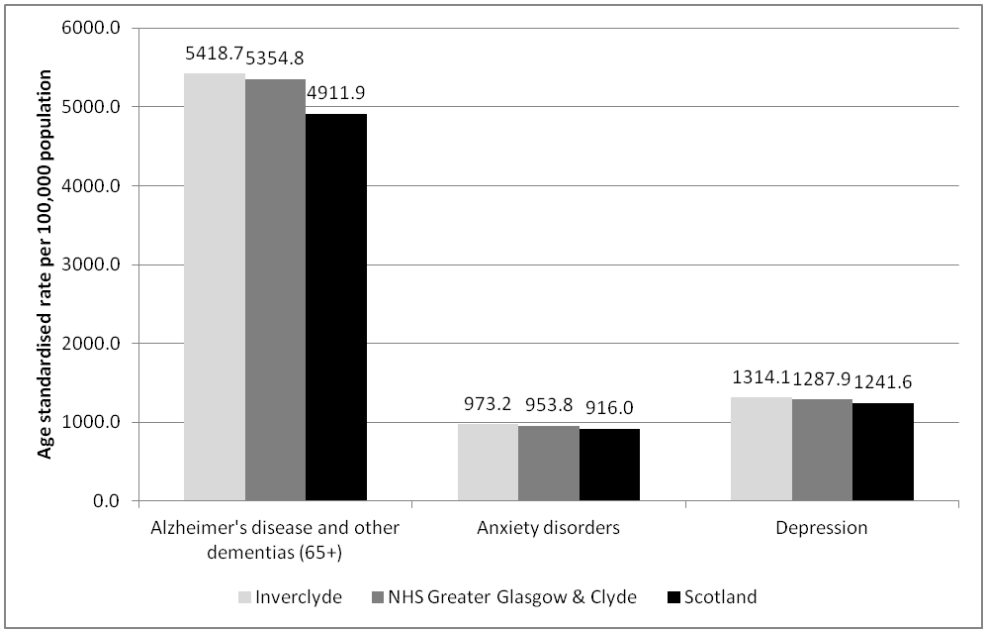
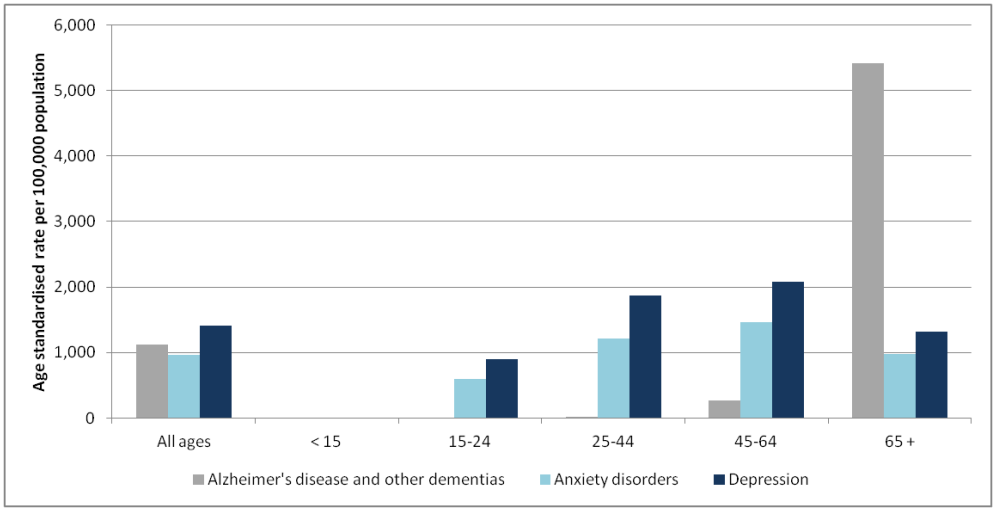


Figure 10 demonstrates the age breakdown of the three diseases for Inverclyde. The DALY rates for anxiety disorders and depression are greatest in the 45-64 age group, whilst Alzheimer's and other dementia is greatest for those aged 65 and over.

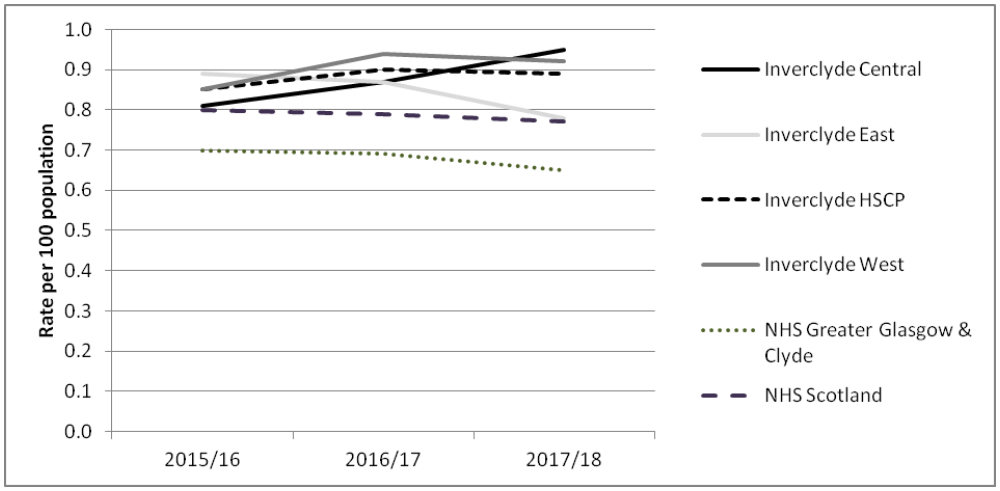
Figure 10 – Inverclyde DALY rates for mental health diseases by age group



Dementia

Dementia prevalence and diagnosis

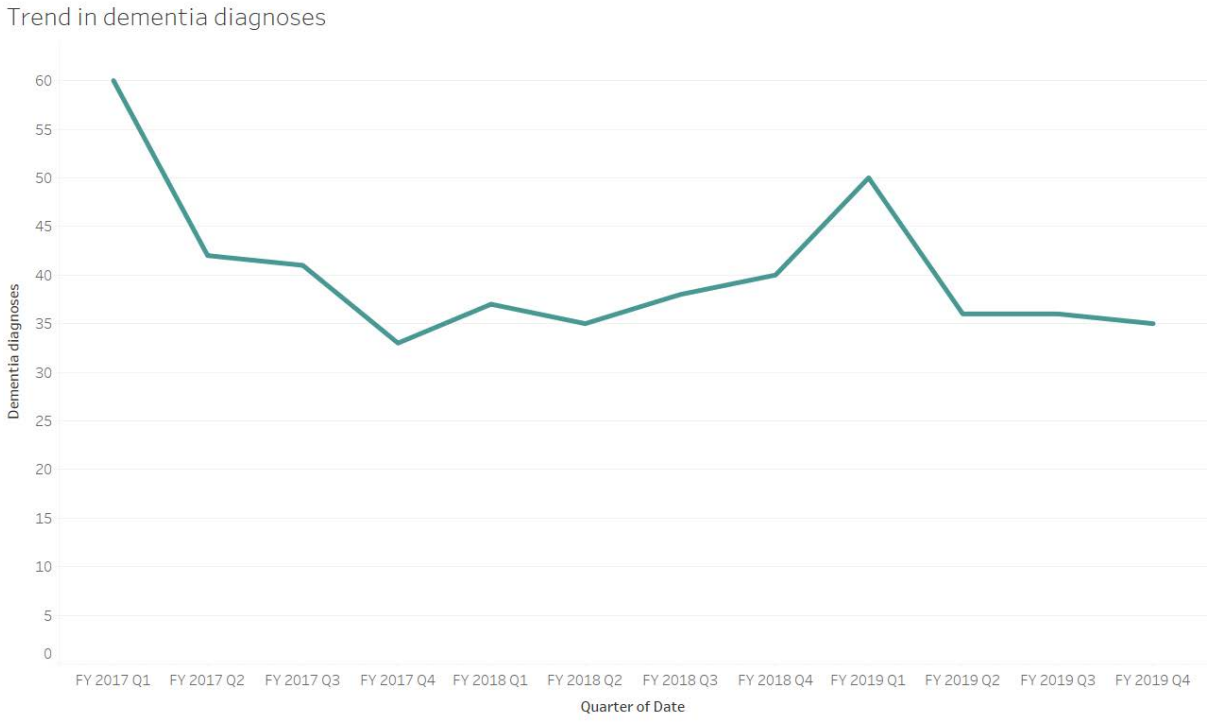
Figure 11 - Rate of dementia per 100 population



Source: PCI dashboards

Overall the rate of dementia is higher in Inverclyde than Scotland and has risen higher in Central Cluster than elsewhere. The overall rate in NHSGG&C has fallen more dramatically than for Inverclyde since 2016/17.

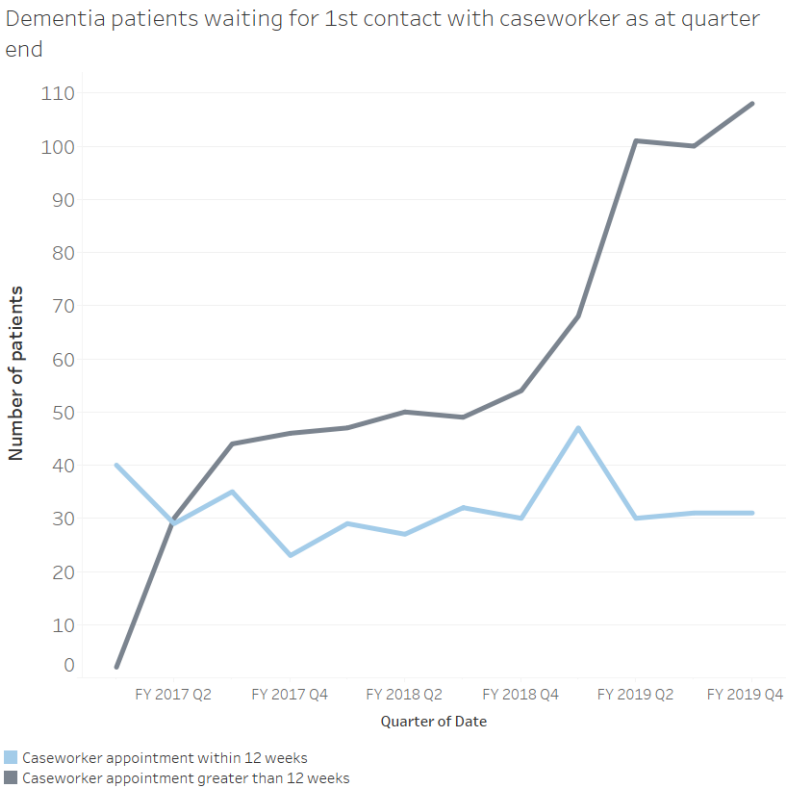
Figure 12 - Trend in dementia diagnoses Inverclyde



Source: Inverclyde HSCP Mental Health Quarterly Service Report Q4 2018/19

Post diagnostic support

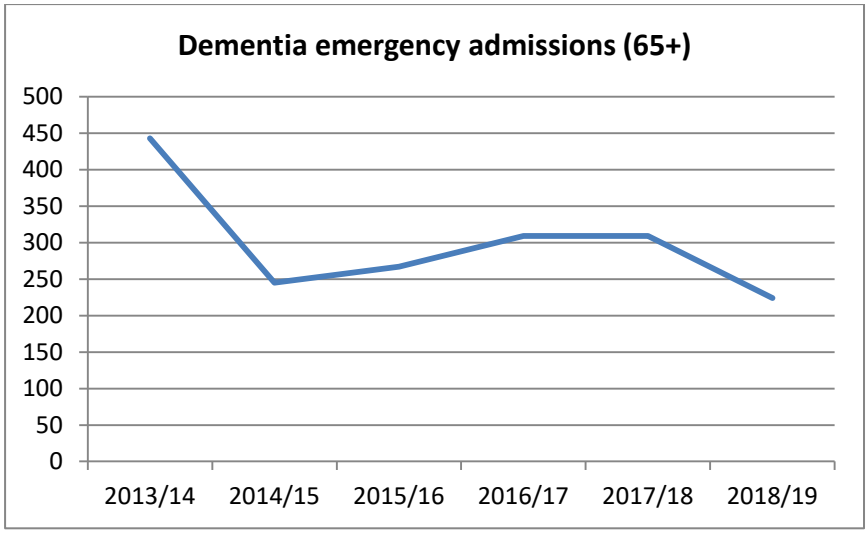
Figure 13 – Post diagnosis dementia support



Source: Inverclyde HSCP Mental Health Quarterly Service Report Q4 2018/19

All patients receiving a new diagnosis of Dementia within Scotland are offered 1 year post- diagnostic support coordinated by a named link worker. There has been an increase in the number of patients waiting longer than 12 weeks for their first contact with a caseworker following a dementia diagnosis due to a vacancy within the service.

Figure 14 - Acute admissions for people with dementia - Inverclyde



Source: SMR01

Emergency admissions in acute hospitals where dementia is recorded at any point.

These are all admissions to any ward/department that is in an acute hospital and not a specialist mental health facility. The reduction in these admissions may be directly related to increased levels of support available within community and people's own homes through the Home First approach in Inverclyde.

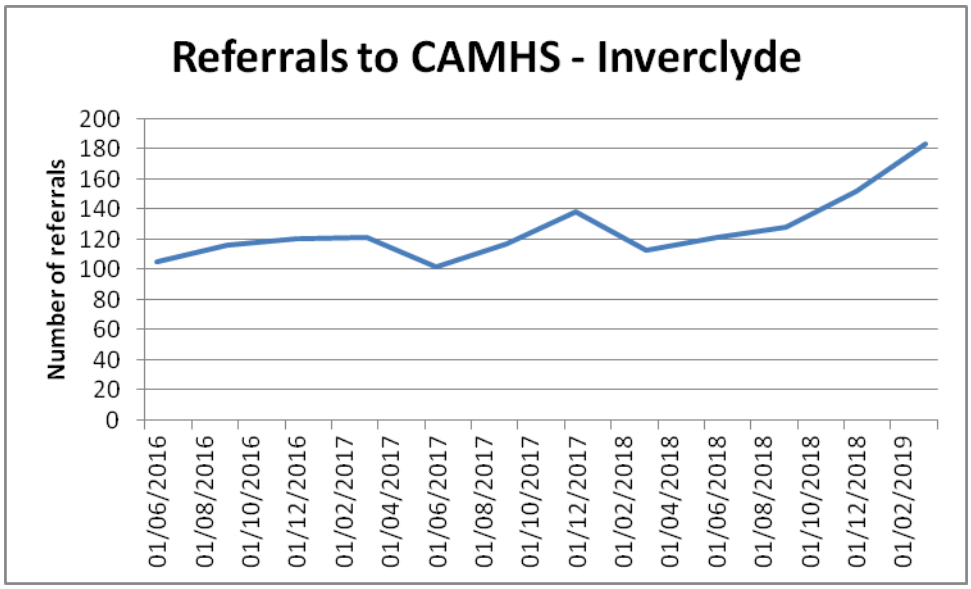
Children and young people

*A health and wellbeing survey is being undertaken and data will be inserted here when available in Autumn 2019

There is growing evidence around the impact of Adverse Childhood Events (ACEs) such as trauma or neglect on child development and the risk of mental illness or substance abuse. Given the stark deprivation, inequalities and drug and alcohol misuse in Inverclyde, children and young people are at significant risk of ACEs and the subsequent consequences.

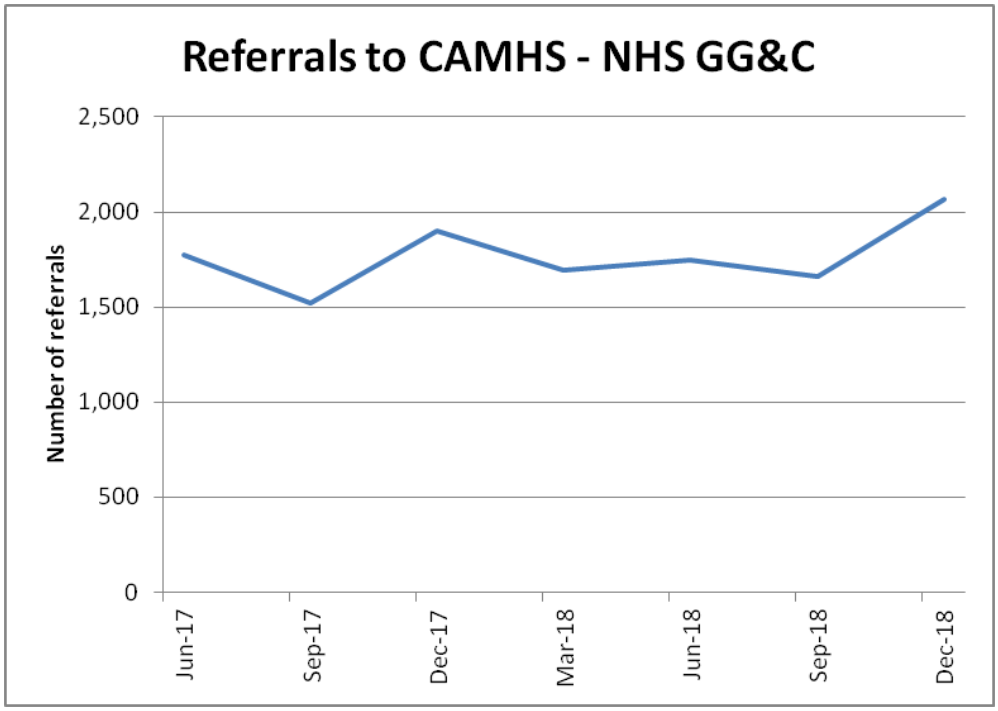
There are a number of factors that contribute to the reason why a child may require a child protection registration. This includes drug and alcohol misuse in families, as well as domestic abuse. The rate of child protection registrations with parental drug misuse is higher in Inverclyde than both GG&C and Scotland and this has been the trend since 2014. Rates for cases with parental alcohol misuse are lower than drugs in Inverclyde, having fallen from 2014. Child protection rates with alcohol misuse are similar between all three Inverclyde localities.

Figure 15 – Referrals to CAMHS Inverclyde



Source: CAMHS, Specialist Children's Services

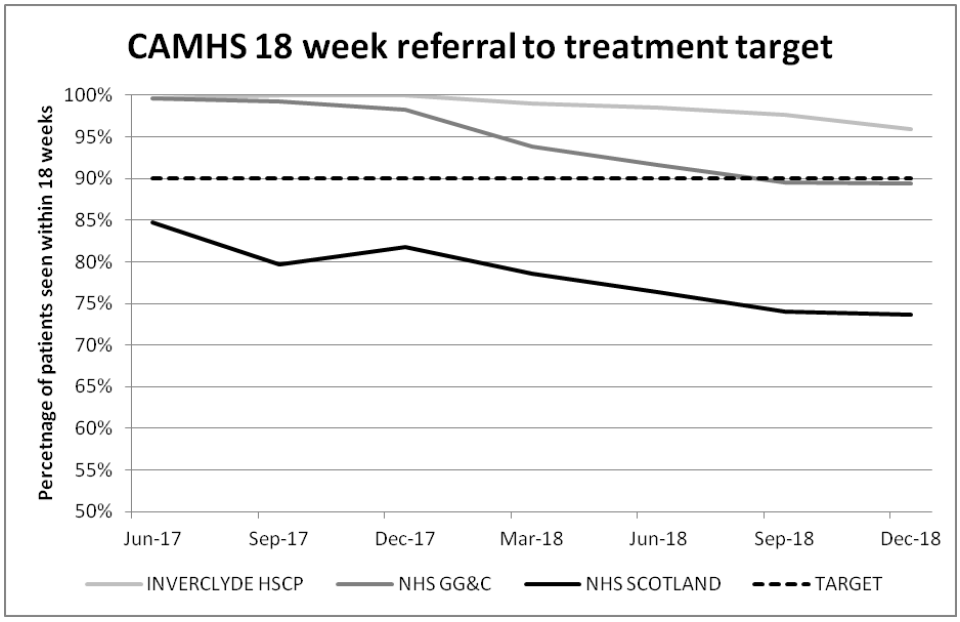
Figure 16 – Referrals to CAMHS NHS GG&C



Source: ISD Child and Adolescent Mental Health Services in Scotland: Waiting Times, Service Demand, and Workforce

Referrals to CAMHS follow the increasing trend seen across Scotland whilst waiting times in Inverclyde remain lower than in NHSGG&C and Scotland.

Figure 17 – CAMHS 18 week referral to treatment by area



Sources: ISD Child and Adolescent Mental Health Services in Scotland: Waiting Times, Service Demand, and Workforce and CAMHS, Specialist Children's Services

Substance misuse

Alcohol

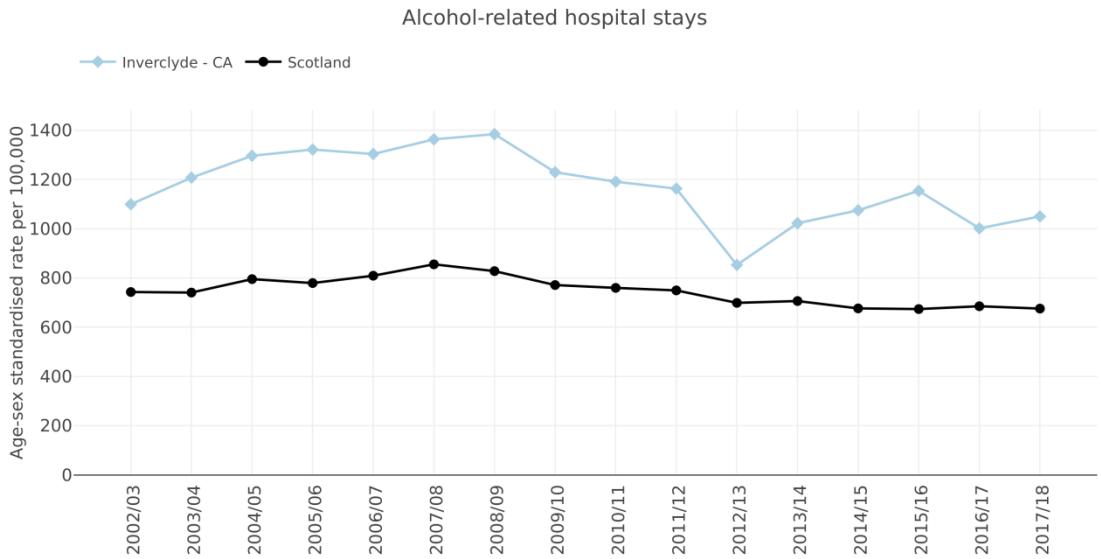
Figure 18 - Alcohol Related Hospital Statistics 2010/11 – 2017/18

Inverclyde	EASR Standardised hospital stay rate	Number of hospital stays
2010/11	1192.2	954
2011/12	1163.2	938
2012/13	851.5	688
2013/14	1020.2	811
2014/15	1072.5	849
2015/16	1151.3	906
2016/17	1001.2	794
2017/18	1035.7	822

Source: ISD Scotland

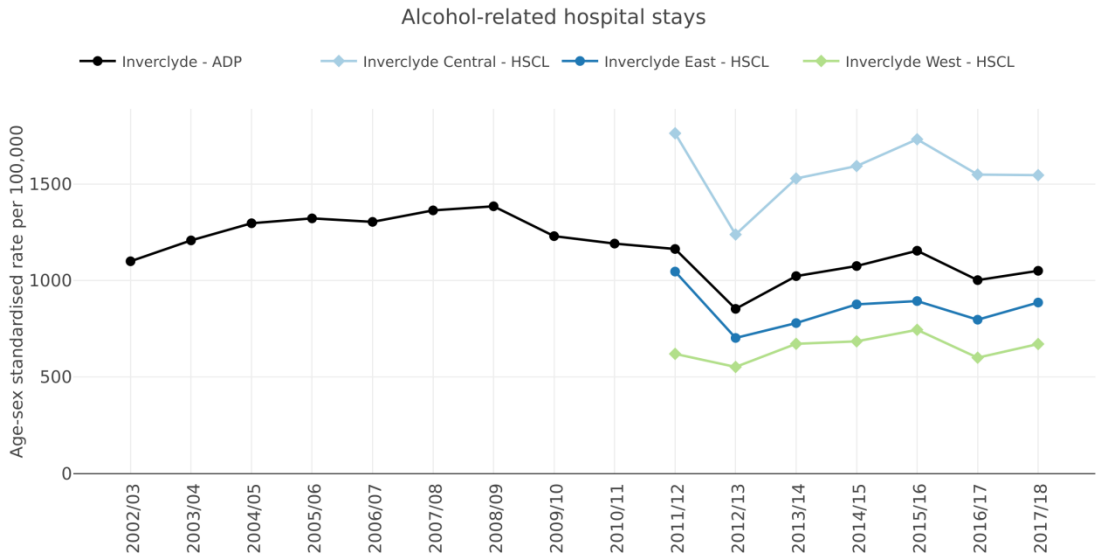
Figure 19 shows the trend information since 2002/03 for alcohol related stays; Inverclyde has consistently had higher rates than the Scottish total. Figure 20 shows a comparison between the localities and the overall Inverclyde rate. The area with the highest rate is Inverclyde Central, with a rate in 2016/17 nearly 2 ½ times greater than the lowest rate in Inverclyde West.

Figure 19 - Alcohol related stays



Source: ScotPHO

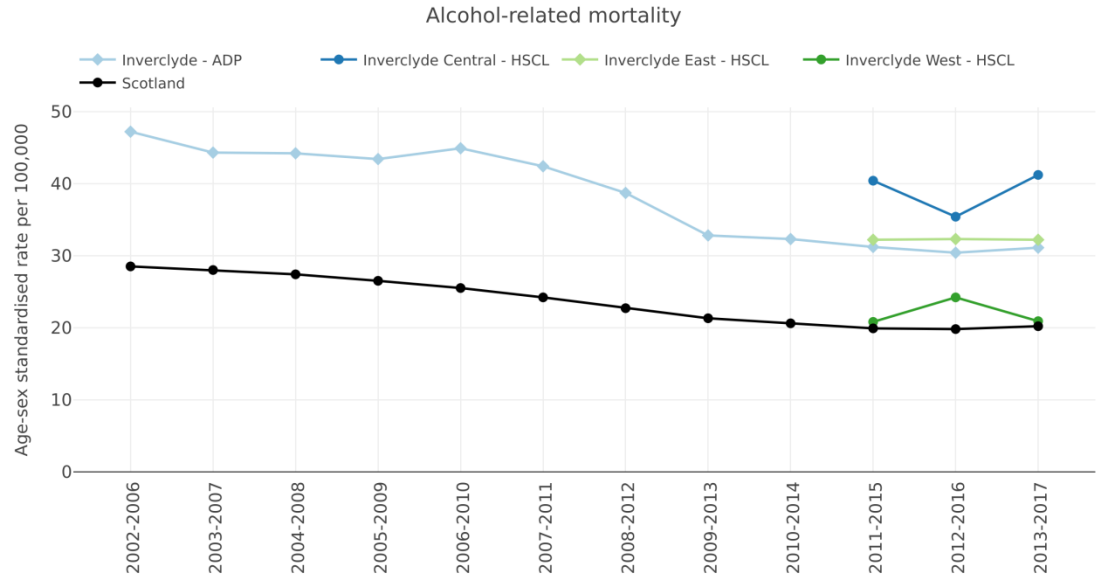
Figure 20 - Alcohol related stays by locality



Source: ScotPHO

Similar to the rate for stays, the rate for alcohol related mortality in Inverclyde is higher than the Scottish average.

Figure 21 - Alcohol related mortality



Source: ScotPHO

In 2017, the alcohol mortality rate in Inverclyde was the third highest amongst local authorities/alcohol and drugs partnerships in the country.

Figure 22 - Alcohol related mortality

Year	Inverclyde EASR standardised alcohol mortality rate	National EASR standardised alcohol mortality rate
2010	48.4	26.1
2011	42.4	24.2
2012	38.7	22.7
2013	32.8	21.3
2014	32.3	20.6
2015	31.2	19.9
2016	30.4	19.8
2017	31.1	20.2

Source: ScotPHO

Excessive or binge drinking is a reason why alcohol use can lead to emergency department attendances or admission to hospital.

The 2017/18 Health and Wellbeing survey asked those who drank alcohol how often they had 6 or more units if female, or 8 or more if male on a single occasion in the last year. In total, 56% of drinkers had drunk alcohol at this level in the last year

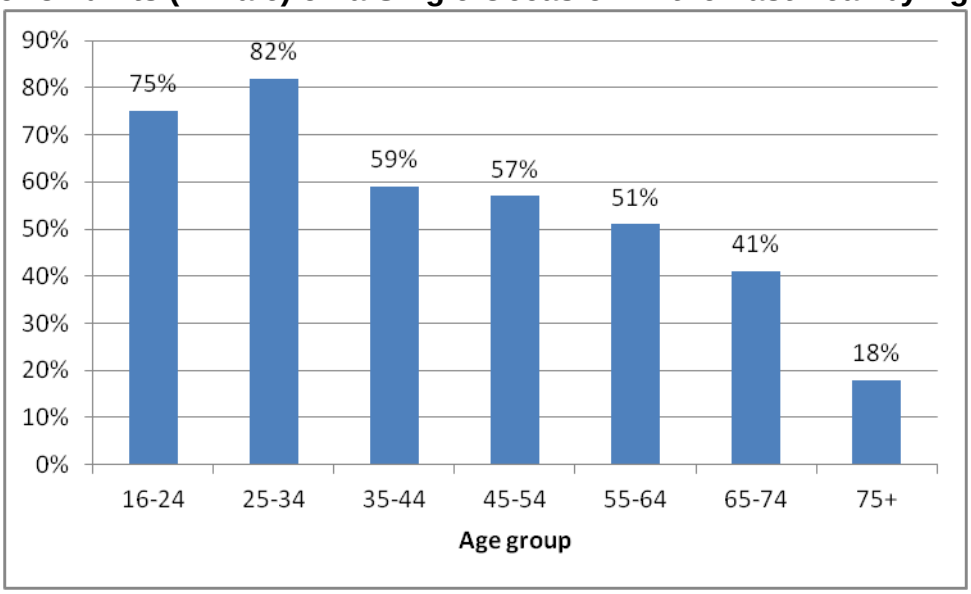
• Drinkers aged under 35 were the most likely to have binged in the last year.

• Men were more likely than women to have binged (61% compared to 52%)

• Drinkers in the most deprived areas were more likely to have binged (62% compared to 54%)

An age breakdown of binge drinking is shown in figure 23.

Figure 23 - Proportion of Alcohol Drinkers who had Exceeded 6+ Units (if female) or 8+ units (if male) on a Single Occasion in the Last Year by Age



Source: NHS Greater Glasgow & Clyde Heath and Wellbeing Report 2017/18

In 2017/18 the NHS Greater Glasgow & Clyde Health and Wellbeing survey asked respondents about their alcohol intake. Those in the youngest and oldest age groups were the least likely to drink alcohol, 41% of 16-14 year olds and 43% of people aged 75 above did not drink alcohol. Across Inverclyde, 32% of respondents did not drink alcohol, compared to 17% nationally. This self-reported data does not correlate with the hospital admission statistics where Inverclyde has higher rates of alcohol related admissions compared to Scotland. The 2017/18 questions about alcohol consumption differed to previous NHSGG&C health and wellbeing surveys, so it was not possible to examine trends.

Drugs

Because the drug using population is hidden, prevalence figures can only ever be estimates. The prevalence of drug misuse can be derived from numerous sources, for example from surveys (among the general adult population, among school children, among prisoners), from drug offences and drug seizures recorded by the police, from drug testing in prisons, from drug users coming into contact with health care providers because of their drug use or coming forward for treatment. Due to this issue data is difficult to gather and is not frequently updated. In 2015/16 in Inverclyde there were an estimated 1,500 people aged 15-64 with a problem drug use.[4]

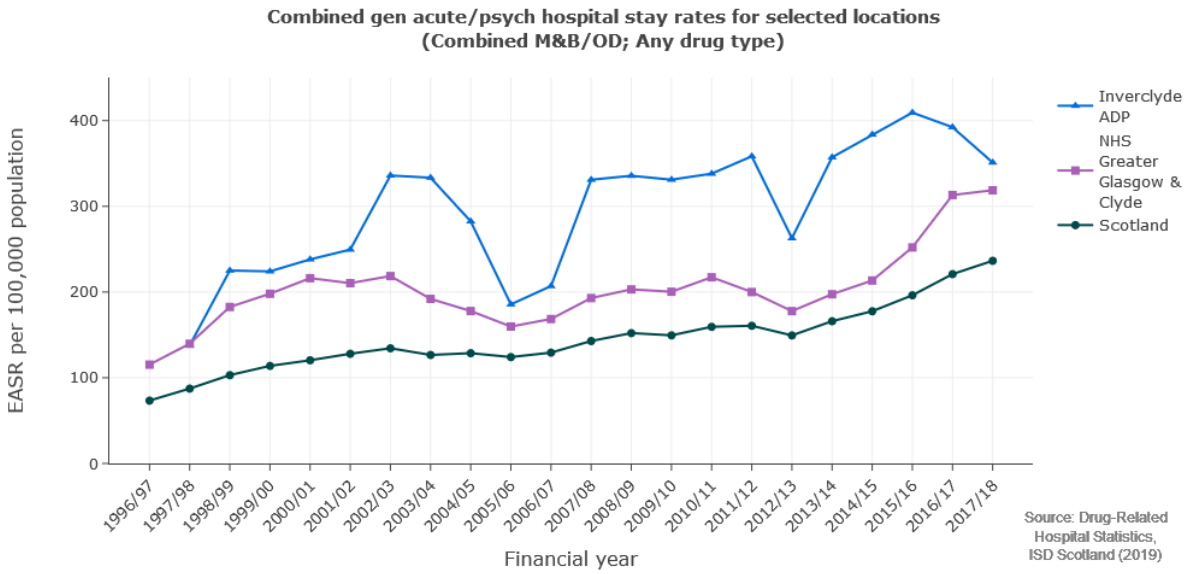
Problem drug use can lead to a number of health and social problems and drug-related hospital stays for the Inverclyde area are higher than the Scottish average. There is

[4] http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2019-03-05/2019-03-05-Drug-Prevalence-2015-16-Report.pdf

however a clear difference between the locality geographies. Drug related stays in Inverclyde East and Central are higher than the Scottish average but the rate in the Central locality is the highest in the whole country at 517.4 stays per 100,000 population.[5]

Figure 22 shows the comparison of age-standardised rates of drug related stays per 100,000 populations between Inverclyde, NHS GG&C and Scotland.

Figure 24 - Trend in drug-related hospital stays

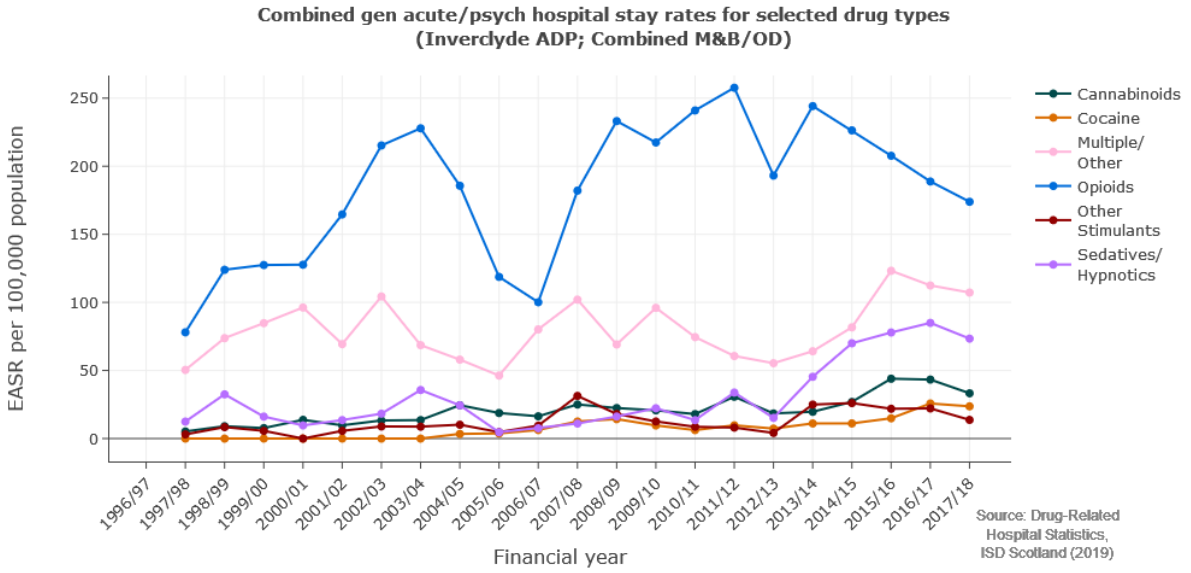


Source: Drug- related hospital statistics ISD Scotland 2019

Nearly half of the drug related stays in Inverclyde involve opioids, although as figure 23 demonstrates, there has been a downward trend in the rate of stays for this drug type since 2013/14.

[5] ScotPHO drug profile

Figure 25 - Trend in drug-related hospital stays Inverclyde by drug type



Source: Drug- related hospital statistics ISD Scotland 2019

Figure 26 - Estimated number of individuals with problem drug use by Council area (ages 15 to 64); 2015/16

Council area	Estimated number of people with a problem drug use
Inverclyde	1500

Source: ISD Scotland

The estimated prevalence of those with a problem drug use increased in Inverclyde between 2009/10 and 2012/13 but fell slightly between 2012/13 and 2015/16. This is in contrast to Scotland as a whole, where the estimated percentage of the population with a problem drug use has fallen year on year. In 2015/16 The estimated prevalence in Inverclyde is the highest of all the alcohol and drug partnerships in Scotland.

Figure 27 - Estimated prevalence of problem drug use by Council area (ages 15 to 64)

Council Area	Estimated Prevalence 2009/10	Estimated Prevalence 2012/13	Estimated Prevalence 2015/16
	%	%	%
Inverclyde	2.61	3.2	2.91
Scotland	1.71	1.68	1.62

Source: ISD Scotland

Problem drug use is higher amongst males than females. In 2015/16, the estimated prevalence amongst males aged 15-64 in Inverclyde was 4.4% and for females 1.6%. Both of these figures were higher than the Scottish averages of 2.4% and 0.9% respectively.

Inverclyde has statistically worse rates of drug prevalence in both men and women, drug related hospital stays, and drug mortality in comparison with Scotland as a whole. The rates for hospital stays related to drugs and the drug mortality rate are the highest in the country.[6]

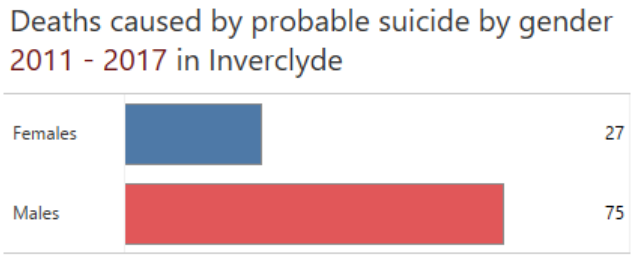
For those aged under 16, the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) reports on drug use among 13 and 15 year olds. The latest statistics for 2013 show that the percentage of 15 year olds who had reported drug use in the previous year was higher in Inverclyde than for Scotland as a whole, 19% versus 16%.[7]

Inverclyde Alcohol and Drug Partnership has made the reduction of drug prevalence a target as part of its Strategic Plan.

Suicide

Suicide statistics are presented as aggregated data due to the sensitive nature of the topic, and some data has been suppressed because the analysis results in small numbers where individuals could potentially be identified. This is especially so when broken down to smaller geographic areas such as local authorities. The following tables show the latest suicide statistics for Inverclyde.

Figure 28 - Deaths caused by probable suicide – Inverclyde council area patients aged 16 and over by gender, 2011-17

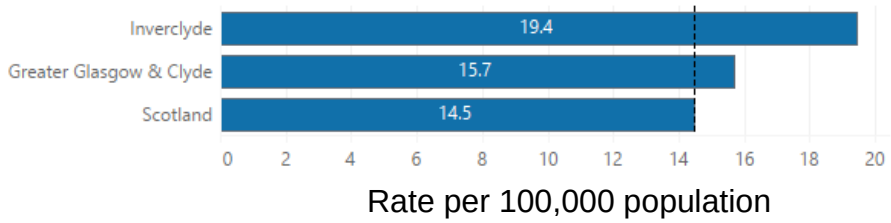


Source: NRS

Figure 29 shows a comparison of the rate of suicide between Inverclyde, NHS Greater Glasgow & Clyde and Scotland. Inverclyde has a higher rate than both the board and the Scottish average.

[6] ScotPHO Drugs Profile
[7] Scottish Schools Adolescent Lifestyle and Substance Use Survey 2013

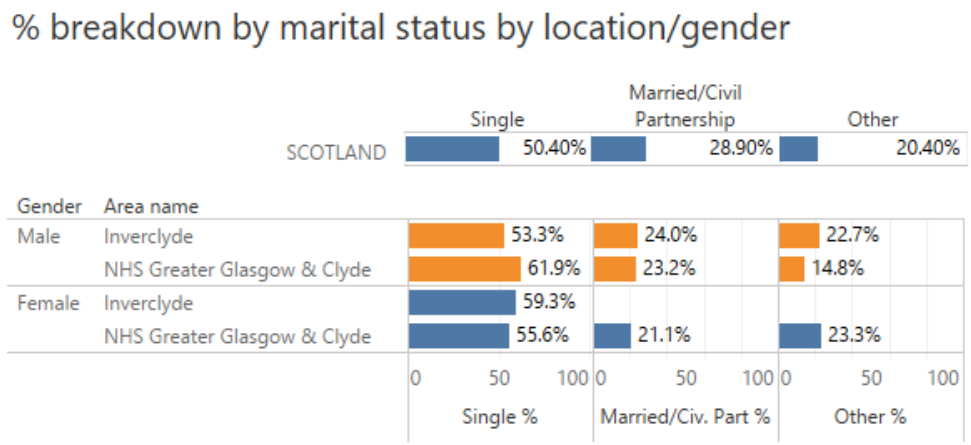
Figure 29 - Deaths caused by probable suicide – Age standardised rates for persons aged 5 years and over, by selected areas in Scotland, 2009-15



Source: NRS

Figure 30 splits the suicide data into sex and marital status.[8] For males in Inverclyde, a higher percentage of suicides are for those who have a marital status of "Other" compared to the board average. This group includes those who are divorced or widowed.

Figure 30 - Deaths caused by probable suicide by marital status – persons aged 16 and over[9]

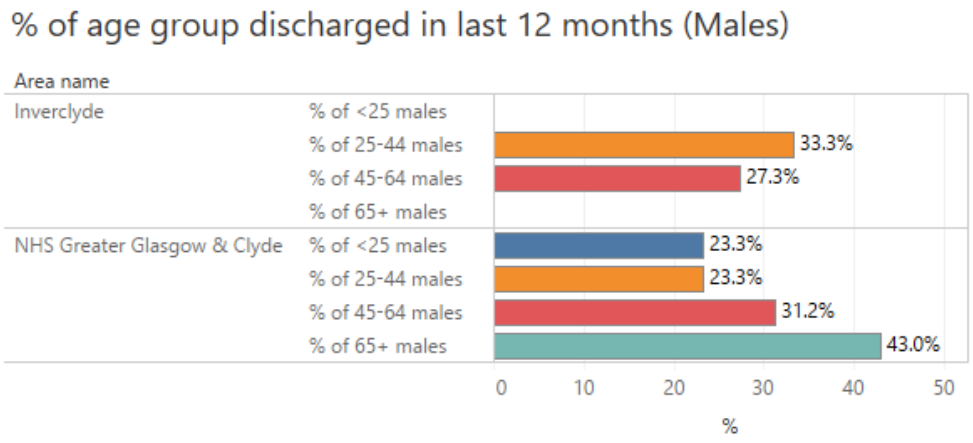


Source: NRS

Figures 31 and 32 show the percentage of deaths cause by probable suicide where the patient had had a discharge from an acute hospital in the 12 months prior to death. The percentage statistics relate to the percentage of the age group who had a discharge in the previous year. For example, 33% of males aged 25-44 had had a hospital discharge compared to 60% of females in the same age group. Data has been suppressed where there are low numbers of people in the different categories which means that there may have been patients with a hospital discharge in the blank rows but they are not shown.

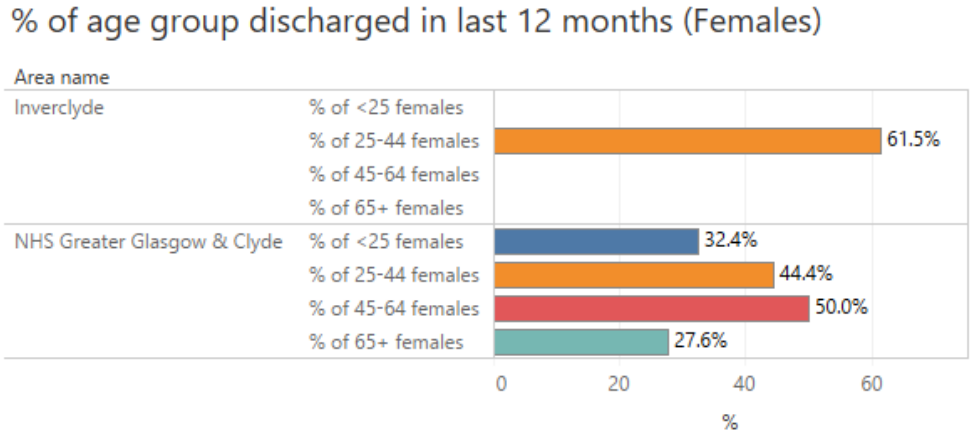
[8] Scottish data is not available by gender.
[9] Some data has been suppressed due to low numbers

Figure 31 - Deaths caused by probable suicide – male patients discharged from a general acute hospital within 12 months prior to death, by age group.



Source: NRS

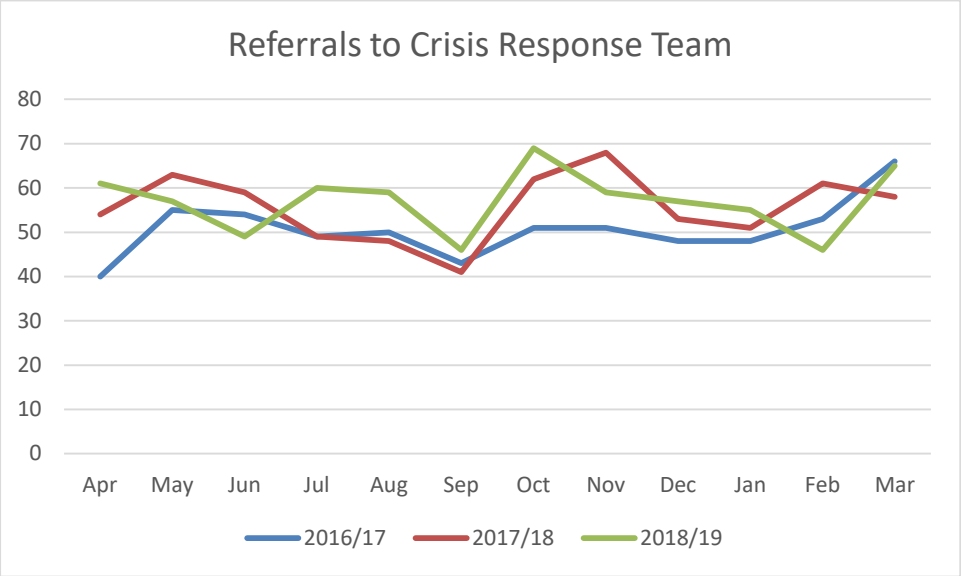
Figure 32 - Deaths caused by probable suicide – female patients discharged from a general acute hospital within 12 months prior to death, by age group.



Source: NRS

Crisis response

Figure 33 Referrals to Inverclyde Community Response Team by month 2016-2019



During this time 61 referrals (8.7%) were rejected by CRS. 49.6% were males and 50.4% were females. There is an upward trend in referrals for people in crisis requiring a community response.

Figure 34 Total yearly referrals to Community Response Team

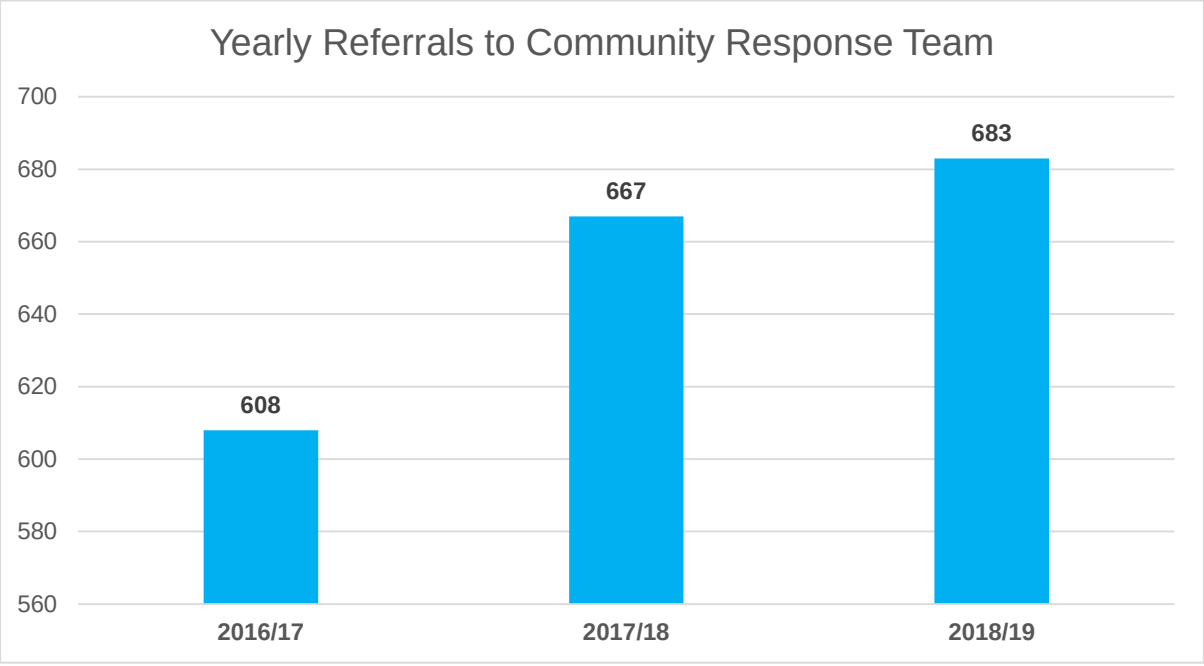


Figure 35 Breakdown of CRS referrals by age

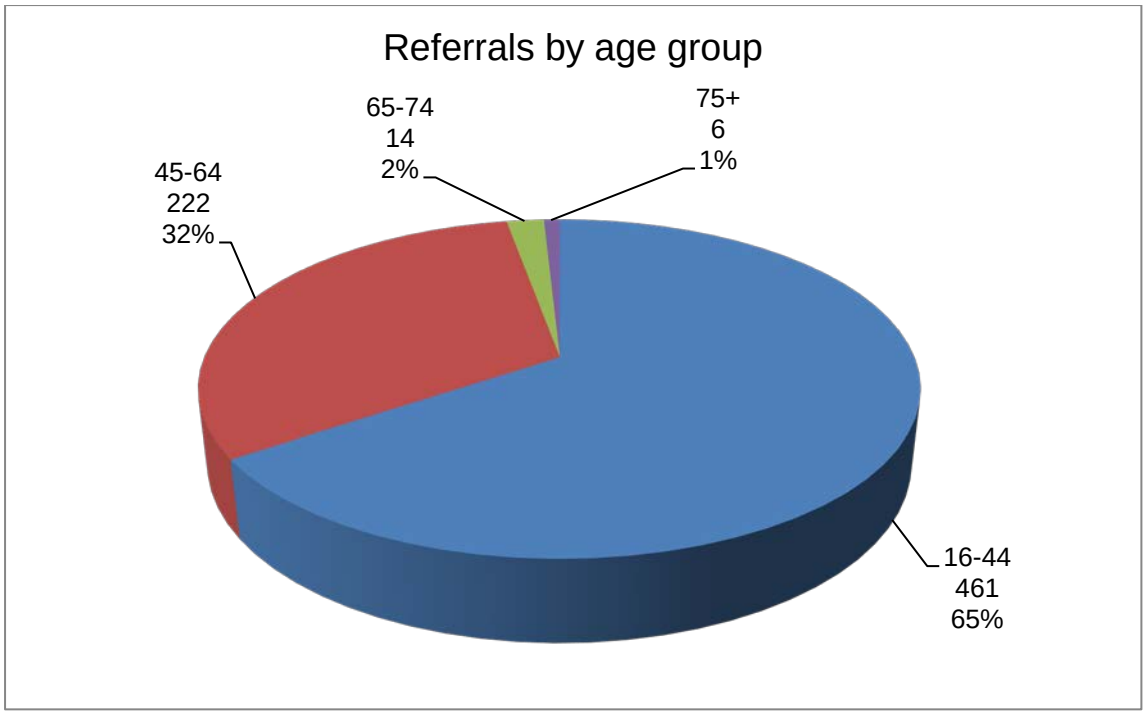
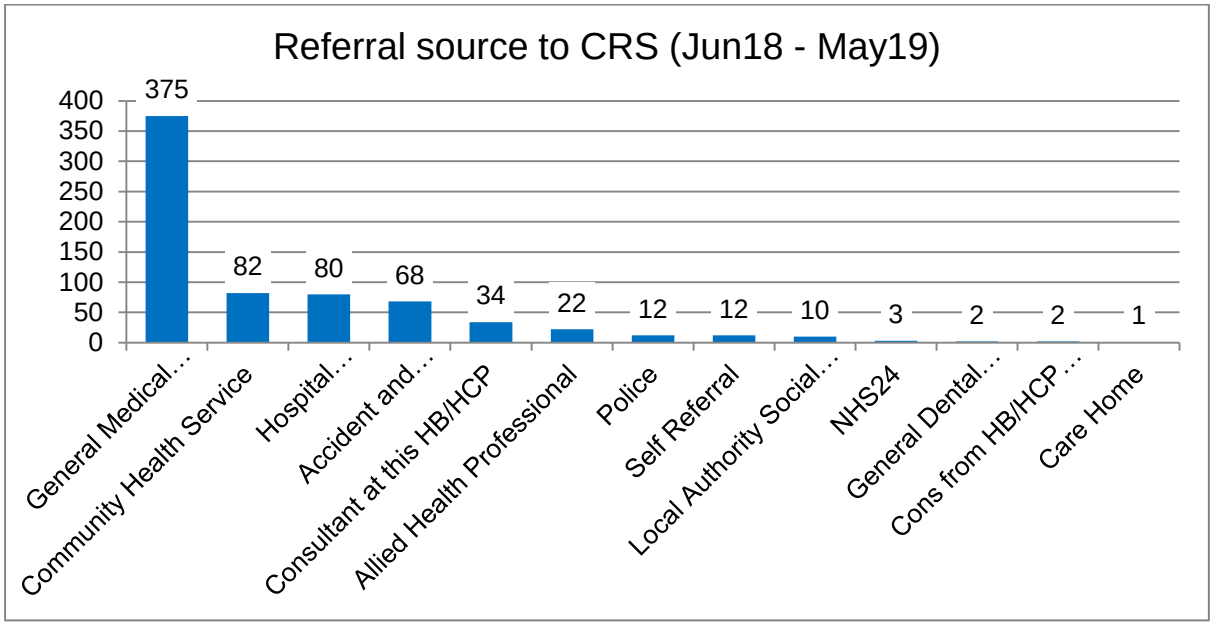


Figure 36 Source of referrals to CRS (1 year snapshot)



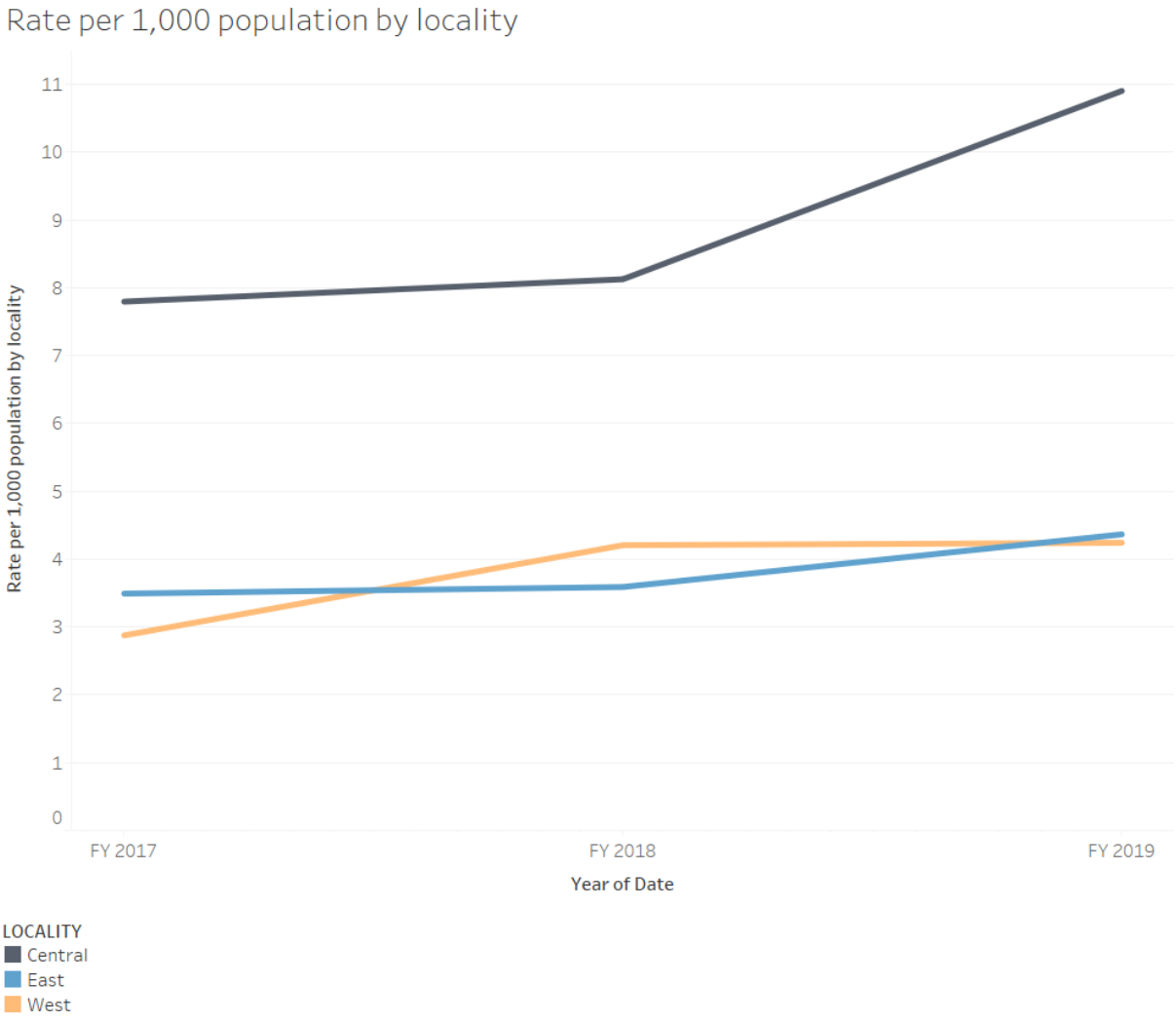
Police incidents

Police incidents indicating involvement of mental health, suicide attempts, and self-harm. Note that there may be a significant element of under-recording as identification of incidents relies upon call-handlers/officers firstly recognising involvement of mental health issues within the incident, and applying the relevant codes.

Nonetheless the data does show an increase of 30% in volume of mental health related police incidents in Inverclyde compared to the preceding two year average.

This is the result of increases in the incidents that have taken place within the Central and East localities. The chart below shows the three year trend for the rate of incidence by locality. In the Central locality is increased from 8.1 to 10.9 incidents per 1,000 population and in the East from 3.6 to 4.4.

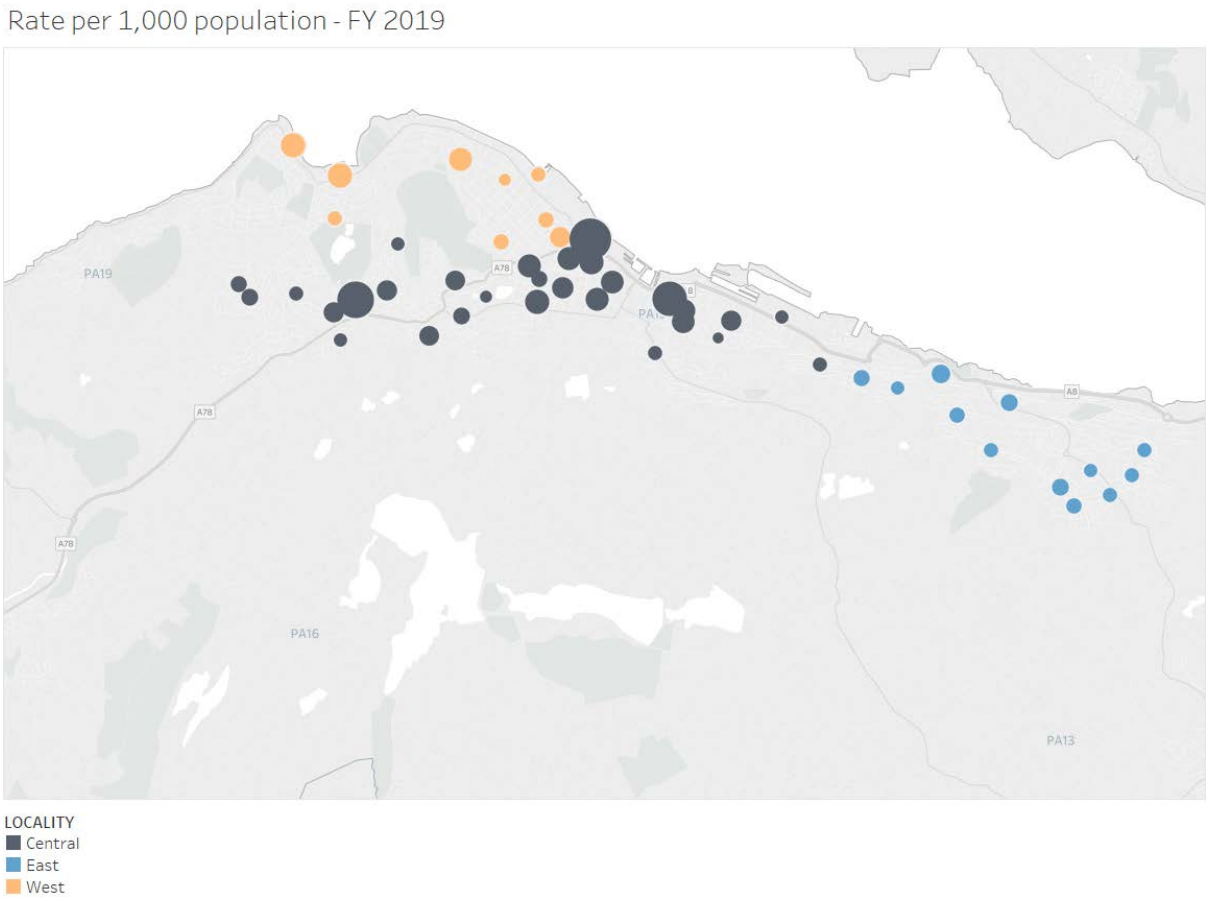
Figure 37 – Rate of police mental health incidents by locality



The map in figure 38 shows the rate per 1,000 population by location of incident in 2018/19 and the larger circles represent the locations with higher incidence rates. Some data has been suppressed due to low numbers of incidents.

The location is based on the datazone that the incident took place in, and shows that the three datazones that encompass Greenock town centre (including Inverclyde Homelessness Centre), Inverclyde Royal Hospital, and the Police Station in Greenock have the highest rate of mental health incidents for the police.

Figure 38 – Map of Police mental health incidents by datazone[10]



[10] Areas with fewer than 4 incidents have been excluded

Medicines and prescribing

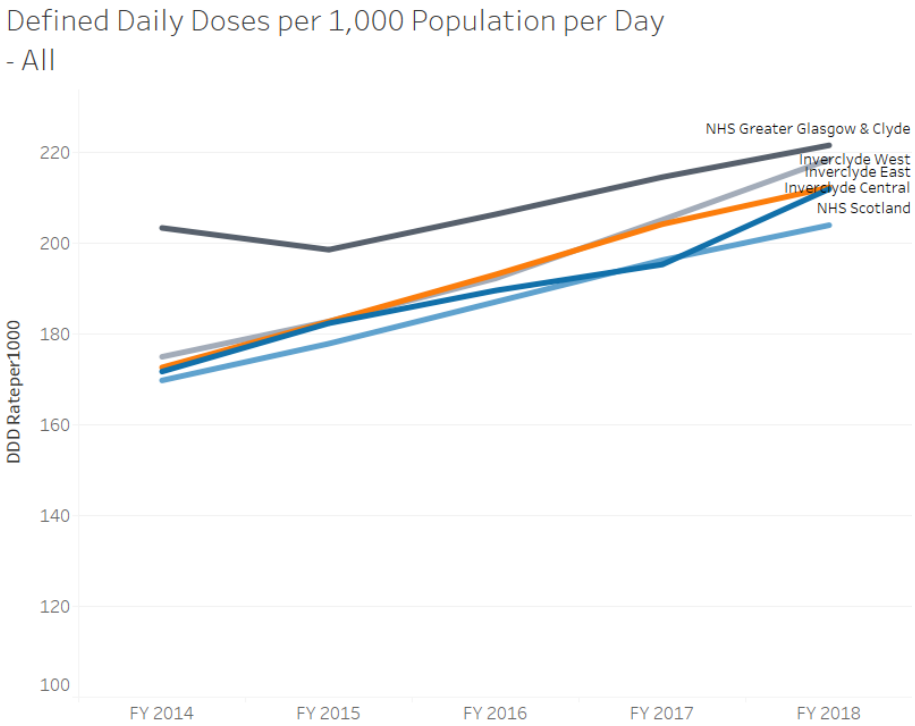
Medicines for Mental Health

The Defined Daily Dose (DDD) is the assumed average maintenance dose per day for a drug used for its main indication in adults (WHO 2018). The DDD allows comparison between population groups and to assess trends in drug consumption.

Significant clinical work was done previously by Prescribing Support Pharmacists in Inverclyde to ensure that prescribing for mental health conditions, particularly for depression is clinically appropriate and meets accepted indicators. The DDD for drugs used for all mental health conditions and for anti-depressants lies somewhere between the NHSGG&C and NHS Scotland average for each Inverclyde cluster. For anti-psychotic prescribing however, all clusters are above the average for NHS Scotland with central cluster being higher than the NHSGG&C DDD.

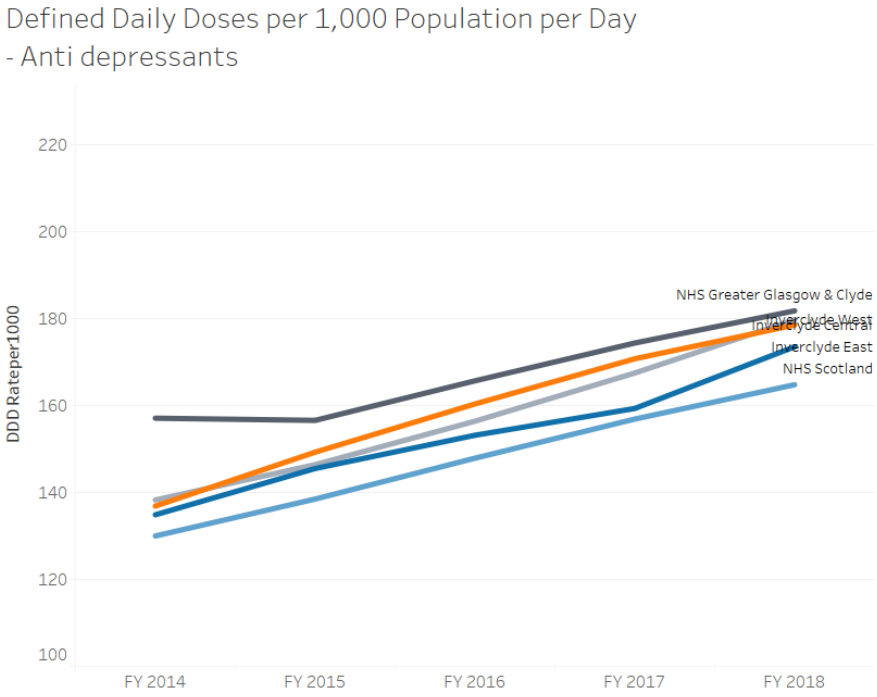
Comparison – all MH medicines for financial years

Figure 39 – Defined daily doses rate for all mental health conditions per 1,000 population



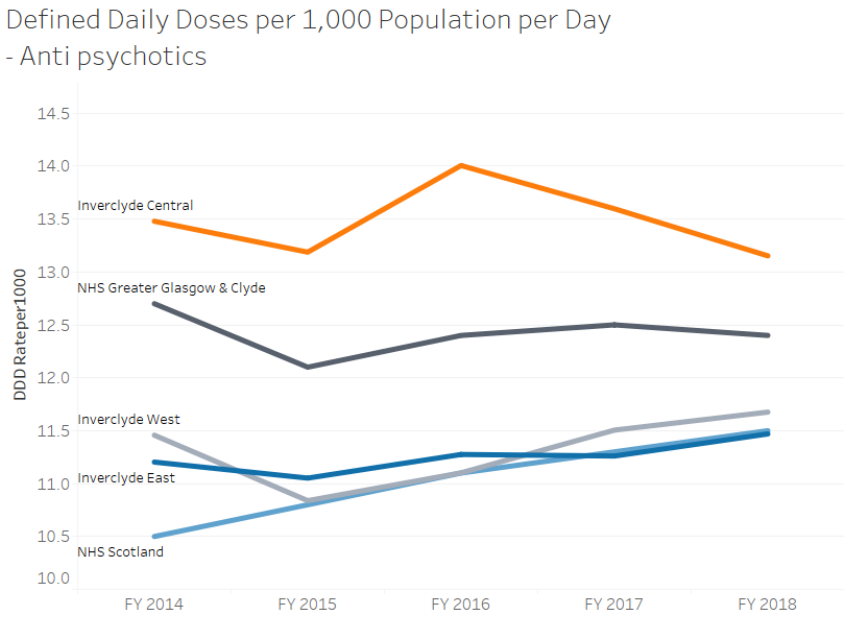
Source: PRISMS prescribing information system

Figure 40 – Defined daily doses rate for anti-depressants per 1,000 population



Source: PRISMS prescribing information system

Figure 41 – Defined daily doses rate for anti-psychotics per 1,000 population



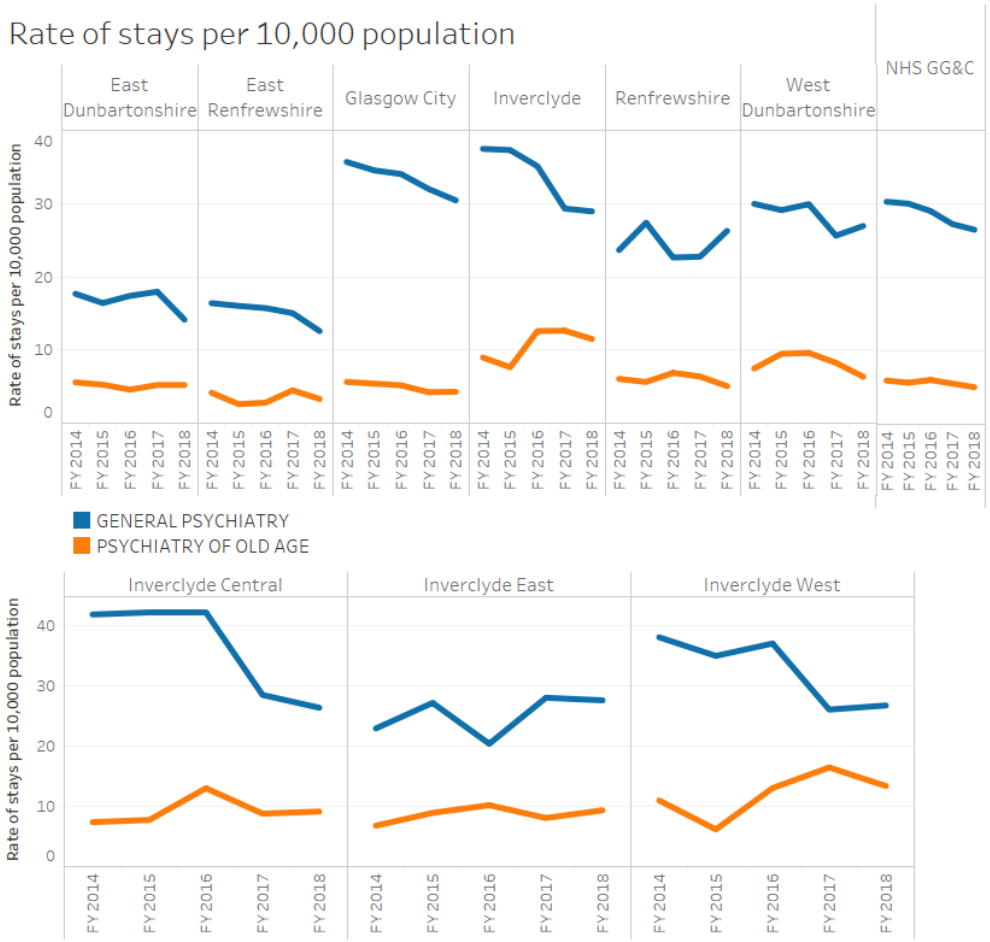
Inpatient activity

Figure 42 - SMR04 Mental Health stays rates per 10,000 populations

Rate of stays per 10,000 population

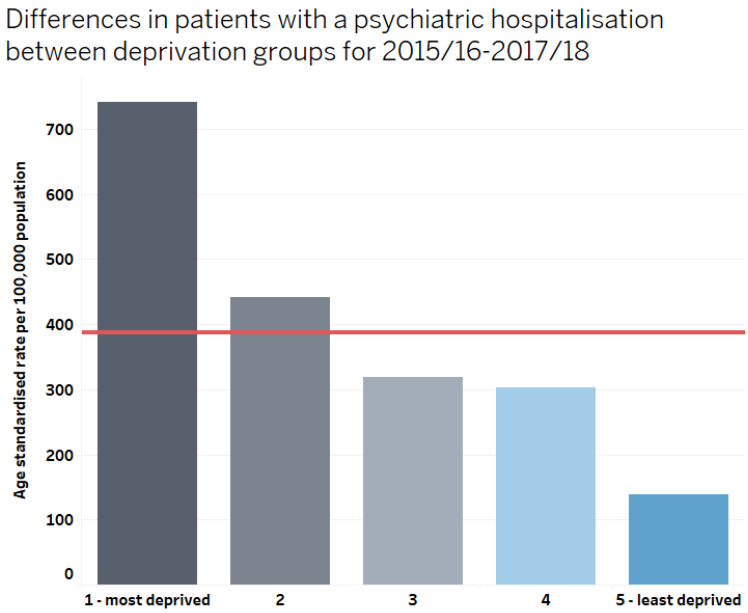
HSCP	FY 2014		FY 2015		FY 2016		FY 2017		FY 2018	
	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE
East Dunbartonshire	17.7	5.6	16.4	5.2	17.4	4.6	17.9	5.2	14.1	5.2
East Renfrewshire	16.4	4.2	16.0	2.6	15.7	2.8	15.0	4.5	12.6	3.3
Glasgow City	35.7	5.6	34.5	5.4	34.0	5.2	32.0	4.2	30.4	4.3
Inverclyde	37.5	9.0	37.3	7.6	35.1	12.6	29.3	12.6	28.9	11.5
Renfrewshire	23.6	6.0	27.4	5.6	22.6	6.9	22.7	6.4	26.3	5.1
West Dunbartonshire	30.0	7.5	29.1	9.5	29.9	9.6	25.6	8.2	26.9	6.3
NHS GG&C	30.3	5.9	30.0	5.7	29.0	6.0	27.2	5.5	26.5	5.1

GP Cluster	FY 2014		FY 2015		FY 2016		FY 2017		FY 2018	
	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE	GENERAL PSYCHIATRY	PSYCHIATRY OF OLD AGE
Inverclyde Central	41.7	7.4	42.1	7.7	42.1	13.0	28.4	8.8	26.3	9.1
Inverclyde East	22.9	6.8	27.1	8.9	20.3	10.2	28.0	8.0	27.5	9.3
Inverclyde West	38.0	10.9	34.9	6.2	36.9	13.0	26.0	16.4	26.7	13.3



Source – AcaDMe

Figure 43 Inverclyde psychiatric hospitalisation rates by deprivation quintile

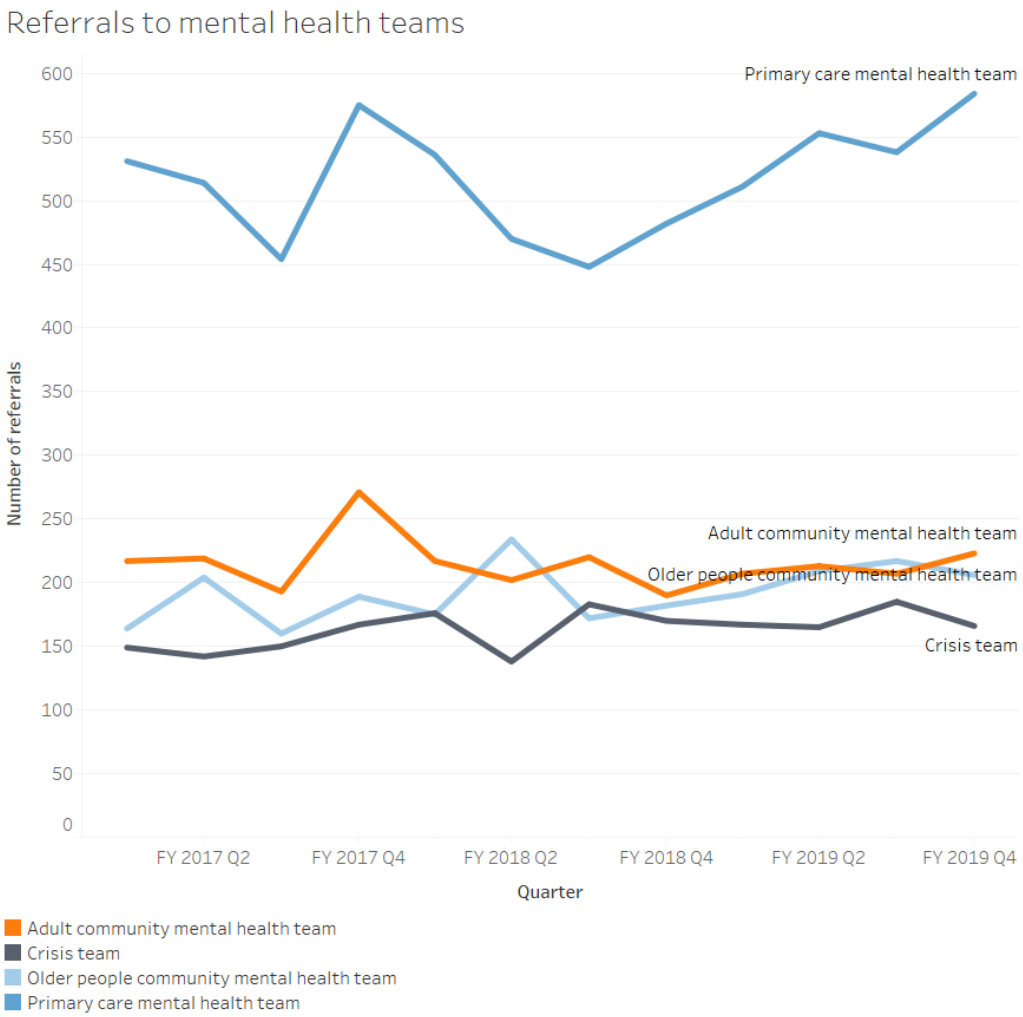


Source: ScotPHO Health Inequalities

- The inequality gap is the difference between the most deprived group and the overall average value. The inequality gap in Inverclyde for psychiatric hospitalisations is equivalent to 532 patients each year.
- The most deprived areas have 87% more patients than the overall average in Inverclyde.
- Patients with a psychiatric hospitalisation would be 64% lower if the levels of the least deprived area were experienced across the whole population.

Community mental health

Figure 44 - Referrals to Inverclyde mental health teams 2016/17 – 2018/19



Source: Inverclyde HSCP Mental Health Quarterly Service Report

Referrals to primary care mental health team and older people's mental health team have been increasing from Q3 2017/18 to Q4 2018/19 whilst all other referrals have remained relatively stable.

Figure 45 Yearly referrals to CMHT and OPCMHT 2016-2109

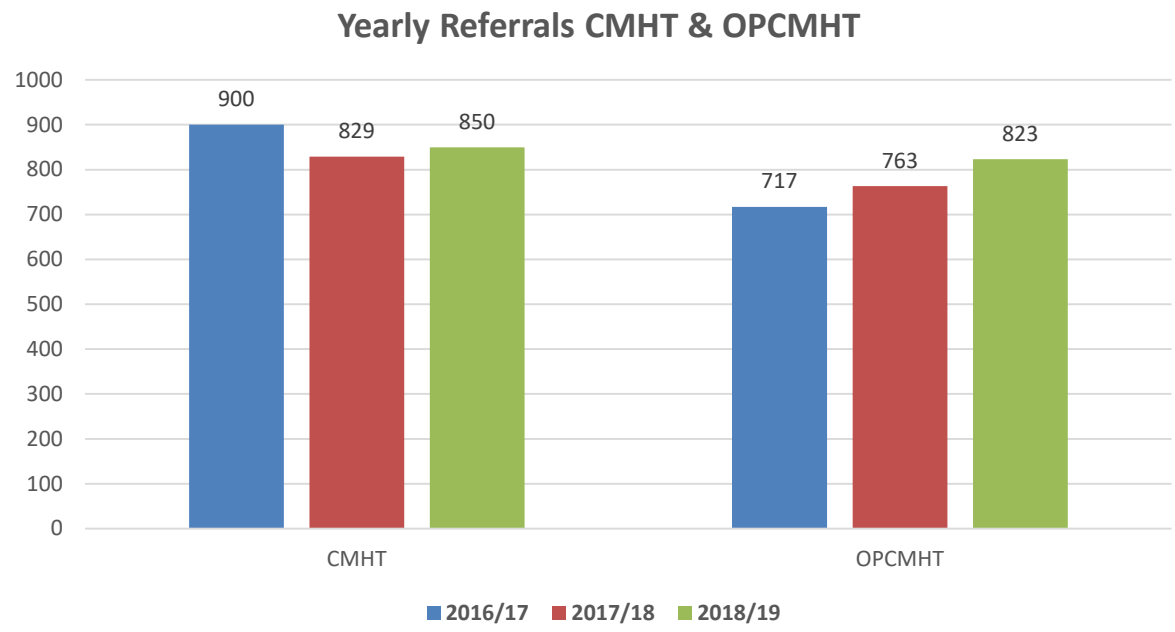
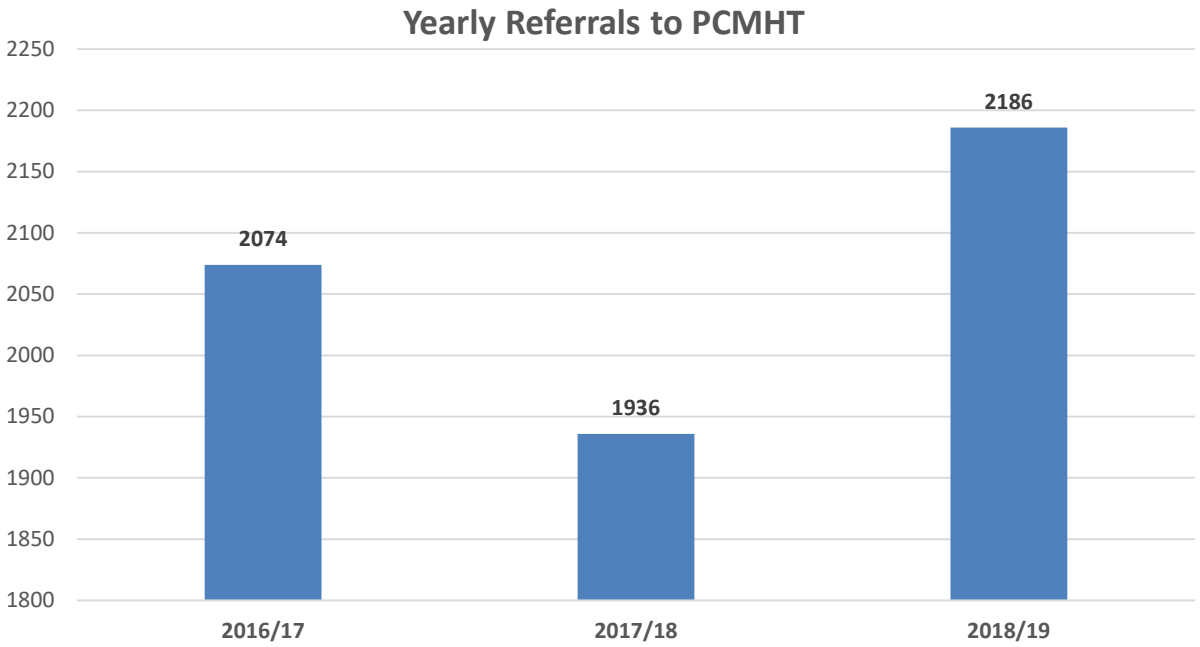


Figure 46 Yearly referrals to Primary Care Mental Health Team 2016 - 2019



Within primary care the Community Link Worker (CLW) is a relatively new addition to the multi-disciplinary team. The CLW is a generalist social practitioner based in a GP practice serving a socio-economically deprived community, who uses non clinical support to allow people to set goals and overcome barriers, in order that they can take greater control of their health and well-being. Figure 47 and 48 show that stress and mental health are amongst the highest reasons for referral alongside a range of issues related to socio-economic circumstances and that identifying sources of support for these issues is a key outcome of the CLW role. Helping people access financial and welfare benefits advice can positively impact on people's mental wellbeing.

Figure 47 – Reason for referral to Community Link Worker Dec 2017 – Mar 2019

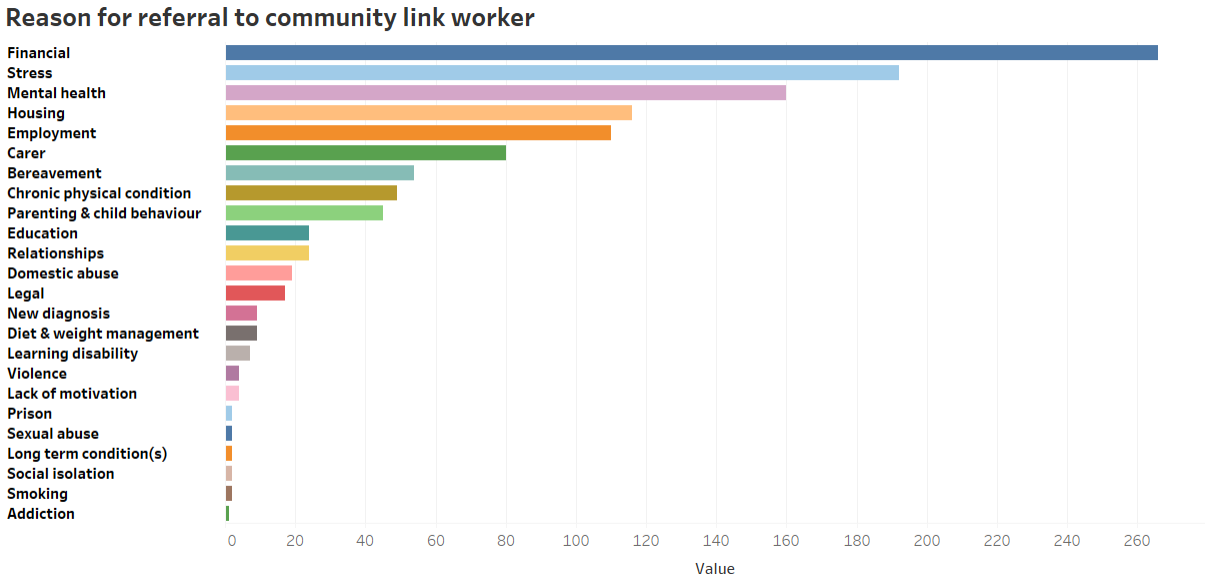
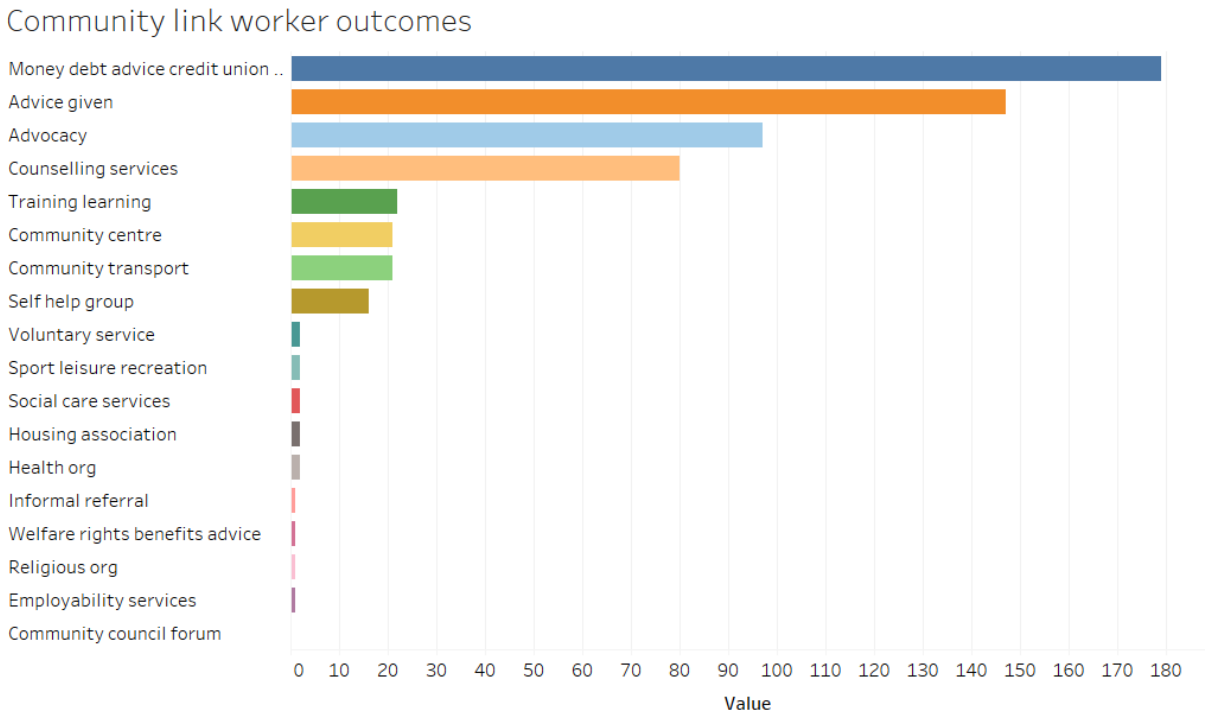


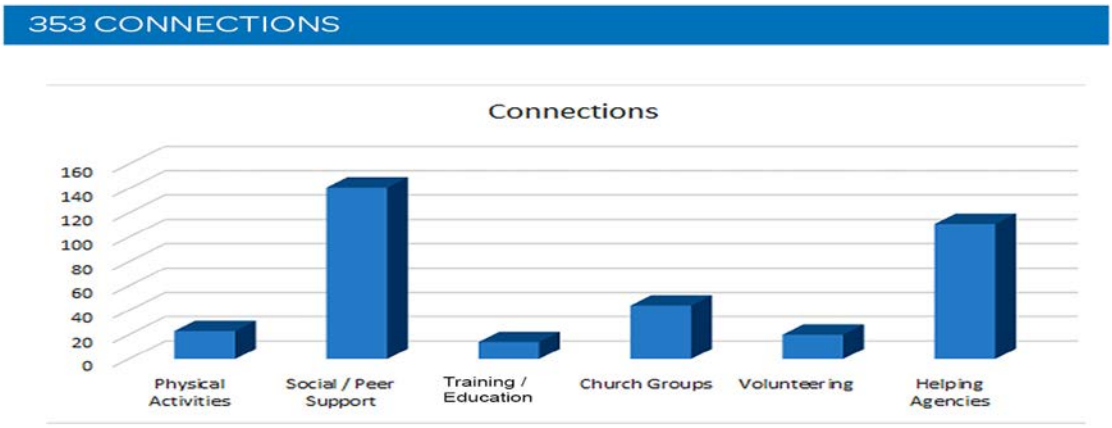
Figure 48 – Outcomes for Community Link Worker Dec 2017 – Mar 2019



Community Connectors

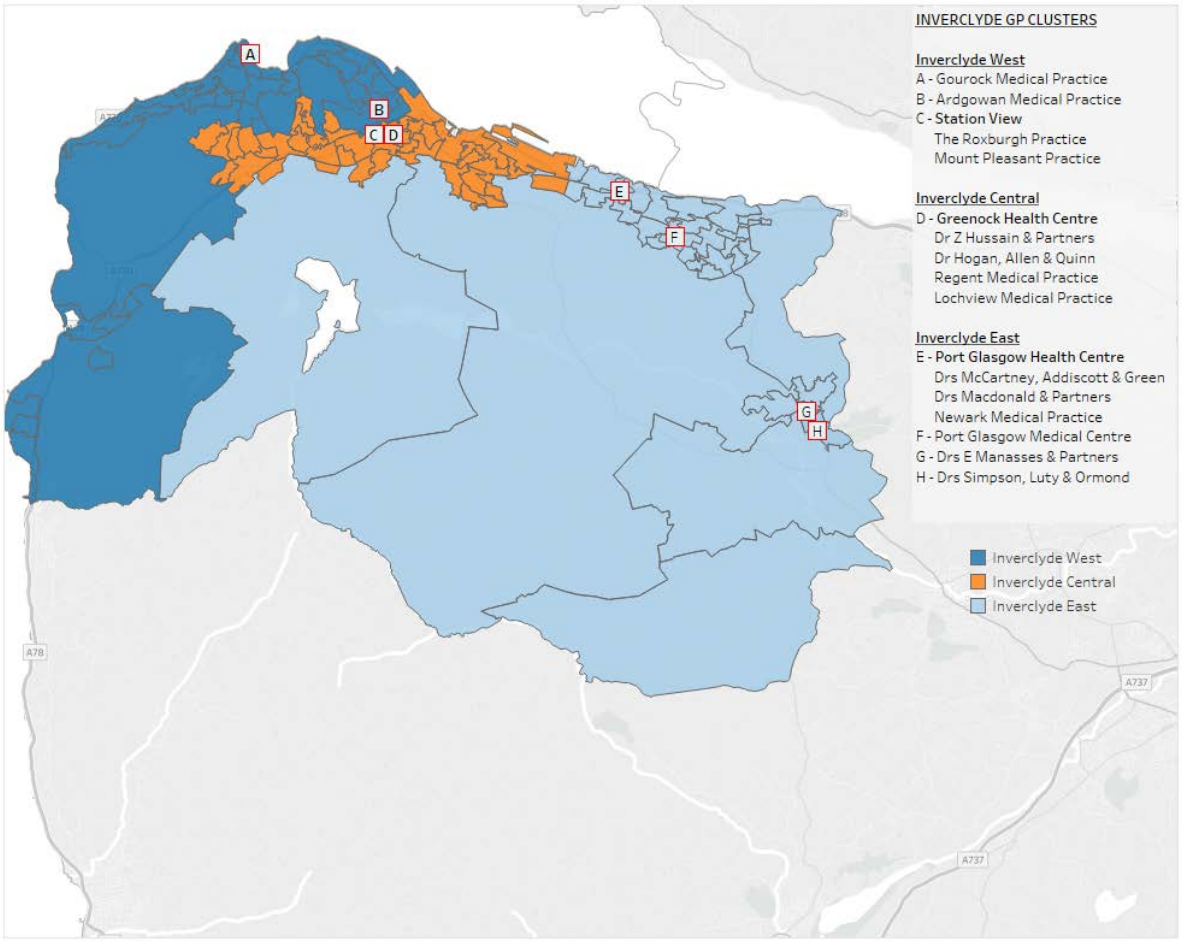
Community Connectors aim to provide connections to local activities, facilities and resources whilst providing short term light support and encouragement for local people to connect, improve their health and wellbeing, reduce their social exclusion, and assist those suffering from low mood. Community Connectors also motivate and encourage people to live as full an independent life as possible. The Community Connectors are based in the community and offer short term assistance to help identify and access resources and activities which help individuals achieve their personal goals. The majority of connections made are for social/ peer support enabling individuals to take better control over their health and wellbeing. Peer support can be very effective in changing health-related behaviour & encouraging the self-management of long-term health conditions and issues surrounding mental health.

Figure 49- Connections Made Between April 2018 - March 2019



Appendix 1

Inverclyde GP Clusters


A
B
C
D
E
F
G
H
A78
A737
A737
INVERCLYDE GP CLUSTERS
Inverclyde West
A - Gourock Medical Practice
B - Ardgowan Medical Practice
C - Station View
The Roxburgh Practice
Mount Pleasant Practice
Inverclyde Central
D - Greenock Health Centre
Dr Z Hussain & Partners
Dr Hogan, Allen & Quinn
Regent Medical Practice
Lochview Medical Practice
Inverclyde East
E - Port Glasgow Health Centre
Drs McCartney, Addiscott & Green
Drs Macdonald & Partners
Newark Medical Practice
F - Port Glasgow Medical Centre
G - Drs E Manasses & Partners
H - Drs Simpson, Luty & Ormond
Inverclyde West
Inverclyde Central
Inverclyde East

2018-2022 INVESTMENT PLANS AND REPORTING TEMPLATE Appendix 2

ACTION 15 - INVERCLYDE

Investment Area	Key Challenge	Proposal & Intended Outcome	Anticipated Investment Measure	18/19		19/20		20/21		21/22	
				£	wte	£	wte	£	wte	£	wte
Prevention & Early Intervention	Increase Cognitive Behaviour Therapy service.	2.64wte OT and Nursing staff within various settings, undertaking CBT training.		0	2.64	0	2.64	0	2.64	0	2.64
	Respond to stress and distress	Investment to support responses to stress and distress - indicative		0	0.00	3,617	0.33	14,901	0.33	15,348	0.33
	Investment in Primary Care Mental Health Pathways	1wte Band 6 PC MH Nurse started Jan 2019.	Increased access for older people to primary care mental health support	9,800	1.00	44,000	1.00	45,320	1.00	46,680	1.00
share of Board wide projects:	*Computerised CBT Service*			0	0.00	1,439	0.09	9,132	0.24	9,407	0.24
	Mental Health & suicide prevention training			491	0.08	4,269	0.15	9,725	0.22	7,327	0.22
	Digital support			0	0.00	443		1,478	0.07	2,439	0.07
	bipolar Programme			0	0.00	0		6,174	0.41	24,694	0.41
	Dementia - young Onsent Dementia			0	0.00	1,677	0.07	2,439	0.07	2,513	0.07
Productivity	Extend access to Psychiatric Liaison Service within A&E and Acute Hospital care.	Senior Crisis Practitioner 1wte Band 6 started Jan 2019, further Liaison nurse started Sept 2019.	Reduce attendances at A&E; increased home based interventions; support to timely discharge for older people within acute setting.	9,900	1.00	53,400	2.00	66,176	2.00	68,162	2.00
	Support young people with parental mental ill health.	Targeted support - indicative investment of 0.33wte Band 6 equivalent role starting Jan 2020		0	0.00	3,617	0.33	14,901	0.33	15,348	0.33
Share of Board wide projects:	*Adult Liaison services to Acute Hospitals*			0	0.00	6,176	0.22	43,348	0.67	44,510	0.67
	OOH CPNs			0	0.00	6,651	0.30	13,700	0.30	14,111	0.30
	Policy Custody			0	0.00	6,637	0.30	13,672	0.30	14,115	0.30
	Borderline Personality Disorder			8,900	0.17	18,343	0.50	35,518	0.65	36,584	0.65
	Project management Support			0	0.00	5,000	0.15	7,354	0.15	7,850	0.15
Recovery	Prevention and recovery practice development to include peer support.	Support to development of recovery peer support workers supplementary to board wide investment - indicative investment of 0.33wte Band 6 equivalent role starting Jan 2020		0	0.00	3,617	0.33	14,901	0.33	15,348	0.33
	Supporting people with Mental ill health back to work.	Third sector provision of support to employment (individual placement support).	Sustainining and increasing access to employment; support to employers.	0	0.00	20,537	1.00	49,288	1.00	50,767	1.00
Share of Board wide projects:	*Recovery Peer support workers & Ops Mgr*			0	0.00	11,148	0.52	26,930	0.52	27,743	0.52
	Psychological interventions in Prisons			0	0.00	8,546	0.69	32,966	0.69	33,955	0.69

Year	Available funding	Planned Expenditure	(Over)/Underspend
18/19	181,485	29,091	152,394
19/20	280,189	199,116	81,073
20/21	395,968	407,923	(11,955)
21/22	527,957	436,898	91,059
	1,385,599	**1,073,028**	**312,571**