Municipal Buildings, Greenock PA15 1LY

Ref: DS

Date: 17 June 2022

A meeting of the Inverclyde Integration Joint Board will be held on Monday 27 June 2022 at 2pm.

This meeting is by remote online access only through the videoconferencing facilities which are available to members of the Integration Joint Board and relevant officers. The joining details will be sent to participants prior to the meeting.

In the event of connectivity issues, participants are asked to use the *join by phone* number in the Webex invitation.

Information relating to the recording of meetings can be found at the end of this notice.

IAIN STRACHAN
Head of Legal & Democratic Services

**** to follow**

8.	**Proposed Use of IDEAS Project Surplus Funds** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**P 87**
9.	**Locality Planning within Inverclyde** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**P 97**
10.	**Mental Health & Wellbeing Service** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**P 105**
11.	**Inverclyde Learning Disability Community Hub** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**P 165**
ITEMS FOR NOTING:		
12.	**The Promise** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**P 185**
13.	**Progress Update Clinical and Care Governance Strategy Workplan 2021-22** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**P 203**
14.	**Annual Report Clinical and Care Governance 2021-2022** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**P 225**
15.	**Minute of Meeting of IIJB Audit Committee of 21 March 2022** NB There will also be a verbal update by the Chair of the IIJB Audit Committee providing feedback on their meeting earlier in the day	**P 259**
16.	**Chief Officer's Report (Verbal Update)** Verbal update by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	
	The documentation relative to the following items has been treated as exempt information in terms of the Local Government (Scotland) Act 1973 as amended, the nature of the exempt information being that set out in paragraphs 6 & 9 of Part I of Schedule 7(A) of the Act.	
ITEMS FOR ACTION:		
17.	**Reporting by Exception – Governance of HSCP Commissioned External Organisations** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on matters relating to the HSCP governance process for externally commissioned Social Care Services.	**P 263**

The papers for this meeting are on the Council's website and can be viewed/downloaded at https://www.inverclyde.gov.uk/meetings/committees/57

Please note that the meeting will be recorded for publishing on the Inverclyde Council's website. Inverclyde Council is a Data Controller under UK GDPR and the Data Protection Act 2018 and data collected during any recording will be retained in accordance with Inverclyde Council's Data Protection policy, including, but not limited to, for the purpose of keeping historical records and making those records available.

By entering the online recording please acknowledge that you may be filmed and that any information pertaining to you contained in the video and oral recording of the meeting will be used for the purpose of making the recording available to the public.

Enquiries to – **Diane Sweeney** - Tel 01475 712147

Inverclyde Integration Joint Board
Monday 21 March 2022 at 2pm

PRESENT:

Voting Members:

Alan Cowan (Chair)	Greater Glasgow and Clyde NHS Board
Councillor Jim Clocherty (Vice Chair)	Inverclyde Council
Councillor Lynne Quinn	Inverclyde Council
Councillor Luciano Rebecchi	Inverclyde Council
Councillor Elizabeth Robertson	Inverclyde Council
Simon Carr	Greater Glasgow and Clyde NHS Board
David Gould	Greater Glasgow and Clyde NHS Board

Non-Voting Professional Advisory Members:

Allen Stevenson	Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership
Jane Simcox	On behalf of Sharon McAlees, Chief Social Work Officer
Craig Given	Chief Finance Officer, Inverclyde Health & Social Care Partnership
Dr Chris Jones	Registered Medical Practitioner
Laura Moore	Chief Nurse, NHS GG&C

Non-Voting Stakeholder Representative Members:

Gemma Eardley	Staff Representative, Health & Social Care Partnership
Diana McCrone	Staff Representative, NHS Board
Charlene Elliot	Third Sector Representative, CVS Inverclyde
Christina Boyd	Carer's Representative
Hamish MacLeod	Service User Representative, Inverclyde Health & Social Care Partnership Advisory Group

Additional Non-Voting Member

Stevie McLachlan	Inverclyde Housing Association Representative, River Clyde Homes

Also present:

Vicky Pollock	Legal Services Manager, Inverclyde Council
Alan Best	Interim Head of Health & Community Care, Inverclyde Health & Social Care Partnership
Anne Malarkey	Head of Homelessness, Mental Health & Drug & Alcohol Recovery Services, Inverclyde Health & Social Care Partnership
Arlene Mailey	Service Manager, Quality & Development, Inverclyde Health & Social Care Partnership
Marie Keirs	Senior Finance Manager, Inverclyde Council
Diane Sweeney	Senior Committee Officer, Inverclyde Council
Colin MacDonald	Senior Committee Officer, Inverclyde Council

Chair: Alan Cowan presided

The meeting took place via video-conference.

Apologies, Substitutions and Declarations of Interest

Apologies for absence were intimated on behalf of:

Sharon McAlees	Chief Social Work Officer, Inverclyde Health & Social Care Partnership (with Jane Simcox substituting)
Dr Hector MacDonald	Clinical Director, Inverclyde Health & Social Care Partnership
Ann Cameron-Burns	Greater Glasgow & Clyde NHS Board

Ms C Boyd declared an interest in agenda item 9 (Reporting by Exception – Governance of HSCP Commissioned External Organisations).

Prior to the commencement of business the Chair acknowledged the forthcoming Local Government Elections and thanked the Councillors who served on the Board for their contributions and support.

Minute of Meeting of Inverclyde Integration Joint Board of 24 January 2022

There was submitted the Minute of the Inverclyde Integration Joint Board of 24 January 2022.
The Minute was presented by the Chair and checked for fact, omission, accuracy and clarity.
Decided: that the Minute be agreed.

Voting Membership of the Inverclyde Integration Joint Board and Membership of the Inverclyde Integration Joint Board Audit Committee

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership advising the Board of (1) a change in its voting membership arrangements and (2) seeking agreement to appoint one voting and one non-voting member of the IIJB to the IIJB Audit Committee.
The report was presented by Ms Pollock and advised that:
Ms Paula Speirs had recently stepped down as a Non-Executive Director of Greater Glasgow and Clyde NHS Board and that this membership role would now be filled by Mr David Gould, who had been appointed by Greater Glasgow and Clyde NHS (NHS GG&C) Board in terms of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.
Mr Stevie McLachlan had recently intimated his resignation from the IIJB Audit Committee, and that the Board should appoint one non-voting member to serve.
Mr Simon Carr had been recommended as Vice Chair of the IIJB Audit Committee.
Decided:
(1) that the appointment by NHS GG&C Board of Mr David Gould as a voting member of the IIJB be noted;
(2) that Mr David Gould be appointed to the IIJB Audit Committee;
(3) that Mr Simon Carr be appointed as Vice Chair of the IIJB Audit Committee; and
(4) that Ms Charlene Elliot be appointed as a non-voting member to the IIJB Audit

Committee.

Rolling Action List

There was submitted a Rolling Action List of items arising from previous decisions of the IIJB.
The Chair proposed that the first two entries in the list be closed and that the list be refreshed prior to the next meeting with dates added where applicable.
Decided: that the Rolling Action List be noted.

Financial Monitoring Report 2021/22 – Period to 31 December 2021, Period 9

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership on the Revenue and Capital Budgets, other Income Streams and Earmarked Reserves position for the current year with a detailed report as at Period 9 to 31 December 2021.
The report was presented by Mr Given and noted that the Covid-19 pandemic had created significant additional cost pressures across the HSCP and that the figures presented included projected Covid costs offset against confirmed Covid funding. The report advised that at Period 9 there was a projected underspend of £0.044m in core Social Care budgets and that if approved, will be transferred to the general reserves. With this and the IIJB financial commitments, the IIJB reserves are forecast to decrease in a year by a net £6.630m.
The Board commented on the layout of the report, requesting that underspends in the Health budget be noted alongside underspends in Social Care and Mr Given agreed to this.
Referring to the underspend in Health Services due to vacancies, at paragraph 6 of the report, the Board sought reassurance that this did not impact on service provision, and Mr Stevenson advised that there were no significant adverse effects, commented on the competitive recruitment market and on how staff prioritised their workloads to compensate.
Referring to Employee Costs at appendix 1, the Board sought clarification on the increase from £52m to £59m, whilst noting that at appendix 2 the Alcohol & Drug Recovery Service had seen spending reduce, and enquired if this was related to the Covid pandemic. Mr Given and Mr Stevenson provided a detailed explanation, involving the impact the pandemic had on budgets, recruitment and the back-filling of posts.
The Board enquired if there were any resources specifically targeting the prevention of gambling related suicides, and Ms Glendinning advised that the HSCP had worked with Gamblers Anonymous and Financial Fitness and that staff training had been provided.
Decided:
(1) that the current Period 9 forecast position for 2021/22 as detailed in the report at appendices 1-3 be noted and that it be noted that the projection assumes that all Covid costs in 2021/22 will be fully funded by the Scottish Government;
(2) that it be noted that in the event that there are any gaps in funding for Covid costs then the IIJB will review the reserves to meet this shortfall;
(3) that the proposed budget realignments and virement as detailed in appendix 4 to the report be approved and that officers be authorised to issue revised directions to Inverclyde Council and/or the Health Board as required on the basis of the revised figures as detailed at appendix 5 to the report;
(4) that the planned use of the Transformation Fund as detailed in appendix 6 to the report be approved;
(5) that the current capital position as detailed in appendix 7 to the report be noted;

and;
(6) that the key assumptions within the forecasts as detailed in paragraph 11 of the report be noted.

Inverclyde IIJB Budget 2022/23

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership seeking agreement for the IIJB budget for 2022/23 in line with the Strategic Plan.
The report was presented by Mr Given and advised that the IIJB Scheme of Delegation requires that the IIJB approves an annual budget and that the IIJB Integration Scheme requires that the annual budget is allocated and managed. Inverclyde Council set their 2022/23 budget on 24 February 2022 and confirmed funding for the IIJB for the year, Greater Glasgow & Clyde Health Board are still to confirm their final allocation but have given the IIJB an indicative allocation on 9 February 2022. The report provided a detailed analyses of anticipated cost pressures, funding and service efficiency proposals.
The Board requested that officers consider ring-fencing the money allocated for Carers, and it was agreed that officers would meet with Ms Boyd, the Carer's Representative, outwith the meeting to discuss this matter further.
The Board enquired as to what forward planning was taking place to address future budget constraints, and Mr Stevenson advised that the HSCP were aware of pressure areas and were taking any necessary action, such as spend to save proposals.
Referring to the table at paragraph 6.2 of the report, the Board asked what constituted 'Multi Disciplinary Teams (MDTs)', and an explanation was provided by Mr Best.
The Chair requested that Mr Stevenson provide a verbal update at future meetings on the Transformation Fund and that it be added to the Rolling Action List to be brought to the Board as an item within the next 9 months. Mr Stevenson advised that he would consider including it within his Chief Officer's Report.
Referring to the attached appendix 'Annual Financial Statement 2022/21 to 2025/26', the Board enquired as to how future demand was captured, and Mr Given provided an explanation as to how he reached the figures in the report.
Decided:
(1) that the content of the report be noted;
(2) that the anticipated funding of £66.071m from Inverclyde Council, including the additional non-recurring £0.550m transfer, be noted
(3) that the anticipated funding of £128.564m from Greater Glasgow & Clyde Health Board, which includes £29.350m for Set Aside, be noted;
(4) that delegated authority be granted to the Chief Officer to accept the formal funding offers from Inverclyde Council and Greater Glasgow & Clyde Health Board;
(5) that the indicative net revenue budgets of £84.363m to Inverclyde Council and £110.272m, including the 'set aside' budget, to NHS Greater Glasgow & Clyde Health Board to be spent in line with the Strategic Plan be agreed, these figures reflecting the £18.294m of Resource Transfer from Health within Social Care;
(6) that the use of £0.348m worth of Transformation funding to fund the relevant spend and save proposals, as detailed in paragraph 5.4 of the report, be approved;
(7) that the Reserve proposals detailed in paragraph 7.3 of the report be approved;
(8) that officers be authorised to issue related Directions to the Greater Glasgow & Clyde Health Board and Inverclyde Council;
(9) that approval be given to the updated financial plan contained within the annual financial statement at appendix 6; and
(10) that the Transformation Fund be added to the Rolling Action List, with verbal

updates provided by the Chief Officer at future meetings.
Ms Eardley joined the meeting at this juncture.

Unscheduled Care Commissioning Plan (Design & Delivery Plan 2022/23 – 2024/25)

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership seeking approval for the appended 'NHS Greater Glasgow & Clyde Unscheduled Care Commissioning Plan and Design & Delivery Plan 2022/23 – 2024/25'.
The report was presented by Mr Best and advised that the Plan ensures that Inverclyde HSCP, along with the other HSCPs who fall within the remit of Greater Glasgow & Clyde Health Board, make full use of their powers and responsibilities, and that since the start of the coronavirus pandemic there had been considerable change in health and social care systems. The Plan sets out aimed responses to pressures and how future demand will be met.
The Board, whilst commenting favourably on the Plan, expressed reservations that expectations may be set too high, and Mr Stevenson provided reassurance that, although early days, the Plan was worth following.
The Board enquired as to how the success of the Plan would be measured, and Mr Stevenson provided an overview of the data analysis in place. The Chair requested that the Board be provided with an annual update report.
There was discussion on GP services and the increasing role of Advanced Nurse Practitioners (ANPs) within service provision, with Mr Stevenson and the Chair emphasising the importance and value of ANPs.
Ms McCrone left the meeting during consideration of this item of business.
Decided:
(1) that approval be given to the Design & Delivery Plan 2022/23 – 2024/25, appended at appendix 1, as the updated and refreshed Board Wide Unscheduled Care Improvement Programme;
(2) that (a) approval be given to the financial framework detailed at section 7 of the updated Plan and (b) the substantial financial shortfall be noted, where of the £11.128m required only £5.089m of funding has been identified on a recurring basis across GG&C level, resulting in a funding gap of £6.039m of which Inverclyde HSCP's share is £163,078, as detailed at Annex C to the report;
(3) that (a) the performance arrangements, to report on and monitor progress towards, delivery of the Plan, and (b) that all six Integrated Joint Boards who come under GG&C NHS Board are receiving similar updates, be noted; and
(4) that (a) a performance report be brought to the Board at the end of the first year and (b) officers give consideration to the merits of an annual performance update report.

Update on Implementation of Primary Care Improvement Plan

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (a) providing an update on the progress of, and financial plans associated with, the Primary Care Improvement Plan (PCIP), and (b) advising the Board of the publication of the Plan, with an attached electronic link.
The report was presented by Mr Best and advised that since the last update the HSCP has updated the local PCIP and progressed plans around vaccinations, Urgent Care (ANPs), Pharmacotherapy Hub and Community Treatment and Care Services.
Referring to the table at paragraph 5.1 of the report 'Estimated costs of full delivery of

all MOU Commitments' and the financial balance proposals, the Board sought reassurance that the proposals would not impact on service provision. Mr Best advised that by focussing on allocating care appropriately, financial balance could be maintained with no impact on service provision. Ms Moore added that all areas were working collaboratively and emphasised the importance of the complete patient pathway. The Chair commented that he hoped the Board were getting a strong sense of assurance that the Plan was well considered.

Decided:

(1) that the progress made in delivery of the 2020/21 Primary Care Improvement Plan be noted;

(2) that the current plans for implementation of the Primary care Improvement Plan be agreed;

(3) that the overall indicative Primary Care Improvement Fund financial commitments for 2021/22 be noted; and

(4) that, due to the imperative associated with deploying resources, it is recommended that, with the engagement with local GP Sub representatives, an update will be presented at a future meeting regarding the reserves and formulation of a spend plan.

CPC Annual Report 2020-21

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership advising of the publication of the Inverclyde Child Protection Committee's Annual Report 2020-21, a copy of which was appended to the report for consideration.

The report was presented by Ms Simcox, and detailed the remit of the Child Protection Committee and noted that the Annual report had been accepted by Inverclyde Child Protection Committee, Inverclyde Chief Officer's Group and Inverclyde Health and Social Care Partnership.

A typographical error at paragraph 2.2 was noted, and it was clarified that the Annual Report appended covered March 2020 to March 2021.

The Chair requested that thanks and appreciation be conveyed at to all staff involved in protecting children in Inverclyde.

Decided:

(1) that the content of the report be noted; and

(2) that thanks and appreciation be conveyed to all staff involved in protecting children in Inverclyde.

Age of Criminal Responsibility (Scotland) Act 2019

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership advising the Board of the implementation of the Age of Criminal Responsibility (Scotland) Act 2019.

The report was presented by Ms Simcox and advised that the intention of the Act is to protect children from the harmful effects of early criminalisation while ensuring that incidents of harmful behaviour by children under 12 can be investigated effectively and responded to appropriately.

Decided: that the (a) content of the report, and (b) enactment of the Age of Criminal Responsibility (Scotland) Act 2019 on 17 December 2021, be noted.

Dementia Care Co-ordination Programme Update

There was submitted a report by the Interim Corporate Director (Chief Officer),

Inverclyde Health & Social Care Partnership providing an update on the Inverclyde Dementia Care Co-ordination Programme.

The report was presented by Ms Malarkey and provided a history of the Programme and detailed priority areas for improvement, actions being implemented and a programme measurement plan. Providing a verbal update to the report, Ms Malarkey advised that the Scottish Government have commissioned an external evaluation of the Programme which will take place over the next 6 months, and that the resulting report will be shared throughout Scotland and brought to the Board when ready.

Referring to table 3 at paragraph 4.5 of the report 'Proportion of people referred who received a minimum of one year's PDS' (post diagnostic support), the Board asked what measures had been taken to improve the outcomes for Inverclyde; noting that the figures for the last three years had been lower than both Scotland and NHS GG&C. Ms Malarkey advised that this area had seen substantial progress, mainly due to an increase in the number of Link Workers, and that in October 2021 there had been 85 people on the waiting list, which had now reduced to 32, with 105 referrals received within the same time period.

Decided:

(1) that the content of the report and the achievements of the Programme be noted;

(2) that the end of Programme planning be noted; and

(3) that the proposed sustainability plans for beyond March 2022 be noted.

Care Homes Assurance Themes and Trends Report

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (a) highlighting the emergent themes and trends identified from care assurance visits undertaken in the 13 older adults care homes across Inverclyde in November and December 2021, and (b) identifying areas of good practice and areas for improvement.

The report was presented by Ms Moore and provided an analysis of the output from the Care Home Assurance Tool (CHAT) visits. The Board viewed a presentation by Ms Moore on this matter.

The Chair praised the presentation and the outcomes that arose from the CHAT visits, particularly those concerning infection control.

Referring to paragraph 4.4 of the report, 'Areas of Strength' and the tenth bullet point 'The majority of homes are over 85% compliant for their IPC (Infection Prevention Control) and COVID training', the Board sought clarification on the number of homes who were compliant. Ms Moore advised that about 9 homes had been compliant, and provided a detailed overview of the measures taken with regard to the other homes.

The Board requested that officers consider a press release expressing the positive nature of the report and praising the staff involved.

The Board asked if the care homes had been welcoming of the CHAT visits, and Ms Moore assured that they were and that working relationships had developed and improved.

The Chair thanked all staff involved with the CHAT visits and requested that officers provide an update the Board on this matter at a future meeting.

Councillors Robertson and Quinn and Ms Elliot left the meeting during consideration of this item of business.

Decided:

(1) that the content of the report and presentation be noted;

(2) that thanks and appreciation be conveyed to all staff involved in the CHAT visits; and

(3) that it be remitted to officers to provide an update to the Board on this matter at a

future meeting.

Chief Officer's Report (Verbal Update)

Mr Stevenson provided a verbal update which included:
Covid pandemic – remains very challenging due to the R number being 1.3, staff sickness levels and the impact on service users;
delayed discharges – the service was still operating within its traditional winter period, and although the pandemic was having an impact, staff were fully sighted on maintaining flow at the hospital;
recruitment for the Chief Officer post – recruitment was now ongoing and moving towards shortlisting, with interviews scheduled for April, and the Board would be updated in due course.
The Chair thanked Mr Stevenson for his update.

Minute of Meeting of IJB Audit Committee of 24 January 2022

There was submitted the Minute of the Inverclyde Integration Joint Board of 24 January 2022.
The Minute was presented to the Audit Committee Chair and checked for fact, omission, accuracy and clarity.
Mr Carr, the Vice Chair of the IIJB Audit Committee, provided a brief feedback on the main issues discussed at their Committee meeting held at 1pm, noting that it had been a positive meeting.
Decided: that the Minute be agreed.

It was agreed in terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973 as amended, that the public and press be excluded from the meeting for the following item on the grounds that the business involved the likely disclosure of exempt information as defined in the paragraphs 6 and 9 of Part I of Schedule 7(A) of the Act.

Reporting by Exception – Governance of HSCP Commissioned External Organisations

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership on matters relating to the HSCP Governance process for externally commissioned Social Care Services for the reporting period 20 November 2021 to 21 January 2022.
The report was presented by Mr Stevenson and appended the mandatory Reporting by Exception document which highlighted changes and updates in relation to quality gradings, financial monitoring or specific service changes or concerns identified through submitted audited accounts, regulatory inspection and contract monitoring.
Updates were provided on establishments and services within Older People, Adult and Children's Services.
Ms Boyd declared a non-financial interest in this item as a Director of Inverclyde Carer's Centre. She also formed the view that the nature of her interest and of the item of business did not preclude her continued presence at the meeting or her participation in the decision making process.
Decided:
(1) that the Governance report for the period 20 November 2021 to 21 January 2022 be noted; and

(2) that members acknowledge that officers regard the control mechanisms in place through the governance meetings and managing poorly performing services guidance within the Contract Management Framework as sufficiently robust to ensure ongoing quality and safety and the fostering of a commissioning culture of continuous improvement.

Councillor Luciano Rebecchi

Having thanked Councillors and noted the forthcoming Local Government Elections at the commencement of business, the Chair acknowledged Councillor Rebecchi's retirement from Local Government and paid tribute to his length of service, passion and commitment, and the strong sense of locality that he brought to meetings, and wished him well in his retirement. Councillor Rebecchi responded with thanks.

AGENDA ITEM NO: 3

Report To:	**Inverclyde Integration Joint Board**	**Report To:**	**27 June 2022**
Report By:	**Allen Stevenson, Interim Chief Officer, Inverclyde Health & Social Care Partnership**	**Report No:**	**VP/LS/047/22**
Contact Officer:	**Vicky Pollock**	**Contact No:**	**01475 712180**
Subject:	**Voting Membership of the Inverclyde Integration Joint Board and Inverclyde Integration Joint Board Audit Committee**		

1.0 PURPOSE

1.1 The purpose of this report is to (i) advise the Inverclyde Integration Joint Board ("IJB") of a change in its voting membership arrangements following the Local Government Elections held on 5 May 2022, (ii) agree the appointment of one voting member of the IJB to the Inverclyde Integration Joint Board Audit Committee ("IJB Audit Committee") and (iii) confirm the re-appointment of the Greater Glasgow and Clyde NHS Board ("NHS Board") voting members for a further 2 year term.

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 sets out the arrangements for the membership of all Integration Joint Boards.

2.2 This report sets out revised membership arrangements for the IJB and the IJB Audit Committee.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Inverclyde Integration Joint Board:-

a) notes the appointment by Inverclyde Council of

Councillor Robert Moran
Councillor Martin McCluskey
Councillor Elizabeth Robertson
Councillor Lynne Quinn

as voting members of the Inverclyde Integration Joint Board;

b) notes the appointment of Councillor Robert Moran as Vice-Chair of the Inverclyde Integration Joint Board;

c) agrees the re-appointment of the Greater Glasgow and Clyde NHS Board voting members as set out in Appendix 1 Section A of this report for a further term of up to two years; and

d) appoints one Inverclyde Council voting member to serve on the IJB Audit Committee, with the nomination and appointment being made at the meeting.

Allen Stevenson
Interim Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the Order") sets out the arrangements for the membership of all Integration Joint Boards. As a minimum this must comprise:

- voting members appointed by the NHS Board and Inverclyde Council;
- non-voting members who are holders of key posts within either the NHS Board or Inverclyde Council; and
- representatives of groups who have an interest in the IJB.

5.0 IJB - VOTING MEMBERSHIP

5.1 In terms of the Integration Scheme, Inverclyde Council is required to appoint four elected members as voting members of the IJB.

5.2 Following the Local Government Elections in May 2022, Inverclyde Council approved its IJB voting members on 19 May 2022.

5.3 To ensure continuity of membership and the development of expertise in the functions of the IJB, named proxy members have been identified by Inverclyde Council. The IJB is asked to note these appointments.

5.4 The appointment of Councillor Robert Moran as Vice-Chair of the IJB was also approved by Inverclyde Council on 19 May 2022.

5.5 The names of the Inverclyde Council voting members and their proxies are set out in Appendix 1, Section A.

6.0 RE-APPOINTMENT OF NHS BOARD VOTING MEMBERS

6.1 The Order and the IJB Standing Orders set out when members' terms of office expire and the process for re-appointment.

6.2 The length of term of each member varies depending upon the category of member. For example, the Chief Social Work Officer, the Chief Officer and the Chief Financial Officer remains members of the IJB for as long as they hold office. Further, any member who has been appointed in place of a member who has resigned is appointed only for the unexpired term of the member they replaced.

6.3 The term of office of the voting members nominated by the NHS Board ends in June 2022.

6.4 The Order and the IJB Standing Orders state that at the expiry of a member's term of office, the member may be re-appointed for a further term, provided that they remain eligible and are not otherwise disqualified from appointment.

6.5 It is therefore proposed that the NHS Board voting members set out at Appendix 1, Section A are re-appointed for a further term of up to 2 years.

7.0 IJB AUDIT COMMITTEE – VOTING MEMBERSHIP

7.1 The current membership of the IJB Audit Committee is set out at Appendix 2.

7.2 Membership of the IJB Audit Committee comprises 4 IJB voting members (2 from the NHS Board and 2 from Inverclyde Council), with an additional 2 members drawn from the wider non-voting membership of the IJB.

7.3 As a result of the Inverclyde Council voting membership change highlighted in paragraph 5 above, it is necessary to change the voting membership of the IJB Audit Committee.

7.4 As membership of the IJB Audit Committee is a matter for decision by the IJB, it requires to agree the appointment of an Inverclyde Council voting member to the IJB Audit Committee to fill the vacancy. The IJB is therefore asked to appoint one Inverclyde Council voting member to serve on the IJB Audit Committee

8.0 PROPOSALS

8.1 It is proposed that the IJB (a) agrees the revised Inverclyde Council IJB voting membership arrangements as set out in Appendix 1 Section A, (b) notes the appointment of the Vice-Chair of the IJB, (c) agrees the re-appointment of the NHS Board voting members set out in Appendix 1, Section A for a term of office of up to 2 years and (d) agrees the appointment of an Inverclyde Council voting member to the IJB Audit Committee.

9.0 IMPLICATIONS

Finance

9.1 None.

Financial Implications:

One Off Costs

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

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A	N/A	N/A	N/A	N/A	N/A

Legal

9.2 The membership of the IJB is set out in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014. Standing Order 13 of the IJB's Standing Orders for Meetings regulates the establishment by the IJB of the IJB Audit Committee.

Human Resources

9.3 None.

Equalities

9.4 There are no equality issues within this report.

9.4.1 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
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.

9.4.2 How does this report address our Equality Outcomes

There are no Equalities Outcomes implications within this report.

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
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

9.5 There are no clinical or care governance issues within this report.

National Wellbeing Outcomes

9.6 How does this report support delivery of the National Wellbeing Outcomes
There are no National Wellbeing Outcomes implications within this report.

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
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.	None
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.	None
People using health and social care services are safe from harm.	None
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.	None
Resources are used effectively in the provision of health and social care services.	None

10.0 DIRECTIONS

10.1

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

11.0 CONSULTATIONS

11.1 The Interim Chief Officer of the Inverclyde Health & Social Care Partnership has been consulted in the preparation of this report.

12.0 BACKGROUND PAPERS

12.1 N/A

Inverclyde Integration Joint Board Membership as at 27 June 2022

SECTION A. VOTING MEMBERS		
		Proxies (Voting Members)
Inverclyde Council	Councillor Robert Moran (Vice Chair) Councillor Martin McCluskey Councillor Elizabeth Robertson Councillor Lynne Quinn	Councillor Colin Jackson Councillor Paul Cassidy Councillor Sandra Reynolds Councillor Drew McKenzie
Greater Glasgow and Clyde NHS Board	Mr Alan Cowan (Chair) Mr Simon Carr Ms Ann Cameron-Burns Mr David Gould	
SECTION B. NON-VOTING PROFESSIONAL ADVISORY MEMBERS		
Interim Chief Officer of the IJB	Allen Stevenson	
Chief Social Worker of Inverclyde Council	Sharon McAlees	
Chief Finance Officer	Craig Given	
Registered Medical Practitioner who is a registered GP	Inverclyde Health & Social Care Partnership Clinical Director Dr Hector MacDonald	
Registered Nurse	Chief Nurse Laura Moore	
Registered Medical Practitioner who is not a registered GP	Dr Chris Jones	
SECTION C. NON-VOTING STAKEHOLDER REPRESENTATIVE MEMBERS		
A staff representative (Council)	Ms Gemma Eardley	
A staff representative (NHS Board)	Ms Diana McCrone	
A third sector representative	Ms Charlene Elliott Chief Executive CVS Inverclyde	Proxy - Ms Vicki Cloney Partnership Facilitator CVS Inverclyde

A service user	Mr Hamish MacLeod Inverclyde Health and Social Care Partnership Advisory Group	Proxy - Ms Margaret Moyse
A carer representative	Ms Christina Boyd	Proxy – Ms Heather Davis
SECTION D. ADDITIONAL NON-VOTING MEMBERS		
Representative of Inverclyde Housing Association Forum	Mr Stevie McLachlan, Head of Customer Services, River Clyde Homes	

Inverclyde Integration Joint Board
Audit Committee Membership – as at 27 June 2022

SECTION A. VOTING MEMBERS		
		Proxies (Voting Members)
Inverclyde Council	Councillor Elizabeth Robertson (Chair) **VACANCY	Councillor Sandra Reynolds
Greater Glasgow and Clyde NHS Board	Mr Simon Carr (Vice Chair) Mr David Gould	
SECTION B. NON-VOTING MEMBERS		
A staff representative (NHS Board)	Ms Diana McCrone	
A third sector representative	Ms Charlene Elliott	

**Nomination and appointment to be made at IJB on 27 June 2022

AGENDA ITEM NO: 4

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**27 June 2022**
Report By:	**Allen Stevenson, Interim Chief Officer, Inverclyde Health & Social Care Partnership**	**Report No:**	**VP/LS/048/22**
Contact Officer:	**Vicky Pollock**	**Contact No:**	**01475 712180**
Subject:	**Inverclyde Integration Joint Board (IJB) and IJB Audit Committee – Proposed Dates of Future Meetings**		

1.0 PURPOSE

1.1 The purpose of this report is to request agreement of a timetable of meetings for both the Inverclyde Integration Joint Board (IJB) and the IJB Audit Committee for 2022/23.

1.2 Members will note from the 2022/23 timetable that it is proposed to hold six meetings of the Integration Joint Board, allowing for an additional meeting in late June and three meetings of the IJB Audit Committee.

1.3 As in previous years, to tie in with the arrangements for signing off the annual accounts, it is proposed that the September IJB and IJB Audit Committee be held on 26 September 2021.

1.4 To avoid a potential clash with a number of meetings arranged by NHS Greater Glasgow & Clyde and which are attended by members of the IJB, the meetings for Inverclyde IJB are on Mondays.

1.5 Meetings of the IJB and IJB Audit Committee are scheduled to begin at 2pm and 1pm respectively. The only exception to this is the IJB Audit Committee on 26 September. It is proposed that on that day, members meet with the External Auditors and Chief Internal Auditor at 12 noon without other senior officers present, as provided for in the Committee's Terms of Reference, and that the usual business of the Committee commence at 1pm.

2.0 RECOMMENDATION

2.1 It is recommended that agreement be given to the timetable of meetings for the Inverclyde Integration Joint Board and IJB Audit Committee for 2022/23 as detailed in the appendix to the report.

2.2 It is recommended that the IJB consider whether all meetings should continue be held via video conferencing.

Corporate Director (Chief Officer)
Inverclyde Health & Social Care Partnership

3.0 BACKGROUND

3.1 The Standing Orders of the Inverclyde Integration Joint Board (IJB) provide for meetings to be held at such place and such frequency as may be agreed by the Board. The proposal in this report is for six meetings to be arranged for the period from September 2022 to June 2023, with all meetings commencing at 2pm.

3.2 In June 2016, an Audit Committee was established as a Standing Committee of the IJB. The Audit Committee's Terms of Reference provide for the Committee to meet at least three times each financial year and that there be at least one meeting a year, or part thereof, where the Committee meets the External Auditors and Chief Internal Auditor without other senior officers present.

3.3 It is proposed that the IJB Audit Committee meets on three of the six dates on which the IJB meets in September, March and June. As requested by the IJB Audit Committee in March 2022, the cycle of IJB Audit Committee meeting dates have been moved from September, January and March to September, March and June.

3.4 The IJB is also being asked to consider whether it wishes to continue to hold all meetings of the Integration Joint Board and IJB Audit Committee via video conferencing.

4.0 IMPLICATIONS

Finance

4.1 There are no financial implications arising from this report.

Financial Implications:

One Off Costs

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

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A	N/A	N/A	N/A	N/A	N/A

Legal

4.2 None.

Human Resources

4.3 None.

Equalities

4.4 There are no equality issues within this report.

4.4.1 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
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.

4.4.2 How does this report address our Equality Outcomes

There are no Equalities Outcomes implications within this report.

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
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

4.5 There are no clinical or care governance issues within this report.

National Wellbeing Outcomes

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

There are no National Wellbeing Outcomes implications within this report.

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
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.	None
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.	None

People using health and social care services are safe from harm.	None
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.	None
Resources are used effectively in the provision of health and social care services.	None

5.0 CONSULTATIONS

5.1 The Corporate Director (Chief Officer) has been consulted in the preparation of this report.

6.0 DIRECTIONS

6.1

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

7.0 BACKGROUND PAPERS

7.1 N/A

TIMETABLE 2022/23

IJB/IJB Audit Committee	Submission Date – 9am	Pre-Agenda Date	Issue Agenda	Date of Meeting
IJB Audit Committee	Friday 26 August	Monday 5 September – 2.15pm	Friday 9 September	**Monday 26 September – 12 noon, then 1pm**
Inverclyde Integration Joint Board	Friday 26 August	Monday 5 September – 3pm	Friday 9 September	**Monday 26 September – 2pm**
Inverclyde Integration Joint Board	Friday 14 October	Monday 24 October – 3pm	Friday 28 October	**Monday 7 November – 2pm**
Inverclyde Integration Joint Board	Friday 16 December	Monday 9 January – 3pm	Friday 13 January	**Monday 23 January – 2pm**
IJB Audit Committee	Friday 24 February	Monday 6 March – 2.15pm	Friday 10 March	**Monday 20 March – 1pm**
Inverclyde Integration Joint Board	Friday 24 February	Monday 6 March – 3pm	Friday 10 March	**Monday 20 March – 2pm**
Inverclyde Integration Joint Board	Friday 21 April	Tuesday 2 May – 10am*	Friday 5 May	**Monday 15 May – 2pm**
IJB Audit Committee	Friday 2 June	Monday 12 June – 2.15pm	Friday 16 June	**Monday 26 June – 1pm**
Inverclyde Integration Joint Board	Friday 2 June	Monday 12 June – 3pm	Friday 16 June	**Monday 26 June – 2pm**

*Date altered to take account of May Day Holiday – 1 May

Appendix 1

INVERCLYDE INTEGRATION JOINT BOARD
ROLLING ACTION LIST
27 JUNE 2022

	In progress, will be done but maybe within another paper		Remove from rolling action list
	Possibly remove or include in CO brief instead		

Meeting Date and Minute Reference	Action	Responsible Officer	Timescale	Progress/Update/ Outcome	Status	Open/Closed
25 January 2021 (Para 3(4))	Review of Decision-Making Arrangements	Chief Officer	March 2021 (and each meeting thereafter)	Review paper to March IJB	Superseded	Closed
29 March 2021 (Para 18(2))	Report on review of SMT structure at HSCP	Chief Officer	July 2022	Paper to IJB September 2022		Closed
17 May 2021 (Para 35(4))	Update report - Primary Care Improvement Plan – Physiotherapy waiting times	Chief Officer	No timescale – a future meeting	Paper to IJB November 2022		Closed
17 May 2021 (Para 38(3))	Further report detailing progress - Inverclyde Adult Support & Protection Partnership	Chief Officer	May 2022	Paper to IJB September 2022		Closed
21 June 2021 (Para 44(2))	Review meeting arrangements with regard to public health situation	Chief Officer	No timescale – a future date	Proposed Hybrid working September 2022		Closed
21 June 2021 (Para 46(4))	Development Session – Strategic Plan Refresh	Chief Officer	By September 2021 –	Session scheduled September 2022		Closed

AGENDA ITEM NO: 5

			before next meeting			
1 November 2021 (Para 82(4))	Report – Advanced Clinical Practice Proposal – with timelines and anticipated outcomes	Chief Officer	By Sep 2022	Paper to IJB By November 2022		Closed
24 January 2022 (Para 7(3))	Report on grant dispersal and impact of changes to Universal Credit	Chief Officer	No timescale – a future meeting	Paper to IJB November 2022		Open

Annual Report Schedule

March • Annual Budget	June • Draft Annual Accounts • Annual Performance Report • Clinical & Care Governance
September • Audited Annual Accounts • Digital strategy • Workforce Update	December • PCIP Update • Update Criminal Justice

Directions Register

- Hard Edges
- Care Homes

AGENDA ITEM 7
IS REMOVED
FROM THE
AGENDA

AGENDA ITEM NO: 8

Report To:	**Inverclyde Integration Joint Board**	**Date: 27 June 2022**
Report By:	**Allen Stevenson** **Interim Chief Officer** **Inverclyde Health & Social Care Partnership**	**Report No: SW/31/2022/CG**
Contact Officer	**Craig Given** **Head of Service: Finance, Planning & Resources**	**Contact No: 01475 715212**
Subject:	**PROPOSED USE OF IDEAS PROJECT SURPLUS FUNDS**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on the proposed use of surplus funds from the IDEAS programme to create a Specialised Money Advice and Resource Team and to support future planning and commissioning of Money Advice and welfare/ anti-poverty services.

2.0 SUMMARY

2.1 Inverclyde Council led a partnership with internal and external partners to provide the IDEAS project with a value of £1.945 million (exc VAT) over a 3 year period. The aim of the programme was to provide a holistic approach to working with individuals on their debt, income maximisation, financial inclusion and financial education creating a more positive household not affected by debt as a barrier.

2.2 The main contract between the Council and the Lottery allowed for any surplus funds to be utilised by the Integration Joint Board to support welfare and Anti-Poverty measures. The residual surplus for the project is £297,000 and it was agreed by all partners that this would be utilised by all partners to spend on welfare related issues and financial inclusion.

2.3 The proposal is to use the surplus funding over two years to directly support Anti-Poverty measures by responding to increased complexity and post-Covid demand and to ensure a viable exit strategy after March 2024. The funding will be allocated within HSCP Advice Services and third sector.

3.0 RECOMMENDATIONS

3.1 It is recommend that the Integration Joint Board:-

(a) agrees to invest the £297, 000 surplus funds as proposed to:

(i) support the appointment of 2 additional Money Advice posts for HSCP Advice Services; and

(ii) provide support to Financial Inclusion Partners to be agreed by the Financial Inclusion Partnership

all as detailed in the report; and

(b) authorises the Interim Chief Officer to issue the Direction attached to this report to Inverclyde Council.

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 IDEAS was a financial inclusion project that supported Inverclyde residents to improve their financial circumstances and money management skills. The IDEAS delivery model has been highlighted as a best practice example providing a benchmark for delivery across the rest of the national programme and has been recognised by the Lottery nationally. The approach worked well in Inverclyde and delivered a very successful Financial Inclusion Programme to Inverclyde residents.

4.2 Many Inverclyde residents' circumstances have changed during Covid 19 due to falls in income arising from furlough, reduced hours at work and redundancy. This is additionally impacted by the rising cost of living; high energy prices, increasing food prices and other inflationary and borrowing costs. All of this creates the conditions for a significant rise in financial exclusion in Inverclyde for not only those traditionally at risk but also whole new parts of the community who were previously financially secure. All commissioned partners will see this impact; Financial Fitness, Wise Group, Food Bank and Starter Packs, alongside the wider third sector.

4.3 Due to the support that was introduced during the lockdown (payment breaks, furlough, UC Uplift, eviction and repossession ban) there was a suppression of the number of people seeking advice for problem debts from Inverclyde HSCP Advice Services and commissioned partners. However, it is anticipated that demand will increase again in 2022 and will exceed that experienced in 2019 (whilst the I:DEAS Project was still operating). The Financial Conduct Authority and the Money and Pension Service believe this could peak in 2023 by as much as 50%.

Emerging risks as a result of the pandemic and other changes include:

- Increase in those who need assistance most but are unable to access credit moving to illegal lenders and we are beginning to see this in Inverclyde.
- Growing levels of problem debt leading to more people making poor financial decisions and needing even more help.

Anecdotal evidence from our own and commissioned services is that callers are much more likely to be expressing despair and hopelessness to frontline staff with an increase in people making choices between food and fuel.

4.4 The table below demonstrates the usual activity seen in Advice Services within the HSCP and the impact on cases of additional supports being in place during the pandemic. The Financial Conduct Authority believe there could be up to a 50% increase in debt levels going forward.

Date	New Cases	Debt Interventions	Level of Debt	Number of Money Advice Staff
2018-2019	441	1433	£4,209,301.19	1 Senior 2 Money Advisors 2 IDEAS Money Advisors
2019-2020	450	1200	£2,773,300.59	1 Senior 2 Money Advisors 2 IDEAS Money Advisors
2020-2021	249	434	£1,209,878.61	1 Senior 2 Money Advisors
2021-2022	201	343	£774,470.03	1 Senior 2 Money Advisors

5.0 PROPOSAL

5.1 The proposal is to use the IDEAS project surplus to support anti-poverty measures through a number of strands:

- 2 additional Grade 6 Money Advisor Posts to April 2024 for HSCP Advice Services to lead on preventative financial inclusion work whilst responding to expected increased demand
- Additional funding for third sector directed and agreed by the Financial Inclusion Partnership
- To ensure the effects of changes to external funding for both HSCP and third sector, such as the ending of Scottish Legal Aid Board (SLAB) funding can be mitigated to support the expected demand in 2022/23 and 2023/24
- To ensure that both internal money advice and anti-poverty services have exit strategies for temporary funding and associated posts

The Money Advice Team is the only service in Inverclyde that is operating at Type II and Type III of the Scottish Government's National Standards and uniquely, in Inverclyde, is able to provide the specialist services that allow people to access all formal debt services.

5.2 This proposal will support both a proactive preventative approach whilst supporting the core team and wider partners to respond to an expected rise in demand. The aim is to ensure a robust response to the financial exclusion experienced in the aftermath of the Covid pandemic and the impact of the increasing costs of living. This includes:

- Increased Coordination and Partnership Working along with additional support for more services to achieve the National Standards
- Debt and Financial Exclusion Awareness Training
- One to One Budget Training
- Education/Classroom Support
- Financial Inclusion Support for Parents
- Raising Financial Awareness

The financial Inclusion Partnership is currently updating its strategy and all of these elements will be addressed within this and an agreed plan for delivery with the aim to implement agreed proposals and associated spend by August 2022.

5.2.1 **<u>Increased Co-ordination and Partnership Working</u>**

The Financial Inclusion Partnership (FIP) will become increasingly important in the next period and as the lead Partner Agency, Inverclyde HSCP will lead and coordinate a new FIP strategy during summer 2022. A new Financial Inclusion Lead/ Senior Money Advisor is now in post and additional Financial Inclusion Workers would allow the team to be more pro-actively involved in working with the FIP and also their clients in raising awareness of financial issues and providing one to one support. They will also be made available to support Partner Agencies in providing in-house training and support for staff. The FIP will consider creation of a time-limited peer review post which would support a wider range of agencies including RSLs to proceed to audit and subsequent accreditation for Scottish National Standards for Information and Advice Providers.

5.2.2 **<u>Debt and Financial Exclusion Awareness Training</u>**

This training will be expanded and targeted at the staff of Inverclyde Council, NHS and other Partner agencies and also local employers to raise awareness of the signs of problem debt and financial exclusion amongst staff members and service users. The aim will be to highlight the consequences of people not receiving advice and assistance and encouraging staff members and local employers to encourage take up of advice services across Inverclyde. The FIP will also explore working towards the *Stop Illegal Loan Sharks Charter Mark* and potential ways of supporting those affected

by gambling related harm.

5.2.3 **<u>One to One Budget Training</u>**

To provide one to one budgeting support to clients across Inverclyde, where it is believed the clients will benefit from more one-to-one, intensive budgeting support and help in developing bill paying strategies and money management skills. The aim of this will be to reduce the likelihood of clients having to seek advice again. This service will also be made available to anyone who wishes to refer themselves, with the benefits of doing being promoted when you have experienced a change in circumstances.

5.2.4 **<u>Education/Class Room Support</u>**

The Financial Inclusion Workers will work with Education Services to develop material that can be made available to all Inverclyde School pupils to increase money skill and will include developing financial awareness and competency skills for those nearing school leaving age. This part of the programme would be further developed and enhanced in partnership with education.

5.2.5 **<u>Financial Support for Parents</u>**

Additional capcity with HSCP and third sector will also ensure that every School in Inverclyde has a Financial Inclusion Officer allocated to it who will not only be involved in developing Financial Inclusion material for use in the School, but will be available to be contacted by any parents of any pupils attending the School in relation to any financial inclusion, income related matters.

5.2.6 **<u>Raising Financial Awareness</u>**

The Project will work with Corporate Communications to increase the availability of material on the Inverclyde Council Website and other corporate media platforms, with the aim of raising awareness of financial products and services as they change and to educate people as to the advantages and disadvantage of them. This would link to proposed work on illegal money lending and gambling.

5.3 It is expected that there will be several long term impacts:

- Increased financial inclusion for the citizens of Inverclyde through both direct support and collaborative working across the Financial Inclusion Partnership
- Continued collaborative working with education including delivery and funding of training/ resource packages
- Evidence of the best way to plan, deliver and commission money advice and anti-poverty services in future leading to implementation of any necessary changes which continue to meet service demands within the expected future financial envelope. This will include exit strategies for temporary posts/ funding.
- Direct contributions to delivery of all 6 Big Actions in the HSCP Strategic Plan, the Child Poverty Action Plan and the Local Outcomes Improvement Plan.

6.0 IMPLICATIONS

FINANCE

6.1 <u>Financial Implications:</u>

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

IDEAS	Employee Costs	2022/23 2023/24	53 83		2 Grade 6 Financial inclusion posts (part year costs) Full year Fully funded by Residual surplus of project £297k
	IT, Training, resources etc	2022-24	10		
	Third sector/ wider FIP support	2022/23 2023/24	60 91		

LEGAL

6.2 There are no legal issues raised in this report.

HUMAN RESOURCES

6.3 Two new fixed term Grade 6 Financial Inclusion Worker posts to be created.

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.

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.	Improved access to specialist money advice.
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	Improved access to specialist money advice.
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	Participation in commissioned services review to develop future service plans
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
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.

NATIONAL WELLBEING OUTCOMES

6.6 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.	Increased financial inclusion allowing wider choices
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	Increased financial inclusion allowing wider choices
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Increased access to services and one to one support
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Increased access to services and one to one support
Health and social care services contribute to reducing health inequalities.	Increased financial inclusion allowing wider choices
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.	Increased financial inclusion allowing wider choices
People using health and social care services are safe from harm.	Increased financial inclusion allowing wider choices
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.	Resources are available to ensure staff are able to deliver a high quality services which meets clients needs
Resources are used effectively in the provision of health and social care services.	Evidence best value in future internal delivery & commissioning

7.0 DIRECTIONS

7.1

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

8.0 CONSULTATION

8.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with

- Council Management Team

9.0 BACKGROUND PAPERS

INVERCLYDE INTEGRATION JOINT BOARD
DIRECTION ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

1	Reference number	IJB/31/2022/CG
2	Report Title	Proposed Use of IDEAS Project Surplus Funds
3	Date direction issued by IJB	27th June 2022
4	Date from which direction takes effect	27th June 2022
5	Direction to:	Inverclyde Council only
6	Does this direction supersede, revise or revoke a previous direction – if yes, include the reference number(s)	No
7	Functions covered by direction	Advice Services
8	Full text of direction	Inverclyde Council is directed to invest the £0.297m surplus funds provided by the IJB to: (a) support the appointment of 2 additional Money Advice posts for HSCP Advice Services; and (b) provide support to Financial Inclusion Partners to be agreed by the Financial Inclusion Partnership all as detailed in the report.
9	Budget allocated by IJB to carry out direction	£0.297m
10	Outcomes	As detailed in paragraph 5 of the report.
11	Performance monitoring arrangements	In line with the agreed Performance Management Framework of the Inverclyde Integration Joint Board and the Inverclyde Health and Social Care Partnership. This Direction will be monitored and progress reported bi-annually.

Appendix 1

12	Date direction will be reviewed	26th June 2023 and any updates will be brought back to the IJB as necessary.

AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**27 June 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde Health and Social Care Partnership**	**Report No:**	**SW/25/2022/AS**
Contact Officer:	**Andrina Hunter Service Manager Planning and Performance**	**Contact No:**	**01476125**
Subject:	**Locality Planning within Inverclyde**		

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on the development of locality planning within Inverclyde and approve changes to this approach based on learning and feedback.

2.0 SUMMARY

2.1 The Community Empowerment Act 2015 and the Public Bodies (Scotland) Act 2014 set out differing requirements for locality planning. Within Inverclyde it was agreed that an attempt to align locality planning processes which met both sets of legislation would be advantageous, and Inverclyde Alliance and the HSCP agreed to put in place arrangements for locality planning across Inverclyde.

2.2 Six Communication and Engagement Groups have been established across Inverclyde and two Locality Planning Groups (Port Glasgow and Inverkip and Wemyss bay localities) piloted with a range of feedback received and learning from this approach. Whilst this joined up approach across Inverclyde was based on good rationale, the concern is by continuing this model it may not meet either set of legislation nor meet the needs of the Inverclyde community and partners.

2.3 A new model is proposed which continues the six Communication and Engagement Groups governed through the Inverclyde Alliance's Local Outcome Improvement Plan (LOIP) Programme Board, and the development of two Health and Social Care Locality Groups governed through the Inverclyde's Integrated Joint Partnership's (IJB) Strategic Planning Group.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the steps undertaken to date to develop locality planning across Inverclyde.

3.2 The Integration Joint Board is asked to note the proposals to retain the six Communication and Engagement Groups and approve the development of the two Health and Social Care Locality Groups for Inverclyde.

Allen Stevenson
Interim Chief Officer, Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 The Community Empowerment (Scotland) Act 2015 places a statutory requirement on Inverclyde Alliance to develop locality plans for the communities of Inverclyde that experience the greatest inequalities.

The three localities of Port Glasgow; Greenock East and Central; and Greenock South and South West were identified as the key localities and locality plans were developed.

4.2 The Public Bodies Joint Working (Scotland) Act 2014 places responsibility on the HSCP in relation to locality planning. Health and Social Care Partnerships must set up two or more localities and the localities should be established to enable service planning and utilisation of resources at a local level within natural communities.

4.3 Within Inverclyde it was agreed that an attempt to align locality planning processes which met both sets of legislation would be advantageous, and Inverclyde Alliance and the HSCP agreed to put in place arrangements for locality planning across Inverclyde. The report to the Alliance Board in June 2019 set out the establishment of six localities across Inverclyde as follows.

- Kilmacolm and Quarriers Village
- Port Glasgow
- Greenock East and Central
- Greenock South and South West
- Greenock West and Gourock
- Inverkip and Wemyss Bay

The full report can be accessed here https://www.inverclyde.gov.uk/council-and-government/community-planning-partnership/inverclyde-alliance-board-papers/inverclyde-alliance-board-papers-2019/inverclyde-alliance-board-papers-17-june-2019

4.4 The original plan was to establish six Locality Planning Groups which would involve a range of statutory and 3rd sector partners meeting on a quarterly basis, supported by six Communication and Engagement Groups, whose membership was community members living within the relevant locality area. The initial plan to focus on establishing the six Communication and Engagement Groups and then pilot the locality planning groups.

4.5 The role of LPGs is to:

- ❖ Develop and oversee delivery of a Locality Action Plan that:
  - Meets the requirements of the Community Empowerment (Scotland) Act 2015;
  - Takes account of strategic issues such as inequalities and poverty;
  - Delivers on the Inverclyde HSCP Strategic Plan objectives;
  - Delivers against the road map of 'what we expect to look like' at the end of the plan period;
  - Achieves transformation to a health and wellbeing partnership; and.
  - Delivers financial and service sustainability
- ❖ Assess progress against the Locality Action Plan which will utilise performance management processes
- ❖ Review the Locality Action Plan on an annual basis

4.6 The purpose of the Communication and Engagement groups are to:

- Ensure that local people can contribute to the planning, design and delivery of local services through effective collaboration and empowerment;
- Discuss and deliberate priorities to assist with prioritising work in communities;
- Enable local communities to have a say in use of defined budgets;
- Make it easier for communities to participate in community planning at a locality level;

- Provide a mechanism for more people to participate in decisions on how local services look; and
- Enable hard to reach groups who do not traditionally engage with services to participate and have a say.

4.7 Initial progress was made in establishing the groups which were led by different partners within the localities. Some communities were easier to engage than others and the Communication and Engagement Groups have all developed at different paces, with greater success in some localities than others. The Covid 19 pandemic impacted on the continued development with changes to service delivery and the shift to online meetings.

4.8 A further report to Alliance Board in March 2021 provided an update on implementation and approved the consolidation of support for Communication and Engagement groups to be provided by the Council's Community learning and Development Service (CLD). https://www.inverclyde.gov.uk/council-and-government/community-planning-partnership/inverclyde-alliance-board-papers/inverclyde-alliance-board-papers-2021/inverclyde-alliance-board-meeting-15-march-2021

5.0 CURRENT POSITION

5.1 Six Communication and Engagement Groups have been established across Inverclyde. Each of the six localities have been allocated a Community Development Worker to engage, consult, encourage participation and to empower members of the locality to actively become involved in local democratic decision making. These groups are developing at different rates and are at different stages of taking forward actions from their locality action plans. There has been ongoing challenges engaging people from across communities onto Communication and Engagement Groups due to the ongoing restrictions around Covid-19 pandemic and social distancing, therefore much of the communication has taken place on line via electronic platforms. However, despite this challenge the Communication and Engagement Groups have taken part in developing the priorities within their own locality such as;

- Port Glasgow are consulting on transport and barriers to access health care.
- Inverkip and Wemyss Bay have implemented action plans to encourage use of the recycling bins in the villages and how they can work together to mitigate risks for young people using Inverkip beach during the school holiday period.
- Greenock West and Gourock worked together to host a local farmers market in Gourock, this was based on local research and requests from people living in the community. The group has also been supported to provide a bowl and soup session on a monthly basis, this not only supports people who have been socially isolating and have poor mental wellbeing but it also provides those facing financial insecurity an opportunity to receive a meal without judgement or stigma. The Communication and Engagement Group for Greenock West and Gourock are working with, and will be supported by, the two Community Councils.
- Kilmacolm and Quarriers Village are identifying further communication methods that will encourage more people to become involved in the locality Communication and Engagement Group.
- South and South West Communication and Engagement Group are working together to support the wider communities concerns around poverty and the impact of increasing cost of living. They have engaged the Wise Group to provide information and advice that they can share throughout the community. There has been ongoing engagement and learning to ensure that participation is across the locality and not contained within one community.
- Greenock East and Central Communication and Engagement Group have had a few successful meetings online, however, further and more intensive support will be offered to increase participation and empowerment within this locality.

The Communication and Engagement Groups have also participated in Inverclyde wide consultations and engagement discussions such as; local community listening events, issues such as poverty, Inverclyde Council efficiency savings, slavery and women's issues.

Recently, the Communications and Engagement Groups have been the local representatives taking forward, promoting and voting on the Community Meliora Fund.

5.2 In terms of Locality Planning Groups, It was agreed that an incremental approach to establishing the six locality planning groups would be taken with two LPGs being developed in Port Glasgow and Inverkip and Wemyss bay localities. These areas were to be pilots and learning from these would help establish future LPG development.

5.3 Both locality planning groups have now met and had very different approaches to how the meetings were run. The group meetings involved, in the main, community representatives from Communication and Engagement Groups with a few statutory partners. Feedback following the meetings from the community has been that many people are keen to be involved in the communication and engagement groups however do not want to be involved in formal governance structures surrounding locality planning. In addition the differing roles of Community Councils and Locality Planning Groups has been the subject of discussion and the need for clarity as to their statutory status.

5.4 Feedback from partners included capacity concerns regarding the expected attendance at six Locality Planning Groups on a regular basis. In particular it has been difficult to involve health and social care professionals e.g. GP's; pharmacists etc. due to the work demands, and concerns raised as to the future requirement for their involvement in six LPGs. The role of LPGs for IJBs is to ensure service planning and utilisation of resources at a local level, therefore with key professionals missing this would prove difficult.

6.0 FUTURE PROPOSAL

6.1 Having piloted the Locality Planning Groups and discussed with a range of partners and community members, learning has emerged which has led to the realisation that one model may not be the best approach. Whilst this was a common sense approach, based on good rationale for a small locality areas such as Inverclyde, the concern is by pursing this approach it may not meet either set of legislation nor meet the needs of the Inverclyde community and partners.

6.2 It is therefore proposed that under the Community Empowerment legislation, the six Communication and Engagement Groups will continue in the locality areas. The communities will be supported by Inverclyde Council CLD colleagues to grow, continue to develop a strong community involvement across Inverclyde, and develop and deliver locality plans for each area. The governance for the C&E Groups will be to the Inverclyde Local Outcome Improvement Plan (LOIP) Programme Board which is chaired by the Inverclyde Council Chief Executive.

6.3 In terms of meeting the requirements of The Public Bodies Joint Working (Scotland) Act 2014, the Integrated Joint Board (IJB) will establish two formal Health and Social Care Locality Planning Groups- one for East Inverclyde and one for West Inverclyde (the boundary will be Baker Street Greenock).

6.4 The Public Bodies Joint Working (Scotland) Act 2014 Act specifically highlights the following must be members of locality planning groups:

- A range of health and social care professionals who are involved in the care of people who use services
- representatives of the housing sector
- representatives of the third and independent sectors
- carers" and patients" representatives

- people managing services in the area of the Integration Authority

These groups will focus their agenda on service planning and utilisation of resources at a local level and their governance will be to the Inverclyde HSCP Strategic Planning Group which is chaired by the Chief Officer Health and Social Care.

7.0 CONCLUSION

7.1 Learning from the current model of locality planning across Inverclyde has concluded that it is not in the best interests of all partners to continue with this approach. A new model of continuing with the six Communication and Engagement Groups and the development of two Health and Social Care Locality Groups is seen as the way forward.

8.0 NEXT STEPS

8.1 A similar report has been submitted to the Alliance Board held on the 20th June 2022. The six Communication and Engagement Groups will continue to meet regularly and the locality plans will be updated. The two Health and Social Care Locality Planning Groups will be developed and will be established by September 2022.

9.0 IMPLICATIONS

FINANCE

9.1

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

9.2 There are no legal implications arising from this report.

HUMAN RESOURCES

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

EQUALITIES

9.4 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.

9.5 How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	The locality groups will involve a range of partners and community representatives
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	
People with protected characteristics feel safe within their communities.	
People with protected characteristics feel included in the planning and developing of services.	The locality groups will involve a range of partners and community representatives
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

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

NATIONAL WELLBEING OUTCOMES

9.7 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.	
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	
People who use health and social care services have positive experiences of those services, and have their dignity respected.	The locality groups will involve a range of

	partners and community representatives
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	
Health and social care services contribute to reducing health inequalities.	
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.	The locality groups will involve a range of partners and community representatives including a carers representative.
People using health and social care services are safe from 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.	
Resources are used effectively in the provision of health and social care services.	None

10.0 DIRECTIONS

10.1

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

11.0 CONSULTATION

11.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

12.0 LIST OF BACKGROUND PAPERS

12.1 None

AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**27 June 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde HSCP**	**Report No:**	**IJB/27/2022/AM**
Contact Officer:	**Anne Malarkey Head of Mental Health, Alcohol and Drug Recovery and Homelessness Services**	**Contact No:**	**01475 715284**
Subject:	**MENTAL HEALTH & WELLBEING SERVICE**		

1.0 PURPOSE

1.1 The purpose of this paper is to provide details of planning for the development and implementation of the Inverclyde Mental Health and Wellbeing Service (MHWS).

2.0 SUMMARY

2.1 Scottish Government require all HSCPs to develop and fully implement a mental health and wellbeing primary care service by April 2026. Service plans are to align with recommendations from the attached report by a national short life working group on Mental Health in Primary Care. A national oversight group has been established by the Scottish Government which is leading on this work and will review the plans submitted by each HSCP.

2.2 A MHWS steering group was established in Inverclyde in February 2022 with representation from key stakeholders. There have been five meetings of the group between February and May 2022, the group will continue to meet on a monthly basis. Two service user focus groups held in March and April have enabled service user contribution to the planning process.

2.3 Indicative budget for implementing the service is:

2022/23 - £156,876.54
2023/24 - £313,263.86
2024/25 - £631,746.06

2.4 The steering group has developed a proposal based on developing and implementing the Inverclyde MHWS in alignment with the existing Primary Care Mental Health Team. This will involve an expansion of the team and an increase in multi-disciplinary roles. Pathways into the service will be developed to ensure it is easily accessible and processes will be established that ensure individuals receive a timely, trauma informed, strengths based and recovery oriented response.

2.5 As well as providing assessment and treatment the service will use prevention/early intervention strategies that improve mental health and wellbeing and support self-management. It will work proactively with people who require support with the aim of avoiding a deterioration in mental health that would lead to a requirement for treatment from clinical mental health service.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board notes the content of this report and approves the proposals to develop and implement the Inverclyde Mental Health and Wellbeing Service as detailed in the report.

3.2 It is recommend that the Interim Chief Officer is authorised to issue the Direction attached to this report to NHS Greater Glasgow and Clyde.

Allen Stevenson
Interim Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 Mental Health has been identified as a key issue across communities and for Primary and Community care services. Primary and Community care services are the services that provide healthcare in a local area. These services are often the first point of contact for individuals who are seeking advice or help with a health concern. There are a wide range of mental health concerns that individuals seek support for, commonly these include stress and distress, emotional and relational difficulties, feelings of anxiety and low mood. Often there are socio economic pressures that contribute to these difficulties and frequently they are underpinned by experiences of adversity or trauma. Experiences of the Covid 19 pandemic have exacerbated mental health concerns for many people and in some cases have led to an increase in social isolation.

4.2 GPs are often the first point of contact for people seeking help for a mental health issue. Some estimates suggest that approximately one third of GP consultations have a mental health component. GPs are able to refer to specialist mental health services if further assessment or treatment is required but often manage mental health concerns themselves if thresholds for specialist treatment are not met. Feedback from GPs indicates that they often feel that they are not best placed to provide the mental health support that people need. The range and complexity of mental health issues that GPs are required to respond to do not all fit with existing pathways of care and would often benefit from a holistic, person centred, multi-disciplinary approach. Individuals who are experiencing mental health difficulties related to social, environmental or circumstantial stressors often require a response that incorporates linking them with appropriate non-clinical supports in the community.

4.3 There has been widespread recognition that the Primary and Community Care part of the mental health service system requires development in order to better meet the needs of individuals seeking support for their mental health and provide a more positive experience of care. Over the last five years a number of different initiatives aimed at addressing the needs of individuals presenting to primary care have been supported across Scotland. Learning from these has been shared and further information can be found in the attached Evidence Paper.

4.4 HSCPs were notified in early 2022 about the requirement for the development of the MHWS and were issued planning guidance at that time. A MHWS steering group was established in Inverclyde in February 2022 with representation from key stakeholders. There were five meetings of the group between February and May 2022, the group will continue to meet on a monthly basis. The steering group will oversee the development and implementation of the service.

4.5 Inverclyde context: There is a well-established Primary Care Mental Health Team that works closely with GP practices across the area. This team offers assessment and psychological therapy based interventions. Each GP practice in Inverclyde also has a Community Links Worker (CLW). The CLWs are practitioners who work within GP practices providing non-clinical support with personal, social, emotional and financial issues. Inverclyde also has a Distress Brief Intervention Programme, currently delivered by SAMH, which offers short term intensive support to individuals experiencing distress. There are also numerous third sector organisations and community groups that offer support with mental health and wellbeing, many of these have benefited from grants awarded through the Inverclyde Communities Mental Health and Wellbeing Fund.

5.0 PROPOSAL

5.1 The Inverclyde Mental Health and Well-being Service (MHWS) will be implemented within the structure of Community Mental Health Services in alignment with the current Primary Care Mental Health Team (PCMHT). The PCMHT has links with GP practices, is accessible by self-referral and provides low intensity psychological therapy. In addition to what is already offered by PCMHT the MHWS will bring an expansion in the scope of the current triage function so that wider mental health and wellbeing needs are considered. The MHWS will be multi-disciplinary and will introduce specialist workers with a focus on children and young people and also the older adult population.

5.2 The overall aim of the MHWS will be to provide a trauma informed, strengths based and recovery oriented service that takes in to account the circumstances (including determinants of health), goals, and preferences of services users. Taking in to account the social and psychological factors influencing mental health and wellbeing in a primary care setting could help reduce the pathologising of normal human responses to difficult circumstances. The MHWS will offer support and specialist advice without the need for diagnosis first. The use of a trauma informed, recovery-oriented and strengths-based framework will support individuals to understand their mental health problems within the context of a psychological, social and situational narrative. Such an understanding will lead to empowerment and give control to the person seeking help while supporting them to set goals and respond effectively to difficult emotions.

5.3 The service will be delivered by a multidisciplinary team made up of a range of mental health professionals and support workers. Strong and productive links with a wide range of stakeholders will underpin the service, these will include, but are not limited to, general practice teams, Community Links Workers, third sector organisations, community groups, secondary mental health services, alcohol and drug recovery services and health improvement colleagues.

5.4 The MHWS will offer a front line, first point of contact service for anyone seeking mental health and wellbeing support. Triage and assessment within the service will involve a compassionate, person centred, holistic assessment of needs and a strengths based approach to identifying goals. If the MHWS is unable to provide the care or treatment an individual requires it will support individuals to engage with an alternative service. The service will be easily accessible and will be delivered in local areas in a way that actively seeks to combat stigma and overcome barriers to access

5.5 In addition to the low intensity psychological therapy that is currently delivered by the PCMHT, Occupational Therapy interventions will be introduced. Group programmes will be developed and delivered, these may include peer support groups.

5.6 The inclusion of a post that is specific to children and young people will mean that the mental health and wellbeing needs of our younger population can be addressed. It is anticipated that including this post within the team will increase the awareness and understanding of all team members about the mental health and wellbeing of children and young people. This worker will provide advice and support to young people and their families and will have well established connections with child and adolescent services. One of the key functions of the role will be to ensure people are aware of supports and services and how to access them. A similar role is proposed for the older adult population.

5.7 Service development and expansion will be informed by demand, it is hoped that once the MHWS is operational across all GP practices there will be scope to include a more proactive approach to supporting mental health and wellbeing in year three. Such an approach would target specific populations such as those affected by inequalities, experiencing multi morbidity or long term health conditions. If demand and capacity allow the service will expand to include an innovative approach to upstream working that will target people at risk of developing poor mental health and wellbeing before they identify themselves as having a problem

5.8 The focus during the first year of implementation will be on establishing robust and efficient processes that deliver a timely and effective response to mental health and wellbeing needs. The service will be rolled out incrementally. A communication plan is under development as part of the planning process and development and engagements events will be carried out with GPs/GP practice teams and wider community members

6.0 IMPLICATIONS

Finance

6.1

Financial Implications:

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
		2022/23	£156,876.54		See indicative allocation letter from Scottish Government

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
		2023/24 2024/25	£313,263.86 £631,746.06		

Legal

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

Human Resources

6.3 This proposal include the introduction of 13 additional post as detailed below. The plan will be reviewed on a six monthly basis and depending on demands on the service the number and type of posts in the second and third year may be amended.

2022/2023
1 x Band 4 Administrative assistant
1 x Band 6 Occupational Therapist
1 x Band 5 Occupational Therapist
1 x Band 5 Child and young person support worker
1 x Band 6 Primary Care Mental Health Clinician

2023/2024
1 x Band 7 CBT Therapist

2024/2025
3 x Band 4 Group activity/Health improvement coordinator
1 x Band 5 Older adult support worker
1 x Band 5 Inequalities outreach worker
2 x Band 6 Primary Care Mental Health Clinician

Equalities

6.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
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.

6.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	The Mental Health and Wellbeing Service will be available to people of all ages without any care group or condition boundaries. Equalities data will be collected so that access to and uptake of the service is monitored and variation responded to if required
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
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 The new service will sit within already established service structures meaning that any clinical or care governance implications will be managed within the processes of these structures structures.

NATIONAL WELLBEING OUTCOMES

6.6 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 overarching aim of the Mental Health and Wellbeing Service is to support people to improve and maintain good mental health and wellbeing. The service will use evidence based interventions and will link closely with third sector partners and community groups that support health and wellbeing.
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	The MHWS will support improvements in mental health and wellbeing that will enable independent living. It will be proactive in reaching out to individuals with long term

	conditions and seek to engage them in activities that will improve their wellbeing.
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Service user experience will be routinely collected, monitored, and responded to.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Quality of life is directly impacted by poor mental health, this service will seek to improve quality of life by enhancing mental health and wellbeing and supporting people to develop skills which will enable them to maintain a good quality of life.
Health and social care services contribute to reducing health inequalities.	Often those most affected by inequalities experience poor mental health and wellbeing – a cyclical pattern is evident where one issue exacerbates the other. By improving mental health and wellbeing, health inequalities can be both directly and indirectly reduced.
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.	The MHWS will link closely with carer support services to ensure that the specific mental health and wellbeing needs of carers are addressed
People using health and social care services are safe from harm.	The service will provide safe and effective care and support. It will be underpinned by trauma informed approaches which ensure people feel safe.
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 wellbeing will be promoted and a positive workplace culture will be established. Learning and development opportunities will be supported and encouraged.
Resources are used effectively in the provision of health and social care services.	By linking with established services and building on what is already available the new MHWS will avoid duplication and increase efficiency

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)	X
	4. Inverclyde Council and NHS GG&C	

8.0 CONSULTATIONS

8.1 Two service user focus groups were conducted in April and May enabling service user contribution to the early planning stages of the service.

8.2 Further engagement and development sessions will be carried out during 2022 with events proposed for GPs/ practice teams and also members of the wider community.

9.0 LIST OF BACKGROUND PAPERS

9.1 Mental Health in Primary Care Short Life Working Group Report

9.2 Primary Care Mental Health Models in Scotland

9.3 MHWPCS Planning guidance

9.4 Letter to stakeholders – indicative funding allocations

EINVERCLYDE INTEGRATION JOINT BOARD
DIRECTION ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

1	Reference number	IJB/27/2022/AM
2	Report Title	Mental Health and Wellbeing Service
3	Date direction issued by IJB	27th June 2022
4	Date from which direction takes effect	27th June 2022
5	Direction to:	NHS Greater Glasgow and Clyde only
6	Does this direction supersede, revise or revoke a previous direction – if yes, include the reference number(s)	No
7	Functions covered by direction	Primary Care Services Mental Health Services- Young People, Adult and Older Adult
8	Full text of direction	NHS Greater Glasgow and Clyde is directed to develop and implement the Inverclyde Mental Health and Well-being Service (MHWS) all as detailed in the report, including the appointment of the proposed 13 additional posts as set out in paragraph 6.3.
9	Budget allocated by IJB to carry out direction	Indicative allocation from Scottish Government 2022/23 - £156,876.54 2023/24 - £313,263.86 2024/25 - £631,746.06
10	Outcomes	As detailed in paragraph 6 of the report. The overall aim of the MHWS will be to provide a trauma informed, strengths based and recovery oriented service that takes in to account the circumstances (including determinants of health), goals, and preferences of services users. Taking in to account the social and psychological factors influencing mental health and wellbeing in a

Appendix 1

		primary care setting could help reduce the pathologising of normal human responses to difficult circumstances. The MHWS will offer support and specialist advice without the need for diagnosis first. The use of a trauma informed, recovery-oriented and strengths-based framework will support individuals to understand their mental health problems within the context of a psychological, social and situational narrative. Such an understanding will lead to empowerment and give control to the person seeking help while supporting them to set goals and respond effectively to difficult emotions.
11	Performance monitoring arrangements	In line with the agreed Performance Management Framework of the Inverclyde Integration Joint Board and the Inverclyde Health and Social Care Partnership. This Direction will be monitored and progress reported bi-annually.
12	Date direction will be reviewed	June 2023 and updates will be brought back to the IJB on a regular basis.

Appendix 2

REPORT OF THE SHORT LIFE WORKING GROUP FOR MENTAL HEALTH IN PRIMARY CARE

Scottish Government
Riaghaltas na h-Alba
gov.scot

27th January 2020

Introduction

1. The Scottish Government Mobilisation and Recovery Group (MRG) was established to support our 'Remobilise, Recover, Redesign Framework for Scotland'. Its aim is to ensure key expert, stakeholder and system-wide input into decisions on resuming and supporting healthcare service provision, in the context of the COVID-19 pandemic. The MRG sub group on Primary and Community Care highlighted the provision of mental health support as a key issue for primary and community services, supporting the parity of esteem between mental and physical health, as we emerge from the Covid-19 pandemic.

2. In response to this, the Short Life Working Group (SLWG) for Mental Health in Primary Care was commissioned and Terms of Reference can be found in Annex A. Its purpose was to consider "what good might look like" in terms of provision of mental health support within Primary and Community care settings.

3. Membership of the SLWG drew on a variety of geographical areas and specialisms and can be found in Annex A. At the outset of the group, a statement of intent (Annex B) was agreed between the Scottish Government, Royal College of General Practitioners and Royal College of Psychiatrists in Scotland, with input from the Royal College of Nursing. This described the ambition of the group – to agree principles and consider clinical models to deliver improved mental health capacity in Primary and Community care.

4. The Group agreed the following principles which should underpin service delivery for mental health in Primary and Community Care:

   - All parts of the system should enable support and care that is person centred, looking to access the most appropriate information, intervention and support in partnership with the individual through shared decision making. Trauma Informed Practice will be the norm. Wherever a person is in touch with the system they will be listened to and helped to reach the most appropriate place for them - there is no wrong door.

   - Primary Care mental health services should have no age or condition/care group boundaries, and meet the needs of all equalities groups.

   - Local systems will positively seek to address health inequalities, proactively engaging those that are less likely to access support.

   - Digital approaches to self and supported management of distress and mental health conditions will be an integral part of the service with the caveat that those who are digitally excluded need to be engaged positively in different ways.

   - Where support can be accessed to help an individual within the Primary Care setting in their own local area this should be the default. If referral to specialist services is required, then this should be straightforward and timely.

- People presenting in the Out of Hours period should have access to the full range of options available in hours, accepting some options may not be available immediately.

- The Primary Care Mental Health Services (PCMHSs) linked to a group of practices or a locality to serve a population needs to be developed and resourced to provide appropriate levels of mental health assessment, treatment and support within that Primary Care setting.

- Staffing levels within PCMHSs will be subject to, and compliant with, safe staffing legislation.

- Evidence based psychological therapies need to be offered, with appropriate supervision and stepping up seamlessly to secondary care mental health services where appropriate.

- The use of screening and clinical measures pre and post intervention is encouraged, as this can indicate efficacy of intervention as well as assist with triage to ensure people are seen in the right service as quickly as possible.

5. The group collated examples of Mental Health models that are in place across various board areas in Scotland, which demonstrate good practice – the evidence paper alongside this report. This gave the group an understanding of current mental health service provision in Primary Care settings, highlighted potential gaps and helped to inform recommendations setting out how services can be improved.

6. The group met four times between September and December 2020 and this report reflects its discussions.

7. In the context of this report “Primary and Community care” is defined as all services that provide healthcare in a local area. These are services that are usually the first points of access for people in the community who are seeking advice or help with a health concern. “Primary and Community care” is linked closely to the wider services and assets within the community such as social care and support, education, community groups, leisure opportunities, workplaces etc. All of which may have roles to play in supporting the wellbeing of the local population.

8. “Mental Health in Primary Care” or “Primary Care Mental Health” (PCMH) in this report refers to a community based response to the following issues:

- stress and distress, including the outcome of socioeconomic pressures and the consequences of complex trauma and adversity;
- emotional and relational difficulties;
- anxiety and depression;
- wellbeing; and
- mental illness.

9. Presentation with such issues is often multifactorial and frequently requires a biopsychosocial formulation and can include the following three factors:

    - A stressor (commonly relational, financial, or social difficulties) which the patient cannot manage within their usual resources.
    - A background history of exposure to adversity and trauma, often in childhood.
    - Limited availability of immediate, confiding social support.

10. Responding to these issues require a multifactorial approach, with the person at the centre. Early intervention especially with first line depression and anxiety can prevent difficulties escalating.

11. There is a considerable evidence base for psychological therapy in relation to presenting issues in mental health.

Discussion

Mental Health in Primary Care

12. General Practice are long-standing anchor institutions of their communities providing ongoing care for the mental and physical health across the whole lifespan. Practices provide universal, comprehensive and accessible care to all individuals offering continuity of care, particularly important for those who are socioeconomically disadvantaged, and oversee care from a range of service providers.

13. GPs are increasingly working as part of Multidisciplinary Teams (MDT) within their practice, based in the community or alongside specialist colleagues. The vast majority of patients are cared for in Primary and Community Care close to their homes, especially when supported by an MDT. To reduce stigma and encourage the creation of mental health communities, there has to be acceptance that the responsibility for Mental Health is for everyone and not only for specialist services.

14. GPs are usually the first port of call for people seeking professional help for mental health issues and the vast majority of mental health consultations occur in Primary Care, covering a diverse range of needs. Approximately 1/3 of GP consultations (c8million / year) have a mental health component. GPs may diagnose, treat and monitor the individual themselves or they may refer the individual to specialist services for further investigation, and / or treatment. People can present with mental health issues to other members of the General Practice team, however, this data is less formally captured.

15. The management of people who present with mental health problems in the Out of Hours (OOHs) period varies across health boards and their associated partnerships. A study has shown that people who present with mental health concerns have on average five contacts before they reach the most appropriate person in the OOHs period compared to physical health concerns which have on average two contacts. As OOHs is an urgent care service, the majority of these presentations will be in crisis. This means that timely and easy access to

secondary care services for all age groups is essential. It is imperative therefore that when considering people who present with mental health concerns in Primary Care, a 24/7 view is taken of service delivery.

Current Challenges in Service Provision

16. The range and complexity of mental health presentations in Primary Care do not all fit existing pathways of care. While GPs can refer to specialist services, those services may reject that referral on the basis that the condition does not meet the criteria for specialist care, or where people require mental health and substance misuse support, resulting in a referral back to the GP. This means GPs become the primary clinical support for individuals with complex needs that they are not always trained to deal with. Having only general practice involvement in this range of complex needs is unsatisfactory for the person and can have a high impact on GP workload, therefore looking to a multidisciplinary response will ensure the best outcomes for people. It is also important to have strong connections with secondary care mental health services in order to be able to "step up" treatment if needed, as seamlessly as possible.

17. Another concern for GPs is management of less complex mental health issues, often associated with other social stressors. This may require little clinical input and while that is important, it will not address the underlying issues. Links to alternative supports in the community, including social services, community groups and those services delivered by third sector organisations is vital for this group.

18. Patients with severe and enduring symptoms of mental illness need referral to specialist services for diagnosis, treatment and for advice about managing risk including those whose presentation is complex or for whom there is diagnostic uncertainty. They may also require ongoing access to support in Primary Care.

19. GPs are often satisfied with the response such patients receive once they have an established place in secondary care services. But any delay in assessment and care planning may lead to a significant reliance on unscheduled presentations, including to crisis and out of hours' services. Improved access to prompt scheduled care therefore has the potential not only to improve the patient experience, but also to reduce the overall resource burden on the system.

20. Specialist services also have an important role to play in providing peer-to-peer decision support for the care of people with complex illnesses in the community. This works best in areas that are able to invest in relationships between clinicians across the health and social care interfaces and where access is available to the electronic patient records such as Clinical Dialogue.

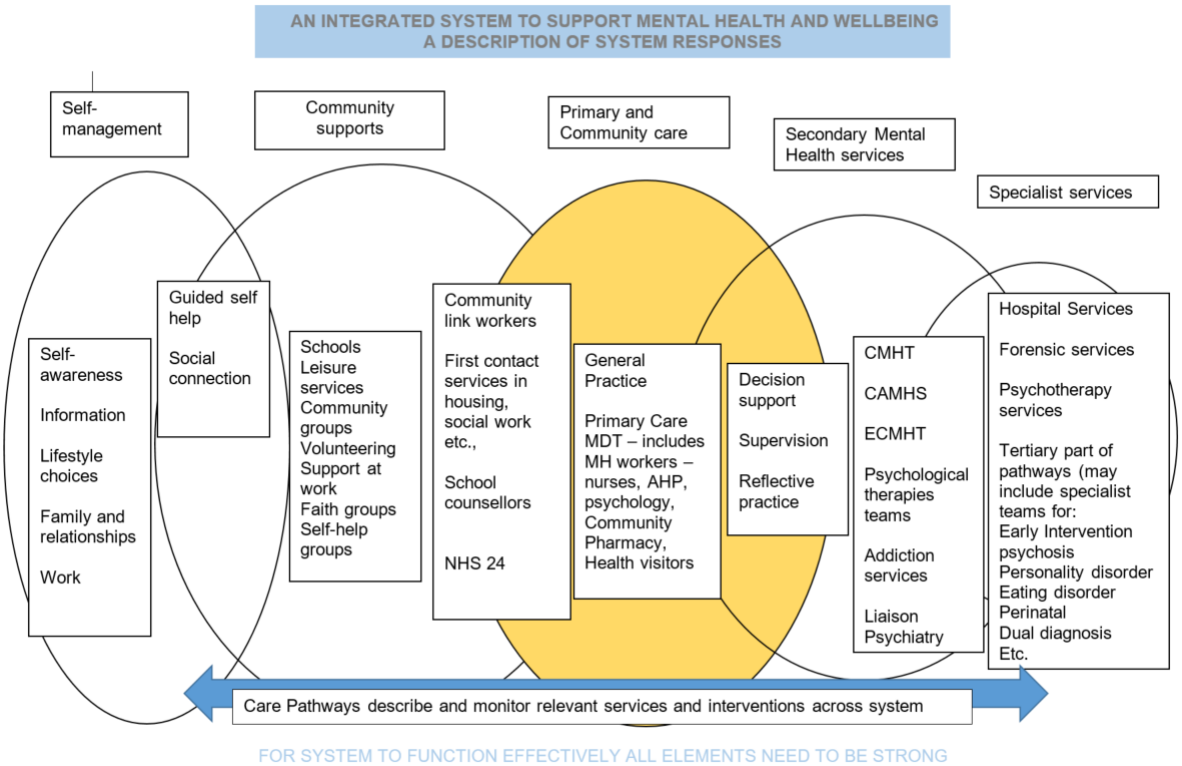
21. There are significant challenges with obtaining access to mental health specialist service provision for children and adolescents. Contributing factors to this include long waiting times and high levels of rejected referrals. Primary Care mental health teams that are able to offer crisis intervention and support to young people early in their journey, significantly limit potential future damage for young people and their families.

Where Primary and Community care fits into an integrated mental health care system

22. Primary and Community Care Teams have a pivotal role within an integrated mental health system and are key in developing and sustaining a system that supports the population with improved mental health and wellbeing. The services provided by such teams is necessary, but not sufficient: they depend on a wider system of care to function optimally. The Scottish Government Mental Health Transition and Recovery[1] plan sets out the range of areas where improvements are required to deliver an improved mental health and wellbeing service to the wider population.

23. An integrated system requires strength across all components, including public health messaging for the whole population, provision of information to assist self-management, third sector provision of community services and Primary and Community care as well as highly specialised aspects of care and treatment.

24. The role of Primary and Community care is central to this system, as illustrated in the diagram below:



[1] https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/

25. Primary Care provides support and care to the majority of those that seek help but also provides the link into secondary and more specialist services where required.

26. There is widespread recognition that the Primary Care part of the Mental Health system requires attention and development. A range of local initiatives have been supported through recent Primary Care Improvement Funding and/or funding via Action 15 of the Mental Health Strategy for Scotland[2]. Many of these initiatives to date are described in the evidence paper that accompanies this report. Further evidence can be found in '*Exploring Distress & Psychological Trauma'* research commissioned by NHS Greater Glasgow and Clyde[3] and '*Mental health and Primary Care networks - Understanding the opportunities'* a report published jointly by the King's Fund and the Centre for Mental Health[4]. These reports highlight both the concerns and the opportunities that exist to improve this aspect of the system.

27. Whist the distress/crisis response element within mental health is very important, it is part of the wider multi-disciplinary system and at the moment services are being developed in silos, without the overview of how different aspects of care and treatment will connect with each other. For the Primary Care team, it is really important that they can understand the system to navigate appropriately on behalf of their patients, with whatever form of mental health problems/symptoms they are experiencing.

28. This report and its recommendations focus on early clinical intervention by MDTs, supporting 'key priority 5' in the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards.[5] This priority requires that additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting. These additional roles should include community clinical mental health professionals (e.g. nurses, occupational therapists, psychological therapists and enhanced practitioners) based in general practice. The MoU envisages that "by 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. In line with the recommendations in this report, it provides for service configuration to vary dependent upon local geography, demographics and demand." Current system configuration/demands present significant challenges to implementation. This report seeks to describe the kind of system changes which would be required to make this possible.

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[2] Mental Health Strategy for Scotland

[3] Exploring Distress & Psychological Trauma - NHS GG&C Report

[4] Mental health and Primary Care networks - Understanding the opportunities

[5] Memorandum of Understanding between SG, BMA, Integration Authorities and NHS Boards

29. Below are examples of existing models demonstrating how mental health support services are integrated in Primary Care settings:

30. In Lanarkshire, Occupational Therapists (OTs) are working in Primary Care settings offering open access appointments to patients requiring prevention and early intervention solutions. This enables patients to self-manage their condition and build resilience. OTs are skilled in assessing components of everyday occupations and roles that matter to people, identifying the impact of development, physical and mental health conditions on these occupations and devising intervention plans to enable people to overcome such impacts and engage fully in their day to day lives. OTs use scientific bases, and a holistic perspective to promote a person's ability to fulfill their daily routines and roles.

31. Mental Health Liaison Nurses are also used in Lanarkshire, providing triage, assessment and short term intervention to people experiencing mild to moderate mental health problems of a short term nature.

32. In Lothian, Dumfries & Galloway and Lanarkshire, Mental Health Nurses have been recruited to meet the needs of patients with mild to moderate mental health difficulties. Their interventions consist largely of clinical advice/triage, crisis management, case management of those with complex mental health needs, general psychological support, brief intervention, treatment for addiction, independent prescribing and signposting to local services. In Lanarkshire, they have built on this to develop a stepped/matched Mental Health & Wellbeing Service model, using Action 15 funding. It has continued to expand, with the service being rolled out to 40 GP practices.

33. In Ayrshire and Arran, they are increasing mental health provision within Primary Care Teams/Clusters by embedding Community Link Workers and Mental Health Practitioners within Primary Care Teams to assist with sign-posting, access, and provision of time limited interventions. They have seen great value in having Mental Health and Psychological Therapy aligned with Primary Care.

34. In Grampian and Lanarkshire, the Accessible Depressions & Anxiety Psychological Therapies model increases access to psychological therapies and interventions in Primary Care adult mental health and develops the specialist mental health workforce in secondary care. This is achieved through expanding the competencies of the existing workforce to deliver the most effective treatments, developing Primary Care Teams with multiple disciplines and providing guidance and support on the model of service delivery. This enables cost-effective stepped care, patient choice, quality assurance and increases capacity.

35. In Fife, a comprehensive matched care model offers a wide and flexible range of early intervention, self-help, groups and one to one psychological therapy including integrating web based, remote and face to face interventions.

36. In Scottish Borders, a recent development is a partnership between GPs/Primary Care and Mental Health utilising funding from PCIP and Action 15.

This is a collaborative Primary Care service that is currently operating completely remotely, offering a wide range of interventions.

37. The most important common factor is that each of these approaches are moving towards a reframing of the 'task' for Mental Health and support workers in Primary Care settings. The traditional model prioritises triage and diagnosis, with a view to identifying people who will be accepted for care by specialist Mental Health services on the basis of 'mental illness'.

38. A more useful model in Primary Care settings is a prompt and compassionate response to all forms of distress, which is provided at a local level using community assets and peer networks wherever possible. Specialist Mental Health input must be available whenever indicated, but should not be the default response for all presentations.

39. Other common factors in the success of these services are:

- Where available, regular reflective practice (or other wellbeing support) to deliver a sustainable, timely and compassionate mental health service.
- Taking a person centred approach to meet the needs of the person in a timely way.
- Integration with digital/remote Primary Care mental health and wellbeing resources, increasing access to resources such as NHS inform, interactive self-care guides, NHS 24's 24/7 mental health hub, Breathing Space crisis line and computerised CBT.
- Alignment with Primary Care and the use of the wider multi-agency team.
- Close linkage with Social Work and addiction services in the locality.
- Raising GP Awareness about the role and availability of the wider multi-agency team.
- Providing continuity of care.
- Highlighting the importance of providing training, standardised operational procedures and opportunities for feedback.
- Increased GP cluster working.
- Integration of psychological therapy pathways, reflective practice, training and supervision.
- Utilising a stepped/matched care model of evidence based treatment. Fidelity to an evidence based model has been shown to consistently improve outcomes.
- Access is available to the electronic patient records.

40. These factors have resulted in people accessing the correct support quickly, leading to better outcomes for them. This in turn leads to a reduction in GP, GP Practice and clinical attendance rates.

Proposals, Recommendations and Principles

Proposed Model

41. Within an area served by a group of GP practices (this could be a locality, part of a locality or a cluster area) there should be a multi-agency team providing assessment, advice, support and some levels of treatment for people who have mental health, distress or wellbeing problems. The multi-agency team may include Occupational Therapists, Mental Health Nurses, Psychologists, Enhanced Practitioners, Link Workers as well as others such as those providing financial advice, exercise coaches, family support and peer networks.

42. That team would provide assessment and support to the individual to access appropriate levels of advice, community engagement treatment or care – some of which would be delivered within the Primary Care setting, depending on the skills and capacity of the team.

43. The team would work closely with and / or be part of the wider community team in that area, engaging with the wider assets of the community, health and social work staff and with other agencies as appropriate.

44. Although the team would be aligned to a group of GP practices, there should be named members of that team that work closely with each individual practice to provide continuity and allow the development of effective clinical or multidisciplinary team relationships.

45. Practice systems should allow patients to be directed to an appointment with the appropriate members of the MDT based on self-directed care, including self-referral. This option should be publicised and communicated to the practice population.

46. The team would provide timely support and treatment for people in that setting with the GP providing clinical leadership and expert general medical advice where needed. Where more specialist input is required the resources of Community Mental Health Team or other appropriate secondary care Mental Health service would be accessed and work in partnership with the Primary Care team where appropriate (e.g. shared care around medication).

47. The team should have members that are trained in mental health and may be drawn from mental health nursing, clinical psychology or Allied Health Professional (AHP) disciplines. The team should also have members or close links with other staff with relevant expertise and experience e.g. Community Link Workers, Addiction Services, Health Visitors, Health Improvement staff and financial inclusion teams.

48. The SLWG recognises that the use of terminology can be a source of confusion about what we are trying to achieve. The terms Primary Care multidisciplinary team or locality multidisciplinary team have different connotations for different professional and geographic groups. Rather than seek to ‘name this model’, the SLWG has sought to describe the function which local areas can name as appropriate.

49. A critical part of this approach will be a local communications strategy to inform local populations about how they can access services. Tools may range from social media channels, website updates and local newsletters, posters, flyers.

Proposed benefits

50. The Group suggest that this approach would realise a number of improvements that would benefit both individuals and practitioners. An enhanced range of service provision, embedded within a range of wider community assets would mean individuals can be better, and more quickly, connected to the support that meets their needs in the right settings. This will also support more efficient and targeted use of resources across a local area. Better communication across service providers will improve early intervention, continuity of care and better support self-management. The Group also considers that such a model would potentially reduce referrals to specialist services while also improving support for those who do and ensuring it is delivered promptly.

Proposed next steps

51. To further develop this approach, initial work should be undertaken to establish the baseline by identifying the level of support currently available in teams across Scotland, however, they are currently named and described. Posts in the Primary Care setting funded through Action 15 or the Primary Care Improvement Fund should be considered, and any opportunities to further expand capacity through those funds should be supported and encouraged.

52. A needs analysis should be conducted to scope the need for expansion of such a team/service. The expansions should be funded through a proposed Primary Care Mental Health (PCMH) development fund that will be jointly managed through the mental health and Primary Care planning processes within Health and Social Care Partnerships (HSCPs).

53. The development of an asset-based community development should be a collaborative one, led by HSCPs as part of Integration Joint Boards (IJBs) strategic commissioning plans. Local communities and 'experts by experience' should be fully engaged in this. As a minimum, local GP sub-committees, HSCPs, locality management, mental health service leads, psychology leads, interfaces with schools and third sector interface structures should be part of this collaborative approach.

Recommendations

54. To support the implementation of 'the model' described in this paper, the SLWG recommends the following:

- **Recognise the central role of Primary Care** within the Mental Health system and of MH & WB within Primary Care. This should be a priority for development within the MH Services Renewal Plan and also the revision of the GP Contract MoU (through further definition of MH as an "additional role"

for expansion and development). In developing PCMH capacity to deliver a 24/7 service, the principles that we have set out above should be followed.

- **Review existing additional role developments** in PCMH, such as those funded under Action 15 of the Scottish Government's Mental Health Strategy or through Primary Care Improvement Plans (PCIP). This work should be led by a newly established **Development Group**. There should be a partnership between the MoU/PCIP process and the MH planning process at local level with objective of maximising PCMH capacity along the lines of the model described in this paper.

- The same Development Group also undertake a "**gap analysis**" to scope workforce and resource requirements associated with providing a 24/7 service with a view to implementing a **funded PCMH development programme** in 22/23 and thereafter. This should include a plan for monitoring impact of this approach going forward.

- The Development Group would also promote implementation of robust systems to deliver **peer-to-peer decision support between community and specialist services and within Primary Care mental health services** to ensure patients are receiving the best care, from the most appropriate staff, irrespective of where they present in the service.

Annex A

Mental Health in Primary Care Short Life Working Group

Terms of Reference and Membership

1. **Background**

Approximately 1 in 4 people experience a mental health problem at some point in their lifetime and at any one time approximately 1 in 6 people have a mental health problem. Early evidence suggests mental health problems will increase following the Covid pandemic with a disproportionate effect on younger people, women and that a widening of already existing inequalities is likely.

The vast majority of mental health and wellbeing issues can be managed appropriately in the community with self-management, community assets, third sector, primary, community care and specialist mental health services all having a part to play. This can only happen if there is capacity across all parts of the system to support management of problems in a timely way

Approximately 1/3 of GP consultations have a mental health component and this constitutes a significant workload within practice settings. While some people need to access secondary care mental health services, many do not and the limited capacity of specialist services can lead to limits on access through waiting times and rejected referrals.

The Short Life Working Group (SLWG) will set out to describe what an improved range of options in the Primary and Community care settings might look like and how these could be achieved

2. **Purpose**

These guidelines are intended to provide clarity and direction to the activities of the SLWG. They can be revised and amended as necessary once the work is underway.

The overall purpose of the SLWG is to improve outcomes for people with mental health problems and distress within the Primary and Community Care setting.

The expectation is that the final document will be issued within four meetings.

3. **Working Group**

Remit

The SLWG will provide a vision of how mental health care could be delivered better in Primary Care and in localities.

The SLWG will review the models currently in place, identify commonalities/success factors and produce a report with actions, suggesting

how these models could be implemented by health and care systems across Scotland.

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4. Method

- **Meeting 1**
  Discuss consensus statement and invite comments by next meeting.
  Discuss evidence paper and strengths/gaps in evidence.

- **Between meeting 1&2**
  Shape consensus statement into a vision.
  Collate additional evidence submitted around models.
  Skeleton report of output.
  Brief Ministers and other relevant stakeholders.

- **Meeting 2**
  Discuss and if possible agree vision.
  Discussion of evidence and describe an agreed model or models.

- **Between 2 & 3**
  Adjust vision.
  First draft of a report with vision, what works and initial estimates of workforce/resource requirements.

- **Meeting 3**
  Discussion of first draft report.
  Discussion about implementation and how that might be managed.

- **Between 3&4**
  Redraft of report to reflect group inputs.
  Draft implementation plan.

- **Meeting 4**
  Final report signs off.
  Discuss implementation plan and agree any next steps.
  Sign off the work of the group and hand over to those tasked with implementation.

5. Timescale

The SLWG will meet monthly or as necessary and agreed by the membership. The first meeting of the group will be Thursday 24th September 2020.

6. Communications

The Scottish Government will co-ordinate communications. There will be a formal minute recorded of each meeting which will be circulated to the members of the group. In this regard, progress updates on the activities of the Working Group will be translated into lines for communication and cleared by Scottish Government and issued to stakeholders for further dissemination.

Public Mental Health and Primary Care
Scottish Government
10 September 2020

Annex B

Mental Health in Primary Care Short Life Working Group

Statement of Intent

1. Background

   Approximately 1 in 4 people experience a mental health problem at some point in their lifetime and at any one time approximately 1 in 6 people have a mental health problem. Early evidence suggests mental health problems will increase following the Covid pandemic with a disproportionate effect on younger people, women and that a widening of already existing inequalities is likely.

   The vast majority of mental health and wellbeing issues can be managed appropriately in the community with self-management, community assets, third sector, primary, community care and specialist mental health services all having a part to play. This can only happen if there is capacity across all parts of the system to support management of problems in a timely way

   Approximately 1/3 of GP consultations (c8million/year) have a mental health component and this constitutes a significant workload within practice settings. While some need to access secondary care mental health services, many do not and the limited capacity of specialist services can lead to limits on access through waiting times and rejected referrals.

   The Short Life Working Group (SLWG) will set out to describe what an improved range of options in the Primary and Community care settings might look like and how these could be achieved.

2. Aim

   To improve outcomes for people with mental health problems and distress within the Primary and Community Care setting.

   By

   Providing a vision of how mental health care could be delivered better in Primary Care and in localities, suggesting models that could be implemented by health and care systems across Scotland.

   Possible elements of that vision:

   That enhanced services within Primary and Community care sit within a wider system that emphasises the value of self-management, access to community assets and linkage to specialist services where required

   That by enhancing access to mental health expertise and resources within the Primary Care setting we will:

- Improve the experience of support and care for those currently already managed in Primary Care through more rapid access to support, within a team that they know and trust, using a shared Primary Care clinical record.
- Reduce the referral burden to specialist services, allowing quicker access to specialist help for those that need it.
- Improve the outcomes for patients through earlier intervention and support.
- Raise awareness and confidence within the wider Primary Care team to support people with their emotional needs.
- Build interfaces with local specialist mental health services (for example, to offer clinical decision support, to plan discharges).
- Build interfaces with local schools, and work collaboratively to support the mental health needs of young people with a common approach and language.
- Support and enable 'reflective practice' for all clinicians managing mental health issues, to sustain compassionate practice and reduce professional burnout.
- Ensure that there is capacity to deliver CBT and other initial talking therapies to support patients with mental health conditions such as anxiety, depression and adverse trauma experience and that this can be accessed directly (face to face or digitally) from Primary and Community care or through self-referral.

This will be achieved by embedding mental health professionals, support workers and others with appropriate skills into Primary Care multidisciplinary teams within clusters or localities. Their role will be to directly assess and support people presenting with mental health problems and distress but also to support the wider Primary Care team in managing mental health problems.

Assessment, advice, support or intervention needs to be tailored as appropriate to the person and a range of skills, expertise and knowledge should be available within the team (or easily accessed by the team) to maximise the options available for individuals and facilitate person-centred care.

Mental health workers in the Primary Care team need to be able to directly access advice, support or make referrals to specialist community mental health teams (CMHTs), psychological therapies (virtual and face to face, individual and group), and Distress Brief Interventions (DBI).

Mental health workers within the Primary Care team would work closely with community link workers (CLWs), peer support workers and third sector and voluntary groups to maximise the assets of their local community.

Depending on the mental health resource and expertise available in the team, there would be the potential for training opportunities for practice based staff, community pharmacists and for all others within the cluster or locality (for example case-based discussion, PLT sessions).

Mental Health workers would support GP practices in the management of acute and ongoing mental health and addiction issues and engage with other community resources to achieve this.

The SLWG is tasked with using the expertise of those on the group to agree the vision and illustrate how this could be implemented by citing examples of good practice, and sharing the available evidence base. The group will also make recommendations about workforce that would be required to support implementation of these models and how that might be deployed.

Drafted with input and comments from Carey Lunan and Miles Mack, RCGP, Linda Findlay, RCPsychiS and Alastair Cook, PMO Mental Health

22/09/20

Appendix 3

Primary Care Mental Health Models in Scotland

December 2021

Scottish Government
Riaghaltas na h-Alba
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Introduction

The purpose of this paper is to outline some of the Mental Health models that are in place across various board areas in Scotland, which demonstrate good practice, and seeks to draw out some of the commonalties and success factors from them. This is not an exhaustive list and the intention is for this to be a live document which can grow to include other examples that Members would like to add. This will give us an understanding of current mental health service provision in primary care settings, where there are potential gaps and help inform recommendations on how services can be improved.

From the models of good practice sourced so far we have gleaned a number of **success factors** and potential impacts that are common across all models cited.

These are:

- Regular reflective practice (or other wellbeing support) is an essential part of being able to deliver a sustainable, compassionate mental health service;
- integration needed with digital/remote primary care mental health and wellbeing resources, such as the health, wellbeing, and mental illness content on NHS inform, interactive self-care guides, NHS 24's 24/7 mental health hub, the Breathing Space crisis line, computerised CBT, telephone CBT, telephone interpersonal counselling, and the various specific digital therapies available through SIlvercloud, Sleepio. These can improve access and reduce clinician time;
- many models are GP Practice based and all use the wider multidisciplinary teams (MDTs);
- some of the models have identified the need to raise GP Awareness about the role and availability of the wider MDTs;
- a skilled assessment at the point of presentation is crucial to the quality of the overall patient experience;
- continuity and a joined up service needed;
- reduction in GP and GP Practice attendance rates;
- some highlight the benefits of no referral system or discharge. MDTs are able to directly access advise and support;
- request for assistance model used in Allied Health Professionals (AHP) Children and Young People services and has shown to promote shared responsibility and decision making;
- all of the models highlight the importance of providing GP teams and wider primary care multidisciplinary teams with training, standardised operational procedures and opportunities for feedback;
- the models highlight the benefits of cluster working; and
- the models bring training opportunities for practice based staff.

As part of the next iteration of this report these factors will be further expanded to provide more detail.

The following sets out a brief summary of the models so far sourced in primary care:

Patient Assessment & Liaison Mental Health Service (PALMS) – Tayside

PALMS was launched in February 2019 in Dundee. The purpose of the project was to enable access to a within-GP practice Mental Health Specialist (MHS) with the outcome being that assessments carried out by MHSs should allow patients access to the most appropriate mental health support through referral/more tailored signposting, whilst also helping to reduce GP workload.

Funding of the project allowed embedding of two Band 8a 0.5 WTE clinical/counselling psychologists into two Dundee-based GP practices. Each of the clinicians held regular 5 sessions a week within the respective practices.

The inclusion criteria was patients 16-64 years old and the pilot was designed to encourage self-referral. As part of this posters and leaflets were added to waiting rooms and adverts added to the practice website. Reception staff, GPs and other clinical staff were provided with flowcharts to guide them on identifying suitable patients for the PALMS service.

Each appointment lasted 30-60 minutes, depending on severity of presentation, and took place in one of the medical centre consultation rooms. Through assessment the MHS considered whether accessing MH/support services would be appropriate and by what method this would be best achieved. Direction of referral/signposting was based on factors such as nature of difficulties, severity, and level of impairment. The MHS role also extends to providing information on mental health coping strategies and self-help material, signposting to local community support services and, if appropriate, making referrals to specialist NHS services for further treatment.

Evaluation:

- GP feedback was highly positive and indicated that consultancy with MHS was valued;
- for reception staff involved in triaging telephone calls and making PALMS assessment appointments, the perception was that this did not cause their roles to become more challenging;
- the PALMS pilot appeared to provide support towards increased MDT;
- significant reduction in re-presentations for mental health consultations four months after PALMS assessment indicating workload for GPs may have decreased in this regard;
- non-referral routes were the most common post-assessment outcomes for patients, followed by referrals to other NHS/non-NHS services; and
- Primary care psychology (NHS) was the largest recipient of referrals that were made. This would fit with severity of presentation, the majority of which were within mild-moderate category.

Data indicated the requirement for 1 session per 2,000 patient population. It also highlighted the need to move towards cluster based working with the view of each practice not having physical space to accommodate the PALMS service. The pilot indicated the best way of moving forward is having a Band 8A responsible for each of the clusters with a number of Band 7 Clinical Associates in Applied Psychology/ Psychotherapists and Band 6 Mental Health Nurses in post.

Occupational Therapy (OT) in Primary Care - Lanarkshire

OT clinicians are skilled in assessing the components of everyday occupations and roles that matter to people, identifying the impact of developmental, physical and mental health conditions on these occupations and devising intervention plans to enable people to overcome areas of dysfunction and engage fully in their day-to-day lives. Funding from the Scottish Government supported the recruitment of two 0.6 whole time equivalent (WTE) Band 7 OT Advanced Practitioner posts to an 18 month secondment opportunity which commenced in October 2017.

The OT service accepted referrals from all of the GP practice team for registered patients aged 16 and over who identified issues arising from mental or physical ill health which related to their occupational performance and/or environment. All those referred were contacted by telephone within two working days and triaged in order to establish patient need, confirm appropriateness of referral to OT or need for alternative intervention/service, and offered an initial assessment appointment.

Depending on need, patients engaged in a brief intervention (1-3 contacts) or an episode of care (4+ contacts). All contacts were recorded in GP Vision. Written and verbal feedback was also provided to GP teams and health and social care providers. The OT service was located within the GP practice. Telephone triage within two working days and initial assessment within two weeks enabled patient need to be met ‘at the right time’ and ‘in the right place’.

Educating GP clinical teams at the start of the test combined with a consistent OT presence, feedback from patients and OT use of Vision electronic records increased GP team knowledge about what OT is able to offer. As a result GPs made fewer inappropriate referrals. This highlights the importance of providing GP teams and wider primary care multidisciplinary teams with training, standardised operational procedures and opportunities for feedback.

Educating reception staff is key to enable them to confidently triage patients to OT as a first point of contact. To date limited protected learning time to train reception staff and the challenge of developing a simple algorithm for reception staff to follow in order to triage relevant patients to OT has prevented this.

Evaluation:

- The test concluded that OT service provision in primary care requires a range of qualified and support staff to meet patient need including Band 7 Advanced Practitioners, band 5 and 6 clinicians, band 4 support staff and administrative support;
- the OT service has increased primary care capacity to manage patients, reduce onward referrals to secondary care services and reduce uptake of social care and sickness benefits, whilst improving health outcomes;
- measurable benefits were recorded for patients in terms of improvement in their occupational performance and quality of life;
- GPs reported a notable reduction in attendance rate;
- GPs valued having direct access to OT through co-location in the GP practice;

- inclusive criteria enabled patients with multiple co-morbidities, whose mental or physical health resulted in reduced occupational performance, to have access to a streamlined service; and
- the test highlighted that GPs lack of awareness about the role and availability of OT services and this had a negative impact on patients' access to OT.

Craigmillar Medical Group – Mental Health Model - Lothian

As GPs working in an area of high deprivation, the prevalence of mental health issues is very high, across all ages. The practice estimates that mental health issues were discussed in around one third to one half of all our GP consultations. Previously all mental health workload was managed by the GPs – or referred on to local voluntary/third sector organisations or specialist services, with varying levels of engagement.

Craigmillar Medical Group have recruited a team of three primary care mental health nurses, (one lead nurse – band 7; two nurses in training and development posts – band 5). The team see a large number of young people, from the age of 12, referred internally from the GPs. They are contacted quickly by telephone and offered an appointment after school. Common issues discussed are social anxiety, gender identity, self-harm and peer pressure issues (drugs, alcohol etc.).

Their interventions consist largely of crisis management, general psychological support and signposting to local services. A very small percentage of patients are referred on to Child and Adolescent Mental Health Services (CAMHS).

Evaluation:

- Around 400 referrals in 6 months. High DNA rate for appointments – team responded by initiating phone triage / consultation both as initial assessment then follow up. About to have a drop-in session by invite – where all of the team will see patients who attend;
- they are based within the GP practice so access is less intimidating;
- 30 minute appointments;
- the practice uses a triage system to meet needs, including having a care plan with a named clinician (GP, PN or MHN) for those in the top tier of need. Trauma informed discussions take place to discuss care needs with patients in a proactive way and there are 4-weekly meetings to discuss cases;
- reception staff are now called Care Co-ordinators and they all look after a cohort of patients so they develop relationships and know them well;
- the whole team has undergone team building and profiling so they know and respect each other's 'type', particularly helpful when having difficult conversations as it makes it less personal;
- they offer a primary care model of mental health provision; no formal internal referral system, rapid access to appointments, shorter and more frequent appointments, no "discharge" from the service;
- they are often already known as healthcare professionals to patients' families (often parents) therefore less stigma, more trust;

- they focus on de-medicalising social issues (estimated 99% of referrals are for mental distress and not mental illness); and
- quality assurance is maintained through regular case discussion, joint consulting and good access to specialist decision support.

ADAPT – Accessible Depressions & Anxiety Psychological Therapies (Grampian & Lanarkshire)

ADAPT was developed by NHS Education for Scotland (NES) and aims to double access to psychological therapies and interventions in primary care adult mental health and to develop the specialist mental health workforce in secondary care. This is achieved through:

- Expanding the competencies of the existing workforce to deliver the most effective treatments;
- increasing the workforce in primary care and providing training, supervision and consultation for the new primary care mental wellbeing workforce associated with Action 15 and the developing Primary Care Multidisciplinary Teams;- and
- providing guidance and support on the model of service delivery that enables cost-effective stepped care, patient choice, quality assurance and increases capacity.

The model draws upon the Increasing Access to Psychological Therapy (IAPT) services in England which demonstrate clinical recovery from anxiety and depression in 50% of people treated and see over 1 million people per year. Adjusting this model for the Scottish context to take into account the workforce commitments in the Primary Care Services Policy and the Mental Health Strategy a 'scalable' ADAPT team would comprise of; Clinical Lead 5%, Psychological Therapists 55%, Psychological Practitioners 25%, Link Workers 10%, and admin support 5%. It is suggested that the minimum ADAPT team size is 10 WTE.

- Clinical Lead provides leadership, governance of service, clinical supervision and psychological therapy.
- Psychological Therapists (e.g. specialist nurses, clinical psychologists, clinical associates and AHPs) provide assessment and therapies such as Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT), Mindfulness-based Cognitive Therapy (MBCT).
- Enhanced Psychological Practitioners (e.g. AHPs, nurses, psychology graduates, other caring professionals) conduct structured assessments and provide brief psychological interventions; such as Guided CBT, Behavioural Activation (BA), Motivational Interviewing (MI) and groups interventions.
- Link Workers & Welfare Advisors provide signposting to community services, psychological informed care and support groups.
- Admin staff provide a first-line contact and ensure the efficient administration of the team's caseload, support the patient pathway, and facilitate data recording and reporting.

Staff are trained in the competencies to deliver evidence based psychological therapies and interventions. Staff in the multidisciplinary primary care team whose role is not primarily to provide psychological treatment, can be upskilled in the competencies required to provide interdisciplinary care.

Staff could have access to NES training programmes including; psychological therapies, specific enhanced psychological interventions and the Enhanced Practitioner Programme.

NES has considerable experience in providing comprehensive education and training programmes in evidence based psychological therapies and interventions to support the provision of match stepped care in mental health services. These link with the NES training programmes for other practitioners working in Primary Care. The NES work-based national training programmes aims to build multidisciplinary capacity within all the NHS boards and partnership organisations across NHS Scotland, to provide psychological therapies and interventions within adult mental health services. This means implementation of expansion in services will involve close working with key national networks e.g. Heads of Psychology Services Scotland (HOPS). NES can provide education and training to support the ADAPT service model including the Clinical Doctorate, MSc in Primary Care, Diploma in CBT, and short training programmes. The Enhanced Practitioner Programme is a new training programme and would represent significant expansion at this level.

Evaluation:

- The pilot provided accessible, effective, person centred, integrated care in primary care settings in Lanarkshire and Grampian;
- training in adapting Cognitive Behavioural Therapy for common LTCs resulted in significantly higher knowledge, confidence and evaluated positively by staff, patients and service managers; and
- clinical outcomes included highly statistically significant improvements in depression, anxiety, quality of life and progress towards healthy lifestyle goals.

<u>Primary Care Mental Health (PCMH) Service - NHS Dumfries & Galloway</u>

The PCMH Service was initially piloted in 4 GP practices in Dumfries and Galloway for 12 months from mid 2017. Following a successful evaluation of the pilot collaborative work began with the GP cluster leads to develop and begin rollout of the service in early 2019.

The model now see’s 13 experienced Mental Health Nurses based in general practice across the region. Sessions have been allocated at GP practice level based on GP population size. People can access the service via the individual triage system within each practice and appointments are booked via the electronic GP system. There is no requirement for people to see the GP or Advanced Practitioner (AP) prior to seeing the Primary Care Mental Health Nurse (PCMHN), thus assisting in reducing GP workload and streamlining pathways.

The service offers mental health triage, assessment, brief interventions, assisted self-management and appropriate signposting for those with mild to moderate mental health issues. The approach aligns itself to the Scottish Governments 2017- 2027 Mental Health Strategy as the focus is on ease of access, early intervention and self management, as well as early identification of more serious mental health issues.

The service uses a multi-disciplinary/multi-agency approach facilitating timely onward referral to other agencies and the wider mental health services where appropriate, ensuring people are seen by the right person at the right time. Active participation with family and Carers is encouraged, recognising the contribution Carers make to an individuals' recovery.

Each PCMHN is aligned to the locality CMHT, operational responsibilities; clinical supervision and training are jointly supported by GPs and CMHTs. This arrangement ensures the PCMHNs receive adequate support, are skilled and confident to carry out their work and quality is developed which supports performance. It maintains the connection with secondary mental health and has improved links and consistency between Primary Care and secondary Mental Health Services.

Covid-19 has moved work towards reduced face to face contacts with more consultations taking place via telephone or NHS Near Me. Remote working has afforded the ability to provide cover across practices and localities to respond to staff absence. So far, feedback from people offered telephone or NHS Near Me appointments has been that this provides the support required and they feel comfortable with this.

Evaluation

Local research study carried out with the GPs identified the PCMH service reduced GP workload and provided capacity for them to focus on the more complex patients, leading to a reduction in GP stress levels. The study highlighted that early assessment and intervention by a skilled specialist provided more effective non-pharmacological management of people with mental health difficulties, thereby reducing prescribing.

PCMHNs were viewed as a resource to educate, support and advise the primary care team, co-location was felt to support delivery of a collaborative approach to person centred care; enabling sharing of knowledge/understanding and building relationships. Joint working between PCMHNs and pharmacists on antidepressant reviews has been welcomed.

Patient/carer feedback (qualitative surveys) has been extremely positive across the region. Core 10 and GIS were used to score patient outcomes on perceptions of their mental health, connections to family, community and social groups. 50% of patients achieved their personal outcomes, 22% were signposted to other appropriate services/agencies, 10% disengaged (18% had an unidentified outcome).

Referrals to secondary services, e.g. CMHT, Psychology, have been dealt with effectively and efficiently, ensuring people see the right person at the right time.

Compassionate Distress Response Service – NHS Greater Glasgow & Clyde

The Compassionate Distress Response Service was commissioned late 2019/early 2020 from Glasgow Association for Mental Health (GAMH) which started providing an out-of-hours (5pm – 2am, 7 days) service by telephone during Covid-19 lockdown from late May 2020. The service is for people aged 18+ resident in Glasgow City who are emotionally distressed and require support but do not require medical or specialist psychiatric assessment.

Distressed people are referred to the service from statutory services, including first responders, GP Out of Hours, Out of Hours CPNs, NHS24, A&E and Mental Health Assessment Units, Urgent Care Resource Hub, etc., provided they have capacity to engage and consent to do so. The service gives 'listening' support to each individual via telephone (this will also be face to face and outreach when appropriate post-Covid), provides support to develop a plan of action to alleviate their distress and onward referral to appropriate support services for each person accessing the service. People who are referred to the service should receive a call within an hour of referral for immediate support and receive a follow up phone call the following day. The case is kept open for a month, or more in some circumstances.

Initial feedback from this research supported the need for in-hours provision for general practice referrals and this service commenced in September 2020.

The Jigsaw Project - NHS Greater Glasgow & Clyde

The Jigsaw Project was established in the Drumchapel GP Cluster, funded as part of the NHS GG&C Primary Care Mental Health Transformation Fund bid to the Scottish Government.

The project aimed to consider, better understand and help find solutions for people who experience longer term mental health difficulties who were not well-served by existing arrangements. The project also helped to raise awareness of other community supports which help improve mental health and a directory of these was produced for each locality to assist GPs to direct patients to these.

The voice of people with lived experience ran throughout the project, alongside those of GPs and their teams (regarding managing their own mental wellbeing as well as that of their patients). A Jigsaw tool kit was developed to engage with the community to identify problems and solutions, and these 'jigsaw lids' helped illuminate wider perspectives on the issues. The project also provided seed funding to local groups to develop solutions to poor mental health.

Mental health services were seen to rely too heavily on GP practices to support those whose needs were not being met, which impacted on their stress levels and mental wellbeing. The study found some evidence of GPs negatively affected by their workload around mental health and the challenges of negotiating the system and, although preserving non-clinical space within the diary was one of the successful approaches to avoiding burn out, most felt they were operating at the full extent of their resilience. Mutual support has improved across the cluster and active

support such as Mindfulness Based Stress Reduction training and yoga practice have supported this within primary care.

Evaluation:

The project highlighted the different ways of working amongst the public and Third Sectors but also the importance of continuing the dialogue and looking at solutions to improve communications, understanding and service delivery to better meet the needs of local people.

Initial data suggests that a significant proportion of those referred to mental health services are not accepted for treatment by the CMHT, but are directed to the PCMHT, Third Sector providers or back to the GP. This may be due to inappropriate referrals, lack of capacity or other issues but this perhaps suggests that better communications between GPs and mental health services (around what is and is not an appropriate referral) and a single point of entry to mental health support – of all kinds – would assist in ensuring patients receive the support they need.

The Govan SHIP Project - NHS Greater Glasgow & Clyde

The Govan SHIP Project was established in 2015 to provide additional resources within primary care to enable a more effective response to the challenges faced by health and social care professionals in deprived areas. The project was prompted by work of the Deep End Group and funded by the Scottish Government Primary Care Transformation Fund.

The project focussed on person-centred care delivered by MDTs, creating capacity for GPs to support more complex patients and understanding demand for health and care services at GP practice level. One part of the project focussed on mental health as more deprived areas have a higher incidence of mental health issues and there was a professional perception that mental health support services were not being accessed by those most affected and in need of support. The work involved consultation with a variety of key players: GPs, CLPs, wider primary care team, social work, PCMHTs, CMHTs, Lifelink, SAMH, GAMH, the Health and Social Care Alliance amongst others. Work was done to develop a better understanding of the type of mental health concerns presenting to primary care. Fresh data was gathered by reviewing GP consultations which had substantive mental health components and an audit of outcomes of referrals to mental health support services.

It was found that 20% of patients attended with a mental health issue, primarily (74%) with depression, anxiety, low mood or stress - a significant proportion (72%) were on medication (mainly antidepressants) to assist with this but were not linked into additional support services, although most had been referred/engaged previously. Overall, less than 20% of patients referred to PCMHTs and CMHTs received treatment, raising questions around processes. The study found that the way in which mental health concerns were responded to by different practitioners was inconsistent, there was not a shared understanding around the definition of mental health needs, and current support services were challenging for both

referrers and patients. This suggested a need for clearer pathways, guidance and consistent practice.

Evaluation:

- Further analysis of referral outcomes to mental health teams needed;
- consultation with patients about their experiences of help for mental health issues needed;
- the need to develop a protocol for the routine mental health screening of all primary care patients with long term conditions (who often develop mental health issues);
- continued mental health input to the development of the CLP role;
- GP input to mental health service planning;
- better links needed with NHS 24, Scottish Ambulance Service and Police Scotland to coordinate local and national efforts;
- online referral guidance needed for GPs; and
- create a visible leadership team to be accountable at a strategic level for mental health, to support joined up, collaborative partnership working.

<u>The National Digital Wellbeing Hub – NHS Tayside</u>

- Enables staff, carers, volunteers and their families to access relevant support when they need it.
- Provides a range of self-care and wellbeing resources designed to aid resilience as the whole workforce responds to the impact of coronavirus (COVID-19).

The National Wellbeing Hub offers a range of resources and self-help materials to help individuals at work and at home. The National Wellbeing Hub also provides direct links that will enable individuals to access e-health programmes. There are computerised programmes and all NHS staff have free access. They provide a structured online programme based on Cognitive Behavioural Therapy, that focuses on supporting wellbeing, including managing mental health, building and maintaining resilience, managing stress and sleep.

The Scottish Government has also launched a new mental health helpline for health and social care workers. This helpline will offer support 24 hours a day, seven days a week.

Trained practitioners at NHS 24 will offer callers a compassionate and empathic listening service based on the principles of psychological first aid, as well as advice, signposting and onward referral to local services if required.

NHS Tayside Psychological Therapies Service are offering NHS Tayside staff the opportunity for brief 1-1 interventions (up to 4 sessions)with a psychologist. These are low intensity, informal but structured support sessions helping staff to:

- understand what they are experiencing, thinking or feeling;
- work out what can help, including practical exercises;
- get the best out of self-help materials; and

- identify other options for support.

These sessions are available to anyone who may be experiencing common psychological or emotional reactions to difficulties at work or home (including stress, anxiety, worry, low mood and sleep difficulties).

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

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Appendix 4

PLANNING GUIDANCE FOR MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES

Scottish Government
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December 2021

Introduction

1. This guidance should be used to support the formation and implementation of the Mental Health and Wellbeing in Primary Care (MHWPC) Service model as proposed in the Mental Health in Primary Care Short-Life Working Group Report. It is intended to guide the establishment of local planning groups, the development of their plans and implementation of the service.

2. This guidance should be used in conjunction with:
   - The MHWPC service Local Planning Template at Annex A;
   - resources to support implementation currently under development, to be published: March/April 2022 [Annex B];
   - Mental Health in Primary Care Short-Life Working Group report at Annex C;
   - examples of good practice used to inform the Mental Health in Primary Care Short-Life Working Group report at Annex D; and
   - Outcomes and Measures currently under development, to be published: March/April 2022 [Annex E].

Mental Health and Wellbeing in Primary Care Services

Improving Mental Health and Wellbeing in Primary Care Services

3. MHWPC Services should be established within an area served by a group of GP practices (this could be a locality, part of a locality or a cluster area). This guidance does not define how the MHWPC Service should be constituted; however, there should be a multi-agency team providing assessment, advice, support and some levels of treatment for people who have mental health, distress or wellbeing needs. The MHWPC Service could include Occupational Therapists, Mental Health Nurses, Psychologists, Enhanced Practitioners, Peer Support Workers as well as linking to others such as those providing financial advice, exercise coaches, family support networks. Every MHWPC Service should ensure that it provides access to a link worker to support wellbeing.

Defining the Link Worker function*:*

- Every GP Practice must have access to a Community Link Worker who, through their role, will support mental wellbeing. This may be a Community Link Worker who is supporting more than one GP Practice; and
- other members of the MHWPC Service should be encouraged to contribute to the link worker function by referring/signposting to wider community services, as appropriate.

4. The MHWPC Service would provide assessment and support to the individual to access appropriate levels of advice, community engagement, treatment or care – some of which would be delivered within the Primary Care setting, depending on the skills and capacity of the team.

5. The MHWPC Service would work closely with and / or be part of the wider community team in that area, engaging with the wider assets of the community, health and social work staff and with other agencies as appropriate.

6. Although the MHWPC Service would be aligned to a group of GP practices, there should be named members that work closely with each individual practice to provide continuity and allow the development of effective clinical or multidisciplinary team relationships.

7. Practice systems should allow patients to be directed to an appointment with the appropriate members of the MHWPC Service based on self-directed care, including self-referral. This option should be publicised and communicated to the practice population.

8. The MHWPC Service would provide timely support and treatment for people in that setting with the GP providing clinical leadership and expert general medical advice where needed. Where more specialist input is required the resources of Community Mental Health Team or other appropriate secondary care Mental Health service would be accessed in partnership with the wider Practice Primary Care team, where appropriate (e.g. shared care around medication).

9. The MHWPC Service should have members that are trained in mental health and may be drawn from mental health nursing, clinical psychology or AHP disciplines. It should also provide access to link worker support to the GP practices it serves. The team should also have members or close links with other staff with relevant expertise and experience e.g. addiction services, health visitors, health improvement staff and financial inclusion teams.

10. It is not expected that the MHWPC Service will only be involved in the most complex of cases, rather they will be a resource that facilitates improved communication, effective triage and provides the right level of support quickly. This would include early intervention and prevention, to a range of people, including access to community assets such as support groups, social activities and exercise.

11. Services had to quickly adapt in light of the Covid-19 pandemic and many of the changes have resulted in significant benefit for both patient experience and service capacity and quality. The MHWPC Service should continue to realise these benefits, for example, through collaboration with multiple partners, improved communication and the use of digital technology to deliver services.

<u>Embedded, Aligned or Hybrid Model</u>

12. There are three options available for implementing an MHWPC Service to serve a practice or group of practices; aligning, embedding or hybrid model.

13. **Aligning** the MHWPC Service to a cluster or group of GP Practices would mean teams are employed or contracted by the relevant Health Board. Service Level Agreements could be considered with professional groups to deliver some of the services which would preserve line management and clinical governance of these groups.

14. We recognise there can be large variances in practice list sizes, therefore by aligning services to a cluster; resource can be spread and distributed where needed. Given workforce limitations, this would make best use of existing resource, while striving to expand mental health capacity.

15. Aligned services may be seen as “distant” and potentially difficult to contact, therefore it is imperative that work is carried out to communicate and promote the MHWPC service and to develop close working relationships with practice staff.

16. **Embedding** the MHWPC Service within General Practice settings may mean they are employed or contracted by the Practice and are dedicated to that Practice for patient care. This model has been traditionally used where there is specific and significant ongoing need in a particular areas that requires dedicated full-time resource.

17. In some areas, particularly with levels of high deprivation, it has been found patients will not attend services out with their GP practice premises, particularly when related to mental health. The GP Practice is a place that patients know and trust, if implementing an aligned model, consideration should be given to having staff employed by the Health Board but basing them within a practice for a number of day/sessions per week. It will also be important to consider resource allocation for health centres with more than one GP Practice in the same building.

18. Using a **hybrid model** to implement the MHWPC Service will include elements of both the embedding and alignment models. This could allow flexibility based on population need, rurality and resource. For example, a MHWPC Service aligned with a GP cluster with psychology, OT and various other workers aligned, could complement a mental health worker embedded in a GP Practice.

19. The model that is implemented will depend on the needs of each local area, including but not limited to; geographic area, population size, additional demographic factors and local need. It is expected that the model used will also be driven by existing structures of service provision and will enable ease of access for patients, as well as ease of “stepping up” to other services in primary and secondary care and mental health/psychology services. It should be noted that in line with other policies and the GP Contract Memorandum of Understanding, additional workers are increasingly being employed by Heath Boards.

<u>Access</u>

20. Individuals should be able to access their MHWPC Service without the need for a referral from a GP or other medical professional. Individuals will normally access their MHWPC service through their General Practice appointment system. All members of the Primary Care team should be able to arrange appointments with the MHWPC Service for patients when deemed appropriate.

21. MHWPC Services will provide mental health support, treatment and assessment across all demographics rather than targeted groups, for example, there will be no lower or upper age limit to the service.

Digital and Self-Help

22. MHWPC Services should make use of appropriate digital approaches to self-help and supported management to complement the provision of the service and make it more accessible.

23. Digital approaches to self and supported management of distress and mental health conditions should be an integral part of the service. Those who are digitally excluded, for any reason, should be engaged positively in alternative ways.

24. There are a number of online and digital resources available nationally to support the MHWPC Service, these are detailed in the resources to support implementation.

Urgent Care

25. People who require urgent mental health care should find pathways easy to access, quick and responsive at the earliest possible point. Individuals may not contact their GP to access mental health support or they may request support during the out of hours period. They should be guided to the right intervention, support or treatment quickly. It should therefore be possible for the MHWPC Service to provide assessment, treatment and support in such circumstances. The MHWPC Service should work with the Out of Hours GP/Primary Care Service and Flow Navigation function (established in each Board to provide access to a Mental Health Competent Decision Maker) to facilitate the ability to make appointments with the team, where appropriate for that individual.

Communities Mental Health and Wellbeing Fund

26. The Fund[1] provides significant investment into community support for adults and builds upon the children and young people's community wellbeing supports currently being rolled out across Scotland. The Fund will be delivered through a locally focused and co-ordinated approach via local partnership groups (building upon existing partnerships), working together to ensure that support to community based organisations is directed appropriately and in a coherent way. Funding will be distributed through a grant to the 32 local Third Sector Interfaces across Scotland in line with current NHSScotland Resource Allocation Committee Formula (NRAC). Working in collaboration with Integration Authorities and other existing local partnerships.

27. The MHWPC Service Local Planning Groups should engage with the Communities Mental Health and Wellbeing local partnership groups to ensure interfaces with further support options can be maximised.

[1] https://www.gov.scot/news/gbp-15-million-to-help-improve-mental-wellbeing/

Timescales, System Change and Workforce

28. It is accepted that it may not be possible to implement the entire MHWPC Service in the immediate term. We recognise the workforce constraints and current pressures in the system. This is why we expect full MHWPC Services to be developed incrementally by spring 2026, this could include phasing different elements of the service. However, we know that mental health support is already provided in primary care settings across Scotland and should continue to be in place through the implementation of service improvement. Dedicated funding has been in place to support mental health in primary care through Action 15 of the Mental Health Strategy and Primary Care Improvement Funding. The development of MHWPC Services will build on this work.

29. Fully staffing MHWPC Services relies on workforce supply. The Scottish Government recognise the current constraints that a finite workforce has on planning for service transformation and that the pandemic will likely have a significant impact on the development of workforce. The Scottish Government will continue to engage with Integration Authorities as workforce policy develops.

30. It is also recognised that that in order for MHWPC Services to be successful, significant system and culture change will be required at a local level to develop the required interfaces with specialist and other services as well as peer to peer support. This is also likely to take time and should be factored into local plans.

Responsibilities

31. Funding will be distributed to Integration Authorities who will convene local planning groups.

Local Planning Groups

Remit

32. These groups will be responsible for developing and implementing MHWPC Services in line with this guidance. This will include:

- Developing and agreeing plans outlining evidence on what is already in place and what is required to incrementally develop MHWPC Services. Plans should be completed using the template at Annex A;
- Equality Impact Assessing local plans;
- identifying funding requirements;
- supporting the ongoing development and implementation of MHWPC Services, including overcoming delivery challenges;
- reporting, monitoring and evaluation to ensure that the service is meeting local needs and plans are being delivered as agreed;
- liaison with the National Oversight Group (see below); and
- local engagement and communication, including securing lived experience to inform local planning.

Membership

33. Local planning groups should be convened with representation from the following groups as a minimum:

- GP sub-committees
- Health and Social Care Partnerships
- Mental Health Service Leads
- Heads of Psychology
- Nursing
- Relevant links to Action 15 and PCIP
- Third Sector
- Experts by Experience
- Primary Care Out of Hours Services
- GPs
- Community Planning Partnerships
- Allied Health Professionals
- Local Authority representation

34. This list is not exhaustive. Initial planning should consider, on the basis of local need, whether other professionals or organisations should be included in the planning process. This could include, for example, School Liaison, Health Visitors, Addiction Services and Third Sector Interfaces. It is for local areas to determine how these local planning groups function, for example, it may not be necessary for all representatives to meet face to face.

National Oversight Group

35. The National Oversight Group will review and scrutinise local area plans submitted by local planning groups and take forward national level activity, as required.

Remit

36. The role of the Group will be to:
    - ensure local plans are aligned with this guidance, the model and principles outlined in the Mental Health in Primary Care Short-Life Working Group report;
    - MHWPCSs provide additionality;
    - liaise with local planning groups;
    - ensure consistency of decision making;
    - approve the release of funding;
    - review local reporting on progress;
    - manage national level risks; and
    - take forward actions at a national level, for example, where delivery challenges arise that require change at a national level.

Membership

37. The following will be included in membership
    - SG – Mental Health/Primary Care
    - Principal Medical Officer
    - GP/BMA
    - Health and Social Care Partnership
    - RCPsychiS
    - RCGP
    - RCN
    - AHPFS
    - HOPS
    - Out of Hours
    - Equalities

Funding

Distribution

38. The level of funding available will be calculated using the NHS Scotland Resource Allocation Committee (NRAC) formula. Consideration will be given to establishing a minimum floor to ensure Boards have access to sufficient funding, to allow a MHWPC Service to be implemented.

39. Funding will be distributed through Integration Authorities (IAs) to implement the plans developed by local planning groups. To inform the development of plans, IAs will be informed of their maximum NRAC allocation in advance of local planning commencing.

40. Once complete, IAs will submit their plan, or joint plan, to the National Oversight Group. On approval of the plan by the group, IAs will be able to draw down funding to allow them to proceed with implementation of their plans. This allocation of funding will be based on the gaps/needs outlined in the plans submitted.

41. A small proportion of the overall funding available may be retained to support national actions, as required.

Set up and ongoing support costs

42. The initial work of establishing local planning groups and developing robust plans will require resourcing. A small proportion of funding will therefore be allocated to resource the development of long-term local plans. This will cover admin or project costs and facilitate the creation and ongoing running of the local planning group.

Additionality

43. Funding will only be allocated to support the implementation of MHWPC Services. The funding should provide additionality, it must not be used to replace existing investment in mental health primary care activity.

44. It should complement, not replace, the progress made through Action 15 and the Primary Care Improvement Fund. How additionality will be achieved should be demonstrated in all aspects of implementation, including planning, monitoring and evaluation.

Funding scope

In scope:

45. **Staffing** –The majority of funding should be used to staff the MHWPC Service.

46. **Out of Hours** – It is expected that people presenting in the Out of Hours period should have access to the full range of options available in hours, while accepting some options may not be available immediately. Any provision of an out of hours service should be detailed in local plans.

47. **Training** – There may be training and CPD requirements associated with the MHWPC Service, this includes training for General Practice staff. Training requirements should be detailed in local plans.

48. **Administration** – It is accepted that there will be administration and support costs associated with the creation of the MHWPC Service. Where possible, this should be provided using existing resource. However, as highlighted funding will be made available to support the coordination and creation of the local planning groups. Any further support necessary for the ongoing implementation of the MHWPC Service should be detailed in local plans.

49. **Equipment** – Any equipment needed (laptops/desks/chairs etc.) should be sourced from existing supplies in HSCPs. Where this is not possible, a small amount of funding may be made available.

50. **Transport** – Staff providing the MHWPC Service may be required to travel between GP practices. It is expected that local arrangements for reimbursement of travel costs will be followed. It is acceptable for these to be included in local plans as part of staff associated costs.

51. **Communications**– It is expected that local areas will plan their own communication to raise awareness and promote understanding of the MHWPC Service. Where this activity is expected to incur costs, this should be detailed in local plans.

52. **Service Accessibility** – The concept of accessibility does not just apply to disabled people - all users will have different needs at different times and in different circumstances. Accessibility should be considered in the planning stages

to ensure the MHWPC Service can meet the needs of people using the service. As a result, there may be costs incurred due to need for interpreters, BSL or Braille translation, easy read formats or resources for physical accessibility requirements. The practice or group of practices the MHWPC Service is supporting will already be accessible, the service therefore will align with existing requirements. Any additional anticipated costs, such as BSL translation and/or interpretation or large print formats should be detailed in local plans.

Out of Scope

53. **Community and secondary services** – While it is expected that there will be an interface with secondary or community care services, this is not within scope of this funding. Referrals to additional primary care services are also not within scope of funding. While these services are out of scope, they will continue to be funded through existing channels. It will be vital for MHWPC Services to interface with community and secondary services.

54. **Accommodation** – Building on the work already achieved to establish Multi-Disciplinary Teams under the Memorandum of Understanding, MHWPC Services should be accommodated within existing infrastructure. If this presents a barrier to implementation this should be reported to the National Oversight Group.

Process

55. The formation and implementation of the MHWPC Service teams will occur in stages. The key stages will be as follows:

December 2021	• Guidance, template and implementation plan issued to IAs • Local planning groups convened. • Discussion and planning of local models commences. • Additional evidence gathering in local areas to identify need.
March 2022 (though plans may be submitted earlier when ready for review)	• Local plans outlining activity to 2026 and robust implementation plans for 2022/23 submitted to the National Oversight Group. • National Oversight Group review of local plans submitted and liaise with local planning groups. • If necessary, any amendments to the local model will be made by the local planning groups. • If necessary, final submission of the local plans will be to the National Oversight Group.
Spring 2022	• Funding agreed and allocated.
Spring 2022	• National implementation of MHWPCS commences.
October 2022	• 6 monthly reporting on progress required.

(each year thereafter)	
March 2022 (and each year thereafter)	• Detailed plans for following 12 month period submitted as well as any changes to initial plans outlining activity to 2026.

Reporting

56. Regular reporting will be required to demonstrate how funding is being utilised. Reporting will be undertaken using the reporting template at Annex A. This template should be completed in full when submitting local plans in March each year.

57. For returns in March, current workforce figures should reflect staff in post on 28 February, and returns in September should reflect the staff in post at 31 August.

58. The tabs for future workforce should reflect staff forecast to 28 February when returned in September each year, and staff forecast at 31 August when returned in March each year. The future workforce to 2026 tab should be updated for every return.

59. IAs will be responsible for reporting and publishing local plans or a summary of those plans when they are submitted each year.

Annex A
Mental Health and Wellbeing in Primary Care: Local Planning Template

[Insert excel spreadsheet link from APS publication page to be added here]

Annex B

Mental Health and Wellbeing in Primary Care: Resources to support implementation currently under development, to be published: March/April 2022.

Annex C

Mental Health in Primary Care: Short Life Working Group Report January 2021

[Insert link from APS publication page to be added here]

Annex D

Mental Health in Primary Care: Examples of Good Practice Used to Inform Short Life Working Group Report

[Insert link from APS publication page to be added here]

Annex E

Mental Health and Wellbeing in Primary Care: Outcomes and Measures currently under development, to be published: March/April 2022

Appendix 5

Minister for Mental Wellbeing and Social Care
Kevin Stewart MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0300 244 4000
E: scottish.ministers@gov.scot

Integrated Joint Board Chief Officers
Integrated Joint Board Chief Finance Officers
NHS Board Directors of Finance
NHS Chief Executives

By e-mail

Our ref: **Mental Health and Wellbeing in Primary Care Services**

17 February 2022

Dear Colleagues,

MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES

In December 2021, I committed to writing to you to confirm the future projected national levels of funding, which will inform the development of Mental Health and Wellbeing in Primary Care Services (MHWPCS).

As I announced in the Scottish Parliament on 12 January 2022, we expect this to be a significant investment reaching £40 million per year by 2024-25, subject to the approval of future Scottish budgets by the Scottish Parliament. Funding for 2025-26 onwards will be modelled on the basis of the plans that are submitted in March but we anticipate that an increase will be required to fund 1,000 additional roles in the final year of implementation.

The expected total national levels of investment are set out below:

2022-23 indicative (£)	2023-24 indicative (£)	2024-25 indicative (£)	2025-26 Indicative (£)
£10 million	£20 million	£40 million	TBC

You will find the indicative maximum allocation for your Board area for 2022-25 at Annex A. These amounts will be in addition to the £1.5 million already allocated in December 2021 to support the initial planning process.

The National Oversight Group for MHWPCSs will make recommendations on the release of annual funding allocations, starting from the 2022/23 financial year, based on receipt of local plans. Local plans should also include detail of how the MHWPCs will interface with other national and local services. The funding will be issued to Integration Authorities (IAs) to support the establishment of multi-disciplinary MHWPCS teams, within GP clusters or localities.

In line with the Local Planning Guidance, a small proportion of the overall funding will be retained for national level activity. The level of funding available for Boards/IAs has been calculated using the 2021-22 NHS Scotland Resource Allocation Committee (NRAC) formula. As you will be aware the formula is updated annually so allocations will be subject to a degree of minimal change. A minimum floor has been established for Island Boards and Highland, in line with the Local Planning Guidance, to ensure that all Boards have access to sufficient funding, to allow a MHWPC Service to be implemented.

Please could I ask, that on receipt of this letter, you nominate a Lead Planning Contact for your area and submit their name and email address; along with an expected submission date for your 2022-23 and long term plan to the Mental Health in Primary Care Team at MHWPCServices@gov.scot. Please do not hesitate to contact the Team if you have any questions or queries.

Thank you again, for your commitment to developing MHWPCS to ensuring they meet the needs of their local communities.

Kevin Stewart
Minister for Mental Wellbeing & Social Care

Annex A

Indicative funding allocations share by Health Board and Integration Authority

2022-23

NHS Board Name	NHS Board Area Indicative Allocation	IA Name	IA NRAC Share of Total Indicative Board Area Allocation
Ayrshire & Arran	£ 709,530.74	East Ayrshire HSCP	£ 229,896.79
		North Ayrshire HSCP	£ 261,159.42
		South Ayrshire HSCP	£ 218,474.52
Borders	£ 204,537.20	Scottish Borders HSCP	£ 204,537.20
Dumfries & Galloway	£ 287,827.74	Dumfries and Galloway HSCP	£ 287,827.74
Fife	£ 655,388.47	Fife HSCP	£ 655,388.47
Forth Valley	£ 523,851.35	Clackmannanshire and Stirling HSCP	£ 246,804.52
		Falkirk HSCP	£ 277,046.83
Grampian	£ 936,798.00	Aberdeen City HSCP	£ 366,761.68
		Aberdeenshire HSCP	£ 405,085.77
		Moray HSCP	£ 164,950.55
Greater Glasgow & Clyde	£ 2,136,844.34	East Dunbartonshire HSCP	£ 178,370.73
		East Renfrewshire HSCP	£ 153,089.26
		Glasgow City HSCP	£ 1,147,733.95
		Inverclyde HSCP	£ 156,876.54
		Renfrewshire HSCP	£ 326,786.85
		West Dunbartonshire HSCP	£ 173,987.00
Highland	£ 704,172.13	Argyll and Bute HSCP	£ 203,157.81
		Highland HSCP	£ 501,014.32
Lanarkshire	£ 1,179,900.70	North Lanarkshire HSCP	£ 610,193.12
		South Lanarkshire HSCP	£ 569,707.58
Lothian	£ 1,440,245.46	East Lothian HSCP	£ 178,824.72
		Edinburgh HSCP	£ 804,915.13
		Midlothian HSCP	£ 154,914.04
		West Lothian HSCP	£ 301,591.56
Orkney	£ 118,226.56	Orkney Islands HSCP	£ 118,226.56
Shetland	£ 116,987.81	Shetland Islands HSCP	£ 116,987.81
Tayside	£ 751,379.63	Angus HSCP	£ 207,838.55
		Dundee City HSCP	£ 278,759.05
		Perth and Kinross HSCP	£ 264,782.03
Western Isles	£ 134,309.87	Western Isles HSCP	£ 134,309.87
Total	£9,900,000.00		£9,899,999.97

2023-24

NHS Board Name	NHS Board Area Indicative Allocation	IA Name	IA NRAC Share of Total Indicative Board Area Allocation
Ayrshire & Arran	£ 1,416,848.80	East Ayrshire HSCP	£ 459,076.65
		North Ayrshire HSCP	£ 521,504.42
		South Ayrshire HSCP	£ 436,267.73
Borders	£ 408,436.56	Scottish Borders HSCP	£ 408,436.56
Dumfries & Galloway	£ 574,757.90	Dumfries and Galloway HSCP	£ 574,757.90
Fife	£ 1,308,733.12	Fife HSCP	£ 1,308,733.12
Forth Valley	£ 1,046,069.06	Clackmannanshire and Stirling HSCP	£ 492,839.38
		Falkirk HSCP	£ 553,229.68
Grampian	£ 1,870,674.59	Aberdeen City HSCP	£ 732,379.61
		Aberdeenshire HSCP	£ 808,908.27
		Moray HSCP	£ 329,386.71
Greater Glasgow & Clyde	£ 4,267,024.91	East Dunbartonshire HSCP	£ 356,185.21
		East Renfrewshire HSCP	£ 305,701.11
		Glasgow City HSCP	£ 2,291,888.69
		Inverclyde HSCP	£ 313,263.86
		Renfrewshire HSCP	£ 652,554.62
		West Dunbartonshire HSCP	£ 347,431.43
Highland	£ 1,406,366.59	Argyll and Bute HSCP	£ 405,745.05
		Highland HSCP	£ 1,000,621.55
Lanarkshire	£ 2,356,121.88	North Lanarkshire HSCP	£ 1,218,483.35
		South Lanarkshire HSCP	£ 1,137,638.53
Lothian	£ 2,875,999.50	East Lothian HSCP	£ 357,091.78
		Edinburgh HSCP	£ 1,607,320.14
		Midlothian HSCP	£ 309,344.98
		West Lothian HSCP	£ 602,242.60
Orkney	£ 236,302.72	Orkney Islands HSCP	£ 236,302.72
Shetland	£ 233,829.10	Shetland Islands HSCP	£ 233,829.10
Tayside	£ 1,500,416.08	Angus HSCP	£ 415,028.95
		Dundee City HSCP	£ 556,648.78
		Perth and Kinross HSCP	£ 528,738.34
Western Isles	£ 268,419.18	Western Isles HSCP	£ 268,419.18
Total	£19,770,000.00		£19,770,000.00

2024-25

NHS Board Name	NHS Board Area Indicative Allocation	IA Name	IA NRAC Share of Total Indicative Board Area Allocation
Ayrshire & Arran	£ 2,857,299.46	East Ayrshire HSCP	£ 925,800.60
		North Ayrshire HSCP	£ 1,051,696.06
		South Ayrshire HSCP	£ 879,802.80
Borders	£ 823,676.85	Scottish Borders HSCP	£ 823,676.85
Dumfries & Galloway	£ 1,159,090.10	Dumfries and Galloway HSCP	£ 1,159,090.10
Fife	£ 2,639,267.10	Fife HSCP	£ 2,639,267.10
Forth Valley	£ 2,109,563.54	Clackmannanshire and Stirling HSCP	£ 993,888.48
		Falkirk HSCP	£ 1,115,675.06
Grampian	£ 3,772,510.86	Aberdeen City HSCP	£ 1,476,959.20
		Aberdeenshire HSCP	£ 1,631,291.33
		Moray HSCP	£ 664,260.34
Greater Glasgow & Clyde	£ 8,605,129.89	East Dunbartonshire HSCP	£ 718,303.74
		East Renfrewshire HSCP	£ 616,494.60
		Glasgow City HSCP	£ 4,621,955.64
		Inverclyde HSCP	£ 631,746.06
		Renfrewshire HSCP	£ 1,315,979.49
		West Dunbartonshire HSCP	£ 700,650.36
Highland	£ 2,833,828.31	Argyll and Bute HSCP	£ 817,576.16
		Highland HSCP	£ 2,016,252.15
Lanarkshire	£ 4,751,492.03	North Lanarkshire HSCP	£ 2,457,264.19
		South Lanarkshire HSCP	£ 2,294,227.83
Lothian	£ 5,799,907.37	East Lothian HSCP	£ 720,131.99
		Edinburgh HSCP	£ 3,241,415.00
		Midlothian HSCP	£ 623,843.02
		West Lothian HSCP	£ 1,214,517.36
Orkney	£ 474,209.65	Orkney Islands HSCP	£ 474,209.65
Shetland	£ 469,221.20	Shetland Islands HSCP	£ 469,221.20
Tayside	£ 3,025,826.07	Angus HSCP	£ 836,971.46
		Dundee City HSCP	£ 1,122,570.22
		Perth and Kinross HSCP	£ 1,066,284.40
Western Isles	£ 538,977.57	Western Isles HSCP	£ 538,977.57
Total	£39,860,000.00		£39,860,000.01

AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**27 June 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/32/2022**
Contact Officer:	**Alan Best Interim Head of Health and Community Care**	**Contact No:**	
Subject:	**Inverclyde Learning Disability Community Hub**		

1.0 PURPOSE

1.1 The purpose of this report is to update the integration Joint Board on the on-going development of the Inverclyde Learning Disability Community Hub project.

2.0 SUMMARY

2.1 The Business Case activity for the new Learning Disability Community Hub was taken forward and approved pre-COVID. The progression of the project was impacted by the initial lockdown and recovery period and the design stage has been protracted due to a combination of continuing construction sector supply chain issues and the requirement to assess site specific development risks and their impact on the developing design proposals.

2.2 The evolving position on achieving net zero emission / carbon standards also has implications for capital projects and future planned investment in the Council's property portfolio. Projects such as the new Learning Disability hub require to consider to what extent future Net Zero targets will be incorporated within the scope / design briefs. The current proposals include a low carbon design approach with an energy in use target that aligns with other National infrastructure programmes. A funding bid has also been progressed through the Low Carbon Fund / Vacant and Derelict Land Investment Programme which has resulted in an allocation of £990,000 to address the enhanced low carbon scope subject to return of the completed final grant offer acceptance which has recently been received.

2.3 Over the past 2 years, supply chain insecurity and associated financial pressures have been a recurring issue through the initial impact of COVID and the UK exit from the EU to the most recent impact of the invasion of Ukraine by Russia. This has created an extremely unpredictable market position in terms of construction sector activity through a combination of sharply rising prices for construction materials, disrupted supply chains and labour shortages. The current tendering climate is markedly different as a result with low numbers of tender responses being experienced in open tender situations and with those that are returned generally being heavily qualified including how long the prices can be held open for.

2.4 The development of the design for the new Learning Disability Hub has also been challenging in respect of a number of aspects of the proposed site. Investigation work has highlighted limiting factors / site abnormals as outlined within section 8.0. This, in combination with market forces outlined in 2.3 above and the influence of a low carbon design approach outlined in 2.2 have necessitated a design review and alternative design response to the brief. As detailed within the report and appendices, although this has had a positive effect in reducing the overall project prime cost from the previously developed stage 2 design, there remains a significant budget gap to be addressed to allow the project to move forward.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board:

- Notes the report and the current stage of development of the project;
- Notes the position with respect to the external grant funding support sought for the project and allocation subject to grant offer acceptance;
- Notes and approves the intended procurement route to market via hub West Scotland;
- Approves the progression of the project based on the alterative design and confirmation of the additional funding support (£1.117 million) required to allow the project to proceed from a combination of prudential borrowing and Reserves; and
- Authorises the Interim Chief Officer to issue the Direction attached to this report to Inverclyde Council.

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 Approval to progress with the Learning Disability Redesign followed a Strategic Review of Services for Adults with Learning Disabilities in Inverclyde which was signed off by the Integration Joint Board in December 2016. The review concluded that building-based day services were not fit for purpose to address the aspiration of providing a modern service that meets the needs of adults with complex learning disabilities and autism. It also concluded that there was no suitable existing building to refurbish and that a new site would be required to develop a community hub which accommodated the agreed service option of Day Opportunities, Autism Support and the Community Learning Disability Team within a single location.

4.2 The Outline Business Case for the new Learning Disability Community Hub was presented to the Corporate Management Team in July 2019 outlining the work undertaken in progressing with the Learning Disability Redesign. The initial site option appraisal identified 28 potential sites across Inverclyde. Following the first stage of the appraisal work, this reduced to eight and then four sites which were considered within the Feasibility Study. A further report was presented to CMT in January 2020 on two preferred sites. Both sites were subject to site investigation work which was completed in December 2019 to allow a final business case to be presented.

4.3 The February 2020 Heath & Social Care Committee approved the final business case, preferred site (former Hector McNeil Baths) and funding support for the project with allocation of resources approved by the Inverclyde Council on 12th March 2020.

5.0 DESIGN STAGE PROGRESS

5.1 The initial COVID-19 lockdown in March 2020 and on-going situation has impacted the ability to progress the project following the approval of the business case noted in 4.3 above. The construction industry phased re-start commenced in mid-June 2020 with the supply chain and consultants return from furlough continuing into 3rd Quarter 2020.

5.2 Design stage work has been progressing through the design team led by Property Services, however, the process has been protracted due to a combination of continuing construction sector supply chain issues and the requirement to assess site specific development risks and their impact on the developing design proposals. Specialist consultants were engaged to assess the flood risk of the site and surrounding area ahead of formal engagement with The Scottish Environment Protection Agency (SEPA) as part of the formal Planning approval process. Surveys of the culverted burn within the site and existing retaining wall on the Brachelston Street site boundary were impacted by ongoing supply chain issues. From the ground investigation information it is also known that bedrock is close to the surface of the site which will impact the drainage design and groundworks solutions.

5.3 In tandem with the technical design process a legal process connected with the inalienable common good status of the site was also progressed. The proposed change of use for a community Learning Disability Resource Hub has now been concluded with an application to the Court granted in June 2021. All identified legal issues around use of the site have been resolved.

5.4 Space planning and accommodation schedule interrogation work has been progressed through Technical Services and the Client Service to inform the development of the design. Consultation with service users, families, carers and learning disability staff continues supported by The Advisory Group (TAG).

5.5 Regular progress reports have been provided to the Health and Social Care Committee and Integration Joint Board on the development process of the Learning Disability Hub.

6.0 NET ZERO CONSIDERATIONS

6.1 The direction of travel for energy efficiency is obvious, globally and nationally with the associated implications for capital projects and future planned investment in the Council's property portfolio connected with the impending Government legislation on achieving net zero emission / carbon standards. The Council's current capital programme includes projects that require decisions to be made as to what extent the future Net Zero targets will be incorporated with the Learning Disability Hub being one of those projects.

6.2 The original Learning Disability Hub project brief and cost plan were developed prior to the evolving position on Net Zero with costs based on meeting current building standards. Any decision to adopt an approach that addresses an improvement on those standards will result in increased cost and also requires to consider the stage of the project and opportunities/constraints of the proposed development site.

6.3 In recognition of the above and the imminent revision of Section 6 (Energy) of the Scottish Technical Standards due in 2022 which will require a significant step change in the energy and carbon performance of buildings, the Property Services team have progressed the design based on achieving an energy in use target which aligns with the targets currently being mandated under the Scottish Government Learning Estate Investment Programme. A similar approach was agreed for another current Council capital project (King George VI Refurbishment project).

6.4 The capital funding landscape is increasingly moving towards ring-fenced funds which require bids / applications to be made. The increased costs associated with the low carbon elements of the King George VI project noted in 6.3 are being met through an enhanced allocation of Regeneration Capital Grants Fund following successful engagement with Scottish Government. Similarly, the Council submitted a stage 1 application in November 2021 to the Low Carbon Fund / Vacant and Derelict Land Investment Programme (VDLIP) in respect of the Learning Disability project as the proposed site is identified on the Scottish Vacant and Derelict Land Register. The £50 million VDLIP is a capital programme scheduled to run over the five years from 2021/22 to help with tackling persistent vacant and derelict land and supporting place based approaches to delivering regeneration and sustainable inclusive growth, as part of the 'just transition' to net-zero by 2045. The Council was invited to submit a second stage bid to the VDLIP programme for the Learning Disability project and this was completed in February 2022 with an initial notification received on Tuesday 10th May of the approval for funding support. subject to a clarification being provided ahead of the issue of a formal grant offer letter. The Scottish Government has recently announced the successful Round 2 projects - Low Carbon Fund: Vacant and Derelict Land Investment Programme projects - gov.scot (www.gov.scot). The low carbon design elements of the project will be delivered through the £990,000 funding support subject to completion of the grant offer acceptance paperwork which has recently been received with the formal grant offer.

6.5 Appendix 3 includes a summary of the estimated project costs including commentary on the elements that have been enhanced to address a low carbon approach to the project delivery and operation.

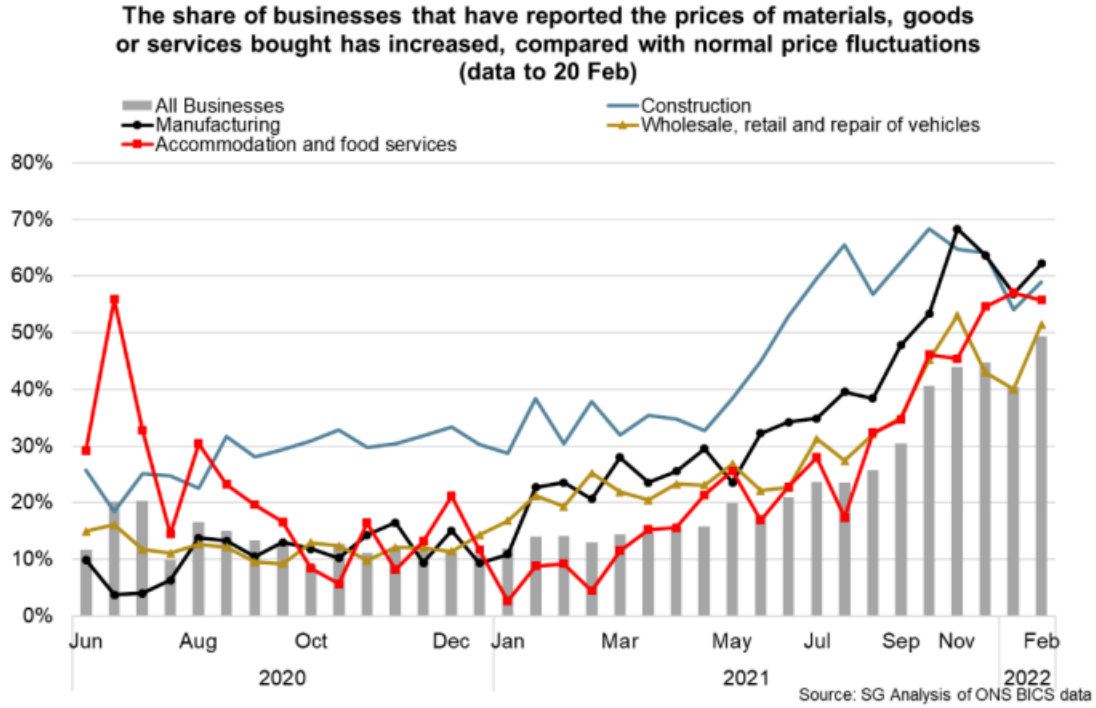
7.0 MARKET CHALLENGES AND RISKS

7.1 Over the past 2 years, supply chain insecurity and associated financial pressures have been a recurring issue through the initial impact of COVID and the UK exit from the EU to the most recent impact of the invasion of Ukraine by Russia. Supply chains at all levels are impacted by rising energy prices due to the influence on operating costs and the impact on outbound and inbound logistics from fuel cost increases. Inflation in most countries has increased to record highs driven by a rebound in economic activity and a further straining of rampant supply chain disruptions. A report by the Interim Director Finance & Corporate Governance was submitted to the April

2022 Inverclyde Council on the contract cost increase and supply issues currently being experienced.

7.2 The original budget cost for the project included in the final business case had a base date in 2nd Quarter 2019 with an inflation allowance based on Building Cost Information Service (BCIS) indices which assumed a construction commencement on site in 1st Quarter 2021. It should be noted that these indices were prior to any of the issues noted in 7.1 above.

7.3 A Glasgow City Region Construction Sector Review was produced by the Glasgow City Region Intelligence Hub and issued in early May. This concluded that economic recovery in the construction sector is threatened by a combination of sharply rising prices for construction materials, disrupted supply chains and labour shortages. It also noted that these factors have led to long delivery delays for many contractors and have threatened the sector's capacity to deliver projects. See extract from report (Chart 3) below:



Source: Scottish Government, Monthly Economic Briefing March 2022

7.4 The Learning Disability project has been impacted by the unprecedented set of circumstances outlined above which has both prolonged the pre-construction stage and resulted in the projected cost of the project being very difficult to ascertain with any degree of certainty ahead of a formal market testing process. It should be noted that the updated costs obtained through hub West Scotland are caveated noting the inability to provide a cost ceiling given the extremely unpredictable market conditions at present which show no signs of levelling off.

7.5 Subject to the identification of additional funding it is intended that the project be progressed to through the remaining design stages to the market testing phase through the hub West Scotland delivery model. The Council has been a participant since 2013 following approval by the Policy & Resources Committee to sign the Territory Partnering Agreement. The Council has successfully delivered seven projects in partnership with hub and this model affords the ability to augment the existing design team with the necessary further resources required to move the project forward. The model also involves early contractor engagement which is a significant advantage in the current market where effective supply chain management is key to obtaining the best response possible through market testing ahead of financial close.

8.0 PROJECT COST SIGNIFICANT FACTORS & DESIGN REVIEW

8.1 There are a number of areas which are impacting the updated cost position beyond the business case work undertaken pre-Covid to inform the initial budget cost. The sections below summarise the significant cost factors and the actions through Property Services to assist in mitigating / reducing as many as possible.

8.2 Site Abnormals

Flood Risk Mitigation – as noted in 5.2 above the flood risk assessment for the site has resulted in a requirement to raise the level of the main developable site plateau by 1m with the subsequent requirement for a retaining wall and drainage channel along a significant proportion of 2 sides of the site boundary (see Appendix 1C – areas highlighted orange and purple).

Existing Retaining Structures – the site includes an existing retaining wall along a significant length of the Brachelston Street side of the site. The proximity of the proposed new building to this structure resulted in a requirement to consider reinforcing this wall (see Appendix 1C – area highlighted blue).

Existing Culverted Burn – the site is bounded on the A78 Inverkip Road side by an existing brick built arched culvert. This location and age of the culvert has been a factor in design / placing of the new building (see Appendix 1C – area hatched red).

Site Levels – the site has an existing vehicular access at one end which served the former Hector McNeil Baths car park. The remainder of the developable site is at a lower level and this presents a challenge in respect of achieving a fully accessible solution for pedestrians. The design solution developed had included an engineered solution involving walls, sloped footpaths and landings (see Appendix 1C – area shaded green).

Shallow Bedrock – the site has a significant amount of bedrock close to the surface. Whilst this can potentially assist in a more economical foundation solution it has a negative impact in respect of the costs involved in providing the necessary foul and surface water drainage including attenuation solution that is generally required of any new development. Whilst the raising of the site by 1m for flood risk mitigation assist this, rock excavation will still be required to a degree in any final design for drainage runs and attenuation crates or similar.

8.3 Initial Design Response to Clients Brief

The design response to the Client's brief evolved through extensive consultation and engagement. The plans included in Appendices 1A-C show how the proposed design solution for the site and building were developed to meet both the accommodation schedule requirements and the need to consider how the building users would engage with internal and external spaces. The solution developed was marginally over the original briefed Gross Internal Floor Area of 1,676m2 at 1,683m2 (an increase of 7m2).

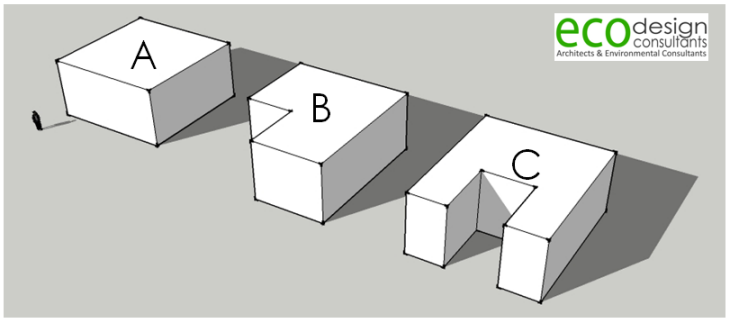
Although the building itself was not significantly in excess of the briefed area, the building form included an internal courtyard (see Appendix 1C – area shaded red) and a significant amount of circulation / activity space impacting the overall efficiency (area hatched red within Appendix 1A). The form also contributed to a footprint that resulted in the proximity to the existing retaining structures and culvert requiring more extensive interventions as outlined in 8.2 above.

In terms of Net Zero and Low Carbon Building Design, there are key considerations in respect of building Form Factor which are outlined below:

- The ratio of external envelope area to floor area or volume ratios can be used as a design driver to improve building energy efficiency;

- Simple singular cubical design is more efficient than multiple, long thin or sprawling buildings;
- Projections from the building envelope increase the form factor;
- Complexity of the external envelope will normally reflect badly in the energy efficiency of a building due to the high risk of air leakage, thermal bridging at corners and junctions, and in the cost of its construction.
- The higher the Form Factor the lower the U-value (rate of transfer of heat through a structure) and the thicker the insulation needs to be to make the building a low energy demand building.

A simple illustration of this is provided below:



	Floor area	Surface area	Heat loss
House A	100m^2	400m^2	1,260 W
House B	100m^2	430m^2	1,354.5 W **7.5% more**
House C	100m^2	470m^2	1,480.5 W **17.5% more**

8.4 Alternative Design Response

As part of the work involved in preparing the stage 2 application for the Vacant and Derelict Land Investment Programme funding bid, the developing design proposals were cost checked against the original budget. It was evident that the multiple factors covered in sections 6 to 8 above were impacting the affordability of the project. It was also evident that even if the external funding bid were successful in addressing a contribution for the low carbon design elements being investigated, there would still be a significant funding gap to address. It was deemed necessary to fundamentally review the approach to the building design and relationship with the site in respect of the abnormals.

The design team led the review assisted by an external architect engaged through hub West Scotland. Appendices 2A and 2B include a revised site layout and floor plans reflecting an alternative approach to the building design. The proposals have been developed in consultation with the Client Service.

The alternative design produces a building of circa 1,436m2 (a reduction of 240m2). The building Form Factor is also greatly improved offering a much better proposition in terms of the ability to meet enhanced air tightness targets and design details that support low carbon design and a more efficient build.

The footprint of the building is more compact and this has the added benefit of a better placement on the site offering an opportunity to avoid the need for reinforcement of the existing retaining wall structure adjacent to Brachelston Street. The site levels and proximity to the A78 Inverkip Road embankment were also able to be reviewed to reduce the extent of retaining wall required for flood mitigation and retention of upfill material which is still required to address the flood risk. It has also been possible to review the access into the site to remove the ramped structure in the original scheme with a more straightforward accessible path beside the vehicular access road. The revised design also introduces increased South facing outdoor space which will allow users to freely connect with nature in covered areas and individually themed zones.

The more compact design also offers advantages and efficiencies in terms of the approach to key mechanical and electrical plant and distribution system design. It should be noted however that in both designs the floor to ceiling heights require to accommodate a mechanical ventilation heat recovery (MVHR) approach in alignment with the low carbon design / energy in use targets which includes challenging air tightness targets and a highly insulated building envelope to reduce heat demand.

9.0 IMPLICATIONS

Financial

9.1 The estimated costs associated with this project have been summarised at Appendix 3.

One off Costs (Savings)

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report £000	Virement From	Other Comments
Current Allocations					
Capital	Learning Disability	2020/24	7,400		Prudential Borrowing
CFCR	Learning Disability	2023/24	265		Estimated kit out and ICT costs. Funded from EMR.
Potential Additional Allocations					
Capital	Learning Disability	2022/24	990		External grant funding VDLIP
Capital	Learning Disability	2022/24	1,117		Potential capital allocation from prudential borrowing / reserves.

Annually Recurring Costs (Savings)

Cost Centre	Budget Heading	With Effect From	Annual Net Impact £000	Virement From	Other Comments
Current Allocations					
General Fund	Loans Charges	2022/23	360		Estimated loans charges to deliver the £7.4m investment.
Learning Disabilities	Running Costs	2022/23	1,327		Estimated sum available for the running costs of the new facility.
Potential Additional Allocations					
General Fund	Loans Charges	2023/24	55		Potential additional loans charges.

As is evident from the summary of costs contained within **Appendix 3** and the tables above, there is a funding gap to be addressed prior to the project being able to be progressed.

The current agreed capital funding allocation of £7.4m is being made available through prudential borrowing funded by the Health and Social Care Partnership. The Inverclyde Integration Joint Board is seeking approval to fund the net cost increase through additional prudential borrowing and from available reserves.

The recent notification from Scottish Government on the approval of funding support through the VDLIP is a positive development and will result in an allocation of £0.99m subject to completion of the grant offer acceptance paperwork which has recently been received with the formal grant offer.

LEGAL

10.1 There are specific legal implications arising from this report.

10.2 The former Hector McNeil Baths site is inalienable common good land and as such it has been necessary to take forward a consultation under Section 104 of the Community Empowerment (Scotland) Act 2015 and to obtain the consent of the Court under Section 75 of the Local Government (Scotland) Act 1973, in relation to the proposed change of use of the site. Minimal legal costs have been incurred which were contained within the earmarked reserve allocation for one-off survey/project costs.

HUMAN RESOURCES

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

EQUALITIES

10.4.1 Has an Equality Impact Assessment been carried out?

There are no equality issues within this report.

	YES
√	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.

10.4.2 How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	Protects characteristic groups
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	Reduces discrimination
People with protected characteristics feel safe within their communities.	Promotes safety within communities
People with protected characteristics feel included in the planning and developing of services.	Promotes inclusion
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	Promotes diversity
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	Promotes opportunities
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	Promotes positive attitudes

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

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

10.6 **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.	Improves heath access
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	Promotes independence within people's own community
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Will give a positive experience
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Promotes quality of life
Health and social care services contribute to reducing health inequalities.	Reduces inequalities
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.	Supports carers
People using health and social care services are safe from harm.	Keeps people safe
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.	Promotes engagement
Resources are used effectively in the provision of health and social care services.	Maximises available resources

10.7 **Repopulation**

No Implications

11.0 DIRECTIONS

11.1

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

12.0 CONSULTATION

12.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

12.2 The Learning Disability Service has been consulted on the review of the building design and its ability to meet the current and future needs of the users, including those with autism and those with the most complex needs. The Service is satisfied that the revised design can be developed through the remaining detail design stages and will meet the needs of the service user group and staff teams.

13.0 BACKGROUND PAPERS

13.1 App. 1A Original Ground Floor Plan

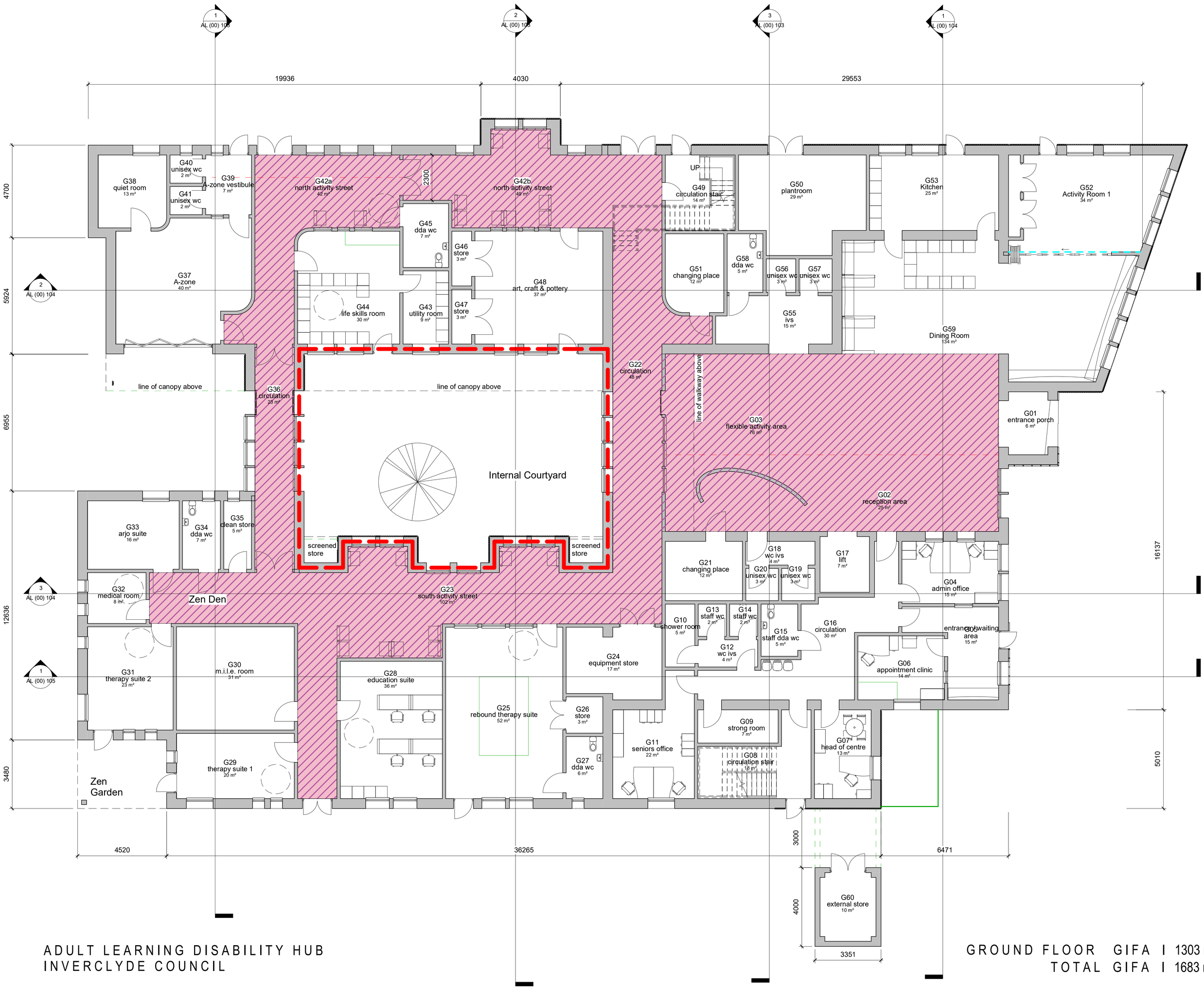
13.2 App. 1B Original First Floor Plan

13.3 App 1C Original Site Plan

13.4 App 2A Revised Proposed Plan

13.5 App 2B Revised Site Plan

13.6 App.3 Cost Summary

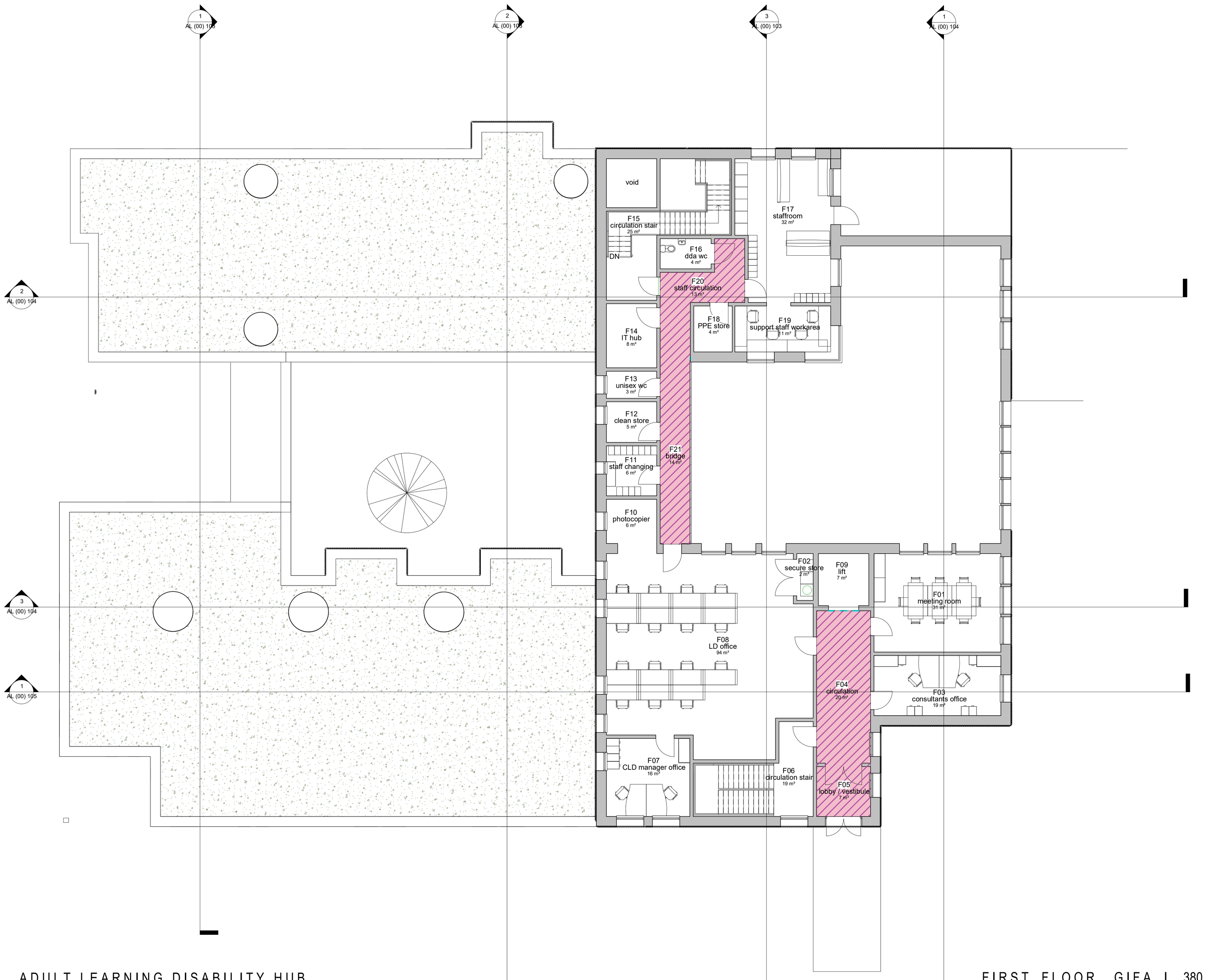


ADULT LEARNING DISABILITY HUB
INVERCLYDE COUNCIL

GROUND FLOOR GIFA | 1303 m²
TOTAL GIFA | 1683 m²

Accommodation Schedule		
Number	Name	Area
F01	meeting room	31 m²
F02	secure store	2 m²
F03	consultants office	19 m²
F04	circulation	20 m²
F05	lobby / vestibule	7 m²
F06	circulation stair	19 m²
F07	CLD manager office	16 m²
F08	LD office	94 m²
F09	lift	7 m²
F10	photocopier	Not Placed
F11	staff changing	6 m²
F12	clean store	5 m²
F13	unisex wc	3 m²
F14	IT hub	8 m²
F15	circulation stair	25 m²
F16	dda wc	4 m²
F17	staffroom	32 m²
F18	PPE store	4 m²
F19	support staff workarea	11 m²
F20	staff circulation	13 m²
F21	bridge	14 m²
F22	Room	6 m²
F23	Room	1 m²
F24	Room	92 m²
F25	Room	1 m²
F26	Room	150 m²
F27	Room	101 m²
F28	Room	0 m²
F30	Room	185 m²
F31	Room	37 m²
F32	Room	6 m²
G01	entrance porch	6 m²
G02	reception area	25 m²
G03	flexible activity area	76 m²
G04	admin office	15 m²
G05	entrance / waiting area	15 m²
G06	appointment clinic	14 m²
G07	head of centre	13 m²
G08	circulation stair	18 m²
G09	strong room	7 m²
G10	shower room	5 m²
G11	seniors office	22 m²
G12	wc ivs	4 m²
G13	staff wc	2 m²
G14	staff wc	2 m²
G15	staff dda wc	5 m²
G16	circulation	30 m²
G17	lift	7 m²
G18	wc ivs	4 m²
G19	unisex wc	3 m²
G20	unisex wc	3 m²
G21	changing place	12 m²
G22	circulation	48 m²
G23	south activity street	102 m²
G24	equipment store	17 m²
G25	rebound therapy suite	52 m²
G26	store	3 m²
G27	dda wc	6 m²
G28	education suite	36 m²
G29	therapy suite 1	20 m²
G30	m.i.l.e. room	31 m²
G31	therapy suite 2	23 m²
G32	medical room	8 m²
G33	arjo suite	16 m²
G34	dda wc	7 m²
G35	clean store	5 m²
G36	circulation	23 m²
G37	A-zone	40 m²
G38	quiet room	13 m²
G39	A-zone vestibule	7 m²
G40	unisex wc	2 m²
G41	unisex wc	2 m²
G42a	north activity street	42 m²
G42b	north activity street	49 m²
G43	utility room	9 m²
G44	life skills room	30 m²
G45	dda wc	7 m²
G46	store	3 m²
G47	store	3 m²
G48	art, craft & pottery	37 m²
G49	circulation stair	14 m²
G50	plantroom	29 m²
G51	changing place	12 m²
G52	Activity Room 1	34 m²
G53	Kitchen	25 m²
G55	ivs	15 m²
G56	unisex wc	3 m²
G57	unisex wc	3 m²
G58	dda wc	5 m²
G59	Dining Room	134 m²
G60	external store	10 m²

Appendix 1A



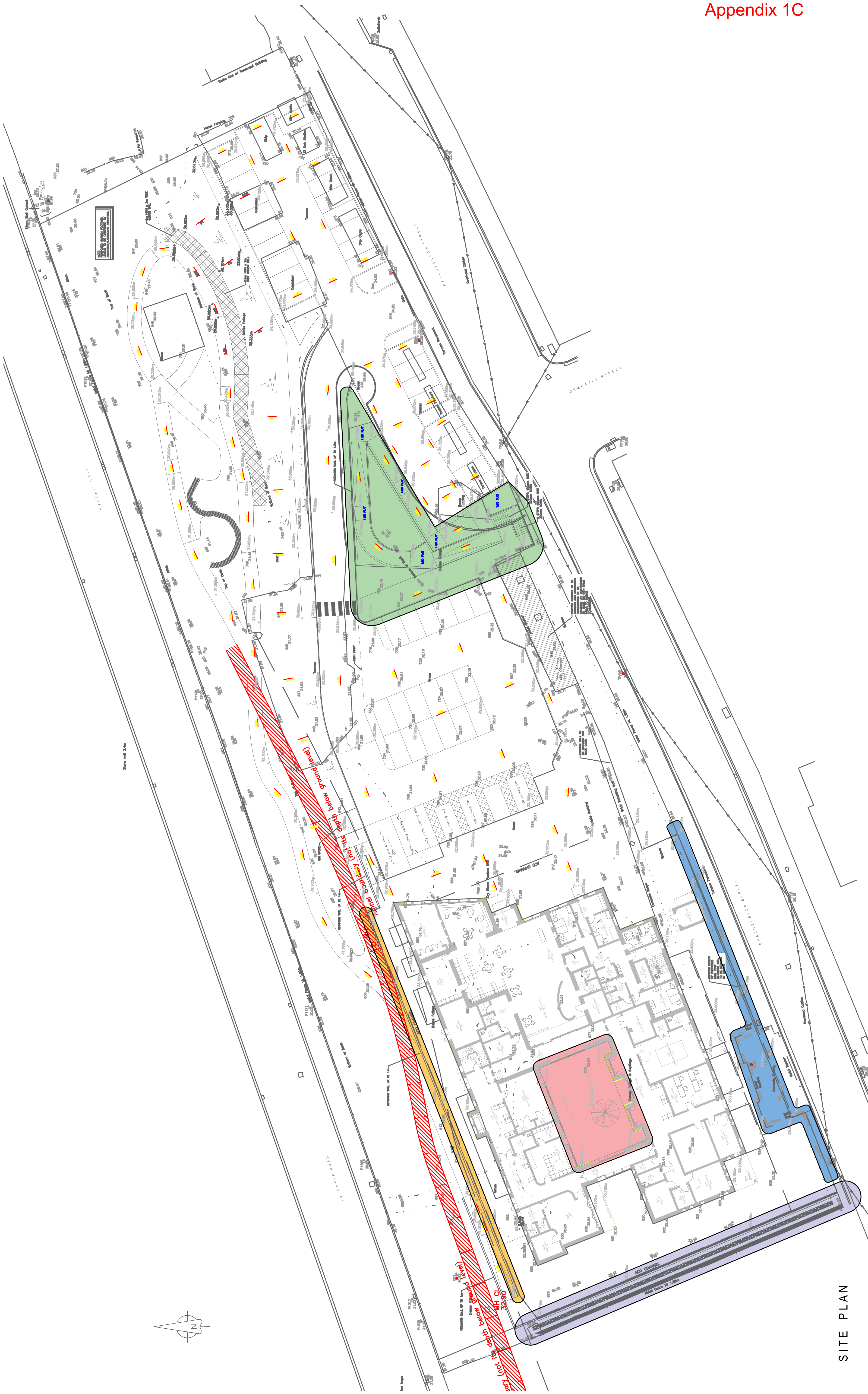
ADULT LEARNING DISABILITY HUB
INVERCLYDE COUNCIL

FIRST FLOOR GIFA I 380 m²
TOTAL GIFA I 1683 m²

Accommodation Schedule		
Number	Name	Area
F01	meeting room	31 m²
F02	secure store	2 m²
F03	consultants office	19 m²
F04	circulation	20 m²
F05	lobby / vestibule	7 m²
F06	circulation stair	19 m²
F07	CLD manager office	16 m²
F08	LD office	94 m²
F09	lift	7 m²
F10	photocopier	Not Placed
F10	photocopier	6 m²
F11	staff changing	6 m²
F12	clean store	5 m²
F13	unisex wc	3 m²
F14	IT hub	8 m²
F15	circulation stair	25 m²
F16	dda wc	4 m²
F17	staffroom	32 m²
F18	PPE store	4 m²
F19	support staff workarea	11 m²
F20	staff circulation	13 m²
F21	bridge	14 m²
G01	entrance porch	6 m²
G02	reception area	25 m²
G03	flexible activity area	76 m²
G04	admin office	15 m²
G05	entrance / waiting area	15 m²
G06	appointment clinic	14 m²
G07	head of centre	13 m²
G08	circulation stair	18 m²
G09	strong room	7 m²
G10	shower room	5 m²
G11	seniors office	22 m²
G12	wc ivs	4 m²
G13	staff wc	2 m²
G14	staff wc	2 m²
G15	staff dda wc	5 m²
G16	circulation	30 m²
G17	lift	7 m²
G18	wc ivs	4 m²
G19	unisex wc	3 m²
G20	unisex wc	3 m²
G21	changing place	12 m²
G22	circulation	48 m²
G23	south activity street	102 m²
G24	equipment store	17 m²
G25	rebound therapy suite	52 m²
G26	store	3 m²
G27	dda wc	6 m²
G28	education suite	36 m²
G29	therapy suite 1	20 m²
G30	m.i.l.e. room	31 m²
G31	therapy suite 2	23 m²
G32	medical room	8 m²
G33	arjo suite	16 m²
G34	dda wc	7 m²
G35	clean store	5 m²
G36	circulation	23 m²
G37	A-zone	40 m²
G38	quiet room	13 m²
G39	A-zone vestibule	7 m²
G40	unisex wc	2 m²
G41	unisex wc	2 m²
G42a	north activity street	42 m²
G42b	north activity street	49 m²
G43	utility room	9 m²
G44	life skills room	30 m²
G45	dda wc	7 m²
G46	store	3 m²
G47	store	3 m²
G48	art, craft & pottery	37 m²
G49	circulation stair	14 m²
G50	plantroom	29 m²
G51	changing place	12 m²
G52	Activity Room 1	34 m²
G53	Kitchen	25 m²
G55	ivs	15 m²
G56	unisex wc	3 m²
G57	unisex wc	3 m²
G58	dda wc	5 m²
G59	Dining Room	134 m²
G60	external store	10 m²

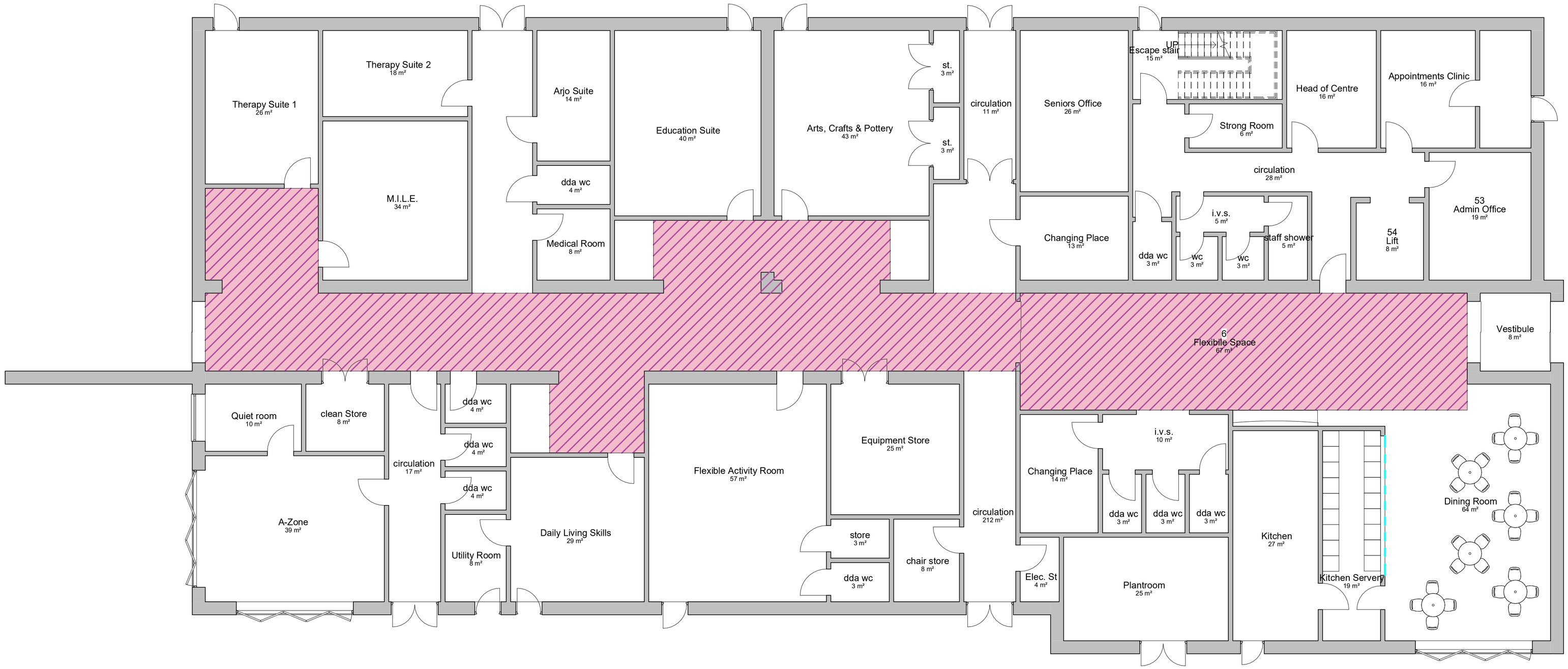
Appendix 1B

Appendix 1C



SITE PLAN

ADULT LEARNING DISABILITY HUB
INVERCLYDE COUNCIL



FIRST FLOOR GIFA I 279 m²

GROUND FLOOR GIFA I 1157 m²

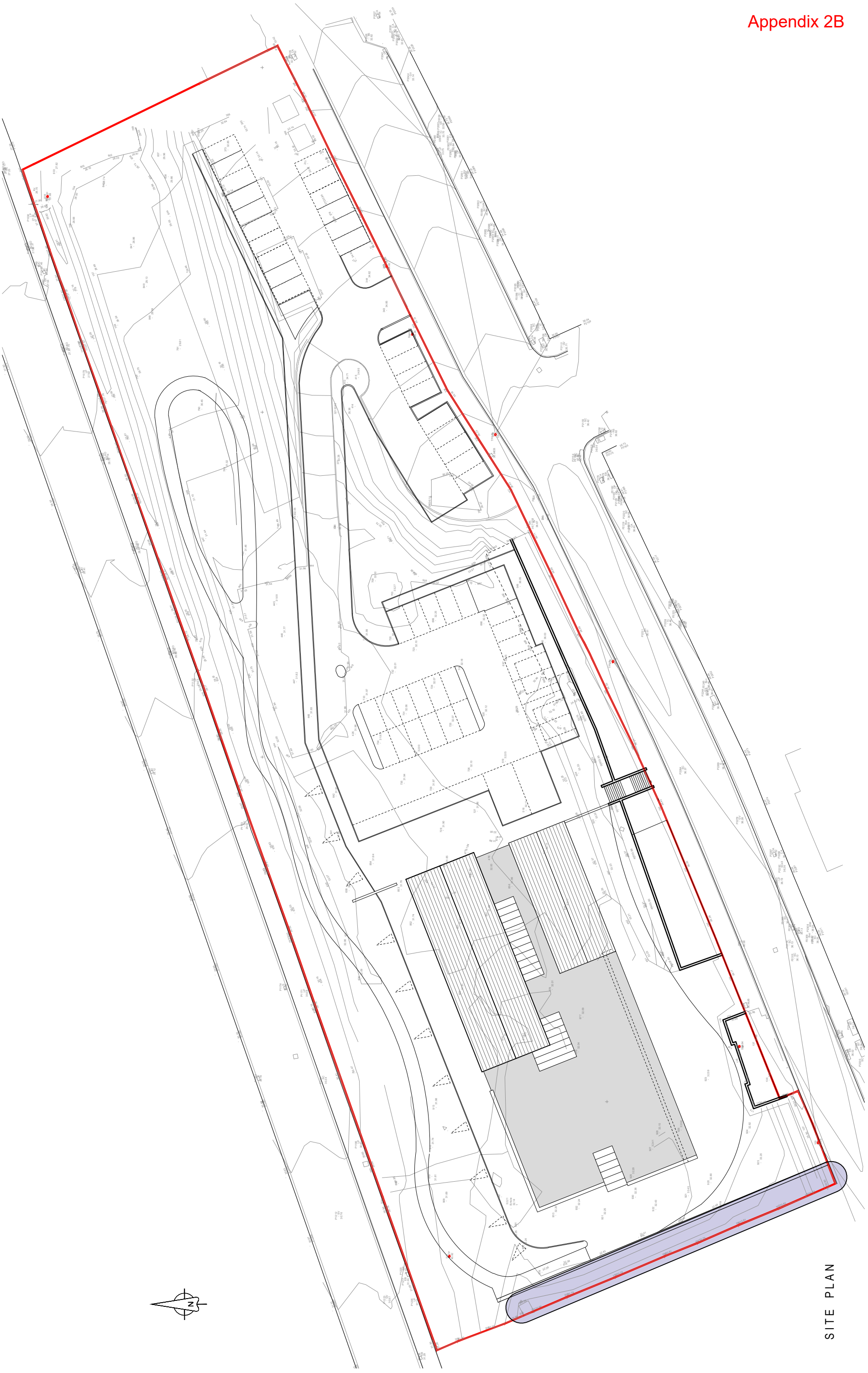
TOTAL GIFA I 1436 m²

ADULT LEARNING DISABILITY HUB
INVERCLYDE COUNCIL

Room Schedule		
Number	Name	Area
1	Vestibule	8 m²
2	Reception	10 m²
3	Dining Room	64 m²
4	Kitchen Servery	19 m²
5	Kitchen	27 m²
6	Flexibile Space	67 m²
7	i.v.s.	10 m²
8	dda wc	3 m²
9	dda wc	3 m²
10	dda wc	3 m²
11	Changing Place	14 m²
12	Plantroom	25 m²
13	Elec. St	4 m²
14	circulation	212 m²
15	chair store	8 m²
16	Equipment Store	25 m²
17	Flexible Activity Room	57 m²
18	store	3 m²
19	dda wc	3 m²
20	Daily Living Skills	29 m²
21	dda wc	4 m²
22	circulation	17 m²
23	dda wc	4 m²
24	dda wc	4 m²
25	Utility Room	8 m²
26	A-Zone	39 m²
27	Quiet room	10 m²
28	clean Store	8 m²
29	Therapy Suite 1	26 m²
30	M.I.L.E.	34 m²
31	Therapy Suite 2	18 m²
32	Arjo Suite	14 m²
33	dda wc	4 m²
34	Medical Room	8 m²
35	Education Suite	40 m²
36	Arts, Crafts & Pottery	43 m²
37	st.	3 m²
38	st.	3 m²
39	circulation	11 m²
40	Changing Place	13 m²
41	Seniors Office	26 m²
42	Escape stair	15 m²
43	Strong Room	6 m²
44	circulation	28 m²
45	dda wc	3 m²
46	i.v.s.	5 m²
47	wc	3 m²
48	wc	3 m²
49	staff shower	5 m²
50	Head of Centre	16 m²
51	Appointments Clinic	16 m²
52	Waiting	9 m²
53	Admin Office	19 m²
54	Lift	8 m²
F01	PPE store	6 m²
F02	Meeting Room	21 m²
F03	Staffroom	29 m²
F03A	Supp Staff Workarea	11 m²
F04	Lift	8 m²
F05	Staff Changing	10 m²
F06	i.v.s.	5 m²
F07	wc	3 m²
F08	wc	3 m²
F09	dda wc	3 m²
F10	ICT hub	12 m²
F11	CLD Manager	16 m²
F12	LD Office	67 m²
F13	Consultant Office	17 m²
F14	meds store	4 m²
F15	circulation	32 m²

Appendix 2A

Appendix 2B



ADULT LEARNING DISABILITY HUB
INVERCLYDE COUNCIL

SITE PLAN

INVERCLYDE LEARNING DISABILITY COMMUNITY HUB

No. BCIS Element/sub-element	**Cost Estimate Prepared** (base Date 2Q 2019)		**Cost Estimate** (re-based to 1Q 2021 for FBC)		**Stage 2 Cost Estimate** (B&W 10/02/22)		**Re-Design Cost Estimate 2Q 2022** (B&W 29/04/22)		**Commentary**
	SITE 2	GIFA M2	**SITE 2**	GIFA M2	**SITE 2**	GIFA M2	**SITE 2**	GIFA M2	
	HECTOR McNEIL	1,676	**HECTOR McNEIL**	1,676	**HECTOR McNEIL**	1,683	**HECTOR McNEIL**	1,436	240 m2 reduction in GIFA from original briefed area.
0 FACILITATING WORK									
0.1 Haz mat removal	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	
0.2 Demolition Works	£ 42,400	£ 25	£ 44,931	£ 27	£ 37,422	£ 22	£ 37,422	£ 26	
0.3 Specialist Groundworks	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	
0.4 Temp Diversion Works	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	
0.5 Extraordinary SI	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	
0 Elemental Total	£ 42,400	£ 25	£ 44,931	£ 27	£ 37,422	£ 22	£ 37,422	£ 26	
1 SUBSTRUCTURE									
1.1 Substructure	£ 159,178	£ 95	£ 168,681	£ 101	£ 139,693	£ 83	£ 110,687	£ 77	Reflects shallow bedrock offering economic foundation solution.
1.2 Solumn/Ground Floors	£ 130,804	£ 78	£ 138,613	£ 83	£ 142,595	£ 85	£ 135,336	£ 94	
1 Elemental Total	£ 289,982	£ 173	£ 307,294	£ 183	£ 282,288	£ 168	£ 246,023	£ 171	
2 SUPERSTRUCTURE									
2.1 Frame	£ 285,139	£ 170	£ 302,162	£ 180	£ 643,221	£ 382	£ 592,587	£ 413	Timber & steel frame costs have faced significant increases over the past 2 years. Timber frame preferred due to low carbon / low embodied energy alignment.
2.2 Upper Floors	£ 52,063	£ 31	£ 55,171	£ 33	£ 56,223	£ 33	£ 41,280	£ 29	Redesign offers more economical footprint.
2.3 Roof	£ 346,136	£ 207	£ 366,801	£ 219	£ 473,478	£ 281	£ 453,328	£ 316	Membrane roof preferred over metal sheet with rooflights and enhanced insulation standard to address low carbon design.
2.4 Stairs	£ 14,443	£ 9	£ 15,305	£ 9	£ 42,177	£ 25	£ 19,830	£ 14	Redesign offers more economical footprint/solution.
2.5 External Walls	£ 521,232	£ 311	£ 552,350	£ 330	£ 589,705	£ 350	£ 554,297	£ 386	Wall area reduced through re-design with enhanced insulation standard to address low carbon design. Floor to ceiling heights remain higher than normal to cater for mechanical ventiltion with heat recovery (MVHR) design approach.
2.6 Window and External Doors	£ 93,610	£ 56	£ 99,199	£ 59	£ 174,155	£ 103	£ 184,610	£ 129	Specification enhanced (triple glazed) to address low carbon desisgn.
2.7 Int Walls & Partitions	£ 362,604	£ 216	£ 384,252	£ 229	£ 409,812	£ 244	£ 338,862	£ 236	Redesign offers more economical footprint/solution.
2.8 Internal Doors	£ 123,825	£ 74	£ 131,218	£ 78	£ 158,733	£ 94	£ 150,862	£ 105	
2 Elemental Total	£ 1,799,052	£ 1,073	£ 1,906,458	£ 1,138	£ 2,547,504	£ 1,514	£ 2,335,656	£ 1,627	
3 INTERNAL FINISHES									
3.1 Wall Finishes	£ 105,000	£ 63	£ 111,269	£ 66	£ 91,139	£ 54	£ 82,208	£ 57	Redesign offers more economical footprint/solution.
3.2 Floor Finishes	£ 164,000	£ 98	£ 173,791	£ 104	£ 186,679	£ 111	£ 146,858	£ 102	Redesign offers more economical footprint/solution.
3.3 Ceiling Finishes	£ 131,000	£ 78	£ 138,821	£ 83	£ 117,962	£ 70	£ 103,562	£ 72	Redesign offers more economical footprint/solution.
3.4 Decoration	£ 60,000	£ 36	£ 63,582	£ 38	£ 71,931	£ 43	£ 70,666	£ 49	
3 Elemental Total	£ 460,000	£ 274	£ 487,463	£ 291	£ 467,711	£ 278	£ 403,293	£ 281	
4 FF&E									
4.1 Fixtures & Fittings	£ 222,000	£ 132	£ 235,254	£ 140	£ 164,983	£ 98	£ 159,132	£ 111	Redesign offers more economical footprint/solution.
4 Elemental Total	£ 222,000	£ 132	£ 235,254	£ 140	£ 164,983	£ 98	£ 159,132	£ 111	
5 SERVICES									
5.1 Sanitary Appliances	£ 39,638	£ 24	£ 42,004	£ 25	£ 32,162	£ 19	£ 34,326	£ 24	
5.2 Services Equipment	£ 43,575	£ 26	£ 46,176	£ 28	£ 65,673	£ 39	£ 58,010	£ 40	
5.3 Disposal Installation	£ 50,925	£ 30	£ 53,965	£ 32	£ 40,798	£ 24	£ 39,115	£ 27	
5.4 Water Installation	£ 97,451	£ 58	£ 103,269	£ 62	£ 110,040	£ 65	£ 110,704	£ 77	
5.5 Heat Source	£ 107,625	£ 64	£ 114,050	£ 68	£ 134,251	£ 80	£ 129,634	£ 90	Air source heat pump (ASHP) proposed for low carbon design.
5.6 Heating and Cooling Installations	£ 131,856	£ 79	£ 139,728	£ 83	£ 205,109	£ 122	£ 198,367	£ 138	Mechanical Ventilation with Heat Recovery (MVHR) aligned to underfloor heating for low caron design.
5.7 Ventilation Systems	£ 83,861	£ 50	£ 88,868	£ 53	£ 180,874	£ 107	£ 182,541	£ 127	Mechanical Ventilation with Heat Recovery (MVHR) aligned to underfloor heating for low caron design.
5.8 Electrical Installations	£ 299,317	£ 179	£ 317,187	£ 189	£ 344,399	£ 205	£ 305,273	£ 213	
5.9 Gas Installations	£ 7,350	£ 4	£ 7,789	£ 5	£ -	£ -	£ -	£ -	No gas proposed due to ASHP.
5.10 Lift Installations	£ 19,688	£ 12	£ 20,863	£ 12	£ 40,541	£ 24	£ 41,291	£ 29	
5.11 Protective Installations	£ 60,686	£ 36	£ 64,309	£ 38	£ 75,429	£ 45	£ 71,762	£ 50	
5.12 Communication Installations	£ 101,802	£ 61	£ 107,880	£ 64	£ 98,758	£ 59	£ 98,247	£ 68	
5.13 Specialist Installations	£ 36,750	£ 22	£ 38,944	£ 23	£ 136,080	£ 81	£ 127,050	£ 88	Increased controls (building management system) due to MVHR inlcuding photovoltaic installation.
5.14 BWICS	£ 53,550	£ 32	£ 56,747	£ 34	£ 54,177	£ 32	£ 52,986	£ 37	
5.15 Testing and Commissioning	£ 16,800	£ 10	£ 17,803	£ 11	£ -	£ -	£ -	£ -	
5 Elemental Total	£ 1,150,874	£ 687	£ 1,219,583	£ 728	£ 1,518,291	£ 902	£ 1,449,308	£ 1,009	
6 PREFAB									

Appendix 3

6.1 Prefabricated Buildings		£	-	£	-		£	-	£	-		£	-	£	-		£	-	£	-	
6 Elemental Total		£	-	£	-		£	-	£	-		£	-	£	-		£	-	£	-	
7 Existing Buildings																					
7.1 Demolition and Alterations		£	-	£	-		£	-	£	-		£	-	£	-		£	-	£	-	
7.2 Repairs to Existing Services		£	-	£	-		£	-	£	-		£	-	£	-		£	-	£	-	
7.3 Damp proofing		£	-	£	-		£	-	£	-		£	-	£	-		£	-	£	-	
7.4 Façade retention		£	-	£	-		£	-	£	-		£	-	£	-		£	-	£	-	
7.5 Existing Surfaces		£	-	£	-		£	-	£	-		£	-	£	-		£	-	£	-	
7.6 Renovation Works		£	-	£	-		£	-	£	-		£	-	£	-		£	-	£	-	
7 Elemental Total		£	-	£	-		£	-	£	-		£	-	£	-		£	-	£	-	
8 EXTERNAL WORKS																					
8.1 Site Works		£	156,600	£	93		£	165,949	£	99		£	280,436	£	167		£	281,548	£	196	Site works more extensive due to site abnormals.
8.2 Roads, paths and pavings		£	443,561	£	265		£	470,042	£	280		£	387,203	£	230		£	338,927	£	236	Re-design reduces overall amounts of surfacing required.
8.3 Planting		£	110,264	£	66		£	116,847	£	70		£	110,752	£	66		£	128,102	£	89	
8.4 Fencing, railings and Walls		£	118,618	£	71		£	125,700	£	75		£	321,109	£	191		£	257,860	£	180	Site abnormals impacted stage 2 cost with re-design reducing the impact as outlined in body of report.
8.5 Site / Street Furniture and Play Equip		£	36,841	£	22		£	39,040	£	23		£	36,841	£	22		£	36,841	£	26	
8.6 External Drainage		£	258,089	£	154		£	273,497	£	163		£	484,759	£	288		£	456,796	£	318	Site abnormals impacted stage 2 cost with re-design reducing the impact as outlined in body of report.
8.7 External Services		£	91,000	£	54		£	96,433	£	58		£	765	£	0		£	7,665	£	5	No incoming gas, sub-station adjacent to site.
8.8 Minor Building Works & Ancillary Building		£	13,750	£	8		£	14,571	£	9		£	2,562	£	2		£	1,932	£	1	
8 Elemental Total		£	1,228,723	£	733		£	1,302,080	£	777		£	1,624,427	£	965		£	1,509,671	£	1,051	
NET PRIME COST		**£**	**5,193,031**	**£**	**3,098**		**£**	**5,503,063**	**£**	**3,283**		**£**	**6,642,626**	**£**	**3,947**		**£**	**6,140,505**	**£**	**4,276**	Redesign offers more economical footprint/solution.
Build Only				**£**	**2,340**				**£**	**2,480**				**£**	**2,959**				**£**	**3,199**	
Externals				**£**	**758**				**£**	**804**				**£**	**987**				**£**	**1,077**	
Uplift for Affordability Cap	**35%**	**£**	**1,817,561**	**£**	**1,084**	**35%**	**£**	**1,926,072**	**£**	**1,149**	**50%**	**£**	**3,421,313**	**£**	**2,033**	**55%**	**£**	**3,366,091**	**£**	**2,344**	Uplift covers professional and statutory fees and charges including allowances for post contract risk, contractor preliminaries, overheads and profit, construction insurances. Original costs assumed start date in 1st Quarter 2021. Latest costs reflect increasing costs of contractor preliminaries post covid for additional site measures and also include inflation/hyper inflation allowances up to mid-point of construction.

Affordability Cap	**£**	**7,010,592**	**£**	**4,183**	**£**	**7,429,135**	**£**	**4,433**	**£**	**10,063,939**	**£**	**5,980**	**£**	**9,506,596**	**£**	**6,620**		

INVERCLYDE INTEGRATION JOINT BOARD
DIRECTION ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

1	Reference number	IJB/32/2022/AB
2	Report Title	Inverclyde Learning Disability Community Hub
3	Date direction issued by IJB	27th June 2022
4	Date from which direction takes effect	27th June 2022
5	Direction to:	Inverclyde Council only
6	Does this direction supersede, revise or revoke a previous direction – if yes, include the reference number(s)	No
7	Functions covered by direction	Learning Disability Day Services
8	Full text of direction	Inverclyde Council is directed to proceed with the approved project on the basis of the alternative design set out in the report and through the intended procurement route via hub West Scotland with additional funding support of £1.117million from the IJB.
9	Budget allocated by IJB to carry out direction	£1.117million, through a combination of prudential borrowing and use of existing reserves.
10	Outcomes	As detailed in paragraph 10 of the report. Progression by Inverclyde Council of the Inverclyde Learning Disability Community Hub.
11	Performance monitoring arrangements	In line with the agreed Performance Management Framework of the Inverclyde Integration Joint Board and the Inverclyde Health and Social Care Partnership. This Direction will be monitored and progress reported bi-annually.
12	Date direction will be reviewed	26th June 2023. Updates will be brought back regularly to the IJB as the project proceeds.

Appendix 4

AGENDA ITEM NO: 12

Report To:	**Inverclyde Integration Joint Board**	**Date: 27 June 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde Health & Social Care Partnership**	**Report No: IJB/28/2022/AG**
Contact Officer:	**Anne Glendinning Acting Head of Children & Families and Criminal Justice Services Inverclyde Health and Social Care Partnership**	**Contact No: 01475 715282**
Subject:	**THE PROMISE**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on the progression of local activity and delivery of The Promise referred to locally as I Promise (Inverclyde's Promise).

2.0 SUMMARY

2.1 The Promise was published in 2020 followed by the 2021- 24 plan outlining Scotland's ambition and commitment to ensure that children grow up loved, safe and respected so that they realise their full potential.

2.2 Inverclyde HSCP in partnership with CVS Inverclyde and Inverclyde Alcohol Drug Partnership made a successful funding bid to the Promise Partnership in 2021 to establish the I Promise Team. The service pressures associated with the pandemic did create challenges in establishing the team however the I Promise Programme Manager took up post in January 2022 is joined by the 3rd Sector development worker and a coaching and modelling worker.

2.3 The I Promise Team is tasked with enabling Inverclyde HSCP to deliver on the five foundations on which The Promise is founded and outlined in Promise Plan 2021-24:-

- A good childhood
- Whole Family Support
- Planning
- Supporting the workforce
- Building capacity

The Promise is embedded within wider strategic planning processes including children's service planning and it is intended that the I Promise team will have a pivotal supporting role in supporting and enabling partner agencies fulfil their Promise plans.

2.4 The I Promise team have produced a quarterly report that outlines the range of activity undertaken:-

1. Awareness raising with all partner agencies throughout Inverclyde.

2. The consultation with children, young people and families who are care experienced in order to provide a good childhood, provide whole family support and building capacity.

3. Development of the I Promise Board.

4. Whole Family Approach that scaffolds the whole family with the aim of ensuring that children can live safely within their family reducing the need for children to be looked after away from home. This has included a small test of change.

5. Test of change focusing on the delivery of Throughcare, Aftercare, and Continuing Care for young people who have been looked after.

6. Maintaining strong links with the national Promise Team.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board note the progression of activity in delivering Inverclyde's commitment to The Promise and the establishment of the I Promise Team.

3.2 That members of the Integration Joint Board continue to actively support the delivery of I Promise and the system shifts required.

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 The Promise was published in 2020 followed by the 2021- 24 plan outlining Scotland's ambition and commitment to ensure that children grow up loved, safe and respected so that they realise their full potential.

4.2 Inverclyde HSCP in partnership with CVS Inverclyde and Inverclyde Alcohol Drug Partnership made a successful funding bid amounting to £250,000 to the Promise Partnership in March 2021. The bid was built on existing work streams and pledges by Inverclyde "help me by helping my family" and "nothing about me without me".

4.3 The funding allocated was aimed at delivering system changes aligned to The Promise with the condition of partnership approaches following the Scottish Approach to Service Design (SAtSD). The I Promise Team was established in line with the aim of progressing the cultural and systems changes required to implement The Promise.

4.4 The I Promise Team was established in January 2022 delays were experienced due to a range of service pressures and covid response priorities. The I-Promise Team were recruited predominantly on experience and the ability to establish effective working relationships. This reinforces the importance of relationships and promotes the foundation of People and Voice in the creation of the I-Promise Team and upholds an agile way of working.

4.5 The I-Promise Team have a key role in modelling for the wider organisation and as such although there is a structural hierarchy within the team in terms of responsibility, there is no hierarchy in the approach or accessibility of the team to wider stakeholders.

4.6 Early activity around the Promise began within the multi-agency Children's Services Planning Partnership in conjunction with the Champions Board. It is hoped that the I-Promise Team will have capacity to support the delivery of the wider Inverclyde planning activity around implementing The Promise providing support from the learning taking place to other agencies and services to develop their own plans to deliver on transformational change.

4.7 The I Promise Team is tasked with enabling the HSCP to deliver on the five foundations on which The Promise is founded and outlined in Promise Plan 2021-24 and have produced a brief quarterly report (attached at appendix 1) that provides an overview of the range of activity on the five foundations of the Promise Plan 2021/24:-

- A good childhood
- Whole Family Support
- Planning
- Supporting the workforce
- Building capacity

5.0 IMPLICATIONS

FINANCE

5.1 I Promise is funded directly Promise Partnership administered by Cora Foundation on a non-recurring basis.

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A	Employee costs Payments to other Bodies		77 130 43		I Promise Programme Manager 3rd Sector Development worker Coaching Modelling worker Resourcing of consultation / discovery exploration activity/ test of change

Annually Recurring Costs / (Savings)

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

LEGAL

5.2 None

HUMAN RESOURCES

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

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

	YES
✓	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.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	none
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	none

People with protected characteristics feel safe within their communities.	none
People with protected characteristics feel included in the planning and developing of services.	none
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	none
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

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

NATIONAL WELLBEING OUTCOMES

5.6 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.	none
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.	none
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.	none
People using health and social care services are safe from harm.	none
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.	none
Resources are used effectively in the provision of health and social care services.	none

6.0 DIRECTIONS

6.1

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

7.0 CONSULTATION

7.1 The report has been prepared by the Interim Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

8.0 BACKGROUND PAPERS

8.1 I Promise Quarterly Report.

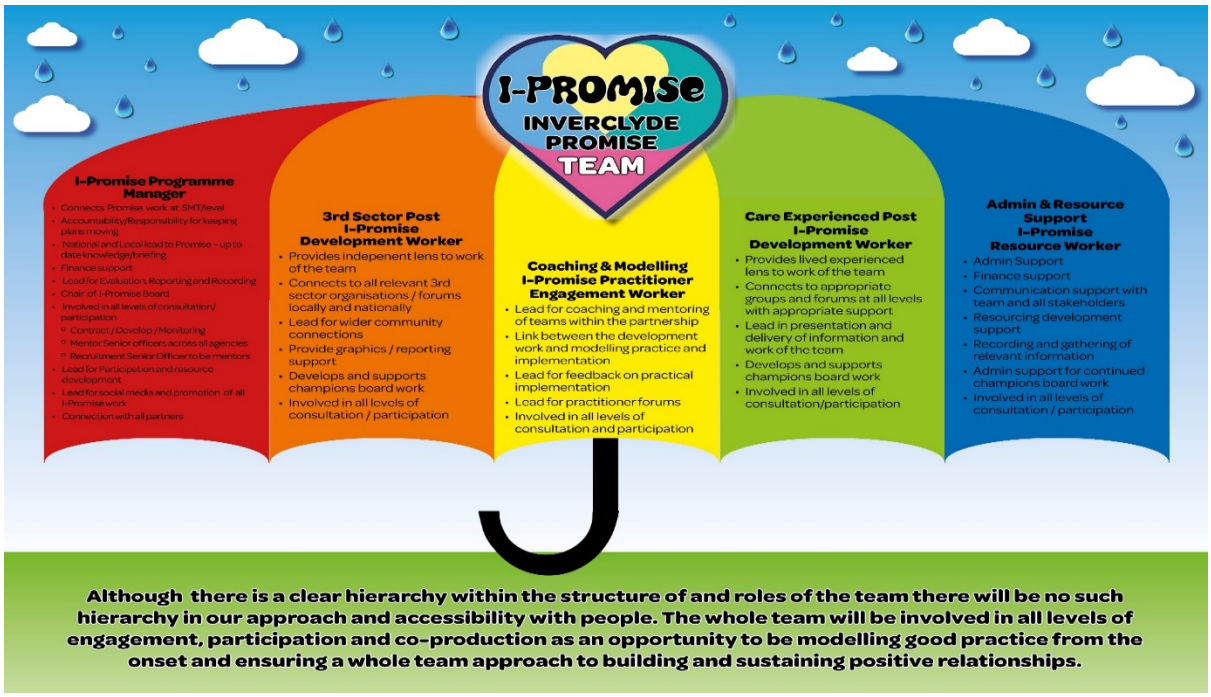
Appendix 1

Inverclyde Promise Team

Quarterly Report April 2022

I Promise team is now been in operation for 3 months with the Coaching and Modelling practitioner joining the Programme Manager and Development Worker. A note of interest in hosting a Business Administration Modern Apprentice is submitted.

The Coaching and Modelling practitioner has also received a place on the Scottish Approach to Service Design School with National Promise Team.



Work is progressing in relation to the **Five Priority areas** within Promise Plan 21-24 in line with national agenda.

A GOOD CHILDHOOD
Inverclyde Young People and Corporate Parents undertook Stop and Go Pledges which the team are now promoting to aim to meet all 5 priority areas, specifically a good childhood and whole family support. The Stop and Go Pledges have been made into larger posters and will be displayed within Hector McNeil House and Princes Street House, there will also be available copies of The Promise, Pinky Promise, Plan 21-24 and Change Programme. As detailed:

INVERCLYDE HSCP PLEDGE 1

Keeping Families Connected

"Help me by helping me and my family"

STOP	My Rights	GO
• Stop birth families from feeling isolated • Stop kinship carers from feeling isolated • Stop services from care planning without the input from appropriate extended family members • Stop separating siblings unless there are safe guarding reasons • Stop putting barriers in place that may limit sibling contact • Stop a lack of information that allows children to form part of their identity	**Article 3** - All adults should always do what is best for you. **Article 8** - You have the right to an identity. **Article 12** - You have the right to an opinion and for it to be listened to and taken seriously. **Article 20** - You have the right to special protection and help if you can't live with your parents. **Article 21** - You have the right to have the best care for you if you are adopted or fostered or living in care **Article 39** - You have the right to help if you have been hurt, neglected, or badly treated.	• Birth Ties – A range of support for birth families of children who have been adopted • Support for parents and family members even if children are not returning home • Ensuring children know that support is being offered to their family • Family Ties – A range of support for Kinship carers and extended family members including parents • Early inclusion of extended family members in care planning • Early support for permanent sibling placements • Increase opportunities for siblings who are separated to spend time together and/or build/maintain relationships

The 5 Inverclyde Stop Go Pledges are:

- Help me by helping my family
- Nothing about me without me
- Try to keep me where I am and support me for as long as needed
- Help me to understand what's happening and why
- Help people to understand me and my experiences

Creation of I Promise Logo and straplines alternating 5 pledges for correspondence/social media/twitter.

The Promise is at the heart of Inverclyde with the 5 foundations of the Promise given consideration.

Consultation with care experienced children and young people regarding logos and correspondence. These have now been placed onto hoodies and also other merchandise that will be distributed throughout launch day/night or I Promise Board and Open Days.

Test of Change – Planning (Throughcare, Aftercare, Continuing Care)

Care experienced young people who have moved into their own accommodation or, will be moving into their own accommodation in the near future formed a focus group to explore and discuss in partnership with staff of the Throughcare, continuing care and Aftercare services what changes could be made to improve the service.

Assessment materials were considered with language at the core, group members proposed changes, and paperwork is now referred to as a check-in rather than an assessment. Young People also co designed the new paperwork to be more user friendly using relatable language within the discussion points and influenced the content and options to better reflect the needs of young people. Understanding of the three services and referral route was also explored within the group and workforce.

- The new check in paperwork is now being piloted with Through Care, After Care and Continuing Care Teams alongside service users.
- Name has been proposed by young people to the Going4Ward service one name and one referral door in.
- Referral process – new referral form designed, referrals to 1 central point then coordinated to appropriate worker/team (3 Teams under G4W Service).
- This particular group began to look at language and a further group will be set up to continue to look at language which will feedback into the I Promise board

What matters to Children and Families?

Consultation mirroring the Independent Care Review with children, young people and families of Inverclyde who are care experienced will determine what we need to do better.

106 letters are being distributed to Social Workers for young people who are currently subject to Compulsory Supervision Orders this week who will share these with young people aged 14-18 years of age in an effort to introduce team and meet in person or virtually to obtain their views in relation to their experience and how as a service we can do better.

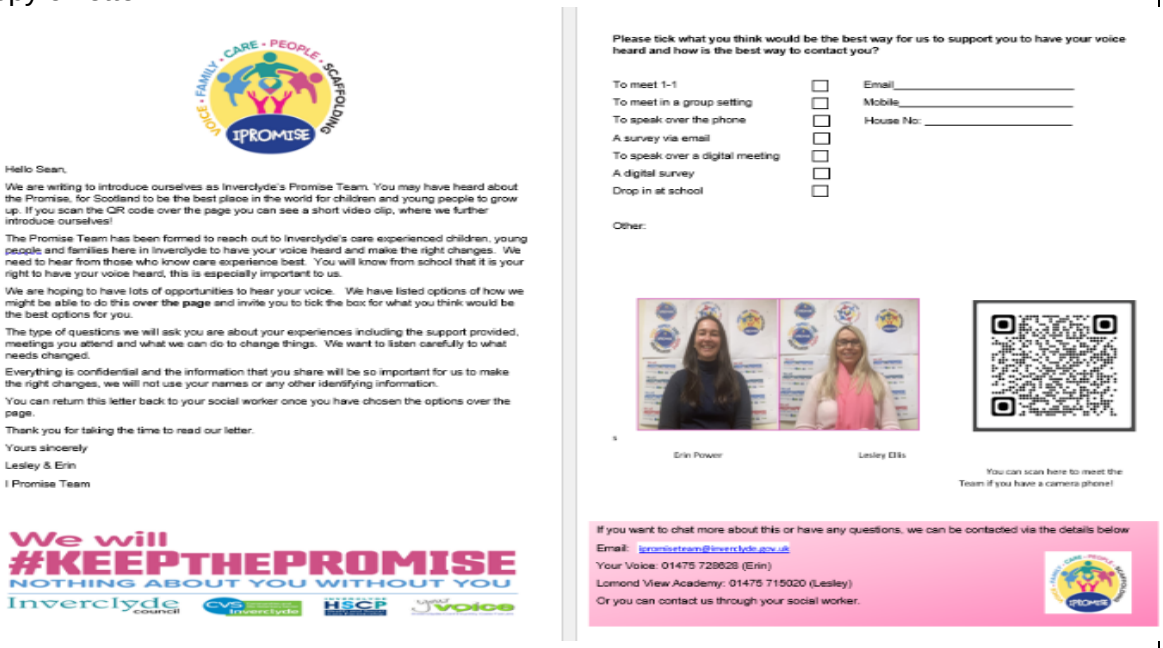
A further **45** letters will be sent to 11-13 year olds.

And **74** letters will be sent to 4-11 year olds.

As noted the consultation that we undertake with children, young people and families will be within the realms of the Scottish Approach to Service Design which we understand and value whilst promoting active participation of those involved and this participation has

been from the onset. Proud2care young people have had continued discussions with the team in relation to progressing forward with raising awareness and beginning the consultation process. Being mindful of the digital element of The Promise and recognition of no assumptions in relation to literacy levels the QR code which contains a video ensuring that we are not disadvantaging anyone along with careful planning ahead. A young person within the group reminded that assumptions can never be made regarding literacy levels.

Copy of letter



Hello Sean,

We are writing to introduce ourselves as Inverclyde's Promise Team. You may have heard about the Promise, for Scotland to be the best place in the world for children and young people to grow up. If you scan the QR code over the page you can see a short video clip, where we further introduce ourselves!

The Promise Team has been formed to reach out to Inverclyde's care experienced children, young people and families here in Inverclyde to have your voice heard and make the right changes. We need to hear from those who know care experience best. You will know from school that it is your right to have your voice heard, this is especially important to us.

We are hoping to have lots of opportunities to hear your voice. We have listed options of how we might be able to do this over the page and invite you to tick the box for what you think would be the best options for you.

The type of questions we will ask you are about your experiences including the support provided, meetings you attend and what we can do to change things. We want to listen carefully to what needs changed.

Everything is confidential and the information that you share will be so important for us to make the right changes, we will not use your names or any other identifying information.

You can return this letter back to your social worker once you have chosen the options over the page.

Thank you for taking the time to read our letter.

Yours sincerely

Lesley & Erin

I Promise Team

We will #KEEPTHEPROMISE

NOTHING ABOUT YOU WITHOUT YOU

Please tick what you think would be the best way for us to support you to have your voice heard and how is the best way to contact you?

To meet 1-1 ☐ Email_____

To meet in a group setting ☐ Mobile_____

To speak over the phone ☐ House No: _____

A survey via email ☐

To speak over a digital meeting ☐

A digital survey ☐

Drop in at school ☐

Other:

Erin Power Lesley Ellis

You can scan here to meet the Team if you have a camera phone!

If you want to chat more about this or have any questions, we can be contacted via the details below

Email: ipromiseteam@inverclyde.gov.uk

Your Voice: 01475 728628 (Erin)

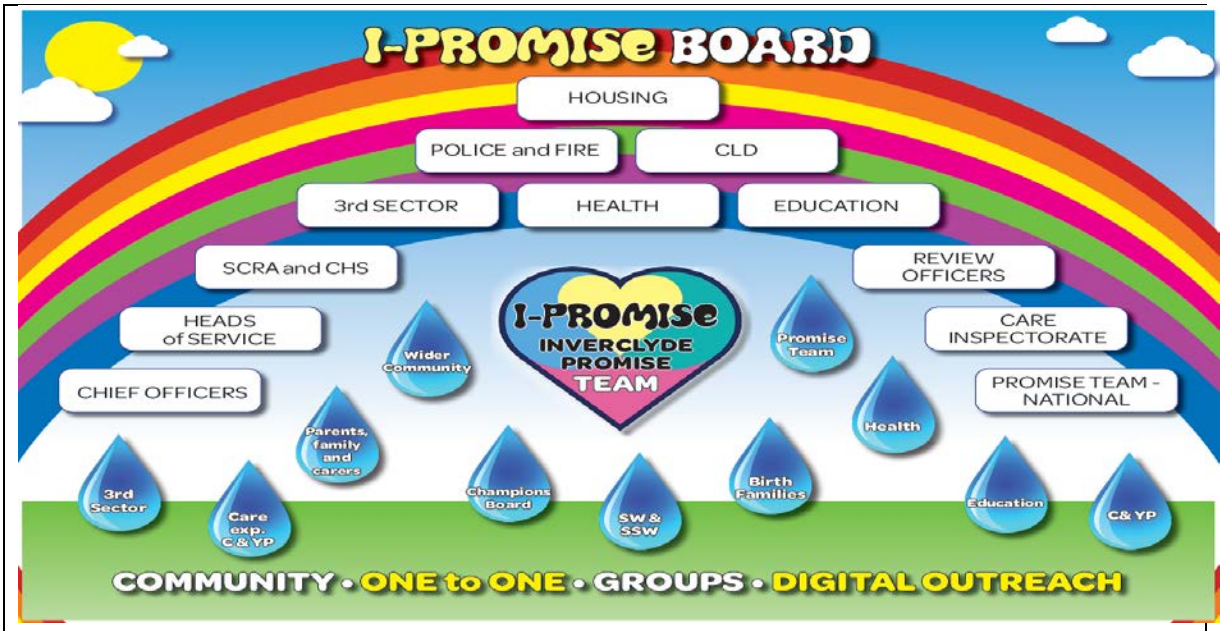
Lomond View Academy: 01475 715020 (Lesley)

Or you can contact us through your social worker.

Stategic plan refresh – Big 6 actions.

The Proud2Care young people were part of consultation process with Head of Service facilitated by I Promise team. The information shared during the discussion was relevant in relation to the priority area of a good childhood in terms of supporting young people with their mental health, having access to information in relation to substance misuse and in addition they shared that in order for this advice to be effective more communication should take place with lived experience people.

I Promise Board/Championship Board – Corporate Parents.



Connections have already been made current corporate parents in line with Champions Board. This diagram demonstrates the vision for I Promise board. As time is spent with partners and colleagues discussion is and will continue around the importance of Keeping the Promise and the need for Promise keepers to be identified.

Key corporate parents to date who have agreed to forming the I Promise Board detailed below and discussion is ongoing to bring on board other partners

- Elected members
- Chief Officer / Executive
- Police Scotland
- NHS
- Scottish Fire and Rescue
- Children's Rights Officer
- Education
- Barnardos
- West College Scotland)

WHOLE FAMILY SUPPORT

Family: where children are safe in their families and feel loved they must stay – and families must be given support together to nurture that love and overcome the difficulties that get in the way**.**
Scaffolding: workforce/ supports that would be ready and responsive to families when this is required.

Test of Change – a small outreach reach service delivered to 10 families has been in operation aimed at reducing the risk of children and young people being accommodated. Consultation undertaken with social worker/parents has included the following:

- Parents have shared this has been so helpful and supportive
- Parents have also said it was difficult to accept at first but the children love having staff there and it has helped them.
- Good relationships with staff and feel supported
- SW advised that emotional support was very much required and beneficial
- SW advised that the service has so far been successful. I'll be contacting the service to withdraw this week following positive improvements for the family.
- The family have said that the supports have been intrusive at times. This is more about the nature of support rather than individual practice however they were able to engage.

Alcohol and Drugs Partnership – Discussion and input has taken place on The National Promise and IPromise regarding Whole Family Approach to Recovery and expectations actions in relation to alcohol and drugs. An input to ADP committee planned for May.

Recovery community supports were set up in November 2021 and information awareness /referral process of support/recovery cafes with connections made with Social work teams to identify referral pathway to recovery community projects.

All information regarding the service being provided within Inverclyde has been shared with SW Workforce that is offered 7 days per week.

Further discussion being offered to those with lived experience.

Kinship Carers – time was spent with Kinship carers who identified a number of barriers with regards to the level of care they are providing to their young people.

PLANNING

Part of National Guidance CP working group- **Family Group Decision Making** with unborn infants webinar with Edinburgh City Council and time with Reviewing Officers and Service Manager regarding test of change/Pilot ,

Focus on **wellbeing assessments**

The introduction of **Mind of My Own** –a digital tool for ensuring we are meeting the requirements of The Promise in relation to promoting the voice of the child is being explored.

I Promise Team plan to undertake **IROC Award** to ensure that all activity has children's rights at the core.

Attendance at NES Scottish Trauma Informed Leaders Training. Recognition of the importance of the LA being **trauma informed** across the whole workforce.

SUPPORTING THE WORKFORCE

Workforce

Awareness raising with SW workforce is almost complete with the consultation and input to 55 plus SSW/SW/SWA/HM within Children and Families. This has included discussion in relation to What are we doing well, what do we need to do better. Statements from The Promise Briefings in relation to our ambitions

A tracking report is underway which includes a baseline of where we are at in terms of plan 21-24/Change programme and what needs to be better in terms of outcomes. This will be shared with workforce following a final session and will include the development day with Throughcare, Aftercare and Continuing Care.

There are a number of key themes being shared from the workforce however what has been identified by the team is the value that the workforce place on relationship based practice with children, young people and families.

Workforce sessions to join the dots of all the supports available to families across Inverclyde from HSCP and 3rd Sector partners.

Emerging themes so far

Family group decision making- Need to facilitate opportunities for families to come up with solutions. Empower our families.

Wellbeing assessments keep repeating the history and almost reaffirming it. Write reports that care experienced children and young people and families WANT to read. Developing a young person report like the Pinky Promise version/style.

Report Writing, needs to be written in a way that young people and families understand. We need to change the language and the way we report. Writing to the child/young person in case notes and also within minutes/plans.

Peer support opportunities – value of lived experience, people supporting each other, building resilience together and empowering each other

Family Time (contact) we need better environments to meet that are friendly and relaxing spaces, family time needs better coordinated so less stigma perceived.

Language -change the language we use to be less stigmatising and more supportive, clear and concise.

Specific actions graded on a traffic light system, used as a baseline for moving forward in terms of their plan.

Youth Justice

Plan 21-24 Youth Justice:

- The disproportionate criminalisation of care experienced children and young person will end
- 16-17 year old will no longer be placed in young offenders institute for sentence or remand
- There will be sufficient community based alternatives so that detention is a last resort
- Children who do need to have their liberty restricted will be cared for in small, safe trauma informed environments that uphold their rights

Social workers involved I delivering youth justice had a session with I Promise team looking specifically at Plan 21-24 objectives and the Change Programme for Youth Justice. In addition information was provided on the National Promise and key details of secure care, restraints and Justice.

Partner Agencies

Child Protection Practitioner's forum were provided with the National Promise and I Promise presentation on 25th April 2022. Also delivered to The Best Start in Life Network. Joint working has also commenced with the Parenting Strategy group.

Communication has commenced with Employability and West College Scotland in relation to how we support care experienced children access college and be supported throughout their course or should they withdraw from their course. Work will continue in relation to a strategy plan along with Virtual Head Teacher for Care Experienced young people.

Continued work with Poverty Action group in terms of contribution to Action plan.

4 Children's Houses

Awareness and development days planned this will include Language matters. National Promise Briefings/Plan 21-24 and specific residential statements.

No 9 27th April 2022
The View 29th April 2022
Kylemore 3rd May 2022
Crosshill 17th May 2022

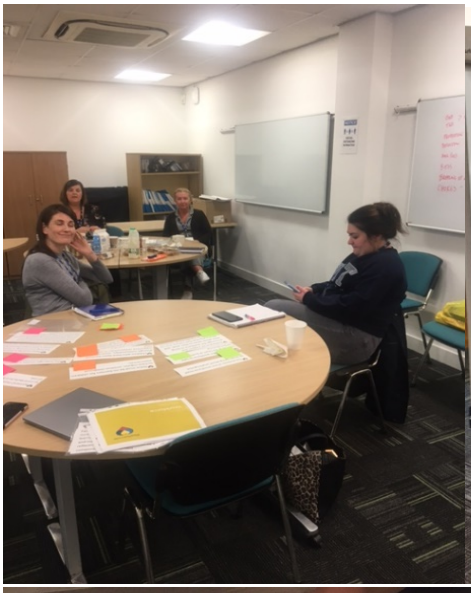
Awareness raising with Fostering/Kinship Services will take place on 4th May 2022

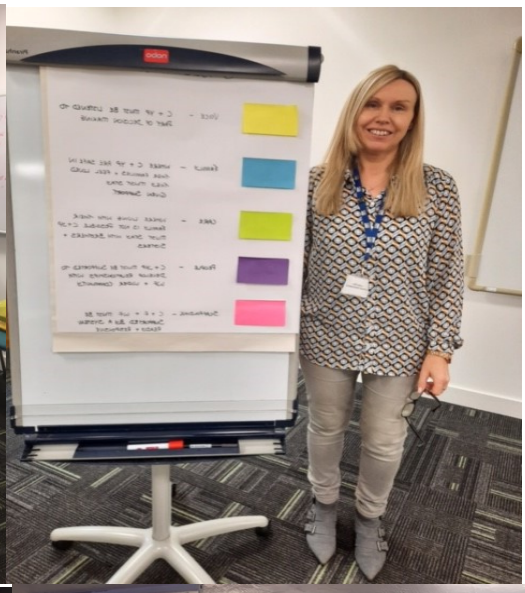
Awareness raising with Adoption Services on 16th May.

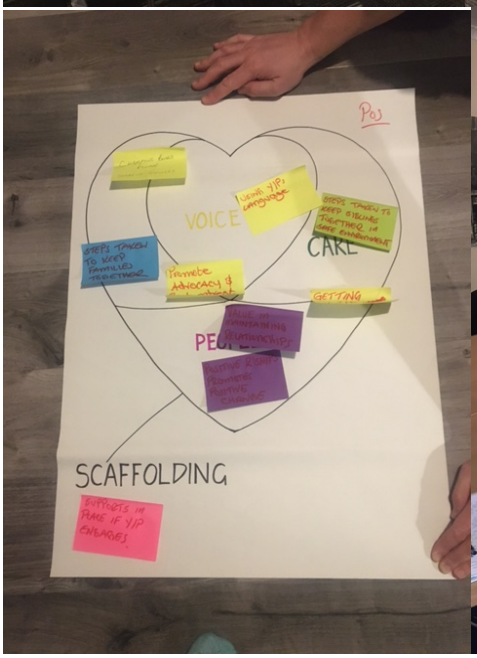
Previous days had been spent with **Throughcare/Continuing Care/After Care** - Development Day held including Promise information directed to this service.

Learning and Development Team /students - Promise input and discussion (awareness raising and what we are doing well and need to do better) March

Some photos attached.







BUILDING CAPACITY

Awareness raising with Children's Panel members took place 7th March and 14th March virtually (Inverclyde panel community) This includes learning from The Promise, what we are doing well and need to improve. These engagements covered local and national Promise plans. The first engagement covered Inverclyde's Promise and then the following week Carol Wassell Head of Area Support and Community Improvement for Children's Hearing's Scotland spoke regarding CHS delivering the promise and legislation.

Local face to face input is planned for **Thursday 5th May 2022** to explore with the panel community regarding keeping the promise. The Foundations will be a focused exercise along with specific briefings from National Promise with regards to Children's Hearings. Photos will follow.

POWERED BY YOUNG PEOPLE = **Jargon Buster/Language Matters**

The young people have been engaging in Jargon Buster/Language Matters. Here is what they have so far.

LETS STOP USING	**THIS SOUNDS AND FEELS BETTER**
ABSCOND	Run away; Go missing
CARE PLAN	Future plans; My plan
CHALLENGING BEHAVIOUR	Having trouble coping; feeling distressed; Difficult thoughts
CONTACT	Making plans to see our family; Family meet up time/Family time; Seeing Dad/Mum/Gran/etc.
PERMANENCE	My home without disruptions
PLACEMENT	Our home; My house or the house where I live
RESPITE	A break for children (not carers); Day out; Stay over; Sleepover
SIBLINGS	Our brothers and sisters; People who are related to me
STAFF, SUPPORT WORKER, UNIT MANAGER	Their name, My person
RELEVENT PERSON	
LAAC	
LAAH	
SAFEGUARDING	
CSO	
ICSO	
ASSESSMENT	
IN CARE	
SCATTER FLAT	
CASE FILE	My Story
TRANSITIONS	

As noted, a previous test of change relates to the Planning of Throughcare, Aftercare and Continuing Care in terms of their Going4ward paperwork.

National Promise linkage

Attendance at 5 day Design school	Complete with additional 1-1 with lead design
Monthly links with National Promise Team	This includes local authorities/3rd sector
Engagement with COSLA	Re The Promise/GIRFEC/National Promise
Link with neighbouring authorities	Peer learning

Meetings with CORRA	Oversight of spending and work progress

I Promise Team

27th April 2022

AGENDA ITEM NO: 13

Report To:	**Inverclyde Integration Joint Board**	**Date: 27 June 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde Health & Social Care Partnership**	**Report No: SW/29/2022/LM**
Contact Officer:	**Laura Moore Chief Nurse Inverclyde Health & Social Care Partnership**	**Contact No: 01475 715212**
Subject:	**PROGRESS UPDATE CLINICAL AND CARE GOVERNANCE STRATEGY WORKPLAN 2021 - 2022**	

1.0 PURPOSE

1.1 This report provides a summary of progress to date on the Clinical and Care Governance Strategy Workplan. The Clinical and Care Governance Strategy is an element of Inverclyde HSCP Strategic Plan.

2.0 SUMMARY

2.1 The report covers the work of the Clinical and Care Strategy Work Plan and the future plans for reporting progress within Inverclyde Strategic Plan.

3.0 RECOMMENDATIONS

3.1 Members of the IJB are asked to note the Clinical and Care Governance Strategy Work Plan for the Inverclyde HSCP.

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 Inverclyde HSCP's Clinical and Care Governance Strategy describes a clinical and care governance framework that fosters and embeds a culture of excellence in clinical and care governance practice, which enables and drives forward the delivery of safe, effective, high quality, sustainable person-centred care based on clinical evidence and service user experience, resulting in positive outcomes for our community

.

The Clinical and Care Governance Strategy covers both structures and processes at all levels within Inverclyde HSCP and services provided on behalf of the Inverclyde Community, leading to and supporting continuous quality improvement.

4.2 The Clinical and Care Strategy WorkPlan was originally progressed by Sharon McAlees. The work is now lead by the Chief Nurse who took over the direction of progress of the workplan from December 2021.

4.3 Progress has been made in all areas of the work plan and the impact of Covid on staffing levels along with operational pressures has resulted in some delays in the work being fully completed. It is anticipated that the remaining aspects will be completed in 2022 -2023 and that future updates be contained in the update of the Strategic Plan. The Clinical and Care Governance Group will continue to oversee progress on the wok plan, and there may be changes of the strategic focus to reflect completion of the initial priorities and to set and meet new challenges.

4.4 Inverclyde HSCP is on target with the work on the implementation of Care Opinion. The launch for Care Opinion is on target for Summer 2022 and there was a staff awareness session that took place on 14th April 2022.

Duty of Candour target will be on track with training sessions planned for 2022. There has been an information repository for all services developed and this will assist staff in the identification, monitoring and investigation of incidents.

The work on standardising the investigation processes for adverse events for the HSCP is on target. There is a review currently ongoing within NHS Greater Glasgow and Clyde for Significant Adverse Event Reviews and the recommendations from this will be incorporated into the plans for Inverclyde HSCP.

4.5 The challenges remaining for 2022 - 2023 are the Quality Improvement ambitions and the work is currently in the process of being mapped out. It is anticipated that this will conclude in 2022 with the recommendations reviewed by the Senior Management team and the Clinical and Care Governance Group.

5.0 IMPLICATIONS

FINANCE

5.1

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

5.2 n/a

HUMAN RESOURCES

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

EQUALITIES

5.4 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.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	Robust Clinical Care Governance ensures that protected groups are considered
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	Robust Clinical Care Governance ensures that protected groups are considered
People with protected characteristics feel safe within their communities.	Public protection, learning from adverse events are within the Clinical Care Governance Framework
People with protected characteristics feel included in the planning and developing of services.	Robust Clinical Care Governance ensures that protected groups are considered
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	Staff are supported through robust professional framework and Clinical Care Governance
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	Robust Clinical Care Governance ensures that protected groups are considered
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	Robust Clinical Care Governance ensures that protected groups are considered

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are clinical or care governance implications arising from this report. The strategic importance of the work for the Clinical and Care Governance Strategy and Work Plan aims to improve and specify outcomes for the role of Clinical and Care Governance in Inverclyde HCSP.

NATIONAL WELLBEING OUTCOMES

5.6 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 Clinical & Care Governance Strategy and Workplan supports high quality care is person centred.
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	The Clinical & Care Governance Strategy and Workplan supports high quality care is person centred.
People who use health and social care services have positive experiences of those services, and have their dignity respected.	The Clinical & Care Governance Strategy and Workplan supports high quality care is person centred.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	The Clinical & Care Governance Strategy and Workplan supports high quality care is person centred.
Health and social care services contribute to reducing health inequalities.	Robust Clinical Care Governance contributes to addressing inequalities
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.	The Clinical & Care Governance Strategy and Workplan supports high quality care is person centred.
People using health and social care services are safe from harm.	The Clinical & Care Governance Strategy and Workplan supports high quality care is person centred.
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.	Clinical Care Governance framework supports continuous improvement
Resources are used effectively in the provision of health and social care services.	The Clinical & Care Governance Strategy and Workplan supports high quality care is person centred.

6.0 DIRECTIONS

6.1

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

7.0 CONSULTATION

7.1 The report has been prepared by the Interim Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

8.0 BACKGROUND PAPERS

8.1 Inverclyde HSCP Clinical and Care Governance Strategy Work Plan: 2021 -2022 (Updated).

Inverclyde HSCP Clinical and Care Governance Strategy

Work Plan: 2021 -2022

Overview:

Inverclyde HSCP's Clinical and Care Governance Strategy describes a clinical and care governance framework that fosters and embeds a culture of excellence in clinical and care governance practice, which enables and drives forward the delivery of safe, effective, high quality, sustainable person-centred care based on clinical evidence and service user experience, resulting in positive outcomes for our community

.

The Clinical and Care Governance Strategy covers both structures and processes at all levels within Inverclyde HSCP and services provided on behalf of the Inverclyde Community, leading to and supporting continuous quality improvement.

Appendix 14

To support the Clinical and Care Governance Strategy, the HSCP has developed the following Action Plan around these key aspects and focuses on a key priority for each domain. The Action Plan has a clearly defined scope (domains) for clinical and care governance, as described below:

Domain	***Priority***
• **Adverse Event and Clinical and Care Risk Management**	**Duty of Candour Process for the HSCP**
• **Continuous Improvement**	**Quality Improvement Plan for the HSCP**
• **Person-Centeredness**	**Consistent Means of Capturing and Analysing Feedback**
• **Clinical and Care Effectiveness**	**Standard Operating Procedure for incident reporting for the HSCP**

Status Key

 Completed

 In progress

 Not on target

Domain: Adverse Event and Clinical and Care Risk Management
HSCP Clinical and Care Governance Priority – Duty of Candour Process for the HSCP
Craig Given, Head of Finance, Planning and Resources

Ref	Activity	Lead	Progressive Actions To Date (Measurable)	Status	Timescale for completion	Measure
1.0	**Outcome: Duty of Candour identification, recording and reporting**					
1.1	**Duty of Candour.** To ensure consistent process for the recording of Duty Of Candour incidents is in place across the Partnership. Duty of Candour is a governance process that came into effect on 1 April 2018. The overall purpose of a duty of candour is to ensure that the HSCP is open, honest and supportive when there is an unexpected or unintended incident resulting in the death of or harm to a patient or service user.	Craig Given	Each HSCP service's Clinical and Care Governance Group will have a Duty of Candour item on the agenda to review progress. Training will be provided by the HSCP in conjunction with NHS Greater Glasgow and Clyde on how to identify Duty of Candour incidents. All HSCP services to input Duty of Candour incidents on their incident reporting system. Each HSCP service Clinical and Care Governance Group to appoint a Duty of Candour Champion to assist staff in the identification, recording and reporting of	   	June 2022 September 2022 September 2022 September 2022	**Standard Agenda items to be updated** **% staff uptake by care group** **HSCP guidance to be issued** **Staff identified**

	The HSCP has a responsibility that patients and service users have a right to be told honestly what has happened, what will be done in response and to know how actions will be taken to stop this happening again to someone else in the future. The key stages of the duty are : • notify the person affected (family/relative) within 10 days • provide an apology • carry out a review into the circumstances leading to the incident • offer and arrange a meeting with the person affected • provide the person affected with an account of the incident • provide information about further steps taken • make available, or provide information about, support to the person affected by the incident • prepare and publish an annual report on the Duty of Candour.		incidents and levels of compliance with the standards Each service to devise a means of ensuring staff understand, record and appropriately action Duty of Candour incidents as follows The duty of candour regulations are highlighted at service governance meetings to ensure service users are fully informed (or their families/carers acting on their behalf) when they have been harmed (physically or psychologically) as a result of the care or treatment they have received. Services ensure that as part of this process they are: • Open & timely communication • Acknowledgement of harm • Apology/expression of regret • Supporting the needs & expectations of Patients/family Adverse events are investigated by HSCP services and that the results of this will be shared with the patient /service user/ family and reported through Clinical and Care Governance Structures. Services ensure that staff who have been involved in adverse events are appropriately			

			supported and staff are trained/developed on the preparation for the disclosure conversation. HSCP to identify a training lead to ensure Duty of Candour Development A SOP has been devised with the aim of summarising how all services record and investigate Duty of Candour incldents and this consistency of process will be reflected in the annual report for clinical and care governance.			**SOP to be fully implemented by May 2022**
1.2	To develop section on Duty of Candour for inclusion in the Annual Clinical and Care Governance Report. This is a requirement for NHS Greater Glasgow & Clyde Candour Policy.	Clinical Director	The Annual Report for Clinical and Care Governance will contain a section for all HSCP incidents that is publicly available. The report will cover an overview of the number of incidents for each service and how learning from duty of candour incidents has been applied.		June 2022.	**Report to IJB**
Additional Information:						

Domain: Continuous Improvement HSCP Clinical and Care Governance Priority – Quality Improvement Plan that Tracks and Commissions Improvement Activity Head of Service to be confirmed						
Ref	**Activity**	**Lead**	**Progressive Actions To Date (Measurable)**	**Status**	**Timescale for completion**	**Measure**
2.0	**Outcome: Quality Improvement Plan that Tracks and Commissions Improvement Activity**					
2.1	The HSCP to develop a plan that streamlines the process for quality improvement across all the services. Quality Improvement is "a systematic approach that uses specific techniques to improve quality" (Health Foundation, 2013) To ensure clear understanding for all services where all improvement activity is commissioned and tracked.	TBC	A short life working group to be convened to define the parameters of the work for a quality improvement plan. Input should be sought from NHS Greater Glasgow and Clyde, Health Improvement Scotland, Scottish Social Services Council, Professional Medical, Allied Health and Nursing bodies and the Care Inspectorate to ensure necessary rigour in the process to be devised. Professional leads network should be utilised to support this process		The Head of Service to oversee this work has yet to be identified. The scoping exercise is underway and is expected to conclude in August 2022. This involves a survey to all services to map out their quality	TBC

			social problems.		improvement activity and the progress on this work will be reported to the Clinical and Care Governance Group and Senior Management Team.	

Domain: Person Centredness HSCP Clinical and Care Governance Priority – Consistent capturing and analysing feedback Head of Service to be identified and supported by Laura Moore, Chief Nurse						
Ref	**Activity**	**Lead**	**Progressive Actions To Date (Measurable)**	**Status**	**Timescale for completion**	**Measure**
3.0	**Outcome: Consistent Process for Identifying, Recording and Learning from Feedback**					
3.1	Staff to be actively encouraged at every local clinical and care governance group to reflect on their practice and in their team meetings to routinely ask for feedback. The groups will review complaint information focusing on: -Learning from complaints where recommendations have been made - SPSO Deciison and Investigation letters -Formal Inspections (Care Inspectorate, Healthcare Improvement Scotland)	Laura Moore	Each clinical and care governance group will be required to evidence how staff have asked for feedback and what changes and learning have occurred as a consequence. HSCP service areas to develop and implement changes that are known to enable health and care services to be truly person-centred based on the learning from events and to be able to evidence this The experience of the service users who are supported by Inverclyde HSCP services is central to the improvement of our service development. Care experience		Standardised Proforma for the collation of information for every service will be devised for July 2022. This work will be completed by the Clinical and Care Governnace Faciliator	**Standard agenda item for all Clinical and Care Governance Groups is in place, alongside the HSCP Clinical and Care Governance Group.**

	-Care Opinion when implemented -Datix actions after a Significant Adverse Event Reivews -Signifciant Case Reviews -Large Scale Investigations		feedback will be utilised to identify the areas that matter most to the people we care for as well as identifying opportunities where services can improve. Care experience will be a standing item on our service clinical and care governance meetings, feeding into the HSCP group, providing an opportunity to implement quality improvement methods and linking in ideas and learning from other areas. The continuous improvement cycle of learning and development will inform an evaluation of service development and identify benefits to the people using and working in Inverclyde HSCP's health and care services. Every local clinical and care governance group will be asked to evidence systems via the proforma for the routine asking and recording of feedback from the public who use their services. Including • Supporting teams to reflect on feedback gathered and learn		and the Complaints Manager.	

			what matters most to people in our care as well as where we can make changes and improvement • Assisting teams and services to constructively apply feedback to improve the quality of care and treatment. • Providing coaching and mentoring support to teams to test and implement changes and improvements to care and service delivery • Analysis and evaluation of all feedback sources to identify common themes, patterns and trends, to identify areas to reward success and identify key priorities where improvement needs to be concentrated • Quarterly feedback reports to services and quarterly to Clinical and Care			

			Governance Group through the four parent CCG groups. • Working in Partnerships with patient and carer experience groups. • Demonstrating the priority of person centred care within communications and meetings • Whisteblowing incidents once identified may also provide learning for the HSCP The impact of this activity will be overseen by each services governance groups and the HSCP Clinical and Care Governance Group.			
3.2	Consideration should be given to the introduction of Care Opinion as a consistent means of evidencing that feedback is being requested and that staff and the public can see what changes have occurred as a result.	Laura Moore	Care Opinion will be live for Inverclyde HSCP in June 2022 and there is a Care Opinion Implementation Group convened, chaired by Laura Moore, Chief Nurse to oversee progress.		June 2022.	**Agreement to roll out Care opinion and signed SLA**

						Completed roll out **Agenda and minutes of meetings to evidence discussion and learning**
Additional Information:						

Domain: Clinical and Care Effectiveness HSCP Clinical and Care Governance Priority – All Significant Incident Systems SOP for all HSCP Alan Best Interim Head of Health and Community Care						
Ref	**Activity**	**Lead**	**Progressive Actions To Date (Measurable)**	**Status**	**Timescale for completion**	**Measure**
4.0	**Outcome: All Significant Incident Recording Systems to Have a Standard Operating Policy for Staff in all HSCP Services**					
4.1	To ensure staff know and utilised the agreed protocol in order to escalation Significant Incidents whilst acknowledging recording systems may differ within each services. Inverclyde HSCP have a responsibility to ensure these incidents are appropriately investigated to minimise the risk of recurrence by applying lessons learned. This opportunity for learning exists at times without a significant adverse outcome for the patient, e.g. a near miss or a lower impact incident which exposes potential clinical system weaknesses that could lead	Alan Best	This work will produce a Standard Operating Procedure that will summarise all the incident reporting systems in operation in the HSCP and guidance on when and how to use for staff. This should ensure that all staff are clear on all the incident recording systems in operation and how and when to use. Inverclyde HSCP NHS services utilise a SAE toolkit to investigate serious incidents found within the Serious Adverse Event policy which contains, guides for local procedures and also		Mental Health and ADRS services are finalising a SOP for SAER. The governance structure has been amended in 2022 to have a Mental Health and ADRS Incident Review Group and the Homelessness Service also has set up an	

	to further significant harm. Such events have been traditionally referred to as Significant Adverse Events (SAE). The purpose of the investigation is to determine whether there are learning points or improvements for the service and wider organisation. It is then our responsibility to implement those improvements that are identified as producing a greater level of clinical safety for our patients. Non clinical systems have their own distinct governance arrangements. The management of a SAE forms part of the current Clinical Risk Management arrangements and should be recognised as an important means of improving the quality of patient care and identifying and minimising risk. It is the policy of NHS GG&C that: whenever events lead to concerns about the quality and safety of care these should be subjected to an appropriate review. · When a review of the quality and safety of care is undertaken, the principle of		guidance on tools and process as well as key information links. The toolkit can be found within the Clinical Governance Support Unit Staffnet site at the following link: http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Clinical%20Governance/Clinical%20Risk/Pages/SCIInvestigationToolkit.aspx NHS GG&C Services ensure that Datix is utilised for all incident reporting and this is a standing item on Service and HSCP Governance groups. Support is available from the Datix Governance Unit. Learning and feedback from incident reporting is implemented in all teams and service leads approve all reviewed outcomes. Professional leads are involved in the learning from all significant incidents and ensuring that these are reported through relevant governance structure for learning across GGC.		Incident Review Group to review incidents in a similar way although the incident reporting systems are not the same (Datix and Figtree). The work will also be influenced by the review of adverse event reporting underway by NHS Greater Glasgow and Clyde, overseen by Katrina Philiips.	

	being open with patients (and families) should be followed. · When the events meet the description of a Significant Adverse Event, then this policy should be applied. NHS Greater Glasgow & Clyde utilises the online Datix system where: • All adverse incidents should be recorded (clinical and non-clinical), including near misses and potential incidents; and involving patients, relatives, visitors, staff, contractors, volunteers or the general public. • An *incident* is any event or circumstance that led to unintended or unexpected harm, loss or damage. A *Near Miss* is an event or occurrence which, but for skilful management or a fortunate turn of events, *would* have led to harm, loss or damage.					

Additional Information:

AGENDA ITEM NO: 14

Report To:	**Inverclyde Integration Joint Board**	**Date: 27 June 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde Health & Social Care Partnership**	**Report No: IJB/30/2022/HMcD**
Contact Officer:	**Dr Hector MacDonald Clinical Director Inverclyde Health & Social Care Partnership**	**Contact No: 01475 715284**
Subject:	**ANNUAL REPORT CLINICAL AND CARE GOVERNANCE 2021-2022.**	

1.0 PURPOSE

1.1 This report provides a summary of the yearly activity of the Clinical and Care Governance Group for 2021 -2022. Members of the IJB are asked to note the report. This report will be sent to NHS Greater Glasgow and Clyde as all Health and Social Care Partnerships are requested to provide an Annual Report covering the role and remit of the group and any future plans for review and evaluation. The Annual Report for Clinical and Care Governance describes the commitment to safe, effective and person centred care in a year of significant pressure for the HSCP.

2.0 SUMMARY

2.1 The report covers the work of the Clinical and Care Governance Group for 2021-2022

3.0 RECOMMENDATIONS

3.1 Members of the IJB are asked to note the Annual Report.

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 Each Health and Social Care Partnership is requested by NHS Greater Glasgow and Clyde to provide an Annual Report of the activity of Clinical and Care Governance.

4.2 The intention is to provide an overview of activity to allow NHS Greater Glasgow and Clyde to overview the work of all the Health and Social Care Partnerships.

5.0 IMPLICATIONS

FINANCE

5.1

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

5.2 n/a

HUMAN RESOURCES

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

EQUALITIES

5.4 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.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	None

Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
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

5.5 There are clinical or care governance implications arising from this report. The Annual Report is part of the Clinical and Care Governance assurance for NHS Greater Glasgow and Clyde for Health and Social Care Partnerships.

NATIONAL WELLBEING OUTCOMES

5.6 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.	None
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.	None
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.	None
People using health and social care services are safe from harm.	None
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.	None
Resources are used effectively in the provision of health and social care services.	None

6.0 DIRECTIONS

6.1

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

7.0 CONSULTATION

7.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

8.0 BACKGROUND PAPERS

8.1 None.

Appendix 1

Inverclyde Health and Social Partnership

Clinical and Care Governance
Annual Report 2021 - 2022

Principal Author:	Dr Hector MacDonald
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Approved by:	
Date approved:	

1.0 Introduction

1.1 The Clinical and Care Governance Annual Report for 2021 -2022 will reflect the work of Inverclyde HSCP in response to the Covid -19 pandemic and the process for assurance regarding standards and quality of care.

1.2 There will be a concise overview of the main areas of activity for governance arrangements and the main challenges for the Covid -19 recovery phase for IHSCP. There will be a focus on Safe, Effective and Person Centred Care for the report.

1.3 On 23rd March 2020 Scotland moved into lockdown in response to the Covid-19 pandemic. This is the second annual report for clinical and care governance that will be focused on the response to the pandemic, and the increased associated risks for the HSCP and how they have been managed in the context of unprecedented operational challenges in maintaining services.

1.4 Staff have worked incredibly hard to adapt to how to provide safe, effective and person centred care in the last two years. Services have continued to be delivered and whilst challenges have and continue to be overcome, the move to recovery and resumption of services to pre pandemic levels will not be a straightforward journey. The strategy and policy landscape is anticipated to change as 'A National Care Service for Scotland' is considered by the Scottish Government. This will have the potential for wide ranging governance changes depending on the direction of travel for this work.

1.5 Significant challenges for Inverclyde have arisen as a result of the Omicron variant of Covid-19 in 2021-22, in line with all Scotland. The Scottish Government Strategic Framework Update was published in February 2022. The challenging winter for 2021 into 2022 was anticipated with the risk of the new variant emerging very quickly. Covid-19 prevalence for all of Scotland peaked in early January 2022. However for Inverclyde, the impact of Covid-19 provides significant risk in managing issues of staffing shortages and sickness absence as a result of the pandemic. The governance processes established provided assurance and mitigation throughout the response to the pandemic. It is clear that services have had to adapt to continue to provide services and that the public have expectations that services will resume to pre pandemic levels. It is crucial that responding to the feedback from the public continues to be strengthened and that the importance of person centred care for all services will be clear as a theme of this annual report. The staff commitment, creativity and resilience has been extraordinary and the governance priority and commitments to staff wellbeing is a crucial component to the pandemic response.

2. 0 Clinical and Care Governance arrangements 2021-2022

2.1 The Clinical and Care Governance Group met on 15th June 2021; 21st September 2021; 16th November 2021 and 15th March 2022. The group chair is Dr Hector MacDonald, Clinical Director for IHSCP.

2.2 The three local clinical care and governance groups resumed their usual meeting schedule for IHSCP (Mental Health, Alcohol and Drug Recovery and Homelessness; Health and Community Care and Children's Health and Criminal Justice).

2.3 Table 1 shows the current clinical and care governance arrangements for IHSCP, and NHS Greater Glasgow and Clyde and Inverclyde Council. The main change that has occurred is that Mental Health, Alcohol and Drugs Services and Homelessness Service set up an Incident Review group, to combine Mental Health and Alcohol and

Drugs Services and a separate Homeless Service Incident Review Group. This started in 2022 and the alteration to the governance processes has led to improved and focused review appropriate for the services concerned.

The governance for commissioned providers is provided by the Strategy and Support team who report to the Health and Social Care Committee.

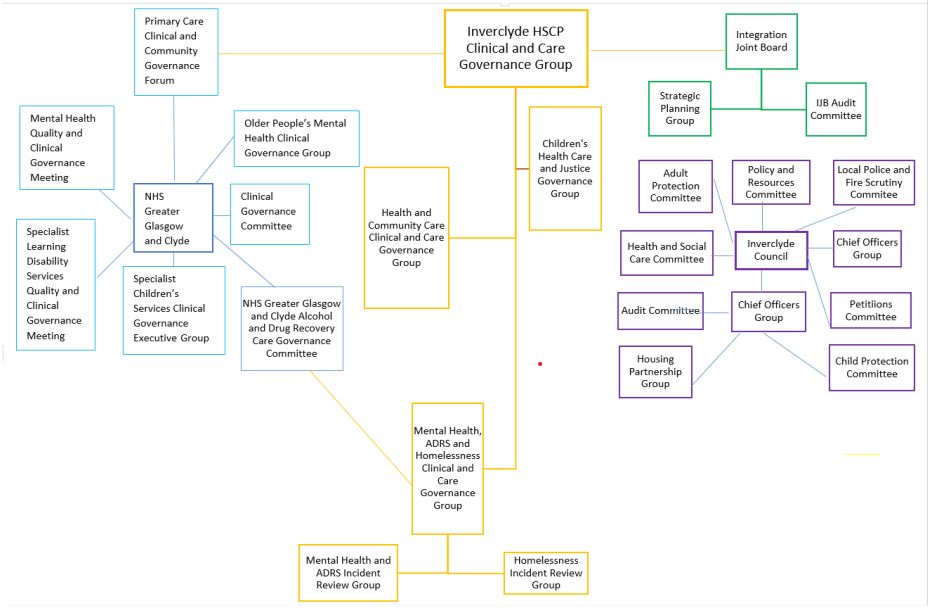
Senior Officers will present reports to the IJB from the Clinical and Care Governance Group.

There is a report that is prepared by the Clinical Director for the Primary Care Clinical and Community Governance Forum.

The Alcohol and Drug Recovery Service also provide governance updates to the NHS Greater Glasgow and Clyde Alcohol and Drug Recovery Care Governance Committee.

2.3.1 Current Clinical and Care Governance arrangements

Table 1 Inverclyde HSCP Clinical and Care Governance Structure



2.4 Covid -19 Strategic Response

2.4.1 Throughout 2021/22, as a result of the Covid -19 pandemic, service provision has continued to be, by necessity, subject to change and reactive to Government guidance and restrictions. At the start of the first national lockdown, action was taken to ensure that essential services continued to be delivered, where possible and the core business of the HSCP was maintained while at the same time ensuring the ongoing safety of both the workforce and the public. Investment in technology has enabled many services to adapt and continue to support Inverclyde's communities, albeit in a 'virtual' capacity. Additional support mechanisms were put in place around all internal and external services during this time. This has included the introduction of a number of new groups and regular safety meetings within the HSCP including: a

weekly Local Resilience Management Team meeting (LRMT), fortnightly Covid -19 Recovery Group meetings, Humanitarian Aid Groups, regular care home safety huddle meetings and weekly multidisciplinary meetings.

Staff within the HSCP and those working for our external providers, as well as a number of local community groups have worked tirelessly throughout the pandemic to ensure that services can continue to be delivered safely and to support the physical and mental health and wellbeing of people across Inverclyde. To ensure we support our staff, the HSCP has created a Wellbeing at Work Plan and a series of support measures to help staff cope with the stresses and strains brought on by the pandemic. A Wellbeing at Work week was recently held in March 2022 promoting, implementing and highlighting these support measures.

Interim governance structures developed in 2020/21 were continued into 2021/22 and a recovery plan was drafted to map out the pathway for services and the IJB as the country moved through this pandemic. Throughout this time the HSCP continued to work to put people at the centre of all that we do and ensure that essential services are delivered safely and effectively and in line with our Strategic Plan. The Strategic Plan was reprioritised to focus on Covid-19 recovery with 28 priorities linked to the IJB 6 Big Actions and included the newly emerging priorities such as Covid-19 recovery, Test and Trace and vaccinations and to also reflect the unavoidable delay in some priorities such as the roll out of locality groups. The revised plan was approved by the Strategic Planning Group in August and officers have worked hard during 2021/22 to deliver against the revised plan.

The IJB Strategic Plan is supported by a variety of service strategies, investment and management plans which aid day to day service delivery. These plans and strategies identify what the IJB wants to achieve, how it will deliver it and the resources required to secure the desired outcomes. The Strategic Plan also works in support of the Inverclyde Community Planning Partnership's Local Outcome Improvement Plan and the Greater Glasgow & Clyde Health Board Local Delivery Plan. It is vital to ensure that our limited resources are targeted in a way that makes a significant contribution to our objectives.

The Strategic Plan and other key documents can be accessed online at:

https://www.inverclyde.gov.uk/health-and-social-care

3. Safe

3.1 Support to Care Homes

3.1.1 Care Home Assurance Tool (CHAT) visits commenced across all NHS Greater Glasgow and Clyde partnerships in May 2020 in response to the impact of Covid-19. The visits set out with the aim of providing additional clinical input, support and guidance to care homes which were under extraordinary pressure. This work also aligned to the Executive Nurse Directors responsibilities set out by Scottish Government in which they were asked to provide nursing leadership, professional oversight, implementation of infection prevention and control measures, use of PPE and quality of care within care homes. Towards the end of December 2020 the roles and responsibilities of the Executive Nurse Directors were again extended to June 2022.

All older peoples care homes across Inverclyde received assurance visits in 2021-22, with adult homes receiving visits in spring 2022. Additional supportive visits particularly during Covid-19 outbreaks were also undertaken

It should be noted that care assurance visits are just one part of the supportive framework around care homes and sit alongside HSCP day to day relationships with individual care homes, HSCP oversight Huddles and the Care Home Assurance Group. However, the CHAT outcomes give the opportunity to discuss with care homes areas of strength as well as key priorities for the next 12 months. Going forward the Care Home Collaborative (CHC) model will support ongoing improvements.

Feedback and Learning from the Process

Overall the visiting team felt that the homes felt friendly and welcoming and it appeared that care home staff were more relaxed about the process, saw it as supportive and were keen to participate. It was agreed that asking the homes to undertake a self-assessment was really helpful and did meet the aim of the visits being more focused as a result of this.

Several areas for improvement were identified, most of which focused around evidence prior to the visit, clarity around the process and collation of the final report.

Key learning points

- To continue with the self-assessment approach, but allow homes a longer time to complete this and request that they complete this electronically to assist with collation of the final report

- Clarity required around the process, particularly pre and post the visit, individual responsibilities and timescales to ensure all of those who are undertaking the visits are clear on what is required and that there is a consistent approach

- Participating in the visits and completing the reports is very labour intensive and is hard to accommodate in busy diaries – more notice and planning around the visits would assist this

- Contacting the home pre the visit to discuss what information is required on the day and confirm who will be attending is helpful preparation

- Until now only 1 nurse has attended the smaller homes as part of the process. Two nurses is beneficial if one of them (Care Home Liaison Nurse,) knows the home and this assists with feedback and follow up of actions

- Collation of 4 separate reports per home is time consuming, having one master copy which everyone adds to, which once completed can be saved in the Master file would be much easier and reduce administrative burden. Process to include feedback to all contributors

Action plans from visits require monitoring as part of commissioning team regular meetings with homes, to ensure all actions are completed as per timescales.
The feedback meeting was a useful exercise. Feedback was also obtained from the care homes themselves who were sent an email asking them for their experience of the visit and thoughts on what went well and what could be improved for next time. Only one home replied to the email however others provided informal feedback at the time.

Key points from the care home feedback were that overall the experience was positive and staff were happy to liaise with the visiting teams. Care homes found that completion of the self-assessment documentation prior to the visit was very helpful in helping them to analyse their current position.

3.3. Covid -19 / Influenza Vaccination

The primary care team have continued to work in delivering the national Covid-19 vaccination programme to our housebound individuals who are unable to attend a vaccination centre. This also includes all our care home residents across Inverclyde. IHSCP remains responsible for delivering the Covid-19 vaccination and any subsequent booster vaccinations to this cohort of patients. All necessary operating processes and governance structures are in place as required. A mixture of staff have been seconded from various services to deliver the vaccinations, including the District Nursing team and also bank staff have been key in this local delivery model.

During the Covid-19 booster campaign, between September 2021 and January 2022 IHSCP vaccinated 594 care home residents and 2173 housebound patients. Data cleansing and preparation was then done, to prepare for the next round of vaccinations.

Mass vaccination clinics remained the responsibility of NHS Greater Glasgow and Clyde and they have continued to operate from large local community venues. IHSCP have supported these clinics during periods of acceleration of the booster programme, where there were significant staffing pressures across the board.

3.4 Adult Flu Vaccination

The normal seasonal flu campaign usually starts end September / October and includes everyone over the age of 65 and anyone under 65 in at risk categories. NHS staff also receive their flu vaccination and this extends across to our social care colleagues, particularly encouraging our care at home staff to get vaccinated.

GP practices historically delivered the flu vaccination programme, however given that last year's programme 2020/21 saw a mixture of practices and mass vaccination clinics delivering both the flu vaccine and the Covid-19 vaccine as it became available this has prompted further changes to the delivery model. The flu campaign has also been extended to include those between 55 and 64, additional social care staff and household members of those in shielding groups. The extended flu campaign is set to continue in Scotland in 2022-2023.

As we entered our 2021/22 flu campaign this was co-administered alongside the Covid-19 booster vaccine dose. NHS Greater Glasgow and Clyde had responsibility for delivery of this in the mass clinics and the housebound individuals and care home

residents remained the responsibility of IHSCP. Our nurses also administered the flu vaccine alongside the Covid-19 booster dose, to those housebound individuals and care homes. Historically, in care homes, the care home staff would administer the flu vaccine to their residents.

During the current 2021/22 influenza vaccine season, 31,582 adults (aged 18+) who reside in the Inverclyde HSCP have received the flu vaccine so far. There was also a pause of the flu campaign delivery, during December 2020, as the Covid-19 booster programme accelerated at pace. This was to ensure as many people as possible could receive their Covid-19 booster dose by the end of 2021. Currently community pharmacies are running a mop up programme of the flu vaccine and final figures will be available later in April, however the uptake numbers at the moment remain low

3.5 GP Out of Hours

During early 2021 a GP out of Hours centre opened again initially on Saturday's and Public Holidays based at Inverclyde Royal Hospital's Outpatient Department. In April 2022 an innovative co-location model with A&E begun with A&E clinicians being able to directly appoint patients to GP out of hours where they were considered more appropriate for that service. This model is planned to allow better clinical support and easier cross referral for the GP out of hour's team and also the ability of A&E to free capacity by transferring across appropriate patients to their GP colleagues. This new model is currently in progress and if successful the intention is to expand the hours beyond the current Saturday / Public Holiday cover.

4. Effective Care

Service Updates

4.1 Learning Disability Services

The Community Learning Disability Team provides services to over 300 people with a wide range of needs. The majority of people using the service experienced changes to their support packages due to Covid -19, with most social activities restricted. The Learning Disability day centre was forced to close initially in 2020 but has been open throughout the past year, operating at reduced capacity due to social distancing requirements. The Fitzgerald Centre also became a PPE Hub and continues to provide additional services such as emergency transport.

Learning Disability Day Services and staff in the community team have kept up regular contact with service users and carers to ensure critical support was maintained, and some alternative supports such as meal delivery were provided. Feedback from carers and services users during this difficult period confirmed the importance of building-based Day services as one of the preferred options for some people with Learning Disability. To ensure Inverclyde has a building base fit for the future, particularly for people with complex learning and physical disabilities, plans for building the new Learning Disability Hub have continued. The Project Board meets every two weeks and has a communication and engagement group involving service users, carers and other stakeholders.

Despite ongoing high rates of Covid-19 infection within Inverclyde, the Day service recovery has continued on a phased basis, following advice from Health and Safety and the regulatory bodies at each stage. Services continue to be provided according to individual need with a combination of building-based and outreach service. Alternative venues such as Parklea have been used creatively to maximise the number of sessions that can be safely delivered. Currently, around 50% of previous capacity is available with those in most need of a base away from the family home coming in for a maximum of 3 sessions per week. The range of activities that can be supported is expected to increase in April and May 2022 when restrictions ease further, so support on public transport and at leisure centres can be resumed.

The Community Learning Disability team continues to provide assessment and support, using Attend Anywhere / NHS Near me and WebEx or MS Teams in place of face-to-face meetings whenever possible. Priority visits are still carried out, with staff wearing PPE to ensure safety. Family carers have had a difficult two years, with respite capacity reduced by more than 60%. The core-and-cluster model of supported living has proved to be very robust when other community supports have been limited. The Learning Disability team have worked in partnership with River Clyde Homes and Cloch Housing to develop two new core-and-cluster services that opened in 2021, and further new developments are planned. The team is currently reviewing all night services (waking nights and sleepovers) and is recruiting another social worker through Transformation Funding to assist in that piece of work.

Services for adults with Autism have been subject to review, and a test of change around transition will soon be completed. There are currently four 'Quick Quotes' being put out to commission further autism training, consultation, transitions work, and support projects in partnership with the voluntary sector. A Social Work post for Autism and Occupational Therapy sessions is required, to take forward these important pieces of work to ensure that vulnerable people with autism do not fall through gaps between services.

4.2 Health and Community Care

4.2.1 Inverclyde HSCP will be participating in a Type 2 Diabetes Remission Programme pilot that was developed 2021-2022.

This will deliver a new Type 2 Diabetes Remission Programme which provides a structured three stage intervention. This is a clinically proven programme based on evidence from the Diabetes Remission Clinical Trial (DIRECT). The programme will be delivered by a small number of Specialist Diabetes Dieticians and focuses on maintaining long term lifestyle changes through education, support and goal setting.

Inverclyde East GP Cluster has been identified as one of the clusters which will take part in the pilot. They have agreed to be involved and the Lead Dietitians met with the relevant GP's. The next stage is for suitable patients to be identified from the cluster practices.

4.2.2 The Covid-19 hybrid care approach model is well established providing flexible opportunities to engage and provides a menu of choice as to how people are seen by the diabetes service, including early morning and evening appointments, face to face telephone, text, email appointments and digital consultation.

This offers a range of options allows for greater engagement and equity of access particularly for people in employment, and hard to reach groups for example, people with Mental Health issues. In addition, digital consultations enables people to be seen safely and promptly within NHS waiting time targets. Evaluation data of peoples preference as to how they are seen by the service evidences high levels of satisfaction with digital consultations, rated a first a choice by most people.

Collation and measuring diabetes data activity is paramount to developing the diabetes service in line with people needs and preferences, and national driver's e.g. Diabetes Improvement Plan 2021-2026.

4.2.3 The Diabetes Dietitian role has expanded / extended to include initiation of GLP-1 (injectable) therapies in line with other specialist dietetic roles within NHS GGC Weight Management Service and GG&C GLP-1 initiation guidelines, enhancing skill mix, continuity and patient experience. Regular clinical supervision, assessment of knowledge, skills, competency and evaluation, will ensure good governance, safe role development and safe practice.

The uptake of Insulin Management Plans (IMPs) amongst DN teams has been low. Refresher training and re-launch has been identified as an important clinical objective moving forward.

4.3 Children and Families

4.3.1 The complexity of work has remained high throughout 2021 -2022. It should be noted however that the number of children on the child protection register has stabilised to previous average levels. Throughout this year core services and 3rd sector partners have resumed their usual business in line with changing public health guidance. This has meant some of the flexible support available during the pandemic period is no longer available and the resourcing of transporting children and facilitating family contact time in line with legal requirements needs to be absorbed by the service again. The recruitment of support staff has created capacity to do this however demand continues to be greater than the available resource. Work is ongoing to consider the best way to meet this need whilst looking at how we offer early help and support and more intensive family support. Delays continue in the court system, this has impacted on time taken for compulsory supervision orders to be granted, often a key tool in the long term care and support of children and their families.

4.3.2 The demands on expectations on children's services throughout the second national lockdown and beyond were high with less flexibility in statutory work than during the first national lockdown. This resulted in a full range of tasks needing actioned during a recent period of high Covid-19 infections across Inverclyde. This has contributed to significant reduction in capacity for early intervention, prevention and voluntary support whilst out focus remained on statutory functions and child protection work.

4.3.3 In the last quarter of 2021/22 we appointed a programme manager to our "I Promise" team. This is our response to the wide ranging system change and development that will be required over the next 10 years to realise the ambition of The Promise. Information gathering and initial developmental activities and consultation

events have gathered pace since January 2022 and will continue throughout the year. I Promise is supported by 3rd sector partners locally.

4.4.1. Development of New Qualified Social Workers

The Quality and Learning Team have been successful in securing funding from the SSSC to be involved in early implementation of the newly qualified social worker supported year. We are working with the SSSC and the other early implementation areas to embed the NQSW Supported Year, to share our learning and inform recommendations to Scottish Government with the view to this being a national, mandatory approach in Scotland.

4.4.2 Trauma Informed/Scottish Trauma Informed Leadership Training

All three social work service managers and the interim head of service have completed the Scottish Trauma Informed Leadership Training (Phase 1). The Scottish Government and its partner agencies have given a commitment to the workforce across Scotland being trauma trained and trauma informed and therefore trauma responsive to our Service users.

The delivery of this leadership and management training and approach is based on research and evidence that identifies the importance of leadership training in developing organisational readiness which then supports wider staff training and trauma-informed practice development. This also follows the approach as recommended by the NHSGGC aligned with the National Transforming Psychological Trauma Programme in fulfilment of the Scottish Governments 2015 commitment to the development of a trauma-informed and trauma-responsive workforce across Scotland.

4.5 Specialist Children's Services

Throughout the Covid -19 recovery phase all services have continued to provide a high level of care utilising a variety of means and methods available, depending on restrictions, in order that the children and families of Inverclyde continue to experience excellent care and support.

Nurses within SCPT Inverclyde have adapted their service delivery over the past two years while continuing to provide uninterrupted care to families within the locality. Covid -19 monies were secured to help with the Disability waiting lists, which has helped greatly and the whole team continue to work cohesively, support each other provide an excellent service.

Within SCS there has continued to be a commitment to adapting the ASD diagnostic service resulting in a significant reduction in waiting times for families. This drive has kept children and families at the forefront, having numerous consultations with young people to seek their views in order to impact change.

As well as adapting existing services to provide seamless support, the SLT team have continued to work on new initiatives alongside colleagues in Health Visiting and Education. This piece of work is focussing on impacting change in the under 3 population in response to data gathered via the 27-30mth assessment. Joint pieces of work mirrored in both Health and Education are being carried out, in particular around upskilling parents and education staff at a universal level to support and nurture early language development.

4.6 Children and Adolescent Mental Health Service

During 2021/2022 Inverclyde CAMHS has continued to offer a high quality service to children and young people in the Inverclyde area experiencing moderate to severe mental health difficulties. The team has worked flexibly offering both near me video appointments and face to face appointments in Greenock health and care centre based on clinical need/ risk, and every effort has been made to accommodate individual family requests and preferences.

The team continues to experience an extremely high volume of urgent and emergency referrals for children and young people who are presenting as a risk to themselves in terms of their behaviours and mental health presentations (challenging behaviours, self-harm or suicidal behaviours, eating disorders, potential psychosis symptoms). All such referrals are responded to promptly and assessment of the risk and mental health carried out as soon as possible, within 24/48 hours of receipt of referral based on clinical need. This has also had a direct impact on Consultant Psychiatry time, as they often need Psychiatry assessment or medication intervention more quickly. As may be anticipated, this high volume of risky referrals, which often need allocated for further assessment and intervention immediately, does have a direct impact on waiting times for children and young people who have been assessed and added to the CAMHS waiting list for intervention, but do not need prioritised due to risk.

The team has worked hard to stay within referral to treatment targets over the past year for first initial assessment appointments (known within the service as Choice appointments) and has managed to see all new referrals with the 18 weeks. The majority of Choice appointments will be tried to be offered sooner than this. This allows redirection to other services and supports more quickly, if CAMHS is not appropriate for the child or young person.

Unfortunately due to the general increased demand on CAMHS, and the significantly increased urgent presentations, this does mean that children and young people who are assessed as requiring CAMHS intervention, but do not meet criteria to be prioritised for risk reasons etc., are waiting longer to be allocated.

There have also been a number of staff changes within the team which has impacted on capacity and we are running with a number of vacancies (psychology, nursing, family therapy) and long term absences. A number of new staff including Speech and Language, Occupational Therapy, Psychology, Support worker role, have recently been appointed which it is hoped will build capacity within the team over the coming year.

Despite the pressures on the service, we have continued to develop our staff and a number of staff have completed additional trainings in Cognitive Behavioural Therapy, CBT for eating disorders, family based treatment for eating disorders, Autism Diagnostic Observation Schedule (ADOS) assessment, to name a few, allowing us to deliver a high standard of evidence based care. Our nursing team have set up a physical health monitoring clinic which has been extremely successful and reduces the need for physical monitoring to be done by GPs and provides a more cohesive experience for children, young people and their families. A number of CAMHS staff are also central to the work being carried out with Skylark staff, SLT, and Community Paediatrics to develop and implement a new neurodevelopmental pathway for children and young people in Inverclyde.

The CAMHS team are hardworking and dedicated, and look forward to facing the challenges of the next year with a larger staff group, and to be able to think about more innovative and effective ways of managing demand on the service.

4.7 Physiotherapy and Occupational Therapy

The services have set up well utilised advice phone lines in response to pandemic.to allow support to be offered promptly and remotely when reduced face to face contact was essential. These are to continue as they promote self-referral; pre referral management, and are now well sign-posted in Inverclyde HSCP as part of the Choose the Right Service campaign.

4.8 Criminal Justice

During 2021/22 there has been much progress around the Early Action System Change (Women involved in the Criminal Justice System) project hosted by Inverclyde Criminal Justice Social Work. Phase one of the project concluded in August 2021 with two broad common themes emerging:

- *A lack of support around initial involvement in the CJS – period between arrest and possible court outcome*
- *A lack of obvious opportunities for positive and supportive community networks or groups.*

Additionally, engagement was carried out with frontline staff from a range of Inverclyde HSCP and third sector organisations about their experiences of working with women. Two broad common themes emerged which staff identified as being significant to women's involvement in the criminal justice system; the impact of trauma and the role of relationships. Phase one of the project has concluded with a Test of Change proposal. The Test of Change proposed is to adopt a trauma informed approach to support women as close to their entry to the CJS as possible. In addition, it will also feature, again with a trauma informed approach, facilitation for opportunities for women to engage in activities, volunteering or employment within their community.

The Inverclyde Community Justice Partnership have extended the Inverclyde Community Justice Outcomes Improvement Plan (CJOIP) by one further year until March 2023, this is based on a review of both the national strategy for Community Justice and a review of the Outcomes Performance Improvement Framework (OPIF). Work commenced in 2021-22 to prepare for a new CJOIP by undertaking a Strategic Needs and Strengths Assessment which will continue into the first quarter of 2022/23.

The focus of Inverclyde Criminal Justice Social Work Services remains on Covid-19 recovery and ensuring a quality of service for those involved with it. Throughout the pandemic the Service has followed appropriate guidance including that issued directly by the Chief Medical Officer for Scotland. This has necessitated the Service pausing and restarting its Unpaid Work arrangements on several occasions. There currently remains restrictions on the numbers of service users on Community Payback Orders being allowed to be present in vehicles at any time impacting on the scale of work undertaken (compared to previous years). Staff do continue to support service users in completing their statutory orders/licences and with any health and wellbeing issues

they may be experiencing. Inverclyde Criminal Justice Social Work Services also submitted a paper to the Health and Social Care Committee in respect of 'Criminal Justice Social Work Statistics 2019/20 - People Dying on Community Payback Orders (CPOs)'. Although based on figures from 2019/20 the matter was also discussed at The Scottish Parliament Committee in September 2021. In order to better understand the wider issues, the inclusion of deaths on CPO's and other orders/licences will be taken forward by the Inverclyde Community Justice Partnership to build a fuller picture on this issue and to consider future developments that might improve this situation. The Inverclyde Community Justice Partnership acknowledges that there are common inequalities experienced by people with lived experience of the criminal justice system. These inequalities include, poorer physical and mental health, the impact of trauma, the likelihood of past and/or current drug and/or alcohol misuse and likely experiencing poverty.

4.9 Rehabilitation and Enablement Service

The service has responded to the challenges of providing services throughout the year.

The Allied Health Professional review is still in progress at the time of writing. It is anticipated that the focus is integrating all AHP services for Inverclyde.

Urgent Hub work was re-launched on 28th March 2022. The preliminary work identified key stakeholders. A Standard Operating Procedure and process flow chart is at final draft stage and work completed to create criteria for identifying urgent referrals and to clarify the role of primary contact within the daily urgent hub team.

Clinical Frailty training is still available and a new Frailty Advanced Nurse Practitioner is now in post. The profile of Frailty is being raised locally within Inverclyde and also within NHS Greater Glasgow and Clyde as part of Falls & Frailty work combined. This work was paused due to the pandemic response but is now progressing.

The Physio clinical audit will be completed with dates to be confirmed. The Internal focus has been on adhering to mandatory operational processes including clinical supervision sessions and caseload management. The results of the audit will be reviewed by the Health and Community Care Clinical and Care Governance Group.

It is important to emphasise that Clinical Supervision, Caseload Management and training through the TURAS system is ongoing. Staff are encouraged to attend the newly revamped Clinical Supervision Training run by the board.

Regular monthly joint health & social care staff meetings restarted via MS Teams at Inverclyde Centre for Independent Living. Terms of reference are in place and agreed. Weekly team catch Up meetings are ongoing – via MS Teams to accommodate all staff and maximise attendance.

NHS Greater Glasgow and Clyde In-Service Training has restarted with Long Covid-19 being the first topic discussed in February 2022.

There has been an ongoing issue with equipment shortages, as per the national picture. Laptops and mobile phones ordered for new staff have been subject to delay. This will effect governance around note taking and accessing patient information in addition to directly affecting staff safety. Teams are working to address this risk.

Issues around poor connectivity and IT support are causing issues at I impacting on patient response and care.

Inverclyde Centre for Independent Living - Community Rehabilitation and Enablement Service has given significant time and input to contribute towards shadowing for a variety of medical professionals and students. Community Rehabilitation and Enablement Service has also been asked to host shadowing for students whose role is evolving and wouldn't necessarily include Community Rehab Teams. It is recognised that this work is invaluable for the longer term within community services however it does place pressures on clinicians which affects the service, however Community Rehabilitation and Enablement Service is happy to support.

Recruitment has been a challenge for the team and this has been raised on the Health and Community Care Risk Register, where the level of risk and actions taken to mitigate the risks are regularly reviewed and monitored.

4.10 Assessment Care Management

The Assessment and Care Management (ACM) service is part of Inverclyde HSCP (Health and community care) as a result the service is integrated with all health professionals allowing good multidisciplinary working practices.

This includes ACM West team, ACM East Team and ACM Gourock.

The services provide an outcome focused review service through the Community care review team and care home review teams. Access First Team provides a single point of access to service users in Inverclyde. This also provides a single point of access for all referrals to the ACM service.

The short breaks bureau provides respite support, alternative day care opportunities and carers support to all service users in Inverclyde. Is also single point of access for day care services.

Discharge Team facilitates an individual's safe discharge from Hospital and ensures all service users receive the care and support on discharge from hospital.

The service provides Adult support and protection service to vulnerable adults that are at risk of harm. Other legislation under pinning the service provided is adult with incapacity act 2000, mental health care and treatment act, social work Scotland act and health and community care act.

The ACM service provides and emergency duty system to all adults in Inverclyde 5 days per week. Social work standby provides an emergency duty service out of office hours.

The ACM Teams have close relationships all Health services, Nursing, RES, support at home and home first through weekly locality meetings.

The Teams have a very close relationship with voluntary sector and third sector partners in Inverclyde which is vitally important to how we provide immediate and longer term support to service users in Inverclyde.

The pandemic did have an impact on how the ACM functioned and provided a service. Covid-19 safe working practices were introduced in work places and home visits and care homes.

A Covid-19 home visit protocol was put in place to assist staff with this. Visits to service users home were limited to critical and substantial need being identified. However ACM service continued to provide an ACM duty service and access first service throughout the pandemic. The team worked closely with the voluntary sector to provide humanitarian support such as shopping, delivering medication and meals to vulnerable adults in Inverclyde. PPE was provided to all carers Personal Assistant and service users who required this.

Covid -19 had a significant impact on Nursing Homes in Inverclyde and impacted on visits from relatives for a long period of time. HSCP provided support through care home liaison nurses to assist care homes to introduce and follow Covid -19 safe working practices. Also ACM completed outcome focused reviews on 77% of services users last year to ensure there care needs were being met during the pandemic. Quality assurance visits took place in care homes in March/April and November 2021.

In January 2021 the Care Inspectorate completed an adult protection inspection virtually, which provided challenges for the inspection process.

Inverclyde was rated 'good' following this inspection. The Care Inspectorate raised that some Adult protection risk assessments and chronologies were not on HSCP Adult Protection templates on Civica. System. Also, evidencing application of the 3 point test in case notes and investigation reports was not explicit. This has now been addressed in terms of the implementation of the shared agency chronology and adult protection inquiry template on Civica System. Going forward adult protection reports will only be accepted on HSCP adult protection templates that are recorded on Swift. The Inquiry template will improve the quality of evidencing the application of the 3 point test in case notes on Swift.

The service continues to work towards to avoid delays from hospital. To avoid substantial delays service users are offered interim care arrangements in local nursing homes.

As we recover from the pandemic more staff are now in the office at same time a rota is in place to ensure required social distancing. Hybrid working practices have been adopted in the service and will continue in future. Day care services have opened up offering respite and day care opportunities to service users and carers.

4.11 Mental Health, Homelessness, and Alcohol and Drug Recovery Services

Mental Health Inpatients

Scotland Deanery completed an inspection of Inverclyde Royal Hospital on 5th October 2021. There had been concerns highlighted about staffing levels and in rota gaps leading to reduced training opportunities and increased workload for trainees.

The concerns raised resulted in an action plan devised and this is currently on track to answer the concerns raised. This has been reviewed at the Mental Health, Alcohol and Drugs Recovery and Homelessness Clinical and Care Governance Group.

Mental Health services continued to experience significant bed management pressures. The service has dealt with ward closures due to Covid -19 at various points in the year. At the time of writing this situation has considerably improved

A Board wide waiting list was also established for Intensive Psychiatric Care Unit due to the number of patients waiting on admission. This waiting list management will continue to be stepped up/down in keeping with pressures in the system.

Staffing pressures continue due to the number of resignations and retirements there have been in the past year. The risk to the HSCP is monitored and tracked via the service risk register.

4.12 Community Mental Health Services

Essential mental health treatment services are coordinated and delivered by the Community Mental Health Services (CMHS) across the adult and older adult population. CMHS continue to provide capacity to serve Inverclyde's needs for urgent mental health assessments in the community in tandem with the centralised GGC wide Mental Health Assessment Units as well as programmes of scheduled treatment/support and an accessible duty service. There are challenges in recruitment across all disciplines with several jobs going through multiple rounds of recruitment due to no applicants and also no suitable applicants.

The hybrid arrangement of placing staff across office/remote based working along with blended approaches to delivering interventions, from face to face to utilising technology where appropriate, has remained a necessity in flexible service delivery. Covid-19 pandemic restrictions and guidance have continued to steer much of this however service delivery remains underpinned by individual service user assessed need, risk, vulnerability, and associated legislation where indicated.

At the onset of the pandemic caseloads were reviewed and individuals allocated a risk assessed priority of Red, Amber or Green to inform frequency and type of contact with regular review to ensure status remains current. This RAG status continues and is now viewed as a critical element in understanding and supporting the demands at an overarching service level as well as for the individual service users.

The Mental Health Officer (MHO) Service now has additional permanent full time staff capacity in place as recommended by the MHO Service Review. Procedures have been reviewed and improved to more fully enable the SWIFT system for recording, monitoring and reporting of the MHO Service statutory work.

Improving interface working arrangements within Community and In-patient Mental Health Services, Homelessness, Alcohol and Drugs Recovery Service (ADRS) and Criminal Justice colleagues has continued. Community and in-patient mental health and ADRS have now established a joint Incident Review Group. This adds further robustness and standards of consistency to related decision making for Inverclyde HSCP as well as further augmenting interface work between these services and their frequently shared service users.

Quality evidence based improvement work also continues within the CMHS to ensure safe, timely and effective person centred care. This supports statutory elements of

service delivery as well as broadening assurance in developments related to NHS GGC Mental Health Strategy and service users receiving the right service at the right time and in a more seamless way. Examples of this include the following.

- Action 15 of the Scottish Government Mental Health Strategy 2017-27 committed to providing 800 additional mental health workers across Scotland by 2022 to improve the accessibility of support within key areas such as Emergency Departments and GP practices. Inverclyde has contributed to a number of GGC wide initiatives as part of this including the development of Mental Health Assessment Units, increased liaison services within general hospitals and the piloting of peer support workers within Mental Health Services. Locally Action 15 funding has been used to support the development of the Distress Brief Intervention initiative, increase capacity and develop new ways of working within the Primary Care Mental Health Team and introduce a new 'Inreach worker' post that helps ensure individuals admitted to hospital are able to be discharged back home with appropriate support at the earliest opportunity.
- Recovery Orientated Care is an underlying principle of the NHS GGC Mental Health Strategy with the Adult Community Mental Health Team (CMHT) promoting the principles of personalised recovery in all aspects of support and interventions.

- Distress Brief Intervention (DBI)

The Distress Brief Intervention Programme, delivered on behalf of Inverclyde HSCP by SAMH (Scottish Association for Mental Health), has been operating in Inverclyde for just over a year. It aims to improve outcomes and experiences for people experiencing distress through delivering connected, compassionate support. DBI is appropriate for individuals over the age of 16 years experiencing acute distress who do not require a clinical service response. The service provides initial contact within 24 hours of referral and offers compassionate, problem solving support, wellness and distress management planning, supported connections and signposting for a period of up to 14 days – reducing both immediate distress and empowering the ability to manage future distress.

The following quotes are examples of the difference that the service has provided.

A referral was received from a Community Links Worker for a 51 year old lady experiencing employment and relationship issues. She reported a distress level of 8 at the first contact and received 9 calls over her 14 days of contact with the DBI service. Issues that were addressed included low self-esteem, pressures of work and family relationships. After engagement with the service and completion of distress management planning she reported a distress level of 2 at her final appointment.

A 38 year old gentleman who was experiencing suicidal thoughts and high levels of distress around family and relationship issues was referred to the

service by his GP. He received six calls during the 14 days of DBI support and his distress levels decreased over the course of the intervention. He said "having someone to open up to and someone who listened had made the world of difference" He found that the coping mechanisms provided had already proved beneficial for him and said that he would continue to use them in future distressing situations.

Referral numbers are averaging at 14 referrals per week with good levels of engagement from those who are referred. The majority of referrals within Inverclyde are made by primary care services including both Community Link Workers and GPs. Police Scotland are the second biggest referrers. Paul Cameron, Chief Inspector and Inverclyde Area Commander at Police Scotland said, "As the Area Commander for Inverclyde, I am delighted we have introduced the DBI process. I am committed to this new service and will ensure all operational officers are fully trained in the referral process. This is a service that meets the needs of people in crisis, working with the DBI process will enhance our ability to keep people safe.

- Commitment to Peer Support Worker (PSW) Test of Change board wide project. Inverclyde has two PSWs employed by NHS GGC embedded in the CMHT. Mutual support and self-help, based on sharing lived experience, are widely known to play a large part in Mental Health recovery. The NHS GGC Mental Health Recovery Work stream anticipates that embedding peer support within services will play a significant role in improving recovery oriented pathways for people accessing Mental Health Services. The aim of the Test of Change is to support reduction in in-patient admissions, length of stay in hospital and reduce unnecessary contact with Community Mental Health Services. The test of change period is due to conclude September 2022 having been extended by six months due to the pandemic. Impacting on delivery of the project. An external evaluation has been commissioned and final report is anticipated end of March 2022.
- The Mental Health service continues to commission SAMH's Individual Placement and Support (IPS) employability service. The IPS worker is embedded in the CMHT. The main aim is to support people with mental health problems to gain employment through an employment specialist model.
- Implementation of Patient Initiated Follow Up (PIFU) for a targeted group of service users where it is clinically indicated. The principle being that the individual can seek a timely appointment with the service when they feel they need it as opposed to appointments being projected forward in an arbitrary manner. Thereby promoting personalised recovery by providing person centred ownership of contact.

The Mental Health service continues to commission SAMH's Recovery Support Services. This service supports individuals to overcome barriers that may prevent them from engaging with recovery focused activities in community settings. It will challenge the stigma around mental health and alcohol or drug related issues and

ensure that individuals accessing support are enabled to participate in evidence based activities that support mental and physical health and wellbeing.

Mental Health and Wellbeing Primary Care Service

Meeting the needs of individuals who seek help for a mental health issue within primary care is something that often proves to be a challenge. The Scottish Government has released guidance for the introduction of Mental Health and Wellbeing Primary Care Services (MHWPCS). Every HSCP is required to plan the implementation of a local service that is easily accessible and provides mental health and wellbeing support, assessment and treatment in a timely manner. Inverclyde have established a MHWPCS steering group which is in the process of developing a local plan that takes account of the other mental health and wellbeing supports and services that are available in Inverclyde. The plan will also build on developments that were made as part of both Action 15 and Primary Care Improvement Plan (PCIP) work.

Adult Attention Deficit / Hyperactivity Disorder

Nationally and within NHS GGC there is an increasing demand for new adult ADHD assessment and intervention capacity. Work is underway across NHS GGC to tackle this with a direction of travel considering totality of neurodevelopmental disorder related need and most effective and efficient way to meet demand while future proofing service delivery. Inverclyde is a key partner in this development work.

Dementia

As part of Scotland's third National Dementia strategy, Inverclyde HSCP was selected as the Dementia Care Coordination Programme implementation site. The programme set out to support improvements and redesign of community based services to improve the experience, safety and co-ordination of care, services and support for people living with dementia from diagnosis to end of life. The programme launched in September 2019 and concluded in March 2022 with a formal evaluation report due to be completed by July 2022. Although impacted by Covid 19 the programme has completed a significant amount of work across multiple work streams, it has generated improvements and there are multiple legacy pieces of work that will continue beyond the end of the programme.

To ensure the sustainability of achievements, the programme steering group recommended that the Inverclyde Dementia Strategy Group be recommenced. Work to continue improvements in dementia care and services within Inverclyde requires strategic leadership and multi- agency involvement. The SMT have accepted this recommendation and the Dementia Strategy Group will be reinstated with joint strategic leadership from across Health and Community Care and Mental Health Services.

Alcohol and Drug Recovery Service

Inverclyde ADRS has continued to deliver essential care, treatment and support throughout the pandemic, ensuring there was capacity in the service to meet demand. Scheduled contact continues to be based on level of risk and need. At the beginning of the pandemic all Board wide service redesign, including the ADRS Review Implementation Plan was suspended. This has since reconvened with the final areas of implementation complete with the recruitment of the social care workforce.

Essential face to face contact has been maintained throughout the pandemic. Initial support to deliver prescriptions to those who were shielding still continues for people confirmed as having Covid -19 and socially isolating has remained in place throughout the pandemic.

As we incrementally increase all functions of the service, community alcohol detoxification, develop our assertive outreach nurse liaison team including acute liaison, test of change pilot in Primary Care and nursing response to near fatal overdose and interface with other partners and service areas. There are plans in place to support GPs in primary care who currently run shared care clinics.

The Scottish Government launched the Medically Assisted Treatment (MAT) standards which the service is currently working towards. Additional clinic time has been made available to ensure there is capacity for same day prescribing, where clinically appropriate.

Key challenges have been continued prescription deliveries; incorporating a caseload from one GP practice who withdrew from the shared care model; uncertainty of temporary funding for the Team Lead and two Band 6 Nurse posts supporting the test of change in Primary Care, Non-Fatal Overdose work and overall reactive capacity to crisis situations; the developing new models of care including implementation and reporting of MAT standards without any additional resource.

Governance and oversight of practice has been reviewed. The Head of Service chairs an overarching Mental Health and ADRS joint Care Governance Group with professional leads and senior officers contributing to the scrutiny. Cases include near misses, deaths or other serious incidents. Learning points, recommendations or the need for a Significant Adverse Event Review is agreed by the group which feeds into the wider Inverclyde HSCP and NHS Greater Glasgow and Clyde governance structures.

Homeless Service

The service continues to make progress with the Rapid Rehousing Transition Plan. Ten people have been established on the Housing First model, successfully sustaining tenancies with commissioned support within their local communities.

A matching process has been devised to ensure that those with low level supports have access to settled permanent housing quicker without the need for extended periods in temporary accommodation.

Work is ongoing with partners to support housing sustainability. A Tenant Grant Fund has been released by the Scottish Government to support homeless prevention. The Homeless Service is working with partners to ensure those at risk of eviction as a result of the impact of the pandemic can sustain their tenancy.

Recruitment of two Wellbeing Co-ordinators and two Team Leaders has enabled the development of a quality assurance framework to support improved performance at operational level.

A change programme planned with additional two year funding to provide additional capacity within the service to modernise the service and determine the future model of emergency and temporary accommodation.

The service is in the early stages of a new governance process for the review of all incidents, with an Incident Review Group, chaired by the Head of Service. This will through time link with the wider HSCP Care and Clinical Governance arrangements.

There were 33 people in Inverclyde who sadly lost their life to a drug related death in 2020, the same as the previous year. When comparing prevalence, Inverclyde remains the third highest area in Scotland next to Glasgow and Dundee.

All of the services the ADP commission aim to help reduce the number of drug related deaths in Inverclyde as well as reflecting the priorities of the new National Drugs Mission.

While Inverclyde ADP commissioned various tests of change, commencing in autumn of 2020; it was agreed to continue these into 2021 / 2022 to allow more time to consider the impact of these.

One of the commissioned services is for family support that Scottish Families Affected by Alcohol and Drugs delivers. From November 2020 – March 2022 SFAD received 97 referrals and provided 996 1:1 support sessions.

Inverclyde ADP received Drug Death Taskforce funding for a Naloxone Link Worker post to raise awareness of Naloxone. Since commencing post in November 2021 the Naloxone Link Worker has delivered training to 144 people in various third sector organisations and distributed 206 Naloxone kits. From November 2020 – 31st March 2022 97 new referrals were made and 996 1:1 support sessions were delivered.

In the same period, Moving On, a further commissioned service, received 372 referrals and completed 217 assessments with a total of 208 people starting the programme of delivery.

Your Voice are commissioned to provide recovery support and supports the lived Experience Network. 20 volunteers have completed peer mentoring training and 8 peer mentors and 4 staff have completed Scottish Recovery coaching and a range of other training to build their skills and asset building in our local recovery community.

A pilot Recovery Hub was opened in November 2021. This hub brings together a venue for several local third sector partners to deliver group work support and Inverclyde ADP has also commissioned peer support so people can also access 1:1

support in drop-ins. The recovery Hub is open seven days a week, including evenings. During the initial opening period from 27th November – 31st March there were 448 attendees at various groups in the Recovery Hub.

All of these tests of change have demonstrated the need for innovation and for partners working closely together.

5. Staff Wellbeing and Resilience

5.1 Work Place Wellbeing Matters Plan

The plan was launched on 30th November 2020 for three years, to support the HSCP's organisational recovery and to ensure support for the mental health and wellbeing of the HSCPs staff remains a priority.

The overall aim of the plan is:

"Across Inverclyde we will deliver on integrated and collaborative approaches to support and sustain effective, resilient, and a valued health and social care workforce"

The work and initiatives carried out last year have been built on and support with health and wellbeing continues throughout the HSCP and throughout Inverclyde with our partners. Below is a summary of what was achieved in 2020 -2021

5.2 Wellbeing Fund

A Wellbeing Fund has been established to support and promote health and wellbeing across the health and social care workforce. Staff and teams can apply for funds to support health and wellbeing initiatives. Staff teams have made the most of the fund by applying for various team activities e.g. team building outdoor events such as paddle boarding, kayaking, scavenger hunts, creating a safe outdoor fire and pizza making. Other teams have opted for indoor events such as team building through art, hatchet throwing, massage, spa days and wildlife identification team building outdoor events, team building indoor events, spa days, lunch and afternoon tea. Some of the teams have applied for funds to decorate and create a quiet, relaxing space for staff to go to and another team has applied to erect a garden of remembrance at their place of work.

5.3 Leisure Activities

We have linked in with Inverclyde Leisure to provide closed fitness classes for Inverclyde Council employees, including Nutrition/health classes and staff challenges i.e. March Into Spring walking challenge.

5.4 Central Repository/Hub

We have developed a Council wide wellbeing hub on the external website which is accessible to all staff (and the local community). The HSCP has a separate page which staff can access to find local and national health and wellbeing resources easily.

5.5 Monday Messages

We continue to circulate information, on a 2-3weekly basis, signposting local and national resources, training etc. to the entire staff team within HSCP and to our 3rd sector and independent sector colleagues.

5.6 Healthy Working Lives

Inverclyde HSCP were awarded Winter Pressures money from Scottish Government for Health and Social Care (including 3rd and independent sectors) and Primary Care staff, advising that it should be used to support the wellbeing of these workforces.

We had a very short timescale to turn around the proposal for spend, and agreed to partner with CVS Inverclyde to arrange a Winter Wellness Week, which commenced on 28th February 2022.

We offered a full programme of events for the week online, including sessions from:

- Compassionate Grit (focussing on taking the lead with mindset, motivation and goals)
- SAMH (soundbites programme focussing on mental health and tools/techniques)
- Marianna Doneva qualified Yoga teacher from Inverclyde Carers Centre
- Ex-footballers Chris Millar and Gary Pettigrew (focussing on how physical activity impacts our mental health)
- Rig Arts Inverclyde hosted a wellbeing drawing workshop
- Hints and tips on back care and ergonomics from John Kelly, Physiotherapist
- The residents of Glenfield Care Home invited us to join their chair based exercise/tai chi class
- Ex-footballer Paul Pettigrew shared his story about gambling addiction
- HSCP Advice Services delivered a session on financial wellbeing in Inverclyde
- Capacitor Tai Chi with Alison Bunce
- A Team Talk session with Jonny Roy from Morton in the Community
- Louise Gray, CLD, delivered a session on alcohol awareness
- Area Commander Chief Inspector Paul Cameron focussed on cyber crime and phone scams

The Greenock telegraph attended the In Person day and published an article: https://www.greenocktelegraph.co.uk/news/19975326.winter-wellness-week-inverclyde-hscp-staff/

6. Clinical and Care Governance Strategy and Work Plan

6.1 Inverclyde HSCPs Clinical and Care Governance Strategy describes a Clinical and Care Governance framework that fosters and embeds a culture of excellence in clinical and care

governance practice, which enables and drives forward delivery of safe, effective, high quality, sustainable person-centred care, based on clinical evidence and service user experience, resulting in positive outcomes for our community.

The HSCP has developed an action plan around the main strategic priorities which focuses on a key priority for each domain, as below -

Table 2 Clinical and Care Governance Strategic Work Plan Priorities

Domain	Priority
Adverse Event, Clinical and Care Risk Management	Duty of Candour Process for the HSCP
Continuous Improvement	Quality Improvement Plan for the HSCP
Person-Centeredness	Consistent Means of Capturing and Analysing feedback
Clinical and Care Effectiveness	Standard Operating Procedure for incident reporting for the HSCP

6.2 Work has progressed throughout 2021 on delivery of the work plan and is tracked via the HSCP Clinical and Care Governance Group. Significant process has taken place around development of a Duty of Candour process for the HSCP and incident reporting. The HSCP has commissioned Care Opinion and is working to roll this out fully as a consistent means of capturing and analysing feedback by summer 2022.

The IJB is due to receive an annual update on progress in June 2022.

7. Person Centred Care

7.1 Care Opinion implementation Inverclyde HSCP

The implementation of Care Opinion is being planned for summer 2022. The link is enclosed for reference. **www.careopinion.org.uk**

Care Opinion is a place where you can share your experience of health or care services, and help make them better for everyone.

It will help people give feedback and receive a response to their issue and the stories and the responses are open for staff and the public to access.

7.1.1. Why use Care Opinion?

Stories tell you why people feel the way they do about their experience. Service user stories are crucial to providing and commissioning the best services possible, and in understanding how to improve the service user journey.

Gathering qualitative information is traditionally expensive and resource intensive. It takes time and money for a member of staff to interview the public about the service they have received. Care Opinion acts as a tool for collecting and engaging with

stories. With online, postal and telephone feedback service, Inverclyde HSCP will reach a wide and more representative range of people.

There is a Care Opinion Implementation Group established, chaired by the Chief Nurse.

7.2 Complaints and Feedback Overview

During the year 2020 and 2021, a total of 113 complaints were received.

Table 3 – Complaints received by service over each quarter.

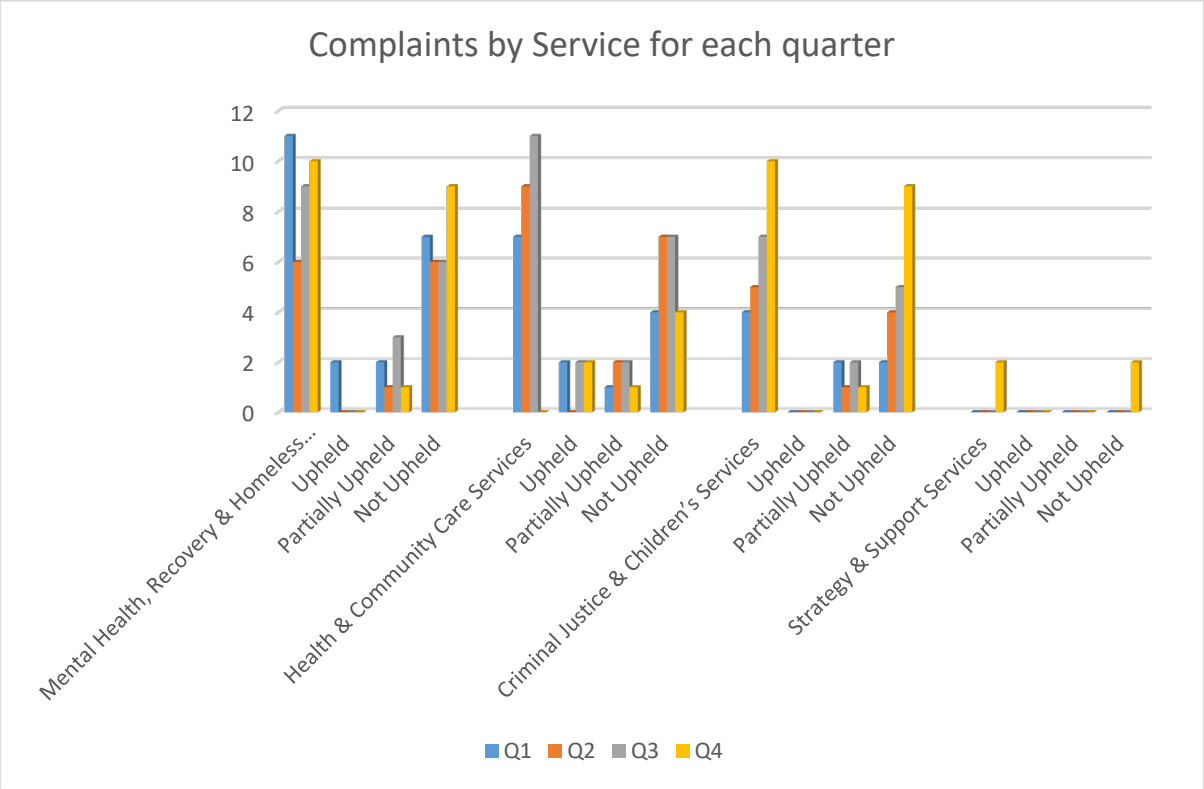


Table 4 – Complaints by timescale for each quarter.

	Q1	Q2	Q3	Q4	Total
Total Complaints	**28**	21	28	36	113
Stage 1 - Total	14	9	11	10	44
Stage 1 - Closed within 5 Days	13	6	6	7	32
Percent Closed within timescale	**92.8%**	**66.6%**	**54.4%**	**70%**	**70.6%**
Stage 2 - Total	8	11	16	19	54
Stage 2 - Closed within 20 Days	5	10	10	7	33
Percent Closed within timescale	**62.5%**	**90.1%**	**62.5%**	**36.8%**	**61.1%**
Complaints Withdrawn or No Consent	6	1	**1**	**3**	**11**

Table 5 - Complaints by service and outcome for each quarter

	Q1	Q2	Q3	Q4
Mental Health, Recovery & Homeless Services	11	6	9	10
Upheld	2	0	0	0
Partially Upheld	2	1	3	1
Not Upheld	7	6	6	9
Health & Community Care Services	7	9	11	7
Upheld	2	0	2	2
Partially Upheld	1	2	2	1
Not Upheld	4	7	7	4
Criminal Justice & Children's Services	4	5	7	10
Upheld	0	0	0	0
Partially Upheld	2	1	2	1
Not Upheld	2	4	5	9
Strategy & Support Services	0	0	0	2
Upheld	0	0	0	0
Partially Upheld	0	0	0	0
Not Upheld	0	0	0	2

2021-2022 saw the country and Inverclyde HSCP remain pressured with the global pandemic though restrictions were lessened at points throughout the year.

The complaints team has now changed for the New Year with a new complaints manager appointed and admin support to be appointed following interviews in May.

It is anticipated we will see improvements in the New Year to make the processes easier and develop our existing methods of working.

7.4 Complaint Themes

A majority of complaints received were within Mental Health, Recovery and Homelessness Services closely followed by Health and Community Care services, the latter being the largest service within Inverclyde HSCP.

The majority of complaints are related to Staff Professional Practice (53%) with a number of other complaints being down to communication as one of the reasons.

7.5 Compliments

At this time there is no mechanism available to collate compliments but with Care Opinion due to be launched in summer 2022, this will provide Inverclyde HSCP with the opportunity to gather feedback.

IHSCP has continued to respond to complaints as normal despite the additional pressures facing the partnership during the global pandemic, however further analysis of themes and learning needs to be undertaken.

7.6 Scottish Public Services Ombudsman (SPSO)

Reviews should complainants be dissatisfied following the resolution of their complaint at the investigation stage, they can request a review by the Scottish Public Services Ombudsman (SPSO).

During the period 2021 – 2022, there was one case reported to the SPSO which was not upheld.

7.7 General Practice Complaints

During 1st April 2021 to 31st March 2022 there were 176 GP complaints received. A breakdown of the complaint outcomes are summarised below.

Table 6: GP Complaints

	Q1	Q2	Q3	Q4	Total
GP Complaints	44	36	43	53	176
Upheld	3	4	7	6	20
Partially Upheld	16	23	13	17	69
Not Upheld	25	9	23	30	97

7.8 Optometry Complaints

During 1st April 2020 to 31st March 2021 there was 2 complaints received. These complaints were resolved at a first stage and were found to be not upheld.

Table 7: Optometrist Complaints

Optometrist Complaints	0	2	0	0	2
Upheld	-	-	-	0	0
Partially Upheld	-	-	-	0	0
Not Upheld	-	2	-	0	2

7.9 Duty of Candour

On 1st April 2018 the Duty of Candour Procedure (Scotland) Regulations came into force. This placed a legal requirement an all health and social care services in Scotland to ensure that when certain forms of unintended or unexpected events happen, the people affected understand what has occurred, receive an apology, and that organisations learn how to improve for the future.

The processes for recording, tracking and monitoring progress are a strategic priority for Inverclyde HSCP as part of the Clinical and Care Governance Strategic Work Plan. Progress on this is reported in the update to the IJB June 2022.

Inverclyde HSCP will "be open" when recipients of services are affected by serious adverse events. The complaints process for the HSCP is now well established. In addition to this, incidents for services in the HSCP that have been recorded on the Datix incident system will follow the process of Significant Adverse Event Review. Factors that may have caused or contributed to the event, which helps identify duty of candour incidents are fully investigated, involving the service user and their family as circumstances dictate.

There have been no complaints for the HSCP that have been identified as a Duty of Candour incident. This includes all services for the HSCP.

Significant Adverse Event Reviews conducted through reporting on the Datix incident management system are considered as Duty of Candour events.

7.10 Significant Adverse Event Review

The table below summarises the amount of Significant Adverse Event Reviews still outstanding at 1st April 2022. The HSCP acknowledge the delays in proceeding with these reviews. They are regularly reviewed and monitored by the service clinical and care governance groups. The Mental Health and ADRS Incident Review Group meet monthly where progress is discussed and tracked. This governance group will review the highest number of Significant Adverse Event Reviews for the HSCP.

The Mental Health service has provided information to the NHS Greater Glasgow and Clyde review for adult services, led by Katrina Phillips, which is assessing the delays across NHS Greater Glasgow and Clyde, and what recommendations are to be made to refine the reviews, whilst maintaining the emphasis on thorough and appropriate investigation.

Table 8 Open Significant Adverse Event Review

ID	Incident date	Directorate	Specialty	Status
557140	05/03/2019	Health and Community Care	Community Nursing	In QA
644651	30/12/2020	Children and Family Services	Family Nurse Partnership Team	Under Review
634992	12/09/2020	Children and Family Services	School Nursing	Under Review
581864	10/09/2019	Mental Health Services	Community Mental Health Team	Under review
596096	24/12/2019	Mental Health Services	CMHT/ADRS	Under review
668559	17/7/2021	Mental Health Services	Crisis Team	Under review
644169	13/1/2021	Mental Health Services	ADRS	Under review
615893	12/6/2020	Mental Health Services	ADRS	Under review
596096	31/12/2019	Mental Health Services	ADRS	Under review
619136	28/6/2020	Health and Community Care	Community Learning Disabilities	In QA
684285	3/11/2021	Acute	In Patients	Under review
678274	23/9/2021	Mental Health	ADRS	Under review
663700	11/6/2021	Mental Health	ADRS	Under review

7.10.1 The Significant Adverse Event Reviews Actions concluded 2021 -2022

During 2021 -2022 there were 7 Significant Adverse Event Reviews concluded that had actions to complete as a result.

Table 9: Summary of completed actions following SAER

Datix ID	Specialty	Priority Status	Action Completed	Date Completed
618526 - 9514	Mental Health Services Community Mental Health Team	High Priority Local Action	Ensured risk assessments and related training current within teams	06/08/2021
618526- 9515	Mental Health Services Community Mental Health Team	High Priority Local Action	All keyworkers received support to ensure all patients have relevant Care	06/08/2021

			Plan (including Safe Plan)	
596096 - 9953	Mental Health Services Addiction Services	Medium Priority Local Action	Assertive follow up recommendation to GP and review of 'opt in letter' and record keeping on EMIS. Reviewed by Primary Care Mental Health Team.	11/8/2021
596096 -9954	Mental Health Services – Addiction Services	Medium Priority Local Action	Record keeping on support plan, risk assessment and documentation to be uploaded on EMIS. Template devised to make process easier.	11/8/2021
612256 - 9352	Specialist Children's Services – CAMHS	High Priority Local Action	Guidance reminder Care Co-ordinator Descriptor paper and identified clinician on EMIS.	8/7/2021
612256 - 9353	Specialist Children's Services – CAMHS	High Priority Local Action	Documentation to be clear on EMIS for medication plan and relate to NICE guidance.	8/7/2021
612256 - 9354	Specialist Children's Services – CAMHS	High Priority Local Action	Improved case tracking for trainees for follow ups in event unplanned absence	8/7/2021

8. Conclusion

Inverclyde HSCP has had a demonstrable commitment to clinical and care governance and there has been considerable change in the governance landscape for the HSCP. This has been seen in the HSCP support to Care Homes and the contribution of Inverclyde HSCP to the work of the Care Home Collaborative within NHS Greater Glasgow and Clyde.

As the HSCP moves to recovery from the pandemic into 2022 -2023, the work for clinical and care governance will be to consolidate the role of the HSCP clinical and care governance groups, and for this to be underpinned by the work involved in the clinical and care governance strategy workplan. The HCSP welcomes the impact of Care Opinion in improving the accessibility and demonstrable response to feedback from the public in receipt of HSCP services.

Inverclyde Integration Joint Board Audit Committee

Monday 21 March 2022 at 1.00pm

Present:

Voting Members:

Councillor Elizabeth Robertson (Chair)	Inverclyde Council
Councillor Luciano Rebecchi	Inverclyde Council
Simon Carr (Acting Vice Chair)	Greater Glasgow & Clyde NHS Board
David Gould	Greater Glasgow & Clyde NHS Board

Non-Voting Members:

Diana McCrone	Staff Representative, Greater Glasgow & Clyde NHS Board

Also present:

Allen Stevenson	Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership
Alan Best	Interim Head of Health & Community Care, Inverclyde Health & Social Care Partnership
Craig Given	Chief Finance Officer, Inverclyde Health & Social Care Partnership
Andi Priestman	Chief Internal Auditor, Inverclyde Council
Vicky Pollock	Legal Services Manager, Inverclyde Council
Diane Sweeney	Senior Committee Officer, Inverclyde Council
Colin MacDonald	Senior Committee Officer, Inverclyde Council

Chair: Councillor Robertson presided.

The meeting took place via video-conference.

Prior to the commencement of business the Chair welcomed Mr Gould to the meeting, noting that his appointment to the Audit Committee was the subject of a report to the following meeting of the Inverclyde Integration Joint Board.

1 Apologies, Substitutions and Declarations of Interest **1**

No apologies for absence or declarations of interest were intimated.

2 Minute of Meeting of IJB Audit Committee of 24 January 2022 **2**

There was submitted the Minute of the Inverclyde Integration Joint Board Audit Committee of 24 January 2022.
The Minute was presented by the Chair and examined for fact, omission, accuracy and clarity.
Decided: that the Minute be agreed.

3 IJB Audit Committee Rolling Annual Workplan **3**

There was submitted a list of rolling actions arising from previous meetings of the IJB Audit Committee.

Referring to the entry for September 2022 'Review of Risk Register' the Board requested clarification on the role that Inverclyde Integration Joint Board members have in identifying risks. Mr Given and Ms Priestman explained the processes in place at present for identifying risk. After discussion it was agreed that officers should consider the role of IIJB members should have in identifying risks and consider options to formalise this, with the suggestion of a three yearly meeting and a possible Development Session.

Decided:

(1) that the Rolling Annual Workplan be noted; and

(2) that it be remitted to officers to consider and formalise a way by which IIJB members are included in the procedures for identifying risks.

4 Internal Audit Progress Report – 20 December 2021 to 25 February 2022 **4**

There was submitted a report by the Interim Chief Officer, Inverclyde Integration Joint Board on the progress made by Internal Audit during the period from 20 December 2021 to 25 February 2022.

The report was presented by Ms Priestman, being the regular progress report, and advised as follows:

1) that the Audit Plan for 2021/22 is now complete;

2) in relation to Internal Audit follow up, there were no actions due for completion by 31 January 2022. There are 8 actions being progressed by officers, all as detailed in appendix 1 to the report;

3) there have been no Internal Audit Reports relevant to the IJB reported to Inverclyde Council since the last Audit Committee meeting in January 2022;

4) there have been no Internal Audit Reports relevant to the IJB reported to NHS GGC since the Audit Committee meeting in January 2022; and

5) Internal Audit within Inverclyde Council and NHS GGC have undertaken to follow up actions in accordance with agreed processes and will report on progress to the respective Audit Committees.

The Chair requested an update on the status of a previous action to invite auditors from NHS GG&C to an IIJB Audit Committee meeting, and Mr Stevenson gave an undertaking to action this.

The Board requested that in future the follow up report be amended to include the original recommendation, and Ms Priestman agreed to this.

Decided: that the progress made by Internal Audit in the period 20 December 2021 to 25 February 2022 be noted.

5 Status of External Audit Action Plans at 31 January 2022 **5**

There was submitted a report by the Interim Chief Officer, Inverclyde Integration Joint Board on the status of current actions from External Audit Action Plans at 31 January 2022.

The report was presented by Ms Priestman and advised as follows:

In relation to External Audit follow up, there were no actions due for completion by 31 January 2022. There are 3 actions being progressed by officers, all as detailed in appendix 1 to the report.

The Chair advised those present of discussions at the pre-agenda meeting pertaining to the scheduled meetings of the Committee, and requested that officers take the necessary steps to change future meeting in the timetable to September, March and June instead of September, January and March.

Decided:

(1) that the progress to date in relation to the implementation of external audit plans be

noted; and

(2) that it be remitted to officers to change the IIJB Audit Committee meeting dates from September, January and March to September, March and June in future timetables.

6 Internal Audit – Annual Strategy and Plan 2022-2023

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership appending the Internal Audit Annual Strategy and Plan for 2022-2023 for approval.

The report was presented by Ms Priestman and advised of the requirement to have the Plan, the risk-based approach taken, and that the total budget for the Internal Audit plan for 2022-2023 has been set at 45 days.

Referring to the 'Proposed Audit Coverage 2022-2023' table set out in appendix 1, the Board questioned if this was the entire Risk Register for the IIJB Audit Committee, and were given assurances that it was.

Referring to the 'Planned Assurance Work 2022-23' column of table, the Board asked if there had been consideration given to expanding this to include business continuity and resilience. Ms Priestman advised that this will be captured within the 'Review of pandemic recovery and response planning arrangements', and provided a detailed overview of the current frameworks in place within the IIJB and Inverclyde Council, including the review of Impact Analysis Documents and Business Continuity Plans undertaken by the Council's Resilience Management Team which she contributes to.

Decided: that the Internal Audit Annual Strategy and Plan for 2022-2023 be approved.

7 IJB Best Value Statement 2021/22

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership appending the draft Best Value Statement in relation to how the IIJB has delivered Best Value during the previous financial year for approval.

The report was presented by Mr Given and detailed the statutory duty to secure best value, and that, as part of evidencing that, officers reviewed and updated the best Value Statement on an annual basis. The report advised that 10 key Audit Scotland Best Value prompts are considered in the Statement, and that draft responses to these were issued to IIJB members for comment, and 7 responses were received.

The Chair requested that going forward officers consider ways to increase the number of responses received from IIJB members, and emphasised the importance and value of this, and the Board suggested including it as a topic in a future Development session.

Decided:

(1) that the Best Value Statement be approved; and

(2) that it be remitted to officers to consider ways to promote responses to the Best Value questionnaire.

8 Inverclyde Integration Joint Board – Directions Update March 2022

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing a summary of the Directions issued by Inverclyde Integration Joint Board to Inverclyde Council and NHS Greater Glasgow & Clyde in the period September 2021 to March 2022.

The report was presented by Ms Pollock and advised that a revised IJB Directions Policy and Procedure was approved by the IJB in September 2020 and as part of the agreed procedure the IJB Audit Committee had assumed responsibility for maintaining an overview of progress with the implementation of Directions, requesting a mid-year

progress report and escalating key delivery issues to the IJB. This report is the third such report and covers the period September 2021 to March 2022.

The report provided an update on the Directions issued between September 2021 and March 2022, noting that 6 Directions were issued; 4 of which were to both Inverclyde Council and the Health Board, one to the Council only and one to the Health Board only.

Decided: that the contents of the report be noted.

9 External Audit – Proposed Audit Fee 2021/22

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership advising of Audit Scotland's proposed External Audit Fee for 2021/22 of £27,960.

Decided: that approval be given to the proposed External Audit Fee for 2021/22.