Inverclyde
council

Agenda 2013

Inverclyde Community Health & Care Partnership Sub-Committee

For meeting on:

24	October	2013

Municipal Buildings, Greenock PA15 1LY

Ref: SL/MS

Date: 8 October 2013

A meeting of the Inverclyde Community Health & Care Partnership Sub-Committee will be held on Thursday 24 October 2013 at 3 pm within the Municipal Buildings, Greenock.

ELAINE PATERSON
Head of Legal and Democratic Services

BUSINESS

**** Copy to follow**

1. **Apologies, Substitutions and Declarations of Interest**

PERFORMANCE MANAGEMENT

2. **Community Health & Care Partnership - Financial Report 2013/14 as at Period 5 to 31 August 2013**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

3. **Reshaping Care for Older People**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

NEW BUSINESS

4. **NHS Clinical Services Fit for the Future - Update**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

5. **Inverclyde CHCP - NHS Continuing Care Facilities and Community Services for Specialist Nursing Older People's Dementia and Adult Mental Health Intensive Supported Living**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

6. **Summary of Mental Health Services - Presentation**
   Report by Corporate Director Inverclyde Community Health & Care Partnership

Enquiries to - **Sharon Lang** - Tel 01475 712112

NHS Greater Glasgow and Clyde

AGENDA ITEM NO: 2

Report To:	**Community Health & Care Partnership Sub-Committee**	**Date: 24 October 2013**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/50/2013/LB**
Contact Officer:	**Lesley Bairden**	**Contact No: 01475 712257**
Subject:	**Community Health & Care Partnership – Financial Report 2013/14 as at Period 5 to 31 August 2013.**	

1.0 PURPOSE

1.1 The purpose of this report is to advise the Inverclyde CHCP Sub-Committee of the 2013/14 Revenue and Capital Budget current year position as at Period 5 to 31 August 2013.

2.0 SUMMARY

REVENUE PROJECTION 2013/14

2.1 The total Health and Community Care Partnership revenue budget for 2013/14 is £119,260,000 with a projected underspend of £222,000 being 0.19% of the revised budget.

2.2 The Social Work revised budget is £48,806,000 with a projected underspend of £211,000 (0.43%). This remains primarily due to turnover savings, partly offset by overspends on the current client commitment costs and is a further underspend of £134,000 since last reported at period 3. This underspend is net of Residential Childcare, Fostering and Adoption as any under / over spend is now managed through the approved earmarked reserve. At period 5, it is projected that there will be a £410,000 increase in the reserve at 31 March 2014.

2.3 It should be noted that the 2013/14 budget includes agreed savings for the year of £480,000 projected to be achieved in full.

2.4 The Health revenue budget is £70,454,000 with a projected underspend of £11,000 (0.02%). This remains due to a number of supplies pressures, offset by vacancy and increment savings and is an increase in projected underspend of £5,000 since last reported to the Sub-Committee.

2.5 The Health budget for 2013/14 does not include any local savings target and has been adjusted to reflect the centralisation of the Continence Service, now hosted by Glasgow.

2.6 Prescribing is currently projected to budget, however there are significant short supply pressures emerging at a board wide level, primarily as a result of increased premiums for drugs on short supply.

2.7 Quantifying the actual overspend is complex due to the number of volatile and variable factors within GP prescribing, however based on current intelligence this could be in the region of £3-£4m. Work is ongoing on at a Board wide level to assess the impact on each CHCP / CHP.

CAPITAL 2013/14

2.8 The total Health and Community Care Partnership approved capital budget for 2013/14 is £285,000 and is projected on budget.

2.9 As agreed at the Policy and Resources Committee on 24 September 2013, the previously reported underspend relating to Kylemore Children's Home has been returned to the Council's capital programme. This underspend of £156,000 will offset the £100,000 shortfall in receipt from the sale of Redholm.

EARMARKED RESERVES 2013/14

2.10 The Social Work Earmarked Reserves for 2013/14 total £3,452,000 with £2,357,000 projected to be spent in the current financial year. To date, £769,000 spend has been incurred which is 35.2% of the projected 2013/14 spend. The spend to date per profiling was expected to be £993,000 therefore slippage equates to £224,000 22.6%. Given the number and nature of the projects this slippage is manageable.

2.11 This position includes three new earmarked reserves agreed at the Policy & Resources Committee on 24 September 2013:

- £50,000 for aids and adaptations
- £80,000 for an additional respite bed at Hillend
- £65,000 to support young carers

2.12 In addition to these new reserves £70,000 has been identified within the Independent Living earmarked reserve to develop a Dementia Strategy, detail of this and the application of the three new reserves will be reported to the next Sub-Committee.

3.0 RECOMMENDATIONS

3.1 The Sub-Committee note the current year revenue budget and projected underspend of £222,000 for 2013/14 as at 31 August 2013.

3.2 The Sub-Committee note the current projected capital position:

- Social Work capital projected to budget at £183,000 in the current year and on target over the life of the projects.
- Health capital projected to budget at £102,000.

3.3 The Sub-Committee note the current Earmarked Reserves position and that a detailed report on new reserves will be presented at the next Sub-Committee.

3.4 The Sub-Committee approve the Social Work budget virements detailed on Appendix 7.

3.5 The Sub-Committee note the position on Prescribing.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 The purpose of the report is to advise the Sub-Committee of the current position of the 2013/14 CHCP revenue and capital budget and to highlight the main issues contributing to the £222,000 projected revenue underspend and the current capital programme position.

4.2 The current year consolidated revenue summary position is detailed in Appendix 1, with the individual elements of the Partnership detailed in Appendices 2 and 3, Social Work and Health respectively. Appendix 4 shows the year to date position for both elements of the Partnership. Appendix 5 provides the capital position; Appendix 6 provides detail of earmarked reserves.

5.0 2013/14 CURRENT REVENUE POSITION: UNDERSPEND £222,000

5.1 SOCIAL WORK £211,000 PROJECTED UNDERSPEND

The projected underspend of £211,000 (0.43%) for the current financial year remains predominantly due to turnover savings of £363,000 offset by projected overspends mainly within the current client committed spend. This is a further projected underspend of £134,000 from the last reported projection as at 30 June 2013.The material projected variances and reasons for the movement since last reported are identified, per service, below:

a. **Strategy: Projected £29,000 (1.39%) underspend**

The projected underspend is due to vacancy and secondment savings and is a minor increase in projected spend of £4,000.

b. **Older Persons: Projected £52,000 (0.25%) underspend**

The projected underspend relates to two key areas:

- £142,000 underspend in Residential and Nursing per the current number of clients receiving care.
  Offset by:
- £92,000 overspend in Homecare

This position reflects the planned shifting balance of care and budgets are being reviewed on an ongoing basis to evidence the recurring saving requirement and realign budgets accordingly.

The 2013/14 budget includes a £60,000 income budget for charging orders and whilst the nature of this income is not easily predictable, at period 5, £37,000 has been received and the full year is projected to budget.

c. **Learning Disabilities: Projected £102,000 (1.70%) overspend**

This is primarily due to the current costs of client residential packages projected to overspend by £46,000 and day care projected to overspend by £56,000 of which transport remains the key factor at £41,000. Work is ongoing to review the day opportunities packages of a number of clients to mitigate the transport costs through a combination of potential location changes and maximising the use of internal transport services and therefore reducing external hire costs.

The projected costs have increased by £56,000 due to required service provision for two new clients who were not known when previous service pressures were identified.

The Service Manager is reviewing all packages on an ongoing basis to minimise the cost pressures within this service.

d. **Mental Health: Projected £5,000 (0.36%) overspend**

This relates to pressures within premises and legal costs of £68,000, offset by client package underspend of £38,000 and vacancy savings (in part due to early achievement of savings) of £25,000.

This is a reduction in spend of £31,000 mainly from vacancies.

e. **Children & Families: Projected £57,000 (0.56%) underspend**

The main reason for the underspend is as previously reported: slippage in filling vacant posts combined with projected savings in overtime and sessional staff costs. This is a minor increase in projected costs of £4,000.

There is significant projected underspend within residential childcare, adoption and fostering of £410,000, however given the volatile nature of the service and the high cost implications this is impossible to predict and, as previously reported, the under or over spend at year end will be transferred to or from the earmarked reserve set up to smooth budgetary pressures.

f. **Physical & Sensory: Projected £86,000 (3.67%) overspend**

The projected overspend remains due to £78,000 client commitment costs, £22,000 transport overspend offset in part by property and vacancy savings.

This is a reduction in costs of £5,000, with transport reducing by £9,000 and client package and other costs increasing by £4,000.

The Service continue to review the cost of commissioned services.

g. **Addictions / Substance Misuse: Projected £98,000 (8.01%) underspend**

The projected underspend is mainly due to the two areas previously reported:

- £56,000 employee cost vacancy savings, net of sessional backfill costs.
- £37,000 underspend on client commitment costs based on the current cost of packages.

This is a further projected underspend of £24,000 as a result of three new vacant posts.

h. **Support / Management: Projected £39,000 (1.67%) underspend**

The projected underspend mainly relates to vacancies.

i. **Assessment & Care Management: Projected £29,000 (1.78%) underspend**

The projected underspend mainly relates to vacancies.

j. **Homelessness: Projected £100,000 (16.00%) underspend**

The main reason for the projected underspend is an over-recovery of Hostel Grant income, in line with prior year income as last reported. This underspend of £80,000 is not recurring as the distribution of the grant is changing in 2014/15.

The additional £20,000 projected underspend relates to vacancies.

5.2 **HEALTH £11,000 PROJECTED UNDERSPEND**

The Health budget is £70,454,000 and is currently projected to underspend by £11,000 with the main reasons for this underspend and the movements from the position as at 30 June 2014 detailed below. This is a further projected underspend of £5,000 since last reported.

a. **Children & Families: Projected £112,000 (3.73%) overspend**

This remains due to historic supply pressures within CAMHS of £35,000 along with salary overspends within CAMHS of £65,000 and £12,000 within SALT due to RAM adjustments.

At this stage non recurring funding has not been applied as the CHCP are containing these cost pressures within the overall position and work remains ongoing to establish a recurring solution.

The projected overspend is an increase of £63,000 as it was assumed at period 3 that non recurring funding would be applied.

b. **Health & Community Care: Projected £55,000 (1.49%) underspend**

The 2013/14 budget has been reduced by £204,000 as the Continence Service has now transferred to Glasgow.

The projected underspend relates to vacancy savings, offset in part by supply pressures, mainly within Diabetes, Podiatry and Pharmacy and is a further underspend of £34,000.

c. **Management & Admin: Projected £42,000 (2.62%) overspend**

This is due to two main factors: pressures within Portering exacerbated by removal of £14,000 budget to fund a hosted ASD Co-ordinator post in another partnership. This was not reported as at period 3 the variance was not material.

d. **Learning Disabilities: Projected £35,000 (6.23%) underspend**

The projected underspend remains due to vacancy and maternity savings, a further underspend of £20,000.

e. **Addictions: Projected £22,000 (1.16%) underspend**

The projected underspend results from slippage in both salaries and supplies and is a further underspend of £11,000.

f. **Mental Health Communities: Projected £39,000 (1.61%) underspend**

This is due to historic pressures within pharmacy costs, offset by underspends in nursing staff costs due to vacancy and maternity savings. The period 3 underspend of £4,000 was not reported as it was not material.

g. **Mental Health Inpatient Services: Projected £1,000 (0.01%) underspend**

Whilst a minimal underspend is reported it should be noted that savings will be achieved from the rationalisation of the Ravenscraig wards to one building; however any saving achieved is ring-fenced for investment into the closure programme.

h. **Planning & Health Improvement: Projected £13,000 (1.30%) underspend**

The underspend is due to slippage in filling a temporary post, offsetting historic travel cost pressures.

i. Prescribing is currently projected to budget, however there are significant short supply pressures emerging at a board wide level primarily as a result of increased premiums for drugs on short supply.

Quantifying the actual overspend is complex due to the number of volatile and variable factors within GP prescribing, however based on current intelligence this could be in the region of £3-£4m. Work is ongoing on at a Board wide level to assess the impact on each CHCP / CHP.

6.0 CHANGE FUND

6.1 The allocation over service areas for 2013/14 is:

Service Area Budget 2013/14	£'000	
Acute – Health	205	11%
CHCP – Health	203	11%
CHCP – Council	1,017	57%
Community Capacity - Health	75	4%
Community Capacity - Council	301	17%
Grand Total	**1,801**	100%
Funded By:		
Change Fund Allocation	1,403	
Slippage brought forward from 2012/13	398	
Total Funding	**1,801**	

6.2 The Change Fund Executive Group meet on a regular basis and review all projects in detail. The latest current year position is:

Service Area Budget 2013/14	Current Budget £'000	Projected Outturn £000	Projected Variance £000
Acute – Health	205	183	(22)
CHCP – Health	203	188	(15)
CHCP – Council	1,017	1,032	15
Community Capacity - Health	75	75	0
Community Capacity - Council	301	323	22
Grand Total	**1,801**	**1,801**	**0**
Projected Slippage at 31 August 2013			**0**

Project performance is continually reviewed and budgets will be reallocated as required to ensure funding is fully utilised and slippage minimised. Any slippage in 2013/14 will be committed in 2014/15.

7.0 2013/14 CURRENT CAPITAL POSITION – £nil Variance

7.1 The Social Work capital budget is £1,314,000 over the life of the projects with £183,000 for 2013/14, comprising £123,000 for Kylemore (replacement residential children's unit) and £60,000 SWIFT Financial software package.

The Kylemore Children's Home opened in March 2013 and is fully operational. The previously reported underspend has been returned to the Council's capital programme as agreed by the Policy & Resources Committee on 23 September 2013. The underspend was from £109,000 furniture and fittings and £47,000 building works and offsets a shortfall of £100,000 from the sale of Redholm.

7.2 The Health capital budget of £102,000 is on target with no reported slippage. This will fund two areas of spend within Health Centres:

- £52,000 Reception upgrades to improve patient confidentiality issues.
- £50,000 Ceiling replacement tiles at Port Glasgow to address infection control and fire compliance issues.

In addition to the capital funding a further £61,000 works will be funded from revenue maintenance:

- £38,000 Treatment rooms within health centres
- £18,000 Car park resurfacing at Boglestone Clinic
- £5,000 Replacement surgery door.

7.3 Appendix 5 details capital budgets and progress by individual project.

7.4 Work is ongoing with the development of the CHCP Asset Management Plan.

8.0 IMPLICATIONS

8.1 The current projected revenue outturn is a £222,000 projected underspend.

8.2 The current projected capital outturn shows a nil variance as projects are to budget.

9.0 EARMARKED RESERVES

9.1 The Social Work Earmarked Reserves for 2013/14 total £3,452,000 with £2,357,000 projected to be spent in the current financial year. To date £769,000 spend has been incurred which is 35.2% of the projected 2013/14 spend. The spend to date per profiling was expected the be £993,000 therefore slippage equates to £224,000, 22.6%. Given the number and nature of the projects this slippage is manageable.

9.2 This position includes three new earmarked reserves agreed at the Policy & Resources Committee on 24 September 2013:

- £50,000 for aids and adaptations
- £80,000 for an additional respite bed at Hillend
- £65,000 to support young carers

9.3 In addition to these new reserves, £70,000 has been identified within the Independent Living earmarked reserve to develop a Dementia Strategy, detail of this and the application of the three new reserves will be reported to the next sub-committee.

10.0 VIREMENT

10.1 The virement requests are detailed in Appendix 7 and are reflected within this report.

11.0 EQUALITIES

11.1 There are no equality issues within this report.

12.0 OTHER ISSUES

12.1 Work remains ongoing to develop protocols and processes relating to the Integration of Health and Social Care.

13.0 CONSULTATION

13.1 This report has been prepared by the Corporate Director, Inverclyde Community Health & Care Partnership and relevant officers within Partnership Finance have been consulted.

APPENDIX 1

INVERCLYDE CHCP

REVENUE BUDGET PROJECTED POSITION

PERIOD 5: 1 April 2013 - 31 August 2013

SUBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
Employee Costs	46,547	47,430	46,998	(432)	(0.91%)
Property Costs	2,732	2,665	2,492	(173)	(6.49%)
Supplies & Services	59,346	60,067	60,380	313	0.52%
Prescribing	16,238	15,912	15,912	0	0.00%
Resource Transfer (Health)	8,863	8,863	8,863	0	0.00%
Income	(15,215)	(15,677)	(15,607)	70	-0.45%
Contribution to Reserves	0	0	0	0	0.00%
	118,511	**119,260**	**119,038**	**(222)**	**(0.19%)**

OBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
Strategy / Planning & Health Improvement	2,803	3,081	3,039	(42)	(1.36%)
Older Persons	20,731	21,021	20,969	(52)	(0.25%)
Learning Disabilities	6,105	6,574	6,641	67	1.02%
Mental Health - Communities	3,790	3,826	3,792	(34)	(0.89%)
Mental Health - Inpatient Services	9,544	9,286	9,285	(1)	(0.01%)
Children & Families	12,922	13,135	13,190	55	0.42%
Physical & Sensory	2,355	2,341	2,427	86	3.67%
Addiction / Substance Misuse	3,122	3,124	3,004	(120)	(3.84%)
Assessment & Care Management / Health & Community Care	5,077	5,312	5,228	(84)	(1.58%)
Support / Management / Admin	4,221	3,939	3,942	3	0.08%
Criminal Justice / Prison Service **	0	0	0	0	0.00%
Homelessness	629	625	525	(100)	(16.00%)
Family Health Services	20,708	20,896	20,896	0	0.00%
Prescribing	16,238	15,912	15,912	0	0.00%
Resource Transfer	8,863	8,863	8,863	0	0.00%
Change Fund	1,403	1,325	1,325	0	0.00%
Contribution to Reserves	0	0	0	0	0.00%
CHCP NET EXPENDITURE	**118,511**	**119,260**	**119,038**	**(222)**	**(0.19%)**

** Fully funded from external income hence nil bottom line position.

PARTNERSHIP ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
NHS	70,020	70,454	70,443	(11)	(0.02%)
Council	48,491	48,806	48,595	(211)	(0.43%)
CHCP NET EXPENDITURE	**118,511**	**119,260**	**119,038**	**(222)**	**(0.19%)**

( ) denotes an underspend per Council reporting coventions

** £2.3 million externally funded

APPENDIX 2

SOCIAL WORK

REVENUE BUDGET PROJECTED POSITION

PERIOD 5: 1 April 2013 - 31 August 2013

2012/13 Actual £000	SUBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
	SOCIAL WORK					
25,997	Employee Costs	25,961	25,977	25,614	(363)	(1.40%)
1,585	Property costs	1,504	1,490	1,431	(59)	(3.96%)
886	Supplies and Services	867	818	855	37	4.52%
456	Transport and Plant	374	389	454	65	16.71%
1,013	Administration Costs	813	925	998	73	7.89%
32,591	Payments to Other Bodies	32,884	33,214	33,180	(34)	(0.10%)
(14,304)	Income	(13,912)	(14,007)	(13,937)	70	(0.50%)
(577)	Contribution to Earmarked Reserves	0	0	0	0	
47,647	**SOCIAL WORK NET EXPENDITURE**	**48,491**	**48,806**	**48,595**	**(211)**	**(0.43%)**

Note	2012/13 Actual £000	OBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over / (Under) Spend £000	Percentage Variance
		SOCIAL WORK					
	2,066	Strategy	2,098	2,084	2,055	(29)	(1.39%)
	21,103	Older Persons	20,731	21,021	20,969	(52)	(0.25%)
	6,223	Learning Disabilities	5,547	6,012	6,114	102	1.70%
	1,159	Mental Health	1,412	1,401	1,406	5	0.36%
3	10,101	Children & Families	10,191	10,135	10,078	(57)	(0.56%)
	2,396	Physical & Sensory	2,355	2,341	2,427	86	3.67%
	804	Addiction / Substance Misuse	1,227	1,224	1,126	(98)	(8.01%)
	2,293	Support / Management	2,830	2,334	2,295	(39)	(1.67%)
	1,528	Assessment & Care Management	1,471	1,629	1,600	(29)	(1.78%)
1	0	Criminal Justice / Scottish Prison Service	0	0	0	0	0.00%
2	0	Change Fund	0	0	0	0	0.00%
	551	Homelessness	629	625	525	(100)	(16.00%)
	(577)	Contribution to Earmarked Reserves	0	0	0	0	0.00%
	47,647	**SOCIAL WORK NET EXPENDITURE**	**48,491**	**48,806**	**48,595**	**(211)**	**(0.43%)**

( ) denotes an underspend per Council reporting coventions

1 £1.9m Criminal Justice and £0.3m Greenock Prison fully funded from external income hence nil bottom line position.
2 Change Fund Expenditure of £1.4 million fully funded from income.
3 Children & Families outturn includes £410k to be transferred to the earmarked reserve at year end 2013/14
4 £8.9 million Resource Transfer / Delayed Discharge expenditure and income included above.

APPENDIX 3

HEALTH

REVENUE BUDGET PROJECTED POSITION

PERIOD 5: 1 April 2013 - 31 August 2013

2012/13 Actual £000	SUBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
	HEALTH					
21,861	Employee Costs	20,586	21,453	21,384	(69)	(0.32%)
1,453	Property	1,228	1,175	1,061	(114)	(9.70%)
3,491	Supplies & Services	3,700	3,825	3,997	172	4.50%
21,172	Family Health Services (net)	20,708	20,896	20,896	0	0.00%
15,828	Prescribing (net)	16,238	15,912	15,912	0	0.00%
8,869	Resource Transfer	8,863	8,863	8,863	0	0.00%
(1,145)	Income	(1,303)	(1,670)	(1,670)	0	0.00%
71,529	**HEALTH NET EXPENDITURE**	**70,020**	**70,454**	**70,443**	**(11)**	**(0.02%)**

2012/13 Actual £000	OBJECTIVE ANALYSIS	Approved Budget 2013/14 £000	Revised Budget 2013/14 £000	Projected Out-turn 2013/14 £000	Projected Over/(Under) Spend £000	Percentage Variance
	HEALTH					
3,319	Children & Families	2,731	3,000	3,112	112	3.73%
3,919	Health & Community Care	3,606	3,683	3,628	(55)	(1.49%)
1,686	Management & Admin	1,391	1,605	1,647	42	2.62%
534	Learning Disabilities	558	562	527	(35)	(6.23%)
1,829	Addictions	1,895	1,900	1,878	(22)	(1.16%)
2,380	Mental Health - Communities	2,378	2,425	2,386	(39)	(1.61%)
9,697	Mental Health - Inpatient Services	9,544	9,286	9,285	(1)	(0.01%)
1,127	Planning & Health Improvement	705	997	984	(13)	(1.30%)
1,169	Change Fund	1,403	1,325	1,325	0	0.00%
21,172	Family Health Services	20,708	20,896	20,896	0	0.00%
15,828	Prescribing	16,238	15,912	15,912	0	0.00%
8,869	Resource Transfer	8,863	8,863	8,863	0	0.00%
71,529	**HEALTH NET EXPENDITURE**	**70,020**	**70,454**	**70,443**	**(11)**	**(0.02%)**

( ) denotes an underspend per Council reporting coventions

APPENDIX 4

REVENUE BUDGET YEAR TO DATE

PERIOD 5: 1 April 2013 - 31 August 2013

SOCIAL WORK SUBJECTIVE ANALYSIS	Budget to Date as at Period 5 £000	Actual to Date as at Period 5 £000	Variance to Date as at Period 5 £000	Percentage Variance
SOCIAL WORK				
Employee Costs	10,775	10,628	(147)	(1.36%)
Property costs	622	597	(25)	(4.02%)
Supplies and Services	432	449	17	3.94%
Transport and Plant	145	175	30	20.69%
Administration Costs	191	224	33	17.28%
Payments to Other Bodies	11,863	11,833	(30)	(0.25%)
Income	(2,770)	(2,810)	(40)	1.44%
SOCIAL WORK NET EXPENDITURE	**21,258**	**21,096**	**(162)**	**(0.76%)**

HEALTH SUBJECTIVE ANALYSIS	Budget to Date as at Period 5 £000	Actual to Date as at Period 5 £000	Variance to Date as at Period 5 £000	Percentage Variance
HEALTH				
Employee Costs	9,177	9,148	(29)	(0.32%)
Property Costs	434	386	(48)	(11.06%)
Supplies	1,834	1,904	70	3.82%
Family Health Services (net)	8,565	8,565	0	0.00%
Prescribing (net)	6,739	6,739	0	0.00%
Resource Transfer	3,693	3,693	0	0.00%
Income	(1,030)	(1,031)	(1)	0.10%
HEALTH NET EXPENDITURE	**29,412**	**29,404**	**(8)**	**(0.03%)**

( ) denotes an underspend per Council reporting coventions

APPENDIX 5

INVERCLYDE CHCP - CAPITAL BUDGET 2013/14

Period 5: 1 April 2013 to 31 August 2013

Project Name	Est Total Cost	Actual to 31/3/13	Approved Budget 2013/14	Revised Est 2013/14	Actual to 31/08/13	Est 2014/15	Est 2015/16	Future Years	Start Date	Original Completion Date	Current Completion Date	Status
	£000	£000	£000	£000	£000	£000	£000	£000				
SOCIAL WORK												
Prudential Borrowing												
Kylemore Childrens Home (see 1 below)	1,244	1,121	123	123	0	0	0	0	01/10/11	30/06/12	19/03/13	The home opened on 19 March. The final cost is a projected £156k underspend, subject to final account adjustments with the contractor, with the underspend returned to the Council's capital programme.
Capital Funded From Revenue Contributions												
SWIFT Finance Module	70	10	60	60	12	0	0	0	03/09/12		31/08/14	Budget allocated for Development and Implementation of SWIFT Finance module.
Social Work Total	**1,314**	**1,131**	**183**	**183**	**12**	**0**	**0**	**0**				
HEALTH												
CHCP Formula Allocation 2013-14 (see 2 below)												
Health Centres Reception Upgrades	52		52	52	0	0	0	0	Oct-13	by 31/03/14	31/03/14	To improve patient confidentiality.
Port Glasgow Health Centre Ceiling Tiles	50		50	50	0	0	0	0	Oct-13	by 31/03/14	31/03/14	To resolve infection control and fire compliance issues.
Health Total	102	0	102	102	0	0	0	0				
Grand Total CHCP	**1,416**	**1,131**	**285**	**285**	**12**	**0**	**0**	**0**				

Note:

1. Original budget was £1.4m with the underspend of £156k returned to the Council's capital programme per Policy & Resources Committee 24/09/13.
The underspend related to £109k furniture and fittings and £47k building works. This offsets a shortfall in receipt from the sale of the building of £100k.

2. Funding comprises £102k local formula capital allocation and £0 capital backlog maintenance (as was accelareated in 12/13).
A further £61k of works will be funded through revenue maintenance:

	£000
Port Glasgow Health Centre - replacement practice door	5
Treatment Rooms (all Health Centres)	38
Boglestone Clinic Car Park	18
	61

EARMARKED RESERVES POSITION STATEMENT

CHCP SUB COMMITTEE

APPENDIX 6

Project	Lead Officer/ Responsible Manager	Total Funding 2013/14 £000	Phased Budget To Period 5 2013/14 £000	Actual To Period 5 2013/14 £000	Projected Spend 2013/14 £000	Amount to be Earmarked for 2014/15 & Beyond £000	Lead Officer Update
Telecare Grant	Joyce Allan	60	25	42	60	0	Full carried forward allocation will be utilised in 2013/14 on tools and equipment. Profiling is based upon the expenditure being evenly spread over the full financial year.
Self Directed Support / SWIFT Finance Module	Derrick Pearce / Andrina Hunter	391	37	31	166	225	SDS project and SWIFT financial module. Current staff costs for SWIFT are included within the deferred income balance below. Profiling is based upon the project being split over the last 9 months of the financial year.
Growth Fund - Loan Default Write Off	Helen Watson	30	1	1	4	26	Loans administered on behalf of DWP by the credit union and the Council has responsibility for paying any delinquent debt. This requires to be kept until all loans are repaid and no debts exist. The profiling assumes that all expenditure will be incurred evenly through out the year.
Advice Services - MacMillan	Andrina Hunter	35	14	14	35	0	Funding from 2014/15 will come from recurring welfare reform monies. The profiling is based upon the timing of the staff payroll.
Deferred Income	Brian Moore	458	153	85	222	236	A number of historical deferred income streams have been brought forward to 2013/14. Profiling takes account of a month's delay at the start of the financial year. However there are 8 individual projects, so the phased budget is difficult to predict. There are plans in place for the full £236k being carried forward.
Change Fund - Older People	Brian Moore	1,314	548	472	1,314	0	Brought forward reflects Council elements of NHS Change Fund. Detailed costs by Project are reviewed on a regular basis by the Change Fund Executive Group and is reported to the CHCP sub committee as an integral part of the financial report. Any slippage in year will be carried forward to 2014/15. Profiling assumes that all expenditure will be incurred evenly through out the year, however with a large number of projects this is not exact.
Support all Aspects of Independent Living	Brian Moore	630	210	119	337	293	This fund will be spent over the next 2 financial years. The £119k spent to date includes a contribution to the 2013/14 Sheltered Wardens' saving of £70k. Of the £293k earmarked to be spent in 2014/15, £245k is supported by spending plans (including £70k Dementia Strategy) leaving an unallocated balance of £48k . Profiling takes account of a month's delay at the start of the financial year, however the nature of the spend is not predictable.
Local Autism Action Plan	Alan Best	35	0	0	18	17	£18k projected to be spent in 2013/14 including Speech Therapy and Psychology services.

EARMARKED RESERVES POSITION STATEMENT — CHCP SUB COMMITTEE — APPENDIX 6

Project	Lead Officer/ Responsible Manager	Total Funding 2013/14 £000	Phased Budget To Period 5 2013/14 £000	Actual To Period 5 2013/14 £000	Projected Spend 2013/14 £000	Amount to be Earmarked for 2014/15 & Beyond £000	Lead Officer Update
Adoption/Fostering/Residential Childcare	Sharon McAlees	219	0	0	0	219	The final spend from/or contribution to this reserve will be identified at year end. The in year operation of this budget will be reported through normal Revenue Monitoring.
Information Governance Policy Officer	Helen Watson	85	6	5	31	54	Post now filled (2 year post), employee in post from July and budget phased accordingly.
Joint Equipment Store	Beth Culshaw	50	0	0	0	50	This new reserve was approved at Policy & Resources Committee on 24 Sept 2013 and is to fund a range of equipment to meet the emerging demand linked to increasing frailty of older people and increased incidence of dementia. Budget will be phased once detail agreed.
Extend Hillend Respite Provision	Beth Culshaw	80	0	0	0	80	This new reserve was approved at Policy & Resources Committee on 24 Sept 2013 and is to fund an extension of the short break respite unit at Hillend to increase the number of beds from 3 to 4 to meet demand. Budget will be phased once detail agreed.
Support for Young Carers	Sharon McAlees	65	0	0	0	65	This new reserve was approved at Policy & Resources Committee on 24 Sept 2013 and is for an 18 month period to enable the implementation of a family pathway approach to young cares, which will aim to develop a sustainable service to young carers and their families. Budget will likely be phased over the next 18 months once detail is agreed.
Total		3,452	993	769	2,187	1,265	

APPENDIX 7

CHCP - HEALTH & SOCIAL CARE

VIREMENT REQUESTS

Budget Heading	Increase Budget £'000	(Decrease) Budget £'000
1. Older People - External Homecare	75	
1. Older People - Employee Costs		(75)
2. Learning Disability - Client Commitments	13	
2. Corporate Director - Pressure Money		(13)
3. Older People - Postages	5	
3. Strategy - Postages	1	
3. Assessment & Care Management- Postages		(6)
	94	**(94)**

Note

1 Shifting the balance of homecare to external provision
2. Allocation of balance of £13k of Pressure Money (full 2013/14 balance of £450k has now been allocated)
3. Reallocation of postages

AGENDA ITEM NO: 3

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 24th October 2013**
Report By:	**Brian Moore** **Corporate Director** **Inverclyde Community Health & Care Partnership**	**Report No: CHCP/53/2013/BC**
Contact Officer:	**Beth Culshaw** **Head of Health & Community Care**	**Contact No: 01475 715387**
Subject:	**RESHAPING CARE FOR OLDER PEOPLE**	

1.0 PURPOSE

1.1 To provide an update on the 2013/14 Mid Year Report of the local Change Plan currently driving the Scottish Government Directive, Reshaping Care for Older People.

2.0 SUMMARY

2.1 As previously reported, the Government has initiated a directive to transform the existing model of care and support for older people. The 10 year strategy 2011- 2021 A Programme of Change, sets out the Scottish Government vision for improving care quality and outcomes for older people in our communities, and presents unique challenges with regard to rapidly changing demographic trends, expectations and economic drivers.

2.2 The Government strategy refresh 'Getting On' published in September 2013 reports good progress nationally on achieving the outcomes of Reshaping Care for Older People whilst acknowledging there is still work to be done.

2.3 This report provides an update for the Community Health and Care Partnership Sub Committee on Inverclyde CHCP's progress as outlined in the 2013/14 mid year report submitted to Scottish Government on September 27th 2013.

3.0 RECOMMENDATION

3.1 The Community Health and Care Partnership Sub Committee members are requested to:
(a) Note the content of the mid year report and the progress made with regard to implementing the local Change Plan.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 Reference is made to previously submitted Sub Committee reports outlining the Scottish Government's strategy on Reshaping Care for Older people. The vision set out by Government is that "Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting".

4.2 The Sub-Committee will recall that a national £70m change fund was introduced in 2011/12 to support the implementation of Reshaping Care for Older People. It was subsequently confirmed that funding would continue for a further 3 years and increase to £80m for 2012/13 and 2013/14. Inverclyde's share of resources is outlined at 7.2 below.

4.3 Reshaping Care for Older People requires investment across five pathways: Preventative and Anticipatory Care, Proactive Care and Support at Home, Effective Care at Times of Transition, Hospital and Care Homes and Enablers. Investment should show a progressive shift towards Preventative and Anticipatory Care and a commitment of at least 20% of the Change Fund must be dedicated to supporting carers to continue to care for older people.

4.4 The Scottish Government requested a mid- year review be submitted in September. The purpose of this review was to share examples of change fund investment by submitting a short case study for each of the five pathways and to undertake a self-assessment of the spread of local approaches.

4.5 Inverclyde CHCP undertook the self assessment and submitted five case studies; Closer Working with Housing, Carers Hospital Discharge Project, Reablement Care at Home, Early Facilitated Hospital Discharge/ Prevention of Care Home Admission, and Closer Working with the Independent Sector.

5.0 PROPOSALS

5.1 Inverclyde CHCP proposes to consolidate its work with a wide range of local partners and stakeholders and to continue to develop approaches which fully embed the required changes outlined in Reshaping Care for Older People across Inverclyde.

6.0 MID- YEAR 2013/14 PROGRESS OVERVIEW

6.1 At the mid-year point 2013/14 there is good progress in spreading and sustaining change across the pathways.

6.2.1 There are a number of areas where 'spread' is self-evaluated as 5: "The approach/ intervention/ improvement action is fully embedded in all localities/ sites/ teams/ older people/ carers and there is an agreed plan to sustain this".

- Rapid access to equipment
- Timely adaptations, including housing adaptations
- Specialist clinical advice for community teams
- Responsive and flexible palliative care
- Medicines Management

6.2.2 There are no areas assessed as 0 and only one area remains where spread has been self assessed as 1: "Agreed plan to take forward the approach/ intervention/ improvement action but not yet began to implement"

- Range of Intermediate Care alternatives to emergency admission

6..2.3 Whilst services aimed at avoiding unnecessary admissions to hospital exist within Inverclyde, the requirement to develop alternatives that are more responsive is noted. Work is underway to scope the potential use of care home beds and sheltered housing as step up/ down facilities.

6.3 The range of short case studies chosen show improved partnership working across housing, independent and third sectors. In particular progress towards:

- Improved communication and processes with housing providers
- Delivering a leadership programme for care home managers *'My Home Life'*
- Improved support for carers when the cared for person is in acute care or being discharged from acute care

6.4 Investment shift from Hospital and Care Homes across the pathways to Preventative and Anticipatory Care and Proactive care and Support at Home is evidenced in the change fund budget allocation at 7.2 below.

6.5 Evidence of our commitment to investing in support for carers is also shown with 19.6% direct and 22% indirect spend in 2013/14.

7.0 IMPLICATIONS

7.1 Legal:

7.2 Finance: Total Change Fund Resources over 3 years with carers allocation for 2012/13 and 2013/14

	2011/12 £000's	**2012/13 £000's**	**2013/14 £000's**
SG Allocation	1228	1400	1403
Additional Local Resources (if any)	0	0	0
Carry Forward	N/A	488	398
Total Allocation	1228	1888	1801
Year-end Spend	740	1491	1801
Anticipated Carry Forward to 2014/15			0
Direct spend on carers (year-end spend)	N/A	203	275
Indirect spend on carers (year-end spend)	N/A	244	309

Total allocation- five pathways showing shift in spend over 3 years

	Preventative and Anticipatory Care	**Proactive Care and Support at Home**	**Effective Care at Times of Transition**	**Hospital and Care Home(s)**	**Enablers**	**Total** *(should equal 100%)*
2011/12 (year-end spend)	15%	23%	12%	47%	3%	100%
2012/13 (year-end spend)	18.99%	36.27%	15.98%	22.71%	6.05%	100%
2013/14 (anticipated year end spend)	21.00%	34.98%	15.75%	14.21%	14.06%	100%

7.3 Personnel:

7.4 Equalities:

7.5 Depopulation:

8.0 CONSULTATION

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9.0 LIST OF BACKGROUND PAPERS

9.1 Change Fund 2013/14 – Mid Year Review
Reshaping Care for Older People – Getting On. Sept 2013

Change Fund 2013/14 – Mid-Year Review

Dear colleagues

The main purpose of this year's mid-year Change Fund survey is to share examples of how local partnerships have deployed their Change Fund to make a difference to the lives of older people and their carers across Scotland. The JIT will use this additional insight to understand what is working well, to share learning about the impact of successful innovations, and to identify areas of work that may require further improvement support in order to make progress on joint strategic commissioning and integration. An overview report will be shared with the Health and Community Care Delivery Group and the Ministerial Strategic Group.

We ask you to describe the learning from at least one initiative that you have taken forward under each pillar of the RCOP pathway. We appreciate that full evidence of impact may not yet be availablefor some of these initiatives. Therefore your comments should describe achieved or anticipated outcomes and gains, along with your learning to date and any implications for future investment decisions.

As in previous years, we have asked you to report spend against the pillars of the RCOP pathway. This is to help track the progressive shift in focus and investment towards preventative and anticipatory care.

We realise that it will take time to fully realise this shift and to show measurable impact on outcomes at scale. Therefore, we invite you to complete a self-assessment proforma to reflect on the extent to which specific approaches and improvements have been spreadlocally and to understand where, and when,further gains can be anticipated through joint commissioning. This will also enable JIT to identify those initiatives that require further support for implementation.

Recognising the growing importance of accessing and using data and information to inform decision making, we have also included a specific question about this in the 2013/14 mid-year review.

Your responses will inform the on-going improvement support for Reshaping Care and Integration provided by JIT and our partner organisations.

Please send your response to Mohamed.Omar@scotland.gsi.gov.uk by **Friday 27th September**. Thank you for taking the time to complete this mid-year review.

DR MARGARET WHORISKEY
Director, Joint Improvement Team

Contact Details

To ensure our records are up-to-date, please complete for all four partners:

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Other Key Contacts (if any – e.g. overall Project Managers/Officers, Development Managers/Officers etc.)

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Name	
Job Title	
Email Address	
Telephone #	

Change Fund 2013/14 – Mid-Year Review

Partnership	Inverclyde CHCP
Contact Name(s)& Job Title(s)	Emma Cummings Project Manager RCOP
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Telephone #	01475 715395
Date of Completion	18.9.13

1. Examples of impact

Please complete a case study template (Annex 1) describingat least one achievement that your partnership has made through use of the Change Fund for each of the Reshaping Care Pathway workstreams (i.e. we would like at least 5 in total to be submitted):

- ***Preventative and Anticipatory Care;Proactive Care and Support at Home;Effective Care at Times of Transition;Hospital and Care Home(s);Enablers.***

Each case study should be no more than one page long, with**at least one of the case studies highlighting either a director an indirect impact on carers**.Question 7 below contains short descriptors of interventions in the pathway.

2. Learning from what hasn't worked as well as anticipated

The Change Fund has been an opportunity for Partnerships to explore innovations that are 'Proof of Concept' or 'Tests of Change'. Please describe any shareable learning gained from initiatives **where a decision not to continue** has been taken – e.g. where barriers to progress were encountered or the initiative was not found to be effective.

We made a decision to disinvest in a project where the person in post was continually asked to carry out duties not relevant to the project. This appeared to be around lack of communication and understanding of the outcomes expected. It is therefore essential that frontline staff and line managers/ supervisors are fully aware of the aims of the change funded post/ initiative, what commitment and outcomes are expected and why. Robust reporting and monitoring processes are now in place to support this and to evidence delivery of outcomes.

3. Option Appraisal

Please describe any option appraisal approaches used to decide Change Fund investment priorities – e.g. whether applied to all / only selected initiatives and who was involved.

Whilst we have prioritised our approaches and improvement areas we have not yet undertaken any formal options appraisals. We have prioritised two for this year, these being around day care and care homes.

4. Use of Data and Information

Please describe your local progress and any barriers to effective use of data and information between partners (both within and out with the statutory sector).

We have recruited an impact analyst with change fund money who has prepared a suite of information and updates this regularly. Some issues surround the timing of data whereby this may already be 6 months out of date when received and it can be difficult to make real time decisions or respond effectively. We are beginning to collect more robust data on outcomes delivered by change fund projects both from statutory and third sector organisations which is informing our decision making processes and investment priorities. We should now agree on how we share more detailed data with our partners eg on use of care home beds to evidence our strategic approaches and options appraisals.

5. Improvement support

Please provide details of any support you would welcome.

Support for decisions on disinvestment/ sustainability

6. Budget 2013/14

Please insert details of your 2013/14 Change Fund budget and the proportion of spend aligned to each of these 5 workstreams:

	2011/12 £000's	**2012/13 £000's**	**2013/14 £000's**
SG Allocation	1228	1400	1403
Additional Local Resources (if any)	0	0	0
Carry Forward	N/A	488	398
Total Allocation	1228	1888	1801
Year-end Spend	740	1491	1801
Anticipated Carry Forward to 2014/15			0
Direct spend on carers (year-end spend)	N/A	203	275
Indirect spend on carers (year-end spend)	N/A	244	309

	Preventative and Anticipatory Care	**Proactive Care and Support at Home**	**Effective Care at Times of Transition**	**Hospital and Care Home(s)**	**Enablers**	**Total** *(should equal 100%)*
2011/12	15%	23%	12%	47%	3%	100%

(year-end spend)						
2012/13 (year-end spend)	18.99%	36.27%	15.98%	22.71%	6.05%	100%
2013/14 (anticipated year end spend)	21.00%	34.98%	15.75%	14.21%	14.06%	100%

7. Assessment of Spread

The Reshaping Care Pathway represents 4 'bundles' of interventions, approaches or actions and the related enablers which collectively improve outcomes for older people.As you take forward Joint Commissioning, it is important to understand the extent to which you have spread new approaches and improvements so that you can understand where and when future gains can be anticipated.

Therefore we invite Partnerships to complete a self-assessment of spread**as at September 2013** by assigning a position statement 0-5 to each approach or intervention in the pathway.

Spread Value	Self-Assessment Position Statement
0	No agreed plan to implement the approach / intervention / improvement action
1	Agreed plan to take forward the approach / intervention / improvement action but not yet began to implement
2	Testing / implementing the approach / intervention / improvement action in a minority of localities / sites / teams / older people / carers
3	The approach / intervention / improvement action has spread to most localities / sites / teams / older people / carers
4	The approach / intervention / improvement action has spread to all localities / sites / teams / older people / carers but is not yet fully embedded in routine practice
5	The approach / intervention / improvement action is fully embedded in all localities / sites / teams / older people / carers and there is an agreed plan to sustain this

Preventative and Anticipatory Care		**Value (0-5)**
Build social networks and opportunities for participation	We are mobilising community support through volunteering, building community capacity, collaborations and social enterprises that promote participation and meaningful activity for older people living at home and in care homes.	3
Early diagnosis of dementia	We continue to work to increase the number of people with dementia who have a diagnosis as this improves access to support and services for the family.	4
Prevention of Falls and Fractures	The Partnership is implementing the recommendations of *Up and About*: a whole system pathway for the prevention and management of falls and fragility fractures.	4

Preventative and Anticipatory Care		Value (0-5)
Information & Support for Self-Management & Self-Directed Support	Practitioners and services signpost older people towards community and third sector resources that help them to stay well, to manage their conditions and provide useful and accessible information and advice on the choices they have about their future care, support and housing. This includes post diagnostic support for people affected by dementia and information and support required to adopt personal budgets.	3
Prediction of risk of recurrent admissions	Community health and social care teams routinely use a risk prediction tool (e.g. SPARRA) and local health and social care data and intelligence to identify older people who are frail and at greatest risk of emergency admission to hospital or care home.	2
Anticipatory Care Planning	Care providers support frail older people and their carers to develop Anticipatory Care Plans (ACPs): a summary or shared record of the preferred actions, interventions and responses in the event of an anticipated deterioration in the health of the person or their carer.	2
Support for carers	Our health and care staff routinely identify carers and are able to signpost them to information, advice and support from social work, carers centres and other agencies to help them to stay well and be supported to continue in their role.	4
Suitable and varied housing and housing support	We are investing in handyperson services, housing support, making better use of our existing stock of sheltered housing and developing new specialist provision to help older people maintain their independence and reduce the risk of accidents at home.	3

Proactive Care and Support at Home		Value (0-5)
Responsive flexible, self-directed home care	All providers of care and support at home adopt a “doing with” approach and formulate packages of care and support around the individual’s personal goals. This includes the opportunity to adopt personal budgets for care and support.	4
Integrated Case/Care Management	Multi-disciplinary community health and social care teams adopt an integrated case / care management approach to monitor and proactively support frail older people with complex and changing needs at greatest risk of emergency admission to hospital or care home.	2
Carer Support and Respite	We provide opportunities for short breaks to help carers continue to provide care, helping reduce isolation, providing a better quality of life and maintaining carers’ health and wellbeing.	4
Rapid access to equipment	There is effective and timely access to health and social care equipment and adaptations and this is an integral part of mainstream community care assessment and service provision.	5
Timely adaptations, including housing adaptations	We have streamlined access to adaptations and alterations which help older people to maintain their independence at home.	5

Proactive Care and Support at Home		Value (0-5)
Telehealthcare	The partnership provides remote monitoring and assistive technology for older people with complex care and support needs who require this technology to remain supported in their own home.	4

Effective Care at Times of Transition		Value (0-5)
Reablement & Rehabilitation	Health and care practitioners adopt an enabling approach and all providers have a focus on maintaining independence, recovery, rehabilitation and re-ablement.	4
Specialist clinical advice for community teams	Primary and community health and care staff, including voluntary and independent sector partners, are supported by access to a range of specialist practitioners for advice on common important conditions in older people such as dementia, continence, nutrition and tissue viability.	5
NHS24, SAS and Out of Hours access ACPs	Community teams share essential information from ACPs (e.g. electronic Key Information Summary) with local emergency and out of hours services and with SAS and NHS24.	4
Range of Intermediate Care alternatives to emergency admission	Working alongside NHS24, SAS and Out of Hours services we provide rapid access to a range of enabling assessment and treatment services at home, in minor injuries units, day hospitals, community hospitals and care homes as safe and effective alternatives to acute hospital admissions and to support timely discharge.	1
Responsive and flexible palliative care	We provide timely access to community based support for palliative and end of life care to increase the proportion of older people who are able to die at home or in their preferred place of care.	5
Support for carers	We promote shared decision making and make sure that carers are informed and supported to help them continue in their role when the health of the person they care for deteriorates or they move to another care setting.	4
Medicines Management	Joint working between GPs, community pharmacists, mental health teams and geriatricians reduces polypharmacy for older people through mindful prescribing, review and reconciliation of medicines and use of pharmaceutical care plans. We support older people and their carers to administer and take medication safely.	5
Access to range of housing options	The range of intermediate care services provided includes timely accessible housing options for people whose functional ability has acutely declined.	2

Hospital and Care Home(s)		Value (0-5)
Urgent triage to identify frail older people	Pathways through A&E and admissions wards are configured to identify frail older people with physical, functional and cognitive impairments who will benefit from coordinated comprehensive geriatric assessment.	4

Hospital and Care Home(s)		Value (0-5)
Early assessment and rehab in appropriate specialist unit	Frail older people with physical, functional and cognitive impairments and those who have fallen are 'pulled' to access multi-professional Comprehensive Geriatric Assessment within 24 hours of emergency admission to hospital.	2
Prevention and treatment of delirium	Pathways through acute hospitals minimise boarding for frail older people and care staff are trained to prevent, detect and effectively manage delirium.	3
Effective and timely discharge home or to intermediate care	All partners work together and with Scottish Ambulance Service to optimise use of estimated date of discharge, improve discharge planning and eradicate delayed discharges, including delays in short stay specialty beds and for Adults with Incapacity.	3
Medicine reconciliation and reviews	Medicine reconciliation is routinely undertaken for older people on admission and at discharge from hospital and care homes, and antipsychotic prescribing is minimised.	5
Carers as equal partners	We identify the carer at an early stage when the person is admitted to hospital and ensure that the carer is involved in the care, rehabilitation and discharge planning.	3
Specialist clinical support for care homes	We provide specialist clinical support to enable care homes to have a greater role in intermediate care and to support staff to care for older people with dementia and palliative / end of life care needs.	3

Enablers		Value (0-5)
Outcomes-focussed assessment	Our providers of care and support deliver personalised care through assessments which focus on personal outcomes and goals agreed with the older person (and their unpaid carer).	2
Co-production	Services are planned and delivered in an equal and reciprocal relationship between professionals, people using services, their families and the community.	3
Technology/eHealth/Data Sharing	We routinely share information across professionals and teams in line with agreed data sharing protocols and using the capability of emerging technology.	3
Workforce Development/Skill Mix/Integrated Working	We are developing a multi-professional workforce that is integrated, capable and fit for the future with core generic skills and appropriate specialist competencies.	3
Organisational Development and Improvement Support	We engage and communicate effectively with all partners, with our workforce and the public, and collaborate across professions and sectors to strengthen strategic leadership for change and to build improvement capacity and capability.	4
Information and Evaluation	We routinely use measurement for improvement and feedback performance measures to our staff and to the public to lever and assure quality.	3

Enablers		Value (0-5)
Commissioning and Integrated Resource Framework	Statutory, community, third and independent sectors, users, carers, providers and commissioners of care come together to agree long term service development and investment proposals including where and how resources should shift from current services and care models to new arrangements. We are using the Integrated Resource Framework to lever a shift in the totality of the partnership spend on service and support for older people.	4

8. Any additional comments?

Thank you for taking the time to complete this mid-year review. Please return this template, along with at least 5 case studies using the pro-forma in Annex 1, to Mohamed.omar@scotland.gsi.gov.uk by **Friday 27 September 2013.**

Annex 1 – Examples of Impact

As per Question 1, please complete the following template for each example of achievement your partnership has made through use of the Change Fund for each of the Reshaping Care Pathway workstreams.We would like at least one example for each workstream, with at least one of the case studies highlighting either a **director an indirect impact on carers**.

Note – This paper is designed to show highlights and not a full case study and ***should be no more than one page long****, allowing readers to have access to further information, if helpful. Please remember to 'tag' the case study appropriately on the next page. Submitted case studies will be published on the JIT website.*

Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP**

Name of Initiative Highlighted	**Closer Working with Housing**
Date of Submission	27/9/13

Primary Contact	**Debbie Maloney**
Email	Debbie.maloney@inverclyde.gov.uk
Telephone	01475 504897

Pathway:	Enablers

1. Summary

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

Within Inverclyde there are six RSL's, three of which are national providers which operate specialist housing for disability and older people. There was a lack of a cohesive approach to implementing the local housing strategy across the CHCP therefore dedicated OT time was sought to develop closer working and appropriate processes.

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

Reviewing and refining processes across services and organisations. Influencing choice based letting to ensure that those who have difficulty engaging with the bidding processes were supported. Working with RSL's to influence housing allocations and adaptations, and to carry out site surveys to ensure appropriate allocations for those with complex housing needs. Strengthening the links to allow housing colleagues access to CHCP services. Signposting RSL's to link with 3rd sector organisations to provide social activities within sheltered housing complexes.

3. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

Dedicated time was afforded via the change fund through employment of a dedicated housing OT and the support of an exerienced OT who is also leading reablement. The approach started in January 2013 and will be ongoing initially for 2 years via

the change fund. A process of active engagement with all providers has taken place and has included for example, planned training with allocation staff at RSL's to raise awareness of disability/carer housing needs. The support of the CHCP director has been crucial to opening channels of communication.

4. What were the outcomes/benefits or otherwise?

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

Overall there is much improved communication with RSL's and we are beginning to develop much clearer transparent processes accross CHCP around housing allocation including:

- Chairing multi disciplinary housing allocations meeting to influence best use of extra care housing provision.
- Testing processes for allocation of adapted or specialist housing with one provider.
- Plan for OT to support 3 local one stop shops being developed by local RSL's.

5. Additional contacts (to find out more)

(People, organisations, link(s) to further information, if available)

Robyn Garcha Housing OT Inverclyde CHCP Tel. 01475 714350

Once submitted, this case study will be published to the JIT website. To help users find case studies relevant to their area of interest, this case study should be tagged with the following search terms (e.g. Reshaping care, re-ablement, community capacity, third sector, preventing admissions, intermediate care)

In order to help us best sort the case studies please enter a Y into each and every box you think this applies to, being cognisant of the primary pathway chosen on the previous page:

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Build social networks and opportunities for participation		Responsive flexible, self-directed home care		Reablement & Rehabilitation		Urgent triage to identify frail older people	
Early diagnosis of dementia		Integrated Case/Care Management		Specialist clinical advice for community teams		Early assessment and rehab in appropriate specialist unit	
Prevention of Falls and Fractures		Carer Support and Respite		NHS24, SAS and Out of Hours access ACPs		Prevention and treatment of delirium	
Information & Support for		Rapid access to equipment	**Y**	Range of Intermediate		Effective and timely discharge	**Y**

Annex 1 – Examples of Impact

Self-Management & Self-Directed Support				Care alternatives to emergency admission		home or to intermediate care	
Prediction of risk of recurrent admissions		Timely adaptations, including housing adaptations	Y	Responsive and flexible palliative care		Medicine reconciliation and reviews	
Anticipatory Care Planning		Telehealthcare	Y	Support for carers		Carers as equal partners	
Support for carers				Medicines Management		Specialist clinical support for care homes	
Suitable and varied housing and housing support	Y			Access to range of housing options	Y		

Enablers	
Outcomes-focussed assessment	
Co-production	
Technology/eHealth/Data Sharing	
Workforce Development/Skill Mix/Integrated Working	
OD and Improvement Support	
Information and Evaluation	
Commissioning and Integrated Resource Framework	

Annex 1 – Examples of Impact

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Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP**

Name of Initiative Highlighted	**Carers Hospital Discharge Project**
Date of Submission	27/9/13

Primary Contact	**Maureen Hamill**
Email	Maureen.hamill@invercyde.gov.uk
Telephone #	01475 715385

Pathway:	**Effective Care at Times of Transition**

6. Summary

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

To improve the experience of carers of older people through the journey of hospital discharge from beginning to end.

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

Carers expressed views that they felt excluded from the process of hospital discharge and needed to access relevant information and support.

8. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

Need identified through carers strategy 2012-15. Change fund secondment of carers centre worker to be located within hospital setting at Inverclyde Royal. Established steering group for all carers projects which included representative from acute and hospital social work team leader to design project. It was decided to focus on the Larkfield unit where care of older adults takes place. Worker focussed on staff awareness raising, established referral system, distributed carers information within hospital and has worked with individuals one to one. There are plans to enable carers to access more support within the hospital rather than needing to visit the carers centre

9. What were the outcomes/benefits or otherwise?

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

Worker has raised awareness amongst staff regarding information and support available to carers. Has offered direct support and information to carers and

signposted carers to relevant services. This has improved joint working between carers centre and social work staff in hospital. Feedback from individual carers is positive and there has been an increase in registration at the carers centre. This was initially funded for one year and has been extended into a second year. A decision has also been taken to increase investment in this project for the next 6 months to roll out wider within the hospital.
Our involvement in the Equal partners in Care (EpiC) pilot will underpin staff awareness across services to further embed our approach to supporting carers.

10. Additional contacts (to find out more)

(People, organisations, link(s) to further information, if available)

Inverclyde Carers Centre Tel 01475 735180

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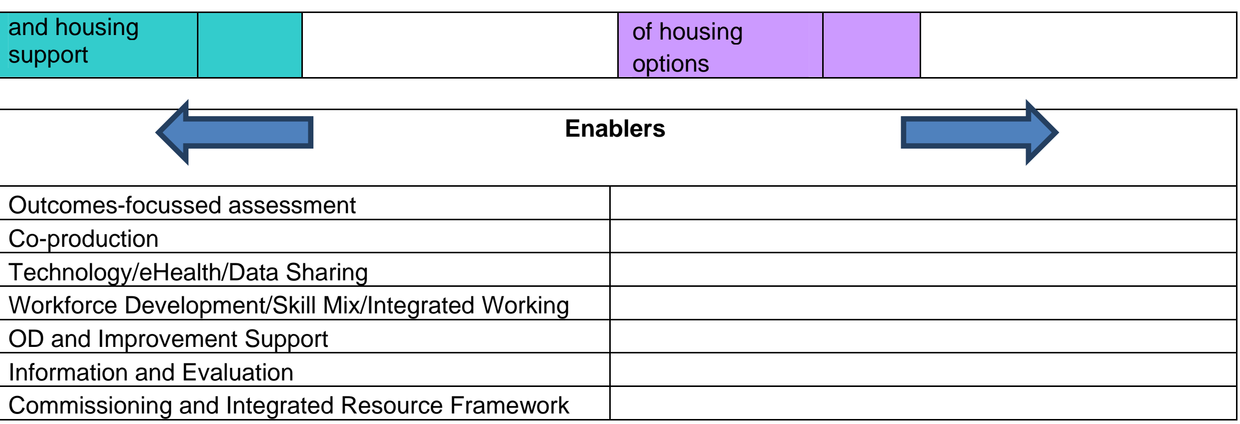
Early diagnosis of dementia		Integrated Case/Care Management		Specialist clinical advice for community teams		Early assessment and rehab in appropriate specialist unit	
Prevention of Falls and Fractures		Carer Support and Respite	Y	NHS24, SAS and Out of Hours access ACPs		Prevention and treatment of delirium	
Information & Support for Self-Management & Self-Directed Support		Rapid access to equipment		Range of Intermediate Care alternatives to emergency admission		Effective and timely discharge home or to intermediate care	Y
Prediction of risk of recurrent admissions		Timely adaptations, including housing adaptations		Responsive and flexible palliative care		Medicine reconciliation and reviews	
Anticipatory Care Planning	Y	Telehealthcare		Support for carers	Y	Carers as equal partners	Y
Support for carers	Y			Medicines Management		Specialist clinical support for care homes	
Suitable and varied housing				Access to range			

Annex 1 – Examples of Impact



and housing support			of housing options		

Enablers	
Outcomes-focussed assessment	
Co-production	
Technology/eHealth/Data Sharing	
Workforce Development/Skill Mix/Integrated Working	
OD and Improvement Support	
Information and Evaluation	
Commissioning and Integrated Resource Framework	

Annex 1 – Examples of Impact

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Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP**

Name of Initiative Highlighted	**Reablement Care at Home**
Date of Submission	27/9/13

Primary Contact	**Debbie Maloney**
Email	Debbie.maloney@inverclyde.gov.uk
Telephone #	01475 504897

Pathway:	**Proactive Care and Support at Home**

11. Summary

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

Reablement and mainstream care at home activity data for Inverclyde shows a positive impact on ability and independence of individuals both immediately post discharge and subsequently over time. Reablement has been delivered as part of a discrete service; however, there is a requirement to embed the ethos across all services and to ensure that any individual's improvements in abilities and confidence of individuals are sustained.

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

Within Inverclyde CHCP Reablement has been fully funded from change fund since early in 2012 and there is a need to identify and release the resource benefits to ensure the service remains viable and the approach is embedded. We see reablement as a crucial part of the assessment process for SDS.

13. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

There have been a number of approaches involving support from local finance and JIT. A review group has been monitoring data from care at home and reablement to understand shifts in demand and capacity and JIT support has framed some of these discussions. The reablement lead (change fund post) has driven the connections with mental health and dementia services in order to embed the approach and to develop joint processes.

14. What were the outcomes/benefits or otherwise?

Annex 1 – Examples of Impact

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

Despite showing successful outcomes for service users, it is only recently that we have started to identify and transfer resource and to be able to transfer posts from temporary change fund posts to permanent posts. We continue to identify areas where reablement has impacted on capacity such as the OT aids & adaptations waiting list and have begun to use this capacity more creatively, through joint working initiatives to support the reablement approach.

15. Additional contacts (to find out more)

(People, organisations, link(s) to further information, if available)

Joyce Allan Service Manager- Care at Home joyce.allan@inverclyde.gov.uk

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Early diagnosis of dementia		Integrated Case/Care Management		Specialist clinical advice for community teams		Early assessment and rehab in appropriate specialist unit	
Prevention of Falls and Fractures		Carer Support and Respite		NHS24, SAS and Out of Hours access ACPs		Prevention and treatment of delirium	
Information & Support for Self-Management & Self-Directed Support		Rapid access to equipment		Range of Intermediate Care alternatives to emergency admission		Effective and timely discharge home or to intermediate care	
Prediction of risk of recurrent admissions		Timely adaptations, including housing adaptations		Responsive and flexible palliative care		Medicine reconciliation and reviews	
Anticipatory Care Planning		Telehealthcare		Support for carers		Carers as equal partners	
Support for carers				Medicines Management		Specialist clinical support for care homes	
Suitable and varied housing and housing support				Access to range of housing options			

Annex 1 – Examples of Impact

Enablers	
Outcomes-focussed assessment	
Co-production	
Technology/eHealth/Data Sharing	
Workforce Development/Skill Mix/Integrated Working	
OD and Improvement Support	
Information and Evaluation	
Commissioning and Integrated Resource Framework	

Annex 1 – Examples of Impact

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Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP**

Name of Initiative Highlighted	**Early Facilitated Hospital Discharge / Prevention of Care Home Admission**
Date of Submission	24 09 13

Primary Contact	**C Hennan / T Bench**
Email	Chrsitine.hennan@ggc.scot.nhs.uk
Telephone	01475 506028

Pathway:	Preventative and Anticipatory Care

16. Summary

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

In order to support individuals to remain in her own home following discharge from acute care an integrated approach involving PHCT / Local Authority / Secondary Care and family members / informal carers is being used. Starting from the pre discharge case conference, joint planning and assessment is being used to co-ordinate the return home and support tailored care to avoid care home admission.

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

Systems & processes are not always conducive to good communication, anticipatory planning and integrated working. This is particularly evident for people with complex needs requiring a multi agency, multi disciplinary approach who may not able to advocate for themselves.

18. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

Examples from one case include:
Assessment & care management team met with senior nurse adult community nursing to scope potential for successful trial period at home.
Subsequent involvement of GP, district nursing both day & OOH teams, Homecare reablement team, Community Alarms service, GG&C Anticoagulant Service.
Initial home assessment over a number of weeks to assess patterns of need / behaviour to establish how best to support patient across 24 hours and minimise risk for example facilitating safe use of medicines.

Annex 1 – Examples of Impact

Reablement in Inverclyde is used as a conduit for problem solving in complex discharges and has been fully funded from change fund. Staff have been given autonomy to create processes and relationships which support joint working.

19. What were the outcomes/benefits or otherwise?

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

There have been some successful outcomes for patients who would in the past have been admitted to long term care and in the example above, the lady still maintains her tenancy within very sheltered housing complex (since Dec 2012). Patient and family pleased with integrated / joint approach to service provision. Some challenges remain in and around communication / collaboration with services not managed by the CHCP. A more collaborative approach to the administration of medicines in the home setting particularly potentially harmful medicines such as Warfarin and this will be explored via the change fund pharmacy technician post. The principles of joint planning and delivery of care will be built upon by the development of integrated frontline teams (including DNs, care managers, AHPs) across the coming months.

20. Additional contacts (to find out more)

(People, organisations, link(s) to further information, if available)

Ava Hallac Team Leader Assessment & Care Management ava.hallac@inverclyde.gov.uk

Once submitted, this case study will be published to the JIT website. To help users find case studies relevant to their area of interest, this case study should be tagged with the following search terms (e.g. Reshaping care, re-ablement, community capacity, third sector, preventing admissions, intermediate care)

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Prevention of Falls and		Carer Support and Respite		NHS24, SAS and Out of		Prevention and treatment of	

Annex 1 – Examples of Impact

Fractures				Hours access ACPs		delirium	
Information & Support for Self-Management & Self-Directed Support		Rapid access to equipment		Range of Intermediate Care alternatives to emergency admission		Effective and timely discharge home or to intermediate care	Y
Prediction of risk of recurrent admissions	Y	Timely adaptations, including housing adaptations		Responsive and flexible palliative care		Medicine reconciliation and reviews	Y
Anticipatory Care Planning	Y	Telehealthcare		Support for carers		Carers as equal partners	Y
Support for carers				Medicines Management	Y	Specialist clinical support for care homes	
Suitable and varied housing and housing support				Access to range of housing options			

Enablers	
Outcomes-focussed assessment	
Co-production	
Technology/eHealth/Data Sharing	
Workforce Development/Skill Mix/Integrated Working	
OD and Improvement Support	
Information and Evaluation	
Commissioning and Integrated Resource Framework	

Annex 1 – Examples of Impact

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Reshaping Care and Integration Improvement Network

Partnership	**Inverclyde CHCP RCOP Partnership**

Name of Initiative Highlighted	**Closer working with Independent Sector**
Date of Submission	27.9.13

Primary Contact	**Brian Polding-Clyde**
Email	brian.poldingclyde@scottishcare.org
Telephone	07780007914

Pathway:	Hospital and Care Homes/ Enabler

21. Summary

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

Since becoming an integrated body in 2010 Inverclyde CHCP has focused energy and resource on the development of Partnership working between the; Statutory, Third and Independent Sector.
We have funded a Development Officer to support our engagement with the Independent Sector; having them participate in the development of all RCOP Policy Development and decision-making processes.
One such activity was the promotion of the; 'My Home Life Inverclyde' Leadership and Community Development Programme

What was the issue you were addressing or working on?

Inverclyde CHCP recognised that we had to develop our partnership working with the Care Home Sector in order that they could deliver care in line with the emerging RCOP agenda, supporting change initiatives in areas such as; Anticipatory Care Planning, Dementia Care and End of Life Care.

22. What did you do?

(Intervention(s), organisations involved, when it happened, development or tools used including use of Change Fund, JIT involvement)

The Change Fund was used to support the Development Officer promote the programme across all of Inverclyde's Care Homes and when sufficient interest was noted a formal bid for funding of the programme was submitted to the RCOP Executive Group for consideration. At this stage in the consultation Extra Care Housing Managers were also invited to participate in the My Home Life programme and they will be involved.

Annex 1 – Examples of Impact

23. What were the outcomes/benefits or otherwise?

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

The programme is set to Launch on 30th September with representation from all four partners. The design of the Launch Programme is such that it reflects Inverclyde CHCP's desire for all four partners to be fully involved in the development of how we reshape care in Inverclyde.

In funding My Home Life we aim to:

a) Promote the Leadership Skills of those managing Care of older people within Inverclyde and
b) Support older people living in institutional settings to become more integrated into their local community
c) Create a direct link from those providing care to the Change Fund Executive Group and thus promote healthy lines of communication.

Those participating in the programme will be supported to write up a report in order to review its impact and the programme will run until Nov 2014.

24. Additional contacts (to find out more)

(People, organisations, link(s) to further information, if available)

Emma Cummings RCFOP Project Manager
emma.cummings@ggc.scot.nhs.uk

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Annex 1 – Examples of Impact

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Support for carers				Medicines Management		Specialist clinical support for care homes	Y
Suitable and varied housing and housing support				Access to range of housing options			

Enablers	
Outcomes-focussed assessment	
Co-production	
Technology/eHealth/Data Sharing	
Workforce Development/Skill Mix/Integrated Working	
OD and Improvement Support	
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Commissioning and Integrated Resource Framework	

AGENDA ITEM NO: 4

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 24 October 2013**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/51/2013/HW**
Contact Officer:	**Helen Watson Head of Planning, Health Improvement & Commissioning**	**Contact No: 01475 715369**
Subject:	**NHSGGC CLINICAL SERVICES FIT FOR THE FUTURE - UPDATE**	

1.0 PURPOSE

1.1 To provide an update to CHCP Sub-Committee on the current NHSGGC Clinical Services Review, following the earlier report in January 2013. The NHSGGC Board has produced a paper setting progress so far in a bid to describe a clearer direction of travel.

2.0 SUMMARY

2.1 NHS Greater Glasgow & Clyde's Clinical Services Review programme aims to reconfigure the shape of clinical services beyond 2015 to ensure that the NHS can adapt to future changes, challenges and opportunities. The Clinical Services Review aims to reshape the provision of clinical services across the whole of NHSGGC to ensure that patients have equitable access to high quality, safe, consistent and cohesive health services.

2.2 The emerging service models have been developed by the seven clinically led groups, who have taken account of outputs from the engagement work, feedback from local authority partners, other commentators and the Scottish Health Council. Prior to publication of the models paper an integrated impact assessment was carried out taking account of equalities, health and human rights. Recommendations from that assessment prompted revisions to the models being proposed.

2.3 The ethos underpinning the Review is that a coherent and consistent approach to health services delivery across the whole of NHSGGC should achieve a shift in the balance of care to support the provision of more care at home and in the community, reducing the number of inpatient hospital beds required. This shift in emphasis should release resources to support investment in primary care and community infrastructure to provide better alternatives to hospital care, and needs to take account of the full range of community supports required including health services, social care services and hosing needs.

2.4 The system of care envisaged aims to provide care where it is most appropriate to the patient, based on strengthened 24/7 community services (potentially both health and social care) and with acute services focused on assessing and managing acute episodes. This would be underpinned by developing a range of services at the interface including shared management of high risk patients and a range of alternatives to having to visit hospital. The principles of this proposal in many ways mirror the current arrangements that Inverclyde has in place for mental health

services, with most of the care being delivered in the community; inpatient services used for acute episodes, and smooth transition of care back into community services once the acute episode has abated. As an integrated CHCP, we are well placed to take this more inclusive model forward in Inverclyde.

2.5 The report recognises that the main thrust of the next stage will be to consider and develop the range of services and supports that need to be in place at the interface between acute and primary care/ community services. Inverclyde CHCP and our Public Partnership Forum (PPF) will be very much involved in that process. We will be developing a programme of communication and engagement locally.

3.0 RECOMMENDATION

3.1 Members are asked to note the emerging service models paper and comment as required to the Corporate Director, Inverclyde CHCP.

Brian Moore
Corporate Director
Inverclyde Community Health & Care
Partnership

4.0 BACKGROUND

4.1 NHS Greater Glasgow & Clyde's Clinical Services Review programme aims to reconfigure the shape of clinical services beyond 2015 to ensure that the NHS can adapt to future changes, challenges and opportunities. The Clinical Services Review aims to modernise the provision of clinical services across the whole of NHSGGC to ensure that patients have equitable access to high quality, safe, consistent and cohesive health services.

4.2 The Clinical Review Board paper outlines the process the review has taken to date, including detailed reporting of engagement and feedback, and reiterates a summary of the case for change. The ethos underpinning the Review is that a coherent and consistent approach to health services delivery across the whole of NHSGGC should achieve a shift in the balance of care to support the provision of more care at home and in the community, reducing the number of inpatient hospital beds required. This shift in emphasis should release resources to support investment in primary care and community infrastructure to provide better alternatives to hospital care.

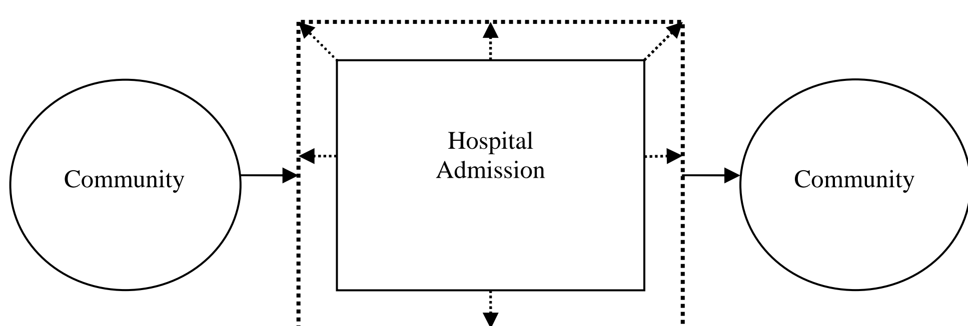
4.3 The system of care envisaged aims to provide care where it is most appropriate to the patient, based on strengthened 24/7 community services and with acute services focused on assessing and managing acute episodes. This would be underpinned by developing a range of services at the interface including shared management of high risk patients and a range of alternatives to having to visit hospital. The principles of this proposal in many ways mirror the current arrangements that Inverclyde has in place for mental health services, with most of the care being delivered in the community; inpatient services used for acute episodes, and smooth transition of care back into community services once the acute episode has abated.

4.4 The service models have been developed by the seven clinically led groups as described in the January 2013 report to CHCP Sub-Committee, namely:

- Chronic Disease
- Emergency and Trauma
- Planned Care
- Children & Maternity
- Older People/ Frailty (including all age stroke)
- Mental Health
- Cancer

4.5 The diagrams below outline a simplified representation of current arrangements and then the sort of system that is envisaged for the future.

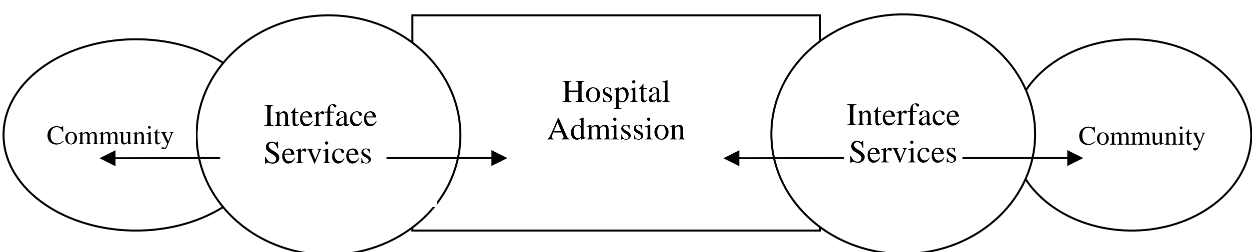
Figure 1



4.6 Figure 1 represents the current position from an NHS GGC perspective, where demand pressures are managed across a system in which 'hospital' and 'community' services are largely seen as separate, with often poor communication and poor joint planning across the system. Within the diagram, "community" includes primary care and community health services. In

integrated CHCPs such as Inverclyde, community also includes social work services. Even in CHCP areas though, 'hospital' and 'community' are largely separate with integration focused across the community services that comprise the CHCP. The Review has identified that if the system continues as it is now, there would be a need for an additional 500 acute beds by 2020. In an environment of constrained resources, the investment required for this would result in a vicious circle, with growing expenditure in acute hospital admissions and less money for investment in community services, which in turn would reduce our ability to support people at home, which is in most cases the preferred choice of those requiring support.

Figure 2



4.7 Figure 2 represents the system of care NHS Greater Glasgow & Clyde wants to move to, seeing a significant focus on providing care where it is most appropriate for the patient as outlined at 4.3 above. Working differently at the interface (represented by the overlap circles below) may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system. The future model aims to have a much stronger focus on the interface service that will be aimed at keeping people out of hospital if another alternative would be better, and supporting people back out of hospital where an admission has been necessary.

4.8 Anticipated Benefits: The Review anticipates a number of benefits as summarised.

- Patients will be in control of their care and empowered to share decisions about it.
- A system of care which is easier to navigate for patients and professionals.
- Clinicians and social work staff at all stages will have the necessary information about individuals, with care better tailored to needs.
- Better patient experience and patient safety, and improved health outcomes with a particular improvement for patients with multi-morbidity.
- A reduction in health inequalities as the most vulnerable people receive better access to holistic person centred care.
- Care which is provided in the most appropriate setting, relative to the person's needs.
- More cost effective use of resources with care focused on early intervention, better management of complex multi morbidity and a reduction in duplication of care.

4.9 The Review document provides some examples of how the proposed model will improve the patient experience.

Patient Story 1
A 58 year old woman with diabetes, hypertension, chronic kidney disease and rheumatoid arthritis, is overweight and smokes and is unable to work.

Now: Has frequent appointments at hospital diabetic clinic, GP chronic disease reviews, podiatrist, renal clinic, hypertension clinic, rheumatology clinic. Frequent non-attendance at appointments because she forgets appointments, doesn't see the point or doesn't have the bus fare to get there. This results in several acute hospital admissions per year.

Future: Risk stratification flags up the patient as high risk due to multi-morbidity (a number of chronic diseases at the same time); case review highlights that multiple teams are involved in

her care. The case manager is identified to develop a co-ordinated care plan involving the GP and appropriate specialists. Routine outpatient review is minimised (reducing the number of times she has to attend hospital) and clear triggers are in place for when she should return. Targeted support is put in place and advice on diet and weight loss, smoking and benefits maximisation.

Patient Story 2
An 80 year old man with mild dementia and mobility problems lives alone and has daily home care visits. His daughter lives 10 miles away, works full time and has small children but tries to visit several evenings a week. She arrives one evening to find her father has an upset stomach and has been unable to get to the toilet quickly enough, and has fallen.

Now: Daughter unsure of where to get help, so phones NHS24. GP arrives, suggests admission to hospital, so the patient is admitted, investigated and treated for a stomach bug. His confusion increases in strange environment, and his mobility decreases as he stays in bed until his stomach is better. He stays in hospital for several weeks and now there is doubt about him being able to return home.

Future: Patient has been identified at risk due to his mobility issues, dementia and living alone and he has anticipatory care plan. This has been informed by a Comprehensive Geriatric Assessment, which sets out steps to take if he is ill or needs additional support. His daughter is able to see on the plan who to contact. The crisis team responds quickly, assesses father and helps to clean up and get him to bed. Arrangements are made for his own GP to visit in the morning. Additional support is put in place for a few days to ensure he is drinking enough and to support mobility until he is better. Care needs are reassessed and the patient is given an alarm and increased support, with planned ongoing review.

These examples highlight approaches to care that are more likely to deliver better health outcomes, and are more in line with what people tell us they would prefer.

4.10 Analysis of feedback suggests support for the direction of travel, and in particular, the whole-systems approach that has been taken. The approach is generally regarded to describe an appropriate response to the issues raised in the case for change. However some important points were raised in the feedback, including:

- The need to be clearer about what the interface services should be – this is recognised by the NHS Board as being central to the next stage of development.
- The need for more emphasis on the role and implications for primary care – Inverclyde CHCP is working on a pilot with the NHS Board to develop a planning process which will enable this action to be further progressed.
- The need for appropriate focus on multi-morbidity – in Inverclyde multi-morbidity is pervasive so we would also support this. Patient Story 1 (above) highlights some of the core issues for patients and our services when trying to support multi-morbidity.
- The need for age-appropriate responses where disease spans a number of life stages.
- An emphasis on the need for continued engagement.

4.11 The report recognises that the main thrust of the next stage will be to consider and develop the range of services and supports that need to be in place at the interface between acute and primary care/ community services. There is a commitment that these will be underpinned by the principles of:

- Patient-centred.
- Integrated between primary and secondary care.
- Efficient, making best use of resources.
- Affordable and provided within the funding available.
- Accessible and provided as locally as possible.
- Safe and sustainable.
- Adaptable, achieving change over time.

4.12 Whilst these principles are a useful foundation to map out the ethos of the review, the work to define the actual services needed will require detailed analysis of current and future patient pathways. This work will be required to ensure smooth transition between the main arena of day-to-day patient care (primary care and community health and social care services), and acute

care in what should in most cases be relatively short episodes of need. It should also be recognised that there will be a challenge in shaping the future in tandem with keeping current services going so that future change can be properly managed. The report recognises that defining interface services might involve new services; extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to communication and the ways in which information is shared across the system. Inverclyde CHCP and our Public Partnership Forum will be very much involved in that process locally. We will be developing a programme of communication and engagement locally.

5.0 CORE COMPONENTS OF THE FUTURE SYSTEM

5.1 The Emerging Service Models paper aims to describe a balanced system of care where people get care in the right place, from practitioners with the right skills, and working across the artificial boundary of hospital and community services. Detailed analysis of need at population level has underscored a reliance on a strong emphasis on prevention, noting that around 80% of the current Long Term Conditions disease burden is a result of lifestyle choices in modifiable behaviours. On that basis there is strong emphasis on the responsibility of all staff to promote healthier lifestyles and appropriately support individuals to take responsibility for doing what they can to improve their own health. The key characteristics of the clinical services required to support this approach are described as:

- Timely access to high quality primary care that deals with the whole person in the context of their socio-economic environment.
- A comprehensive range of community services integrated across health and social care, and working with the third sector to provide increased support at home.
- Co-ordinated care at crisis and transition points, especially for those most at risk.
- Hospital admission that focuses on early and comprehensive assessment to ensure that patients are directed to the right place and the right practitioner.
- Planned care that is locally accessible on an out-patient or ambulatory care basis where possible.
- Low volume and high complexity care is provided in defined units equipped to meet needs.

5.2 The cultural shift required is recognised, and the paper proposes a structured change-management programme that includes leadership development; clinical engagement and improved IT systems that support easier information sharing. All of these areas will require development to ensure that the anticipated benefits are realised. The need for care pathways development is also recognised, along with appropriate targeting for prevention and anticipatory care. Governance and performance management are also recognised as important change enablers as well as ensuring that contractual arrangements with Independent Contractors support the change programme.

A further important core component recognised in the paper is the need to develop approaches that promote personal outcomes for service users and carers. This represents a move away from a prescriptive or directive approach towards patients being central to defining recovery goals or ways of managing or living well with their condition(s).

6.0 CHANGES REQUIRED TO DELIVER THE MODEL

6.1 A number of changes in practice or delivery are suggested, including:

- Cease age-based exclusions (e.g. psychological interventions and liaison psychiatry).
- Shift from age-based configuration of adult and older people's mental health services.
- Address service gaps in the dementia care pathway (e.g. memory assessment services; post-diagnostic support services).

6.2 These examples highlight an overall drive to streamline services so that people get what they need, when they need it, where they need it, and from the right practitioner. They also represent a shift in thinking from configuring services to suit the system and its professionals, towards configuring to suit the needs of patients and carers.

7.0 NEXT STEPS

7.1 Clearly there is still considerable work to be done, however it is important to recognise the positive shifts represented in the paper. It sets out a future direction of travel and recognises the significant changes required to develop a person-centred care system that meets a vast and diverse range of needs and complexities. Importantly it provides a framework for future decision-making and describes the parameters for more detailed development.

7.2 The next stage will be to start developing specific options, and the NHS Board has given a commitment that this will be done within a clear process of engagement. Options appraisals will then be undertaken and brought back to the NHS Board, and we would anticipate that these should be brought to the CHCP Sub-Committee as well. There will also be a development programme to test out the whole-system approach and effectiveness of the interface models, including the impact of change.

8.0 IMPLICATIONS

8.1 Legal: None

8.2 Finance: None from the current paper, however there may be implications depending on the interface service options that are developed. It is not possible to quantify at this stage.

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

8.3 Personnel: It is not possible to quantify at this stage.

8.4 Equalities: It is not possible to quantify at this stage, however the integrated impact assessment identified some possible issues that have been addressed, and also identified some benefits that should support more equal health outcomes.

8.5 Repopulation: It is not possible to quantify at this stage, however improved clinical services and pathways in Inverclyde could potentially have a positive impact on repopulation.

9.0 CONSULTATION

9.1 The PPF Advisory Group and Involvement Network have been given routine updates on progress (such as after the large scale events at Hampden Park) and have had newsletters/ briefings etc shared with them. An open meeting took place within the Your Voice premises on Wednesday 18th September, which was attended by the Board's lead officer for the programme, who gave a presentation and fielded questions. Some local involvement network members also attend patient panel sessions and are patients representatives on the Clinical Services Review reference fora.

10.0 LIST OF BACKGROUND PAPERS

10.1 Clinical Services Fit for the Future – Service Models

AGENDA ITEM NO: 5

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 24th October 2013**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/52/2013/SMcCR**
Contact Officer:	**Susanna McCorry-Rice Head of Mental Health, Addictions & Homelessness**	**Contact No: 715375**
Subject:	**Inverclyde CHCP – NHS Continuing Care Facilities and Community Services for Specialist Nursing Older People's Dementia and Adult Mental Health Intensive Supported Living**	

1.0 PURPOSE

1.1 To update the CHCP Sub-Committee on the current progress of provision of new NHS Continuing Care facilities on the IRH site and of the commissioning process for the provision of specialist nursing care for older people with dementia and adult mental health supported living service in Inverclyde.

1.2 To note the approval by the Quality & Performance Committee of the NHS GG&C Board to provide non-recurring funding to develop the community based services required for the period to July 2015 when the Ravenscraig Hospital is scheduled to close and the agreed Resource Transfer will be available.

1.3 To note that the timetable for the provision of services and Ravenscraig Hospital Closure timetable.

2.0 SUMMARY

2.1 Inverclyde CHCP will commission the NHS Continuing Care and Social Care community elements of service in separate contractual arrangements. A previous report on the position went to the Inverclyde Council meeting of 4th October 2012. A report on the outcome of the Option Appraisal for the NHS element was submitted to NHSGG&C Q&P Committee on 19th November 2012.

2.2 NHSGG&C / Inverclyde CHCP is in the process of procuring 42 NHS mental health continuing care beds, (30 for older persons and 12 for adults). An option appraisal has been carried out to agree the procurement process. It has been agreed that the buildings will be procured by HUB West Scotland (The Scottish Futures Trust) and leased to NHSGG&C for a 25 year period after which time the ownership will transfer to the NHS. An Initial Agreement was submitted to Capital Investment Group (CIG) of the Scottish Government for consideration in February 2013. This was approved on 21st March 2013 and NHSGG&C were invited to submit an Outline Business Case (OBC). The OBC is being produced by Turner Townsend, the advisors to NHSGG&C. The New Project Request was accepted by Hub West Scotland on 2nd April 2013. Governance arrangements have been put in place. A Design workshop was held on 3rd May 2013 to agree the design. Service users are fully involved. The OBC will be considered by the CIG on the 17th December 2013 once approved the final business

case will be prepared for consideration in the New Year.

2.3 The Social Care community elements of the original tender have been reviewed. The needs analysis has determined that 12 older people mental health / dementia beds and 8 adult mental health Intensive Supported Living packages with housing accommodation are required to be commissioned.

2.4 The accommodation requirement for the 8 individuals currently using continuing care beds in Ravenscraig Hospital who require discharge into their own homes has been identified.

2.5 The independent sector in Inverclyde have capacity to provide specialist dementia and functional mental health services for older people and intensive supported living for adults with mental health conditions and associated behaviours.

2.6 Five local providers have indicated an interest in providing the service for older people. Thirteen providers have indicated an interest in the adult mental health element. The will have a positive impact on employment locally, providing more employment for people in the care and support profession.

In addition there is a need to strengthen the community infrastructure for older people's mental health services to prevent admission into hospital and residential care.

The following developments are key areas for investment in which a detailed commissioning plan will be produced linked to the ongoing commitments of the Change Plan:

1. Home Assessment of people with Mental Health/Dementia with co-morbidities
2. Post diagnosis support for people with Mental Health/Dementia

Strengthening of liaison with care homes / community / acute to increase capacity to support older people with Mental Health/Dementia

2.7 The timetable to close Ravenscraig Hospital is by July 2015. The development of the community services will be commenced in October 2014 with 8 service users moving out of Ravenscraig during early 2014/15.

3.0 RECOMMENDATIONS

3.1 To note the report and progress on the development of the NHS continuing care facilities.

3.2 To note the agreement by NHSGG&C to non-recurring transitional funding to develop the community based mental health services.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND - NEXT STEPS FOR NHS CONTINUING CARE FACILITIES

4.1 For the NHSGG&C/ Inverclyde CHCP the 42 mental health NHS continuing care beds (30 for older people and 12 for adults) will be developed on the IRH site. The buildings on the site have been demolished and site investigations will be carried out in August 2013. Governance arrangements have been put in place. The Inverclyde HUB Project Board is chaired by the Head of Mental Health, who also sits on the NHS GGC Projects HUB West Scotland Project Steering Group.

4.2 The Stage One report is in the process of being produced and will be considered by the HUB West Scotland Board on 3rd September 2013. The OBC will be submitted to the Capital Investment Group on 2nd October 2013 for decision at the CIG Meeting of 17th December 2013. We will then proceed to Full Business Case in the New Year 2014.

4.3 The drawing up of and the lease arrangements for the NHSGG&C who own the site with HUB West Scotland are in hand.

4.4 It is anticipated that the Inverclyde project will be bundled with the first two NHSGGC replacement health centres.

5.0 NEXT STEPS FOR COMMUNITY SOCIAL CARE SERVICES

5.1 Inverclyde CHCP will commission 12 older people's mental health / dementia places locally. Five providers have indicated an interest, three local and two from outwith Inverclyde. A tender process will be undertaken to select the provider.

5.2 For the 8 adults with mental health needs, a specialised mental health intensive supported living service is required. This will be in core and cluster accommodation with individual tenancies with a Registered Social Landlord and tailored care and support. Thirteen care and support providers have indicated an interest. A mini tender process will select the successful provider.

5.3 The properties will be available from April 2014 once they have been decorated and upgraded. The tender process for the care and support provider to provide 24/7 presence will be completed in September / October 2013 so that the provider will in-reach into the hospital to prepare the individuals for their move into their own home. We anticipate that this element of the service will create up to 6 new jobs.

5.4 For the Dementia Service, the process to select the local provider is scheduled to take place in December 2013 with the service to be operational for October 2014. This timetable will be flexible to tie in with the hospital closure and the progress with HUB West Scotland to provide the new services on the IRH site.

6.0 TIMETABLE

6.1		
	17/09/13	NHSGG&C Quality & Performance Committee agreement on non-recurring transitional funding for the development of community based mental health services for the period up to the closure of Ravenscraig Hospital.
	October 2013	Seclection process for the preferred care provider to work with the 8 individuals in Ravenscraig Hospital. Agreement on the timetable and arrangements for the refurbishment of accommodation. Consultation with the local community on the developments in mental health services and use of the IRH site.
	November 2013	Consideration by the NHSGG&C Capital Planning Group and the Quality & Performance Committee.
	17/12/13	Submission of the Stage 1 Business Case to Scottish Government Capital Investment Group for approval to develop a final Business Case for the new NHSGG&C facility on IRH.
	Jan / Feb 2014	Submission of final Business Case to CIG.
	April 2014	Service users move into their own flats.
	July 2014	Building the new facility.
	October 2014	Older Persons mental health beds confirmed.
	April 2015	Older Persons mental health beds operational.
	July 2015	Patients from Ravenscraig move to the new facility. Ravenscraig Hospital closure.

7.0 IMPLICATIONS

7.1 Legal:

Legal have been consulted.

7.2 Finance:

The total recurring resources held on the NHS side is £3.247 million recurring, with the current allocations in a full year of service expected to be:

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

Residential (Council CHCP via resource transfer)	Older People Adults	**	£470,000 £472,000	N/A N/A	12 Specialist Dementia 8 Supported Living
Continuing Care (NHS CHCP)	Older People Adults		£1,382,000 £551,000	N/A N/A	30 beds 12 beds
Resources Committed to date			£2,875,000		
Uncommitted Resource			£372,000		
Total Resource			£3,247,000		

**The recurring cost shown in the table above represents the costs and income for a full financial year. The timing will be determined by the closure timetable for Ravenscraig.

7.3 It should be noted that the balance of unallocated resource, currently shown at £372,000 is dependent on the outcome of the final cost of both the commissioned places and the continuing care bed provision. The final balance of this resource will be subject to further discussion with NHS GG&C and will ultimately be invested in community infrastructure. Community Service specification is currently being drafted by officers of Inverclyde CHCP in involvement with service users and carers organisations.

7.4 In addition to resource transfer funding for the Council commissioned places there will also be an element of client contribution and benefit income of between £3,000 and £9,000 per client, dependent on appropriate financial assessment.

7.5 Transitional funding required for a period before the expected closure of Ravenscraig Hospital date to allow the CHCP to progress commissioning arrangements and have a suitable service in place. This will enable Inverclyde CHCP to bring services into management prior to closure of the hospital. The period of time that transitional funding will be required will be informed by the commissioning timetable.

Cost Centre	Budget Heading	Budget Year	Proposed Spend this report	Virement From	Comments
Residential	OPS/Adults	2013/14	Nil	N/A	Transitional Funding will be drawn on as required.
		2014/15	£322,000	N/A	
		2015/16	£139,000	N/A	

7.6 The timetable for the Resource Transfer from the NHS GGC Health Board to Inverclyde Council is on the closure of Ravenscraig Hospital which is scheduled for July 2015 but this is under review dependent on the confirmation of the hospital closure options.

8.0 CONSULTATION

8.1 ACUMEN mental health services users group have agreed to be a reference group for this scheme.

9.0 LIST OF BACKGROUND PAPERS

9.1 Previous Council reports have been submitted 25th April 2013.

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AGENDA ITEM NO: 6

Report To:	**Community Health & Care Partnership Sub Committee**	**Date: 24th October 2013**
Report By:	**Brian Moore Corporate Director Inverclyde Community Health & Care Partnership**	**Report No: CHCP/54/2013/SMcC**
Contact Officer:	**Susanna McCorry-Rice Head of Mental Health, Addictions & Homelessness**	**Contact No: 715375**
Subject:	**Summary of Mental Health Services - Presentation**	

1.0 PURPOSE

1.1 To update the Sub-Committee with a presentation on how and what mental health services are delivered to the people of Inverclyde.

2.0 SUMMARY

2.1 The report outlines the delivery of mental health services in Inverclyde.

2.2 It explains how mental services are delivered to ensure the whole population are able to access appropriate services.

2.3 It also notes that the population of Inverclyde has a high prevalence rate of mental health issues that impact upon the vulnerability of the local population and the demands for services.

3.0 RECOMMENDATIONS

3.1 To note the detail of this report on how mental health services are delivered to the people of Inverclyde by the CHCP.

3.2 To note the proposed developments for the period 2014/15.

Brian Moore
Corporate Director
Inverclyde Community Health & Care Partnership

4.0 BACKGROUND

4.1 The purpose of this report is to outline how mental health services are delivered by the CHCP

4.2 Inverclyde has a long history of providing mental health services in integrated health and social work teams. This approach has been strengthened by the establishment of the CHCP two years ago.

4.3 The approach Inverclyde has taken in how mental health services are delivered, places the CHCP in a positive position to adapt easily to the introduction of the new Health & Social Care Partnership requirements in 2015.

5.0 INTRODUCTION

5.1 Context for delivery of mental health services in Inverclyde .

5.2 NHS Scotland services at a national, board and local level are described in brief below .

Table 1

National – Dimensions of Quality NHS Scotland Quality Strategy	Board : Community Services Review – clinical framework for mental health services	Local-Mental Health Service Redesign Integrated services in Inverclyde
• Person Centred • Safe • Effective • Efficient • Equitable • Timely	• Person Centred • Stepped/ Matched Care • Outcome focused • Efficient and Effective • Equity • Accessible	• Planned care locally accessible • Co-ordinated care at crisis/transition points for those most at risk • Comprehensive range of community services, accessible 24/7 • Hospital admission which focuses on early comprehensive assessment driving care in the right setting • Access to care is equitable • Low volume and high complexity care provided in defined units equipped to meet the care needs • Timely access to high quality Primary Care

5.3 NHS GG&C's aim is to ensure that MH Services across the board area have a systematic approach to the delivery of effective treatments for the following conditions:

1. Anxiety and depression
2. Bipolar disorder
3. Borderline personality disorder (including trauma and self-harm)
4. Psychosis
5. Dementia
6. Autistic Spectrum Disorder
7. Eating disorders
8. Drug and alcohol misuse

5.4 The clinical framework for mental health describes 5 levels of care that might apply to all clinical conditions – ranging from public (community mental health & well being) at one end of the scale to Intensive treatment at the other. Table 2 below describes in brief how care may be provided across the 5 levels.

5.5 **Table 2 Levels of care:**

Care level	**public (community mental health & wellbeing)**	**open access (self-care and peer support for vulnerable groups)**	**ERBI: early response, brief intervention (eg PCMHT)**	**longer-term, multi-disciplinary care (equivalent to CMHT)**	**intensive treatment (inpatient care, crisis and home treatment services)**
Who is the service for?	A public health and health improvement approach to the general population, but especially those who may be at risk of developing a condition	Anyone concerned about their own or other peoples' health.	A prompt response for people who develop symptoms/ problems associated with a condition	longer-term and more intensive care when when multidisciplinary or multi-agency input is required, or when brief interventions proved to be inappropriate or ineffective	Home care or inpatient care, typically requiring >3 contacts per week, especially to minimise risk of harm to self or others
Type of Interventions	information, screening, self-help	education, self-help, peer support, group classes	"low intensity" work: brief interventions, psychological therapies, guided self-help	longer-term psychological therapies; community rehabilitation;	risk management, physical health care
Access	everyone	open, self-referral	self-referral and GP referral	GP or secondary care referral	GP or secondary care referral
Step up to more intense care when…	service user chooses	service user chooses, GP referral	non-response or ERBI approach unlikely to be useful- by referral only	non-response, risk- by referral only	

5.6 In addition to *providing* care across the 5 levels above, in Inverclyde MH services are *organised* as tiered care, a model is widely accepted nationally.

5.7 **Tier 1:** This tier reflects level 1&2 proposed above in the framework. It acknowledges that a range of resources have to be available to support a community's mental well being and to prevent individuals from entering traditional statutory mental health (illness) services. This requires the co-ordination and further development of community activities that support issues such as employment, education, leisure and recreation. This should also include activities such as mental health promotion.

5.8 While Tier 1 is not specifically about services for people with a mental illness, it should include activities which reduce stigma and allow the majority of people with mental health problems to access mainstream activities. Examples in Inverclyde include 'Making Well-being Matter' the Inverclyde Mental Health Improvement Framework and training of all frontline staff to raise awareness of suicide prevention.

5.9 **Tier 2:** This tier reflects level 3 above. The majority of common mental health problems can (and are) responded to within primary care. In all but exceptional circumstances, the primary care team is the initial point of contact for people with mental health problems. In most cases their needs are addressed at this tier; however some people will require referral on to specialist mental health services. The main tier 2 services in Inverclyde is the Inverclyde Primary Care Mental Health Team, this ensures that each GP practice has direct access to mental health staff and that people with concerns about their mental health can self refer for advice and support. The team has an extended network of treatment clinics as demonstrated by their activity last year.

5.10 **Inverclyde Primary Care Mental Health Team** (Figures relate to period 01/10/12 to 30/09/13).

Annual Referrals	1900
Annual contacts	7293
Team Caseload at 02.10.13	397

5.11 **Tier 3:** This tier reflects level 4&5 above and provides an integrated service to people with severe/complex mental illness. Tier 3 services include the CMHTs and the local In-patient provision. The majority of clients who may require statutory intervention (under the mental health act or adults with incapacity act) fall into this group. Community services (Adult and Older persons Joint CMHT) form the core of Inverclyde's Mental Health System, acting as a gateway to a full range of specialist MH services the role of which is to:-

- Provide treatment and care and specialist interventions within a "stepped care approach" which includes day services and hospital admission
- Assessment and case/care management and access to specialist treatment and ongoing care for people with complex and enduring needs
- Provide advice, guidance and direct support to primary care and other agencies e.g. Addictions services and CAMHS
- Develop knowledge and facilitate access to a full range of local resources
- Provide assertive outreach function

5.12 **Inverclyde Community Mental Health Team** (Figures relate to period 01/10/12 to 30/09/13).

Annual Referrals	1040 (611 from GPs others internal)
Annual Contacts including Out-Patients	34020
Team Caseload at 02.10.13	1437

5.13 Acute inpatient services (adult and older people) are provided in purpose built, modern facilities on campus at Inverclyde Royal Hospital and include.

Adult	Acute admissions unit 20 bed	Intensive Psychiatric Care Unit (board wide resource)8 bed	Intensive Day service Liaison	ECT
Older people	Acute admissions unit 20 bed	Access to IPCU	Intensive Day service and Liaison	Memory assessment and fast tract assessment

5.14 In addition there are 30 older peoples and 20 adult continuing care beds, currently situated on Ravenscraig hospital site, an alternative purpose built dementia friendly facility is proposed on the IRH campus.

5.15 **Tier 4:** There is a range of mental health needs which cannot be met by locally provided services. This may be because the incidence of such need is so small as to make a local service response unsustainable, or because of a scarcity of specialist expertise available within Inverclyde. In such circumstances Inverclyde contributes toward (and have access to) regional services. These include:-

- Specialist mother & baby in-patient provision
- Eating disorder services
- Forensic Services (high risk or high tariff offenders)
- Personality Disorder Services (for those whose personality disorder requires statutory intervention)
- Intensive Psychiatric Care Beds- this facility provides 8 beds for both Renfrewshire and Inverclyde and provided at Langhill clinic Inverclyde Royal

Hospital

6.0 LOCAL CONTEXT

6.1 The tables below highlight a high level of need which the tiered model meets. Inverclyde has particular challenges in terms of its ageing population, its difficult relationship with drugs and alcohol and relatively high levels of serious mental disorders

6.2 **Table 3 Inverclyde Population Projections**

Age	2011	2016	2021	2026	2031
0-15	13686	13092	12729	11814	10650
16-29	13943	12793	11278	10414	10045
30-49	20477	18227	17067	16737	16026
50-64	16438	16932	16663	14509	11988
65-74	7807	8665	8945	9295	10120
75+	6837	7362	8123	9324	10112
All Ages	**79188**	**77071**	**74805**	**72093**	**68941**

Data extracted from General Register Office for Scotland

6.3 **Table 4 Comparison of Income Deprivation, Population and Mental Health**

	Population	Income Dep	Suicide	1st Adm	Alc Patients	Alc deaths	Drug Patients	Drug deaths
Inverclyde	81080	38%	22%	54%	61%	75%	85%	67%
South West Glasgow	117341	75%	7%	12%	73%	120%	115%	103%
South East Glasgow	101348	57%	2%	-3%	82%	45%	139%	91%
North Glasgow	99669	99%	71%	43%	66%	119%	89%	223%
West Glasgow	139853	47%	36%	25%	26%	113%	-1%	104%
East Glasgow	123729	114%	41%	22%	90%	153%	128%	227%
Renfrewshire	169600	7%	-2%	27%	12%	35%	-16%	-5%
West Dunbartonshire	91090	42%	31%	15%	29%	59%	-5%	37%
East Renfrewshire	87840	-46%	-44%	-36%	-19%	-26%	-44%	-47%
East Dunbartonshire	85322	-47%	-23%	-32%	-30%	-38%	-59%	-53%

GCPH data on income deprivation, suicide and drug and alcohol misuse expressed as % above or below Scottish average.

6.4 The relationship between income deprivation and poor mental health outcome in Inverclyde is not clear cut. Although a relationship seems clear at the extreme ends of both affluence and deprivation the relationship is less clear in the intermediate ranges. This is demonstrated more clearly below in

Table 5 severe mental disorder

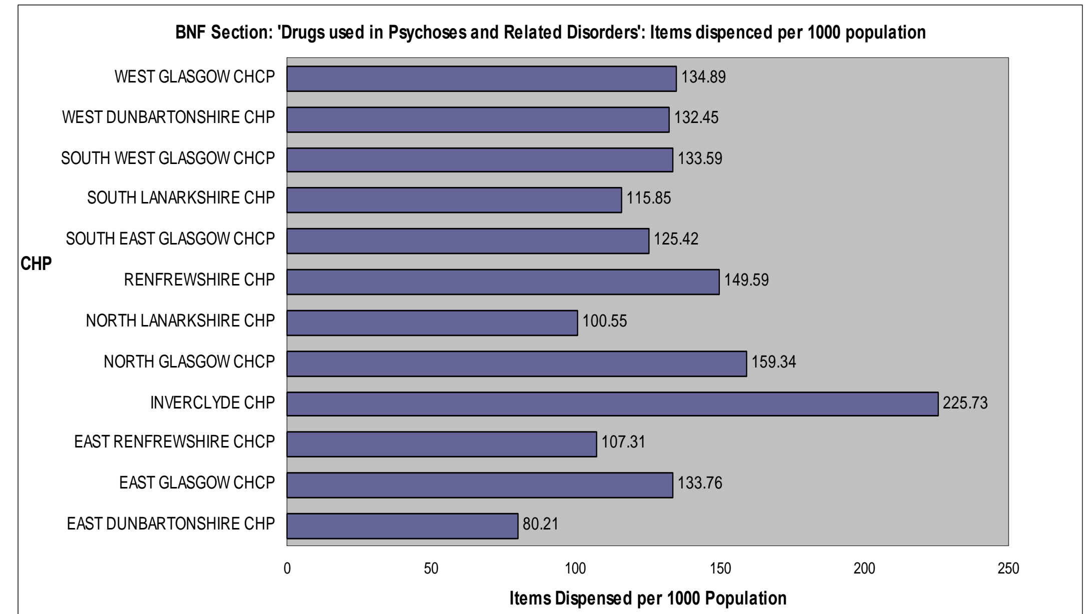
	Population	Income Dep	Psychosis*
Inverclyde	81080	38%	1011
South West Glasgow	117341	75%	872
South East Glasgow	101348	57%	840
North Glasgow	99669	99%	797
West Glasgow	139853	47%	754
East Glasgow	123729	114%	751
Renfrewshire	169600	7%	722
West Dunbartonshire	91090	42%	500
East Renfrewshire	87840	-46%	389
East Dunbartonshire	85322	-47%	327

7.0 OTHER SIGNIFICANT FACTORS

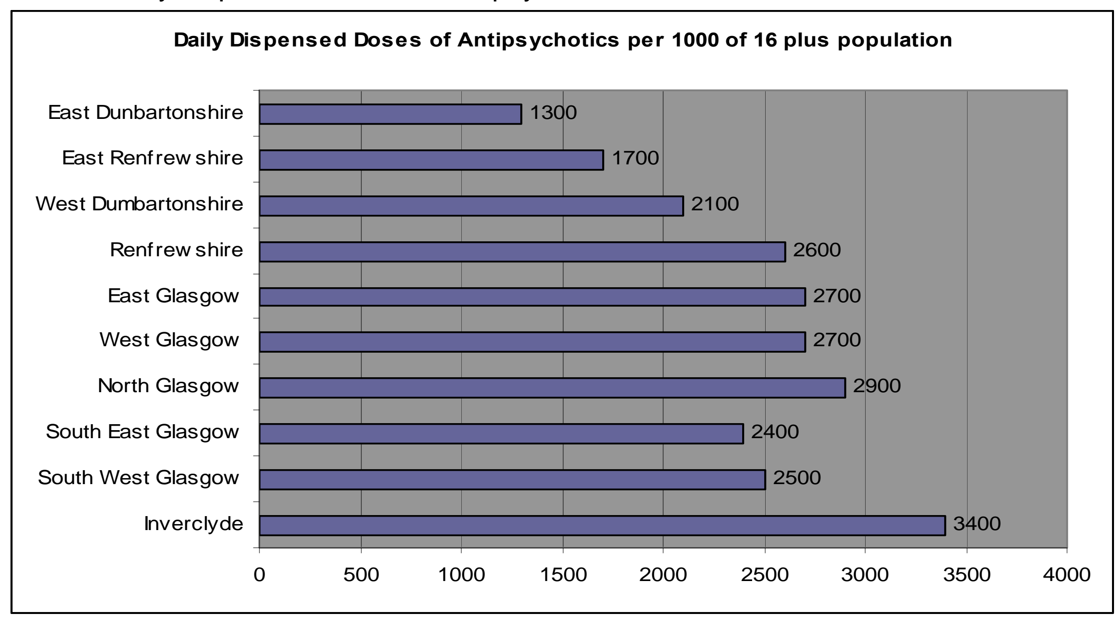
7.1

- The Scottish average for prevalence of mental health disorder per 100 population is 0.82. Within Inverclyde the prevalence is 1.03.
- The variation in presence of mental disorder is most significant in the prevalence rates for psychosis. Inverclyde has the highest prevalence of psychosis, per 100,000 of population, of all of greater Glasgow and Clyde at 1,011. This is significantly higher than the next highest area and approximately double the average for the rest of the health board area.
- The excessive consumption of alcohol and drugs can result in many health problems. As well as inducing physical problems excessive alcohol consumption can also lead to mental health problems such as dependency and depression.
- Regular consumption of alcohol, even in relatively moderate amounts and/or consumption of illicit substances can have a particularly negative impact on the health and wellbeing of people with a pre existing Mental Disorder. A study conducted in Inverclyde found that 21% of patients with a psychosis were drinking heavily or dependently and that 20% of patients with a psychosis were using illicit substances. This places a significant burden on the health and social care services within the area.
- Inverclyde has a significantly higher QOF prevalence of mental disorder than areas of comparable population and deprivation.
- Inverclyde's QOF prevalence is 33% higher than that of West Dunbartonshire which has a slightly higher population but a similar demographic profile.
- Inverclyde's prevalence of psychosis related diagnosis is 50% higher than its most comparable CHP area within GG&C and 35% higher than the average of the rest of GG&C CHP areas. This has clear implications for resource use as demonstrated within prescribing data.

7.2 Table 6 Anti Psychotic Drugs (Items dispensed).

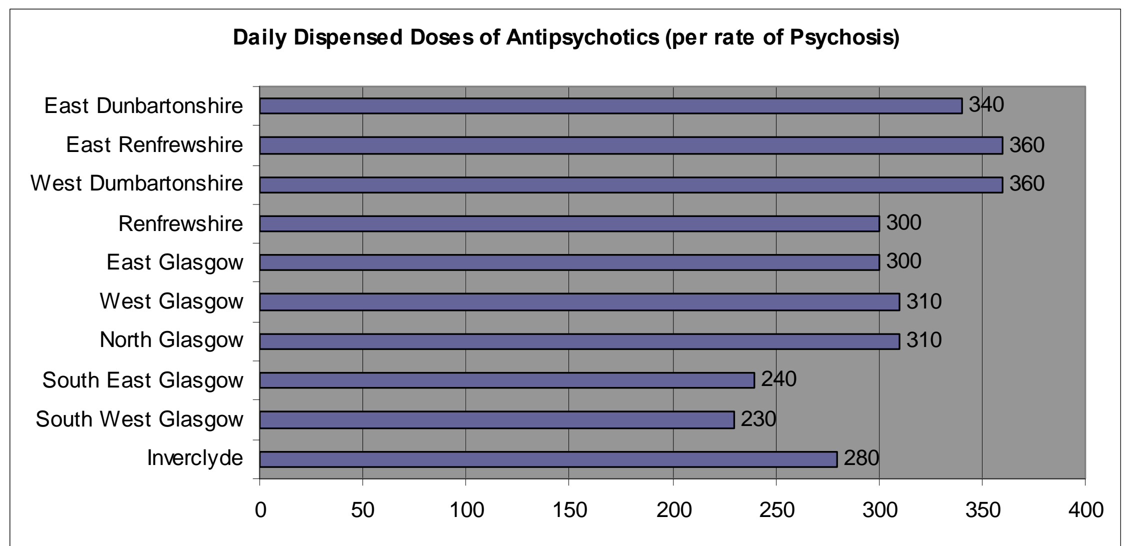


7.3 Table 7 Daily dispensed doses of Antipsychotic



7.4 Inverclyde shows a high level of antipsychotic daily dispensed doses (DDD) in relation to other CHP areas. This is a consequence of the higher levels of psychosis within the area. Using regression to consider both population and psychosis prevalence on antipsychotic prescribing reveals that psychosis accounts for 89% of the variance in antipsychotic DDD rates. The additional explanatory power of population is less than 3%. Adjusting antipsychotic DDD rates for psychosis rates shows considerably less variation in prescribing.

7.5 Table 8:DDD adjusted per rate of psychosis.



7.6 Although Inverclyde prescribing is appropriate to the rate of Psychosis, with prescribing some 3% lower than would be predicted against prevalence nevertheless the total cost of prescribing represents a significant resource burden on services. Prescribing per 1000 of population is 61% per cent higher than the CHP of most similar population and deprivation.

8.0 RECENT DEVELOPMENTS

8.1 Developments in mental health services in Inverclyde are based on ensuring for our populations:-

- *Equity;* overcoming barriers such as geography & language.
- *Access;* receiving services in a timely manner-*easy in easy out, responsive Interfaces and transitions*; delivering integrated care.
- *Person Centred*; Effective assessment and formulation focused on the individuals needs.
- *Effective and efficient*; Care pathways are organised by broad clinical conditions that are widely understood, care based on *minimum effective dose* delivered by the most appropriate person/professional.
- *Outcome focused;* Clinical outcome measures are applied and views of service users are sought to improve services.
- *Stepped/Matched care*; Seamless transitions and built upon existing knowledge of the service user.

8.2 Recent developments across the 5 care levels have included:-

Care level	**public (community mental health & wellbeing)**	**open access (self-care and peer support for vulnerable groups)**	**early response, brief intervention (eg PCMHT)**	**longer-term, multi-disciplinary care (equivalent to CMHT)**	**intensive treatment (inpatient care, crisis and home treatment services)**
Recent developments		Implementation of self referral procedures to PCMHT	Single point of access PCMHT Implementation of fast track assessment , Nurse led hospital liaison	Single point of access CMHT (adult and older people) Revised operational policy, standards and KPI's Ongoing work with HUB Scotland re proposals for continuing care facility on IRH campus	Revised operational standards, policy and KPI's for inpatient acute services and community response services

8.3 Proposed development to be implemented by Summer 2014.

Care level	**public (community mental health & wellbeing)**	**open access (self-care and peer support for vulnerable groups)**	**early response, brief intervention (eg PCMHT)**	**longer-term, multi-disciplinary care (equivalent to CMHT)**	**intensive treatment (inpatient care, crisis and home treatment services)**
Proposed development			Implementation of community based extended hours response to people with mental health crisis Implementation of memory assessment services (Older persons MH services) Implementation of assessment clinic model in CMHT	Developing 8 highly supported tenancies for individuals with long terms mental health problems Developing 12 specialist dementia care beds within an existing care home	Extending the ESTEEM specialist service for early intervention in psychosis to Inverclyde

9.0 CONCLUSION

9.1 The approach outlined takes account of the development of the integration of Health and Social Care Partnership as a way of delivering health and social care services. Inverclyde mental health services are delivered and managed by fully integrated health and social care teams.

10.0 IMPLICATIONS

10.1 Legal: none

10.2 Finance: None

Cost Centre	Budget Heading	Budget Year	Proposed Spend this Report	Virement From	Other Comments

10.3 Personnel: No implications.

10.4 Equalities: No implications.

10.5 Repopulation: Not applicable

11.0 CONSULTATION

11.1 None.

12.0 LIST OF BACKGROUND PAPERS

12.1 None.

INVERCLYDE COMMUNITY HEALTH CARE PARTNERSHIP

AGENDA AND ALL PAPERS TO:		
Councillor McIlwee		1
Councillor Jones		1
Councillor McCabe		1
Councillor Rebecchi		1
Councillor MacLeod		1
All other Members (for information only)		15
Officers:		
Chief Executive		1
Corporate Communications & Public Affairs		1
Corporate Director Community Health & Care Partnership		1
Head of Children & Families and Criminal Justice		1
Head of Community Care & Health		1
Head of Planning, Health Improvement & Commissioning		1
Clinical Director		1
Head of Mental Health & Addictions		1
Corporate Director Education, Communities & Organisational Development		1
Chief Financial Officer		2
Acting Corporate Director Environment, Regeneration & Resources		1
Head of Legal & Democratic Services		1
J Douglas, Legal & Democratic Services		1
S Lang, Legal & Democratic Services		1
Chief Internal Auditor		1
File Copy		1
Dr Mustafa Kapasi, NHS Greater Glasgow & Clyde		1
Ken Winter, NHS Greater Glasgow & Clyde		1
Diana McCrone, Staff Partnership Forum		1
Nell McFadden, Public Partnership Forum		1
	TOTAL	**41**
AGENDA AND ALL NON-CONFIDENTIAL PAPERS TO:		
Community Councils		10
Karen Haldane, "Your Voice", 12 Clyde Square, Greenock		1
	TOTAL	**52**