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Argyll and Bute Council
Comhairle Earra-Ghàidheal Agus Bhòid

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29 November 2018

SUPPLEMENTARY PACK 1

MID ARGYLL, KINTYRE & THE ISLANDS AREA COMMITTEE - **TEMPLARS HALL, TARBERT** on **WEDNESDAY, 5 DECEMBER 2018** at **10:30 AM**

I enclose herewith **item 17 (STRATEGIC PLAN CONSULTATION)** which was not included on the Agenda for the above meeting.

Douglas Hendry
Executive Director of Customer Services

ADDITIONAL ITEM

17. STRATEGIC PLAN CONSULTATION (Pages 3 - 28)

Report by Health Improvement Principal, NHS Highland - Argyll & Bute Health and Social Care Partnership

Mid Argyll, Kintyre & the Islands Area Committee

Councillor John Armour
Councillor Robin Currie (Chair)
Councillor Donald Kelly
Councillor Douglas Philand
Councillor Sandy Taylor
Councillor Rory Colville
Councillor Anne Horn
Councillor Donald MacMillan (Vice-Chair)
Councillor Alastair Redman

Contact: Adele Price-Williams - Senior Committee Assistant - 01546 604480

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Report to: **MAKI Area Committee**
Title of report: **Strategic Plan Consultation**
Presented by: **Alison McGrory**
Date: **5th December 2018**

The Area Committee is asked to:

- note the contents of this report

1. PURPOSE OF REPORT

The attached report seeks to present the findings of the feedback from citizens, service user and carer representatives, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022).

2. BACKGROUND

The purpose of the consultation was fourfold:

- To inform people about the HSCP proposed strategic areas of change.
- Invite comments on eight specific service change areas.
- Invite suggestions around what the HSCP needs to do to make sure people are involved in the process of change.
- Use the information gathered in the consultation to inform strategic priorities

3. METHODOLOGY

The consultation process (July-Oct 2018) involved (a) presentations to service user and carer representatives and partner organisations through a range of groups; (b) cascade presentations to a wide range of health and social care staff; and (c) Survey Monkey questionnaire via website, social media and hard copy.

The attached report presents a précis of the findings from all these processes.

4. CONCLUSIONS

The consultation engaged with a wide variety of groups and individuals. The process enabled respondents to comment generally about the HSCP priorities as well as providing more detailed feedback about each specific priority. This approach also enabled comprehensive views about how the HSCP is able to strengthen the ways it engages with all stakeholders.

6. RECOMMENDATIONS

The Area Committee is asked to note the contents of the attached report.

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A&B HSCP | Transforming Together

Argyll & Bute Health & Social Care Partnership

STRATEGIC PLAN CONSULTATION

OCTOBER 2018

1. Introduction

The Health & Social Care Partnership (HSCP) invited feedback from citizens, service user and carer representatives, partners and staff [Appendix 1] on the development of the 2nd Strategic Plan (April 2019- March 2022).

2. Consultation Process

The purpose of the consultation was fourfold:

- To inform people about the HSCP proposed strategic areas of change.
- Invite comments on eight specific service change areas.
- Invite suggestions around what the HSCP needs to do to make sure people are involved in the process of change.
- Use the information gathered in the consultation to inform strategic priorities

The consultation process (July-Oct 2018) involved:

- presentations to service user and carer representatives and partner organisations through a range of groups/forums [Appendix 2];
- cascade presentations to a wide range of health and social care staff; and
- Survey Monkey questionnaire via website, social media and hard copy [Appendix 3 - 78 responses].

This report presents a précis of the findings from all these processes.

3. General Feedback

The feedback suggests there was broad agreement with the 8 key areas of service change, *"All very relevant, good coverage to address challenges and clear messages". Others felt they were "aspirational, ambitious but needed out-of-the-box thinking to succeed".*

"The 8 areas should not be considered in isolation as their cross cutting themes, their impact on each other and the potential gains are inter-related".

There were strong views that 'transformational change' should not just about savings but should also be about maintaining and improving the quality.

Views were expressed about the need to manage public expectations of health and social care services within the current financial climate. There was an understanding of the need to balance expectations and resources within the available budget.

"Need to be much clearer about the inevitable service cuts that are going to result from the next plan".

It was suggested that for years public services created an 'open door' system whereby service users have become dependent on things 'being done to them' by professionals. People perceive recent policy changes as 'rationing' due to financial savings rather than positive changes associated with quality. There was support for shifting people from being dependent to becoming more self-reliant but recognition that "this won't happen overnight and requires a cultural shift and an evolving journey".

There was a suggested that people can have an emotional attachment to bricks and mortar, presenting challenges in persuading the public and staff to accept alternative service models. There was support for moving away from office hours to a more 24/7 model to better meet need. Successful service delivery was thought to hinge on effective recruitment and retention of health and social care staff.

"Sounds good but can [the HSCP] recruit and maintain staff to ensure provision of services"?

4. Priority Areas Feedback

4.1 Children's Services

There were very few comments regarding the proposed priorities for children's services. There were suggestions that supporting children and families as earlier as possible was important and promoting health and well being should be integral to the work of the HSCP. Many respondents strongly believed that children being looked after away from their home and community would be detrimental to positive outcomes including, social, emotional, education and ultimately their life circumstances.

> *"It is a nice idea to keep children in their area when fostered but does that not bring potential challenges* ……[in relation to] *parental issues?"*

Continuity of midwifery care was important to respondents and there were concerns about differences between urban and rural services in relation to routine check-ups throughout pregnancy but also the trend toward……..

> *"fewer mothers have the option of giving birth in Argyll & Bute and more are being sent to Paisley….this means that, when they are in need of seeing a familiar face, they are instead faced with a midwife they have never met before and who may not know their birth plan."*

There was some concern about the HSCP's ability to balance 'new funding' with the need for savings, for example……..

> *"a requirement to increase Health Visitors, but this has to be reconciled with* [£XXk] *savings, so how is this possible?*

A number of respondents believed there was an opportunity to bring planning for services together where there were obvious overlaps.

> *"The [HSCP] could identifying key themes around* [Adverse Childhood Events]*(ACEs) and what needs to be done by families, schools, health visitors, social workers, the police to reduce ACEs and create a culture where children are valued and value themselves - this is the holy grail".*

4.2 Care Homes and Housing

Respondents felt it was vital to work with housing services, including registered social landlords, to effectively identify future housing needs and models such as 'step up and step down', 'extra care' homes and 'transition' housing to enable people to remain in their home as their needs change. There was a perception that the cost of adapting individual service users' homes was costing more than care homes, however the overwhelming view was there is a strong case for adaptations, assistive technology and the various forms of supported living.

> "[The HSCP needs to] *clearly articulate the rurality challenges e.g. you cannot have a nursing home in every community."*

4.3 Learning Disability Services

Respondents advised of the need to develop new models of care that were modern, flexible and more able to support people with a learning disability into an older age. There were however concerns about the growing cohort of older carers who are likely to require support in order that they can continue in their caring role for as long as possible.

There was a view that developing a service strategy, such as an Autism Strategy, that is not supported by the required resource creates unrealistic expectations.

> *"learning disabilities population is dispersed - need to work hard to engage people* [in designing new models]*."*

4.4 Community Models of Care

Respondents believed there is a need to look at how responsive the current equipment service is and if there is room for improvement to better align with multi-disciplinary teams. Telecare was cited as an important contribution to enabling people to remain independent for longer and that the pace of change for introducing new technologies needs to significantly increase. Respondents reflected that consideration is required with regard to the needs of carers, particularly in light of the new Carers Act.

The Third Sector was believed to be an invaluable asset, providing a wide range of services spanning preventative approaches to direct support. The 'non bureaucratic' nature of the third sector meant it has the potential to be creative, innovative and able respond at a faster pace that public sector organisations. Social connectivity was felt to be a key strength of the sector that should be exploited to its full potential in order to address social isolation in particular.

> *"I think that the Core Cluster needs to be fully investigated and rolled-out properly*.....[to better meet the needs of individuals]*."*

> *"sounds good but can you recruit and maintain provision of services? more carers will be needed especially in rural areas."*

Respondents highlighted the ageing population and the potential that almost everyone will be a carer or caree at some stage and almost definitely in the latter stages of their lives. Given this population profile, there were questions raised about the HSCP's capacity to support caring at home within the context of a multi agency approach involving public, private and third sector arrangements and particularly in rural settings.

Respondents reflected the need to "encouraging social enterprise in health and care", break down barriers, encourage NHS staff to refer to and utilise more preventative social prescribing approaches, recognising the value of what is being offered in the third sector.

4.5 Mental Health Services

It was felt by some that Mental Health Service needs the biggest change with some commenting that the pace of change in mental health services was too slow and that a focus on resilience building would achieve improved outcomes for service users.

> *"I think the Mental Health Service needs the biggest change"*

"more safe places for mentally ill people are needed."

One respondent felt that waiting lists for community mental health services are too long and there needs to be more rapid access to talking therapies. This was cited as a particular issue for children, where it was stated that the lack of Child Psychiatrists or Child Psychiatric Services based in Argyll & Bute was a cause of long waiting list. Journeys to services based in Glasgow were felt to be unacceptable for children and young people in particular experiencing distress. Respondents felt there should be more provision within Argyll and Bute.

Respondents cited self-management as an essential approach to supporting those experiencing mental ill health. This should include the wider determinants of wellbeing such as mitigating the impact of debt and loneliness. There was also a perception that there was limited access to psychology services in some communities and that this could be the single biggest change that could be made.

There was a suggestion that in-patient services could be improved if there was better access to interview rooms, physiotherapy and other activities such as gardening.

It was felt that new technologies were emerging but further improvements and funding is required to the IT infrastructure which would better enable electronic notes and case management systems.

Respondents were keen to highlight the need to focus on mental health and wellbeing and not just mental illness.

"Mental illness [priorities] feel very illness heavy and needs more on prevention and wellbeing - this is also a community responsibility."

4.6 Primary Care Services

There was limited understanding of the implications of a new primary care contract but may respondents believed that GPs need to work collegiately to meet the very different needs of the populations. There was some concern about the changing nature of GP services and the move to delivery through a range of different professionals and services and there were comments about the new contract not taking account of rural communities. Respondents also posed questions about the ability to creatively attract permanent GPS and other health professionals to this area?

"Value local GP services but have worries about new contract."

"There is ongoing concern about the new GP contracts not taking account of the rural nature of our practices and it is hoped this will be recognised."

"Very unhappy about Primary Care [contract]. There is a SLWG looking at rural and remote issues with the new contract so it should not be implemented in a manner which cause change to these areas."

"I have some awareness of primary care changes - these seem positive. However some changes already in place, e.g. take phone triage in Lochgilphead."

"This requires staffing resource input: GP Workload - free up time and support the changing role of GPs so they can concentrate on patients with more complex health

and care conditions. All models tested so far have required significant resource input, without this, pressure will be put already stretched services. A&B already have staff recruitment problems. The GPs expectations around this need to be realistic without more staff this won't be possible."

Respondents also suggested that promoting wellbeing for the whole population should be a focus for primary care and cited opportunities to deliver or signpost to preventative services. Activities such as social and recreational activities and befriending services were believed to be important in combat loneliness. However, there was a belief that preventative activities are a 'soft option' when facing savings.

4.7 Hospital Services

Very few responses were provided in relation to hospital services However, the consensus from those who did comment was that hospital services need to be retained within Argyll and Bute and out of area provision to Glasgow should specialist services and not routine.

"People value local hospital services. In some areas like Oban the population is growing so there is a need to retain local services."

There was a clear consensus that people wanted to stay in their homes rather than being in hospital where they are likely to become more dependent. A few respondents cited difficulties patients have in getting an appointment with their own GP, or being unable to get a response from, NHS24, as a reason for inappropriate attendance at Accident & Emergency. Respondents emphasized the need to develop sufficient community services in order to prevent patients inappropriately remaining in hospital long after their clinical needs require.

4.8 Corporate Services

Respondents believed that looking to make corporate services more efficient was eminently sensible and could reduce unnecessary saving being taken from frontline services.

"Mostly seem sensible, especially integrating admin , finance jobs, hopefully more training for care workers to cope with the situations they have to deal with."

"These are the main areas that require focused change due to population changes and recruitment difficulties. They appear all inclusive and not just focused on services to communities but back room services also."

Some concerns were raised about reducing and centralizing administrative services which was thought to place a greater burden of administrative tasks on professionals which was considered an inefficient use of money.

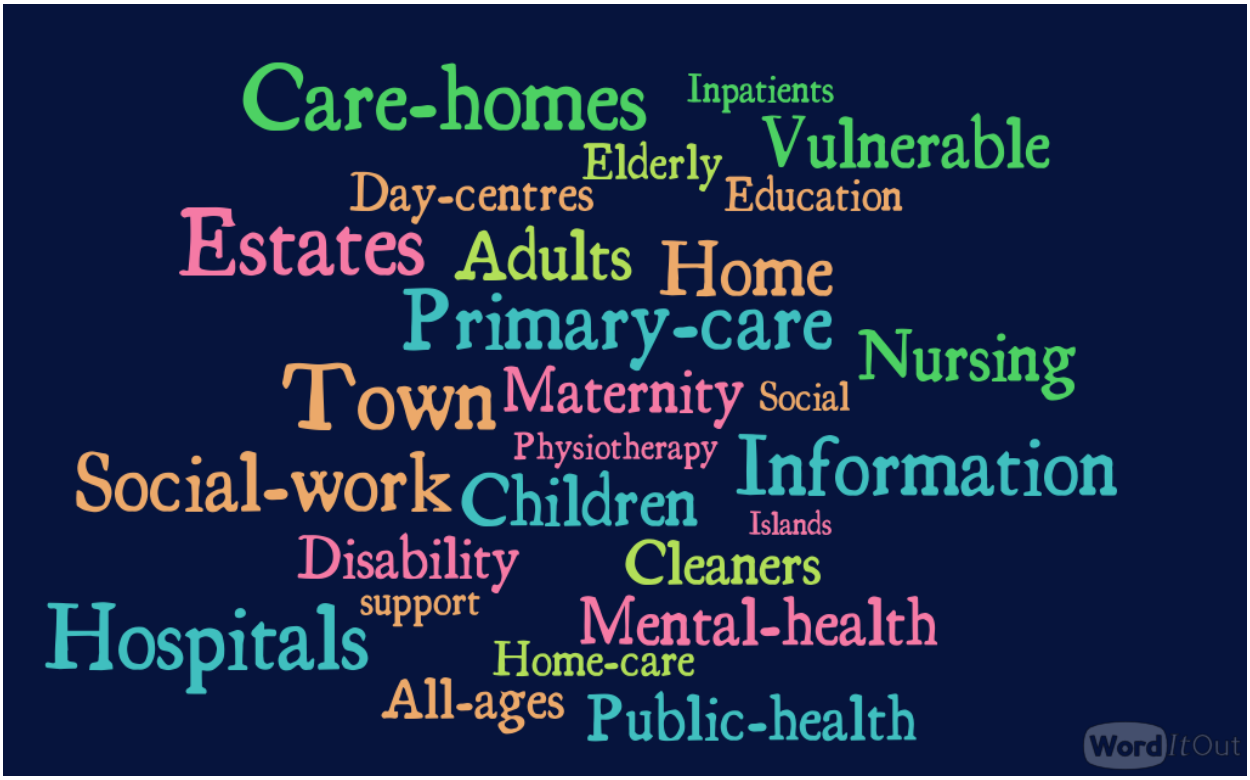
"In addition, many services benefit from the expertise that builds up within their admin teams and there is huge concern about the quality of service being reduced if admin teams become more dispersed from the services/areas they support."

Respondents felt the HSCP should focus on modernising the IT infrastructure in order to improve access and sharing a wide range of information and better supporting performance management.

"We are still using internet version which is no longer seen as secure and no longer used by NES, the NHS education for Scotland. IT needs to be funded and staffed appropriately."

5. Respondents' understanding of the types of services that are provided by the Health & Social Care Partnership

Many responses said they had good understanding of the wide range of services devolved to the HSCP. Others went further, describing what they considered to be integration arrangements *"encompass the needs of the community" [*particularly for people with] "*complex and varied needs"* [and for those] "*who are the most vulnerable people in the community"*. A range of services was articulated for example:



6. How can individuals and our partners work with us to help people stay healthy and well?

Respondents made reference to reducing poverty as a means of improving overall health outcomes. There was some support for government to legislate for more regulation relating to tobacco, alcohol and food sales and availability and specific age related interventions, for example reduce numbers of alcohol off-sales and outlets; reduce and regulate unhealthy foods and fast food outlets.

Respondents also suggested there were actions that could be taking locally (Argyll & Bute) including access to free healthy school meals and affordable leisure facilities, as well as maximising school playing fields for community use. Others emphasised the need to create safe communities that promote "*social and recreational opportunities, as well as activities such as walking and cycling".* Many responses highlighted the need for communities that generate a sense of people looking after each other.

"Helping neighbours and looking after their own health"

"Support exercise and social inclusion. Encourage a more community spirit."

A number of respondents acknowledged that people should take responsibility for their own health.

"People need to take ownership of their health and rely less on services."

"People can try to live a healthy lifestyle and not depend on being treated when they get to crisis point"

It was suggested that for people to be more independent, there was a need for service user education to enable self-management and to enable people to take more ownership and responsibility for their own health. Increasing opportunities that enable people to remain or improve levels of physical activity was important to respondents including:

"Walking groups……promote benefits of these groups."

"Structured exercise programmes for chronic diseases."

There was recognition that *"everyone has a part to play in helping people to remain healthier for longer including public sector and voluntary organization, volunteers, communities, patients and carers".*

Respondents commented that third sector organisations and volunteers provide a wide range of valued services for example home safety services; volunteer sitters preventing conveyance to hospital; home from hospital service enabling faster/safer discharge; buddying service; and spiritual support in a variety of settings, and involvement of faith-based groups in service provision.

However, reference was made to the fact that.....

" we are running out of volunteers in Argyll and Bute.....[and not to rely on] volunteers and community solutions instead of funded services with paid staff."

7. Supporting Engagement

Responses reflected different aspects of engagement including who should be engaged with, the level of engagement that is undertaken and included suggestions for how engagement should take place i.e. the tools used and the way the message is delivered.

The need for an engagement strategy was specifically highlighted in order to effectively plan for engagement, not including it as an 'add on' and providing sufficient time to ensure service changes are not implemented overnight, "avoiding a clifftop approach". There was thought to be a need to develop strong 'building blocks' for engagement but there was acknowledge this could take time and would require being clear about the difference between planning and engagement.

"clearer [engagement] entry points for influencing instead of multiple different

meetings for example, health and wellbeing meetings, locality planning groups, health and care fora etc."

"Being really clear what service redesigns are taking place and building in co-production from the start of the process".

It was suggested that ample time and budget allocated to do this effectively, utilise some of the engagement matrix`s that are available to plan this and be able to show transparency. An effective approach was also perceived to be a "*cycle of engagement and that information is not just collected, or people consulted but are part of the process*".

There was acknowledgement that for engagement to be meaningful it should primarily involve those who are experiencing services and who will be directly impacted by service change. Engagement should be part of the journey towards change.

Respondents suggested the need for honest debate, particularly with the community about what we can and can't do regarding their expectations. Being honest means....

"making it very clear that the financial envelope is fixed.....the only choices are within that spending cap. This questionnaire is a good start".

"Engage with the people making the changes before decision are made."

"Speak to front line services, listen to their concerns and reflect back to those working at the grass roots."

"Provide regular communication to staff and the public on progress of the various workstreams."

Many respondents felt strongly about the need to engage directly with service user, carers and families and not just focus on 'representatives.

"Need a consistent approach…….not engaging with the same people all the time…….important to engage with people actually using services…….. be flexible about how best to involve different people."

"Broaden your range of ways to engage so you don't get the same folk attending groups, modernise your engagement methods"

"Talk to the service users. Too many working groups made up of representatives and professionals who only see one side of things. Invite service users to forums such as 'Our Voices' and encourage more connected communities."

Responses highlighted additional support or effort that is needed to engage effectively with particular groups.

"Older adults, people with learning difficulties and mental health issues will need support to be involved. If the primary worker……. is given the opportunity to spend time and gather information this would be valuable."

"Need to reach out to inequalities groups eg learning disabled; mental health service users and families on low incomes in particular"

"You need to involve the carers, guardians, social workers and other health professionals e.g. Occupational Health, on what are the main needs of the people with Learning Disabilities."

How the message is delivered was important for respondents who indicated the need for clear, easy to understand material used in engagement.

"Present the information in simple language…….ask simple straight forward questions using plain English that is understandable."

"Present the information in simple language…….ask simple straight forward questions using plain English that is understandable."

"Communicate frequently and offer updates regularly."

Respondents highlighted that the knowledge of the person delivering the message is crucial.

"The people delivering the message need to be honest, approachable and have relevant knowledge"

"Ensure all [staff] in sectors understand plan and communicate clear and consistent messages in their local communities"

Responses included comments on the methods used to engage with people, highlighting the need to reach communities through a variety of methods. This including having an effective feedback system.

"Find out how [people] like to receive information- may be different in each area, may be a combination. Look at how other businesses etc have been able to successfully reach people and learn from them in each area. It may be the local paper, local FB site or it may be as simple as notices/flyers in local shops."

"keeping [people] informed, publicising to inform everyone what is happening……..need to publish information in a variety of formats, roadshows, leaflets, radio, newspapers and not just rely on social media."

"Convening specific public meetings less successful unless [the public can be involved in] vital decision to be made"

"Need to go to people (not public meetings) recognising that people don't always attend community events….. therefore have to target people or [attend] events that are already where people will be."

"Younger people use social media - should have questionnaires there for them."

Responses suggested specific engagement methods including;

- Informing community councils; general public meetings; people available in GP practices and health clinics; community hubs ie each locality Co-op
- roadshows; service user forums
- Posters /leaflets – buildings and public transport; newsletters in print in surgeries
- Mail drops – using volunteers if expensive
- Websites; Social media; Email updates
- Local papers/press/radio
- Third sector evaluation tools
- Surveys

8. Appendices

A. List of Consultees

B. Survey Monkey Questionnaire

C. Consultation Presentation

Appendix 8a

HSCP STRATEGIC PLAN ENGAGEMENT

1. Survey Monkey questionnaire running from August, September to mid October 2018. https://www.surveymonkey.co.uk/r/AB-HSCP2019-23
2. HSCP Locality Manager, Local Area Managers and Team Leads delivered presentations to staff across Argyll and Bute to **inform** and **consult** on the Strategic Plan.
3. The Public Health Team have delivered presentations to a number of multi-agency groups across Argyll and Bute to **inform** and **consult** service user and carer representatives and partners organisations on the Strategic Plan.

1. Survey Monkey questionnaire

The survey monkey questionnaire was widely available on the HSCP website and social media channels, as well as promoted through the face to face staff and multi-agency presentations. A total of **78** responses were received. These responses have been summarised and incorporated into the range of other responses received via the presentation sessions with staff and multi-agency groups. A more full write up of the survey monkey responses is available on request.

2. HSCP Staff Consultation

DATE	TEAM
July 2018	▪ A&B Council Finance Team (who support the HSCP)
	▪ Income Maximisation Team (who support admissions and contracting for residential care and carefirst financial support)
	▪ Succoth ward staff
	▪ Campbeltown local staff sessions
	▪ Kintyre and Islay local staff sessions
	▪ Islay Heads of Department
	▪ Mental health Heads of Department
	▪ Helensburgh Adult Services Management meeting and Team Leader Community Nursing, Adult Services, Social Care and Learning Disabilities Service staff
	▪ Adult Services Management Team
August 2018	▪ Cowal and Bute Team Leaders, Unit Managers, Heads of Department
	▪ Campbeltown hospital staff staff session 1
	▪ Campbeltown hospital staff staff sessions 2
	▪ Woodlands staff session
	▪ Greenwood staff session
	▪ Maternity staff session

	▪ Helensburgh Community Nursing Team, Mental Health/Discharge Team, OTs, Social Work, Admin staff, Dietetics Team
	▪ Islay Maternity and Social Work services
	▪ ABAT Team (Addictions)
	▪ OLI Joint Heads of Department Meeting
September 2018	▪ Helensburgh Physiotherapy staff
	▪ Mental Health OTs
	▪ Radiography staff
	▪ Mid Argyll Community Care Team
	▪ Speech and Language Therapist - Mid Argyll, Kintyre and Islay
	▪ Learning Disability Team
October 2018	▪ Children & Families Operational Management Group

3. Multi-Agency Groups Consultation

DATE	GROUP
July 2018	▪ Strategic Planning Group
	▪ Kintyre Comms and Engagement Group
	▪ Kintyre Health and Wellbeing Network
August 2018	▪ TSI disseminated to 225 third sector organisations
	▪ MAKI Community Planning Group
	▪ OLI Community Planning Group
	▪ Cowal/Bute Community Planning Group
	▪ Helensburgh Community Planning Group
	▪ Elected Member Seminar
	▪ Kintyre Locality Planning Group
	▪ Oban, Lorn & Isles Locality Planning Group
	▪ Oban, Lorn & Isles Health and Wellbeing Network
	▪ Bute Health and Wellbeing Network
	▪ Information sent to Community Councils
	▪ Argyll and Bute CPP Bulletin
September 2018	▪ Coll/Colonsay & Tiree Locality Planning Group
	▪ Helensburgh and Lomond Locality Planning Group

	▪ Islay & Jura Locality Planning Group
	▪ Mull & Iona Locality Planning Group
	▪ Cowal Health and Wellbeing Network
	▪ Argyll and Bute CPP Bulletin
	▪ OLI Communications & Engagement Group
October 2018	▪ Cowal Locality Planning Group
	▪ Bute Locality Planning Group
	▪ Mid Argyll Locality Planning Group
	▪ OLI Health Forum
	▪ Argyll and Bute CPP Bulletin

Appendix 8b

Survey Monkey Questionnaire

STRATEGIC PLAN (2019/22)

The Health & Social Care Partnership (HSCP) is seeking feedback from service user and carer representatives, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022), specifically on eight strategic areas of service change required to deliver the ambitions of the Partnership over the life of the Plan.

The Challenging financial position means the Health & Social Care Partnership cannot do everything to meet the public's expectations of care. The ageing population and increasing health and care demands mean it is not possible to continue to provide services in the same way. Simply we need to utilize our staff, buildings and money differently to achieve the best impact.

Delivering services within a balanced budget will require a shift of focus to delivering high quality and effective services for people with a complex range of needs and investing in communities, enabling and supporting people to enjoy the best quality of life possible, informed by choices they make for themselves.

The HSCP engagement process involves three stages, with stage 1 taking place from summer 2018 to early autumn 2018:

- **Stage 1 – Informing and Consulting on the Strategic Plan**
  - Informing people about what the HSCP is going to do
  - Inviting comments on the key service change areas that are required
  - Inviting suggestions around what we need to do to make sure we involve people as we make these changes
  - Use the information gathered in this stage to inform what we do next
- **Stage 2 – Involving and Collaborating on service redesign**
  - Developing the areas of work around the 8 key areas for service change
  - Involve staff, citizens and partners as we take forward this work
  - Publicise what we have found out and how this information will be used to make service changes
- **Stage 3 – Involving and Collaborating on implementing service change**
  - Involve people who use services, carers, staff and partners in how we implement service change

The key service change areas are outlined below. We welcome and value your feedback to better inform the Strategic Plan and the transformational service changes required over the next three years and beyond.

Please could you complete your response to the following five questions online via https://www.surveymonkey.co.uk/r/AB-HSCP2019-23
Alternatively, you can post your response to:

Caroline Champion - Public Involvement Manager
Argyll & Bute Health & Social Care Partnership FREEPOST RRYT-TKEE-RHBZ
Blarbuie Road, LOCHGILPHEAD, Argyll, PA31 8LD.

1. CHILDREN'S SERVICES

What do we Know?

Data for 2017 shows 13,163 children aged 0-15 years live in Argyll& Bute (6705-males and 6458 females). The children and young people population is declining. The number of children with complex needs is increasing. The single biggest challenge is the recruitment and retention of midwives, health visitors and social workers. £844K of savings will need to be delivered over the next year.

Being exposed to adverse and stressful experiences (ACEs) can have a negative impact on children and young people throughout their lives. Trauma-informed and resilience-building practices should be embedded within services.

What do we plan to do?

- Provide continuity of midwifery care.
- Increase visits by health visitors.
- Prevent children and young people coming into care.
- Increase the number of fostering and kinship placements.
- Place children close to their families and communities.
- Reduce youth and adult reoffending rates.
- Preventing problems through early intervention such as breastfeeding support and reducing poverty.

2. CARE HOMES AND HOUSING

What do we Know?

The number of older people is set to rise significantly in the coming years with the steepest rises being in the over 75 year age group. 10.7% of the current population is aged 75 and over. There is an increasing demand for adapted properties as more older people are enabled to stay at home.

The challenge is to provide suitable housing and sustainable 24 hour care and care at home services for people with high levels of need in the context of workforce recruitment difficulties. As service demand rises there is a requirement to make £0.1 million of saving over the next year from this service.

A Health and care housing needs assessment has been undertaken to inform need and a Care & Nursing Home Modelling Tool is being developed to better assess future needs.

What do we plan to do?

- Understanding current scale and profile of nursing, residential care & supported accommodation for older people.
- Working across health, social care, housing and independent sector to determine future demand.
- Plan future provision around 24 hour care and housing.

3. LEARNING DISABILITY SERVICES

What do we Know?

Argyll & Bute has a growing number of people living with learning disabilities who are living healthier for longer. There is an increasing demand for Learning Disability services, both internal and external, with this trend not predicted to slow given the population profile. The challenge will be to deliver community based supported living services with a reducing resource, increasing need while meeting quality standards.

Other models of care will be required which will involve moving away from individual tenancies which are unsustainable. Engaging with Third Sector providers will enable the development of new opportunities for supported living with a view towards delivering alternative models of care and support.

What do we plan to do?

- Further develop service and resources that will support individuals to return from out of area placements.
- Review and evaluate current 'sleepover' services and increase usage of Telecare whilst maintaining service user safety and wellbeing.
- Work with housing services to develop 'Core and Cluster' models of care.
- Develop HSCP internal services that are able to support individuals with complex needs.
- Sustain and further improve on the positive feedback from external regulators regarding the quality of service provision.
- Increase the uptake of Self Directed Support.
- Support the co-production of community based services for families living with learning disabilities.

4. COMMUNITY MODEL OF CARE

What do we Know?

There are more elderly people living in Argyll and Bute and it is anticipated this will increase significantly in future years. There will be more people living with care needs in our communities and some of these care needs will be complex. It is also predicted that more people will be living with dementia requiring support and care in our communities. There are a number of challenges to meeting service demand including recruiting care workers; high public expectation of care provision; the availability of appropriate homes/housing for people with care needs; and the delivery of care across a large geographical area.

Evidence suggests that a multi disciplinary team provides more efficient and effective community care, reducing hospital admissions and supporting discharges. Focussed re-ablement following a period of ill health can improve health and wellbeing outcomes for people and reduce the demand on homecare. A team approach to falls prevention and frailty supports people to continue to stay at home.

What do we plan to do?

- Develop and implement multi-disciplinary community care teams
- Develop a multi skilled care worker role to work within the multi-disciplinary community care teams.

- Ensure anticipatory care planning is adopted to reduce the incidence of emergency hospital admissions.
- Prioritise the prevention e.g. empower people to self manage long term health conditions and connect people with sources of support in their community such as opportunities to be more physically active.
- Further develop the use of technology to support people living at home who have health and care needs.

5. MENTAL HEALTH SERVICES

What do we Know?

There are increasing numbers of people living with mental health problems in our communities. Demand for support and care services centre around in-patient beds for people with severe and acute episodes of mental ill health and community services to support people living at home. There continues to be an increasing demand for services and recruitment to specialist mental health professionals and care support workers remains challenging. The nature of the large geographical area presents difficulties in delivering care and support, particularly responding to acute episodes of care out with normal working hours.

It is well recognised that anticipatory and crisis care planning reduces admission to a hospital bed and a positive therapeutic environment supports recovery. A multi disciplinary team approach provides more efficient and effective care in the community and new technologies can support care delivery.

What do we plan to do?

- Establishment of the in-patient beds within Mid Argyll Community Hospital.
- Review of the community mental health teams.
- Explore new technological ways of delivering therapy.
- Implement the Locality Based consultant model of care.
- Further develop the WRAP approach to enable people to self manage their mental wellbeing (Wellness Recovery Action Planning).
- Mitigate the impact of problems such as debt and loneliness on mental health through connecting people to community based support.

6. PRIMARY CARE SERVICES

What do we Know?

There are 33 GP practices in Argyll and Bute, with a registered patient population of 88,657 as at 1 April 2018. The national priority is to reduce the future workload on GPs and practices and to transfer work to HSCP to deliver services through other clinicians such as Pharmacy, Physiotherapy, Advanced Nurse Practitioners.

The new GP Contract was implemented in April 2018. Sustainable services delivered by wider teams are being planned within the context of Primary Care Service Redesign. This will see extra funding over the next 3 years in Argyll and Bute - £848,000 in the first year expected to rise to £2.9 Million.

What do we plan to do?

- Musculoskeletal (MSK) Services - More physiotherapists employed so that patients can benefit from quicker access and treatment reducing unnecessary referrals to GPs.
- Community Mental Health - Increasing the number of community mental health nurses better placed to support up to 25% of patients who currently see GPs.
- GP Workload - Free up time and support the changing role of GPs so they can concentrate on patients with more complex health and care conditions. Make the role more attractive to recruit to.

7. HOSPITAL SERVICES

What do we Know?

There is one Rural General Hospital in Oban and six Community Hospitals all with Accident & Emergency departments.

As more people live longer there is more demand on services. The number of A&E attendances continues to increase; more care is now being delivered in the community and hospitals are being used for more day care services. A challenge is that the general population decline in Argyll and Bute is also mirrored in the workforce impacting on the ability to recruit a sustainable workforce.

International and national evidence advises that people have better outcomes when they receive care as close to home when it is safe and possible to do so; hospital care should be used when needed for acute care; and A&E departments should only be for urgent care.

What do we plan to do?

- Standardise role and function of each community hospitals.
- Bed model each in-patient area to ensure we make best use of all resources.
- Workforce review to ensure we are utilsing the full potential of all individuals.

8. CORPORATE SERVICES

What do we Know?

HSCP corporate services include finance, planning, IT, HR, pharmacy management, medical management and estates, as well as all IT and corporate asset infrastructure. Demands are increasing alongside new corporate demands of health and social care integration. There is a requirement to make corporate services more efficient and integrated for front line managers.

There are a number of challenges in improving the effectiveness and efficiency of these services. These include less people and buildings; not all corporate support services from Council are delegated to the partnership; the balance between efficiencies and reduced level of service; and more efficient use of technology and systems requires significant investment. The recurring budget is expected to reduce, requiring savings of £1.3m over the next year. However, if efficiency and effectiveness are to be achieved non-recurring investment may be required.

The National health and wellbeing outcome indicators require HSCPs to use resources effectively and efficiently and to integrate support services to provide efficiencies. The HSCP will model corporate efficiencies on those already realised by the Council.

What do we plan to do?

- Health and social care corporate staff (eg finance, planning, IT, HR, estates) are co-located to work together in the same locations and in the same teams.
- Integrate health and social work administration and implement digital technology.
- Efficiencies in catering and cleaning services through shared services.
- Rationalise estates and properties by co-location of staff.
- Efficiencies in travel and subsistence costs.

Your views are important and we welcome your feedback.

Q1:	**What is your understanding of the types of services that are provided by the Health & Social Care Partnership?**

Q2:	**What are your thoughts about the 8 key areas of service change?**

Q3:	**What do we need to do to make sure we involve people as we go about making these changes (effective engagement)?**

Q4:	**How can individuals, communities and our partners work with us to help people stay healthy and well?**

Q5:	**What would help communities to work with us and play an active role in developing and delivering future services?**

Appendix 8c

Consultation Presentation

A&B HSCP Transforming Together

STRATEGIC PLAN (April 2019- March 2022)

STAKEHOLDER ENGAGEMENT

Healthy Together Argyll & Bute

Health & Social Care Partnership

- The Integrated Joint Board was established as a new public body on the 1st April 2016.
- First Strategic Plan (2016/19) identified key areas of focus to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and require support from both health and social care.
- There have been some notable successes in the first two years.

Successes in the first 2 years

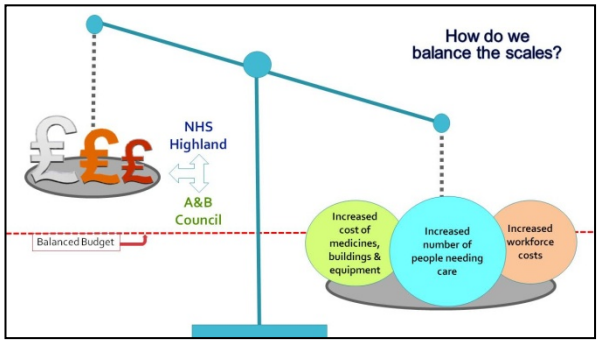
- Developed Community Care Teams with a single point of access in Kintyre and Mid-Argyll.
- Developed a single point of access for health community referrals in Dunoon.
- Development of an extra care housing unit in Lorn Campbell Court Campbeltown.
- Relocation of in patient mental health facility in Mid Argyll.
- Embedding a re-ablement approach to care that enable a people to reach their highest level of independence, reduce the need for continued care at home.
- Developing process to improve referral into a community team, how referrals are triaged and allocated, to reduce the time and simplify the process.
- Working with the carer centres and respite providers to implement the Carers Act which gives carer rights to be assessed and supported in their caring role.
- Graded VERY GOOD for children's residential and fostering services.
- More Looked After Children placed in family type placements.
- Implemented 'Attend Anywhere' within Maternity Services.

2nd Strategic Plan (April 2019 - March 2022)

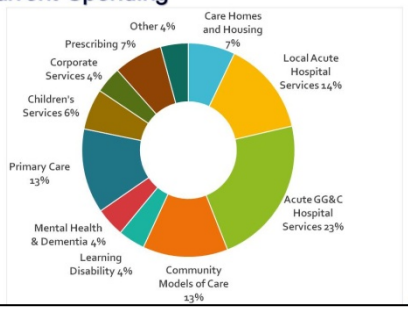
- The Challenging financial position means the Health & Social Care Partnership cannot do everything to meet the public's expectations of care.
- The ageing population and increasing health and care demands mean it is not possible to continue to provide services in the same way. Simply we need to utilise our staff, buildings and money differently to achieve the best impact.
- Delivering services within a balanced budget will require a shift of focus to:
  - delivering high quality and effective services for people with a complex range of needs, and
  - investing in communities, enabling and supporting people to enjoy the best quality of life possible, informed by choices they make for themselves.

Engagement Process

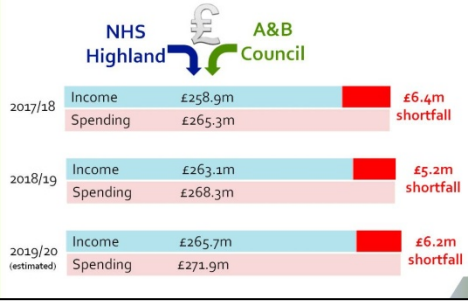
- Stage 1 – Informing and Consulting on the Strategic plan
  - Informing people about what the HSCP is going to do
  - Inviting comments on the key service change areas that are required
  - Inviting suggestions around what we need to do to make sure we involve people as we make these changes
  - Use the information gathered in this stage to inform what we do next
- Stage 2 – Involving and Collaborating on service redesign
  - Developing the areas of work around the 8 key areas for service change
  - Involve staff, citizens and partners as we take forward this work
  - Publicise what we have found out and how this information will be used to make service changes
- Stage 3 – Involving and Collaborating on implementing service change
  - Involve people who use services, carers, staff and partners in how we implement service change.



Current Spending



Spending Shortfall



High Level Service Changes

1. Children's Services
2. Care Homes and Housing
3. Learning Disability Services
4. Community Model of Care
5. Mental Health Services
6. Primary Care Services
7. Hospital Services
8. Corporate Services

Each of the high level Service Changes will involve a major area of work, needing their own improvement plan and engagement process.

1. Children's Services

Population Profile
Data for 2017 shows 13,163 children aged 0-15 years live in Argyll& Bute (6705-males and 6458 females). The children and young people population is declining.

Service Demand
The number of children with complex needs is increasing.

Challenges
The single biggest challenge is the recruitment and retention of midwives, health visitors and social workers.

Evidence Base
Being exposed to adverse and stressful experiences (ACEs) can have a negative impact on children and young people throughout their lives.
Trauma-informed and resilience-building practices should be embedded within services.

Current Service Cost
£19.1 million

Estimated Savings
Required to make **£0.8 million** savings over the next year.

Service change

1.1	Provide continuity of midwifery care.
1.2	Increase visits by health visitors.
1.3	Prevent children and young people coming into care.
1.4	Increase the number of fostering and kinship placements.
1,5	Place children close to their families and communities.
1.6	Reduce youth and adult reoffending rates.
1.7	Preventing problems through early intervention such as breastfeeding support and reducing poverty.

2. Care Homes & Housing Services

Population Profile
The number of older people is set to rise significantly in the coming years; with the steepest rises being in the over 75 year age group. 10.7% of the current population is aged 75 and over.

Service Demand
Increasing demand for adapted properties as more older people are enabled to stay at home.
Long-term sustainable solutions for high level needs (24 hour care).

Challenges
Our challenges are providing suitable housing and sustainable 24 hour care and care at home due to our workforce difficulties.

Evidence Base
A Health and care housing needs assessment has been undertaken to inform need.
A Care & Nursing Home Modelling Tool is being developed to better assess future needs.

Current Service Cost
£18.8 million

Estimated Savings
Required to make **£0.1 million** savings over the next year.

Service change

2.1	Understanding current scale and profile of nursing, residential care & supported accommodation for older people.
2.2	Working across health, social care, housing and independent sector to determine future demand.
2.3	Plan future provision around 24 hour care and housing.

3. Learning Disability Services

Population Profile
Argyll & Bute has a growing number of people living with learning disabilities who are living healthier for longer.

Service Demand
There is an increasing demand for Learning Disability services, both internal and external, with this trend not predicted to slow given the population profile.

Challenges
The challenge will be to deliver community based supported living services with a reducing resource, increasing need while meeting quality standards.

Evidence Base
Engaging with Third Sector providers will enable the development of new opportunities for supported living with a view towards delivering alternative models of care and support.

Current Service Cost
£10.8 million

Estimated Savings
Required to make **£1.4 million** savings over the next year

Service change

3.1	Further develop service and resources that will support individuals to return from out of area placements.
3.2	Review and evaluate current 'sleepover' services and increase usage of Telecare whilst maintaining service user safety and wellbeing.
3.3	Work with housing services to develop 'Core and Cluster' models of care.
3.4	Develop HSCP internal services that are able to support individuals with complex needs.
3.5	Sustain and further improve on the positive feedback from external regulators about quality of service provision.
3.6	Increase the uptake of Self Directed Support.
3.7	Support the co-production of community based services for families living with learning disabilities.

4. Community Model of Care

Population Profile
There are more elderly people living in Argyll and Bute and it is anticipated this will increase significantly in future years.

Service Demand
There will be more people living with care needs in our communities and some of these care needs will be complex.
There will be more people living with dementia requiring support and care in our communities.

Challenges
Recruiting care workers.
High public expectation of care provision.
The availability of appropriate homes/housing for people with care needs.
The delivery of care across a large geographical area.

Evidence Base
A multi disciplinary team provides more efficient and effective community care, reducing hospital admissions and supporting discharges.
Focussed re-ablement can improve outcomes for people and reduce demand on homecare.
A team approach to falls and frailty supports people to continue to stay at home.

Current Service Cost
£34.2 million

Estimated Savings
Required to make **£1.7 million** savings over the next year

Service change

4.1	Develop and Implement Multi-disciplinary Community Care Teams.
4.2	Develop a multi skilled care worker role to work within the Multi-disciplinary Community Care Teams.
4.3	Ensure anticipatory care planning is adopted to reduce the incidence of emergency hospital admissions.
4.4	Prioritise the prevention e.g. empower people to self manage long term health conditions and connect people with sources of support in their community such as opportunities to be more physically active.
4.5	Further develop the use of technology to support people living at home who have health and care needs.

5. Mental Health Services

Population Profile
There are increasing numbers of people living with mental health problems in our communities.

Service Demand
In patient beds for people with severe and acute episodes of illness.
Community services to support people living at home.

Challenges
Increasing demand for services.
Recruitment to specialist mental health professionals.
Recruitment to care /support workers.
Delivery of care in a large geographical area.
Ability to provide a response to acute episodes of care out with normal working hours.

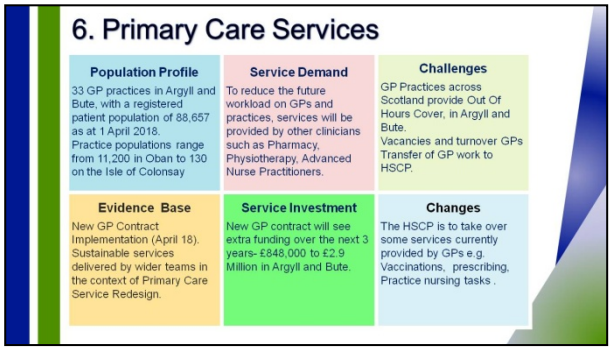
Evidence Base
Anticipatory and crisis care planning reduces admission to a hospital bed.
A positive therapeutic environment supports recovery.
A multi disciplinary team approach provides more efficient and effective care in the community.
New technologies can support care delivery.

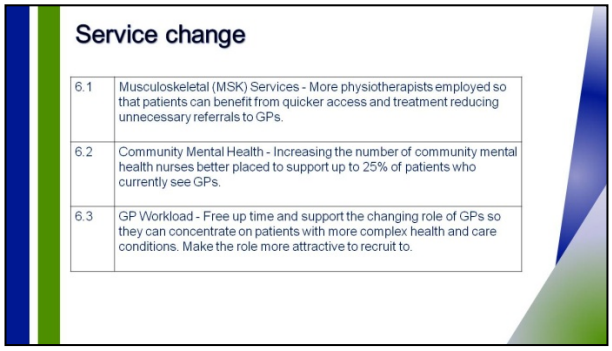
Current Service Cost
£11.6 million

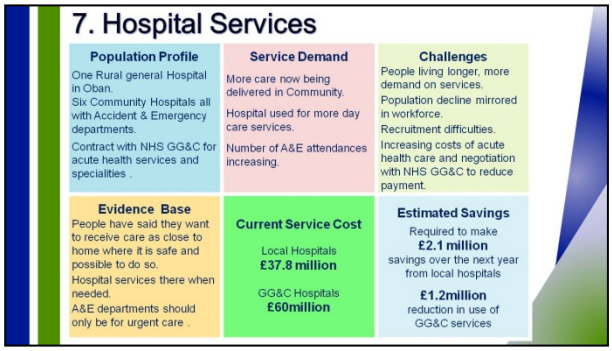
Estimated Savings
Required to make **£0.6 million** savings over the next year

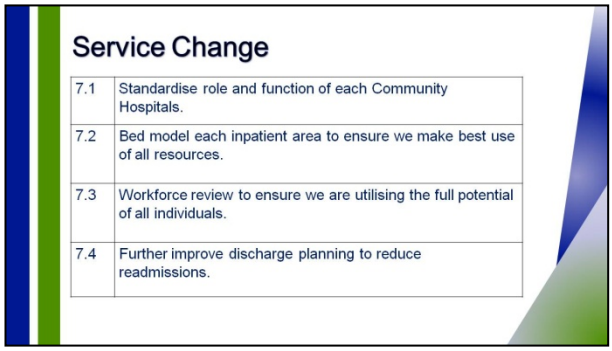
Service change

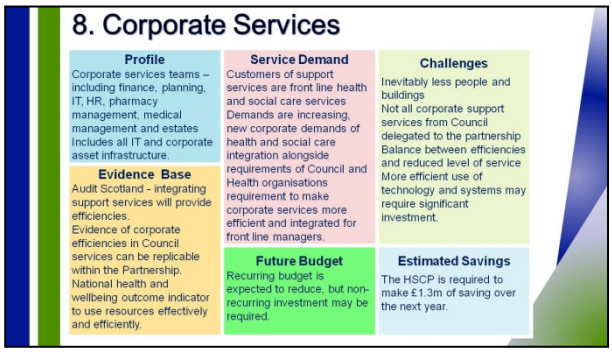
5.1	Establishment of the in patient beds within Mid Argyll Community Hospital.
5.2	Review of the Community Mental Health Teams.
5.3	Explore new technological ways of delivering therapy.
5.4	Implement the Locality Based consultant model of care.
5.5	Further develop the WRAP approach to enable people to self manage their mental wellbeing (Wellness Recovery Action Planning).
5.6	Mitigate the impact of problems such as debt and loneliness on mental health through connecting people to community based support.

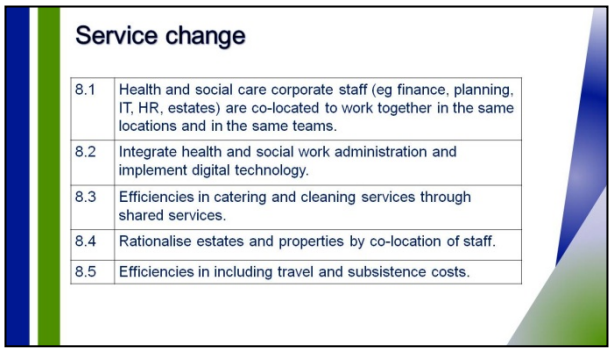

6. Primary Care Services
Population Profile
33 GP practices in Argyll and Bute, with a registered patient population of 88,657 as at 1 April 2018.
Practice populations range from 11,200 in Oban to 130 on the Isle of Colonsay
Service Demand
To reduce the future workload on GPs and practices, services will be provided by other clinicians such as Pharmacy, Physiotherapy, Advanced Nurse Practitioners.
Challenges
GP Practices across Scotland provide Out Of Hours Cover, in Argyll and Bute.
Vacancies and turnover GPs
Transfer of GP work to HSCP.
Evidence Base
New GP Contract Implementation (April 18).
Sustainable services delivered by wider teams in the context of Primary Care Service Redesign.
Service Investment
New GP contract will see extra funding over the next 3 years- £848,000 to £2.9 Million in Argyll and Bute.
Changes
The HSCP is to take over some services currently provided by GPs e.g. Vaccinations, prescribing, Practice nursing tasks .

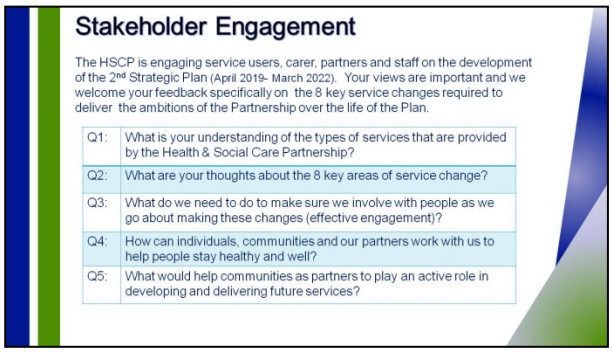

Service change
6.1 Musculoskeletal (MSK) Services - More physiotherapists employed so that patients can benefit from quicker access and treatment reducing unnecessary referrals to GPs.
6.2 Community Mental Health - Increasing the number of community mental health nurses better placed to support up to 25% of patients who currently see GPs.
6.3 GP Workload - Free up time and support the changing role of GPs so they can concentrate on patients with more complex health and care conditions. Make the role more attractive to recruit to.


7. Hospital Services
Population Profile
One Rural general Hospital in Oban.
Six Community Hospitals all with Accident & Emergency departments.
Contract with NHS GG&C for acute health services and specialities .
Service Demand
More care now being delivered in Community.
Hospital used for more day care services.
Number of A&E attendances increasing.
Challenges
People living longer, more demand on services.
Population decline mirrored in workforce.
Recruitment difficulties.
Increasing costs of acute health care and negotiation with NHS GG&C to reduce payment.
Evidence Base
People have said they want to receive care as close to home where it is safe and possible to do so.
Hospital services there when needed.
A&E departments should only be for urgent care .
Current Service Cost
Local Hospitals
£37.8 million
GG&C Hospitals
£60million
Estimated Savings
Required to make
£2.1 million
savings over the next year from local hospitals
£1.2million
reduction in use of GG&C services


Service Change
7.1 Standardise role and function of each Community Hospitals.
7.2 Bed model each inpatient area to ensure we make best use of all resources.
7.3 Workforce review to ensure we are utilising the full potential of all individuals.
7.4 Further improve discharge planning to reduce readmissions.


8. Corporate Services
Profile
Corporate services teams – including finance, planning, IT, HR, pharmacy management, medical management and estates
Includes all IT and corporate asset infrastructure.
Service Demand
Customers of support services are front line health and social care services
Demands are increasing, new corporate demands of health and social care integration alongside requirements of Council and Health organisations
requirement to make corporate services more efficient and integrated for front line managers.
Challenges
Inevitably less people and buildings
Not all corporate support services from Council delegated to the partnership
Balance between efficiencies and reduced level of service
More efficient use of technology and systems may require significant investment.
Evidence Base
Audit Scotland - integrating support services will provide efficiencies.
Evidence of corporate efficiencies in Council services can be replicable within the Partnership.
National health and wellbeing outcome indicator to use resources effectively and efficiently.
Future Budget
Recurring budget is expected to reduce, but non-recurring investment may be required.
Estimated Savings
The HSCP is required to make £1.3m of saving over the next year.


Service change
8.1 Health and social care corporate staff (eg finance, planning, IT, HR, estates) are co-located to work together in the same locations and in the same teams.
8.2 Integrate health and social work administration and implement digital technology.
8.3 Efficiencies in catering and cleaning services through shared services.
8.4 Rationalise estates and properties by co-location of staff.
8.5 Efficiencies in including travel and subsistence costs.


Stakeholder Engagement
The HSCP is engaging service users, carer, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022). Your views are important and we welcome your feedback specifically on the 8 key service changes required to deliver the ambitions of the Partnership over the life of the Plan.
Q1: What is your understanding of the types of services that are provided by the Health & Social Care Partnership?
Q2: What are your thoughts about the 8 key areas of service change?
Q3: What do we need to do to make sure we involve with people as we go about making these changes (effective engagement)?
Q4: How can individuals, communities and our partners work with us to help people stay healthy and well?
Q5: What would help communities as partners to play an active role in developing and delivering future services?

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