Argyll & Bute Health and Social Care Partnership Strategic Plan 2016/17 – 2018/19

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STRATEGIC PLAN FOREWORD

The vision of health and social care expressed by people in Argyll and Bute is that they want to lead long, healthy and independent lives supported by health and social care services when they need them.

The Health and Social Care Partnership will work within the six principles of integration which are that health and social care:

1. is integrated from the point of view of recipients
2. takes account of the particular needs of different recipients
3. takes account of the particular needs of recipients in different parts of the area in which the service is being provided
4. is planned and led locally in a way which is engaged with the community and local professionals
5. best anticipates needs and prevents them arising
6. makes the best use of the available facilities, people and other resource

Some of the challenges we face lie in our geography and demography and the difficult financial context we will have to operate in and apply. Many of us live in remote and rural areas, where local services are limited and we have to travel considerable distances for treatment and support. Our population is living longer, but declining in numbers, which means we will be facing greater demand for services, with a reduced budget to provide them. This population change is mirrored in our workforce who is also ageing and, we have difficulties in recruiting and attracting suitably experienced and skilled younger people to fill the expected vacancies in our health and social care services.

Continuing doing more of the same is no longer safe or a viable option, we have to change in the way we provide and access services. We need to release untapped resources in individuals, communities and in the Third and Independent sectors by taking an asset-based approach to the future.

The integration of health and social care provides us with an opportunity to change the way we get things done. It is a chance to put people at the heart of the process; focusing on the outcomes they want; by operating as a single health and social care team at locality level.

The fundamental transformational change required is facilitating the shift of our services and resources (workforce and money) to ones which prioritise anticipatory care, preventative measures and maintenance of health and wellbeing. This means spending less money on acute care, disinvesting and transferring this money to prevention and anticipatory care services in the community.

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This requires to be done in partnership with people, also taking more responsibility for their health and wellbeing by being supported and helped to make healthy life style choices, maintaining and improving their own health and wellbeing, as individuals and families.

Working together we can transform health and social care to achieve our joint vision for the future "**to lead long, healthy, independent lives".** This plan aims therefore to provide a road map on the actions we need to take to achieve this.

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Christina West
Chief Officer
Argyll & Bute Health & Social Care Partnership

1. EXECUTIVE SUMMARY

1.1 This is the first Argyll and Bute Health & Social Care Partnership (HSCP) Strategic Plan to be developed and is for a 3 year period to 2019. The Partnership has been established in accordance with the provisions of the Public Bodies (Joint Working) (Scotland) Act, 2014 and corresponding Regulations. The Partnership has responsibility for all health and social care functions relating to adults and children and will oversee the strategic planning and budgeting of these, together with corresponding service delivery for Argyll and Bute's residents.

1.2 The Argyll and Bute HSCP has been established as a separate legal entity from either The Council or the Health Board, with a new board of governance the Integration Joint Board. The Integration Joint Board comprises eight voting members appointed from Elected Members of the Council, and NHS Board members. In addition there are a number of other non- voting appointees, representing other sectors and stakeholder groups, such as the Third Sector, Independent Sector, Patients and Service Users, Carers and Staff. The arrangements for the operation, remit and governance of the Integration Joint Board are set out in the Integration Scheme (Partnership Agreement) which has been prepared and approved by Argyll and Bute Council and NHS Highland. They are provided for in an Order of the Scottish Parliament on the recommendation of Scottish Ministers.

1.3 The Integration Joint Board is responsible for all health and care services in Argyll and Bute; this includes the services, staff, and resources (budget of circa £250m). To undertake this responsibility the IJB will develop and approve this Strategic Plan once it has been finalised following our formal consultation.

1.4 NHS Highland and Argyll and Bute Council will then agree to delegate the functions and resources included within the Integration Scheme so that the IJB goes live from the 1st April 2016.

1.5 The Integration Joint Board has agreed the following Vision, Mission and Values for the Health and Social Care Partnership:

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1.6 Vision

People in Argyll and Bute will live longer, healthier, independent lives

1.7 Mission for Plan Period

Argyll and Bute Health and Social Care Partnership will work with you to improve health, support social care, tackle health inequalities, and improve community wellbeing. We will work in partnership with local communities to offer services that are:

- Easily understood.
- Accessible, timely and of a high quality
- Well-coordinated.
- Safe, compassionate and person-centred.
- Effective and efficient, providing best value.

1.8 Values

The following are the key values to which those employed or contracted by the Partnership, or who are stakeholders in it, will be expected to adhere:

- Person centred
- Integrity
- Engaged
- Caring
- Compassionate
- Respectful

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1.9 In this Plan period, and at this stage in its development, the Integration Joint Board has determined that the following seven areas of focus will drive its work:

- Promote healthy lifestyle choices and self-management of long term conditions
- Reduce the number of avoidable emergency admissions to hospital and minimise the time that people are delayed in hospital.
- Support people to live fulfilling lives in their own homes, for as long as possible.
- Support unpaid carers, to reduce the impact of their caring role on their own health and wellbeing.
- Institute a continuous quality improvement management process across the functions delegated to the Partnership.
- Support staff to continuously improve the information, support and care that they deliver.
- Efficiently and effectively manage all resources to deliver Best Value.

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These are reflected within its agreed Strategic Objectives designed to deliver the National Outcomes for Adults, Older People and Children are:

(A) We will work to reduce health inequalities.

(B) We plan and provide health and social care services in ways that keep people safe and protect them from harm.

(C) We will ensure children have the best possible start in life and plan services in a person-centred way that benefits the person receiving the service, so that they have a positive experience – right service, right place, and right time.

(D) We will plan for and deliver services in person-centred ways that enable and support people to look after and improve their own health and wellbeing.

(E) We will prioritise community based services, with a focus on anticipatory care and prevention to reduce preventable hospital admission or long term stay in a care setting.

(F) We will deliver services that are integrated from the perspective of the person receiving them and represent best value with a strong focus on the wellbeing of unpaid carers.

(G) We will establish “Locality Planning, Owning, Delivery” operational and management arrangements to respond to local needs.

(H) We will strengthen and develop our partnership with specialist health services with NHSGG&C and Community Planning Partners as well as with the Third and Independent sectors.

(I) We will sustain, refocus and develop our partnership workforce on anticipatory care and prevention.

(J) We will put in place a strategic and operational management system that is focused on continuous improvement, within a clear governance and accountability framework.

(K) We will underpin our arrangements by putting in place a clear, communication and engagement arrangements involving our staff, users, the public and stakeholders.

1.10 The Integration Joint Board has committed the Integrated Budget (amount to be defined when Argyll & Bute Council and NHS Highland have confirmed allocations) in 2016-17 a total of £ (amount to be defined when Argyll & Bute Council and NHS Highland have confirmed allocations) over the 3 years of the Plan to the delivery of these Strategic Objectives.

1.11 As functions, strategies, services and workforce are reviewed and integrated within Argyll and Bute, it is likely that the current pattern of spend will alter as the Partnership applies its Integration Planning Principles. This will see it take steps, along with the two Statutory Partners and other sectors, to shift the balance of care from institutional to community settings. The total figures shown include the cost of Acute Hospital Services provided by NHS Greater Glasgow and Clyde as these are within the scope of the Partnership for Strategic Planning purposes.

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2 INTRODUCTION AND BACKGROUND INFORMATION

2.1 Introduction

2.1.1 The Public Bodies (Joint Working) (Scotland) Act[1], came in to effect on 2 April 2014. The purpose of the Act is to provide a framework that supports improvements in the quality, efficiency and consistency of health and social care services, through the integration of NHS and Local Authority community based services in Scotland. This is in line with the Scottish Government's key goal "to focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth".

2.1.2 The main purpose of Integration is 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.

2.1.3 Additionally, the integration of health and social care services, aims to:

- improve the quality and consistency of services for patients, carers, service users and their families;
- provide seamless, joined up, high quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with longer term and often complex needs.[2]

2.1.4 NHS Highland and Argyll and Bute Council have agreed an Integration Scheme (Partnership Agreement) that enabled the establishment of the Integration Joint Board. A body corporate (a separate legal entity), acting independently of the Health Board and the Council, the Integration Joint Board is tasked with delivering the purpose behind the legislation in Argyll and Bute. The Board comprising of eight voting members appointed in equal numbers by the Health Board and the Local Authority, with a number of representative members also serving who are drawn from patients/service users, carers, staff, the Third Sector and Independent Sector – is advised by a number of professionals, including the Chief Officer, Clinical Director, Lead Nurse and the Chief Social Work Officer as well as other professionals.

[1] Public Bodies (Joint Working) (Scotland) Act 2014, Scottish Parliament 2014
http://www.scottish.parliament.uk/S4 Acts/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Act/b32bs4-aspassed.pdf

[2] Consultation on the Draft Regulations relating to the Public Bodies (Joint Working) (Scotland) Act 2014 (Set 1 of 2) Scottish Government May 2014
http://www.scotland.gov.uk/Publications/2014/05/5284/2

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2.1.5 As specified in the Regulations made under the terms of the legislation, the Health Board and Council has delegated Children's Community Health Services and Children and Families Social Work Services, along with Criminal Justice Social Work Services and Community Health and Social Care functions for adults and older people to the Integration Joint Board. A full list of the functions and services delegated to the Integration Joint Board is included at Appendix 4.

2.1.6 The key functions of the Integration Joint Board are to:

- Prepare a Strategic Plan for Integrated Functions that is in accordance with National and Local Outcomes and Integration Principles.
- Allocate the Integrated Budget in accordance with the Strategic Plan.
- Be accountable for the delivery and performance of services within the scope of the Partnership.

2.1.7 This Strategic Plan is the first to be produced by the new Partnership and will be approved by the Integration Joint Board following a three month period of formal consultation on this plan. It contains a three-year strategic planning framework which sets out priorities for the new Partnership and how it will use its resources to integrate and deliver services in pursuit of National and Local Outcomes.

2.1.8 All Acute hospital-based services are within the scope of the Strategic Plan, as these are central to one of the primary objectives of Integration, which is to shift the balance of care from a hospital or institutional setting to the community. These acute services are:

- Unplanned inpatient admissions - (medical care for the treatment of urgent or emergency conditions that require an emergency admission to hospital).
- Accident and Emergency services - (services provided within a hospital for the treatment of urgent or emergency conditions).

2.1.9 Future versions of this Strategic Plan will set out how the Partnership intends to commission services to meet local needs in a way that is compliant with the Principles of Integration and ensures progress in terms of National and Local Outcomes. Details of current commissioning arrangements are provided in Appendix 10.

2.1.10 At the heart of this approach to strategic planning will be the provision of services and support across the sectors in a way that meets the needs of particular individuals, communities and localities. The HSCP is clear that to achieve this, Localities must plan, own and deliver services within a performance and accountability framework. A Locality Planning framework, which is described in Section 6 of this Plan, has been developed by the Partnership. Locality Needs Assessment Profiles have been developed and a link to these can be found at www.healthytogetherargyllandbute.org.uk/ see Appendix 5.

2.1.11 The Strategic Planning process is outlined in Appendix 2.

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3. SUMMARY OF NATIONAL AND LOCAL CONTEXT, AND POLICY PRIORITIES

3.1 Why change is necessary?

3.1.1 This section looks at the main issues facing us in Argyll and Bute now. We recognise that the way we provide care needs to change in order to meet both current and future demand. Health and care services as they are now will not be able to deliver the high quality service we expect. It may not be possible to fund them or recruit enough staff to sustain them.

There are a number of reasons why we need to change, which include:

- To keep people healthy and independent
- To deliver better services and improve patient and care outcomes
- To give our children and young people the best possible start in life
- To continuously improve the quality of services – faster, responsive services
- To make sure that services are cost effective and sustainable – not dependant on locums or temporary staff
- To make jobs and professions in health and social care desirable, so that we address recruitment problems
- To recruit the right staff to vacant posts
- To make best use of our workforce in terms of their capacity and capability
- To meet the likely rise in demand for services, as the overall population of Argyll & Bute ages
- To meet plans for economic growth and help reverse the trend of a falling population in Argyll & Bute
- To show we have listened to people who have said they only want to tell their health and care story once when undergoing care or treatment.
- To put in place what people have said they want; a single point of access to health and care and to stay in their homes and communities as far as is practicable
- To support our new service models with modern buildings that are occupied and used to their full extent, with no wasted space, no duplication in function and with flexibility evidenced by all partners being able to use them if appropriate.
- To provide services with, in real terms, a reducing budget over the next 3 years
- To agree new ways of locally planning, owning and delivering services, by devolving budgets, accountability, responsibility and decision making to localities within a performance management framework.

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3.1.2 Whilst demographic changes present significant challenges to public sector organisations, it should be noted that the demand associated with the ageing population should be considered positively. Older people are living longer and wishing to remain economically active and be valued. This should be celebrated and their continuing contribution to life in Argyll and Bute is recognised and welcomed.

3.1.3 A lot of our current provision is based on historical service design, focused on buildings and dating back to a time when treatment and services were often provided on an emergency and in-patient basis in which people went into hospital and stayed there for longer, for treatments that we now consider routine and quick.

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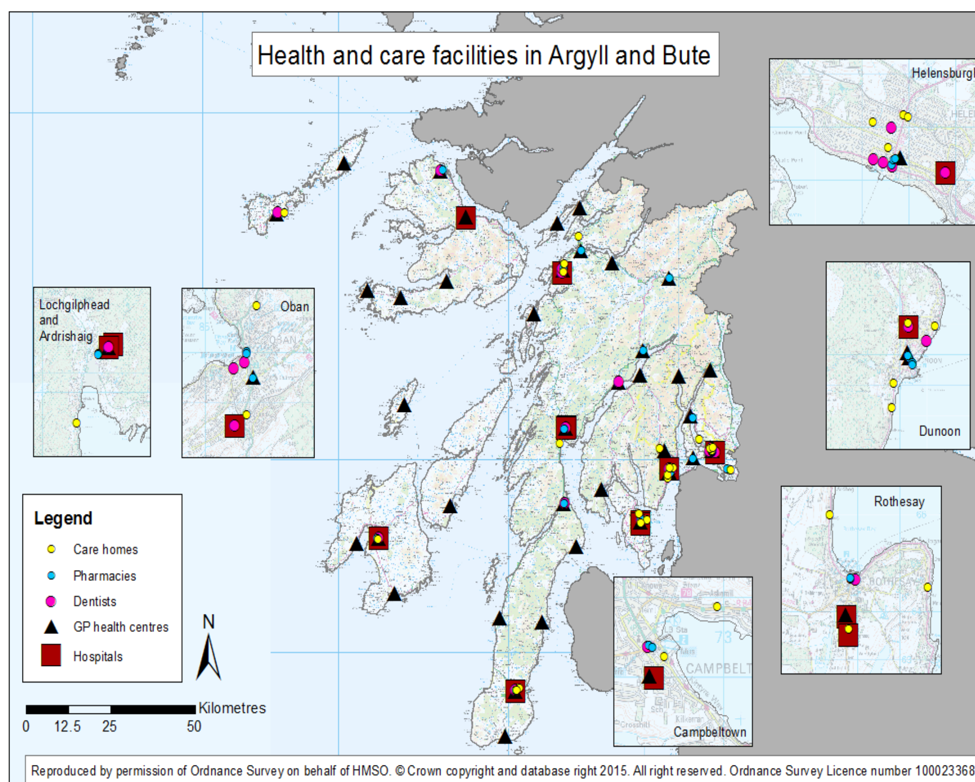
3.1.4 Better medication, new treatments, greater knowledge of health improvement and prevention of ill health have reduced the need for emergency response and in-patient treatment, aided by the ability of a range of health and care professionals to offer support in the person's own home.

3.1.5 Technology has changed things too, as people learn how to manage long-term conditions and use technology so professionals can remotely monitor their well-being. This saves many lengthy journeys and worrying appointments. Technology Enabled Care provides valuable assistance to many people, either using telehealth homepods to monitor long-term conditions; or using a range of Technology Enabled Care devices to increase their safety and confidence in their own homes by readily linking them with family, care workers and the emergency services. Living it Up *https://portal.**livingitup**.org.uk/* is a national initiative using innovative technology to help people stay connected and avoid isolation even if they live in remote places.

3.1.6 Personal expectations have changed in the years since the NHS was established in 1948. Many people live with less extended family support, either alone or as a single parent, leading people to increasingly rely upon support from health and social care services. See weblink: Health Promoting Health Service: Action in Hospital Settings http://www.sehd.scot.nhs.uk/mels/CEL2012_01.pdf

3.1.7 Our geography of scattered communities in remote and rural areas and islands presents a challenge to and an increase in the cost of, service delivery. However, more people are being enabled to monitor and manage their own conditions (with support from doctors and specialist nurses) to reduce the number of incidents when they become unwell.

The map shows the distribution of health and care facilities across Argyll and Bute (Note only independent pharmacies are shown).

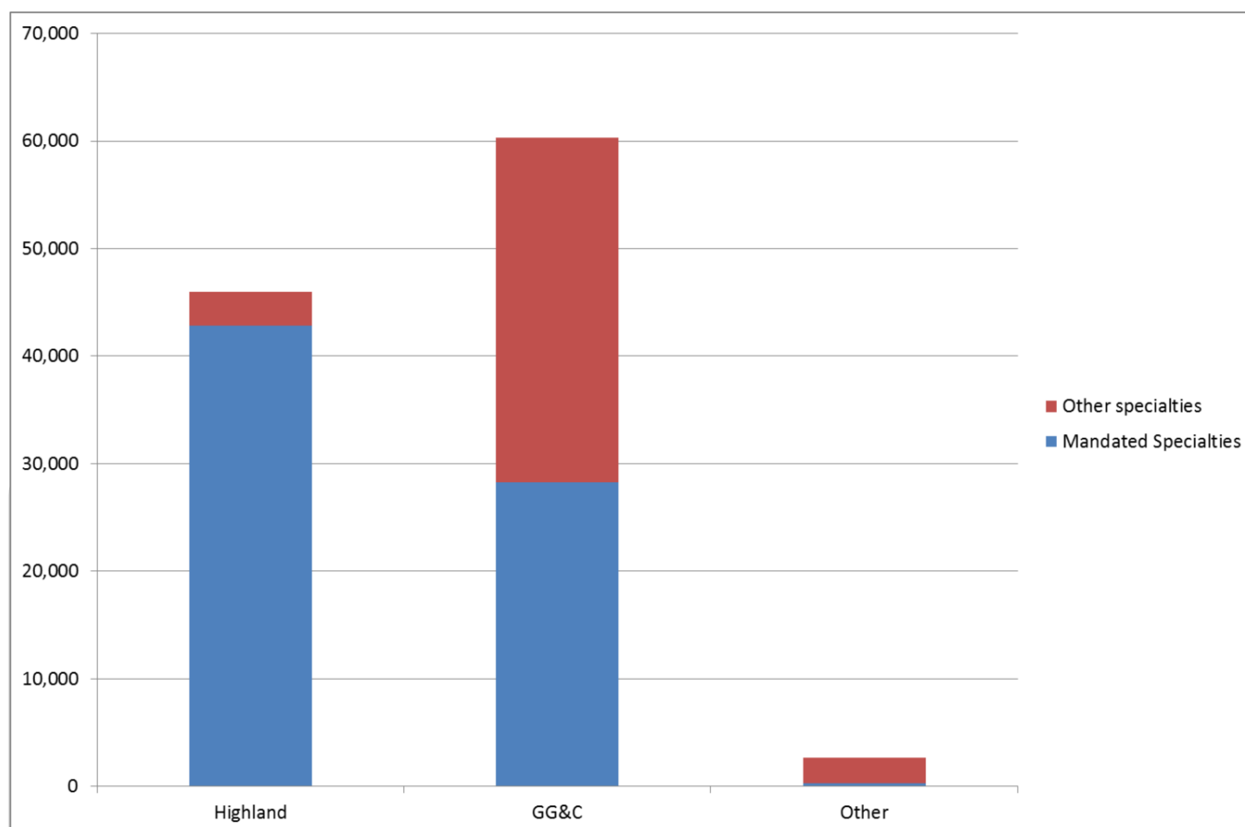


3.1.8 Much of our acute in-patient care is provided in the large acute hospitals in Inverclyde, Paisley and Glasgow, this is not a free service to Argyll & Bute as it costs circa £45 million per annum, although of course it is free to patients who require it.

.

The chart below, Figure 1, shows how much of our acute care is provided in NHS Greater Glasgow and Clyde (NHS GG&C), 55% with 42% being provided in Argyll and Bute hospitals (the measure is hospital bed-days used).

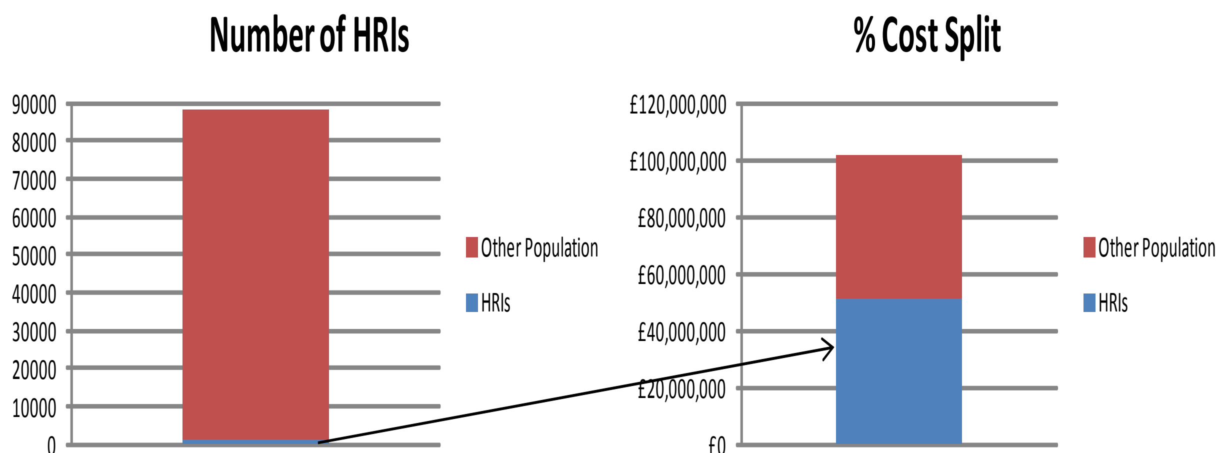
Fig1 – Graphical representation of hospital occupied bed days Argyll and Bute and NHS GG&C



Source: Argyll & Bute Health & Social Care Partnership - High Resource Individuals Analysis Nov 2015

The chart below, Figure 2, is initial analysis of linked individual level data which shows that in 2012/13 less then 2% of people used 50% of hospital and prescribing expenditure. Of that 50% of expenditure, 73% of the total is the cost of unplanned hospital admissions equalling approximately £36 million.

Fig 2 – Measure of the proportion of the population classed as High Resource Individuals from Argyll and Bute



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Source: Argyll & Bute Health & Social Care Partnership – ISD High Resource Individuals Analysis report Nov 2015

•Under 2% (1,1612) of the population account for use of 50% of resources
•Total Expenditure on HRIs in 2013/14 was £50,995,270
•The average cost of an HRI is £31,634 (variance min £11,929– max £405,545).

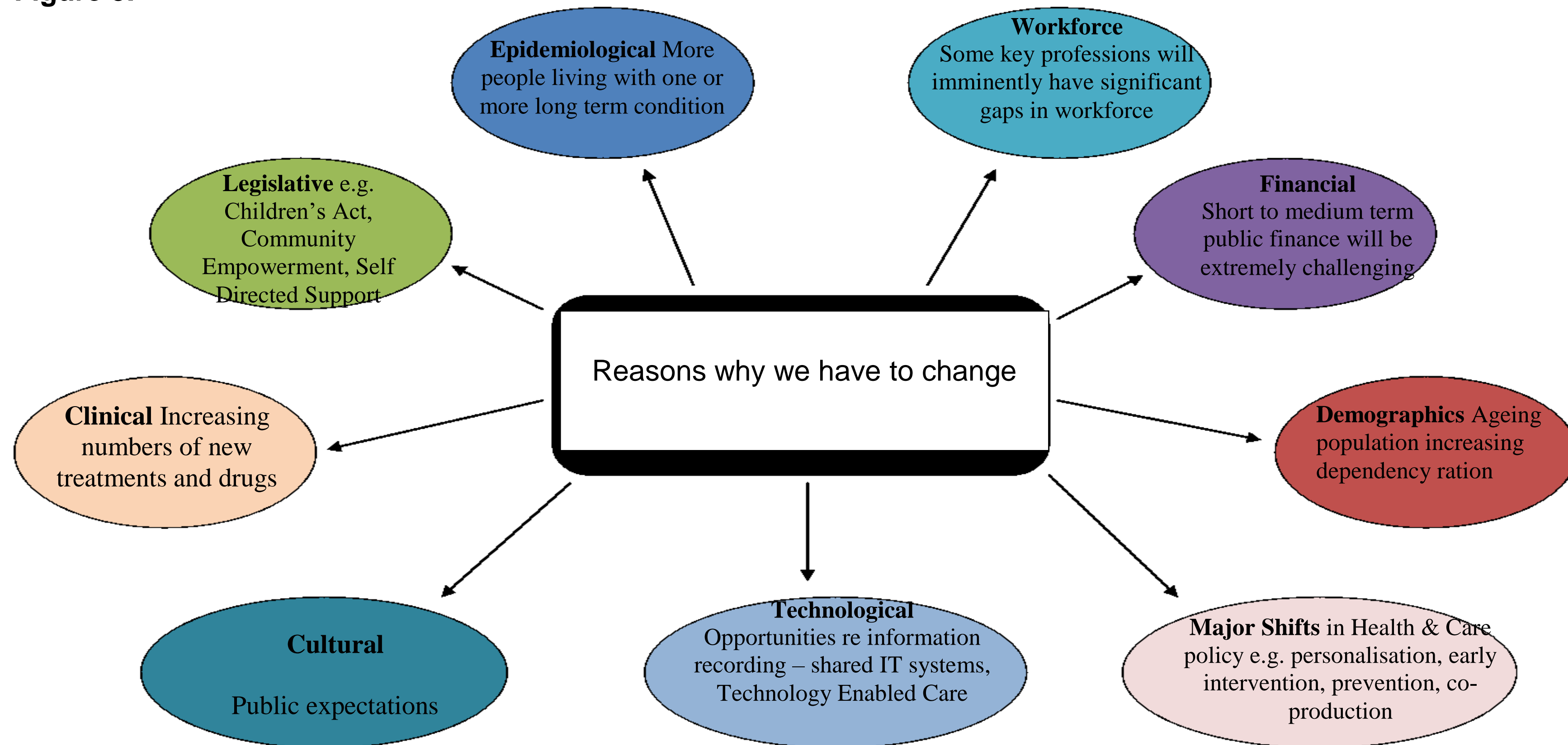
If we can prevent 20% of these acute unplanned admissions then we could redirect **£7.3m** into community and preventative services

Of course people need to go to hospital if they have an accident or a serious illness, but by reducing the number and frequency of admissions and re-admissions that relate to long term conditions, age and frailty for example, we could free up resources to use in other parts of health and social care. At the same time the quality of life that people enjoy would be enhanced. There are a number of key elements that will bring about this change:

- Better understanding of long-term conditions
- Better self management (with professional support)
- More anticipatory and preventative care
- Use of Technology Enabled Care
- Healthier lifestyle choices

3.1.9 All these factors when they are brought together provide an irresistable pressue for change. The figure below summarises these issues and this has led us to conclude why doing the same, will not be sufficient to meet future needs over the next 3 years.

Figure 3.



3.1.10 Among the challenges set out in the diagram, the increased demand linked to constraints on ***public service finances*** and ***changing demographics*** remain our dominant challenges.

For example:

- It is estimated that between 2010 and 2035 the population of Argyll & Bute will decrease by 7% overall. The number of working age adults will decrease by 14%, whilst the number of people aged 75+ will increase by 74% *(data source NRS).*
- Many older people will live in single occupancy households.
- Many older people will not have extended families that live locally.
- Many of these older people will live healthy, active lives, contributing to Argyll & Bute in many ways, but a significant percentage will live with a range of health conditions (often many at the same time, sometimes called multi-morbidity) and will require substantial health and social care support.

http://healthyargyllandbute.co.uk/wp-content/uploads/2013/03/Joint-Health-Improvement-Plan-2013.pdf

3.1.11 Another example of challenge is in relation to children living in Argyll & Bute:

- 19.24% of children in Argyll & Bute are living in poverty, calculated as the family having an income of less than £204 per week, after housing costs.
- While the numbers of looked after and accommodated children remain relatively stable, the complexity of the issues that children and young people face – such as parental substance misuse, parental mental health and domestic violence – has intensified.
- In 2014/15 there were 156 looked after accommodated children in Argyll and Bute.

3.1.12 The following Figure[4] shows the extremely challenging short to medium term public service funding situation and the projected financial context for the public sector for the next 15 years. This shows an anticipated gap in funding for public services if no changes are made.

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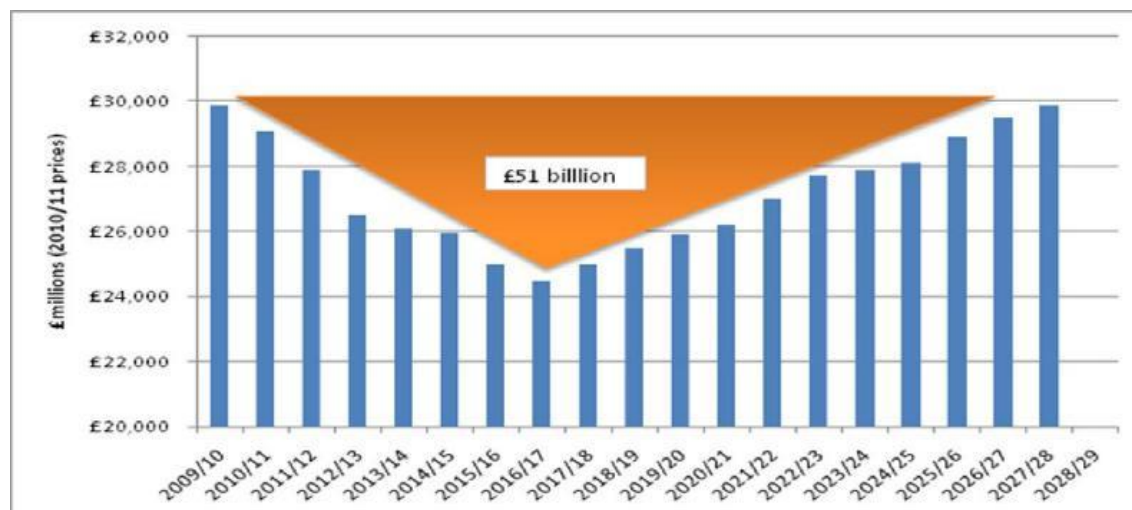
Figure 4 : Medium Term Outlook for Scottish DEL – Autumn Statement 2011 illustrative Projections



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Source - office of the Chief Economic Advisor Scottish Government April 2010
http://www.scotland.gov.uk/Resource/Doc/918/0101183.pdf

[5] Outlook for Scottish Government Expenditure http://www.scotland.gov.uk/Resource/0042/00421327.pdf

Doing the same things we have always done is no longer sustainable in service delivery and quality terms nor is it affordable.

These real terms cuts in funding for Health and Social Care in Argyll and Bute are being faced now and so we have to plan for these reductions in our strategic plan i.e.

- Argyll and Bute Council's overall savings targets will be around £9 million in both 2016/17 and 2017/18 with further savings in future years.
- NHS Highland's saving targets for Argyll and Bute are likely to be between 2-3% (£3.6- £5.4 million) each year

Within this challenging context Argyll and Bute Health and Social Care Partnership will need to maximise its efficient and effective use of resources (workforce, buildings and money), ensuring best value by taking action in the following areas:

- Workforce planning and deployment
- Partnership working
- Implementing a continuous improvement management system and culture
- Prioritise service investment/disinvest aligned with objectives

3.1.13 Workforce

We need to make sure that we have single integrated health and care teams who are working to their full capability and capacity operating in an efficient and effective way, i.e.

- Mobile and agile working- not wasting time having to travel back to offices to get records or equipment
- Focus on continuous quality improvement – ensuring everything we do meets patient/client needs and reduces the burden of work on our workforce
- Reduce waste, duplication of effort, under- utilisation of equipment, staff etc. waiting times, over stocking and reduce errors and mistakes
- Utilising new technology, rationalise and put in place single point of contact customer services in health and support service operation e.g. ring one Golden Number for your health appointment or book it on line.

- Develop a workforce fit for purpose for the medium to long term by:
    - Quantifying the staff group in terms of number of staff, turnover, capacity and skills base.
    - Predicting future service demands and related workforce capability and capacity needs
    - Developing training plans and programmes to ensure our workforce has the right skills to provide our core services
    - Proactively managing and supporting our workforce in partnership with trade unions to ensure our workforce remains fit and healthy, minimising sickness and absence and offering development and career opportunities.
    - Reducing our dependence on expensive locum and agency staff by reviewing and redesigning our workforce to meet service need in partnership with trade unions
    - Working with Community Planning and other partners to develop an appropriate workforce plan for the medium to long term.

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3.1.14 **Partnership Working**

- Focus, increase and strengthen partnership working with our Independent and Third sector partners (Carers Network, Third Sector Interface, Alzheimer Scotland and other Third Sector organisations) and service users and carers, who are better placed to meet need and demand. We will look to enable change in the nature and types of services by:

    - Developing additional and more extensive self-management programmes.
    - Prioritising investment in more preventative, early intervention and anticipatory interventions.
    - Using new health and care technologies as the norm helping users meet their health and care monitoring needs in a safe, responsive and effective way.

- Ensuring we are providing person centred care and outcomes, NOT disease specific treatments or support. So we have service approaches which recognise that increasing numbers of people will live with two or more long-term conditions (multi-morbidity).
- Developing flexible locally-based access to a range of information supports and activities for people from different care groups.

3.1.15 New Management system and Culture

- Implement an organisational development programme to deliver the continuous quality improvement management system and culture in the HSCP over the next 3 years:
  - Leadership programmes in change management.
  - Implementing a continuous quality improvement management system i.e. Highland Quality Approach by training and developing our clinical leadership and all management posts to conduct and apply the system
- Put in place a comprehensive Communication, Involvement and Engagement Plan including staff, user and public engagement and involvement arrangements at locality level
  - Ensuring community and stakeholder involvement and engagement
  - Ensuring feedback and information is utilised to support service change and performance and informs service planning

3.1.16 Service Investment/disinvestment

- Utilise appropriate evidence and decision-making tools to inform service prioritisation and disinvestment aligned with strategic objectives such as
  - Joint Strategic Needs Assessment
  - Programme Budgeting Marginal Analysis (PBMA)
  - Option Appraisal
  - PDSA cycle
  - Continuous Quality Improvement metrics

3.1.17 A National Clinical Strategy for Scotland

The newly published national strategy found at www.gov.scot/Publications/2016/02/8699 sets out a framework for the development of health services for the next 15 years. It provides a high level perspective of why change is necessary and the direction for change that will enable the NHS to adapt to changing circumstances.

The National Clinical Strategy is confined to the delivery of health care services to meet assessed need and challenges us to meet the aim of providing a world class health service for the future, whilst echoing the many challenges outlines in this Strategic Plan – an ageing population; increasing demand for services over the next 15 years, linked to long-term conditions such as diabetes, hypertension, cancer, sensory impairment, dementia and impairment of mobility.

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It also recognises staffing challenges, as many experienced staff members will retire in the course of the next 10 years. One of the biggest challenges is to recruit medical staff in general practice and hospital doctors.

Whilst recognising the financial constraints, the National Clinical Strategy has a focus on a continuous drive to deliver services of the highest quality and value.

There is a need for a new clinical paradigm to ensure that healthcare delivery is proportionate and relevant to individual patient's needs and uses minimally disruptive interventions wherever possible.

In summary the National Clinical Strategy sets out the case for:

- Planning and delivery of primary care services around individuals and their communities
- Planning hospital networks at national, regional or local levels based on the population paradigm
- Providing high value, proportionate, effective and sustainable healthcare
- Transformational change supported by investment in e-health and technological advances.

3.2 Where are we now?

3.2.1 Our Outline Strategic plan and this draft of our formal Health and Social Care Partnership Strategic Plan have been built on a significant amount of work already undertaken jointly between Argyll & Bute Council, NHS Highland and other Partners. This has been focused on improving health and social care, over the last 5 years including, for example, Reshaping Care for Older People programme and actions and the Integrated Children and Young People's Service Plan 2014 – 2017:

The following sections capture the priorities and progress we have made in changing and transforming services and help inform our direction of travel over the next 3 years.

3.2.2 **Older People**

Reshaping Care for Older People, contacted a high number of older people throughout the 3 year project period. This includes carrying out a survey, with 549 respondents, and feedback on our strategic plan consultation who told us they want:

- Better access to health services (more local)
- Better care in the community (homecare)
    - Quality of service via training and workforce development
    - SDS and length of home care visits

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- More social activity
- Early intervention and prevention (keeping fit and healthy)
- More joint working and communication

Service priorities for older people have been identified in the Social Work Plan as:

- Provision of Care at Home, particularly in extra care housing complexes
- Provision of carers respite services
- Support for carers
- Specialist Dementia Services
- Technology Enabled Care and equipment
- Expansion of Night Care and Out of Hours Services including Extra Care Housing Developments

3.2.3 Progress has been made towards realising these needs (personal outcomes) over the last five years. We have:

- Moved services to community settings, including some within the home.
- Implemented a comprehensive programme of falls prevention and rapid reablement following hospital admission
- Moved to a 'reablement' approach that supports the older person's ability to remain independent and carry out much of their own care and support.
- Moved towards more personalised services where people's personal 'goals' are pre-eminent in the planning process.
- Made significant progress in our use of technology to improve people's health and social care.
- Begun to recognise more fully the pivotal role that unpaid carers play, and through partnership support and led by the carers support network develop more comprehensive services to support them e.g. the Carers Centres.
- Continuously review care at home, in and out-of-hours, both strategically and at Locality level.

3.2.4 **Mental Health - Adults**

Mental health is defined by the World Health organisation as:

'….a state of wellbeing whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully and make a contribution to their communities. Being mentally healthy at any age means having reasonable self-esteem and social relationships and the ability to master or adapt to difficult challenges. It is not same as the absence of a diagnosable mental illness.'

Strategic Priorities have been identified to support both wider Adult Mental Health and Wellbeing together with supporting those with particular mental health conditions. These include:

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- Meet the increased demand for the provision of support for mental health clients within community setting
- Ensure we have a range of appropriate accommodation options for mental health service users, with different levels of severity and degree of difficulty, and varying care and support needs.

The Mental Health (Care and Treatment) (Scotland) Act 2003, which is currently under review, is applied to people defined in the Act as having a mental disorder, specifically:

- People affected by mental illness
- People with a personality disorder
- People with a learning disability.

National statistics suggest that 1 in 4 adults in Scotland will experience some form of mental health problem during adult life, but not all will require measures under the Act.

NHS Highland and Argyll & Bute Council jointly produced a Strategic Framework for Mental Wellbeing in Argyll & Bute 2012-2014. This will be updated when the national legislative review is complete.

http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/Mental%20Health%20Services/Strategic%20Framework%20for%20Mental%20Wellbeing%20FINAL%20May%202012[1].pdf

The strategy focused on 6 key themes:

- Mentally healthy children and young people
- Mentally healthy later life
- Mentally healthy communities
- Mentally healthy employment and working lives
- Reducing suicide and self-harm
- Improving the lives of those experiencing common mental health problems

Within Argyll and Bute significant progress has been made in reshaping and redesigning our mental health service including:

- Community focused with the balance of resource and service provision transferring to localities
- Reshaping and redesigning our acute in-patient service aligned with our plans for new fit for purpose hospital building
- Investing and developing in partnership with 3rd sector providers dementia services, including diagnostic, assessment and treatment and support services
- Establishing an acute mental health local transfer and retrieval service, alongside place of safety provision in our community hospitals

- Co-location of health and social work teams has supported integrated services and needs

During the consultation on this strategic plan people across Argyll & Bute expressed a need for improved mental health services, both for adults and children/adolescents. This is a priority that will be considered both strategically and within the Locality Planning process, being reviewed at Locality level on a continuous basis.

3.2.5 **Learning Disability**

'*People with a learning disability have a significant, lifelong condition that started before adulthood, which affected their development and which means they need help to:*

- Understand information
- Learn skills
- Cope Independently

The Scottish Government Keys to Life 2013

'Keys to Life' is a 10 year national strategy aimed at improving life for people with learning disabilities. The strategy follows on from 'Same as You'. The Keys to Life Strategy has at its heart the human rights of people with a learning disability. It is integral to the Healthcare.

Quality Strategy for NHS Scotland.
The Strategy recognises that what is needed now is a cultural shift, true participation in our society by people with a learning disability and empowerment to make this happen. 'Keys to Life' aims to make this happen.

The focus is a shift to rights, based on the individual's ability and opportunities. This will require all those involved to work together in partnership with the individual, to achieve his or her desired outcomes.

The original strategy has been followed by an implementation framework and priorities:
http://keystolife.info/wp-content/uploads/2015/06/The-Keys-to-Life-Implementation-Framework-and-Priorities.pdf

The principle of the 2015 – 2017 framework and priorities are captured in 4 strategic Outcomes (Partnership)

A Healthy life:
We will aim to reduce health inequalities, as people with learning disabilities currently have a life expectancy 20 years shorter than someone without a learning disability. People with learning disability should be able to enjoy a higher standard of living as a result of having their income maximised, having full health assessments and equal access to all health services. We will actively promote the right to family life.

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The Health Equalities Framework (HEF) is a systematic, evidenced based outcomes framework which was developed by four members of the UK LDCNN. It measures the extent to which services are delivered to reduce the impact of service users' exposure to determinants of health inequalities. Exposure to these determinants is known to be associated with premature, avoidable deaths and grossly impoverished quality of life. All four countries are supporting the implementation of this framework. Learning Disability Nurses have been involved in large scale pilots across Scotland and it has now been recommended that it is rolled out to all health board areas.

Choice and control:
People with learning disabilities are treated with dignity and respect and protected from neglect, exploitation and abuse. Integral to this is the need to ensure that there is choice and participation in how support is delivered

Independence:
People with learning disabilities are able to live independently in the community with equal access to all aspects and resources available within their communities in Argyll and Bute.

Active citizenship:
People with learning disabilities are able to participate in all aspects of community and society. We will actively promote access routes to further education and employment.

In terms of prevalence, there are approximately 16,000 school age children and young people who have a learning disability, whilst 26,000 adults in Scotland are known to have a learning disability and require support. It is recognised that there will be a number of people who, whilst having a degree of learning disability, are not in receipt of formal support.

Within Argyll and Bute Strategic Priorities for Adults with Learning Disabilities are:

- Providing community based support to people with a learning disability through individualised person centred supports and developmental work promoting independent living and independence, supporting people with complex and challenging behaviours and those who have a physical disability or sensory impairment.

- Implementing the Heath Equalities Framework into Community Learning Disability Nursing practice alongside Health Assessments.

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- Ensuring that a comprehensive range of specialist providers for community based services such as supported living is available and that these specialist providers meet the needs of our clients by training their staff in learning disabilities and the associated needs and conditions.

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- Promotion of Adult Support and Protection Policies and Procedures ensuring appropriateness and accessibility for adults with a Learning Disability

- Integrated housing solutions and increased choices for clients with varying care needs in order that people can access shared support and utilise SMART Technologies to increase independence and allow people to live safely in their communities.

- Residential care services for those clients over 65 years old should be able to meet the additional needs of people also affected by Learning Disability.

- Aiming to reduce the number of residential or specialist placements Out of Area, by developing specialist resources and working in partnership with providers within Argyll & Bute.

- Self-Directed Support to be embedded into the assessment and review process to give people realistic choices and options.

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3.2.6 **Autism**

Argyll & Bute Council commissioned Scottish Autism to produce a local Autism Stratgey in 2014, it is based on the Scottish National Strategy for Autism. Autism is complex, and the issues it generates for people on the autism spectrum are often dictated by other co-existing or co-morbid conditions which can include learning disability, anxiety, depression, psychosis, OCD, dyslexia, dyspraxia, ADHD, Tourette's Syndrome, vision and other sensory issues and epilepsy.

Many individuals on the autism spectrum wish to assert themselves as neurologically diverse, as having a different way of being in, perceiving and engaging with the world and those with whom they share it. Such individuals would consider that being on the autism spectrum does not necessarily equate with impairment but can give rise to a unique world view, assets and skills. Others face significant challenges in their daily lives and are in need of high levels of service, tailored to their individual needs.

The strategic vision for people on the autism spectrum is:

'That individuals on the autism spectrum are respected accepted and valued by their communities and have confidence in services to treat them fairly so that they are able to have meaningful and satisfying lives.'

Specific local priorities were identified:

- Education – more training, awareness, better provision for specialist and mainstream education
- Better support to carers and families
- More and better service provision
- A Lead Professional with health and social care experience who would work at planning level
- On-going multi-agency working around national developments with lessons for local processes clearly planned, implemented and reviewed
- Increased knowledge at senior manager/commissioner levels
- A clear point of contact for carers and people on the autism spectrum, to provide information and signposting

Priorities for the life of the strategy are:

Foundation

2016	Access to mainstream services where these are appropriate to meet needs
2016	Access to services which understand and are able to meet the needs of people specifically related to their autism
2016	Removal of short term barriers such as unaddressed diagnoses and delayed intervention
2016	Access to appropriate post-diagnostic support for families and individuals
2016	Implementation of existing commissioning guidelines by local authorities, the NHS and other relevant providers

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Whole life journey

2019	Access to integrated service provision across lifespan to address the multi-dimensional aspects of autism
2019	Access to appropriate transition planning across the lifespan
2019	Consistent adoption of good practice guidance in key areas of education, health and social care across Argyll & Bute
2019	Capacity and awareness building in mainstream services to ensure people are met with recognition and understanding of autism

Holistic personalised approaches

2024	Meaningful partnership between central and local government and the independent sector
2024	Creative and collaborative use of service budgets to meet individual need
2024	Access to appropriate assessment of needs throughout life
2024	Access to consistent level of appropriate support across the lifespan into older age

www.argyll-bute.gov.uk/argyll-and-bute-strategy-autism

3.2.7 **Physical Disabilities**

The World Health Organization Disabilities (2011), define physical disability as:

'any impairment which limits the function of limbs or fine or gross motor ability. Other physical disabilities include impairments which limit other facets of daily living.'

Physical disabilities can be present from birth or acquired as a result of illness or injury Because of the diverse range of causes and effects there is no single specific service provision. All mainstream statutory and independent sector and voluntary agencies provide a range of services, support and information, based on individual need, which may include:

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- Specialist nurses who offer the most up to date knowledge relating to the cause of the disability e.g. stroke nurse, a nurse specialist in Multiple Sclerosis and Parkinson's disease.
- Adults and children will be supported by a Registered Social Worker, who will assess their unique needs and assist them to access a suitable package of support.
- Occupational Therapists are a group of professionals who can assess physical capabilities and recommend equipment and adaptations to assist in daily life. For some people exercises and treatment provided by Physiotherapists can also be useful.

More general assistance that may be available to people with physical disabilities might include:

- Travel card (bus pass) allowing free travel across Scotland. People who need a companion to travel with them can apply for a card with companion entitlement, which allows the companion to also travel free
- A 'Blue Badge' parking permit
- A designated street parking space outside of the person's home
- Grants for adaptations to the person's own home
- Adaptations to social housing
- Council tax exemptions

Within the Third Sector there are many organisations specific to the cause of the physical disability, all of whom offer advice and support and in some cases additional services to people who meet their criteria. For example:

- Arthritis Care Scotland takecontrol@arthritiscare.org.uk
- Multiple Sclerosis Society UK www.mstherapycentres.org.uk/centre-lochgilphead.htm
- Motor Neurone Disease www.mndscotland.our.uk

3.2.8 **Sensory Impairment**

Sensory impairment is defined in the See Hear Strategic Framework (2013) for meeting the needs of people with sensory impairment in Scotland http://www.gov.scot/Resource/0041/00417992.pdf as:

'Sensory impairment covers people living with a range of impairments. It includes people with varying degrees of hearing loss, sight loss and also with loss of both senses. Both hearing and sight loss can be present from birth, but for the majority of people a sensory loss will occur later in life, and the longer a person lives the more likely they are to develop either or both losses.'

In terms of prevalence, it is estimated that 850,000 people in Scotland have a hearing loss, 1 in 6 of the population; 180,000 people have sight loss, 1 in 30 of the population. Deafblind Scotland estimates that some 5,000 people have significant hearing and sight loss. These sensory losses can be present from birth, but all increase in likelihood as part of the ageing process.

The priorities outlined in the Social Work Plan are:

- To continue to deliver a quality service for people requiring Talking Books.
- To provide specialist services on a 'one off' basis as required from legitimate providers including the local authority Sensory Impairment Team.
- To develop support services in partnership with the Voluntary and Independent sectors to address the need for
  - Sighted Guiding
  - Note taking
  - Interpretation
  - Volunteers and Staff to deliver training in these skills

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The See Hear strategic framework has 6 recommendations that need to be considered by Argyll & Bute Health and Social Care Partnership within its strategic and locality planning process:

1. An audit of all current spend on sensory impairment, including that relating to carers, across statutory health and social care and third sector agencies, in relation to specialist services and also to those elements of other services that impact on people with sensory impairment.
   In light of the findings consideration should be given to options for realignment of spend as appropriate.
2. Local partnerships should consider options for the introduction of basic sensory screening, for example, for people of a certain age, and at agreed times in their care pathway.
3. There should be mandatory training in sensory awareness and assessing non - complex needs across staff in health and social care settings, targeted in the first instance at older people's services
4. Local partnerships should be able to evidence that their service planning reflects needs in their area. They should develop care pathways for people with sensory impairments which confirm the component parts of the individual's journey. In doing so they should assess performance against the care pathway and key factors for effective pathways…… and use this as the basis for service improvement, and identify relevant responsibilities across agencies for delivery of this. Accessible local information strategies should be developed to include preventative measures and good self- care in retaining sensory health, but also providing information on how to access services.
5. There should be a robust system for maintaining information locally, and sharing this between agencies in relation to people who have received a diagnosis of a sensory impairment from birth onwards (*would this perhaps be through continuation of in-house Sensory Impairment Service who currently maintains the Registered Blind/Visually Impaired/Hearing Impaired register)*
6. Compliance with the Equality Act 2010 should be scrutinised in relation to sensory impairment and any review of existing service, particularly in relation to communications, and consideration given to what future actions may be required

3.2.9 **Dementia**

Dementia is an umbrella term used to describe various different brain disorders that have in common a loss of brain function that is usually progressive and eventually severe. There are many types of dementia. The most common are Alzheimer's disease, vascular dementia and dementia with Lewy bodies. There are other less common forms of dementia. Although dementia is commonly associated with older age, there are types of dementia that can affect people as young their 20s or 30s.

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Approximately 90,000 people have dementia in Scotland in 2015; around 3,200 of these are people under the age of 65. In Argyll & Bute 1,941 people have been diagnosed with dementia, of those 57 are people under the age of 65. *(Source, Alzheimer Scotland)* http://www.alzscot.org/information_and_resources/about_dementia

Within Argyll and Bute we have developed a Dementia Friendly Argyll and Bute strategy that reflects the key outcomes of Scotland's National Dementia Strategy 2013 – 2016, http://www.gov.scot/Topics/Health/Services/Mental-Health/Dementia/DementiaStrategy1316 the second strategy to be developed in Scotland.

The strategy identifies 7 key outcomes:

- More people with dementia living a good life at home for longer
- Dementia-enable and dementia-friendly local communities that contribute to a greater awareness of dementia and therefore help reduce the stigma of dementia
- Timely, accurate diagnosis of dementia
- Better post-diagnostic support for people with dementia and their families
- Increased involvement from dementia sufferers, their carers and their families in the provision of their care
- Better respect and promotion of rights in all settings, together with improved compliance with the legal requirements in respect of treatment
- People with dementia in hospitals or other institutional settings always being treated with respect and dignity
- The Dementia Friendly Argyll and Bute Strategy and Action Plan lay out the future direction of travel with a primary aim to embed awareness of living well with dementia, across our local services & communities.

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The Argyll and Bute Community Dementia Teams are an integrated service, embedded in localities, that support people and their carers who are living with dementia by providing a range of services including -

- support following diagnosis on how the person with dementia can self-manage their symptoms and concerns
- support with the activities of daily living such as personal care, shopping, meal preparation, budgeting or attending appointments
- support in day care facilities in Lochgilphead, Rothesay, Dunoon and Oban,
- referral to a community nurse who specialises in dementia
- Providing information on local support groups for people with dementia and their carers
- Dementia resource centres in Helensburgh and Oban

The Community Dementia teams also work closely with the Occupational Therapy service to help people and their carers to continue doing as much as possible in their day to day lives. This can include advice and support, learning coping strategies, cognitive rehabilitation (i.e. aids to help memory and concentration), education about dementia, as well as the provision of equipment and technologies to support independent living.

3.2.10 **End of Life care**

The World Health Organisation defines palliative care as *"an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."*

The WHO has also recommended that planning for care at the end of life should be responsive to patient choice regarding place of care and place of death.

We know that the number of deaths over time will increase, linked to a growth in the proportion of elderly people in society. In addition, issues such as frailty and dementia, multi-morbidity, and complexity of care will continue to require the development of response and more tailored personalised care plans. In August 2012, the Delivering Choice Programme (DCP) was commissioned through Change Fund monies to review and further develop palliative and end of life care within Argyll and Bute, complementing both the Living and Dying Well and the Reshaping Care for Older People strategies.

The needs assessment phase of the DCP identified a number of key issues to be addressed within the Argyll and Bute area, including addressing the culture around death, dying and bereavement; inequalities relating to the remote and rural context (including access to transportation); and palliative care for non-malignant conditions.

The vision for the programme is to enhance palliative and end of life care for patients, families and carers within Argyll and Bute through the provision of services as close to home as possible. The programme objectives are as follows:

- To increase capabilities to identify patients and to plan care in anticipation and in advance of needs.
- To improve co-ordination of care, within and across settings, to support patients and families with complex and unstable palliative and end of life care needs.
- To increase community based care service provision, and accelerate progress in shifting the balance of end of life care towards greater community based care.
- To raise public awareness of, and promote community involvement in death, dying and bereavement.

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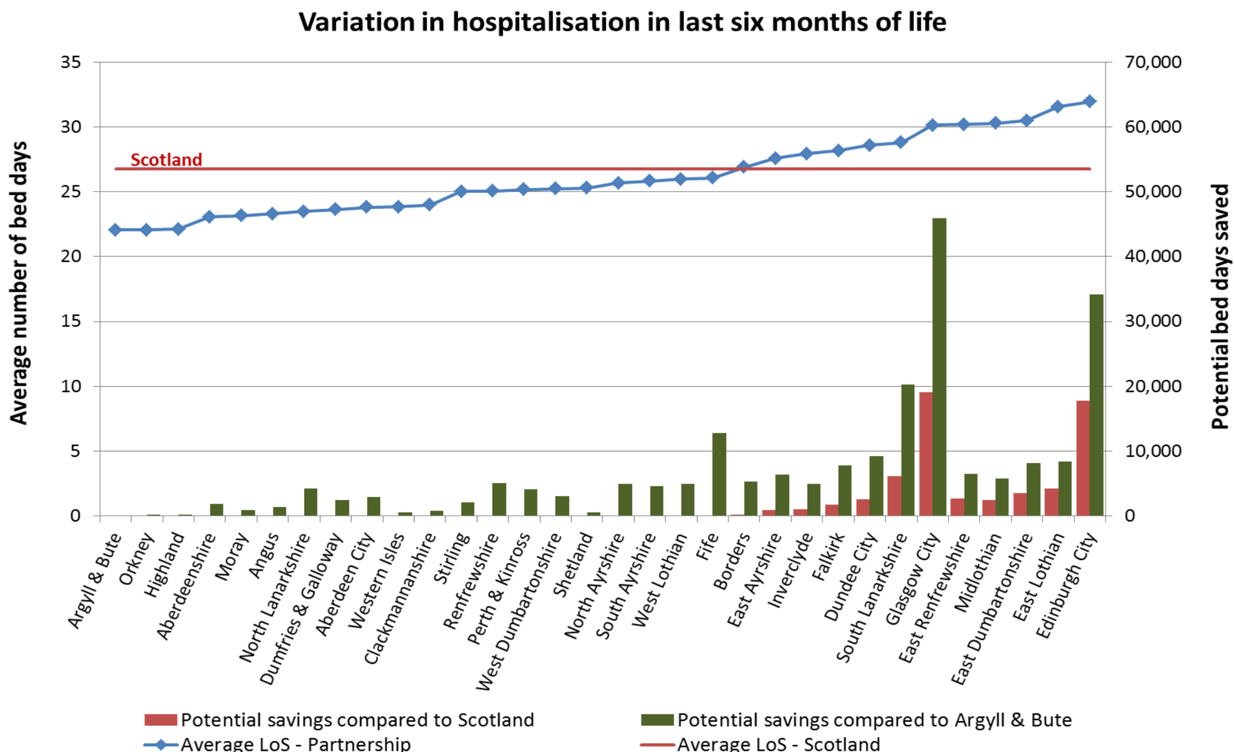
Following extensive consultation and joint planning with local stakeholders, a number of projects designed to achieve these objectives are now in place, these include:

- A new model of providing Marie Curie's nursing care;
- Training for care home staff;
- Training and information for carers;
- Support from trained volunteers; and
- Out of hours care and transport pathways.

A health- promoting palliative care project was also run between April and December 2014, involving a number of community-based initiatives designed to help increase public awareness and get people talking about the taboo subjects of death, dying and bereavement. The programme is due to close in early 2016 and will be evaluated to measure achievement of the objectives and benefits, and to identify key learning points.

The impact of this work and model of service at macro level is demonstrated in the graph below which shows 20% of bed days used by Argyll and Bute population are used by people in last six months of life-an average of 22 days per decedent.-2012/13 data. This chart shows that A&B has the lowest average days per decedent in Scotland



We will work to evaluate any variation between A&B localities and by using further information linking community health and social care data will be able to understand the end of life pathway and see if there are opportunities for further redesign to meet peoples aspirations for end of life care at home where that is safe and appropriate.

3.2.11 **Drugs and Alcohol**

The Argyll and Bute Alcohol and Drugs Partnership are focused on the provision of community based recovery and support which includes:

- Information and Advice
- Carers Support
- Social/Psychological user support
- Relapse prevention
- Harm reduction
- Assessment and referral
- Identification of parents and risk assessment of children
- Recovery planning
- Employment/Volunteering and training
- Counselling
- Support at home

In addition:

- Specialist residential care with input from statutory services to ensure initial assessment, review and progression to aftercare package.

Argyll & Bute developed a discrete and focused Alcohol and Drug Partnership Strategy 2013 - 2016, which included our partnership with West Dunbartonshire and other areas.http://www.argyll-bute.gov.uk/moderngov/documents/s74011/Ag%20Item%2010a%20-%20Final%20ADP%20Strategy%202013-16.pdf

The four priorities identified are:

- Health in Argyll & Bute is maximised and communties feel engaged and empowered to make healthier choices regarding alcohol and drugs
- Effective integrated care pathway is established offering a flexible range of services from assessment to recovery and is in place in Argyll & Bute
- Individuals' families and communties in Argyll & Bute are protected against substance misuse harm
- Children affected by parental or personal substance misuse are protected and build resilience through the joint working of adult and children's services in Argyll & Bute.

3.2.12 **Adult Protection**

The Adult Support and Protection (Scotland) Act 2007

http://www.legislation.gov.uk/asp/2007/10/section/1 provides a legal framework to ensure that all key staff work together to keep adults who may be at risk safe from harm. The Act places statutory responsibility for supporting and protecting adults on the council, this will not transfer to the HSCP unless the law changes. However, NHS staff and other public bodies such as the Police, have legal duties, too. Working together everyone in the new partnership has a responsibility to identify when an adult may be at risk and to find ways to support them and enable them to live their life as safely as possible. All aspects of adult support and protection are overseen by the multi-agency Adult Protection Committee led by an independent chair. Further information about all aspects of this work is available at: http://www.argyll-bute.gov.uk/adult-protection

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3.2.13 **Asset Based approach and Co-production**

The HSCP recognises that a cultural shift is under way and needs to become the focused approach for all support and intervention. People are at the centre of every process and services and supports need to be co-produced, with them, working toward their desired outcomes.

We will challenge outdated values by moving from a concentration on illness, limitations and deficits at both individual and community levels towards Asset and Strength-based approaches within the overall framework of co-production.

Reshaping Care for Older people has demonstrated the strength and value of this approach. The Health and Social Care Partnership will continue to focus on taking forward this change programme and accelerate the pace of change in developing an environment where everyone can embrace new ways of working.

3.2.14 Children and Young People receive support when they need it when they need it

Argyll and Bute Health and Social Care Partnership focuses on providing support to children, young people and their families in a timely manner. Supporting families by intervening early to make a difference and reduce health and social inequalities.

In the next three years, Argyll and Bute will focus on implementing the universal health visiting CORE programme to ensure that appropriate support from pre-birth until school, is in place for all children. Regular assessment and support will allow us to ensure we deliver the following:

- Reduce by 15% the rate of still births and infant mortality by 2015
- 85% of children to reach all of the expected development milestones by the time of the child's 27-30 month health review by December 2016.
- 90% of children to reach all of the expected developmental milestones by the time they start primary school by December 2017.

For all children the HSCP will address social and health inequalities by working with partners including the 3rd sector to develop and deliver local services.

Universal services provide the backbone of preventative and social/health enhancing work. Over the next 3 years the HSCP will prioritise four key areas relating to children:

- Improving immunisation rates
- Increasing breast feeding rates
- Reducing health inequalities in child dental health
- Improving child healthy weight

These key areas underpin the aim to give all of our children the best start in life. People across Argyll & Bute agree that all of our children should have the best possible start in life.

Specialised Service

For children and young people who require additional support, health visitors, maternity service, social work, Child and Adolescent Mental Health services (CAMHS) and specialist paediatric services will work together to identify children and young people in need of support and assess through the Getting It Right practice model.

With regards to (CAHMS) waiting times data the latest Quarter 1 (2015/16) returns notes 97% success, against Target of 100% and alongside this Q1 (2015/16) notes that with regards to supporting children with additional needs, a success of 100% against Target of 100%.

Over the past five years, the Social Work Service in Argyll and Bute has seen the number of referrals increase by 18%, comparing 2010/11 with 2014/15 while child protection has reduced by 20% across the same period, including a significant reduction in child protection registrations, 41% comparing 2010/11 with 2014/15. Research is being undertaken by With Scotland to verify the cause and this will inform the strategic plan going forward.

The number of referral to services continues to increase and it is working with more families on a voluntary basis, in line with GIRFEC principles. There is expectation that this trend will continue with more support given to children and young people at earlier stage to avoid the need for statutory measures, such as referral to the Reporter and children

placed on supervision. Over the last five years, the number of children on Supervision Order (Looked After Children (LAC)) has reduced by 16%, comparing 2010/11 with 2014/15, alongside a reduction in Looked After and Accommodated Children (LAAC) of 9%, comparing 2010/11 with 2014/15 (see figure 1 below).

A Children & Families Data Table & Source Reference can be found at Appendix 10.

All figures show positive trends created by services working together using the GIRFEC model. Midwives, Health Visitors, Social Work and schools will build on this across next three years.

A key priority moving forward is the support of children impacted on by parental mental health, substance misuse and domestic violence.

Argyll and Bute has a higher level of domestic violence than comparative authorities with 642 incidents reported to the police for Quarter 4 (2014/15). Within this population the total crimes/ offences detection rate for domestic violence reported in Quarter 4 (2014/15), success of 85% against Target of 85%.

Early identification and appropriate intervention to support children, young people and their families is key priority of Health and Social Care Partnership and this has been captured in our Integrated Children's Services Plan.

www.argyll-bute.gov.uk/.../integrated_childrens_service_plan_v6_2.pdf

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3.2.15 **Child Protection**

The most recent guidance in respect of child protection is the National Guidance for Child Protection in Scotland 2014 http://www.gov.scot/Resource/0045/00450733.pdf It provides an operational framework to be used in conjunction with The Children and Young People (Scotland) Act 2014.

Child protection is a multi-agency responsibility, with families and members of the public having responsibility, alongside professionals in health, education, social work, police and other agencies to ensure that all of our children live in a safe environment, based on the principles:

- The welfare of children and young people takes paramount consideration

- All children and young people whatever their age, culture, disability, gender, ethnic origin, religious belief and/or sexual identity have a right to protection from abuse and exploitation

It is the responsibility of Child Protection Agencies such as social work and the police, to determine whether or not abuse has taken place.

The role of the Lead Professional for a child can normally be taken by professionals from a range of agencies but where is risk of significant harm the role is typically taken by a Social Worker, who will ensure that a Child Protection Plan is incorporated in the Child's Plan and remains in place for as long as the risk of significant harm is deemed to last.

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3.2.16 **Criminal Justice Social Work Services**

What does the Criminal Justice Partnership do?

The Criminal Justice Social Work Service undertakes a range of responsibilities including:

- Provide reports to the Court to help them decide on appropriate sentencing.
- Supervise offenders on a regular basis to assist them to stop offending.
- Supervise offenders on a community based punishment such as unpaid work.
- Depending on the type and length of a prison sentence, have contact with the prisoner, report on any issues regarding home leave and release, and supervise his/her return to the community.
- Manage high risk offenders within the community and work very closely with the Police, Health Board and other agencies to support public protection and make our communities a safer place to live in.

The purpose of the Criminal Justice Social Work Partnership is to work with offenders towards desistance so that the community as a whole can expect to:

- experience low levels of crime
- experience low levels of fear, harm and distress
- be at low risk of unintentional harm

The CJSW partnership will work together with partners to reduce re-offending in its work with offenders; the Service maintains close links with a range of service providers, including those engaged in employment and education. As many offenders are also parents, an effective interface with Children and Families Social Work is important and co-location has been an important development in this regard. The level of support offered to offenders by all public agencies, particularly those who have served long sentences, is a current area of focus.

The Criminal Justice Service, in partnership with East and West Dunbartonshire, is currently working to a three year strategic plan 2014-17 (see Partnership Strategy Map). The Partnership will continue to develop local practice whilst implementing the new national structure as part of the Criminal Justice (Scotland) Bill that is currently out for consultation. The Bill will abolish the Community Justice Authorities and place the requirement to plan community justice with the Local Authority and Community Planning Partnerships.

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Work is under way to review the Partnership governance and operational arrangements in readiness for the new service to be in place by 1st April 2017. Argyll and Bute Criminal Justice Service will, over the next year, look to strengthen relationships with local partners and plan local implementation of the new arrangements. The service will continue to review effective means of developing resilience for both management and frontline workers within a small and geographically diverse team.

Argyll, Bute & Dunbartonshires'

Criminal Justice Social Work Partnership

PARTNERSHIP STRATEGY MAP 2014-17

Vision:	**Safer and Stronger**
Mission:	• Our aim is to reduce re-offending and contribute to safer and stronger communities by promoting and delivering effective interventions with offenders. • We will promote social inclusion and the values of respect and anti-discrimination whilst challenging behaviours and attitudes which undermine community safety and work with other partners towards achieving this.

Priorities:	**Justice**	Reducing Re-offending	Strengthening community engagement and resilience	Enhancing efficiency

Outcomes:	**National (Single Outcome**	We live our lives safe from crime, disorder and	We have strong, resilient and supportive	Our public services are high quality, continually

	Agreement)	danger	communities where people take responsibility for their own actions and how they affect others	improving, efficient and responsive to local people's needs
	Justice	We experience low levels of crime We experience low levels of fear, alarm and distress We are at low risk of unintentional harm	Our people and communities support and respect each other, exercising both their rights and responsibilities Our public services respect the rights and voice of users	Our public services are fair and accessible Our institutions and processes are effective and efficient We have high levels of public confidence in justice systems and processes
	Community (Partnership)	We work together with partners to reduce re-offending	We engage and consult with our communities and partners to improve and strengthen our services	Our Partnership delivers effective and efficient services

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Objectives:	**Customer** **(service delivery, engagement)**	Effective relationships with service users and partners	Assisting service users and staff to maintain constructive contact with families	Assisting service users to have appropriate access to quality services and interventions
		Interventions meet service user outcomes	Assisting service users to engage effectively with their local community	
		Service user opportunities and skills are enhanced		
		National Standards are delivered		
	Internal Process **(Performance, operations, partnerships)**	Work effectively with partners to deliver services	Meaningful two way communication with staff, partners and communities	Consistent approach to service delivery across the Partnership
	Resources	A competent and skilled		Working environment and equipment are fit for

	(finance, staff, information, IT, environment)	workforce		purpose
		Work effectively as a team		Effective governance of resources
		Fully integrated risk assessment & management		Strong and effective management/leadership
				Planned local implementation of national CJ service redesign

Values:	Innovation	Excellence	Respect	Partnership	Inclusion

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3.2.17 **Unpaid Carers**

Unpaid carers are people who provide care and support to family members, other relatives, friends and neighbours. The people they care for may be affected by disability physical or mental health issues, often long term, frailty, substance misuse or some other condition. They may care intensively or for a short period and some are lifelong carers. Any one of us can become a carer at any time in our lives and sometimes for more than one person at a time. A carer can be any age from young children to very elderly people. Carers are not paid workers and they are not volunteers.

Unpaid carers rarely identify themselves, they tend to see all the care and support they provide as an extension of their relationship to the person needing help, to enable them to remain at home for as long as possible. Health and social care staff will encourage unpaid carers to attend their local Carers Centres where they can access some of the emotional support and information they need to keep caring. All Carers Centres are independent, but they may be affiliated to a national organisation such as the Carers Trust. They are free to access and available to any unpaid carer. Outreach workers from the centres are able to support carers who live in remote and rural areas.

There are 13,396 carers in Argyll & Bute, recorded by the Carers' Network, this includes young carers. It is likely that many more people are providing unpaid care, but do not identify themselves as carers. Using the calculation from 'Valuing Carers, May 2011' the cost of replacing this unpaid care with formal, purchased support would be £272.1 million per annum.

Anyone who provides unpaid care can request a carers assessment, which will be carried out by a worker from the local Carers Centre it is not necessary to live with the person being cared for to be their unpaid carer. Any carer who feels that he/she needs help and support to continue to support a person they care for can make contact in a number of ways in a number of ways:

Call Argyll & Bute Council on: 01546 605517 or drop into one of the council's local Customer Service Points or ask at the nearest Carers' Centre.

One example of support for carers is 'Caring with Confidence', a new initiative beginning in Oban for people living with terminal illness. Weekly sessions over a six week period will explore:

- caring for yourself
- talking about the illness
- how to manage symptoms

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- facing an uncertain future

People attending will have an opportunity to meet and be supported by others in the same situation. Contacts are:

mairi@northargyllcarers.org.uk lisa@northargyllcarers.org.uk

Respite care

A key element in ensure carers are supported to maintain their own health and wellbeing is the opportunity to access respite care Any carer may need to arrange a break for themselves or the person they care for. This can be arranged in several ways, depending on the needs and preferences of carer and the person being cared for. Some options are:

- a short stay in our of our care homes for the person being cared for
- arranging for someone to come to the person's home to let the carer take a break away
- Crossroads in Oban, Dunoon and Lochgilphead provide direct care through respite services at home
- arranging a short break or holiday for the person being cared for
- getting a direct payment to arrange the respite care yourself (this is known as self-directed support)
- accessing day care services for older people
- accessing day care services for people with learning disabilities
- short breaks service for children and young people at Ardlui House
- family breaks at Robin House, Children's Hospice

These are only some options, and they can be a one-off or regular arrangement - respite and short breaks are arranged to suit the carer and the person being cared for, to meet individual needs.

3.2.18 **The Independent Sector**

The independent sector is a significant provider of Adult Care services in Argyll and Bute. The main services are provided by:

- 24 independent companies that are registered to provide a care at home or housing with support service.
- 15 independent companies who provide a residential care home or nursing care home service.

Independent companies provide 83% of all care at home hours delivered across Argyll and Bute. This is significantly more hours of care at home than is provided by the statutory or third (voluntary) sector.

The number of care home places provided by independent companies is also notably more than those provided by the other sectors.

Independent providers are a key partner in developing services that respond to the needs of local communities. Providers are represented at the locality Improving Care meetings by the Local Integration Lead, Independent Sector. There are two Local Integration Leads who job share one post. The post is funded by the Integrated Care Fund.

Prior to each locality Improving Care meeting the Local Integration Leads meet with providers to update them on what is happening strategically and at a local level. Independent providers are viewed as valuable partners and are encouraged to work with each other and with other partners to develop services in response to identified gaps in local services.

3.2.19 **The Third Sector**

Third Sector providers are also essential contributors to the economy of care delivering contracted services such as overnight care teams in 7 areas of Argyll & Bute, providing both planned care and emergency response at home between 11pm and 7am. This enables people to retain their independence for as long as possible, helping them stay at home by meeting their overnight care needs and supports family carers by responding to Technology Enabled Care alarm calls during the night, giving the family carer peace-of-mind and unbroken sleep. They also handle all calls to out-of-hours social work teams, triage the calls and arrange for input from the right staff member, at the right time, when required.

A wide range of other contracted services delivered by Third sector providers to people in all age groups, include - day care for people with learning disabilties in Helensburgh; day care for older people in Garelochhead; addiction recovery services; dementia services (in a fully integrated team of professionals); carers support through carers centres and outreach work; support for young carers; respite care at home (Crossroads); advocacy service; support for victims of abuse; support for victims of domestic violence; Children First working with violence against children.

The Third Sector plays an invaluable role in deveoping community resilience, engaging people and reducing social isolation. Argyll & Bute Third Sector Interface works to engage with local organisations, volunteers and communities in a variety of ways. With over 3,400 registered volunteers and the largest time bank in the UK, they are able to reach and involve a significant number of people.

Time banking is an informal, equality based volunteering mechanism and better suited to socially excluded or disadvantaged people who do not traditionally engage in more formal volunteering (Time bank UK poll, 2007, 80% had not previously volunteered).

- by giving a range of people the opportunity to build trusting relationships between different generations time banking will support the development of a cohesive, stronger community.
- older people can become mentors and befrienders to younger people and thereby young people can increase their knowledge and social skills
- as young people gain confidence they will develop the ability to make informed life choices and to access opportunities for training and education
- by bringing people together time banking participation will improve understanding of community needs and aspirations for various support services and people will develop their ability in identifying community-driven solutions.
- as relationships build across generations, people with disabilities and disadvantaged people, perceived inequalities will reduce as each has the ability to contribute as equals to time banking activities.
- through sustained community networking, a range of people will develop the skills to achieve representation and involvement in shaping future public services.
- by being valued and developing a sense of self-worth people with mental health issues will improve their self-help skills and abilities and achieve some reduction in recurring periods of hospitalisation.
- time banking participation has the ability to build and engage communities making them stronger, safer and forward looking.
- through engagement of partner businesses in the community young people can access training opportunities not otherwise available

In addition, channels of communication with local groups include network meetings, events for specific themes, a website www.argyllcommunities.org and regular bulletins and circulars. Connections with schools across Argyll and open events for young people are coupled with Saltire volunteering and the website 'Argyll Young Entrepreneurs' – www.aye.biz . Some events are open to all our communities and the Third Sector Interface works closely with Scottish Government to enable people to have their say in issues affecting them.

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3.3 Key Drivers

Key Drivers

3.3.1The key drivers for this plan, including legislative and policy drivers, are listed in Appendix 1.

Key Change Imperatives

3.4 The Need to Tackle Growing Health Inequalities and their Causes

3.4.1Inequalities in health outcomes are directly linked to wider socio-economic inequalities in society, such as the distribution of power, money and resources, and through the direct influence this has on environmental factors, for example the availability of regular employment, access to quality, affordable housing; social and cultural experiences; transport; education and learning opportunities; and services. These wider environments in which we all live ultimately shape our individual experiences. Poor experiences are more likely to result in people living in poor housing, encountering poor access to health care, living on a low income and being unemployed or undertaking low paid work. This ultimately results in unequal outcomes in health, illness and death across the population. In addition, as these conditions are all underpinned by the same fundamental factors, they tend to be clustered in neighbourhoods and population groups. This relationship between the fundamental causes, environmental influences, individual experiences and resulting health inequalities is summarised in the diagram below:

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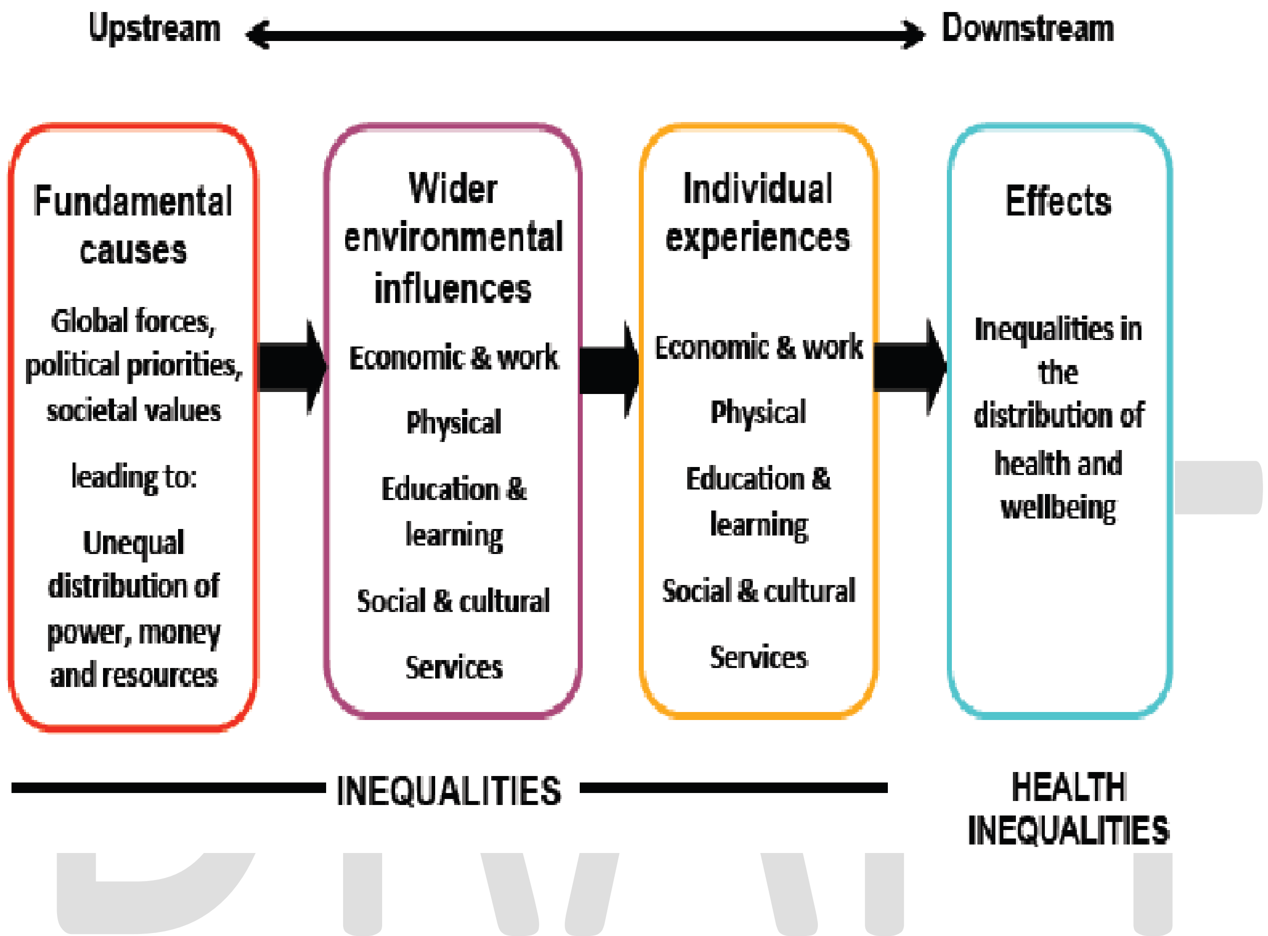
Figure 1: Health inequalities: theory of causation (summary version)



3.4.2 Health inequalities can be observed across the social gradient and are, therefore, experienced by all but the most affluent and affect us all in society. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is known as proportionate universalism.

3.4.3 Despite overall improvements in population health and mortality rates, health inequalities have persisted in Argyll and Bute and the rest of Scotland. Local data confirms that people living in more deprived areas live proportionately more years in ‚poor‟ health than people in less deprived areas. It also details that those from more deprived areas are consistently observed to have higher levels of long-term physical ill health, poorer mental health and more addiction issues.

3.4.4 Although there has been some progress in bringing about an improvement in individual risk factors and in certain preventable causes of death, research has now demonstrated that the socially patterned risks of today will be replaced by new, avoidable causes of mortality in the future if action is not taken to tackle the fundamental root causes of health inequalities.

3.4.5 It is therefore important to be mindful that strategies focused on addressing traditional risk factors, such as lifestyle behaviours or specific diseases, are important but will not ultimately be enough to tackle inequalities in overall mortality. Therefore, the HSCP will promote concurrent action at the three levels of: fundamental causes, environmental influences, and individual experiences.

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3.5 A Decisive Move Towards Health and Wellbeing

3.5.1 The promotion of wellbeing and prevention of ill health together with early intervention (to prevent the need for more complex and costly treatment in the future) is a priority for the Partnership.
http://www.argyll-bute.gov.uk/moderngov/documents/s96329/Physical%20Activity%20Paper%20CPP%20March%202015.pdf

This requires our workforce to be developed and supported to become increasingly focused on preventative and anticipatory care. This will mean our workforce needs to understand and act accordingly with regard to:

3.5.2 **Primary intervention** - Many people in Argyll and Bute live with and manage long term conditions such as heart disease, diabetes and COPD. With input from specialist nurses, increasing use of technology to monitor their status and modern medications they are able to live well, despite their condition. There are increasing numbers of people have two or more long term (or chronic) conditions – this is sometimes called co-morbidity or

multi-morbidity. By understanding more about their conditions, their medications and the links between these and other, lifestyle, factors, people are more 'in charge' and can monitor their wellbeing and seek early intervention, so that they spend more of the time feeling well. This is often termed 'self-management'.

3.5.3 Some conditions are preventable, or can be improved by lifestyle changes – smoking cessation; weight management; a healthy diet; regular exercise; reducing alcohol consumption and being socially fulfilled can all contribute to our health and wellbeing. As we are living longer and we want to live in good health we need to take responsibility for maintaining a lifestyle that supports our wellbeing.

3.5.4 The HSCP wants to empower people and communities to become healthier. To achieve this we need to invest in public education and the prevention of ill health. We need all of our communities to help raise awareness of health and well-being and a belief that we can use all the benefits of living in Argyll & Bute to promote our own health and well-being. People need information so they can make positive choices and enjoy healthier lifestyles.

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3.5.5 We are all responsible for taking the best possible care of our own health and for promoting our own wellbeing but there are things the HSCP can do to help – small changes can make big differences. We will support our communities by further training and developing our workforce to help signpost and provide education and information to assist people to make informed lifestyle choices and support opportunites to change.

3.5.6 Social prescribing – is widely used in the treatment of mental ill health, it can include physical activity, learning new skills, volunteering, art therapy, befriending and self-help. A 2 year project in Oban, Healthy Options http://www.lornhealthyoptions.co.uk/ focussed on physical wellbeing with some measurable positive outcomes.

3.5.7 **Falls Prevention**

There is good evidence for interventions to prevent falls in various settings (the community, nursing home facilities and in hospitals). This is particularly important because of the large amount of hospital and other health and social care resources being applied to cope with the implications of falls in the elderly. The Department of Health within its published Package for Older Persons Resources (2009), provides estimates of this and in a population approximating to NHS Highland (320,000), it is likely that:

- 15,500 will fall each year,
- 6,700 will fall more than once
- 2,200 fallers will attend A & E or minor injuries unit
- 2,200 will call the ambulance service
- 1,100 will sustain a fracture, 360 will be of the hip. (Hip fractures account for >20% orthopaedic bed occupancy, 30% die within 12 months and >50% of those

previously independent become partly dependent and 33% become totally dependent)

The RCOP programme funded falls prevention interventions for older people in Argyll & Bute, using exercise programmes and Tai Chi to improve balance and confidence. Tai Chi group exercise proved to be effective both in reducing the rate of falls by 37% (number of falls per person over a set time period of follow-up) and in the risk of falling by 35% (number of people falling at least once during the set follow-up period).

3.5.8 **Healthy eating weight management**

HSCP staff are trained to assist people with healthy eating and weight management requirements, to work towards a healthier lifestyle. Also, Counterweight www.counterweight.org.uk provides training to other interested individuals and Third Sector staff to become accredited practitioners. The Counterwieght vision is *'Empowering overweight and obese adults to make long term changes to enable them to live as a thinner person'.* It is a structured lifestyle programme that aims for 5-10% (5-10kg) weight loss by equipping customers with skills to change their behavious around eating and activity, using every day foods.

3.5.9 **Smoking cessation and reducing alcohol intake**

Specialist advice is available for lifestyle changes related to both smoking and drinking alcohol. Small changes in either or both habits can radically improve health and wellbeing.

3.5.10 There is support for people who want to take steps to a healthier lifestyle and community. Across Argyll & Bute the Health and Wellbeing Networks assist people who have an interest in building healthy communties. They provide an opportunity for people to come together to find out what issues matter to their local community; to plan activities and events together; and to distribute grant funding of up to £2,000 per project. Health and Wellbeing Networks are a Strategic Partnership of the Community Planning Partnership. http://healthyargyllandbute.co.uk/health-and-wellbeing-networks/

3.5.11 Secondary Prevention aims to mitigate the effects of harm that may already be evident. This might include supporting people to make positive lifestyle changes, building resilience in individuals and communities to cope with, and adapt to, adverse life circumstances; anticipatory care programmes to detect and deal with risk factors for disease, screening programmes, the Positive Steps Programme targeting those at risk of falling, alcohol brief interventions; targeted home visiting support, such as employability programmes, income maximisations services; fuel poverty initiatives; and early Social Work intervention.

3.5.12 Tertiary Prevention aims to alleviate the consequences of harm by stopping things getting worse and improving quality of life. Examples include: condition-based rehabilitation, diabetic retinopathy screening; reablement; intensive housing support programmes; Recovery Orientated Systems of Care in relation to alcohol or drug addiction; and housing modifications for people with disabilities and long term conditions.

3.5.13 **Children and Families**

Argyll & Bute faces many of the same challenges as the rest of Scotland: financial circumstances are demanding and the pressures on services to deliver early and effective interventions in communities are intense. Welfare Reform has added to the pressure on some local families and individuals. Whilst Argyll & Bute overall is considered to be a relatively wealthy community, there are areas of significant poverty and deprivation. The numbers of vulnerable children and young people has increased.

3.5.14 The core objective across much of the policy and practice is Early Intervention, but much of the available resource is focused on remedial action, rather than preventive support.

3.5.15 Scottish Government and the Argyll & Bute Community Planning Partnership recognise that the early days, months and years of a child's life are the best opportunity to improve the outcomes for the most vulnerable children. The HSCP wants the best outcomes for all children in Argyll & Bute and will apply the principle of Early Intervention at any stage of a child or, indeed, any adult's life.

Early intervention presents a challenge. It requires a change in the way services are collectively provided. It requires:

- A shift away from dependence on services to deliver outcomes, to one that is based on building the capacity of parents, families and communities to create improved secure outcomes for themselves. A streamlining and development of capacity in the systems and processes between partners.
- A continued development of workforce capacity and capability by creating the skills to deliver agreed outcomes.

3.6 The Move Towards Personalisation and Self Directed Support (SDS)

3.6.1 There has been a gradual shift in the way care has been delivered from a culture where the professional identifies the need and delivers a service with a passive role for the service user, to one that *"enables the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the services they receive".*[8]

3.6.2 Personalisation seeks to enable people to plan and choose health and social care support that is more flexible and can better suit their individual needs. As part of personalisation, individuals are supported to make informed choices about meeting their

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assessed needs and, where they wish to, are supported to manage the support they receive.

3.6.3 Self Directed Support aims to empower people to direct their own care and support and to make informed choices about how their support is provided. Regardless of the care setting, services can be tailored to become more suited to individuals' choices and preferences. For some service users, this may mean choosing to use a direct payment to manage their own support. For others, it may mean being a recipient of a service provided by the NHS, Council, Independent or Third Sector, or a combination of these.

8 "Changing Lives" A Personalised Commissioning Approach to Support and Care Services, Service Development Group, Scottish Government 2009
http://www.scotland.gov.uk/Resource/Doc/269193/0080033.pdf

3.7The Move Towards Co-Production

3.7.1 Co-production means "delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way both services and neighbourhoods become far more effective agents of change".[9]

3.7.2 The purpose of co-production is to encourage people and communities to use the human skills and experience they have to help deliver public or voluntary services.

3.7.3 Potentially the move towards co-production will radically alter the way that the Partnership will plan for the provision and delivery of services during the first three-year strategic planning period. In the next planning period, the first steps towards the scaling up of co-production approaches will be supported throughout the component parts of the Implementation Plan (see Section 14) and through the broader developmental work that needs to be in place to support such a fundamental change.

3.8The Move Towards

3.8.1 The move towards greater utilisation and mainstreaming of (TEC) is an integrated part of health and care service provision and planning.

3.8.2 The '20:20 vision for Health & Social Car' provides the strategic context for TEC and is seen as vital to the successful delivery of this vision. is defined as "*where the quality of cost-effective care and support to improve outcomes for individuals in homes or community settings is enhanced through the application of technology as an integral part of the care and support*".[10]

3.8.3 The National vision is to mainstream and deploy at scale technologies across Scotland. The drivers for this are the National TEC Programme (2014-2016), the National Technology Enabled Care Delivery Plan (2015) and the Integrated Care Fund for Scotland which aims to

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New Economics Foundation http://www.neweconomics.org/page/-/files/In_This_Together.pdf

[10] Joint Improvement Team Partnership Guidance for Technology-enabled Care Programme (2014-2016)

"*enable greater choice and control in health and wellbeing services for an additional 300,000 people by March 2016, enabling more of our citizens to remain at home in their communities".*[11]

3.8.4 Technology Enabled Care enables and supports people to remain in their own homes for longer by providing support through technologies. We have in place 1069 basic Technology Enabled Care packages, 487 enhanced Technology Enabled Care packages and 71 telehealth homepods in stock, with 42% of them assigned (*Source: Pyramid, June 2015)*

- Living it Up is the Scottish Centre for telehealth and Technology Enabled Care. The service is mainly aimed at over 50's with multiple long-term conditions, but health and wellbeing advice and local information is good for anyone who wants to improve their wellbeing and quality of life.
- Living it Up have spoken to over 3,000 people to find out what they want and need. As a result they have deveoped a huge range of resources for example:
- CONNECT – helps people to find ways of easily connecting with family, friends, each other and local health and wellbeing providers. For example, you can learn to use Skype, WhatsApp or Twitter.
- FLOURISH – Has news and information about getting well and staying well, being active, monitoring your health (perhaps using your mobile phone), digital postcards and much more.
- NEWS - local news, views, events, and things to do/places to go.

Key facts

- Argyll and Bute emergency admission rate is lower than the Scottish average.
- However , the length of time they are in bed is longer than the Scottish Average
- We also know that Argyll and Bute performs well with regard to delayed discharge numbers (17 per month on average in 2014). But we need to improve when people are delayed in a hospital bed whilst waiting for care or support closer to home.

3.8.5 Technology Enabled Care, with advancing technologies developed through the Living it Up initiative has great potential for rural areas like Argyll & Bute. With improved technologies providing more reliable connectivity and ease of use we might:

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- Reduce social isolation by keeping people in touch with family, friends and communties
- Provide community information/news
- Develop technology enabled social activities, such as keep fit or falls prevention, delivered at home, reducing the need for travel
- Enable people to monitor long term conditions and raise their confidence to self-manage
- Respond to queries about medication through links to pharmacies
- Reduce the need for GP appointments using Telehealth homepods
- Use Telemedicine to link with consultants, instead of making lengthy journeys to Glasgow for appointments.

3.8.6 The Health and Social Care Partnership intends to take advantage of this opportunity for people in Argyll & Bute by making wider use of platforms such as Living it Up[12] and ALISS[13] to expand use of community-based supports

3.9 Health Care as close to home as possible.

There is good evidence that it is better to care for people as close to home as possible. Inpatient hospital care is only for when you have an urgent clinical need and should be short stay with rapid rehabilitation. Throughout the strategic plan consultation process people have told us that is what they want and need.

The ‘care closer to home’ approach is about:

- Being clear about the role of hospitals in meeting the health treatment needs of the population – acute medical care
- Making community care the norm with a range of alternatives to meet people’s changing health and care needs over their lifetime.
- Making sure that all care, wherever we deliver it is person-centred and is what the person wants.

Joint Improvement Team Partnership Guidance for Technology-enabled Care Programme (2014-2016)

[2] Living it Up – Portal site for health and care self-management and general information on self-help and services - https://portal.livingitup.org.uk/

[13] ALISS – A Local Information System for Scotland - http://www.aliss.org/

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4. VISION, MISSION & VALUES; NATIONAL & LOCAL OUTCOMES; AND INTEGRATION PRINCIPLES

4.1 Within the context of the provisions of the Public Bodies (Joint Working) (Scotland) Act, 2014 and of the Single Outcome Agreement for Argyll & Bute, this section sets out the Partnership's vision statement, mission, values, strategic objectives and measurable tasks. These are all designed to deliver progress and continuous improvement against the national and local outcomes, which are set out later in this section.

4.2 **Vision**

People in Argyll & Bute will live longer, healthier, independent lives

4.3 **Mission for the Plan Period**

Argyll and Bute Health and Social Care Partnership will work with you to improve health, support social care, tackle health inequality, and improve community wellbeing. We will work in partnership with local communities to offer services that are:

- Easily understood.
- Accessible, timely and of a high quality
- Well-coordinated.
- Safe, compassionate and person-centred.
- Effective and efficient, providing best value.

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4.4 **Values**

The following are the values to which those employed or contracted by the Partnership or who are stakeholders in it will be expected to adhere to:

Person centred
Integrity
Engaged
Caring
Compassionate
Respectful

4.5 National Outcomes for Integration

The National Outcomes for adults and older people as set out in Regulation as part of the provisions of the 2014 Public Bodies (Joint Working) (Scotland) Act are as listed below. It will be for this Partnership, through its Annual Performance Report and by a range of other means, to demonstrate progress towards the delivery of these:

a) Healthier Living

People are able to look after and improve their own health and wellbeing and live in good health for longer.

b) Independent Living

People, including those with disabilities, long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

c) Positive Experiences and Outcomes

People who use health and social care services have positive experiences of those services, and have their dignity respected.

d) Quality of Life

Health and social care services are centred on helping to maintain or improve the quality of life of service users.

e) Reduce Health Inequality

Health and social care services contribute to reducing health inequalities.

f) Carers are Supported

People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing.

g) People are Safe

People who use health and social care services are safe from harm.

h) Engaged Workforce

People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.

i) Effective Resource Use

Resources are used effectively in the provision of health and social care services, without waste.

National Outcomes for Integrated Children's Service Planning

The following are the key child outcomes from "Scotland Performs - the National Performance Framework":

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j) Our young people are **successful learners, confident individuals, effective contributors and responsible citizens**.

k) Our children have the **best start in life** and are ready to succeed.

l) We have improved the **life chances** for children, young people and families at risk.

National Outcomes and Standards for Social Work Services in the Criminal Justice System are:-

m) Community safety and public protection.

n) The reduction of re-offending.

o) Social inclusion to support desistance from offending.

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4.6 This Strategic Plan has been developed in a way that sets a direction via a number of Strategic Objectives listed in Section 5 and corresponding Measurable Tasks detailed in Section 14, all designed, along with the Performance Framework laid out in Section 10, to demonstrate progress against these National Outcomes in all functional areas delegated to the Partnership.

4.7 The Integration Planning Principles which inform the vision, mission, and values of the Partnership are set out below:

The Act states that the main purpose of services which are provided in pursuance of integration functions is to improve the wellbeing of service users, and that those services should be provided in a way which, so far as possible:–

- is integrated from the point of view of service users.
- takes account of the particular needs of different service users.
- takes account of the particular needs of service users in different parts of the area in which the service is being provided.
- takes account of the particular characteristics and circumstances of different service users.
- respects the rights of service users.
- takes account of the dignity of service users.
- takes account of the participation by service users in the community in which service users live.

- protects and improves the safety of service users.
- improves the quality of the service.
- is planned and led locally in a way which is engaged with the community (including, in particular, service users, those who look after service users and those who are involved in the provision of health or social care).
- best anticipates needs and prevents them arising.
- makes the best use of the available facilities, people and other resources.

5. STRATEGIC OBJECTIVES

5.1 Overarching Partnership Strategic Policy Drivers

5.1.1 The Integration Joint Board, in approving this Strategic Plan, has determined in this first planning period that the following seven areas of focus will drive its work:

- Promote healthy lifestyle choices and increase self-management of long term conditions
- Reduce the number of avoidable emergency admissions to hospital.
- Minimise the time that people are delayed in hospital.
- Reduce the adverse events for children and young people, and provide the best start in life for them.
- Institute a continuous quality improvement management process within a change process across the functions delegated to the Partnership.
- Operate as a single services and single health and care team at locality level by integrating services and our workforce supported by integrated strategy, corporate service, systems and procedures.
- Efficiently and effectively manage all resources to deliver Best Value.

5.2 These will be achieved through the following Strategic Objectives, which are designed to deliver the National Outcomes detailed in Section 14:- The Strategic Objectives for the Plan period, designed to deliver the National Outcomes for Adults, Older People and Children are:

(A) We will work to reduce health inequalities

(B) We plan and provide health and social care services in ways that keep them safe and protect people from harm

(C) We will ensure children have the best possible start in life plan services in a person-centred way that benefits the person receiving the service, so that they have a positive experience – right service, right place, right time

(D) We will plan for and deliver services in person-centred ways that enable and support people to look after and improve their own health and wellbeing

(E) We will prioritise community based services, with a focus on prevention and anticipatory care to reduce preventable hospital admission or long term stay in a care setting.

(F) We will deliver services that are integrated from the perspective of the person receiving them and represent best value with a strong focus on the wellbeing of unpaid carers

(G) We will establish "Locality Planning, Owning, Delivery" operational and management arrangements to respond to local needs

(H) We will strengthen and develop our partnership with specialist health services with NHSGG&C and Community Planning Partners

(I) We will sustain, refocus and develop our partnership workforce on prevention and anticipatory care.

(J) We will put in place a strategic and operational management system that is focused on continuous improvement, within a clear governance and accountability framework

(K) We will underpin our arrangements by putting in place a clear, communication and engagement arrangements involving our staff, users, the public and stakeholders

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5.3 The Measurable Tasks outlined in the Implementation Plan in Section 14 are grouped under these Strategic Objectives. They have also been designed to deliver progress against one or more of the National Outcomes.

5.4 What will it all look like in 2019/20

So taking all this into account we expect to see the following changes in health and care services over the next 3 years.

- GP and other 'front-line' services will continue to be provided locally through at least as many local surgery buildings (also known as Primary Care Centres) as at present. However, few GPs feel that they can offer the best levels of care working on their own. We expect that, through mergers and federations there will be fewer GP practices, each with several GPs working together. There will still be local access to primary and community care services via local surgeries as well as through the appropriate use of technology and home visits. This will provide a greater choice to patients e.g. a male or female doctor and offer a range of GPs

and nurses with special interests and training.

- Most hospital treatments will not require a stay in hospital, with hospital beds being used only for those needing more complex medical care.

- With more care delivered in the home, and with more support for carers (especially family and friends), nursing and care home beds will be used for those who need a higher level of care.

- Re-ablement will be the aim for everyone.

- A single Health and Social Care team will provide more services in your home, all day, every day – and night.

- You will only need to contact one person for all Health and Social Care in your community

- More people will choose self -directed support to design and deliver services that meet their personal needs and objectives.

- There will be more expectation, support and referral for keeping yourself healthy and using everyday social and leisure pursuits to help keep you healthy.

- We will become used to using Technology Enabled Care to support care at home, by allowing, for example, remote monitoring of long term conditions and enabling consultations with trained staff.

- Your local hospital will continue to co-ordinate and deliver emergency medical care, with fast access to Glasgow hospitals when necessary.

6. LOCALITY PLANNING ARRANGEMENTS

6.1 Locality planning is a key element of Health and Social Care Integration which, with the enactment of the Public Bodies (Joint Working) (Scotland) Act, 2014, becomes a legal requirement in relation to the planning and delivery of health and social care services. This Strategic Plan must provide details of the way in which the statutory partners plan to commission services in identified localities.

6.2 Locality planning is:

- joint strategic planning that is effectively and demonstrably informed by, and responsive to, local priorities and needs, as articulated and fed back by professional leaders and other stakeholders, including users of services, Third

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Sector representatives, elected members and community representatives who understand local needs.

- professionals being empowered to agree and initiate changes to services at the locality level which are of benefit to the local population.

6.3 In working towards the delivery of the National Outcomes, the Public Bodies (Joint Working) (Scotland) Act states that services and support should be planned and provided in a way that is consistent with the Integration Principles as set out in Section 25 of the Act, which include:-

(a) that the main purpose of services which must or may be provided in pursuance of the integration functions for the council area is to improve the wellbeing of recipients.

(b) that those services should be provided in a way which:

- is integrated from the point of view of recipients.
- takes account of the particular needs of different recipients.
- takes account of the particular needs of recipients in different parts of the area in which the service is being provided.
- is planned and led locally in a way which is engaged with the community and local professionals.
- best anticipates needs and prevents them arising.
- makes the best use of the available facilities, people and other resources.

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6.4 Within Argyll Bute HSCP our ambition is that we will implement "Locality Planned, Owned and Delivered" arrangements which will:

- Understand the health and care needs of your community
- Bring together partners to plan within a strategic framework to meet needs and achieve national outcomes
- Organise and deliver services in local areas which are integrated and of high quality, safe, appropriate, sustainable and continually improving.
- Operate within budgets, complying with care, workforce, and audit standards
- Manage performance ensuring this is informed by service user and public involvement and feedback
- Be the local focus for service delivery and support to the population or communities within the area concerned.

6.5 For this Strategic Plan to take account of local needs and resources and the varying needs of different people in each area, it will require to be constructed from the bottom up. There will, therefore, require to be effective engagement with all key stakeholders at a

range of different levels, each with its own unique purpose within the strategic and locality planning process.

6.6 From the perspective of local community representatives and groups, carers and service users, this is likely to be most effective at locality level within which natural communities such as the islands and smaller communities will need to be facilitated. It is here that individuals are likely to have a more detailed knowledge of the range of needs of those who live there and of the support networks that may already be in place to provide a level of care and support which, with further development, may have the capacity to grow and be extended further, enhancing a community resilience and co-production economy. Service and support providers across all of the sectors are, in many cases, able to work effectively with local communities at locality and natural community level to identify local needs and to shape the most appropriate responses to these requirements.

6.7 The role of Locality Planning will be to assess evidenced, identified need in terms of issues relating to health and social care; to suggest how these needs might be addressed; to plan and prioritise actions and services on the basis of what is most important to the local community, which is within the overall strategic framework; to be supported in this task as required by the workforce from the statutory and voluntary sectors; to be informed by the experience and views of service users and carers; to monitor performance in relation to prioritised actions and outcomes; and to reflect all of these within an agreed Locality Plan.

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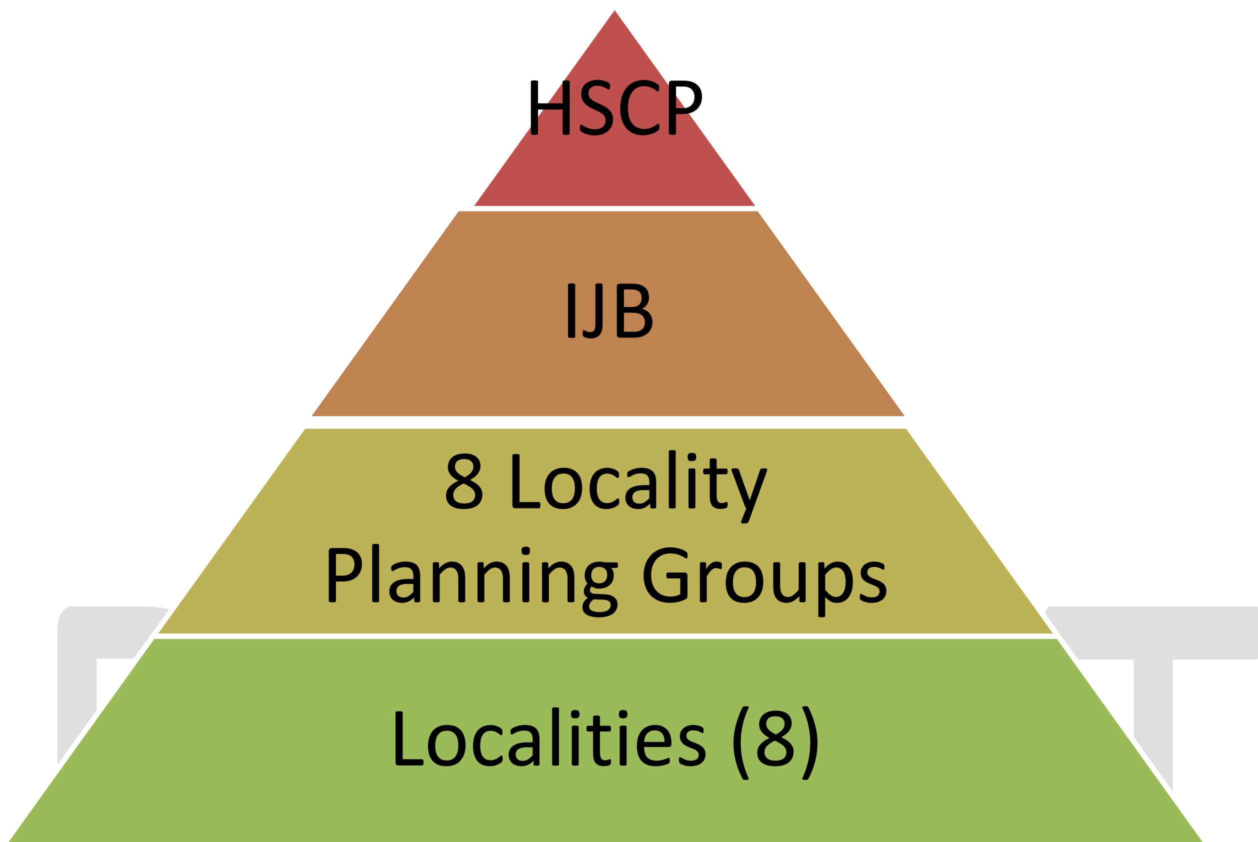
6.8 Natural communities represent the foundation of localities, whilst localities represent the level at which effective and efficient operations, organisation, management and resources can be formed and deployed. These support the effective planning, commissioning and delivery of community-based health and social care services. The locality arrangements for Argyll and Bute are illustrated below:



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6.9 The locality planning intent of Argyll and Bute HSCP intent is in accordance with the findings of the Christie Commission and the recently released guidance on locality planning. This locality level is well recognised and evidenced as offering meaningful engagement Integration principles and with, GP practices, pharmacies, Third Sector partners, district nursing teams, and social work/home care. This is where the formal commissioning and partnership plans for the independent sector and acute services can be assessed to need, developed, commissioned and performance monitored/managed.

6.10 The Argyll and Bute model of Locality Planning proposes the continuation of the well -recognised and adopted localities and informed from our strategic plan the addition of Isles of Mull and Iona as a locality as detailed below:

Locality	Population	Locality Description
Oban, Lorn & the Isles	17,180	Easdale to Oban, to Port Appin to Dalmally & Isles of Tiree and Coll
Isles of Mull and Iona	3,068	Isles of Mull and Iona
Mid Argyll,	9,399	Tarbert, Lochgilphead, Ardfern, Inveraray,
Kintyre	7,741	Southend, Campbeltown, Muasdale, Carradale, Gigha
Islay and Jura	3,393	Isles of Islay & Jura and Colonsay
Cowal	14,489	Lochgoilhead, Strachur, Tighnabruaich, Dunoon,
Bute	6,227	Isle of Bute
Helensburgh & Lomond	26,163	Helensburgh, Kilcreggan, Garelochhead, Arrochar
Argyll & Bute CHP	**87,660**	

Source: NRS 2011 Mid-year estimate for 2014.

6.11 Initial profiles for each of the eight Localities are in development informed from the locality profiles in Appendix 5.

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7. BUILDING AND SUPPORTING STRATEGIC PARTNERSHIPS

7.1 This Health and Social Care Partnership will be built on strong relationships and partnerships with a number of key Partners and stakeholders. Its ability to realise the National and Local Outcomes set out in this Strategic Plan will largely be dependent on how well founded our partnership relationships are and how well they are integrated into the Partnership's Strategic Planning process.

7.2 Significantly, the development of Locality Planning, as outlined in the previous section, will afford a very significant opportunity for much more extensive partnership engagement at a more local level.

7.3 The new Partnership will establish robust and comprehensive partnership arrangements with the following key groups:

7.4 **Public Partnership- Health Care Forum**

7.4.1 A new relationship will be established with the general public, thus ensuring that they are much more active participants in shaping their own health and social care in the future. Local performance and accountability informed by user and carers experience will be essential to drive forward the transformation in health and wellbeing.

7.4.2 The locality Health and Care forum will act as the coordinating hub for facilitating and supporting this work with Scottish Health Council guidance. The HSCP expects nominated representatives from the local forum to be members of the Locality Planning Groups.

7.4.3 The work of the Health and Care Forum at locality and specifically at the natural community scale will play a key role in getting active communities and families to take steps to maintain and improve their own health and wellbeing.

7.4.4 Giving practical effect to this policy intent has been identified as an early priority area for the HSCP.

7.5 **Partnership with service users and carers**

7.5.1 The accepted way of working is one based on co-production which will include supporting service users and carers to be equal partners in, and contributors to, their own health care and support.

7.5.2 The Partnership will put in place its “common currency” of person centred care with structural arrangements for ensuring good joint work, for example, building on the strong foundation of the Health and Care Forum and Carers Network driving change in working practice.

7.6 **Partnership with staff within Health and Social Care Partnership**

7.6.1 The workforce, including the statutory, independent and third sector are the main resource for the delivery of quality services and achievement of outcomes for people in Argyll and Bute.

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7.6.2 The Partnership believes it needs its workforce to be motivated, committed, skilled and valued, working to its maximum capability and capacity. We will put in place over the 3 years of the plan a workforce plan which:

- Ensure it is aligned with the objective of establishing and operating single integrated teams
- Support our workforce by reducing the burden of work on them by removing waste, duplication and instigating standard operating procedures to free up staff time and resource
- Establish workforce development and training programmes that are directly related to core service and organisational objective, workforce skills and competency development within a personal development plan process

7.6.3 Extensive involvement of staff through staff partnership groups and staff involvement in strategic and locality planning and within operational teams is a necessity to drive forward the transformation in health and social care to achieve the partnerships vision.

7.7 Partnership with Primary Care Independent Contractors

7.7.1 General Practice

As the primary universal service for the majority of people, General Practice is a vital component in the work of the HSCP. General Practitioners are already engaged in a range of work programmes that support the strategic objectives of this Plan.

The HSCP recognises the centrality and importance of this work and will consequently seek to strengthen its relationship with General Practitioners (through formal planning arrangements, at locality level, and in the way it shapes and manages its services) to allow GPs to be integrated fully into the HSCP's strategic planning and policy development.

The challenges facing primary care at present with regard to recruitment and sustainability have been particularly severe in remote and rural areas. We are faced with redesigning and establishing new methods of service delivery to meet core patient needs in and out of hours. Services for the future will focus on maximising capacity and capability in primary care implementing new models of delivery through merger and federations.

7.7.2 Community Pharmacy

Community Pharmacists play an increasingly clinical role. This provides major opportunities for the HSCP to work more collaboratively with Community Pharmacists to support local people. Community Pharmacies are located throughout Argyll and Bute and are an important point of contact for the general public and service users. The HSCP will ensure that Community Pharmacists form an important part of our strategic planning and policy development and will, jointly with them, explore opportunities for the development of services provided from their premises.

7.7.3 **Dentistry**

Dentists and Dental Practices are located extensively throughout and are a vital point of contact for a range of service users and the general public. The role traditionally played by dentists is changing, for example, in relation to public health issues, ensuring that general dental service needs are met by Independent Dental Practices and not the salaried public dental service. Therefore the contribution made by dentists will be important to the delivery of agreed National and Local Outcomes.

7.7.4 **Optometry**

Optometrists and Optician Practices are located extensively throughout Argyll and Bute and form a vital point of contact for eye care service users for both routine eye examinations and for the early detection, treatment and referral of both eye disease and other general health problems. Increasingly Optometrists are playing a wider role within Primary Care. This includes provision of Low Vision Services, Diabetic Retinopathy Screening, Bridge to Vision, Hospital Contact Lenses and both pre and post- operative cataract reviews. In addition, Optometrists provide domiciliary eye care services for those unable to leave their place of residence unattended. Optometrists are also playing a wider role in relation to Public Health issues such as smoking cessation and falls prevention. Optometrist are increasingly becoming involved in shared care services which allow for patients with stable pathology to be monitored within the Primary Care setting instead of within the Hospital Eye Service outpatients. This work can be developed further as part of “Shifting the Balance of Care” and their contributions will form a part of the HSCP’s strategic approach to the delivery of its objectives.

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7.8 **Partnership with Third Sector**

7.8.1 The Third and Community sector play an important role in supporting the delivery of the HSCP's Vision and Mission. In Argyll and Bute there has been significant strengthening of the valuable role of this sector and there is a positive relationship in place which provides a solid foundation for future work.

7.8.2 At the strategic level, Third Sector Interface plays a key leadership role in ensuring that the sector they coordinate and support is part of the strategic planning process for key groups (e.g. children and older people).

7.8.3 Third Sector Interface has been active in ensuring lower profile providers (such as faith groups) are supported to play a substantive role at local level.

7.8.4 Third Sector Interface will be important in ensuring that the Locality Planning arrangements have good representation and engagement with Third Sector organisations at local level.

7.9 **Partnership with Independent Sector**

7.9.1 Our existing commissioning arrangements ensure Independent Care Providers are included and engaged within significant planning processes, particularly in relation to adults and older people. As Locality Planning develops our intention is to strengthen this to ensure local needs and service/workforce planning focuses on service delivery.

7.9.2 Scottish Care has a significant leadership role, including coordination and information dissemination, and provides a variety of practical resources to members.

7.9.3 Relevant independent providers of Children's Services will be fully included in the partnership.

7.10 **Partnership with other Local Authority Departments**

7.10.1 In creating the Partnership it is vital that strong internal connections with council services are not lost or weakened.

7.10.2 In particular, continuity and partnership planning will include:

- Education and Early Years.
- Housing and Housing Support Services.
- Leisure Services.
- Libraries.
- Other support services.

7.11 **Partnership with Outside area Health Services**

7.11.1 The Partnership will have a responsibility to commission and contract specialist clinical and care pathways that lead to and from Acute Hospital sites, including services provided by other NHS Boards and specifically NHS Greater Glasgow & Clyde.

7.11.2 NHSGG&C Acute sector representation in the Strategic Planning Group and operational engagement at locality level with the development of patient pathways creates an opportunity for engagement across the sectors in a way that ensures a joint approach to the shift in the balance of care and attainment of outcomes. The continued development of , etc. for some conditions also enables stronger partnership working across the community and acute sectors.

7.11.3 In addition, the Partnership will establish working relationships with other parts of NHS Highland for non- delegated health service, including Policy, Professional Leadership, Estates, etc.

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7.12 **Partnership with and within Community Planning Partnership**

7.12.1 The HSCP will have an important role within the Community Planning Partnership arrangements for Argyll and Bute and support the delivery of specific key Single Outcome Agreement results.

7.12.2 The recent review of Community Planning in Argyll and Bute makes particular reference to the potential, and challenge, of the new Health and Social Care Partnership:

"The integration of Health and Social Care provides both an opportunity and a challenge for the Community Planning Partnership. This is a very significant area of spend and is fundamental to the role of the CPP in tackling inequality. It will be very important to ensure that the Health and Social Care Partnership is able to work as an integral part of the community planning framework. The opportunity for the CPP is to provide a way of connecting the priorities and actions of the Health and Social Care Partnership to the wider array of services, notably in terms of community safety and employability."[14]

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7.12.3 The HSCP will build on the strong partnership arrangements with the Community Planning Programme Board. The Health and Social Care Partnership will lead the Community Planning Health and Wellbeing theme on behalf of the partnership.

7.13 **Partnership Working on Alcohol and Drugs**

7.13.1 Argyll and Bute Alcohol and Drug Partnership (ADP) were formed in August 2009 as a Thematic Group within the Argyll and Bute Community Planning Partnership structure.

7.13.2 The ADP is currently reviewing and updating the Alcohol and Drug Strategy (2013-2016[15]) which is aimed at working with individuals and local communities to identify their strengths and assets and how they can reduce the impact of alcohol and drug misuse on individuals, families and communities. This revised Strategy will cover 2017–2020.

7.13.3 The ADP will work with the Integration Joint Board to ensure that strategic and delivery plans for alcohol and drug outcomes are embedded within Health and Social Care arrangements.

7.13.4 The current ADP strategy can be found at http://www.argyll-bute.gov.uk/moderngov/documents/s74011/Ag%20Item%2010a%20-%20Final%20ADP%20Strategy%202013-16.pdf

[15] Argyll and Bute Alcohol and Drug Strategy, 2013

8. HOUSING

8.1 Having a suitable and affordable place to live is at the very core of addressing every individual's health and social care needs and in meeting one of the National Outcomes for Health & Social Care regarding 'Independent Living' – namely that *"people, including those with disabilities, long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community".*

8.2 Housing providers, and those who provide housing services, will be key partners in the provision of health and social care services and in meeting the needs of individuals and families within our communities. Therefore, they will be essential to this Strategic Planning process and will be part of the membership of the Strategic Planning Advisory Group.

8.3 **Local Housing Strategy**
Every local authority in Scotland has a statutory duty[16] to produce a Local Housing Strategy (LHS) supported by an assessment of housing need and demand. Local Housing Strategies are the sole strategic document on housing and housing-related services in a local authority area and include homelessness, housing support and housing for older people.

The current Local Housing Strategy www.argyll-bute.gov.uk/sites/default/files/housing/14._local_housing_strategy.pdf was adopted by Argyll & Bute Council in 2011 and runs for a five-year period up to 2016. The LHS identified 4 strategic priorities:

- People successfully access a choice of suitable and affordable options in the area that they want to live and can participate in the housing market
- Less people will become homeless as a result of our pro-active approach to prevention and support
- More households with particular housing needs will live in their own homes as a result of pro- active forward planning, investment and support strategies.
- More people in Argyll & Bute live in well repaired and maintained homes that are affordable to heat.

A fully revised and updated LHS will be implemented in 2016/17, and the provision of specialist housing and support for independent living will remain a critical strategic outcome over the next five years.

8.4 **Scottish Government Guidance**
8.4.1 The latest LHS guidance published on 21 August 2014 clearly states that:

"The LHS has a key role to play in contributing to the effective integration of health and social care. It should set out clearly the contribution that housing can make in support of this agenda, through the design and delivery of housing and housing related services that are capable of responding to the needs of individuals as and where they arise."

8.4.2 The Guidance goes further to suggest:

"The LHS should be clear on what the integration of health and social care means in terms of providing suitable accommodation and the care and support required to fully support this agenda, whilst enabling people to live independently within their own home for as long as possible."

8.4.3 Specialist Provision and Independent Living

The guidance requires all local authorities to address specific issues in relation to "Specialist provision" which refers to the wide range of accommodation needs and care and support services (housing support) needed, to allow people of all ages, to live well and independently. Delivery of specialist provision housing can be achieved through new build or the re-provisioning or adapting of existing properties. It can also be delivered in non-adapted properties through the provision of aids and/or care and support service through:

- Accessible/Adapted Housing
- Wheelchair Accessible Housing
- Non-Permanent Accommodation
- Supported Accommodation
- Care & Support Services
- Sites and Pitches

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[16] Housing (Scotland) Act 2001 http://www.legislation.gov.uk/asp/2001/10/contents

8.5 Housing Need and Demand Assessment (HNDA)

The Local Housing Strategy must be underpinned by a formal, robust and credible Housing Need and Demand Assessment (HNDA). Argyll and Bute Council published a *Housing Need and Demand Assessment (2010, revised April 2011)*. This has a section detailing need and demand for housing for older people and other groups with particular needs. At that time, the majority (over 70%) of older people in Argyll and Bute, including those aged 75+, live in private accommodation. Approximately 3% of those aged 75+ live in sheltered accommodation. In a 2009 survey for the Housing Need and Demand Assessment (HNDA), 1% of those aged 75+ considered their health to be suffering because of the condition of their home. ~10% of older households reported their accommodation had damp, ~4% had condensation and ~3% needed major structural repairs. Of those households unable to carry out repairs, the most likely reasons were 'Repairs are responsibility of landlord/Council/HA', 'Cannot physically manage' and 'Need DIY skills'. ~7% reported that they could not afford the repairs.

The Council is currently reviewing and updating the HNDA, in accordance with revised guidance issued by the Scottish Government in 2014, and this will provide the evidence base for the next LHS, which is to be launched in 2016/17. To inform this HNDA, the council commissioned a report on The Housing and Support Needs and Aspirations of the Ageing Population of Argyll & Bute, which was published in February 2015. The report found that Registered Social Landlords provide 993 units of specialist housing for older people, of whom 313 are sheltered housing and 29 units are very sheltered housing. Around 600 households of people aged 65+ were found to have unmet need for specialist support. The most common areas of difficulty were mobility related – getting up and down stairs; in and out of bed; in and out of the house; cooking and using the bathroom. Amongst a number a recommendations the report suggested policy considerations to meet future need should include: new build 2 bed bungalows to allow home owners to down-size; refurbishment and upgrading of existing housing stock; provision of sheltered, extra care and specialist housing with care and support, suitable for people with greater health and care needs.

The unmet need is not limited to older people. In 2001, 11% of all households below the age of 60 had a long term illness or disability, predominantly this was physical disability.

1550 people required specialist accommodation, 1170 had an unmet need for housing support and 2000 awaited aids or adaptations to their home.(The revised HNDA will provide a robust and credible update on these figures).

According to the Scottish House Condition Survey 2011-13, 11% of the dwellings in Argyll and Bute exhibit extensive disrepair: 53% were not energy efficient; 15% lacked modern facilities/services; and 28% were deemed to be not 'healthy, safe and secure'.

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The social rented sector (Housing Association) owns 8,366 homes, of which 1,301 comprise some form of specialist accommodation. Over 9% of the total RSL stock comprises amenity/medium dependency/elderly or retirement accommodation. 4% is sheltered or very sheltered provision (a number of previously designated sheltered units have been reconfigured as retirement or amenity housing). Only 2.4% of the RSL stock is defined as wheelchair / adapted/ambulant disabled / or other adapted

8.6 **Fuel Poverty**

8.6.1. In Argyll & Bute Council's *Local Housing Strategy 2011-16* the following were identified as reasons for relatively high levels of fuel poverty in Argyll and Bute:

- A housing stock dominated by hard to treat construction & design.
- A majority of owner occupied and privately rented stock.
- Limited access to mains gas, high fuel costs and poor awareness of social tariffs.
- Low household income.

Argyll and Bute Housing Need and Demand Analysis December 2010, revised April 2011 presents the results of a local private sector house condition survey. Fuel poverty occurred in 38% of households and varied within Argyll and Bute; in Helensburgh and Lomond fuel poverty is less likely as mains gas is available. Fuel poverty was found to be more likely in older (pre-1919) housing and in private rented rather than owner-occupied housing.

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Fuel poverty is defined as spending 10% or more of household income on fuel. Fuel poverty has a negative impact on health.[1] Mortality increases during the colder months in winter[2]. Fuel poverty may be particularly acute for elderly people who are most likely to have chronic life-limiting conditions. They may spend relatively large amounts of time at home and may be stationary for relatively long periods of time. The number of households in fuel poverty is estimated from the Scottish House Condition Survey: Local Authority Report. 40% of households were estimated to be in fuel poverty in Argyll and Bute (2009-2011), which was an increase from 37% (2008-10) and 34% (2007-09). Fuel poverty is more likely in households with private tenure (46%) than households with public tenure (27%). Fuel poverty is also more likely in pensioner households; with an estimated 60% of pensioner households in fuel poverty in Argyll and Bute. (This compares to 49% in Scotland as a whole.)

In 2014, the council commissioned a new house condition survey for the Atlantic Islands (David Adamson, 2014) which provides updated estimates of fuel poverty for this area. It

[1] The health impacts of Cold Homes and Fuel Poverty. Marrnot Review Team, May 2011.

[2] Winter Mortality in Scotland 2011/12, NRS

suggests that the incidence of fuel poverty within Argyll and Bute has increased and remains significantly higher than the national average.

Improving the energy efficiency of housing can help alleviate fuel poverty. In Argyll and Bute, ALIenergy and Changeworks (with Home Energy Scotland) promote better use of energy and local energy resources.

Fuel poverty needs to be addressed, through the HSCP working closely with strategic planning for housing and with housing providers, to ensure that people can continue to live in and heat their homes, at a cost that does not impact their other daily living requirements.

8.7 Strategic Housing Investment Plan

8.7.1 All Local Authorities are required to submit a Strategic Housing Investment Plan (SHIP) which sets out how resources will be used over the following five year period to deliver affordable housing priorities articulated in their Local Housing Strategies. Essentially it forms a plan of what new houses will be built over a given period. When selecting which developments to bring forward, the needs of a range of stakeholders are considered, including older people and those with particular needs.

8.7.2 In the latest Argyll & Bute SHIP submitted to the Scottish Government in November 2014 (and covering the period 2015–2020)

http://www.argyll-bute.gov.uk/sites/default/files/argyll_bute_ship_nov_2014_v1_0_2.pdf#overlay-context=housing/housing-strategies-consultations-and-research-0

the minimum Resource Planning Assumptions(RPA) (i.e. the amount of money available to spend on affordable housing from the Scottish Government's core funding) was confirmed as follows:-:

Table 8.1: Affordable Housing Supply Programme 2015-20

	15/16	2016/17	2017/18	2018/19	2019/20	Totals
RPA	£7.246m	£6.216	£4.976	£3.317m	£3.317m	£25.072m

Additional funding is usually required from the council's Strategic Housing Fund as well as private finance/RSL contributions.

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8.7.3 Addressing the housing and support needs of older people is one of the prioritisation criteria used as part of the SHIP process. The SHIP currently proposes an annual benchmark of around 110 completions per annum pending the results of the emerging HNDA. 10% of this new build should be suitable to the needs of particular household's e.g. older people; those with physical or mental disabilities and other vulnerable groups through the provision of specialist housing such as wheelchair accessible and Extra Care accommodation and in particular medium dependency amenity (sheltered) housing. All new build affordable housing is built to the Scottish Government Housing for Varying Needs standard.

8.8 **Adaptations**

8.8.1 Funding for housing adaptations currently comes from –two key sources:

- Private sector – Scheme of Assistance (Private Sector Housing Grant).
- RSL Tenants – Scottish Government funding (Stage 3 Adaptations).

8.8.2 The approaches to processing and resourcing housing adaptations are still very inconsistent and uncoordinated between the private sector, and RSLs. Access to adaptations therefore, is currently different depending on whether the individual lives in the private or social rented sector. This is being reviewed at both national and local level currently, and the integration agenda will afford potential opportunities to address these anomalies and drive greater efficiencies in the future.

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8.9 **Scheme of Assistance**

Within the Housing (Scotland) Act 2006 Section 71, powers have been given to Local Authorities to provide assistance for housing purposes. This is often referred to as the 'Scheme of Assistance' and it is linked with adaptations for people with disabilities. However, the Scheme of Assistance relates to a wider range of powers, including advice and information to improve, repair or adapt privately bought homes. Eligibility for assistance will be determined in accordance with the Council's criteria for accessing Community Care Services.

8.10 **Housing Options**

The Council operates an online housing options service which provides detailed and targeted information and advice on a wide range of accommodation and support services. This includes options suitable for older persons and those with particular needs. Specific accommodation options will include Extra Care housing, sheltered and amenity housing, wheelchair accommodation, and other forms of adapted or supported properties.

Extra Care Housing is a model of care where older people are offered individual tenancies in

suitably adapted flats or under Sheltered Housing schemes.

Facilities are usually provided in partnership between a housing association, a care provider and NHS community services. The housing provider is responsible for maintenance of the property aspects of the flats, communal corridors and the grounds. The care provider is responsible for meeting the assessed needs of individuals, supplemented by community health staff and overnight care teams.

Eligibility for the service will be determined by the HSCP's individual assessment process.

In 2010, Argyll and Bute Council in partnership with Registered Social Landlord's agreed the model of 10 tenancies within each housing complex, to be allocated to tenants with extra care needs.

Agreement was then reached on the referral and allocation process and three pilot sites were identified. A joint consultation exercise was completed within the pilot sites. The consultation proved successful and the model was quickly rolled out across all sheltered schemes in all localities.

In July 2015 there are 84 people receiving extra care services within the existing sheltered housing schemes.

Purpose designed, new build extra care accommodation has been provided in recent years in Jura, Mull, Helensburgh and Lochgilphead, and further developments are being considered for inclusion in future updates of the SHIP

8.11 **Care and Repair**

Care and repair services help people aged 60+ and disabled owner-occupiers, tenants of private landlords and crofters to repair, improve and adapt their homes. They do this by helping people to decide what work is required, help to choose reliable tradesmen, obtain finance and oversee the work. Small repairs services are available directly from Care and repair at a low cost. http://argyllcommunities.org/careandrepair/what-we-do/

8.12 **Registered Social Landlord Tenants (RSL)**

Assessed need by RSL tenants is funded through grants provided by the Scottish Government.

8.13 **Housing Support**

Argyll and Bute Council's Housing Service is committed to preventing homelessness, helping people to stay in their own homes and promoting realistic housing options. The Housing Support Service aims to:

- Assist people to sustain their tenancies, and prevent homelessness

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- Support homeless clients to prepare for the allocation of a permanent home
- Provide quality services and work with internal and external partners to ensure Best Value
- Promote independent living

The type of support that is provided will be tailored to meet the specific needs of the individual. The following list isn't exhaustive but housing support can include things like advising or assisting with:-

- resettlement
- move-on to new accommodation where less intense support is required.
- dealing with benefit claims and/or other official correspondence relevant to sustaining occupancy of the dwelling
- arranging minor repairs to, and servicing of, domestic equipment and appliances.
- personal budgeting or debt counselling
- preparation for independent living
- general form filling
- accessing furniture

Currently, the council Housing Service funds and co-ordinates services provided by local support agencies such as Carr Gomm, HELP, KYES, Women's Aid, and Blue Triangle Housing Association.

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8.14 **Homelessness and Tenancy Support Services**

Argyll & Bute Homeless Service assists people who have nowhere to live or are worried about losing their home. All staff are trained to Scottish National Standards to provide advice, information and signposting on all issues related to future housing security. There is an out of hours emergency telephone line **0345 056 5457.**
A member of the Homeless team is always available, to respond to callers to this number.

8.15 **Housing Contribution Statement**

Argyll & Bute Council have provided a Housing Contribution Statement which can be found at Appendix 14.

9. RESOURCE OVERVIEW (Finance, Workforce, Corporate services OD etc.)

9.1 **The Financial Plan and Available Financial Resources**

9.1.1 The Financial Plan, an integral part of this Strategic Plan as detailed in Appendix 7, will be further developed in the first full year following the creation of the Integration Joint

Board. The plan sets out the indicative financial resources that are available during the period of an extremely challenging public spending round and prioritises how these will be utilised in supporting the needs of the Partnership population.

9.1.2 The methodology for determining the resources to be made available by the Council and the Health Board to the Integration Joint Board for the delegated functions is set out in the Integration Scheme.

9.1.3 The Financial Plan, which covers a period of three years, comprises:

- The Integrated Budget, i.e. the sum of the payments to the Integration Joint Board.
- The notional budget, i.e. the amount set aside by the Health Board for large hospital services used by the Integration Joint Board population.

9.1.4 As well as the core funding, there are two additional funding sources that will be available to meet, in part, the cost of delivering Strategic Plan Objectives. These are:

  - Legacy funds from the Reshaping Care for Older People concluded on 31.03.2015
  - The Integrated Care Fund Plan for 2015-16. This was approved by the Shadow Integration Board at its meeting on 11 December 2014 and forms Appendix 11 to this Plan.

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9.1.5 As part of the financial planning process initial work has identified an indicative available funding for 2015-16 which amounts to £250.4m across both Health and Social Care. For 2016-17, there will be inflationary uplifts on some costs however, due to a continuing challenging financial outlook, there is likely to be savings required.

- Argyll and Bute Council's overall savings targets will be approximately £9 million in both 2016/17 and is estimated to be between 4% and 6% in 2017/18.
- NHS Highlands saving targets for Argyll and Bute are likely to be between 2-3% (£3.6-£5.4 million)

Decisions on the level of funding allocated and savings the HSCP will be made by February 2016 and over the Plan period is estimated at Figure *to be inserted in February when Argyll & Bute Council and NHS Highland have agreed a budget allocation*. As functions, strategies and services are reviewed and integrated, it is likely that the current pattern of spend will alter as the HSCP seeks to operate in accordance with the Integration Planning Principles and takes steps, along with the two Statutory Partners and other sectors, to shift the balance of care from institutional to community settings.

9.2 Financial Resources: Services for Adults and Older People

9.2.1 The figure below, which fits the 'Reshaping Care for Older People' model reasonably well, shows considerable activity taking place at the 'top' end of each triangle.

9.2.2 The majority of financial and staff resources from health are focused on clinical interventions in institutional settings, illustrated by the second triangle in the Figure 6 which highlights the proportional spend in each of the service categories.

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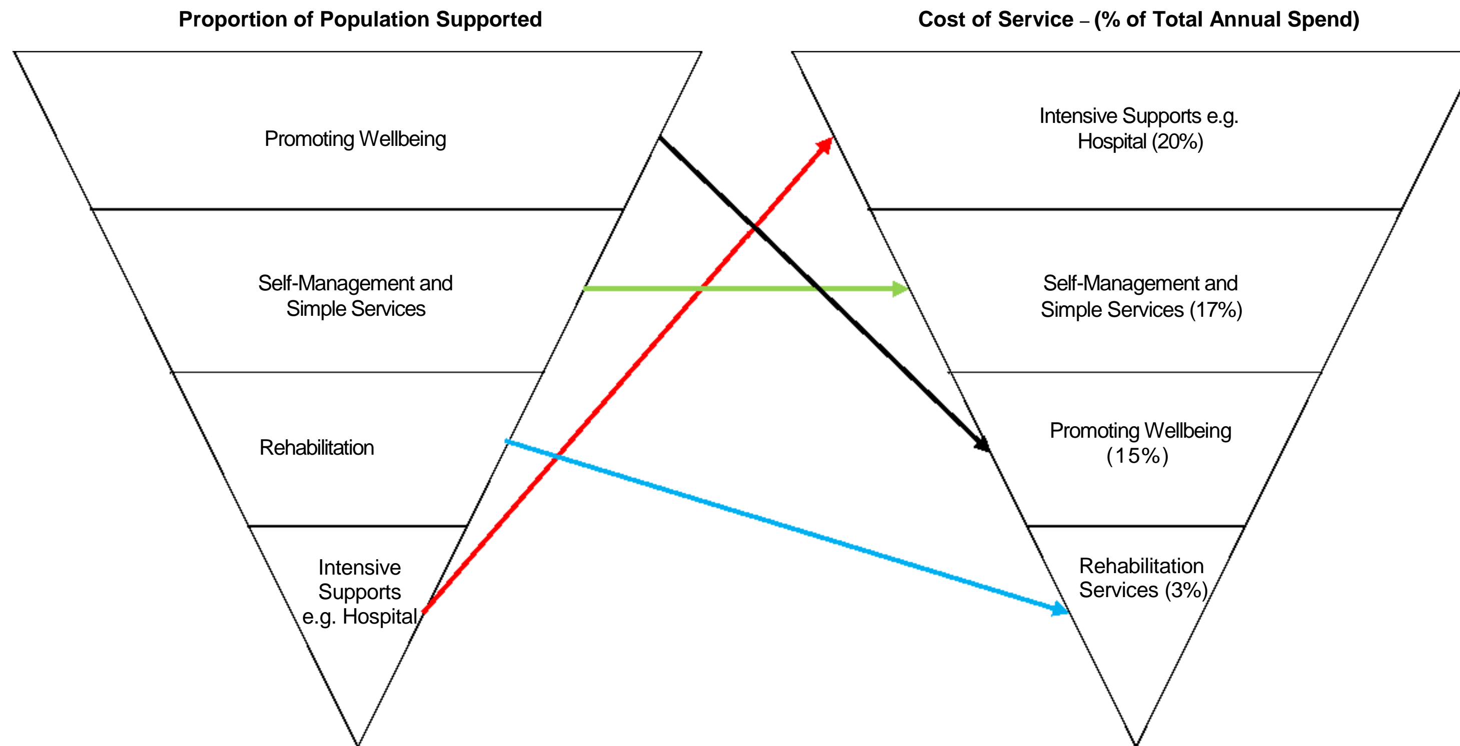
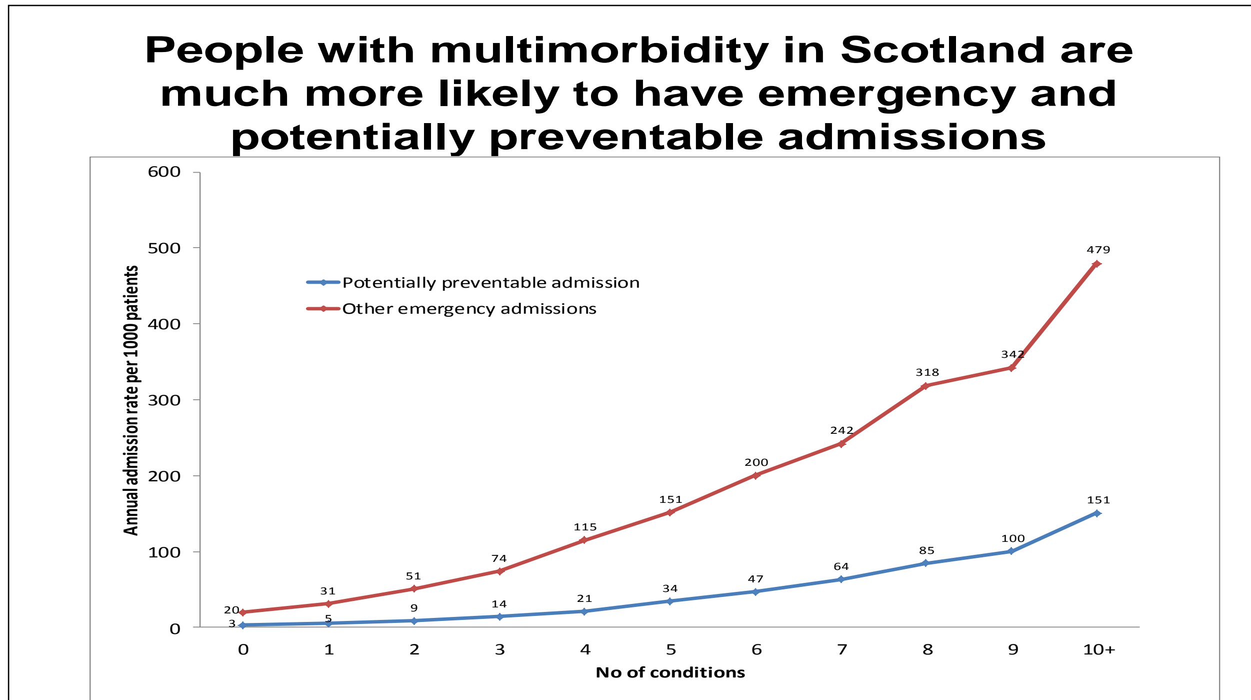
Figure 6: Service Activity and Indicative Spend on Adult Services across Argyll and Bute



9.2.3 Whilst some people will require hospital or other institutional-based care at some time, given the demographic challenges outlined earlier in this Plan, combined with the aspiration to support more people at home for longer, there is a need for change in the services provided and the way in which they are provided which will require a shift in the resources to community settings.



Source: Professor Stuart Mercer CHP Planning Conference Feb 2014

This is particularly relevant with regard to planning our response to meet the increasing health and care needs of an ageing population who will have more complex co morbidity needs. This is illustrated in the graph below

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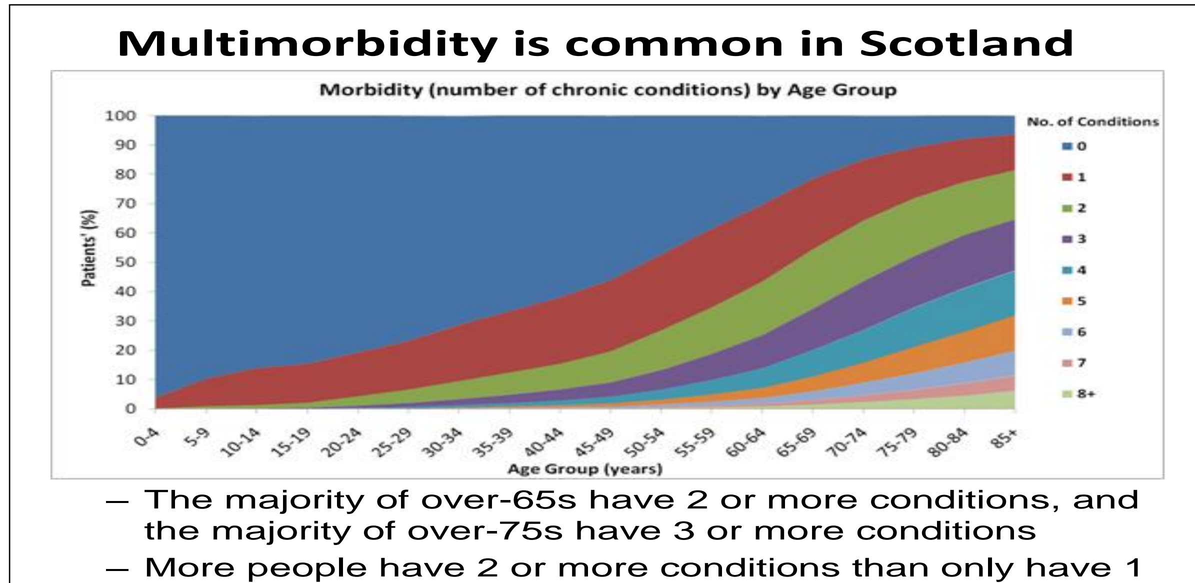

Source: Professor Stuart Mercer CHP Planning Conference Feb 2014

The graph illustrates the majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions. More people have 2 or more conditions than only have 1.

9.2.4 **Financial Resources: Children's Services**

The implementation on 1 April 2015 of the Children and Young People (Scotland) Act 2014 will result in a potentially significant rise in the numbers of children and families eligible for services and places a

requirement on the HSCP to establish an additional range of resources and services to meet the changes. Section 10 - Aftercare and Section 11 - Continuing Care of the Children and Young People Act ensures better permanence planning for children and young people, and extends support to Looked After Children and Care Leavers by increasing the eligible age of accessing services to Age 25.

There is a further challenge of the geography of Argyll and Bute in recruiting and retaining staff, often leading to employing higher cost agency staff. Ongoing budget planning will need to consider any implications arising as a result of the statutory duties placed on the Council by the Children and Young People Act.

9.3 Financial Planning 2016/17 to 2018/19

9.3.1 This section will summarise the future financial planning assumptions regarding service demand and reduction in budget and the cost savings required. This will be populated from Information from NHS highland and Argyll and Bute Council informed from their budget setting processes.

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Indicative budgets 2016/17 and 2017/18 (to be inserted when budgets are agreed)

Health:

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Health Services	**Budget 2016/17 £**	**Indicative Budget 2017/18 £**
GP Acute In-patients		
Surgical In-Patients & Day Cases		
Medical In-Patients & Day Cases		
Psychiatry In-patients		
Dementia Assessment In-Patients		
Dementia Long Stay In-Patients		
Casualty		
Out-Patients		
AHP Services		
Community Mental Health Services		
Community Nursing		
Community Care Teams		
Alcohol & Drug Partnership		
Learning Disabilities		
Community Dental Services		

General Dental Services		
GP Services		
Opticians		
Chemists		
Prescribing		
Out of hours		
Hospital Services outwith A&B and GG&C		
GG&C Surgical In-Patients & Day Cases		
GG&C Medical In-Patients & Day Cases		
GG&C Out-Patients		
GG&C Mental Health		
GG&C Renal Dialysis		
Regional Services		
GG&C Homecare Services		
Public Health/Health Promotion		
Total		

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Social Care:

Social Care Services	**Budget**	**Indicative**

	2016/17 £	Budget 2017/18 £
Assessment and Care Management		
Carer Groups		
Day Care		
Dementia		
Technology Enabled Care, Equipment and Adaptations		
Homecare		
Older People Other		
Residential Care		
Respite		
Sheltered Housing		
Total		

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Externally Purchased Services: (to be completed when expenditure is agreed)

Externally Purchased Services	Budget 2016/17 £	Indicative Budget 2017/18 £
Marie Curie Nursing		
Carr Gomm overnight care		
Alzheimer Scotland Dementia Services		
Carers' Centres		
Crossroads Respite Care		

Total		

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9.4 Staff Resources

9.4.1 A summary of the staffing resources within the scope of the Partnership is provided in the table below. A fuller breakdown is provided in Appendix 8.

Service Area	Staff Numbers in Full Time Equivalents (FTE's)
Social Work & Social Care Staff	**564.13**
Health Care & Support Staff	**1548.00**
Senior and management	**44.80**
TOTAL	**2156.93**

9.5 New Ways of Working

Change and Organisational Development

9.5.1 The Integration Joint Board will oversee a programme of new ways of working which will see all activity areas, strategies, policies and operational procedures reviewed and appraised. Through this process, decisions will be made on how resources will be deployed in future years. This work will run in parallel with the Strategic and Locality Needs Assessment process.

9.5.2 In terms of Organisational Development (OD), a Strategy and Action Plan over the period of the strategic plan is detailed at Appendix 9. A fuller OD Implementation Plan designed to meet operational and emergent locality needs going forward will be developed and consulted on in 2016-17 and in future years as part of the refresh of this Strategic Plan.

9.5.3 The Partnership will develop a Workforce Strategy in its first year (2016-17) which will build on that already developed by NHS Highland and Argyll and Bute Council, but aligned with our strategic and transformation objectives. This has been included as an action item within the Implementation Plan.

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9.5.4 The Partnership is committed to the continuous improvement management system, utilising Self Evaluation, PDSA, audit and inspection and best value to assess how it is performing, examining where there are particular strengths to be built upon and where there is scope for improvement.

9.6 Information Resources

9.6.1 An Information Sharing Protocol for the Partnership has been agreed by the Statutory Partners and is included within the Integration Scheme.

9.6.2 A single integrated information system has been identified as a key priority for health and social care services in Argyll and Bute. There is a recognition that we must start from the current arrangements driving forward our work on single shared assessment tool in 2015/16 and looking forward over the next 3 years. Our expectation is that we will develop a business case and secure funding to put in place a future-proofed system which will incorporate access to acute services information in NHS GG&C via a “portal” type interface which is also accessible by primary care across Argyll and Bute.

9.6.3 In the interim the Senior Management Team working with professional and staff representatives will seek to identify opportunities for improved information sharing. This will aid and support effective frontline service delivery, a single shared assessment tool is the priority. We recognise that as a quality improvement activity, this will be critical to the success of the HSCP in achieving a shift in organisational culture, establishment of person centred care and the single team approach to service delivery.

9.7 Property Resources

9.7.1 Work is now complete on mapping the location, suitability, condition and operational effectiveness of the combined property estate currently used to deliver delegated services. This information will be used to develop a Property and Asset Management Plan for the Partnership which will have as one of its objectives the development of an efficient and effective property estate designed to support operational frontline service delivery. This will prioritise action items over short, medium and long-term time periods.

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9.8 Corporate Services

9.8.1 The integration scheme specifies that the Council, NHS Board and HSCP will identify and put in place the corporate support required to fulfil the duties of Argyll and Bute Integration Joint Board. The Parties will, by 01.04.2016:

- Identify the corporate resources currently utilised to deliver the delegated functions.
- Agree the corporate support services required to fully discharge Argyll and Bute Integration Joint Board's duties under the Act.
- The provision will be reviewed within the first year to ensure that it is adequate.

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9.9 Disinvest to Reinvest

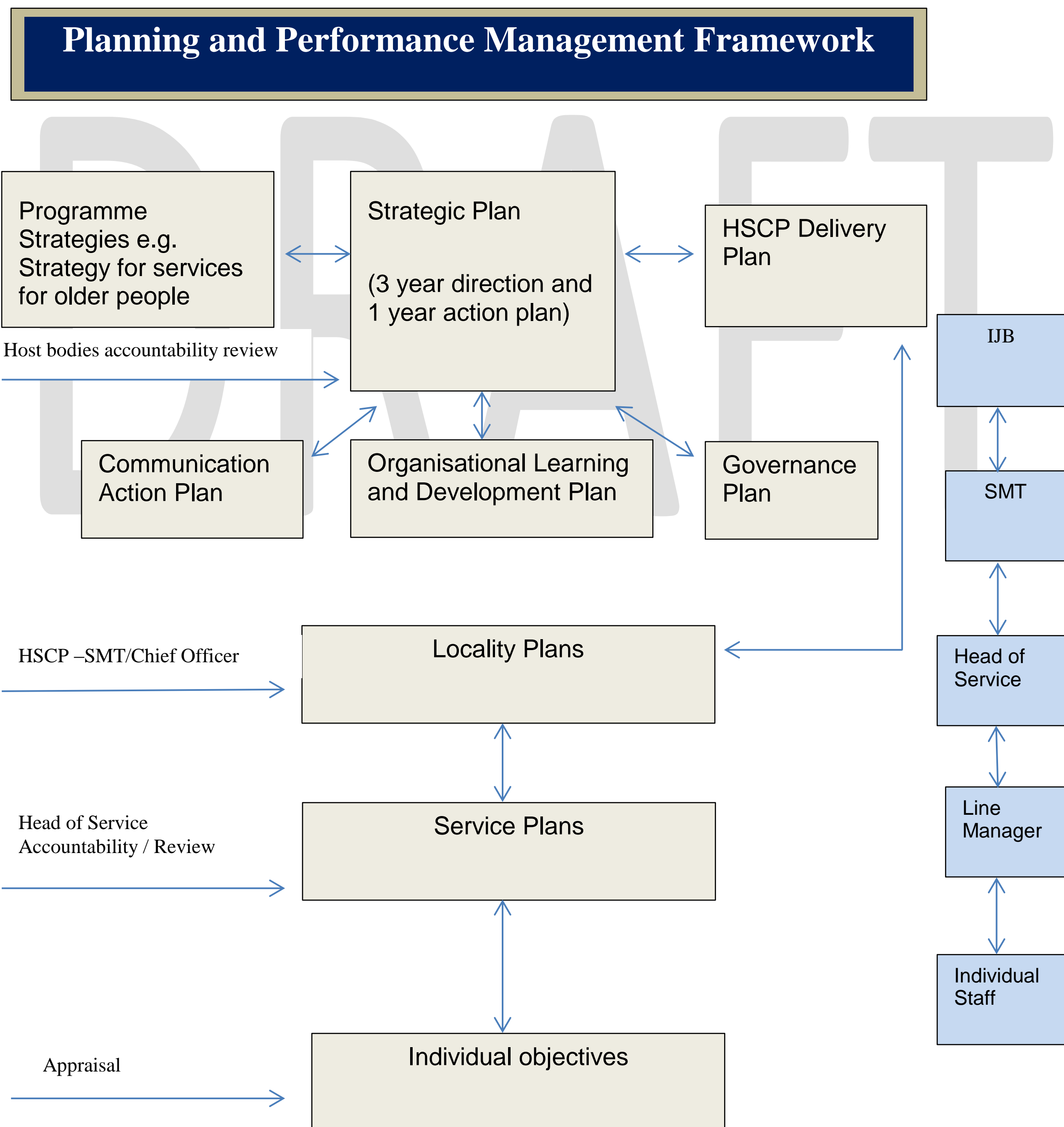
9.9.1. Over the period of this plan, as the Partnership is established and services are integrated, we are planning for opportunities to be created for efficiencies in the delivery of corporate and front line services which will lead to rationalisation in a number of areas, including in the number of premises required, IT infrastructure, facilities, workforce deployment, front of service access arrangements, management reduction, etc. Opportunities and developments in this area will be identified through 2015/16 and 2016/17 with prioritisation and implementation plans developed through 2017-2019

9.10 Equalities Impact Assessment

9.10.1 An Equalities Impact Assessment of this Plan will be undertaken through and at the conclusion of the consultation process on this draft plan and will be included at Appendix 15. The Equalities Impact Assessment will be completed by appropriate officers as identified in legislation.

10. OVERVIEW OF PLANNING AND PERFORMANCE

10.1 The Planning and Performance management Framework for the Partnership is outlined in Figure 7 below:



***Note:** *Approval level for major capital schemes or major change may require NHS Board, Council and SGHD sign off*

10.2 This has been designed to simplify the planning and performance process yet at the same time ensure the IJB can meet its accountability requirements against the nine National Health and Wellbeing Outcomes for adults and older people. In addition, the key national child outcomes from 'Scotland Performs – The National Performance Framework' have also been included along with those for Criminal Justice Services which will be included within the functions and services that will be delegated to the Integration Joint Board and the Partnership. It will, in the first instance, provide a framework to support the necessary internal controls to ensure that the objectives and tasks set by the HSCP are being achieved and, where they are not, provide the framework to evidence and address the underlying issues. Secondly, it will fulfil the reporting requirements of the NHS Board, Local Authority and Scottish Government.

10.3 The Health and Wellbeing Outcomes are a high-level statement of what all Health and Social Care Partnerships across Scotland should achieve through Integration and form a significant part of the National Performance Framework in respect of services for adults and older people. A national suite of indicators and measures has been developed to support the National Outcomes.

10.4 The Health and Wellbeing Outcomes and associated suite of National Indicators have been prescribed by the Scottish Government. A core set of indicators have been developed locally to describe the level 2 tier of performance (Publicly Accountable Indicators and Targets). This core set comes from the publicly accountable indicators and targets that Argyll and Bute Council and NHS Highland currently report against, which relate to the services within the scope of the Partnership. Details of these indicators are provided in Appendix 12.

10.5 The gradient of performance reporting which will be adopted will encompass a wide suite of indicators and measures that will be defined locally and which will support management in the efficient and effective delivery of services and help show that Partnership strategic objectives are being delivered and serve as an indicator of continuous improvement. It is intended to identify:

- How the HSCP manages performance in the organisation, with identified accountability at each level, from Board, to individual employees.
- The annual planning and performance reporting cycles including alignment with financial and workforce planning.
- Links between PMF and improvement drivers such as inspections, audits, feedback, reviews and risk management.
- Reporting performance to the public and its host bodies.

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- Initially using both the Council's performance management system, "Pyramid" and NHS Highland balance score card performance reporting system but looking by the end of 2016/17 to have a single integrated performance reporting system.

The table below provides a summary of the Performance Management Framework. An outline of commissioning and contracting across the various social work areas is shown at appendix 7.

Performance Management Framework

Outcomes/ Targets Level	**What?**	**(Accountable Officers)**	**How? (Mechanism for Monitoring)**
HSCP	Strategic plan incorporating National Health and Well Being Outcomes LDP SOA Governance – Clinical and Care, Finance, Staff, Public Involvement etc.	Chief Officer & Chair IJB	• **Reviewed at IJB board meetings** • Performance and Accountability Review meetings **NHS Board and Council – Annual report** • **Progress reports support monitoring and actions.** • Corporate level use of Pyramid system and Balanced Scorecard • Appropriate and supported public and user **feedback.**

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Outcomes/ Targets Level	What?	(Accountable Officers)	How? (Mechanism for Monitoring)
Locality	Locality Delivery plan	Head of Adult and Children's Services	• **Reviewed by Locality Management team and Locality planning group at** regular team meeting led by Heads of Service • Accountability meetings held with CO supported by Finance/ Planning • Locality Pyramid/Scorecard • Appropriate and supported public and user feedback**.**
Department/ Service	Department/ Service Plan	Head of Department or Service Manager	• **Reviewed by Team regularly** using Pyramid system tailored to the service. • **Objectives** and progress reported on specific projects/initiatives • Appropriate and supported public and customer **feedback.**
Individual	Work Plan and/ or IPR Plan	Each Member of Staff	• **Reviewed with line manager regularly through appraisal.**

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10.6 Reporting against the framework will provide information on current performance and explore shifts in performance trends over time, where available and appropriate. The information will support the production of the Partnership's Annual Performance Report and will enable it to report on the areas specified in Regulation, including the following:

- Progress on the delivery of the national health and wellbeing outcomes.
- Information on performance against key indicators or measures.
- How the strategic planning and locality arrangements have contributed to delivering services that reflect the integration principles.
- Details of any review of the Strategic Plan within the reporting year.

- Processes and major decisions taken out with the normal strategic planning mechanisms.
- An overview of the financial performance of the Integration Authority.
- The extent to which the Integration Authority has moved resources as part of the shift in the balance of care.

11 APPROACH TO RISK MANAGEMENT

11.1 There are a number of strategic level risks which, if not mitigated, would impact adversely on the implementation of this Strategic Plan. The mitigation will be achieved through the Strategic Objectives and Measurable Tasks, as detailed in Sections 5 and 14 and the strategic level risks are summarised in Appendix 13.

11.2 These risks will be reported to and reviewed by the Integration Joint Board on a quarterly basis.

12 CLINICAL AND CARE GOVERNANCE

12.1 The Health Board, the Council and the Integration Joint Board are accountable for ensuring appropriate clinical care governance arrangements for integrated services. They are accountable for ensuring appropriate clinical and care governance arrangements for their duties under the Public Bodies (Joint Working) (Scotland) Act 2014.

12.2 The quality of service delivery will be measured through performance targets, inspections, improvement measures and reporting arrangements designed to address organisational and individual care risks, promote continuous improvement and ensure that all professional and clinical standards, legislation and guidance are met.

12.3 Plans will be put in place, as set out in this Strategic Plan, to ensure that staff working in integrated services have suitable skills and knowledge to provide the appropriate standard of care. Where groups of staff require professional leadership, this will be provided by the relevant Health Lead or Chief Social Work Officer, as appropriate. The Organisational Development Strategy will identify training requirements that will be put in place to support improvement in services and outcomes.

12.4 The members of the Integration Joint Board will actively promote an organisational culture that supports human rights and social justice; value partnership working through example; affirm the contribution of staff through the application of best practice, including learning and development; and be transparent and open to innovation, continuous learning and improvement.

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12.5 The Chief Officer, Health and Social Care's role is to provide a single senior point of overall strategic and operational advice to the Integration Joint Board and be a member of the senior management teams of the Health Board and the Council. The Chief Officer will manage the Health and Social Care Partnership and the Integrated Services delivered by it, and has overall responsibility for the professional standards of staff working in integrated services.

12.6 The Integration Joint Board will put in place structures and processes to support clinical and care governance, thus providing assurance on the quality of health and social care. A Clinical and Care Governance Committee has been established. It will comprise representatives from the Health Board, the Council and others, including:

- The Senior Management Team of the Partnership.
- The Clinical Director.
- The Lead Nurse.
- The Lead from the Allied Health Professionals.
- Chief Social Work Officer.
- Director of Public Health, or representative.
- Service user and carer representatives.
- Third Sector and Independent Sector representatives.

12.7 The Clinical and Care Governance Committee will be able to invite appropriately qualified individuals from other sectors to join its membership. This will include NHS Board professional committees, managed care networks and the local authority adult and child protection committees.

12.8 The role of the Clinical and Care Governance Committee will be to consider matters relating to the strategic plan development, governance, risk management, service user feedback and complaints, standards, education, learning, continuous improvement and inspection activity. The Clinical and Care Governance Committee provides advice to the strategic planning and locality planning groups within the Partnership.

12.9 Further assurance is provided through the responsibility of the Chief Social Work Officer to report directly to the Council and the responsibility of the Health Leads to report directly to the Medical Director and Nurse Director who in turn report to the NHS Board on professional matters.

13 STRATEGIC PLAN REVIEW

13.1 This Strategic Plan has been written for the period 2016–19 and will be reviewed and rolled-on each year. The first review will be undertaken in the period January to March 2018 and the updated document for 2016–19 will be submitted to the Integration Joint

Board for approval in April 2018. The process followed in this regard will be in accordance with that laid out by Scottish Ministers in Regulation.

14. MEASUREABLE TASKS TO DELIVER PLAN OBJECTIVES

14.1 The Strategic Objectives for the Plan period detailed in Section 5 will be delivered through the completion of the following measurable tasks:

STRATEGIC OBJECTIVE (A): We will work to reduce inequalities

The Role of the Health and Social Care Partnership

Efforts to tackle health inequalities will permeate everything the HSCP does – from population public health to community based care and more specialist services.

The HSCP will ensure that its services are distributed fairly and in proportion to need across its geographical communities and population groups as far as is practicable taking account of our geography and infrastructure. The HSCP will improve the experience of individuals by exercising non-discriminatory practice on the grounds of protected characteristics. There will also be a need, when implementing national policy and delivering local services, to constantly apply an inequalities lens to mitigate the risk of widening inequalities through policies which may inadvertently be taken up more successfully by the most advantaged individuals and groups.

The Partnership will seek to mitigate the impact of more fundamental and environmental inequalities by supporting individuals to make positive lifestyle decisions and assist them to address social and economic problems at an individual level, such as accessing good work, better housing that meets their needs, or to maximise their income. This will require ongoing workforce development and partnership links with services outwith the Health and Social Care Partnership.

The following actions have been grouped in line with the health inequalities summary model on page 24 and are focused around both preventing and mitigating against health inequalities.

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Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Economy and Work			
• Develop integrated employability pathways/employability programmes/bridging services directly linked to health and social care services.	Senior Management Team	31.03.18 subject to annual review	d, e & j
• Work through the statutory partners to ensure community benefits clauses are included, where appropriate, in commissioned contracts and procured services; that recruitment is promoted in those furthest from the labour market; and that employability programmes and volunteering is actively supported.	Senior Management Team	31.03.18 subject to annual review	d & e
Physical Environment			
• Work in partnership with the Licensing Board and Forum to consider and develop local policies on alcohol.	Senior Management Team	31.03.18 subject to annual review	a, d, e & i
Education and Learning			
• Promote inequalities sensitive practice (recognising and responding to life circumstances) through training staff and promoting the use of inequalities self-assessment.	Senior Management Team	31.03.18 subject to annual review	h
Services			
• Ensure inequalities impact assessments are undertaken as new and social care, strategies, policies and services are developed and advocate for equalities impact assessment of key Community Planning Partnership policy and service developments e.g. transport, housing.	Senior Management Team	31.03.18 subject to annual review	e

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Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
• Within the resources available, ensure that universal services are delivered in proportion to need and combine these with targeted and intensive support services for those experiencing the greatest need or at highest risk. Examples include: • Treatment and recovery support for those experiencing addictions e.g. alcohol, drugs and tobacco. • Anticipatory care programmes. • Housing aids and adaptations	Senior Management Team	31.03.18 subject to annual review	a, d, e, i & k

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STRATEGIC OBJECTIVE (B): We will plan and provide health and social care services in ways that keep people safe and protect them from harm

Child Protection

The Partnership will ensure that its work is in line with Scotland's National Action Plan for Human Rights and the United Nations Convention on the Rights of the Child.

The Integration Joint Board will continue to improve inter-agency processes to identify, assess and plan for children at risk and support the work of the Child Protection Committee.

The Child Protection Committee is the key local body for developing and implementing child protection strategy across and between agencies in. The integrated Children's Service will continue to work with partners to ensure that appropriate arrangements are in place to protect children who are identified as being at risk.

Adult Support and Protection

Adult Protection responsibilities are specified within the Adult Support and Protection (Scotland) Act 2007. Specific responsibilities under the Act apply to adults (16 years and over) who are known, or believed, to be at risk of harm and meet the three-point criteria of the Act:

- They are unable to safeguard their own well-being, property, rights or other interests.
- Are at risk of harm.
- Are vulnerable to being harmed because they are affected by disability, mental disorder, illness or physical or mental infirmity.

The multi-agency Adult Protection Committee undertake a strategic and monitoring function in relation to the implementation of the Act and its associated responsibilities and is convened by an Independent Chair. A range of public bodies and their office holders have a duty to report Adult Protection concerns and to co-operate with adult protection enquiries made by the Council.

Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Implement the refreshed Corporate Parenting Strategy for Argyll and Bute Argyll and Bute and CPP Plan	Head of Children Services	31.03.16	j, k & l
Provide a clear definition of corporate parenting, and define the bodies to which it will apply.	Head of Children Services	31.03.16	j, k & l
Implement a Whole Systems Approach to young people's service delivery within the context of Youth Justice.	Head of Children Services	To 31.03.18 subject to annual review	l, m, n & o
Continue to improve arrangements and processes to identify, assess and plan for Criminal Justice Service user risk/need.	Head of Children Services	To 31.03.18 subject to annual review	n & o

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STRATEGIC OBJECTIVE (C): We will ensure that children have the best possible start in life

Getting It Right for Every Child

Getting it Right for Every Child (GIRFEC) is a wide ranging change programme for Children's Services that was developed in pathfinder areas across Scotland from 2006 and implemented more broadly since 2011. The Children and Young People Scotland Act 2014 puts some elements of GIRFEC into statute, while other elements remain as policy. GIRFEC grew out of a concern that service provision needed to be better integrated, more efficient and better focused on the child. It seeks to create a change in culture, systems and practice in Children's Services and in Adult Services that have particular impact on children (such as in relation to services dealing with domestic abuse and substance abuse). A plan for national implementation was published in 2006. The Multi-Agency Argyll and Bute GIRFEC Implementation Plan has been in place since 2011.

The National Plan included a change programme to:

- Place a duty on agencies to be alert to the needs of children and to act to improve a child's situation.
- Place a duty on agencies to co-operate with each other in meeting the needs of children and to establish local coordination and monitoring mechanisms.

- Require agencies involved to agree an action plan and keep it under review where a child's needs are complex or serious and where multi-agency input or compulsory measures are likely to be needed.

Early Years Collaborative

The Early Years Framework published in 2009 signified an important milestone by encouraging partnership working to deliver a shared commitment designed to give children the best start in life and to improving the life chances of children, young people and families at risk.

The Partnership will participate fully in the Early Years Collaborative.

The aims of the Early Years Collaborative are:

1. to ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1,000 births in 2010 to 4.3 per 1,000 births in 2015) and infant mortality (from 3.7 per 1,000 live births in 2010 to 3.1 per 1,000 live births in 2015).

2. To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review, by end-2016.

3. To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017.

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Action	Responsible Officer	Target Date(s)	National Outcomes Delivered
Implement the Children and Young People Act 2014. Ensure that all children and young people from birth to 18 years old have access to a Named Person.	Head of Children & Families Services	31.03.16	j, k & l
Implement Getting it Right for Every Child in Argyll and Bute - the South Argyll and Bute Integrated Children's Services Plan 2013/18.	Head of Children & Families Services	To 31.03.18 subject to annual review	j, k, & l
Continue to deliver Looking After Every Child: People's Health Strategy for Argyll and Bute , including Breastfeeding and Infant Mental Health.	Head of Children & Criminal Justice Services	To 31.03.18 subject to annual	j, k & l

		review	

STRATEGIC OBJECTIVE (D): We will plan for and deliver services in person-centred ways that enable and support people to look after and improve their own health and wellbeing.

In recent years national and local policy for a range of care groups and for people experiencing ill health has been focussed on early intervention and promoting independence.

The adopted vision nationally for older people through Reshaping Care is: 'Older people are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting'.

Core to the delivery of these has been a strategic Reshaping Care Plan that sets out a range of inter-linked interventions. A catalyst for the change process to create a range of interventions has been the Change Fund and this has facilitated innovation and experimentation designed to deliver better outcomes for older people. A core priority of this work has been establishing a pathway approach to improve prevention and reablement and reduce delayed discharge and to address the high numbers of older people who are admitted to acute hospitals in Argyll and Bute and NHS GG&C.

The core Reshaping Care strategy is illustrated in the diagram below:

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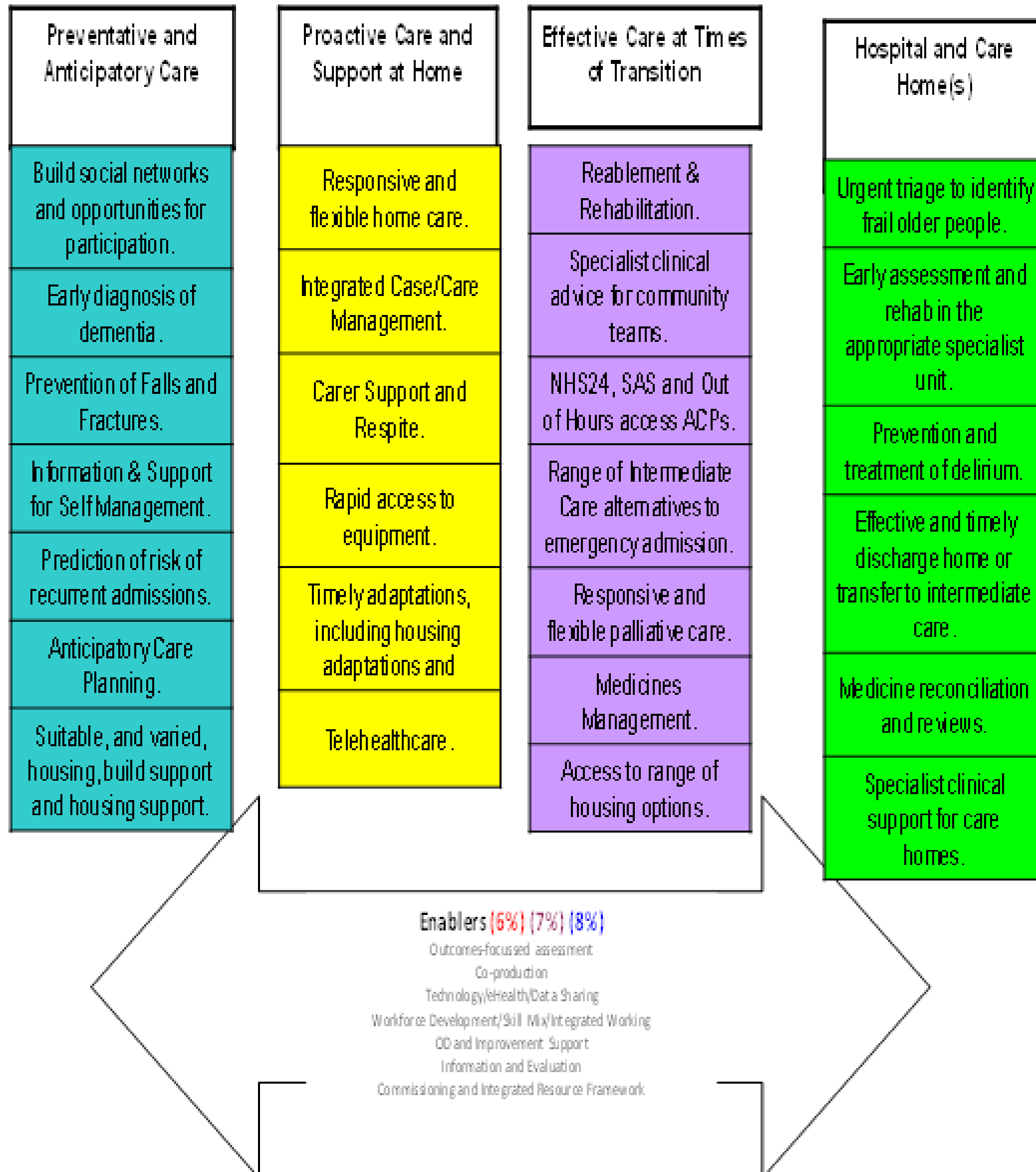

In addition to the older people's programme there are linked strategies and action plans supporting carers, people affected by dementia and others, for instance reflecting the housing needs of older people. Other plans have been developed at an Argyll and Bute level. These include work on Falls Prevention, Technology Enabled Care and Anticipatory Care Planning, single shared assessment. In addition, the Partnership will seek to implement actions linked to the Strategic Framework for Action on Palliative and End of Life Care (2016 - 2021) associated with End of Life and Palliative Care issues.

In 2015/16 the Integrated Care Fund will be available to support people living with two or more long-term conditions – multi-morbidity – and the planning work for this will be explicitly linked to the Reshaping Care for Older People Programme. We will be

commencing work on bringing this together with the funding, and Delayed Discharge unscheduled care planning in 2015/16 to ensure we have a co-ordinated and integrated pathway approach. See Appendix 11.

In relation to adults suffering poor mental health, Argyll and Bute's Mental Health strategy and accompanying action plan in was published in 2012. The high level outcomes that are to be achieved are:

- People experiencing mental ill-health experience optimum health and wellbeing.
- People experiencing mental ill health have their rights respected and do not experience discrimination, stigma or harm.
- People experiencing mental ill health are empowered to make their own life choices.
- Our communities are inclusive and supportive and nurture mental wellbeing.
- The needs of families and carers are fully met.

A similar Strategy and Plan for people with Learning Disability was also produced in 2012 with corresponding outcomes.

A major development in social care that will remain a priority within this Strategic Plan is related to the implementation of Self Directed Support (SDS). As SDS becomes embedded within social care delivery this will present opportunities and challenges for the HSCP and service providers as the traditional approach to service delivery changes to one based on personal choice.

Other work is currently in development, for example, in relation to Sensory Impairment and to Autism will need to be developed Argyll and Bute wide but enacted at locality level through their planning and prioritisation processes over the 3 years of this plan.

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Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
The Integration Joint Board will take steps with its Partners to alter hospital flows in a way that will seek to mitigate demographic pressures and make it possible for more people to remain within their communities with the supports they require to maintain their wellbeing. Key Priorities will include • Investigating and mapping unscheduled care pathways into NHSGG&C and local acute services • Establishing fast, responsive reablement services • Pharmacy reconciliation between acute and primary care • Utilising the full capability and capacity of the local NHS, Independent and 3rd sector to provide safe and appropriate care locally	Senior Management Team	31.03.18 subject to annual review	a, b, c, d, e, f, g, h & i
Support the implementation of Self Directed Support in line with the National Work Plan.	Heads of Adult Services East and West	To 2020 subject to annual progress updates	b, c & g
Implement the ***Carers Strategy*** ***(2012-2017***). Key priorities are: Actively support carers in our community and establish a Carers Forum to represent the views and interests of all carers in Argyll and Bute. Appoint a carers representative to be a non-voting member of the Integration Joint Board.	Heads of Adult Services East and West	30.06.15 30.06.15	f f

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Implement the ***Adult Mental Health Strategy (2013- 16)***. Key priorities for 2016/17 are: □ Integrate and adopt a person centred care that supports recovery, self-management and personalisation.	Heads of Adult Services East and West	31.03.17	a, b, c, d & g

Action	**Responsible Officer**	**Target Date(s)**	**National Outcomes Delivered (p32/33)**
• Develop wider opportunities for people experiencing mental ill-health within communities. • Support 18-week "Referral to Treatment" target regarding access to talking therapies. • Improve transitions arrangements between children and adult services. • Develop new Strategy with outcome focussed action plan based on available resources. • Finalise the plan and funding arrangements for the new acute mental health building	Senior Management Team	31.03.16	b, d & g

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Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Implement the ***Learning Disability Strategy (2013-16).*** Key priorities for 2015-18 include: • Implementation of Self Directed Support in Learning Disability Community • Develop opportunities for people with Learning Disability in the community – and improve access to activities and services. • Support stronger service user and carer engagement/co-production in the design of services and activities (including both mainstream and Learning Disability specific). • Support transition between children and adult services through development of multi-agency transition planning and protocols.	Heads of Adult Services East and West	31.03.16	b, d, e & g b, d & g c, d, e, f, g & i b, c, d, g & l

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Technology Enabled Care • Establish Technology Enabled Care and telehealth as part of normal / standard operating service across Argyll and Bute: • Implement the TEC care programme in Argyll and Bute including:	Head of Strategic Planning and Performance	To 31.03.18 subject to annual review	a, b, d, e, g & i
• Increasing Telehealth support for multi-morbidity including Exacerbation Pulmonary Disease Heart Failure Home Monitoring (& Diabetes Monitoring • Increase uptake of Technology Enabled Care services as per trajectories		31.03.16	a, b, d, e, g & i
Dementia • Following the outcome of the Review of Mental Services, develop new Strategy with outcome focussed action plan based on available resources.	Heads of Adult Services East and West	31.03.16	d j
End of Life and Palliative Care • Integrate and adopt a philosophy of care that supports self-management and personalisation.	Heads of Adult Services East and West		
Develop with partners across Argyll & Bute an Autism Plan			

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Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Strategy and Implementation Plan which Strategy in the development of robust diagnostic processes and post diagnostic support services for children and adults. This will support and influence child, family and individual person centred needs and aspirations within the individual's community.	Heads of Adult Services East and West	31.03.16	a, b, c, d, e, f, g, i, j, k and l

STRATEGIC OBJECTIVE (E): We will prioritise community based services, with a focus on prevention and anticipatory care to reduce preventable hospital admission or long term stay in a care setting.

Section 3 within this Strategic Plan sets out the direction of travel to be embraced by the new Partnership, which is linked to the Christie Commission recommendations on the Reform of Public Services. One of the key 'Christie Pillars' is to make a decisive shift towards Early Intervention and Preventative approaches. This Objective will also play an important part in tackling Strategic Objective A on Reducing Health Inequality and in Strategic Objective C in relation to Outcomes for Children.

Anticipatory Care approaches are implicit within the terms of the work programme linked to Strategic Objective D.

The Partnership will work with Third Sector Interface to enhance the capacity of community and voluntary sector services.

The Integration Joint Board will contribute to the strategic Community Planning approach of supporting prevention and early intervention.

Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Pilot Social Prescribing approaches within at least one General Practitioner practice.	Heads of Adult Services East and West	31.03.16	a, b, d, e & i
Develop wider "Co-production" approaches within Argyll & Bute.	Head Adult Services East and West	31.03.16	b, d & i

Work with the EQUIP Project Group to manage admissions to Accident and Emergency.	Senior Management Team	To 31.03.18 subject to annual review	b, d, e & i
Update the Locality Strategic Needs Assessment every year and the area wide assessment fully every three years to ensure that the strategic commissioning plan accurately reflects local priorities and provides a sound basis for the allocation of resources.	Consultant Public Health	31.03.18 subject to annual review	i

Action	**Responsible Officer**	**Target Date(s)**	**National Outcomes Delivered (p32/33)**
Work with wider partners to implement the mental health and wellbeing strategy (2014-2026). The three priorities for population mental health are: • Helping people develop their individual mental health. • Increasing opportunities for individuals to engage positively with one another within their own communities and building trust in families and communities. • Creating mentally healthy environments for working and learning.	Consultant Public Health	31.03.18 subject to annual review	a, b, c, d, e, g & j
Work with wider partners to implement the Healthy Weight Strategy Action plan (2014-24). In order to achieve this the action plan will focus on seven key themes: • Awareness, knowledge, skills and empowerment. • Maternal and infant nutrition. • Availability and affordability of healthier food and drinks. • Active travel and active workplaces. • Built/natural environment and infrastructure for active travel. • Physical activity. • Weight management.	Consultant Public Health	31.03.18 subject to annual review	a, d, e, g, i & l

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Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Implement the tobacco control strategy (2012-2021) and develop a new action plan for 2015-2018. Priorities are likely to be (subject to consultation): • Working with **nursery** teachers in relation to second hand smoke. • Working with **schools** supporting pupils with smoking cessation as well as providing prevention messages. • Working with **Looked After and Accommodated Children** units to support young people with cessation. • Working in partnership with community **midwifery** staff to support pregnant women. • Delivering training or information sessions to **workplaces** on smoking and smoking related issues. • Working with hospital staff and with **inpatients**.	Consultant Public Health	31.03.18 subject to annual review	a, d, e, i & l
Work with our partners to implement the "oral health strategy and action plan".	Consultant Public Health/ Lead Dental Officer	31.03.18 subject to annual review	a, d, e, i, k & l

STRATEGIC OBJECTIVE (F): We will deliver services that are integrated from the perspective of the person receiving them and represent best value with a strong focus on the wellbeing of unpaid carers During the period of this first Strategic Plan (2015-18) the HSCP will focus on integrating its workforce and specifically the employed staff to operate as a single health and care team delivering person centred care as a single health and social care services. This will be evidenced by the appointment of single integrated management posts and team leads.

In developing this way of working the HSCP will, where appropriate, seek to extend integration beyond those working within the public sector to include personnel and services from the Third and Independent Sectors. This approach will ensure that Partners, their staff and volunteers are all working in a collaborative and co-productive focus towards the attainment of National Outcomes and in pursuit of Integration Principles. Intimately aligned with this is a focus on unpaid carers, their support needs,

training, education, information and respite and as a key partner we will to plan and work collaboratively with unpaid carers and their representatives.

The development and organisation of single integrated teams will be a priority for the Chief Officer and the Senior Management Team. Stakeholders will be consulted on developed proposals which will be shaped in a manner that will be complementary to the agreed approach to Locality Planning outlined in Section 6.

Integrating health and social care services will require significant cultural and organisational change on the part of those leading and working within the various sectors, within the operating environment we will be facing. The HSCP is clear that there is a sense of urgency expressed by all stakeholders and our workforce to see this happen quickly. However, facilitating and achieving this scale of change in the provision of services will be *challenging, intrusive and intensive* as it seeks to equip people to undertake their roles in new and different ways and put in place different delivery models for service. The HSCP will develop a full Organisational Development Programme and a Workforce Plan in 2016-17 which will build on work already completed in this transition period.

As important to achieving effective integration by winning the hearts and minds of those involved in a new partnership-based approach to service delivery, will be access to all of the information required to support this new integrated way of working. A new Information Sharing Protocol has been developed and adopted by the Partnership and by the Statutory Partners. However, far from being a conclusion to this issue, the protocol represents the first step in what is likely to prove to be a long and complex process. Information systems, such as that for interfacing health and social work, will require to be modernised through replacement. This and others will require to be integrated technically, and legal issues around the safeguarding and the protection of information will require to be considered and addressed, within the 3 years of this plan.

Action	**Responsible Officer**	**Target Date(s)**	**National Outcomes Delivered (p32/33)**
Working with key stakeholders, the management team will develop proposals which enable the more effective delivery of outcomes for the people of through integrated working.	Senior Management Team	31.03.18 subject to annual review	c, e, f, g, h, i & l
Review and streamline our existing health and social care pathways and ensure overall system coherence.	Heads of Adult Service (E&W)	31.03.18 subject to annual review	i

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Ensure that patients and carers are fully involved in their care and future needs are more effectively anticipated.	Senior Management Team	31.03.18 subject to annual review	c, d, e, f, g, i, & l
Working with stakeholders, the management team will develop proposals for the delivery of key services in conjunction with universal primary care services, adopting, where possible, clearer pathways utilising single access points.	Chief Officer/ Heads of Adult Service (E&W)	31.03.18 subject to annual review	a, b, c, d, e, h, i & l
Put in place initial arrangements for the effective sharing of information within the Partnership.	Chief Officer	31.03.16	h & i
Develop work plan and investment strategy to integrate information systems to support single team service provision.	Senior Management Team	31.03.18 subject to annual review	h & i
As part of locality planning, performance management and operational service delivery establish involvement and engagement arrangements for public, users and carers	Head of Strategic planning and Performance	31.03.16	c, f, g & h

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STRATEGIC OBJECTIVE (G): We will establish “Locality Planning, Owning, Delivery” operational and management arrangements to respond to local needs

Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Utilise the Strategic planning consultation process to commence the establishment of Locality Planning Groups in each of the eight Localities.	Senior Management Team	01.04.16	b, d, e, h & i
Develop initial data profiles for each of the eight localities.	Senior Management Team	01.04.16	i
Work with Locality Planning Groups to enhance and augment the data profiles and information base for each locality.	Senior Management Team	31.03.16 & annually to 31.03.18	i

Provide staff and financial resources to facilitate the creation and development of the 8 localities of the strategic planning process (Community Capacity Building).	Senior Management Team	31.03.16 & annually to 31.03.18	h & i
Prepare locality plans for inclusion within the Partnership Strategic Plan.	Senior Management Team	31.12.16	i
Review the success and operation of the approach to Locality Planning and ensure that it is delivering the outcomes envisaged.	Senior Management Team	31.03.18	i
Refresh locality action plans on an annual basis, utilising information to inform production of the annual report	Senior Management Team	01.04.17/18/19	i

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The HSCP's approach to Locality Planning is outlined in Section 6 of this Plan and initial Locality Profiles, designed to aid early discussion in Locality Planning Groups, will be set out at Appendix 5 once complete.

The table below sets out the actions that the Integration Joint Board will take to develop its Locality Planning agenda and to ensure that Locality Planning becomes a cornerstone of how it will plan, commission and monitor services and activity in a way that contributes towards the attainment of national and local outcomes and the implementation of Integration principles.

Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Work to ensure that local commissioning arrangements support changing service requirements brought about by Self Directed Support are incorporated in locality plans	Heads of Adults Services	To 2020 subject to annual review	i

STRATEGIC OBJECTIVE (H): We will strengthen and develop our partnership with specialist services, with NHS GG&C and with Community Planning.

Section 7 within the Strategic Plan sets out the range of partnership working arrangements that will need to be established and supported to enable the National Health and Social Care Outcomes to be achieved. Partnership working will be at the

heart of the new Health and Social Care Partnership and will be vital to supporting seamless health and care service delivery as well as broader health improvement activity.

Action	Responsible Officer	Target Date(s)	National Outcomes Delivered
Partnership with NHS Greater Glasgow and Clyde Senior • The Integration Joint Board will: • Further strengthen its partnerships with NHSGG&C to ensure delivery of specialist acute services for the people of Argyll and Bute. • develop an effective working Partnership to ensure that its Strategic Plan and Locality plans for Acute Services deployment and realign resources in a way designed to maximise delivery against the National outcomes and support the shift in the balance of care in a planned way	Senior Management Team	To 31.03.18 subject to annual review	i
Partnership with Bordering Health and Partnerships • The Partnership will work co-operatively with its neighbouring partnerships (Inverclyde, West Dumbarton etc.) Ensure appropriate levels of consistency in the provision of Argyll and Bute strategies and services and to share and pool resources, as necessary.	Senior Management Team	31.03.17	i
Partnership with and within Community Planning Partnership • The Partnership will play a full role within Argyll & Bute Community Planning Partnership in order to achieve the outcomes set out in the Single Outcome Agreement.	Chief Officer	31.03.16 and on-going annually to 31.03.18	a, b, d, e, f, g, i, j, k, l, m, n & o

STRATEGIC OBJECTIVE (I): We will sustain, refocus and develop our partnership workforce on prevention and anticipatory care The Scottish Government's Integration

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Legislation through the agreed National Outcomes and the Integration Principles has as primary drivers (1) that Partnerships should ensure that people are able to live at home or in a homely setting in good health rather than in a hospital or other institution; (2) that people are supported in a way that is co-produced with local communities through community based assets and that resources are deployed in a way that supports this approach; (3) a focus on prevention; and (4) that the balance of care and the consumption of all resources moves over time from acute hospitals to community provision.

To achieve these fundamental shifts in approach, the HSCP is committed to the development of the staff who work within the functions delegated to it and to adopt new and partnership-based ways of working with patients, carers and those in other sectors. This will see a fundamental change in 'culture' both in terms of the provision and delivery of services.

Similarly, the Partnership is committed to helping local people become involved and engaged in a way that sees them able to articulate the health and social care priorities of their communities and assists them to play an active role in the planning, commissioning and delivery of local services sustaining and developing the wider economic viability of their communities.

Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Establish a forum to engage with employees on the development and improvement of the Partnership.	Chief Officer	01.04.16	h & i
Develop, consult and implement a Workforce Strategy and action plan for the Partnership, which will reflect potentially changing service requirements arising from the introduction of • Self Directed Support., • prioritisation and refocusing of services to anticipatory care and prevention • Community resilience	Senior Management Team	31.03.17	h & i

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Develop, consult and publish a full Organisational Development Plan for the Partnership which will seek to: • Facilitate a change in culture within the organisation. • Ensure that all staff are supported to change their approach to meet the requirements of Self Directed Support and new roles. • Build on initial strategy and plan outlined in Appendix 9.	Senior Management Team	31.03.16	h & i

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STRATEGIC OBJECTIVE (J): We will put in place a strategic and operational management system that is focused on continuous improvement, within a clear governance and accountability framework.

The duty of Best Value in Public Services as outlined by the "Public Finance and Accountability (Scotland) Act"[17] will apply to the Partnership.

The duty is as follows:

- To make arrangements to secure continuous improvement in quality and performance whilst maintaining an appropriate balance between quality, safety and cost, and in making those arrangements and securing financial balance.
- To have regard to economy, efficiency, effectiveness and equal opportunities requirements, and to contribute to the achievement of sustainable development.

There are nine characteristics of Best Value that public service organisations are expected to demonstrate:

- Commitment and Leadership.
- Sound Governance at a Strategic and Operational Level.
- Accountability.
- Sound Management of Resources.
- Responsiveness and Consultation.
- Use of Review and Options Appraisal.
- A Contribution to Sustainable Development.
- Equal Opportunities Arrangements.
- Joint Working.

Compliance with the duty of Best Value is an auditable requirement and subject to external scrutiny. Service reviews will be undertaken to ensure the nine characteristics are fully embedded and will follow national guidance.[18]

[17] Best Value in Public Services – Public Finance and Accountability (Scotland) Act
http://www.legislation.gov.uk/asp/2000/1/section/11

[18] Best Value in Public Services - Guidance for Accountable Officers Scottish Government 2011
http://www.scotland.gov.uk/Resource/Doc/347561/0115733.pdf

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Action	Responsible Officer	Target Date(s)	National Outcomes Delivered
Develop, publish and consult on an Asset Management Plan for the HSCP informed by the Council and NHS Boards plans and arrangements	Senior Management Team	30.09.17	i
Use performance information to drive continuous improvement.	Senior Management Team	31.03.17	i
Implement the HQA quality based management system throughout the HSCP to drive continuous improvement and to improve the quality of services.	Senior Management Team	To 31.03.18 subject to annual review	h & i
Develop a long-term financial strategy for the Partnership.	Senior Management Team	31.03.18	i
Plan for capital and revenue recurring expenditure and income on a rolling three-year basis using projections from the parent bodies.	Senior Management Team	01.04.16 & Annually Thereafter	i
Identify strategic and operational risks to the Partnership and develop a plan for effectively mitigating these.	Senior Management Team	01.04.16 Review Annually	h & i
Produce a business continuity/disaster recovery plan for the Partnership.	Senior Management Team	01.04.16 Review Annually	g & i
Develop a protocol/approach for ensuring effective partnership working with other Council and NHS Services.	Senior Management Team	30.09.16	i
Provide an effective and efficient corporate support service for operational services.	Head of Finance/ Head of Strategic Planning and Performance	31.03.17	i

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Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Review service provision during the period to 2020 to reflect changes required as a result of the introduction of Self Directed Support by undertaking appropriate scenario planning, measuring the outcome of the introduction and review the funding model for the provision of social care services.	Heads of Adult Services East and West	31.03.17 & Annually Thereafter	i

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STRATEGIC OBJECTIVE (K): We will underpin our arrangements by putting in place a clear, communication and engagement arrangements involving our staff, users, the public and stakeholders

Effective involvement and engagement and communication with users, carers and the public and other stakeholder groups will be a key success factor for the HSCP, particularly when seeking to act in accordance with the Integration Principles. The Integration Joint Board will develop and approve a Communications and Engagement Strategy and an Initial Plan which will be taken forward and developed further.

A review of public information currently available and how this is communicated, including the use of electronic media, is being planned.

Internally, regular communication with all staff and unions will be essential in terms of securing new approaches to service delivery, including integrated working and the change in organisational and professional culture referred to earlier in this Plan.

An effective working relationship will be encouraged with existing representative groups, such as the Locality Health Care Forums –who will have a central role to play within the seven Locality Planning Groups being established.

Building capacity within local communities to encourage a relationship based on co-production and prevention will be dependent on successful communication, involvement and engagement. The Communications and Involvement Strategy and Plan will be designed, in part, to support this important work.

As well as advising and being consulted on the content and development of the Partnership's Strategic Plan, the Strategic Planning Group will play a broader consultative and advisory role in policy development. Its membership, which is inclusive of all stakeholder groups, including professionals and independent health

contactors, will represent the views of constituent groups within this setting and provide a conduit for the broad communication of information.

Action	Responsible Officer	Target Date(s)	National Outcomes Delivered (p32/33)
Development of Partnership Public Involvement and Engagement Strategy and Implementation plan.	Senior Management Team	30.09.16	c, d, e, f, g, h, i & l
Review of public information and methods of communication. Development of approach to meet Partnership requirements.	Head of Strategic Planning and Performance	30.12.16	i
Review, publish and consult on a revised Involvement and Communications Plan for the Partnership based on the initial Plan produced during the transitional period.	Senior Management Team	30.09.16	h & i

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Appendices

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APPENDIX 1 - KEY DRIVERS

1.1 **The context for the plan is determined by the key drivers which are:**

- Legislative/Policy drivers.
- Population needs currently and in the future.
- Available resources including workforce and finance.
- Available innovation including new technology.
- Focus on quality of service, efficiency and Best Value.
- Principles of Co-Production, Personalization, and Self Directed Support (SDS).
- Need to tackle growing health inequalities.
- Early intervention/prevention and the development of community based assets.
- Early intervention with children and adults at risk and need of protection.

1.2 **Legislative/Policy Drivers:**

There are a number of key policy drivers that affect the content of this Plan:

- National Health Service and Community Care Act 1990.
- Public Bodies (Joint Working) (Scotland) Act 2014.
- Social Care (Self Directed Support) Act 2013 & Wider Framework.
- Welfare Reform Act 2012.
- Scotland's National Action Plan for Human Rights (SNAP) (2013).
- Children & Young People (Scotland) Act 2014.
- Early Years Framework (2009).
- Reshaping Care for Older People (2011).
- Children (Scotland) Act 1995.
- Getting It Right for Every Child (2006).
- UN Convention on the Rights of the Child (1989).
- Protecting Children and Young People: Framework for Standards (2004).
- Commissioner for Children and Young People (Scotland) Act (2003).
- We Can and Must Do Better (2007). These are our Bairns (2008)
- Curriculum for Excellence (2004).
- Equally Well (2008), The Early Years Framework (2009) and Achieving Our Potential (2008).
- Community Planning and Single Outcome Agreements.
- Action Plan for Multi-morbidity (to be published).
- Procurement Reform Activity.
- Prescription for Excellence (2013).

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- AHP's as agents of health and social care integration, the National Delivery Plan 2012–2015.

1.3 The Public Bodies (Joint Working) (Scotland) Act 2014 coincided with the enactment of the Children and Young People (Scotland) Act 2014, which plans for actions across the life course to improve health and wellbeing, contributing to delivering the Government's overall purpose of Increasing Sustainable Economic Growth.

1.4 The Children and Young People (Scotland) Act 2014 has a similar duty to that in the Public Bodies (Joint Working)
(Scotland) Act to create joint plans, based on the local authority area, which covers all children's services that have a significant impact on their wellbeing. This Act requires NHS Boards and local authorities to develop Joint Children's Services Plans every three years and to report on progress annually.

1.5 There is an Integrated Children's Service Plan for Argyll and Bute that encompasses services beyond those that are part of the Integrated Health and Social Care Partnership, such as Education, Early Years and Hospital Paediatrics. This will require further review to ensure it continues to meet the requirements of the Children and Young People (Scotland) Act 2014. It has been agreed that the Health and Social Care Partnership Strategic Plan and the Children's Services Plan will cross reference rather than duplicate the information related to Children's Services within the Partnership.

1.6 At the point of publication of this Plan there has been a national consultation on the future delivery of Criminal Justice Services across Scotland. Any outcomes from this exercise, and any subsequent legislation, will be included within a future version of this Strategic Plan.

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APPENDIX 2 - THE STRATEGIC PLANNING PROCESS

2.1 A Writing Group of officers was established to draft this version of the Strategic Plan. The direction for this was set by the Programme Board, IJB and HSCP management team and Strategic Planning Group.

2.2 Statutorily the group that will review and comment on the development of the Strategic Plan is the Strategic Planning Group.

- The Group will express its views on the initial outline Strategic Plan and feedback received
- Comment on the draft plan and implementation of the actions outlined in the Plan, including overseeing contingency planning on an on-going basis
- Work with the HSCP Management Team to update the plan annually at the Strategic Planning Group reflected needs and priorities and the changing environment.

2.3 The strategic planning group membership is largely determined by Ministerial direction in Regulation. In Argyll and Bute the Integration Joint Board has agreed that it will include the following:

Argyll and Bute Strategic Planning Group membership	
Representative	**Other**
Chief Officer HSCP	1
At least 1 member of NHS Highland Board	1
At least 1 Elected member of Argyll and Bute Council	1
Health Professionals (GP, Consultant RGH & MH, AHP, Nurse)	10
Social Care Professionals	10
Users of Health and Social Care	2
Carers of users of Health and Social Care	2
Commercial providers of health care	0
Non-commercial providers of health care	1
Commercial providers of Social care	1
Non-commercial providers of Social care	1
Non-commercial providers of Social housing	1
Third sector bodies within the Local Authority carrying out activities related to health or social care	1
Locality Representatives *	4
Representative of NHSGG&C *	1
Total	**39**

2.4 The Group is chaired by the Programme Lead Integration and is a Committee of the Integration Joint Board.

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2.5 Locality Planning Groups are being established as part of the Strategic Planning process (see Section 6) and the plans developed for each locality will be an integral part of future versions of this Strategic Plan.

2.6 Specialist Acute Services

2.6.1 All acute service planning will require to be cognisant of NHS GG&C Clinical Services strategy and its HSCP Strategic Plans.

2.6.2 More specifically, Scottish Statutory Instrument 2014, No 344, Schedule 3 Part 2 (SSI) sets out which Acute Hospital Services must be included in Integration. This means that although operationally they may be managed within Acute, the strategic direction and priorities will be set through the Health and Social Care Partnerships. These services are:

- Accident and Emergency services provided in a hospital;
- Inpatient hospital General Medicine;
- Inpatient hospital Rehabilitation Medicine;
- Inpatient hospital Respiratory medicine;
- Inpatient hospital psychiatry - learning disability (already operationally managed by NHS Highland Health and Social Care Partnership as the Lead Partner Mental Health);
- Palliative care services provided in a hospital;
- Inpatient hospital services provided by general medical practitioners (already operationally managed within this Health and Social Care Partnership);
- Services provided in a hospital, in relation to an addiction or dependence on any substance (already operationally managed by Argyll & Bute Health and Social Care Partnership); and
- Mental health services provided within a hospital, except secure forensic mental health services (already operationally managed by Argyll & Bute Health and Social Care Partnership).

2.6.3 The detail of interface arrangements, including joint planning, integration between plans and communication issues, will be developed across Argyll & Bute in the first year of this Plan.

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APPENDIX 3 – STRATEGIC NEEDS ASSESSMENT

Population needs currently and in the future

Argyll and Bute

The Scottish Index of Multiple Deprivation (SIMD) ranks small areas (datazones) in Scotland using data from 7 different domains relating to aspects of deprivation: income, employment, crime, education, health, housing and geographic access. Ranks within Scotland are also available separately for each individual domain.

There are 10 datazones (out of 122) within Argyll and Bute which are ranked amongst the 15% most deprived in Scotland as a whole (SIMD, 2012) By individual domain, 53 datazones are ranked amongst the 15% most geographic access deprived in Scotland (Table 1). This reflects the remote rural and island geographies in Argyll and Bute.

It is recognised that the SIMD tends to highlight deprivation in urban areas where there are likely to be datazones which are relatively homogeneous, with people of similar socio-economic status, compared to rural datazones. Rural datazones tend to cover larger areas (although not necessarily with more people) and are inhabited by a greater mixture of people of different socio-economic status; they are therefore less likely to be highlighted in within the most deprived by SIMD.

Within Argyll and Bute, the areas highlighted as most deprived overall in Scotland are within the towns of Campbeltown, Dunoon (and Hunter's Quay), Helensburgh, Oban and Rothesay, with 5 out of the 10 most deprived datazones in Cowal and Bute.

A Socio-economic performance (SEP) index, for rural datazones in Scotland, was published recently for the Scottish Government by the James Hutton Institute. In addition to areas in the small towns already highlighted in SIMD, there were areas in the poorest performing in Scotland in Rosneath, rural Kintyre and Cowal.

Highland and Island Enterprise also have a measure of economically fragile areas which identify Mull, Iona, Coll and Tiree, Islay, Jura and Colonsay and some areas on Cowal as fragile with Rothesay and Campbeltown identified as areas of employment deficit (Submission from Highlands and Islands Enterprise 2011).

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Table 1. Number of datazones in Argyll and Bute in the 15% most deprived nationally, by datazone rank. Shown by Intermediate Geography.

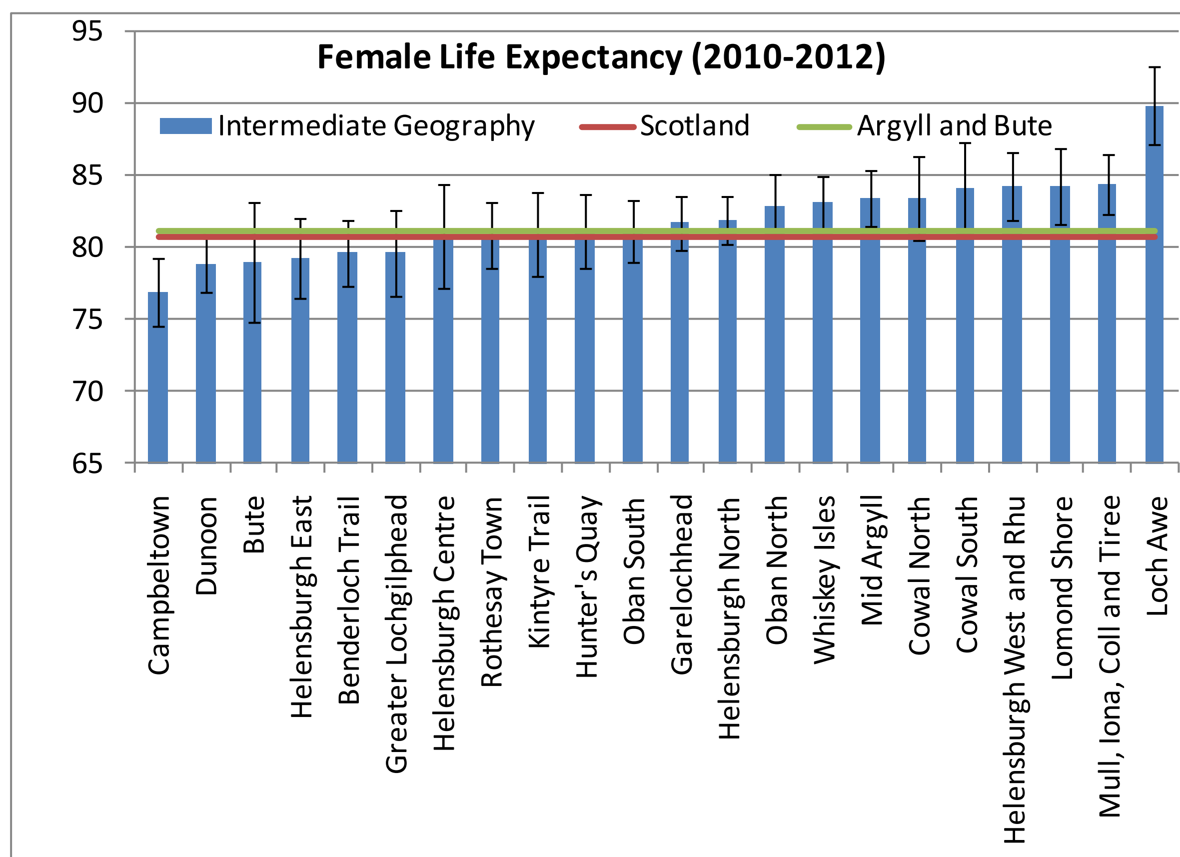
Area (Intermediate Geography)	Number of datazones in the 15% most deprived according to							
	Overall rank 2012	Income domain rank 2012	Employment domain rank 2012	Health domain rank 2012	Education domain rank 2012	Housing domain rank 2012	Geographic Access domain rank 2012	Crime domain rank 2012
Benderloch Trail							5	
Bute						1	1	
Campbeltown	2	1	1	3	1	1		2
Cowal North							4	1
Cowal South							4	
Dunoon	2	2	2	3	1	1		4
Garelochhead					1		5	
Greater Lochgilphead							1	
Helensburgh Centre						1		2
Helensburgh East	2	2	2	2	1			2
Helensburgh North							2	
Helensburgh West and Rhu							3	
Hunter's Quay	1	1	1	1			1	
Kintyre Trail							6	
Loch Awe							4	
Lomond Shore							4	1
Mid Argyll							4	
Mull, Iona, Coll and Tiree						1	4	
Oban North								1
Oban South	1	1		3	1	1		2
Rothesay Town	2	2	2			1	1	2
Whiskey Isles							4	
Total Number of datazones	10	9	8	12	5	7	53	17
Population in datazones (2013)	6246	5687	4849	8428	3352	4095	40292	11077
% total population	7%	6%	6%	10%	4%	5%	46%	13%

Source: SIMD 2012: Scottish Government, Crown Copyright and 2013 population estimates, National Records of Scotland, Crown Copyright.

It is beyond the remit of this paper to provide a comprehensive or systematic analysis of health inequalities in Argyll and Bute. This could be the focus for future health intelligence

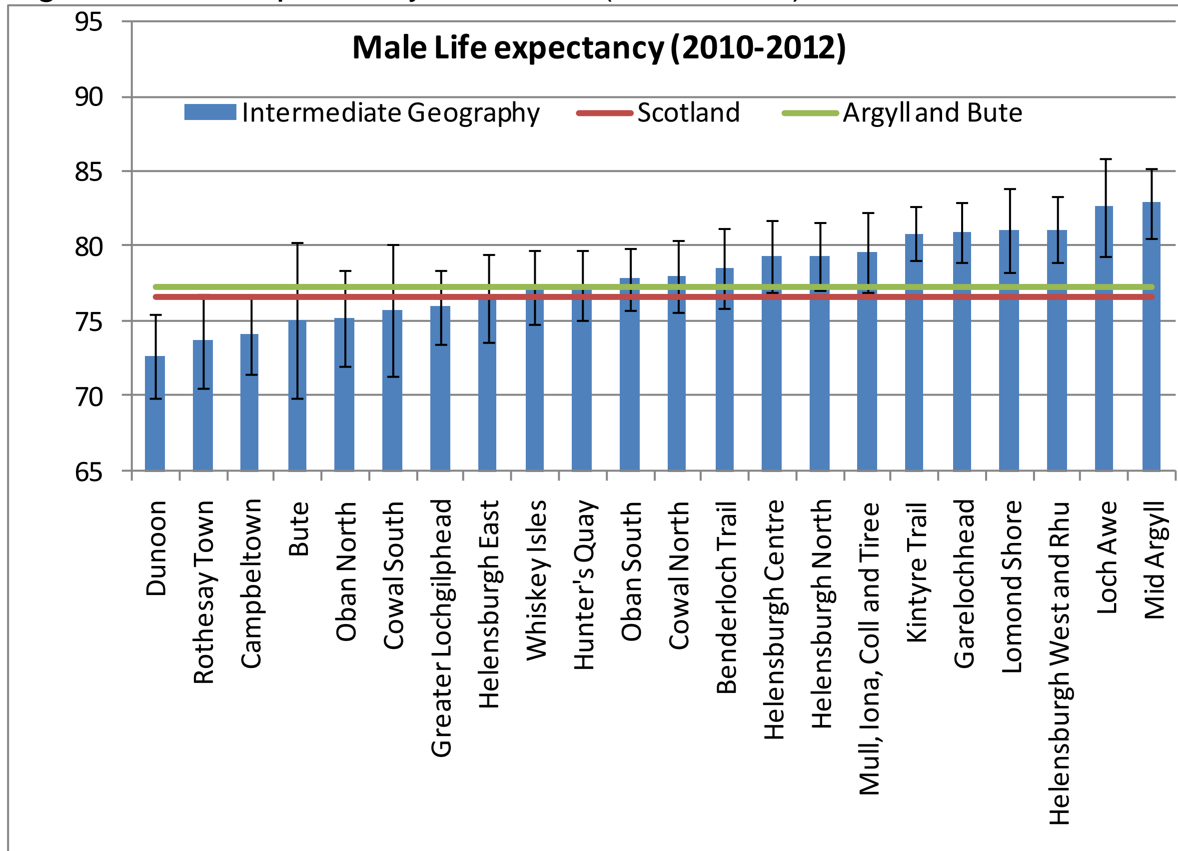
work. Data is shown below for life expectancy (2010-2012) for Intermediate Geography areas in Argyll and Bute, for males and for females. This data was taken from the 2015 ScotPHO health and wellbeing profiles which contain health and wellbeing information for Intermediate Geography areas in Argyll and Bute (http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool). It can be seen that there is variation in life expectancy between these intermediate geography areas within Argyll and Bute.

Figure 1. Life Expectancy for females (2010-2012)



Source: Scottish Public health Observatory 2015 Health and Wellbeing Profiles. Error bars show 95% confidence interval. Data © copyright Scottish Public Health Observatory

Figure 2. Life Expectancy for males (2010-2012)



Source: Scottish Public health Observatory 2015 Health and Wellbeing Profiles. Error bars show 95% confidence interval. Data © copyright Scottish Public Health Observatory

National policy context and evidence on approaches to addressing inequalities

Equally well (2008) was the report of the Scottish Government ministerial task force on health inequalities. This has been reviewed twice since publication, with two further documents published, in 2012 and 2014. The latest review identified 4 areas of priorities as:

- *“Development of Social Capital*
- *Support for CPPs and the community planning process*
- *Focus on the 15-44 age group*
- *Support the implementation of a Place Standard”*

Report of the Ministerial Task Force on Health Inequalities (2013)
http://www.gov.scot/Publications/2014/03/2561/0

NHS Health Scotland carried out a review of policy and the evidence regarding what works to address health inequalities, which was published in 2014 (Health Inequalities

Policy Review for the Scottish Ministerial Task Force on Health Inequalities). This highlighted tackling causes of inequalities. Both national and local actions were recommended to tackle inequalities with a focus on preventative and early intervention approaches, working on wider determinants and at the level of the individual.

ScotPHO have recently published, "Informing Investment to Reduce Inequalities (III)" which takes a modelling approach to assess what interventions have the largest impact on reducing health inequalities. The conclusions to this work were that interventions that impact on income (regulatory and tax options) were the most effective interventions; this was above targeted interventions by individual agencies (III, ScotPHO 2015).

Argyll and Bute policy context and work to address local inequalities

Community Planning

As part of community planning, the Argyll and Bute Single Outcome Agreement highlights that, '*Improving health and wellbeing and reducing health inequalities" is one of the key challenges facing Argyll and Bute. Equality runs as a theme through the delivery plans associated with the single outcomes agreement.* '

Integrated Children and Young People's Service Plan

Argyll and Bute Integrated Children and Young People's Service Plan aims that:

> *"Our children and young people have the best start in life to enable them to become*
> - *successful learners*
> - *confident individuals*
> - *effective contributors and*
> - *responsible citizens*
>
> *And that we continue to improve the life chances for children, young people and families at risk."*

Argyll and Bute Integrated Children and Young Peoples Service Plan 2014-17
Argyll and Bute Community Planning Partnership
http://www.argyll-bute.gov.uk/sites/default/files/argyll_bute_broch_lo_res.pdf

Health Improvement

Health Inequalities was identified by Argyll and Bute Health and Wellbeing Partnership (in 2012) as a strategic priority for Argyll and Bute (Joint Health Improvement Plan 2013-16). The Joint Health Improvement Plan (2013-16) notes that:

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"Health inequalities is relevant to all of the strategic priorities and we should all be asking how "inequalities sensitive" our health improvement practice is, for example, are those most in need benefiting from the activity. Equality and diversity impact assessments can help with targeting interventions to those most in need."

The Health Improvement Team identifies specific work on health inequalities in their 2012-2014 strategic priorities document. This work includes:

- Keep well (cardiovascular checks targeted at those in the most deprived areas). Targeting vulnerable groups: Gypsy travellers, substance misuse, carers, homeless, offenders and ethnic minorities.
- Asset mapping in communities
- Training programme for staff responsible for looked after and accommodated children around suicide prevention
- Delivery of motivational interviewing training

National initiatives

Measures to address inequalities in Argyll and Bute also include those within national targets e.g. HEAT target for smoking cessation has specific targets for the most deprived areas, where smoking rates are highest.

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APPENDIX 4 - PARTNERSHIP SERVICES

The services to be included within the Health and Social Care Partnership are detailed in the integration scheme and are summarised as follows:

NHS Highland Health Board:

- Hospital inpatient (scheduled and unscheduled)
- Rural General Hospitals
- Mental Health
- Paediatrics
- Community Hospitals
- Hospital Outpatient Services
- NHS Community Services (Nursing, Allied Health Professionals, Mental Health Teams, Specialist End of Life Care, Homeless Service, Older Adult Community Psychiatric Nursing, Re-ablement, Geriatricians Community/Acute, Learning Disability Specialist, Community Midwifery, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Audiology
- Community Children's Services - Child and Adolescent Mental Health Service, Primary Mental Health workers, Public Health Nursing, Health visiting, School Nursing, Learning Disability Nursing, Child Protection Advisors, Speech and Language Therapy, Occupational Therapy, Physiotherapy and Audiology, Specialist Child Health Doctors and Service Community Paediatricians
- Public Health
- GP Services
- GP Prescribing
- General Dental, Opticians and Community Pharmacy
- Support Services
- Contracts and Service Level agreements with other NHS boards covering adults and children

Argyll and Bute Council

All permitted Council functions apart from housing and housing support services, other than aids and adaptations aspects of housing support.

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- Social Work Services for Adults and Older People
- Services and Support for Adults with Physical Disabilities and Learning Disabilities
- Mental Health Services
- Drug and Alcohol Services
- Adult Protection and Domestic Abuse
- Carers Support Services
- Community Care Assessment Teams
- Support Services
- Care Home Services
- Adult Placement Services
- Health Improvement Services
- Housing support including Aids and Adaptions
- Day Services
- Local Area Co-ordination
- Self -Directed support
- Respite Provision for adults and young people
- Occupational Therapy Services
- Re-ablement Services, Equipment and Technology Enabled Care
- Social work services for children and young people
- Child Care Assessment and Care Management
- Looked After and accommodated Children
- Child Protection
- Adoption and Fostering
- Special Needs/Additional Support
- Early Intervention
- Through-care Services
- Youth Justice Services
- Social Work Criminal Justice Services
- Services to Courts and Parole Board
- Assessment of offenders
- Diversions from Prosecution and Fiscal Work Orders
- Supervision of offenders subject to a community based order

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- Through care and supervision of released prisoners
- Multi Agency Public Protection Arrangements

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APPENDIX 5 – LOCALITY PLANNING PROFILES

Extensive information in respect of the 8 locality profiles and Argyll & Bute profiles in total can be found at

www.healthytogetherargyllandbute.org.uk/resources

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APPENDIX 6 – CLINICAL AND CARE GOVERNANCE FRAMEWORK

"Governance is a system through which Organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in care will flourish."

Scally and Donaldson, 1998.

1 Introduction

The main purpose of the integration of health, social work and social care services in Scotland is to improve the wellbeing of people who use such services, in particular those whose needs are complex and who require services and supports from health and social care at the same time. The Integration Scheme drawn up for Argyll & Bute is intended to achieve improved outcomes for the people of Argyll and Bute, in line with the National Health and Wellbeing Outcomes (attached at Appendix 1) that are prescribed by Scottish Ministers in Regulations under Section 5(1) of the Public Bodies (Joint Working)(Scotland) Act 2014.

It is clearly recognised that the establishment and continuous review of the arrangements for clinical, care and professional governance for all services which are' in scope' are essential to the delivery in Argyll and Bute Council, NHS Highland Quality Framework. The arrangements for clinical, care governance and professional governance described in this paper are designed to assure Argyll & Bute's Integrated Joint Board (IJB), NHS Highland and Argyll and Bute Council of the quality and safety of service delivered by its staff, and the difference services are making to the lives and outcomes of the people of Argyll and Bute who need them.

This paper sets out the proposed framework for clinical, care and professional governance arrangements to be used by NHS Highland and Argyll and Bute Council. The framework proposed describes and shows schematically the relationship between all of the relevant bodies in Argyll and Bute and outlines the specific responsibilities they carry for governance.

The framework has been developed to ensure that there are explicit and effective lines of accountability from care settings within the IJB. The proposed framework recognises that such accountability is essential to assure high standards of care and professionalism in the services provided by Argyll and Bute Health and Social Care Partnership with the aim of achieving the best possible outcomes for service users in line with the National Outcomes Framework.

Within this governance framework, there are three core elements to accountability:

- Each individual's professional accountability for the quality of his or her own work, in line with the requirements of the relevant professional regulatory bodies
- The accountability of individual professionals to the requirements of the organisation in which they work
- The accountability of senior members of staff for the organisation's performance, and more widely for its provision of services to the people it serves

2 Definition of Clinical and Care Governance

2.1 Definition

Clinical and care governance is the system by which Health Boards and Local Authorities are accountable for ensuring the safety and quality of health and social care services, and for creating appropriate conditions within which the highest standards of service can be promoted and sustained. The following definition of clinical and care governance underpins the clinical and care governance and professional governance framework for Argyll and Bute Health and Social Care Partnership outlined in this paper.

Annex C of the Public Bodies (Joint Working) (Scotland) Act 2014 Clinical and Care Governance Framework sets out in some detail the working definition to be applied to Integrated Health and Social Care Services in Scotland. This working definition is as follows.

Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation – built upon partnership and collaboration within teams and between health and social care professionals and managers.

It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening – whilst at the same time empowering clinical and care staff to contribute to the improvement of quality – making sure that there is a strong voice of the people and communities who use services.

Clinical and care governance should have a high profile, to ensure that quality of care is given the highest priority at every level within integrated services. Effective clinical and care governance will provide assurance to patients, service users, clinical and care staff and managers, Directors alike that:

Quality of care, effectiveness and efficiency drive decision-making about the planning, provision, organisation and management of services;
The planning and delivery of services take full account of the perspective of patients and service users;
Unacceptable clinical and care practice will be detected and addressed.

Effective clinical and care governance is not the sum of all these activities; rather it is the means by which these activities are brought together into this structured framework and linked to the corporate agenda of A&B HSCP, NHS Boards and Local Authorities.

A key purpose of clinical and care governance is to support staff in continuously improving the quality and safety of care. However, it will also ensure that wherever possible poor performance is identified and addressed. All health and social care professionals will remain accountable for their individual clinical and care decisions.

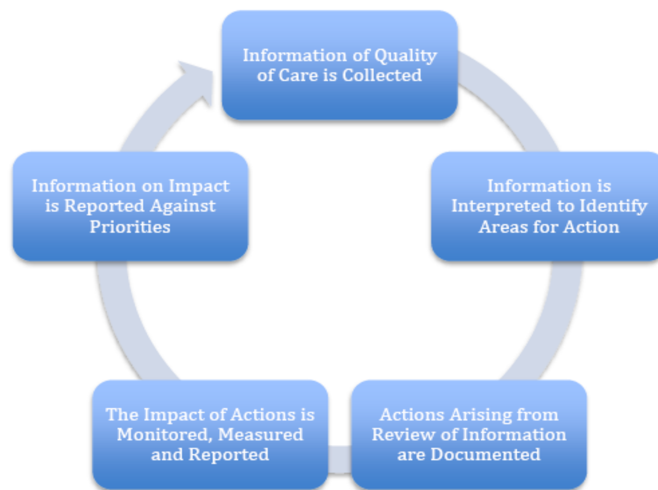
Many clinical and care governance issues will relate to the organisation and management of services rather than to individual decisions. All aspects of the work of A&B HSCP, Health Boards and Local Authorities should be driven by and designed to support efforts to deliver the best possible quality of health and social care. Clinical and care governance is principally concerned with those activities which directly affect the care, treatment and support people receive whether delivered by individuals or teams.

2.2 The Process of Clinical and Care Governance

The Chief Officer for Argyll and Bute HSCP and the CEOs for NHS Highland and Argyll and Bute Council will have in place management structures that ensure accountability and responsibility for professional, clinical and care governance in the A&B HSCP.

Annex C of the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 Clinical and Care Governance Framework sets out a series of five process steps to support clinical and care governance as follows:

- Information on the safety and quality of care is collected.
- Information is interpreted to identify areas for action.
- Actions arising from scrutiny and review of information are documented.
- The impact of actions is monitored, measured and reported
- Information on impact is reported against agreed priorities.



These five steps form the basis of the proposed performance framework described in this paper for Argyll and Bute and this information will be used to demonstrate achievement of the nine national Health and Well-being outcomes and the local outcomes expressed in each authority Single Outcome Agreement (SOA).

2.3 The principles contained in this framework are designed to integrate with the Strategic 2020 Vision and the patient safety agenda. While there is no similarly overarching articulation of these, the principles for Local Authority services align closely with those articulated by the Christie Commission, in the Social Care (Self Directed Support) (Scotland) Act 2013 and the Community Empowerment Bill. Core outcome measures will be agreed in line with the principles and proposed framework to ensure consistency of approach between Local Authorities, NHS Board and the Argyll and Bute IJB.

3. Professional Governance

3.1 Professional governance is an accountability framework that empowers health and social care professionals at the front line to collaborate effectively in the delivery of integrated services. The framework for professional governance includes such core elements as codes of conduct, standards of practice, policies and procedures, resource utilisation and stewardship, evidence-based practice and research, use of technology, quality and performance improvement. The purpose of system-wide professional governance is to coordinate the activities of the health and social care workforce to achieve the health and wellbeing outcomes for patients, service users and carers in integrated health and social care settings across Argyll and Bute.

3.2 The Professional Governance Framework provides assurance to the Argyll and Bute IJB that effective processes for health and social care professional practice are in place and implemented to develop, support and monitor workforce compliance with agreed accountability and governance frameworks.

4. Performance Assurance Framework

Clinical and care governance in Argyll and Bute is currently monitored through NHS Highland and Argyll & Bute Council's existing performance management systems. Professional governance is achieved through the agreed accountable professional officers, namely the Medical Director, the Executive Nurse Director (with responsibility for nurses, midwives and AHPs), the Chief Social Work Officer and the Director of Pharmacy.

Principles of Clinical and Care Governance will be embedded at service user/clinical care/professional interface using the framework outlined below. Argyll and Bute Integration Joint Board will ensure that explicit arrangements are made for professional supervision, learning, support and continuous improvement for all staff.

Argyll and Bute Integration Joint Board will fulfil its devolved responsibility in terms of overseeing delivery of delegated functions by ensuring that there is evidence of effective performance management systems. Professional and service user networks or groups will inform the agreed Clinical and Care Governance framework directing the focus towards a quality approach and continuous improvement.

The Clinical and Care Governance and Professional Governance framework will encompass the following:

- Professional regulation and workforce development.
- Information governance
- Safety
- Experience
- Quality and Effectiveness of Care
- Social Justice

Each of these six domains will be underpinned by mechanisms to measure quality, clinical and service effectiveness and sustainability. They will be compliant with statutory, legal and policy obligations strongly underpinned by human rights values and social justice. Service delivery will be evidence-based, underpinned by robust mechanisms to integrate professional education, research and development.

Argyll and Bute Integration Joint Board is responsible for embedding mechanisms for continuous improvement of all services through application of a Clinical and Care Governance and Professional Governance Framework.

4.1 Professional Regulation and Workforce Development

This domain reflects the need for our organisations to have assurance that we have a workforce fit for purpose and sustainable into the future. This is particularly important as we move towards new models of care where professionals will need to retain their accountability through professional leads in health and social care. There are also important provisions in existence that protect professional standards in education and research that would be essential for success in the future.

- Ensures organisational development and professional practice is evidence based and continuously improved supported by a culture of learning and high performance.
- Ensures compliance with professional standards, codes of practice and performance requirements.
- Encourages and enables our staff to work in multi-disciplinary and multi-professional teams and use reflective practice.
- Promotes learning from good practice, adverse incidents, complaints and risks.
- Creates an environment that supports the contribution of staff and their safety as well as supporting and enabling innovation.
- Ensures our staff act with honesty and integrity and comply with the duty of candour.

4.2 Information Governance

This domain reflects the duties related to the protection of information, information sharing, records management, Information Technology management, data reporting and documentation standards, whose purpose is as follows

- Ensures compliance with data protection requirements
- Ensures transparent, open, accessible and robust performance reporting.
- Provides a framework to assess documentation standards, including documentation audits, using a sampling methodology
- Provides a framework for development of multi-professional electronic patient and service user records that include Integrated Care & Support Plans.
- Understands and minimises unnecessary variation by the intelligent use of data, measurement and improvement science.
- Ensures performance reporting is used to enable continuous improvement

4.3 Safety

This domain reflects our duties to create a safe working environment for staff along with our duty of care to patients, service users and carers.

- Ensures services are as safe and effective as possible for the people who use services and the staff who provide them
- Ensures planned, strategic approaches to innovation and development through an organisational learning and improvement culture.
- Ensures accountability, management and mitigation of risk through joint risk registers and aligned strategic, operational and service level risk assessment and management processes.
- Anticipates and prevents harm through active use of learning from near misses, initial case reviews and demonstrates robust systems for risk assessment and management; for example, use of patient, service user and carer safety plans.
- Learning identified from brief/debrief processes.
- Ensures compliance with Health and Safety requirements.
- Requires reporting of incidents, complaints and feedback and promotes learning from these
- Develops a culture of openness, communication and accountability, where learning from critical incidents and successes takes place informed by significant Case reviews, local adverse event reviews, Significant Adverse Event reviews, and is incorporated into training and education for staff

4.4 Experience

This domain reflects the importance of involving service users and carers in the design and delivery of health and social care supports and services. It also reflects the importance of staff at the front line having the opportunity to shape services in line with specialist and best practice knowledge alongside their awareness of the needs specific care groups and local communities. This domain:

- Provides a framework for Staff and patient/user/carer feedback, culture surveys and patient experience
- Ensures planning, delivery and monitoring of services is informed by service user experience.
- Promotes patient, service user and carer involvement in identifying their individual outcomes; shaping individual care plans, services and organisational practices to achieve personalisation and person-centred approaches to care.
- Promotes staff, service user and carer involvement in the planning and development of services.

4.5 Quality and Effectiveness of Care

This domain reflects the drive towards evidence based practice to improve outcomes and achieve best value in the design, organisation and delivery of services. Good governance in this domain should deliver on the Christie Commission requirements and the 20:20 vision of person centred, high quality services for the people of Argyll and Bute. This domain:

- Establishes a system of governance that is designed to produce best outcomes for people who use, or may need services with specific outcome measures.
- Delivers high quality, evidence- based care and prevention, informed by the development and monitoring of cross organisational measures and service specific outcomes
- Best practice guidelines etc.
- Ensures active service evaluation though Individual, Team-based, service or partnership level, case and practice based audit programmes self-assessment and performance review processes
- Monitor inspection report and associated action plans.

4.6 Promotion of Equality and Social Justice

This domain reflects responsibilities of local authorities and Health Boards to have clear strategies in place to address inequalities which have an adverse effect on wellbeing, and to promote social inclusion, equity of access to services and improved outcomes for people across Argyll and Bute. There are three linked national social policy frameworks: Achieving Our Potential, Equally Well and the Early Years Framework. These policy frameworks are complementary and are underpinned by principles of fairness and social justice. Together they reflect the joint aims of tackling poverty, addressing health inequalities and giving children the best start in life.

In Argyll and Bute there is a commitment through the SOA and other policy documents, to address social inequalities and the impact that these have on other aspects of life in our communities, including health, employability and financial inclusion.

5. Performance measurement

For each domain, an agreed number of measures will be applied. These measures will align with the national and local outcomes and will be developed jointly over time to reflect the needs of and outcomes from services for the population of Argyll and Bute. This will be achieved through self -assessment and an agreed performance review processes.

6 Accountability for Clinical, Care and Professional Governance

NHS Highland Board and Argyll and Bute Council have existing mechanisms to demonstrate accountability to the Scottish Government and the public. Argyll and Bute HSCP will integrate existing methods of professional performance management and governance within the integrated health and social care partnerships including arrangements for adult and child protection, strategic and community planning.

6.1 Accountability for Clinical, Care and Professional Governance

Chief Executives

The Chief Executive of Argyll and Bute Council NHS Highland hold ultimate accountability for delivery of clinical and care governance.

Chief Officer

The Chief Officer has both strategic and operational responsibility for the delivery of services. The Chief Officer will be directly responsible to and line-managed by the Chief Executive Officers of both Parties, and via the Chief Executive Officers is responsible to NHS Highland and the Council. The Chief Officer is also accountable to Argyll and Bute Integration Joint Board. The Chief Officer will be accountable directly to Argyll and Bute Integration Joint Board for the preparation, implementation of and reporting on the Strategic Plan. The Chief Officer will also be responsible for operational delivery of services and the appropriate management of staff and resources. The Chief Officer will establish a senior management team, equipped to direct and oversee the structures and procedures necessary to carry out all functions in accordance with the Strategic Plan. The Chief Officer's objectives will be set annually and performance appraised by the Chief Executive Officers of both Parties, in consultation with the Chair and Vice Chair of Argyll and Bute Integration Joint Board. The Chief Officer will be a full member of both the Council and NHS Highland's corporate management teams, as well a non-voting member of Argyll and Bute Integration Joint Board.

Chief Social Work Officer

The Chief Social Work Officer, through delegated authority holds professional and operational accountability for the delivery of safe and high quality social work and social care services within the Council. An annual report on these matters will be provided to the Council, NHS Highland and Argyll and Bute Integration Joint Board. The Chief Social Work Officer will be a member of the Clinical and Care Governance Group and will provide professional advice in respect of the delivery of social work and social care services by Council staff and commissioned care providers in Argyll and Bute.

NHS Highland Medical Director

The role and responsibility for the NHS Highland Medical Director is to lead the formation and implementation of clinical strategy, taking lead on clinical standards, providing clinical advice to the board, providing professional leadership, and being a bridge between medical staff and the board. Other key responsibilities include; clinical governance, acting as the Responsible Officer for revalidation, quality and safety, education, medical staffing planning, disciplinary issues concerning doctors. The Board Medical Director, or his/her depute, will be a member of the Clinical and Care Governance Committee and will provide clinical and professional leadership and advice in respect of the overview and consistency of the Clinical and Care Governance and Professional Governance Framework.

NHS Highland Executive Nurse Director

The Executive Nurse Director, or his/her deputy, will provide leadership, assurance and professional accountability of all nursing, midwifery and AHP staff within NHS Highland. The Board Nurse Director, or his/her depute, will be a member of the Clinical and Care Governance Committee and will provide clinical and professional leadership and advice in respect of the overview and consistency of the Clinical and Care Governance and Professional Governance Framework.

Professional Leads

Chief Officer will have an appropriate senior team of ‘direct reports’ in order to fulfil their accountability for the 3 year Strategic Plan that has been developed for Argyll and Bute, and for the safe, efficient and effective delivery of services to the population of the local area.

7 Membership of the Argyll and Bute Clinical and Care Governance Committee

7.1 Terms of Reference

The Argyll and Bute Clinical and Care Governance and Professional Governance Forum is a professional reference group, bringing together senior professional leaders across Argyll and Bute. This group, chaired by one of its members, will oversee the delivery of integrated care and support along with change and innovation to ensure the delivery of safe and effective person-centred care within Argyll and Bute. This group will ensure that the responsibilities for Clinical and Care Governance and Professional Governance, which remain with NHS Highland and the Council relate to the activity of the Board.

The group will provide oversight and advice and guidance to the Strategic Planning Groups and to the IJBs in respect of clinical and care and professional governance for the delivery of Health and Social Care services across the localities identified in their strategic plans.

7.2 Roles and Responsibilities:

NHS Highland Executive Medical, Nursing and Pharmacy share accountability for Care Assurance, Clinical and Professional Governance across NHS Highland services as a statutory duty delegated by the NHS Highland Chief Executive. As part of their statutory duties, these officers or their designated deputes are required to attend the Integration Joint Board of the A&B HSCP to provide professional advice and assurance in respect of Clinical and Care Governance and Professional Governance in Argyll and Bute.

The Chief Social Work Officers, through delegated authority hold professional and operational accountability for the delivery of safe and innovative social work and social care services provided by the Council, as well as by external organisations from whom the Council has procured and commissioned services. An annual report on these matters will continue to be provided to the relevant committee of the Council. The Chief Social Work Officer will attend the Integration Joint Board of A&B HSCP to provide professional advice and assurance in respect of Social Work staff and commissioned care providers.

8 Assurance Framework for Integrated Health and Social Care Partnerships in Argyll and Bute

The Integration Joint Board provides governance, accountable for strategic planning and ensuring the operational delivery of those integrated services that are delegated to the authority. The Health Board and Local Authority are ultimately accountable for the operational delivery of integrated services, with the Chief Executive Officers accountable for the delivery of those delegated functions and accountable for improvement responses to external inspections.

Clinical and care governance arrangements for integrated services must fully align with the existing arrangements for governance within NHS Highland and Argyll and Bute Council. These public bodies must develop a consistent approach to assurance for quality and safety of care across all services, whether integrated or not. The integration scheme for Argyll and Bute sets out the means by which the IJB will assure the quality and safety of care.

Each of the domains will be underpinned by mechanisms to measure, quality, clinical and service effectiveness and sustainability. They will be compliant with statutory, legal and policy obligations strongly underpinned by human rights values and social justice. Service delivery will be evidenced based, underpinned by robust mechanisms to integrate professional education, research and development.

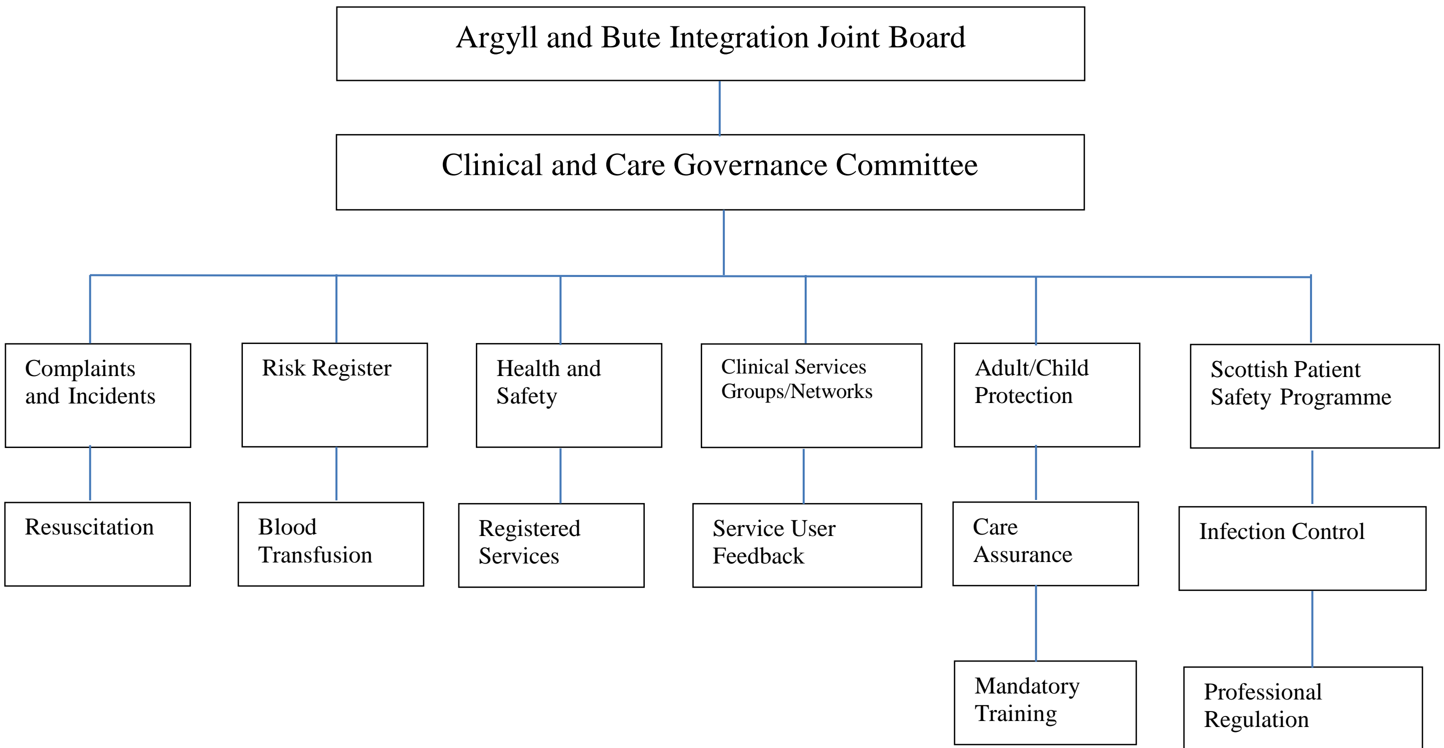
Health and well-being Outcomes under Health and Social Care Integration

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

By working with individuals and local communities, Integrated Joint Board will support people to achieve the following outcomes:

Outcome 1:	People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 2:	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Outcome 3.	People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 4.	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 5.	Health and social care services contribute to reducing health inequalities.
Outcome 6.	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
Outcome 7.	People using health and social care services are safe from harm.
Outcome 8.	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Outcome 9.	Resources are used effectively and efficiently in the provision of health and social care services.

Planned Clinical and Care Governance structure



Terms of Reference for Clinical and Care Governance Committee

1. PURPOSE OF THE COMMITTEE

To ensure delivery of professional standards of care and practice to ensure the delivery of safe and effective person-centred care within Argyll and Bute

To provide assurance to the Integrated Joint Board that systems, processes and procedures are in place and are delivering effective clinical and care governance throughout Argyll and Bute and

This will include the following:

- To develop and monitor clinical and care assurance systems to regulate the quality and safety of health and care services
- To monitor implementation of Care Inspectorate and NHS Healthcare Improvement Scotland clinical standards and other external review body standards and guidelines – such as Mental Welfare Commission, SPSO etc.
- To oversee self-evaluation and preparation for joint inspections and to oversee local implementation of recommendations following review
- To review all incidents to identify trends, to take appropriate action and disseminate lessons learnt across Argyll and Bute (and NHS Highland where appropriate)
- To review all feedback, including complaints and compliments, to ensure proper management, identify trends and disseminate lessons learnt across Argyll and Bute (and NHS Highland where appropriate)
- To review Significant Event Review findings and ensure completion of resulting action plans
- To oversee the Clinical and Care Governance Risk Register and to ensure that risk management procedures are followed across Argyll and Bute
- To oversee the development of local risk registers and action plans. To identify risks requiring attention and report to the IJB as required
- To ensure that professional standards are adhered to and that systems for governing regulatory requirements for professionals are in place
- To oversee implementation of framework for professional supervision of clinical and care professionals working in Argyll and Bute.

2. REPORTING

The Clinical and Care Governance Committee is accountable to the Integration Joint Board and will provide assurance report for each of the IJB meetings. It will also provide assurance reports to the NHS Highland Clinical Governance Committee and to Argyll and Bute Council Community Services Committee.
The CCG Committee will receive reports and advice from the following groups:

- Locality CCG groups
- Specific clinical and care groups e.g. maternity services, blood transfusion, infection control, child protection, adult protection, health and safety

3. HOW THE COMMITTEE WORKS

- The CCG Committee will meet on a regular basis (frequency to be determined by IJB schedule).
- Agendas will follow standard template which will cover all elements of the CCG framework.
- Assurance reports will be developed and delivered in advance of each meeting to ensure that all group members have time to scrutinise and analyse the information.
- CCG Committee will develop briefing for all staff after each meeting covering key points and actions agreed
- CCG Committee will provide assurance report to IJB for each of its meetings
- CCG Committee will provide assurance/exception reports as required by NHS Highland/Argyll and Bute Council

4. MEMBERSHIP

Members Nominated by the Parties		**Deputies**
Argyll & Bute Council	Councillor Douglas Philand Councillor Anne Horn Councillor Mary Jean Devon Councillor Elaine Robertson	
NHS Highland Board	Robin Creelman Elaine Wilkinson Garry Coutts Anne Gent	Heidi May
Professional Advisors (non-voting)		
The Chief Social Work Officer of the Constituent Local Authority	Louise Long	N/A

The Chief Officer of the IJB	Christina West	N/A
The Chief Financial (Section 95 Officer) of the IJB	TBC	N/A
General Medical Practitioner (Stakeholder GP)	TBC	N/A
Lead Nurse	Elizabeth Higgins	N/A
IJB Clinical Director	Dr Michael Hall	
Medical Practitioner who is not a GP	TBC	N/A
Stakeholder Members (non-voting)		
A staff representative (Council) A staff representative (NHS)	Kevin McIntosh Dawn Gillies	N/A
Independent sector representative	Denis McGlennon	
A third sector representative	Glenn Heritage	Katrina Sayer
Service User Representative - Public x 2	Elizabeth Rhoddick Maggie McCowan	N/A
Service User Representative - Carer x 2	Heather Grier Vacancy advertised Jan. 2016	N/A
Additional Members (non-voting) – locally determined		
Lead Allied Health Professional Advisor	TBC	
Mental Health Advisor	TBC	

APPENDIX 7- INDICATIVE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET

2014/15 Financial Analysis

Service Area	Sub-Service	Activity	1415 Net Expenditure	1415 Net Budget
Central Support	Central/Management Costs	Management and Support	1,988,870	2,184,108
Central Support Total			**1,988,870**	**2,184,108**
Children and Families	Child Protection	Assessment, Care Management and Support	3,008,943	2,859,362
		Child Protection Committee	169,337	185,391
		Contact & Welfare Services	279,625	235,093
		Early Intervention Project	145,699	114,276
		Youth Crime	2,287	5,000
	Child Protection Total		**3,605,891**	**3,399,122**
	Children with a Disability	Care at Home	302,108	422,836
		Respite and Support for Carers	309,443	299,969
		Third Sector Grants	259,568	252,065
	Children with a Disability Total		**871,119**	**974,869**
	Criminal Justice	Criminal Justice Services	19,269	2,131
	Criminal Justice Total		**19,269**	**2,131**
	Looked After Children	Adoption	154,716	143,087
		Assessment, Care Management and Support	267,762	237,497
		Children's Houses	1,533,911	1,461,547
		Consultation Support Forum	3,197	9,000
		Family Placement Team	398,067	345,616
		Fostering	1,130,478	1,224,630
		Hostels	1,163,957	1,163,114

		Residential Placements	1,263,832	994,501
		Supporting Young People Leaving Care	481,648	483,281
	Looked After Children Total		**6,397,568**	**6,062,273**
Children and Families Total			**10,893,848**	**10,438,394**
Adult Care	Addictions	Addictions / Substance Misuse	349,771	387,492
		Residential Care	24,280	40,000
	Addictions Total		**374,051**	**427,492**
	Learning Disabilities	Assessment & Care Management	669,917	698,177
		Care at Home	5,871,550	5,989,576
		Day Services	1,884,727	2,390,763
		Other Services & Projects	20,224	20,224
		Residential Care	1,831,478	1,877,490
		Respite and Support for Carers	77,336	119,018
	Learning Disabilities Total		**10,355,231**	**11,095,248**
	Mental Health	Assessment & Care Management	344,304	359,552
		Care at Home	479,620	606,921
		Day Services	602,076	678,253
		Other Services & Projects	109,765	114,628
		Residential Care	36,533	70,398
		Respite and Support for Carers	0	(1,477)
	Mental Health Total		**1,572,298**	**1,828,275**
	Older People	Assessment & Care Management	3,564,101	3,455,887
		Care at Home	11,876,075	10,577,712
		Day Services	387,244	370,180
		Delayed Discharge	251,913	270,360
		Dementia Services	202,040	221,953
		Integrated Care Teams	326,101	388,592

		Meals on Wheels and Lunch Clubs	48,496	43,837
		Occupational Therapy	90,425	104,176
		Other Services & Projects	108,043	254,610
		Residential Care	11,628,857	11,832,459
		Resource Release	(38,394)	0
		Respite and Support for Carers	297,918	329,277
		Sheltered Housing	122,262	122,496
		Technology Enabled Care	(52,265)	(27,526)
	Older People Total		**28,812,818**	**27,944,012**
Adult Care	Physical Disability	Assessment & Care Management	138,501	139,425
		Care at Home	876,583	790,556
		Equipment & Adaptations	170,279	155,719
		Residential Care	96,203	102,931
		Respite and Support for Carers	10,503	25,058
		Sensory Impairment Services	33,083	42,441
	Physical Disability Total		**1,325,152**	**1,256,130**
	Vulnerable Adults	Adult Protection	92,034	93,805
	Vulnerable Adults Total		**92,034**	**93,805**
Adult Care Total			**42,531,584**	**42,644,961**
Social Work Overall Total			**55,414,301**	**55,267,463**

Note: All management support costs across Social Work have been grouped together under Central Support to isolate management and support costs from frontline service costs.

APPENDIX 8 – WORKFORCE – STATUTORY SECTORS 2015/16

Service		FTE
Adult Health		
	Central services (health)	152
	Adult health – Cowal & Bute	285
	Adult health – Helensburgh & Lomond	68
	Adult health - OLI	454
	Adult health - MAKI	332
	Adult mental health teams	159
Adult Social Care	Learning Disability	76.23
	Operations Mental Health	24.28
	Operations Older People	88.33
	Operations Substance Misuse	4
	Resources Older People	187.08
	Service Development	3.69
Child Health	Child Health and Maternity	98
Children & Families Social Care	Children & Families Operations	72.81
	Children & Families Resources	80.37
	Early Years	15.68
	Children & Families other	11.66
Senior & Management	Chief Officer Health & Social Care	1
	Head of Children & Families/Criminal Justice	1
	Head of Strategic Planning & Performance	1
	Head of Adult Services	2
	Integrated Managers tiers 2 & 3	39.8
PARTNERSHIP TOTAL ESTABLISHMENT		**2156.93**

Dental Services (not included in HSCP		
Dental services		92

Other essential support services are provided directly by Argyll & Bute Council and NHS Highland. These would include functions critical to maintaining the organisations, for example, payroll, human resources, finance and legal services.

APPENDIX 9 - ORGANISATIONAL DEVELOPMENT STRATEGY & PLAN

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Background

The Public Bodies (Joint Working) (Scotland) Act 2014 has placed duties on the Argyll and Bute Health and Social Care partnership to establish and implement an Organisational Development Plan to support the Integration of Health and Social Care and emphasises the need for the plan to reflect the integration agenda which details a comprehensive, systematic and practical approach to improving individual outcomes and organisational effectiveness.

Specifically, the Bill notes states:
'The shared endeavour will be necessary to support culture change that will be required to underpin greater multi-disciplinary and multi-agency joint working and to reflect the move towards a greater community focus from service planning and delivery'

The key detailed priorities for Organisational Development support to be focussed on are:

- Integration joint board and integration joint monitoring committees development sessions, including work locally on the development of a shared set of values, purpose and vision for the Board and its members;
- Development sessions for Health Board non–executive directors and local authority elected members;
- Supporting the development of skills and behaviours needed for the chief officer posts;
- Targeted programme of support for Health Board and local authority chief executives and chief officers;
- The Scottish Government will work with national partners via public sector leaders forum to support development for key groups of staff and professional;
- Development support for senior professional teams, including GPs and Chief Social Work Officers to lead change within localities and as part of the strategic commissioning process locally;

- Support for staff working in non-statutory organisations.

We need to do more than simply integrate or co-locate teams, the change required will put the person at the centre of the process, empowering them to direct their services and supports, choosing from a range of supports that includes the independent and third sectors as equal partners.

'If all you do is create joint teams but offer the same service it does not change anything for the patient' Martin Farran, Executive Director of Adult and Community Services, Barnsley Council, 2014.

Strategic and Operational Managers are under pressure to create and maintain an environment where cultural change can take place. People need to be empowered to be at the centre of the process at all times and staff from all organisations need support to value each other as equal professionals and team members.

WHAT IS ORGANISATIONAL DEVELOPMENT?

Organisational Development is a planned and systemic change effort using organisation theory and behavioural science, knowledge and skills to help the organisation become more vital and sustainable. OD is not a technique or a group of tools but rather, something that can be applied at any time an organisation wants to make planned improvements, (McLean, 2005).

The benefits of an OD approach supports the development of a culture which underpins more innovation and creativity, increases job satisfaction, develops more positive interpersonal relationships and fosters greater participation in creating plans and defining organisational goals and outcomes.

Organisational Development and continuous improvement are central to the delivery of effective, efficient and economic Health and Social Care Services in Argyll and Bute. An ability to anticipate

and respond to change and to take advantage of new opportunities is crucial to the long-term sustainability and delivery of these services. Further, a key challenge for Health and Social Care Integration requires us not only to focus on what services we provide, but how we provide them. We need to grow to meet changing needs, customer expectations and personalised outcomes, while remaining effective, and build our human and other resources to sustain our work with the aim of preparing and supporting the Partnership to deliver the Health and Wellbeing Outcomes when the Partnership assumes full responsibility for these.

Vision, aim and outcomes

The vision of Argyll and Bute Council and NHS Highland is that the people in Argyll and Bute will live longer, healthier, independent lives. The core values of Argyll and Bute Council and NHS Highland are: compassion; respect; integrity; team work; equality; fairness; transparency; efficiency; improvement; involvement ,co-production and a person centred approach.

Argyll and Bute Integration Joint Board will set out within its Strategic Plan how it will effectively use allocated resources to deliver the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in regulations under section 5(1) of the Act. The Organisational Development (OD) Plan is developed to help deliver the National Health and Wellbeing Outcomes by building capacity and capability to sustain workforce development and to achieve culture shift and culture change.

KEY AREAS

In Argyll and Bute the following key areas will progress within the Organisational Development Plan:

1. Vision and Strategic Direction
2. Communication, Involvement and Engagement

3. Cultural and Behavioural Change
4. Capacity and Capability for Change
5. Leadership
6. Workforce and Team Development
7. Governance
8. Quality and Improvement
9. Partnership

SHARED OUTCOMES FOR THESE AREAS

1. Vision and Strategic Direction

- The strategic vision will be set out in the Strategic Plan for the Health and Social Care Partnership and OD will align with this overall plan
- The vision is communicated to and shared with the wider community and the workforce.
- Strategic planning reflects an outcome focussed approach to service delivery linked to the national and local Single Outcome Agreement Framework.
- Locality planning is developed and delivers local solutions for the communities in Argyll and Bute.

2. Communication, Involvement and Engagement

- Services and practice are developed and delivered which put the person at the centre.
- Practice demonstrates a personalised outcomes approach.
- Co-production and community engagement are embedded into service planning and practice.
- Effective consultation and person involvement strategy reflects genuine involvement of communities.
- There is a communication and engagement strategy for engaging and involving staff, partners and the community in development of Health and Social Care Integration.

3. **Culture and Behavioural Change**
    - Shared Vision and Values are agreed.
    - Health and Social Care Integrated Service design reflects outcomes for people.
    - Agreed Leadership and Management behaviours are in place and are communicated to staff.
    - Our staff feel valued, respected and are treated well.
    - Staff are engaged in the development of services and practice.
    - People have an improved experience of health and social care services and a person-centred approach
    - Staff have an improved experience of working in health and social care in a healthy organisational culture.

4. **Capacity & Capability for Change**
    - Support and develop staff with change programmes to encourage new ways of thinking in a culture of continuous improvement
    - Staff are supported and involved in changes
    - Employees are involved in locality service and governance development.
    - Self- reflection is embedded into everyone's practice.
    - Change is communicated to staff and people who use our services

5. **Leadership**
    - Our Leaders are confident and effective at all levels within the partnership to deliver integrated services.
    - There is an integrated leadership and management development framework.

6. **Workforce and Team Development**
    - Effective integrated teams will be in place

- Teams will be supported in challenging the status quo and developing a culture of continuous improvement
- The workforce will feel engaged in the change process
- A joint workforce and organisational development strategy will be developed to reflect the needs of teams delivering integrated services

7. Governance

- There is a clear and comprehensive Governance Framework in Argyll and Bute, incorporating locality plans which support integrated Health and Social Care.
- Financial planning framework is integrated with strategic planning outcomes.
- A Framework for the 'Hosting' services across Argyll and Bute is agreed and implemented.
- Professional workforce regulation, standards and related workforce development is mapped to inform workforce planning.

8. Quality Improvement

- There are clear links with Heath and Social Care Integration to the Single Outcome Agreement and the Community Planning process in Argyll and Bute.
- The Workforce and Organisational Development Strategy supports leaders and employees with skills, knowledge, training and development to deliver person centred, improved services.
- Change management approaches and OD activities will be used to engage and support staff to work with service improvement methodologies (e.g. Highland Quality Approach, Lean, Business Process Re-engineering) and develop the concept of continuous improvement.

9. Partnership

- The shared vision and values influences the service delivery model and is developed through partnership and collaboration
- Engagement is across the independent, voluntary and public sector
- Services are developed and delivered in a locality based and in a co-located way with all partners, including the involvement of people who use our services and their families.

APPENDIX 10 - STRATEGIC COMMISSIONING ARRANGEMENTS

10.1 Joint Strategic Commissioning (JSC), which has been adopted by the National Steering Group for Joint Strategic Commissioning, is defined in Scotland as being:

"The term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget".[43]

10.2 The complete Joint Strategic Commissioning process is set out in the following model, which is based on the premise of Analyse, Plan, deliver and Review as illustrated below:

10.3 Future versions of this Strategic Plan will, across all care groups, provide an opportunity for the Integration Joint Board to design and commission services in new ways in collaboration with its partners. It will not be desirable, or financially viable, for services to be delivered as they have been historically. With the full involvement of all stakeholders, the Partnership has the chance to think innovatively about how services might be provided in the future. This will

mean the adoption of a robust option appraisal process which could lead to the Board making decisions about disinvesting in current provision to reinvest in other services and supports that are required to meet on-going demand.

10.4 This Strategic Plan also recognises the important role of informal community capacity building and asset-based approaches in delivering more effective and preventative interventions as an effective way of reducing unnecessary demand at the front door of the formal health and social care system (see Section 6 on Locality Planning).

10.5 In Social Work Services the tables below provide A summary of current service commissioning and contracting across the different Social Work service areas is shown at Appendix 7.

Children & Families referral Activity Data 2010-2015

Description	2010/11	2011/12	2012/13	2013/14	2014/15	Comment: Data source
No. of Referral s (1)	2909	3101	3111	3427	3559	Source: CareFirst
No. of Children subject of a Referral (2)	1411	1478	1490	1430	1545	Source: CareFirst
No. of 'new' referrals	757	852	1249	1125	1131	Source: CareFirst
No. of Children subject to a 'new' referral	659	721	905	813	840	Source: CareFirst
Looked After Children (3)	219	190	200	175	183	
Looked After Accommodated Children (3) (4)	148	133	125	123	134	
Child Protection Investigations	164	185	195	185	132	CPC Management Report – based on live operational data at the time
Child Protection Registrations (3)	39	48	16	21	23	
Children placed outwith Authority	16	15	>5 (5)	13	10	
No. Children with UCA (7)	NA	NA	NA	300 (8)	476	Source: CareFirst
No. Children with a Permanency Plan	89	81	84	103	100	As at 31/3 Source: Pyramid
No. Children with a Permanency Plan – with authority to adopt	0	5	7	4	2	Source: Legal Services
No. of Foster Care Placements (3)	42	50	47	54	57	
No. Kinship Placements	66	55	53	42	44	
No. Throughcare Clients (3)	52	44	55	51	40	

Description	2010/11	2011/12	2012/13	2013/14	2014/15	Comment: Data source
No. Ex-care leavers with a Pathway Plan	16	13	9	6	37	

The main Children's Social Work Statistics publication is available here:

http://www.gov.scot/Topics/Statistics/Browse/Children/PubChildrenSocialWork

(1) Referrals defined as Carefirst Initial Contacts, where Contact set as 'Child', and 'Age at initial contact' ranges from 0-18.

(1a) 'New' Referrals defined as Carefirst Initial Contacts made where Referral Type set as 'New Referral'.

(2) Children may be the subject of >1 referrals within year period. Definition of referral as above.

(3) Data for 2010/11 - 2013/14: source is nationally published Annual Children's Social Work Statistics (see link) using as at date of 31st July 2011, 2012, 2013, 2014. Data for 2014/15 will not be published until 2016. Data source for 2014/15 is Pyramid.

(4) All looked after children except children on a supervision order looked after at home with parents

(5) < 5 represent numbers that are supressed in nationally published statistics to maintain confidentiality.

(6) Outwith Authority - defined as: Other Residential Care includes crisis care, secure accommodation and in residential school (as per Children's Social Work Statistics published data).

(7) This figure counts the number of children who have been the subject of a UCA completed in the year, a child may have >1 assessment completed within the period.

(8) The electronic UCA was not launched until Nov. 2013 so figures for 2013/14 are not year total

(9) Children looked after and accommodated ≥ 1 year

APPENDIX 11 - THE INTEGRATED CARE FUND PLAN AND CHANGE FUND LEGACY

We need to redesign services and increase the range of supports to ensure that they are sustainable for the future, and that they improve outcomes for people. Given the option, people want to stay in their own homes for as long as possible, and have care that is personalised to their own needs and preferences. The Change Fund available from 2011-2014 was established to provide bridging finance to facilitate these shifts in the balance of care and help the Partnership make better use of resources by promoting community capacity building and new models of care in communities, shifting the balance of provision away from institutional care to primary and community settings with a more preventative focus.

Within the four years to March 2015 of the Change Fund, we have made significant progress in prevention, in co-production, and in shifting that balance of care for older people, as well as in partnership working across the different sectors. A wide range of activity has been taking place for example, increased carer support, community resilience, tele-health and Technology Enabled Care, equipment and housing adaptations, and management and prevention of falls.

As this agenda weaves into the wider Integration work, we inherit examples of good practice and some new ways of working. However, we also recognise that we now have an even greater task ahead and the Scottish Government has also taken notice of prior progress in establishing an Integrated Care Fund, now extended to a three year funding allocation for all adults, to help move resources and achieve outcomes across health, wellbeing, care and social justice as well as ensuring effective and efficient services.

In 2014 Scottish Government set out in the Act the clear principles for the Integration of Health and Social Care which brought similar ambitions, in Argyll and Bute, to all health and social care services including to criminal justice. These principles link directly to the nine health and wellbeing outcomes and underpin the Scottish Government vision. The vision for Integration is to ‘ensure better care and support for people; users of health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. This will result in better outcomes for people, enabling them to enjoy better health and wellbeing within their homes and communities.’

Scottish Government is clear that the Integrated Care Fund should have a focus on adults with multi-morbidity (multiple illnesses and conditions), reduce future demand, and target care to those who need it most. This builds on work under Reshaping Care and seeks to shift support to maximise the assets of communities and individuals, work within principles of co-production, prevention and facilitate greater choice and control.

In Argyll & Bute we have engaged with the principles set out for use of the ICF is by Scottish Government (co-production, sustainability, locality, leverage, and involvement) and adopted locality key priorities as follows:

Locality Key Priorities for 2015-16

1. Person centred working and outcomes focussed approach
   a. Building capacity to really listen to what is important to people e.g. utilising the Caring Connections approach and coaches

2. Early intervention and prevention
   a. Support for carers
   b. Medicines management
   c. Preventing emergency admissions
   d. Reducing hospital length of stays
   e. Multi-morbidity management and holistic care pathways
   f. Anticipatory care plans

3. Communications, involvement and engagement
   a. Continue health asset mapping and identifying services and gaps in local areas
   b. Co-producing services to fill these gaps with people who will use the services
   c. Knowledgeable staff for cross referral/sign posting to services
   d. PR and marketing of key messages with public e.g. Conversation Cafes

4. Improving health and wellbeing outcomes with an emphasis towards active and healthy lives
   a. Increase physical activity levels
   b. Falls prevention
   c. Raise awareness of mental health needs and sources of support

5. Connecting Communities
   a. Reduce social isolation and loneliness
   b. Self- management of long term health conditions
   c. Social prescribing to sources of social support in the community e.g. money advice, relationship advice, support groups etc.

Our Argyll & Bute allocation is £1.84 million anticipated to be at the same level for each of the three years. Investments already made include:

- Care and Repair – support to people enabling them to live independently and safely at home.
- Commissioning posts – to support locality delivered use of ICF
- Management and Prevention of Falls – critical to reducing emergency admissions
- Reablement – a major contributor to keeping people safe and at home
- Integrated Equipment Store – infrastructure investment to support staff in the community
- Public Health data analyst post – supporting greater improvements in general public health and supporting localities to understand their local health information, prioritise

investment in relation to available ICF funding, and measure the impact of activities and evaluate new services

- Health and Wellbeing networks and small grants – an enabling network, and funding for smaller community actions
- Scottish Care Independent Care Advisor Role – engaging with our independent sector
- Self- Management – giving people the skills and knowledge to better manage their conditions
- Telehealth care – crucial in our area of remote islands and fragmented peninsulas
- Community and District nursing Review – refreshing and focussing these roles

In addition we have already embedded approaches which were demonstrably successful within the Change Fund such as investments in Carers, Community Resilience (capacity building), Dementia support and end of life care.

Our commitment to Locality Planning, Design and Delivery is underpinned by a significant allocation of £200,000 to each of the four localities in addition to the above area wide investments. This was preceded by a workshop in November 2014 where staff, partners and stakeholder put forward their perspective of priorities for investment. Over this year plans will be confirmed, and we will have set out a clear pathway for service improvement, engaging with service users and communities as we progress.
Our workforce is vital to a shift in care and to successful delivery and we have committed to supporting all staff in new ways of working throughout each agency and partner agencies. We intend to leave a legacy of reform which gives real meaning to an engaged and person centred way of delivering all our services.

We have been successful in attracting funding through Delayed Discharge and which will complement ICF and allow us to push forward new boundaries in how we deliver services; at the same time there should be no impact on service users, in terms of accessing services. We want to make this as simple as possible, and stress less; in future people should only need to tell their story once to access all levels of support and care they need.

Argyll & Bute is a place where strong partnerships between public, independent and third sectors already exist. At strategic level we challenge each other, and strive to make decisions which result in positive change. We expect that level of partnership to continue to grow and develop, nurturing connections with our communities and building on local assets.

We also expect to achieve the best care and quality of health services for those who are most frail, vulnerable and in greatest need. We will tackle financial challenges jointly, and merge efficiency with quality relentlessly as we work toward the 2020 Vision for healthcare and the ambitions of our Vision for Integrated Health and Social Care.

APPENDIX 12 - PERFORMANCE MEASURES - NATIONAL OUTCOMES

Performance and Improvement.

1. As referenced the HSCP will develop a suite of measures to enable the Integration Board and partners to routinely use to check on performance and to build improvement within integrated services. These will require to focus on the nine National Health and Wellbeing outcomes and their associated integration indicators and the NHS improvement priorities for 2015/16 within the integration framework:

- Health Inequalities and prevention
- Antenatal and early years
- Person centred care
- Safe care
- Primary care

2. The Strategic Plan requires to have the ability to assess and forecast needs, link investment/disinvestment to desired outcomes and consider options for alternative interventions; and to plan for the range, nature and quality of future services. The Scottish Government has commissioned the Information Services Division to work in partnership with NHS Boards, Local Authorities and others to develop a linked individual level longitudinal social care dataset. The Integration Board will ensure work on this development and its subsequent use informs performance data.

3. A range of improvement tools are available (Care Inspectorate, Joint Improvement Team, etc.) which the partnership will develop for routine improvement analysis and usage of performance.

4. Work will be progressed with partners to coproduce locality solutions on well- being, and to design appropriate local services and service change within locality and within specialist ‘service’ areas (care pathways, health inequality, housing, activity and prevention and health improvement).

The tables below detail the outcome area, description, indicator and source of performance information which will be used to inform performance reports to the HSCP on the National Health and Well Being outcome indicators.

Adult Health and Social Care		
No	**Outcome Area**	**Outcome Description**
1	***Healthier Living***	*Individuals, families and local communities are able to look after and improve their own health and wellbeing, so that*
2	*Independent Living*	*People, including those with disabilities, long-term conditions, or who become frail, are able to live as*
3	*Positive Experiences & Outcomes*	*People have positive experiences of health and social care services, which are centred on meeting individuals' needs and providing choices that help to maintain or improve quality*
4	*Maintained or Improved Quality **of** Life*	*People have positive experiences of health and social care services, which are centred on meeting individuals' needs and providing choices that help to maintain or improve quality*
5	*Reduced Health Inequalities*	*Health and social care services contribute to reducing health*
6	*Carers are Supported*	*People who provide unpaid care are able to maintain their own health and wellbeing, including having a life*
7	*People are Safe*	*People using health and social care services are safeguarded from harm and have their dignity respected.*
8	*Engaged Workforce*	*People delivering health and social care services are positive about their role, and supported to continuously*
9	*Effective Resource Use*	*Best value is achieved with resources used effectively within health and social care, without waste or unnecessary*

Children's Health and Social Care		
No	**Outcome Area**	**Outcome Description**
1	*Best Start Possible*	*Our children have the best start in life and are ready to*
2	*Successful Learners and Responsible*	*Our young people are successful learners, confident individuals, effective contributors and responsible*
3	*Positive Life Chances*	*We have improved the life chances for children, young people*

Criminal Justice		
No	**Outcome Area**	**Outcome Description**
1	***Community Safety***	*Community safety and public protection.*
2	***Re-offending***	*The reduction of re-offending.*
3	***Social Inclusion***	*Social inclusion to support desistance from offending.*

National Health and Wellbeing Outcomes	Core Suite of Integration Indicators	Data	Bench mark	Published Data
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	% Percentage of adults able to look after their health very well or quite well	95%	94%	Health and Care Experience Survey 2013/14
	Rates of Premature Mortality	353.7	423.2	National Records for Scotland 2014
	Rate of emergency admissions per 100,000 population for adults.	9,223	10,215	ISD In-patient & day case activity 2013/14
2. People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	% Percentage of adults supported at home who agree that they are supported to live as independently as possible	88%	84%	Health & Care Experience Survey 2013/14
	% of adults supported at home who agree that they had a say in how their help, care or support was provided?	87%	84%	Health & Care Experience Survey 2013/14
	Rate of emergency admissions per 100,000 population for adults.	9,223	10,215	ISD In-patient & day case activity 2013/14
	Emergency Admissions bed day rate	71,018	73,572	ISD In-patient & day case activity 2013/14
	Readmission to hospital within 28 days	N/A	N/A	
	Proportion of last 6 months of life spent at home or in a community setting	93%	91%	ISD End of Life Care 2012/13
	Falls rate per 1,000 population aged 65+	N/A	N/A	
	% of adults with intensive needs receiving care at home	66.9%	61.2%	SG Health & Social Care Benchmarking Dashboard 2014
	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	783	1,044	ISD Delayed Discharges ISD Standard Outputs, Health & Social Care Data

National Health and Wellbeing Outcomes	Core Suite of Integration Indicators	Data	Bench mark	Published Data
	% of health and care resource spend on hospital stays where the patient admitted in an emergency	N/A	N/A	
	% of people admitted to hospital from home during the year, who are discharged to a Care Home.	N/A	N/A	
	% of people who are discharged from hospital within 72 hours of being ready	N/A	N/A	
	Expenditure on end of life care	N/A	N/A	
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	% of adults supported at home who agree that they had a say in how their help, care or support was provided?	87%	84%	Health & Care Experience Survey 2013/14
	% Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	87%	84%	Health & Care Experience Survey 2013/14
	% Percentage of adults receiving any care or support who rate it as excellent or good	95%	94%	Health & Care Experience Survey 2013/14
	% of people with positive experience of their GP practice.	89%	87%	Health & Care Experience Survey 2013/14
	Readmission to hospital within 28 days	95%	94%	Health & Care Experience Survey 2013/14
	Proportion of last 6 months of life spent at home or in a community setting	91.8%	90.8%	ISD End of Life Care (March 2015)
	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	N/A	N/A	
	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	783	1,044	ISD Delayed Discharges
	% of people who are discharged from hospital within 72 hours of being	N/A	N/A	

National Health and Wellbeing Outcomes	Core Suite of Integration Indicators	Data	Bench mark	Published Data
	ready			
	Expenditure on end of life care	N/A	N/A	
4. Health and social care services are centred on helping to maintain or improve the quality of life of service users.	% Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	86%	86%	Health & Care Experience Survey 2013/14
	Rate of emergency admissions per 100,000 population for adults.	9,223	10,215	ISD In-patient and Day Case activity 2013/14
	Emergency Admissions bed day rate	71,018	73,572	ISD In-patient and Day Case activity 2012/13
	Falls rate per 1,000 population aged 65+	N/A	N/A	
	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	N/A	N/A	Care Inspectorate Inspection Grading
	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	783	1,044	ISD Delayed Discharges
	% of health and care resource spend on hospital stays where the patient admitted in an emergency	N/A	N/A	
5. Health and social care services contribute to reducing health inequalities.	Rates of Premature Mortality	353.7	423.2	National Records for Scotland 2014
	Rate of emergency admissions per 100,000 population for adults.	9,223	10,215	ISD In-patient and Day Case Activity 2013/14
6. People who provide unpaid care are	% of carers who feel supported to continue in their caring role	45%	44%	Health & Care Experience Survey 2013/14

National Health and Wellbeing Outcomes	Core Suite of Integration Indicators	Data	Bench mark	Published Data
supported to reduce the potential impact of their caring role on their own health and well-being.				
7. People who use health and social care services are safe from harm.	% of adults supported at home who agree they felt safe	86%	85%	Health & Care Experience Survey 2013/14
	Rate of emergency admissions per 100,000 population for adults.	9,223	10,215	ISD In-patient and Day Case Activity 2013/14
	Emergency Admissions bed day rate	71,018	73,572	ISD In-patient and Day Case Activity 2012/13
	Readmission to hospital within 28 days	N/A	N/A	
	Falls rate per 1,000 population aged 65+	N/A	N/A	
	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	N/A	N/A	Care Inspectorate Inspection Grading
	% of health and care resource spend on hospital stays where the patient admitted in an emergency	N/A	N/A	
8. People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.	% of staff who say they would recommend their workplace as a good place to work	N/A	N/A	Staff Surveys across HSCP
9. Resources are used effectively in the provision of health and social	% Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	79%	80%	Health & Care Experience Survey 2013/14

National Health and Wellbeing Outcomes	Core Suite of Integration Indicators	Data	Bench mark	Published Data
care services, without waste.	Readmission to hospital within 28 days	N/A	N/A	
	Proportion of last 6 months of life spent at home or in a community setting	91.8%	90.8%	ISD End of Life Care (March 2015)
	Falls rate per 1,000 population aged 65+	N/A	N/A	
	Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	783	1,044	ISD Delayed Discharges
	% of health and care resource spend on hospital stays where the patient admitted in an emergency	N/A	N/A	
	% of people who are discharged from hospital within 72 hours of being ready	N/A	N/A	
	Expenditure on end of life care	N/A	N/A	

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
1	NHS	Alcohol Brief Interventions (ABIs).	ABIs		Yes	Level 3: Management Information
2	NHS	Percentage of Adult population	Ash Scotland		Yes	Level 1: QOIs
3	NHS	Numbers of deaths, with age-standardised mortality rates, by	Cancer Deaths		Yes	Level 1: QOIs
4	NHS	Numbers of deaths, with age-standardised mortality rates, by year of death registration for CHD.	CHD Deaths		Yes	Level 1: QOIs
5	NHS	Estimated percentage of children in P1 at risk of obesity.	Child Health		Yes	Level 1: QOIs
6	NHS	Percentage of babies exclusively breastfeeding at First Visit/6-8 week review by year of birth.	Child Health	Yes Yes	Yes	Level 2: Publicly accountable measures
7	NHS	Number of patients waiting more than four weeks for appropriate discharge.	Delayed Discharges Census	Yes	Yes	Level 2: Publicly accountable measures
8	NHS	Percentage Satisfaction with health services (H&C Experience Survey).	Health and Care Experience Survey	Yes Yes Yes	Yes	
9	NHS	Rate of emergency admissions to hospital for people aged 75+.	HEAT Target	No	Yes	Level 2: Publicly accountable measures

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
10	NHS	Emergency inpatient bed day rates for people aged 75+	HEAT Target	No No	Yes	Level 2: Publicly accountable measures
11	NHS	LTC – Asthma, COPD, Diabetes, CHD.	Long Term Conditions		Yes	Level 3: Management Information
12	NHS	Percentage of Children in Primary 1 with no obvious Dental Caries.	NDIP		Yes	Level 1: QOIs
13	NHS	WEMWBS.	NHS Health Scotland	No	Yes	
14	NHS	Percentage of staff survey respondents who say they feel supported to do their job as well as possible.	NHSAA Staff Survey		Yes	Level 1: QOIs
15	NHS	Percentage of staff survey respondents who would recommend their organisation as a good place to work.	NHSAA Staff Survey		Yes	Level 1: QOIs
16	NHS	Percentage of staff who have had a PPD interview in last 12 months.	NHSAA Staff Survey	Yes Yes		Corporate Measures
17	NHS	Number of general acute inpatient and day case drug-related discharges (any position), age-sex standardised rates (EASR).	Scotpho		By request	Level 2: Publicly accountable measures
18	NHS	Number of general acute inpatient and day case alcohol-related discharges (any position), age-sex standardised rates (EASR).	Scotpho		By request	Level 2: Publicly accountable measures

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
19	NHS	Proportion of adults who assess their general health as good or very good in the Scottish Health Survey.	Scottish Health Survey	No No	Yes	Level 1: QOIs
20	NHS	Number of deaths, with age-standardised mortality rates, by year of death registration for Stroke.	Stroke Deaths		Yes	Level 1: QOIs
21	NHS	Number of deaths, with age-standardised mortality rates, by year of death registration for Under 75s.	Under 75 mortality		Yes	Level 1: QOIs
22	NHS	Naloxone Dispensing.	Local	Yes Yes	Yes	Level 3: Management Information
23	NHS	Diagnosis of Dementia.	Primary Care		Yes	Level 3: Management Information
24	Community Care	Percentage of people who say they are able to look after their health very well or quite well.	GP Survey	Yes Yes		Level 1: QOIs
25	Community Care	Talking Points: Staying as Well as you can (various wording).	CAREFIRST	Yes Yes Yes		Level 2: Publicly accountable measures
26	Community Care	Percentage of referrals of service users (to Money Matters) with health issues.	CAREFIRST	Yes		Level 3: Management Information

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
27	Community Care	Percentage of service users who report that they are supported to live as independently as possible.	GP Survey	Yes Yes		Level 1: QOIs
28	Community Care	Enablement/reablement measure (various wording).	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
29	Community Care	Proportion of service users age 75+ with a Technology Enabled Care Package.	SG Social Care Survey Publication	Yes Yes		Level 2: Publicly accountable measures
30	Community Care	Talking Points: Feeling safe (various wording).	CAREFIRST	Yes		Level 2: Publicly accountable measures
31	Community Care	Number of service users (65+) with a community alarm package.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
32	Community Care	Number of service users with an enhanced Technology Enabled Care package.	CAREFIRST	Yes		Level 3: Management Information
33	Community Care	Percentage of people aged 65 or over with intensive needs receiving care at home.	SOLACE/Local Government Benchmarking Framework Publication	Yes Yes		Level 2: Publicly accountable measures
34	Community Care	SDS Option indicators (various wording).	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
35	Community Care	Talking points: Living where you want (various wording).	CAREFIRST	Yes Yes Yes		Level 2: Publicly accountable measures

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
36	Community Care	Percentage of people receiving care and support who agree they were treated with respect.	GP Survey	Yes Yes Yes		Level 1: QOIs
37	Community Care	Percentage of people receiving care and support who report that they were treated with compassion and understanding.	GP Survey	Yes Yes		Level 1: QOIs
38	Community Care	Percentage of people receiving any care or support who rate it as excellent or good.	GP Survey	Yes Yes		Level 1: QOIs
39	Community Care	Percentage of service users who said that people took into account what was important to them.	GP Survey	Yes Yes		Level 1: QOIs
40	Community Care	Percentage of service users satisfied with their involvement in the design of their care packages.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
41	Community Care	Percentage of learning disability service users with a completed Person Centred Plan (PCP).	CAREFIRST	Yes		Level 3: Management Information
42	Community Care	Percentage of learning disability service users accessing	CAREFIRST	Yes		Level 3: Management Information
43	Community Care	Percentage of MH Service Users accessing employment support activities.	CAREFIRST	Yes		Level 3: Management Information

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
44	Community Care	Talking points: Having things to do (various wording).	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
45	Community Care	Percentage of service users who report that the help, care or support they receive has either maintained or improved their quality of life.	GP Survey	Yes Yes Yes		Level 1: QOIs
46	Financial Inclusion	Debt Advice indicator (£).	CAREFIRST	Yes		Level 3: Management Information
47	Financial Inclusion	Money Matters – income generation for service users (£).	CAREFIRST	Yes		Level 3: Management Information
48	Community Care	Percentage of service users in receipt of an outcome focussed support plan.	CAREFIRST	Yes		Level 3: Management Information
49	Community Care	Percentage of service users 65+ with a Community Support package reviewed.	CAREFIRST	Yes		Level 3: Management Information
50	Community Care	Percentage of carers who report they have a good balance between caring and other things in their life.	GP Survey	Yes Yes Yes		Level 1: QOIs
51	Community Care	Percentage of carers who are still able to spend enough time with people they want to spend time with.	GP Survey			Level 1: QOIs

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
52	Community Care	Percentage of carers for whom caring has had a negative impact in their own health and wellbeing.	GP Survey			Level 1: QOIs
53	Community Care	Percentage of carers who have a say in the services provided for the person they look after.	GP Survey			Level 1: QOIs
54	Community Care	Percentage of carers who report that services are well coordinated for the people carers look after.	GP Survey			Level 1: QOIs
55	Community Care	Percentage of carers who feel supported to continue caring.	GP Survey	Yes Yes Yes		Level 1: QOIs
56	Community Care	Percentage of carers who have been offered a carers assessment.	CAREFIRST	Yes Yes*		Level 3: Management Information
57	Community Care	Measure of respite care - older people 65+ - overnight.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
58	Community Care	Measure of respite care (older people 65+) daytime hours.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
59	Community Care	Measure of respite care - adult 18- 64 - overnight respite.	CAREFIRST	Yes Yes Yes		Level 2: Publicly accountable measures
60	Community Care	Measure of respite care - adult 18- 64 – daytime hours.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
61	Children & Young People	Measure of respite care – Children and Young People - overnight respite.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
62	Children & Young People	Measure of respite care - Children and Young People – daytime hours.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
63	Children & Young People	Percentage of contact centre staff that have completed training.	CAREFIRST	Yes Yes		Level 3: Management Information
64	Children & Young People	Percentage attendance at CP case conferences where substance misuse has been identified as a risk factor.	CAREFIRST	Yes Yes		Level 3: Management Information
65	Community Care	Number of Carers assessments completed.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
66	Community Care	Percentage of people receiving care or support who agree that they felt safe.	GP Survey	Yes Yes Yes		Level 1: QOIs
67	Community Care	Percentage of Adults at Risk of Harm consulted who feel safer as a result of Social Work Intervention.	CAREFIRST	Yes		Level 3: Management Information
68	Children & Young People	Percentage of children and young people consulted who report that they feel safer as a result of involvement with Child Protection processes.	CAREFIRST	Yes		Level 3: Management Information
69	Community Care	Percentage of staff satisfied with supervision process.	CAREFIRST	Yes		Level 3: Management Information

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
70	Community Care	Percentage of personal carers qualified.	CAREFIRST	Yes		Level 3: Management Information
71	Community Care	Percentage of care staff with appropriate qualifications in council residential care for older people.	SSSC	Yes Yes Yes		Level 3: Management Information
72	Community Care	Percentage of care staff with appropriate qualification for level of post held (day services).	SSSC	Yes Yes		Level 3: Management Information
73	Children & Young People	Percentage of care staff with appropriate qualifications in local authority residential children's homes.	SSSC	Yes Yes		Level 3: Management Information
74	Community Care	Balance of spend across institutional and community settings.	GP Survey	Yes Yes		Level 1: QOIs
75	Community Care	Percentage of adults satisfied with social care or social work services	SOLACE/Local Government Benchmarking Framework Publication	Yes Yes		Level 2: Publicly accountable measures
76	Community Care	Self Directed Support spend for people aged 18+ as a percentage of total social work spend on adults.	SOLACE/Local Government Benchmarking Framework Publication	Yes Yes		Level 2: Publicly accountable measures
77	Community Care	Home care costs for people aged 65 or over per hour £.	SOLACE/Local Government Benchmarking Framework Publication	Yes Yes		Level 2: Publicly accountable measures

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
78	Children & Young People	The gross cost of 'children looked after' in residential based services per child per week £.	SOLACE/Local Government Benchmarking Framework Publication	Yes Yes		Level 2: Publicly accountable measures
79	Children & Young People	The gross cost of 'children looked after' in a community setting per child per week £.	SOLACE/Local Government Benchmarking Framework Publication	Yes Yes		Level 2: Publicly accountable measures
80	Community Care	**Delayed Discharge Costs.**				Level 2: Publicly accountable measures
81	Children & Young People	Balance of Care for looked after children: percentage of children being looked after in the community.	SG CLAS Publication	Yes Yes		Level 2: Publicly accountable measures
82	Children & Young People	Number of children on CP register who were previously deregistered within one year.	SG CP Publication	Yes Yes		Level 2: Publicly accountable measures
83	Children & Young People	Number of children (pre-birth to 8) looked after at Home / accommodated.	SG CLAS Publication	Yes Yes		Level 2: Publicly accountable measures
84	Children & Young People	Number of young people receiving community support from purchased providers.	CAREFIRST	Yes		Level 3: Management Information
85	Children & Young People	Percentage of children in a kinship care placement subject to residence order.	CAREFIRST	Yes		Level 3: Management Information
86	Children & Young People	Number of moves before permanent placement (Throughcare).	CAREFIRST	Yes		Level 3: Management Information

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
87	Children & Young People	Percentage of children in Foster Care or LA residential units who are either rehabilitated back into the family home or approved for Permanency, within six months of admission.	CAREFIRST	Yes		Level 3: Management Information
88	Children & Young People	Percentage of parents of children admitted to Foster Care or LA residential units who then receive a parenting assessment.	CAREFIRST	Yes		Level 3: Management Information
89	Children & Young People	Percentage of fostered LAAC who are fostered by an in-house placement.	CAREFIRST	Yes		Level 3: Management Information
90	Children & Young People	Number of in-house foster carers.	CAREFIRST	Yes		Level 3: Management Information
91	Children & Young People	Percentage of substance misusing parents who have completed a Parenting Impact Assessment.	CAREFIRST	Yes		Level 3: Management Information
92	Children & Young People	Percentage of Child Protection Investigations completed from recorded initial Child Protection Concerns.	CAREFIRST	Yes		Level 3: Management Information
93	Children & Young People	Percentage of child protection plans circulated within five days.	CAREFIRST	Yes Yes Yes		Level 3: Management Information
94	Children & Young People	CP Register.	CAREFIRST	Yes Yes		Level 3: Management Information

No.	Indicator Name	Indicator Description	Source identified	Argyll & Bute	NHS Highland	Level identified
95	Criminal Justice	Percentage of new CPO clients with a supervision requirement seen by a supervising officer within a week.	CAREFIRST	Yes Yes Yes		Level 2: Publicly accountable measures
96	Criminal Justice	Percentage of CPO Unpaid work requirements commenced induction within five working days.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
97	Criminal Justice	Percentage of individuals on new CPO unpaid work requirement began work placements within seven days.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
98	Criminal Justice	Percentage of individuals subject to level 1 Community Payback Order Unpaid Work completed within three months.	CAREFIRST	Yes Yes		Level 2: Publicly accountable measures
99	Criminal Justice	Percentage of individuals subject to level 2 Community Payback Order Unpaid Work completed within six months.	CAREFIRST	Yes Yes Yes		Level 2: Publicly accountable measures

APPENDIX 13 - STRATEGIC RISK REGISTER

Risk Title	Risk Description	Impact Description	Risk Owner	Risk Manager
Demographic Pressure	An ageing population is increasing demand for health and social care services.	The projected rise in demand will be unable to be sustained through current approaches and with the existing level of resource.	IJB	Head of Adult Services East and West & Head of Children's Services
Balance of Care	Institutional care is expensive to provide and is inappropriate for some people who could equally be cared for in other ways in the community.	People continue to be cared for in a way that is more expensive than it needs to be, and are removed from their familiar surroundings which can be detrimental to their wellbeing. Providing care in this way will also increase cost as a result of the demographic pressures.	IJB	Chief Officer
Health Inequalities	Some people's life chances are poorer than others and have a negative impact on their health and wellbeing.	Life expectancy remains below average, the prevalence of disease is higher, care needs are greater and there is a greater incidence of substance misuse and excessive consumption.	IJB	Chief Officer
Vulnerable Persons	Vulnerable people are not adequately protected.	Children and adults are put at unnecessary risk of harm due to inadequate policies, procedures, systems and culture.	Council	Heads of Adult Services (East & West) (E&W) / Head of Children's Services

Risk Title	Risk Description	Impact Description	Risk Owner	Risk Manager
Unplanned Admissions	The number of unplanned admissions to hospital increases or remains the same.	People are admitted to hospital when they could be cared for or treated in other ways, and high cost base is maintained or increases.	IJB	Chief Officer
Delayed Discharge	The national two week target for delayed discharge is not met.	People remain in hospital for longer than necessary, impacting negatively on their wellbeing. National policy guidelines are breached. Reputational damage.	IJB	Head of Adult Care (E&W)
Resource Allocation	The level of resource provided by the Statutory Partners is insufficient to meet national and local outcomes and to deliver Strategic Plan Objectives.	Reputational damage. Risk of dispute arising between partners. Partnership breaks down because it cannot deliver its objectives.	Statutory Partners & IJB	Chief Officer
Operational Integration	Sufficient progress towards operational integration is not made within the period of this Strategic Plan.	Separate services do not come together as expected, resulting in services to service users not being seamless, patient centred and as efficient as they could be.	IJB	Chief Officer

Risk Title	Risk Descrip	Impact Description	Risk Owner	Risk Manager
Culture Change	Staff do not adapt and/or are not supported to adopt new ways of working required as part of an integrated partnership approach.	Impacts adversely On Integration of service and delivery of National Integration Principles. Potential reputation damage.	IJB	Chief Officer
Locality Planning	Locality Planning Groups established as part of Integration are not effective and do not reflect local needs.	Local needs assessment, commissioning and the monitoring of services is not established due to inadequate local engagement. Integration Principles are not met.	IJB	Head of Strategic Planning and Performance
Information Sharing	Information sharing acts as a hindrance to effective integrated working rather than facilitating it.	Impacts negatively on the provision of seamless services service users and impacts adversely on service efficiency.	IJB	Chief Officer
Effective Communication	The partnership fails to properly engage with all stakeholders.	Stakeholders are not engaged in the transformation service planning and delivery with negative implications for the Integration Project and for business efficiency.	IJB	Chief Officer

APPENDIX 14: LOCAL HOUSING CONTRIBUTION STATEMENT

Draft January 2016
(Prepared by Argyll & Bute Council/Strategic Housing Forum)

1) Introduction

1.1 Housing Contribution Statements provide the main link between the strategic planning processes for housing and for health & social care at a local level. Following the establishment of the Integration Authority and localities, the Housing Contribution Statement (HCS) is intended to become an integral part of the Strategic Plan. It sets out an overarching strategic statement on how housing services intend to work with the Integration Authority, whether functions have been delegated to it or not, to deliver its outcomes.

1.2 This HCS therefore summarises the role and contribution of the Argyll and Bute housing sector in meeting the outcomes and priorities identified within the Strategic Plan. As the strategic housing authority for the area, Argyll and Bute Council has a lead role in preparing this statement for the Integrated Authority, in partnership with the wider housing sector[3], in particular local Registered Social Landlords (RSLs or housing associations); national RSLs operating within the area; and Argyll and Bute Care & Repair.

1.3 Essentially, the HCS provides a “bridge” between the Local Housing Strategy (LHS) and Strategic Plan; and it is anticipated that a seamless strategic process will be developed over time, that is focused on shared objectives, priorities and investment decisions that positively contribute to health and well-being in Argyll and Bute.

1.4 The HCS therefore will:

- Briefly articulate the role of the local housing sector in the governance arrangements for the integration of health & social care;
- Provide a short overview of the shared evidence base and key issues identified in relation to housing needs and the link to health/social care;
- Set out the shared outcomes and service priorities linking the Strategic Plan and Local Housing Strategy;
- Set out the current and future resources and investment required to meet these shared outcomes and priorities, and identify where these will be funded from the integrated budget and where they will be funded by other (housing) resources;

[3] The RSL sector in Argyll & Bute includes the HOMEArgyll partnership comprising ACHA, Fyne Homes, Dunbritton, and West Highland Housing Associations; as well as national associations such as Bield, Trust, Key Housing, Cairn and Blackwood who provide specialist accommodation suitable for those with particular needs.

- Provide an overview of the housing-related challenges going forward and improvements required.
- Cover key areas such as adaptations, housing support and homelessness. It will also aim to articulate the housing contribution across a wide range of groups including older people and those with disabilities, mental health and addictions.

2) Governance Arrangements, Partnership Working and The Strategic Housing Framework

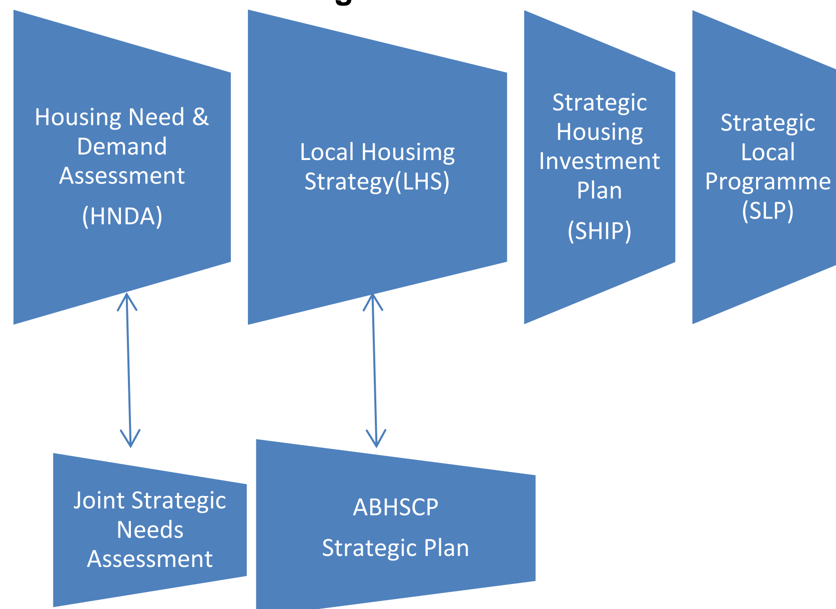
2.1 The Local Authority Housing Service, Housing Associations (Registered Social Landlords or RSLs) and other housing providers and interests have a significant role, and must be involved, in the governance arrangements for the Health & Social Care Partnership (HSCP). This should be established across all relevant levels and structures, covering the Integration Authority itself, as well as Strategic Planning and Locality Planning Groups.

2.2 Argyll & Bute Council no longer has a direct landlord function but remains the strategic housing authority for the area, and has a statutory duty to assess the need and demand for housing across all tenures, as well as housing-related services; and to develop and implement a Local Housing Strategy (LHS) in collaboration with key partners. The Council also continues to deliver key frontline services in respect of homelessness, housing options, tenancy support, private sector house conditions and adaptations, welfare rights, energy efficiency and fuel poverty, all of which can impact on the health and well-being of the local population.

2.3 In Argyll and Bute, the overarching body with responsibility for overseeing the delivery of the LHS and the Strategic Housing Investment Plan (SHIP) is the Argyll and Bute Strategic Housing Forum which comprises a range of key community planning partners and meets quarterly. It is chaired by the Council's policy lead for Housing and administered by the Council's Housing Service but also involves the Scottish Government, local RSLs, the Loch Lomond & Trossachs National Park, Care & Repair, Alienergy and others. Health and Social Care representation on the Forum has been enhanced in recent years and in the future the senior management of the Integrated Authority are being asked to nominate appropriate representation to the core membership of the Forum.

2.4 The strategic framework for housing in Argyll and Bute basically follows the process outlined below:

FIGURE 1: The Strategic Framework



2.5 The Integrated Authority responsible for the Strategic Plan was established in 2015 with board membership drawn from the Council and NHS Highland. There are two housing representatives on the Strategic Planning Group to ensure the housing sector's role in health and social care integration is actively promoted. The Council's senior Housing Services Manager ensures that necessary linkages are maintained between the LHS and the Strategic Plan and that further opportunities for joint working are identified. In addition, the RSL sector has representation on the group with individual landlords (initially CEOs/Directors from ACHA and Dunbritton Housing Association) taking it in turn to attend and to articulate the views of the social rented sector and provide a practitioner perspective. At the local level, area housing managers and other officers will participate in locality planning groups meetings as directed by the Housing Services Team Leaders, who will be the named contacts for all initial contact and communication at area level. In addition, local operational officers will continue their regular informal liaison with health and social care colleagues on a case by case basis.

3) <u>Shared Evidence and key issues</u>

3.1 The Scottish Government, and specifically the Centre for Housing Market Analysis (CHMA), provide formal guidance for local authorities to carry out "robust and credible" Housing Need and Demand Assessments (HNDAs). The purpose of the HNDA is to provide a robust, shared and agreed evidence-base for both the LHS and local development plans (LDPs i.e. land-use planning). The Council's housing strategy team produced a series of technical HNDA papers in 2015, in consultation with the Strategic Housing Forum, and the final report will be completed in early 2016. This collates a wide range of primary and secondary data on the key drivers of the local housing market, and identifies significant trends underpinning the local housing system. As well as providing

an estimate of the number of additional homes required to meet existing and future housing need and demand, the HNDA captures information that will inform local policies on new housing supply, the management of existing stock, and the provision of housing-related services. There is also a key requirement that the HNDA should identify the need for “specialist provision” for persons with particular needs to enable independent living. This refers to both “bricks and mortar” accommodation and support services, under 6 specific categories:

- Accessible and adapted housing;
- Wheelchair housing;
- Non-permanent housing e.g. for students, migrant workers, refugees;
- Supported provision e.g. care homes, sheltered housing, hostels/refuges;
- Care/support services for independent living;
- Site provision e.g. pitches for Gypsy/Travellers or Travelling Showpeople

3.2 The HNDA guidance emphasises the need for housing practitioners to engage with health and social care planners in developing a joint Strategic Needs Assessment (JSNA) to share evidence, identify needs and plan for solutions across health, social care and housing. Council officers responsible for developing the HNDA have consulted with their counterparts in the HSCP, in particular the Senior Information Analyst, Public Health, and liaised on the shared evidence base. There is a strong commitment to ensure this process is further developed and a key action for the next LHS will be to promote closer alignment of the HNDA and JSNA.

3.3 As far as possible, the HNDA aims to analyse data at a sub-authority level based on 9 housing market areas (HMAs) which have been identified within the local authority boundaries. The HMAs provide a close, practical, best-fit match with the 8 HSCP localities that have been established, and should allow for data to be further aggregated or disaggregated as required.

Housing Market Area	HSCP Locality
Bute	Isle of Bute
Coll & Tiree	Included in OLI
Cowal	Cowal
Helensburgh & Lomond	Helensburgh & Lomond
Islay, Jura & Colonsay	Isles of Islay & Jura (Colonsay included)
Kintyre	Kintyre
Lorn	Oban, Lorn & the Isles (including Coll & Tiree)
Mid Argyll	Mid Argyll

Mull & Iona	Isles of Mull & Iona

3.4 The Argyll and Bute housing profile is summarised in the following table.

Population	• Population of 87,660 persons (2014) • -0.4% decrease 2013-2014 • 27,494 persons (31.4%) aged over 60 years
Household	• 40,857 households (2014) • -0.2% decrease2013-2014 • Average household size 2.08 persons (2012)
Household Composition	• 14,719 (36%) single adult households (2012) • 2,084 (5%) one adult with one or more children • 2,852 (7%) three or more adults • 6,850 (17%) two or more adults with one or more children
Dwellings	• 47,500 residential dwellings (2014) • 0.3% increase 2013-2014 • 32% flats • 15% terraced • 19% semi-detached houses • 34% detached houses
Completions	• Annual average 250 new homes (2009/10 to 2013/14) • Target of at least 110 affordable homes per annum
Occupancy	• 87% occupancy rate • 4% vacancy rate • 9% second homes
Tenure	• 67% owner occupation (2011 Census) • 19% social rented • 13% private rented
Specialist Housing Provision	• 21% homes with adaptations (all tenures, SHCS 2014) • 15.5% RSL stock is purpose-designed, specialist homes (2015)
Non-permanent accommodation	• 30 pitches for Gypsy/Travellers across 3 official sites • 131 temporary accommodation units for homeless people (2015)
RSL Common Housing Register (HOMEArgyll)	• 2,577 active waiting list applicants (2015) • -23% decease (2014-2015) • 999 households received RSL let (2014/15) • 172 households with particular needs rehoused (2014/15)
Homeless Applicants	• 431 homeless presentations (2014/15) • -46% decrease since 2010

3.5 In support of the new HNDA, the council commissioned extensive, dedicated research into the housing and support needs of the ageing population of Argyll & Bute in 2014[4] which has been shared with the JSNA team, as well as completing in-house studies of specific groups including Gypsy/Travellers and persons with learning disabilities. This has informed the development of the draft LHS for 2016-21 and provides a summary of the housing needs of a range of equality groups and other vulnerable stakeholders. These

[4] The full report can be accessed at:

http://www.argyll-bute.gov.uk/housing/housing-strategies-consultations-and-research-0

groups are likely to require a housing contribution to either improve health and well-being or to prevent a health and social care issue arising in the future. Outline findings are summarised overleaf.

3.5 Housing Issues/Health & Well-being Concerns by Client/Equality Group

3.5.1 Older Persons - A net increase of over 160% in the population aged 85+ is projected over the next 25 years. While the majority of people aged 65+ do not anticipate that they will need or want to move home in the next 5 years, there are around 1,128 older households with a long-term illness, health problem or disability currently living in housing which does not meet their needs. Around 600 households over 65 have an unmet need for specialist support. There is a gap in relation to the provision of information & advice on available housing options for the elderly – 10% of those who would like or need to move cite this lack as the main reason for not moving.
46% of the elderly spend more than 10% of their income on heating costs and would therefore be defined as being in fuel poverty. In certain HMAs the level of fuel poverty is considerably higher e.g. 73% on Coll & Tiree.

The majority of older households will choose to meet their housing needs in the private sector and want to stay in the area where they currently reside.
The increasing elderly population is likely to result in increased requirement for smaller homes, and a wider range of accommodation models, including extra care, retirement, amenity or supported housing; as well as increased demand on support services including Care & Repair/handyperson.

3.5.2 **Disabled Persons** - It is estimated that around 3% of all dwellings in Argyll and Bute require some form of adaptation, amounting to around 1,230 properties. In terms of tenure, this amounts to 3% of owner occupied homes and 5% of RSL homes. In addition, the commissioned research carried out by the council indicates that 42% of households aged 65+ have or require adaptations (with the most frequent need being specially-designed/adapted bathroom/ shower and external grab rails). Up to 100 households with a wheelchair user could have an unmet housing need and, while the majority could be met via adaptations and turnover in existing stock, there is likely to be a small-scale requirement for purpose-designed new build homes. Around 48 persons aged 65+ require wheelchair access/ramp adaptations to their homes.

3.5.3 **Learning Disabled/Mental Health Issues** - This is a small but significant client group within the wider population with a degree of unmet need. Assessment of the level of need is ongoing, and further joint exploration by Housing and the Integration Authority of specific housing options for this client group is required. Liaison with RSLs in order to assess the potential for reconfiguration of existing units for this purpose will be carried out and specific needs should be identified early in the SHIP process when new build proposals are being developed.

3.5.4 **Homeless -** While homeless presentations have reduced significantly in Argyll & Bute in recent years, due primarily to the effective delivery of the Housing Options information & advice service, evidence suggests that people who are homeless can experience some of the worst health problems in society and are more likely to have unhealthy lifestyles and complex needs which lead to long-term health issues or exacerbate existing problems. The incidence of physical ill-health, depression and substance misuse issues is significantly higher amongst homeless people and those living in poor housing conditions; and, at a national level, hospital admissions for this group are far in excess of the population living in settled accommodation. Those at risk of homelessness and people living in unstable or vulnerable housing, including non-permanent accommodation, overcrowding and homes in poor condition also must be considered in relation to the impacts on health and can benefit from some form of housing contribution. Young single males are particularly affected in this group, but children in homeless families and women subject to domestic abuse are also client groups with particular housing and health or social care needs. There is an ongoing requirement to maintain an adequate supply of suitable temporary accommodation, with local-authority leased properties being preferred (RSL accommodation in general is most effectively utilised as long-term, permanent accommodation) and a primary focus on smaller units, mainly for single persons.

3.6 Moving forward, the council will continue to enhance the connections between the HNDA and JSNA and in particular seek to consider the following issues with HSCP colleagues:

- How well suited is the housing and place offer to the needs, wants and resources of older and disabled households?
- How is the structure and shape of care home and specialist housing market changing and why?
- What key challenges may need to be addressed if the housing offer, including upstream services, is to make a bigger impact?
- What additional specialist provision might be needed for the foreseeable future?
- What further analysis is required and how will the most critical gaps in the evidence base be addressed?

The agenda is potentially very extensive and it will be necessary to prioritise pragmatically. Over time, analysis and needs assessments will be expanded with a focus on understanding why imbalances and frictions are occurring. Ultimately, estimates of any “demand gap” for specialist provision will reflect policy choices and value judgements of local partnerships.

4) Shared Outcomes and service priorities

4.1 The housing sector, via the LHS, has an important and direct contribution to make to meeting national health and well-being outcomes as well as the local service priorities identified in the Strategic Plan. Of the 9 national outcomes, the housing contribution is

particularly relevant to Outcome 2: "*People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community*". This will involve the provision of good quality, suitable housing to support a range of needs; as well as housing support services to sustain homes and tenancies; other forms of specialist provision such as aids, adaptations and other equipment; and preventative measures including timeous information & advice and assistance in tackling fuel poverty, improving energy efficiency, or maximising income through welfare rights assistance.

4.2 Housing can also contribute to other national outcomes such as Outcome 9: "*Resources are used effectively in the provision of health and social care*" where effective housing solutions and policy interventions can prevent crises arising and obviate costly health and social care responses. Research[5] has established, for instance, that for "*every pound spent on reducing fuel poverty, a return in NHS savings of… 42 pence can be expected*"; while a recent study[6] by Bield, Hanover & Trust housing associations estimated that housing provision generates savings and value for the health and social care budget far in excess of the amount invested: e.g. a total return of £5.50-£6 for every £1 invested in adaptations, while every £1 invested in Very Sheltered housing creates a total Social Return of between £1.50 and £2.50.

4.3 The local Strategic Plan's overarching vision is "**Helping the people in Argyll and Bute to live longer, healthier, independent lives**"; and there are 11 strategic objectives underpinning this aim, focusing on reducing health inequalities; promoting effective, person-centred services; prioritising anticipatory care and preventative approaches; and developing community-based, locality planning and delivery

4.4 The Housing sector and the LHS have a clear and direct contribution to make in support of this vision and will have an impact across many of these strategic objectives. The next LHS for 2016-20 will aim to deliver "**A housing system in Argyll & Bute that makes a strong contribution to thriving and sustainable communities and economic growth**". This will be underpinned by four key priorities which are likely to focus on

I. Facilitating access to sufficient, suitable and affordable housing across all tenures
II. Promoting individual housing options to meet housing need
III. Enabling people to live independently in their own homes
IV. Regenerating communities through improving the quality, condition and energy efficiency of housing.

[5] "The Impact of Poverty on Children", C. Liddell/Save the Children, 2008.

[6] "Social Return on Investment on Adaptations and Very Sheltered Housing", Bield, Hanover & Trust Housing associations and Envoy partnership, 2013

While Priority iii clearly has the most explicit relevance in the context of the Strategic Plan, each of these four priorities will make a strong contribution to the integration agenda and the local health and social care objectives.

4.5 Consultation on the draft action plan for the next LHS will be completed by the end of March 2016, however a number of key options are already emerging which will support joint working and the joint outcomes and objectives across the housing, health and social care sectors. These include:

- Using evidenced based need and demand to identify specialist housing requirements early in the development of the SHIP and SLP
- Early engagement with health and social care partners (e.g. OTs, learning disabled team) in the planning processes for the SHIP, and to help inform practical design issues etc.
- A more co-ordinated approach across housing, health and social care to address homelessness
- Ensuring housing improvements and home energy efficiency programmes are targeted at the most vulnerable and fuel poor households.
- Ensuring access to social rented housing and allocation policies do not present unforeseen barriers or impediments to those with particular needs
- Increasing the supply of suitable affordable housing across an appropriate range of models and types and tenure, as appropriate, to meet local need and reverse population decline
- Ensuring housing services help to tackle and eradicate health inequalities and address disadvantaged individuals and communities
- Benefitting general health and financial well-being by providing warm, energy-efficient homes

4.6 It should also be recognised that Housing staff provide key local connectivity through regular contact with and visits to service users, tenants and estates. Improving/enhancing linkages between RSL staff and H&SC staff would ensure early interventions as required to prevent, where possible, the need for more expensive care or hospitalisation at a later stage. Frontline RSL and Council staff can identify vulnerable tenants or prospective tenants. Knowing who to contact to ensure these people are getting the services they require is a valuable link in the H&SC Integration agenda. RSLs have a track record in partnership working, involving delivery of a range of services and projects that go beyond the 'bricks & mortar' of housing provision. Such 'wider-role' activities include welfare advice services, social, community, environmental and employment initiatives, many of which have direct or indirect links to improving the sustainment of peoples' lives in urban and rural communities. Recognising RSLs' real and potential contribution to H&SC Integration can ensure that the 'wider role' activities they can offer (subject to appropriate financial support being available where required)

can make a difference in this Integration agenda and help deliver more community-based services.

5) Housing challenges

There are a number of challenges in the housing system and among providers which may impact on the housing contribution to health and well-being. The housing sector can be quite diverse and diffuse and many housing services are distinct or separate. All services are subject to significant budget pressures and there are concerns regarding capacity and pressures on staff time. However, through the Strategic Housing Forum and partnerships such as HOMEArgyll and the Energy Efficiency Forum, and within the framework of the LHS, a positive and co-ordinated approach is now well established and this places the Housing Sector in a solid position to deliver an effective contribution to health and social care. Some of the main challenges moving forward are summarised below.

5.1 Improving strategic and operational structures and partnerships

Crucially, the effective linkages and joint working processes across the housing health and social work sectors require further focused improvement. With the establishment of the Integrated Authority, positive progress has begun towards a more streamlined and efficient approach to service planning and delivery, however a degree of "silo" culture may still remain and complex bureaucratic structures continue to present some problems in terms of co-ordinated communication and joint working. There is also a need to improve understanding and share greater awareness of the different sectors throughout and across all agencies and at all levels. A review of common terminology and vocabulary would be a useful and necessary start (e.g. in relation to housing models, there is a need to establish clear, unequivocal definitions of "amenity", "ambulant disabled", "sheltered", "very sheltered", "extra care" and "progressive care" housing, as well as clarifying distinctions in terminology regarding housing support etc).

5.2 Addressing the key drivers of the local housing system

The factors that define and drive the local housing market are well evidenced and also reflect the main challenges for health and social care: the changing demographic trends leading to a significant decline in the local population combined with an exponential growth in the older persons; a fragile economic structure exacerbating affordability issues; and the dispersed rural geography which impedes service coordination and delivery. Inevitably, the wider financial context of public sector resource constraints will present a key challenge in addressing all these issues; and it is worth reiterating the reciprocal benefits of joint working i.e. the important contribution that health and social care can make in turn to housing.

5.3 **Aligning and synchronising service delivery and needs assessments**
Problems continue to arise at an operational level within both housing and health and social care when trying to co-ordinate access to suitable accommodation with the provision of appropriate support packages. Delays can occur during either part of the process, and a concerted effort to promote early intervention and better understanding of the relevant allocation and needs assessment processes is required.

5.4 **Addressing inequalities in the delivery of adaptations**
The provision of private sector adaptations is a housing function that must be delegated to the Integrated Authority while adaptations for the RSL sector will remain separate and continue to be funded by the Scottish Government. This can promote inequality and lead to operational confusion; and also means that funding can be constrained dependent on the household's tenure. An issue with budget constraints for adaptations in the RSL sector has been identified and will need to be closely monitored. Again, early notification of requirements will help to improve and streamline the process; but eventually a national policy for a tenure-blind approach needs to be implemented.

5.5 **Tackling poor stock condition, fuel poverty and energy efficiency**
Apart from the basic imbalances in housing supply and demand in Argyll and Bute, a key challenge for the future is to address the significant levels of disrepair and inefficient housing stock that have a major, negative impact on the health and well-being of individuals and the wider community. In general, this authority has higher than average incidence of poor condition and fuel poverty and this will be a key priority for the next LHS and should be an important consideration for the health and social care partnership. Continuing to support the local Care and Repair service; providing advice and assistance to home owners, landlords and tenants; and targeting home energy programmes effectively will help to alleviate this problem.

5.6 Other identified challenges will include: meeting need in the private sector, particularly in the owner-occupied sector; the need to explore and expand current models of provision with more flexibility; establishing detailed assessments of need for certain vulnerable groups beyond the elderly, where data and evidence are less readily available; and meeting rural demand for example the needs of carers supporting vulnerable people in remote locations and ensuring sufficient support staff are available to service rural accommodation.

5.7 In moving forward with the integration agenda, Housing will continue to remain focused on the strategic outcomes and seek to ensure that all partners are involved in decision-making, and that there is cohesion and coordination between individual housing organisations themselves in order to present a unified contribution to the health and social care partnership.

6) Resources and Investment

6.1 **Delegated Housing Functions.**
A number of local authority housing functions are required by legislation to be delegated to the Integrated Authority, and in Argyll and Bute the provision of private sector adaptations is the primary function which will make a direct financial contribution to the outcomes of the health and social care partnership. The provision of mandatory and discretionary disabled grants is funded from the council's Private Sector Housing Grant (PSHG) and administered by the Council in partnership with the Occupational Therapist Service, Third Sector, and Argyll & Bute Care & Repair. It is projected that the PSHG budget for private sector adaptations will total £500k for 2016/17 (which, applying the SROI multiplier effect outlined at 4.2 above, could provide actual investment benefits to Health & Social Care of £2.5m - £3m); and on average there have been 150 private sector properties adapted annually.

6.2 **Non-Delegated Housing Functions**
There is a wide range of additional housing functions which are not delegated for transfer but do make a significant contribution to support the integration agenda and outcomes. These include Care & Repair budgets (funded primarily within the PSHG), tenancy support services (focusing on tenancy and home sustainment as opposed to personal care type support), homeless services, new supply housing, and RSL adaptations. In addition, significant investment in home energy efficiency projects and tackling fuel poverty will provide positive returns for health and social care and have a preventative impact on their budgets further down the line.

6.3 The delivery of new build affordable housing is directed via the Strategic Housing Investment Plan (SHIP) and funded primarily from

- Scottish Government's Affordable Housing Investment Programme (AHIP)
- Argyll & Bute Council's Strategic Housing Fund (SHF)
- RSL private borrowing

The current minimum resource planning assumptions for the AHIP in Argyll & Bute over 2016/17 - 2018/19 is **£14.508m**. Additional allocations from the Scottish Government are anticipated but have not been confirmed at this stage. The current benchmark figure for grant assistance per RSL unit in rural Argyll is £59k. Currently the Council provides grant assistance of £25k per new build unit and average accruals to the Strategic Housing Fund amount to around **£1.8m** per annum. All new builds are required to meet Houses for Varying Needs standards, and should be suitable to meet the changing needs of individuals over time. The SHIP currently aims to deliver a minimum of 110 new affordable homes per annum i.e. at least 550 over the next five-year planning period.

6.4 Investment in the existing housing stock to improve conditions, including energy efficiency, is substantial and has increased in recent years. The Scottish Government

provides funding to local authorities to deliver the Home Energy Efficiency Programme Scotland (HEEPS) which offers grant funding to households to install a range of energy efficiency measures including external wall insulation. Argyll and Bute has secured £1,986,773 to deliver the third phase of this programme which commenced in 2015/16, working primarily with partner agencies such as Alienergy. Additional funding will be sought for future years. The social rented sector are required to meet national housing quality and energy efficiency standards which entails significant programmes of work and levels of investment, all of which, again, will contribute towards overarching health and social care outcomes and objectives.

6.5 The key resources outlined above are summarised in the following table.

Funding Source	Delegated	Housing Function	Total Investment
AHIP (Scottish Government)	No	New build homes	£14.508m (2016/17- 18/19)
Strategic Housing Fund (Council)	No	New build & empty homes	£1.8m per annum (est.)
PSHG (Council)	Yes (partial)	Private sector adaptations; Care & Repair;	£500k per annum (of total budget of c. £750k)
HEEPSABS (Scottish Govt.)	No	Home energy efficiency measures	£1.987m (2016/17)
Stage 3 Adaptations (Scottish Govt.)	No	RSL adaptations	£540k per annum (est)
RSL Private Finance	No	New build homes	£13m est. (2016/17–18/19)

7) Final Comments

7.1 The integration agenda presents potential opportunities to maximise effective joint working particularly to apply housing resources directly and indirectly to prevent costly health and social interventions at a later date. Conversely, the direct influence of health and social care on relevant housing activities will require focused, on-going dialogue between the Strategic Housing Forum and individual organisations and the H&SCP, with a view to forging even closer linkages between the LHS 2016-21 and the Strategic Plan.

7.2 As part of the formal monitoring and review process for the LHS, specific outcomes, milestones, timescales, indicators and targets in respect of housing's contribution to health and social care will be subject to

- Appraisal by the Scottish Government, and peer review via the Scottish Housing Network
- Scrutiny by the Scottish Housing Regulator

- Regular progress reporting, including annual updates, to the Strategic Housing Forum, Members, individual organisation boards, community planning partners and groups and general stakeholders
- Formal reports on specific outcomes to wider thematic partnerships (e.g. economic fora) including the HSCP on a regular basis.

7.3 The ethos and principles of the Housing Sector are clearly already aligned with that of the HSCP, with a strong focus on preventative policies, home and person-centred services, a holistic approach to strategic planning, a fundamental commitment to reducing and eradicating inequalities, and pursuing efficiency and cost effectiveness.

7.4 In summary, this contribution statement has highlighted the key role that the housing sector will have in joint planning, commissioning and delivery of services as well as influencing investment decisions to support the Strategic Plan's outcomes and objectives. There are crucial links between

- the LHS and the Strategic Plan;
- the HNDA and JSNA;
- homelessness, tenancy support, fuel poverty, energy efficiency and adaptations services and the strategic plan and HSCP services; and
- the Strategic Housing Forum and the HSCP/Integration Authority structures.

The Housing Sector in Argyll and Bute positively welcomes this opportunity to strengthen these connections and to improve the alignment of strategic planning, focusing on common outcomes; with a view to prevention; increased supply of suitable housing options; and, in addition, to support and promote partnership and community capacity building.

APPENDIX 15 – GLOSSARY

Phrase	Definition
Allied Health Professional (AHP)	A person registered as an Allied Health Professional with the Health Professions Council: they work in health care teams providing a range of diagnostic, technical, therapeutic and direct patient care and support services and include physiotherapists, dieticians, Speech and Language Therapists, psychologists, Occupational Therapists, podiatrists, audiologists, etc.
Asset-Based Approach	Mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits. The approach aims to empower individuals, enabling them to rely less on public services.
Care Package	A term used to describe all the different types of care that make up the total care received by an individual. For example, they may receive support from Community Alarms or a Mobile Warden, and have home care. All these services together make up the 'Care Package'.
Care Pathway	The route followed by the service user into, through and out of NHS and social care services.
Care Plan	A single, overarching plan that records the outcome of discussion between the individual and the professional. It could be electronically stored or written on paper. It should be accessible to the individual in whatever form is suitable to them.
Carer	Someone who spends a significant proportion of their time providing unpaid support to family or friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.
Change Fund	As part of the Reshaping Care for Older People initiative, short-term funding was provided to NHS Boards and local authorities to refocus health and social care of Older People towards prevention and early intervention. The Fund ceased to be allocated from April 2015, with some services sustained as part of mainstream health and social care services.

Change Management	Change management is a systematic approach to dealing with change, of an organisation. There are three different aspects of change management: adapting to change; controlling change; and effecting change.

Phrase	Definition
Co-creation	Involving users in service design (see co-production).
Co-location	Co-located services are those that are established physically and organisationally as part of an integrated service. Co-location can be a key enabler in the development of integrated working at a service user's level.
Community Capacity	Activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and leading roles in the development of communities.
Community Planning	Community Planning is a process by which public agencies work in partnership with communities, the private and Third Sector to plan and deliver better services. The partnership process has been in place for 10 years and is led by a Board of representatives from the local authority, NHS Job Centre Plus, Further and Higher Education colleges, Scottish Enterprise, Skills Development Scotland, Strathclyde Fire and Rescue, Strathclyde Partnership for Transport, and the voluntary and Independent sectors.
COPD	COPD (Chronic obstructive pulmonary disease) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. Typical symptoms of COPD include: increasing breathlessness when active; a persistent cough with phlegm and frequent chest infections. The main cause of COPD is smoking.
Co-production	Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents. There is a difference between co-production and participation: participation means being consulted while coproduction means being equal partners and co-creators, including service users and the community taking over some of the work done by practitioners.
Department for Work and Pensions	(DWP) is responsible for welfare and pension policy and is a key player in tackling child poverty. It's the biggest public service department in the UK and serves over 20 million customers.
Dietician	Dietetics is the interpretation and communication of nutrition science to enable people to make informed and practical choices about food and lifestyle in health and disease.

Phrase	Definition
Elective admissions	Planned admissions to hospital inpatient and day care services.
Emergency admissions	Unplanned admissions to hospital inpatient services.
Equality and Diversity Impact Assessment (EQIA)	EQIA is a strategic process to be considered when planning a new, or redesigning an existing, policy, function or service.
Getting It Right for Every Child (GIRFEC)	Getting it Right for Every Child (GIRFEC) is a programme of reform and to place the child at the centre of service provision in Scotland. It establishes the principle of giving all children and young people the best possible start in life as a priority for all services. It sets out the approach for all services to assess and understand how best to meet individual needs, building from the universal services of health and education and sets out a national programme of new ways of working change to ensure that each child is: safe, healthy, active, nurtured, achieving, respected, responsible and included. It provides a framework for practitioners in all agencies to gather, structure, and analyse information in a consistent way to help identify and understand the child or young person's needs, the strengths and pressures on them and their carers, and consider what support is required.
Home Care or Care at Home	Help provided directly to you in the service user's own home. Home carers are people employed to provide direct personal physical, emotional, social or health care and support to service users, and are accountable for dealing with routine aspects of a care plan or service.
Independent sector	The independent sector encompasses individuals, employers, and organisations contributing to needs assessment, design, planning, commissioning and delivery of a broad spectrum of health and social care, who are wholly or partially independent of the public sector. This includes care homes, private hospitals and home care providers as well as consultancy and research work.
Integration Joint Board	An Integration Joint Board will be established to oversee the integrated arrangements and onward service delivery. The integration joint board will exercise control over a significant number of functions and a significant amount of resource.

Phrase	Definition
Joint Strategic Commissioning (JSC)	The term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.Joint commissioning is where these a more agencies working together, typically health and local government, and often from a pooled or aligned budget.
Long-Term Conditions	Long-term conditions are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support, medication and other therapies. Long-term conditions become more prevalent with age.
Managed Clinical Network/ Managed Care Network (MCNs)	Linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner. Unconstrained by existing professional boundaries (non-hierarchical) to ensure equitable provision of high quality, clinically effective services. These can be located at NHS Board, regional or national level depending on the condition.A clinical network is usually b condition (cardiac, stroke, diabetes, etc) but at national and regional level can be even more precise. A care network focuses of care groups such as older people.
Morbidity	The incidence or prevalence of a disease or of all diseases in a population.
Mortality	The death rate, which reflects the number of deaths per unit of population in any specific region, age group, disease, or other classification, usually expressed as deaths per 1000, 10,000, or 100,000.
Multi-disciplinary Team (MDT)	A team made up of professionals across health, social care and Third Sector who work together to address the holistic needs of their patient service users/clients in order to improve delivery of care and reduce fragmentation.
Multi-morbidity	Multi-morbidity is the presence of two or more long-term health conditions.
Named Person	Part of Getting it Right for Every Child (GIRFEC) and the Children's Act requires a Named Person to be available for every child, from birth until their 18th birthday. Depending on the age of the child or young person, a health visitor or senior teacher, already known to the family, usually takes the role of Named Person. The Named Person – who will be the first point of contact for the child and their family – needs to take action, help, or arrange for the right help in order to promote, support and safeguard the child's development and wellbeing.

Phrase	Definition
Occupational Therapy	Occupational Therapy gives people the tools and skills to promote health, wellbeing and independence through participation in activities or occupation. Occupational Therapists will analyse the patient's physical, psychological, social, cognitive and environmental needs, and provide rehabilitation, or develop new strategies to enable patients to continue to do the activities they need or want to do.
Organisational Development Plan	Deliberately planned, organisation-wide effort to increase an organisation's effectiveness and/or efficiency and/or to enable the organisation to achieve its strategic goals.
Personal Outcomes	Personal outcomes are about the impact or end result of services, support or activity on a person's life.
Personalisation	Personalisation is a means of giving service users more control over the services and support they receive, and includes Self Directed Support, asset management and co-production.
Preventative interventions	Action taken to support people to do things for themselves as much as possible.
Primary Care	Services provided by GP practices, dental practices, community pharmacies and high street optometrists.
Psychology	Psychology is the scientific study of human thought and behaviour. Clinical psychologists help a wide range of people of all ages with all sorts of problems, such as emotional or mental health problems, and people with difficulties with their thinking, such as problems with memory or perception after a head injury, a learning disability or dementia.
Physiotherapist	Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible.
Podiatry	Podiatrists/chiropodists diagnose and treat abnormalities of the lower limb. They offer professional advice on preventing foot problems and care. In the NHS, they'll see many patients at high risk of amputation, such as those suffering from arthritis or diabetes.

Phrase	Definition
Prevention (Primary Secondary and Tertiary)	**Primary prevention** includes health promotion and requires action on the determinants of health to prevent disease occurring. It has been described as refocusing upstream to stop people falling in to the waters of disease. **Secondary prevention** is essentially the early detection of disease, followed by appropriate intervention, such as health promotion or treatment. **Tertiary prevention** aims to reduce the impact of the disease and promote quality of life through active rehabilitation.
Primary Care	Health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment. Main primary care services are provided by GP practices, dental practices, community pharmacies and high street optometrists, as well as community nurses and Allied Health Professionals.
Programme Budgeting Marginal Analysis	A method for separating healthcare spending into categories for analysis. It looks at the marginal benefits that can be made by moving investment to more cost-effective programmes or interventions. PBMA information could inform discussions such as: • Could better value for money be achieved by expanding investment in preventative activities? • Does the distribution of expenditure between programmes reflect the priorities for the Partnership? And • Could better value for money be obtained by redistributing among programmes?
Proportionate Universalism	The opposite of the inverse care law, i.e. reducing health inequalities through universal actions that are delivered with a scale and intensity that is proportionate to the level of disadvantage.
Reablement	Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.
Scottish Patients at Risk of Readmission and Admission (SPARRA)	A tool which predicts a patient's risk of emergency admission and therefore can be used to identify those people at greatest risk of emergency admission to hospital over the following year.

Phrase	**Definition**
Secondary Care	Medical care provided by a specialist or facility. Referral would be made by a primary care physician that requires more specialised knowledge, skill, or equipment.
Self Directed Support	The support individuals and families have after making an informed choice on how their Individual Budget is used to meet the outcomes they have agreed. There are four options that Partnerships will have a duty to offer: • the local authority makes a direct payment to the supported person in order that the person can then use that payment to arrange their support. • the supported person chooses their support and the local authority makes arrangements for the support on behalf of the supported person. • the local authority selects the appropriate support and makes arrangements for its provision by the local authority. • a mix of options 1, 2 and 3 for specific aspects of a person's support.
Self-Management	The service users and all appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more long-term condition. It encourages people to take decisions and make choices that improve their health, wellbeing and health-related behaviours
SHANARRI	Outcome indicators for GIRFEC – Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible.
Shifting the Balance of Care	Changes at different levels across health and care systems from institutional care to community care, intended to bring about better health outcomes for people.
Single Outcome Agreement	The Single Outcome Agreement is an agreement between the Community Planning Partnership and the Scottish Government. Those using the agreed Community Planning Partnership identify priorities to be addressed and outcomes to be achieved. The SOA also includes an Action Plan to show how performance targets and Performance Indicators measure progress.

Phrase	Definition
Speech and Language Therapy	Speech and Language Therapists assess, treat and help to prevent speech, language and swallowing difficulties.
Talking Points	A specific process used in identifying personal outcomes.
/ Telehealth care	Technology Enabled Care and telehealth is technology that can be used to help service users live safely and independently in their home. '**Technology Enabled Care**' is used as an overarching term to describe both telehealth and Technology Enabled Care together. • '**Telehealth**' is the provision of health services at a distance using a range of digital and mobile technologies. This includes the capture and relay of physiological measurements from the home/community for clinical review and early intervention, often in support of self-management. • '**Teleconsultation**' is where technology such as email, telephone, telemetry, video conferencing, digital imaging, web and digital television are used to support consultations between professional to professional, clinicians and patients, or between groups of clinicians. • '**Technology Enabled Care**' is the provision of care services at a distance using a range of analogue, digital and mobile technologies. These range from simple personal alarms, devices and sensors in the home, through to more complex technologies such as those which monitor daily activity patterns, home care activity, enable "safer walking" in the community for people with cognitive impairments/physical frailties, detect falls and epilepsy seizures, facilitate medication prompting, and provide enhanced environmental safety.
Tertiary care	Highly specialised medical care involving advanced and complex procedures and treatments performed by medical specialists working in a centre that has personnel and facilities for special investigation and treatment. Referrals are usually made from secondary medical care personnel, but occasionally from primary care personnel.
Third Sector and Third Sector Interface (TSI)	The generic title for those involved in the Health and Social Care Partnerships comprising non-governmental and non-profit-making organisations or associations, including charities, voluntary organisations, community groups, tenants and residents groups, faith groups, housing associations, most co-operatives and social enterprises (provided profits are retained for the benefit of the members or community served), and most sports organisations.

Argyll & Bute Health and Social Care Partnership

Equality Impact Assessment of the Strategic Plan 2016-2019

1: Policy or function details

Name of policy or function	Argyll & Bute HSCP Strategic Plan 2016 - 2019
Lead officer/person	Christina West, Chief Officer, Health and Social Care Partnership
Supporting team	Stephen Whiston, Head of Strategic Planning and Performance Patricia Trehan, Project Officer, Integration David Clements, Programme Manager, Improvement & HR

What are the main aims of the policy?	The aims of the Health and Social Care Strategic Plan are: A. We will work to reduce health inequalities. B. We plan and provide health and social care services in ways that keep people safe and protect them from harm. C. We will ensure children have the best possible start in life and plan services in a person-centred way that benefits the person receiving the service, so that they have a positive experience – right service, right place, and right time. D. We will plan for and deliver services in person-centred ways that enable and support people to look after and improve their own health and wellbeing. E. We will prioritise community based services, with a focus on anticipatory care and prevention to reduce preventable hospital admission or long term stay in a care setting. F. We will deliver services that are integrated from the perspective of the person receiving them and represent best value with a strong focus on the wellbeing of unpaid carers. G. We will establish "Locality Planning, Owning, Delivery" operational and management arrangements to respond to local needs. H. We will strengthen and develop our partnership with specialist health services with NHSGG&C and Community Planning Partners as well as with the Third and Independent sectors. I. We will sustain, refocus and develop our partnership workforce on anticipatory care and prevention. J. We will put in place a strategic and operational management system that is focused on continuous improvement, within a clear governance and accountability framework. K. We will underpin our arrangements by putting in place clear communication and engagement arrangements involving our staff, users, the public and stakeholders.
Who will benefit?	The main purpose of Integration is 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.

Is the policy intended to increase equality of opportunity by permitting positive action or action to redress disadvantage?	The integration of health and social care services, aims to: • improve the quality and consistency of services for patients, carers, service users and their families; • provide seamless, joined up, high quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with longer term and often complex needs.

2: What are the likely impacts of the policy?

For each protected characteristic you should identify any particular impact that the policy may have for the group. Impacts could be positive or negative and both should be described.

If there are no impacts on a particular protected characteristic then state your reasons for this within the response box. This demonstrates that you have considered the impact on each characteristic.

Will the policy impact on the whole population of Argyll and Bute?	The main purpose of Integration is 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.
Will the policy impact on particular groups within the population of Argyll and Bute?	The Strategic Plan seeks to improve services for everyone, whilst recognising that some groups use a higher proportion of services. These would include: children and young people; people with disabilities; people with long-term conditions and/or multi-morbidities; frail older people.

Consider the following protected characteristics. What are the likely impacts for the group or community?

Protected characteristic	Positive and/or negative impacts
Race: relating to people from different racial groups, ethnic or national origins, ethnic minorities, including gypsy travellers and migrant workers	The Strategic Plan does not introduce any change to the non-discriminatory ethos of health and social care services. All staff and contractors are expected to work with every patient or service user in a way that demonstrates delivery that is: • Person centred • Delivered with integrity • Engaged • Caring • Compassionate • Respectful
Gender: specific to women and/or men	The Strategic Plan does not introduce any change to the non-discriminatory ethos of health and social care services. All staff and contractors are expected to work with every patient or service user in a way that demonstrates delivery that is: • Person centred • Delivered with integrity • Engaged • Caring • Compassionate • Respectful
Disability: relating to people with either mental or physical disability	The Strategic Plan does not introduce any change to the non-discriminatory ethos of health and social care services. All staff and contractors are expected to work with every patient or service user in a way that demonstrates delivery that is: • Person centred • Delivered with integrity • Engaged • Caring • Compassionate • Respectful

Protected characteristic	Positive and/or negative impacts
Age: relating to different age groups e.g. older people or children and young people	The Strategic Plan does not introduce any change to the non-discriminatory ethos of health and social care services. All staff and contractors are expected to work with every patient or service user in a way that demonstrates delivery that is: • Person centred • Delivered with integrity • Engaged • Caring • Compassionate • Respectful
Religion or Belief: relating to a person's religion or belief (including non-belief)	The Strategic Plan does not introduce any change to the non-discriminatory ethos of health and social care services. All staff and contractors are expected to work with every patient or service user in a way that demonstrates delivery that is: • Person centred • Delivered with integrity • Engaged • Caring • Compassionate • Respectful
Sexual orientation: relating to whether a person is lesbian, gay, bi-sexual, heterosexual	The Strategic Plan does not introduce any change to the non-discriminatory ethos of health and social care services. All staff and contractors are expected to work with every patient or service user in a way that demonstrates delivery that is: • Person centred • Delivered with integrity • Engaged • Caring • Compassionate • Respectful

Protected characteristic	**Positive and/or negative impacts**
Marriage and civil partnership: relating to people who are married or are in a civil partnership	The Strategic Plan does not introduce any change to the non-discriminatory ethos of health and social care services. All staff and contractors are expected to work with every patient or service user in a way that demonstrates delivery that is: • Person centred • Delivered with integrity • Engaged • Caring • Compassionate • Respectful
Gender reassignment: relating to people who have proposed, started or completed a process to change his or her sex	The Strategic Plan does not introduce any change to the non-discriminatory ethos of health and social care services. All staff and contractors are expected to work with every patient or service user in a way that demonstrates delivery that is: • Person centred • Delivered with integrity • Engaged • Caring • Compassionate • Respectful
Pregnancy and maternity: relating to the condition of being pregnant or expecting a baby and the period after the birth	The Strategic Plan does not introduce any change to the non-discriminatory ethos of health and social care services. All staff and contractors are expected to work with every patient or service user in a way that demonstrates delivery that is: • Person centred • Delivered with integrity • Engaged • Caring • Compassionate • Respectful

3: Evidence used in developing the policy

Involvement and consultation In assessing the impacts set out above what evidence has been collected from involvement, engagement or consultation? Who was involved, when and how?

The Strategic Planning Group decided to precede the formal consultation on the full strategic plan with an information signposting leaflet (included in local papers, alongside virtual copies) and an Outline Strategic Plan – "A conversation with you", detailing the major themes in our strategic plan from the 2nd July 2015. The Outline Strategic Plan prompted 703 responses through seven public events, seven staff events and on-line engagement.

A draft Strategic Plan 2016 – 2019 was produced and published prior to a three month consultation period, September to November 2015.

Consultation took place across the seven Localities with 394 responses gathered:

- Oban, Lorn and the Isles
- Mid Argyll
- Kintyre
- Islay and Jura
- Helensburgh and Lomond
- Bute
- Cowal

Local events were organised in Mull & Iona and on Tiree. Two larger events were held in Lochgilphead and Arrochar.

Responses were gathered through a variety of methods:

- In person at an event
- By post
- Email
- SurveyMonkey
- From relevant organisations and Community Councils, who were contacted directly, by letter, as required by the terms of the Integration Scheme.
- At separate staff consultation events, supported by Trades Unions/NHS staff side representatives and the Organisational Development Lead.

As a result of the consultation the Strategic Planning Group agreed a number of changes to the draft Strategic Plan:

- Mull & Iona was agreed as a separate locality, bringing the total to 8
- The Learning Disability section of the plan was re-drafted by a small group of LD professionals
- The Mental Health section of the plan was amended by a small group of MH professionals
- The section of the plan pertaining to the GP services and primary care was re-drafted, for clarity, by the Public Representatives
- The section on care at home, (which predominantly, but not exclusively, relates to older people) was amended to recognise that many respondents expressed concern about the availability, quality, length of visits and provision of appropriately trained staff in this service
- A number of other, minor, changes were made to clarify various points that were raised

Data and research Please specify what research was carried out or data collected, when and how this was done, and what other available research or data did you use?	• In line with Scottish Government guidance we assembled a Strategic Planning Group, comprising 40 people representing all relevant disciplines, including the Third and Independent sectors, Public and Carer representatives. • We reviewed all relevant policies and plans existing in Argyll & Bute Council and NHS Highland and accepted these as extant within the draft Strategic Plan, taking account of consultation that had been carried in relation to each of these.
Partners' data and research What evidence has been provided by partners? Please specify partners.	• Published Strategic Plans from other areas were examined in detail; many were not a 'best-fit' for Argyll & Bute because few areas have chosen to delegate such a wide range of services. The closest fit with our needs was the South Ayrshire Strategic Plan • Some Scottish Government Guidance was available and we took full account of this • Throughout the process we had support from a JIT Associate • We are members of a National Integration Managers' Network, which meets regularly to share learning
Gaps and uncertainties Have any gaps or uncertainties been identified in your understanding of the issues or impacts that need to be further explored?	We had produced a comprehensive Joint Strategic Needs Assessment, which was Argyll & Bute wide. During the process we realised that Locality Planning Groups would need this information for their own locality. As a result we arranged for the NHS Public Health team to produce the information for each locality.

4: Detailed Action Plan to address gaps in evidence and to reduce negative impacts

No	Action	Responsible Officer(s)	Timescale
1	No further action required		
2			
3			
4			

5: Performance monitoring and reporting

Please describe how the policy will be taken forward. This will act as a record for future reviews and the monitoring of the policy.

When is the policy intended to come into effect?	01.04.2016
When will the policy be reviewed?	Annually
Who is responsible for reviewing the policy?	Christina West, Chief Officer, Health and Social Care Partnership

6: Summary

Name of policy: Argyll & Bute Health and Social Care Strategic Plan 2016 - 2019

This policy will help the HSCP to meet the general equality duty to eliminate discrimination; advance equality of opportunity; and foster good relations by:

Eliminate discrimination In reviewing the Strategic Plan there is no evidence to indicate that the policy may: • Result in less favourable treatment of particular groups • Give rise to indirect discrimination
Advance equality of opportunity In reviewing the Strategic Plan there is evidence that: • Actions have been taken to remove or minimise disadvantage • The Plan meets the needs of different groups
Foster good relations In reviewing the Strategic Plan there is evidence that: • The existing ethos of the workforce promotes understanding • The needs of communities have been considered to promote good relations

When completed, the assessment must be signed off by the Lead Officer and by the relevant Head of Service.

Signed:

Head of Strategic Planning and Performance
Date: 10.2.16

Signed:

Chief Officer, Health & Social Care Partnership
Date: 10-02-16