A&B HSCP Transforming Together

# STRATEGIC PLAN (2019/22)

# ENGAGEMENT PROCESS

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

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

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

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

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

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

Please could you complete your response to the following five questions online via

https://www.surveymonkey.co.uk/r/AB-HSCP2019-23

Alternatively, you can post your response to:

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Public Involvement Manager

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## 1. CHILDREN'S SERVICES

**What do we Know?**

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

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

**What do we plan to do?**

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

## 2. CARE HOMES AND HOUSING

**What do we Know?**

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

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

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

**What do we plan to do?**

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

## 3. LEARNING DISABILITY SERVICES

**What do we Know?**

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

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

**What do we plan to do?**

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

## 4. COMMUNITY MODEL OF CARE

**What do we Know?**

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

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

**What do we plan to do?**

- Develop and implement multi-disciplinary community care teams
- Develop a multi skilled care worker role to work within the multi-disciplinary community care teams.
- Ensure anticipatory care planning is adopted to reduce the incidence of emergency hospital admissions.
- Prioritise the prevention e.g. empower people to self manage long term health conditions and connect people with sources of support in their community such as

opportunities to be more physically active.
- Further develop the use of technology to support people living at home who have health and care needs.

## 5. MENTAL HEALTH SERVICES

**What do we Know?**

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

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

**What do we plan to do?**

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

## 6. PRIMARY CARE SERVICES

**What do we Know?**

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

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

**What do we plan to do?**

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

## 7. HOSPITAL SERVICES

**What do we Know?**

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

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

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

**What do we plan to do?**

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

## 8. CORPORATE SERVICES

**What do we Know?**

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

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

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

**What do we plan to do?**

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

**YOUR VIEWS ARE IMPORTANT AND WE WELCOME YOUR FEEDBACK.**

| Q1: | What is your understanding of the types of services that are provided by the Health & Social Care Partnership? |
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| Q2: | What are your thoughts about the 8 key areas of service change? |
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| Q3: | What do we need to do to make sure we involve people as we go about making these changes (effective engagement)? |
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| Q4: | How can individuals, communities and our partners work with us to help people stay healthy and well? |
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| Q5: | What would help communities to work with us and play an active role in developing and delivering future services? |
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