A&B HSCP Transforming Together

STRATEGIC PLAN (April 2019- March 2022)

STAKEHOLDER ENGAGEMENT

Healthy Together Argyll & Bute | working together for you

NHS Highland | Argyll & Bute Council | ScottishCare | TSI

Health & Social Care Partnership

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

Successes in the first 2 years

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

2nd Strategic Plan (April 2019 - March 2022)

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

Engagement Process

➢ Stage 1 – Informing and Consulting on the Strategic plan

- Informing people about what the HSCP is going to do
- Inviting comments on the key service change areas that are required
- Inviting suggestions around what we need to do to make sure we involve people as we make these changes
- Use the information gathered in this stage to inform what we do next

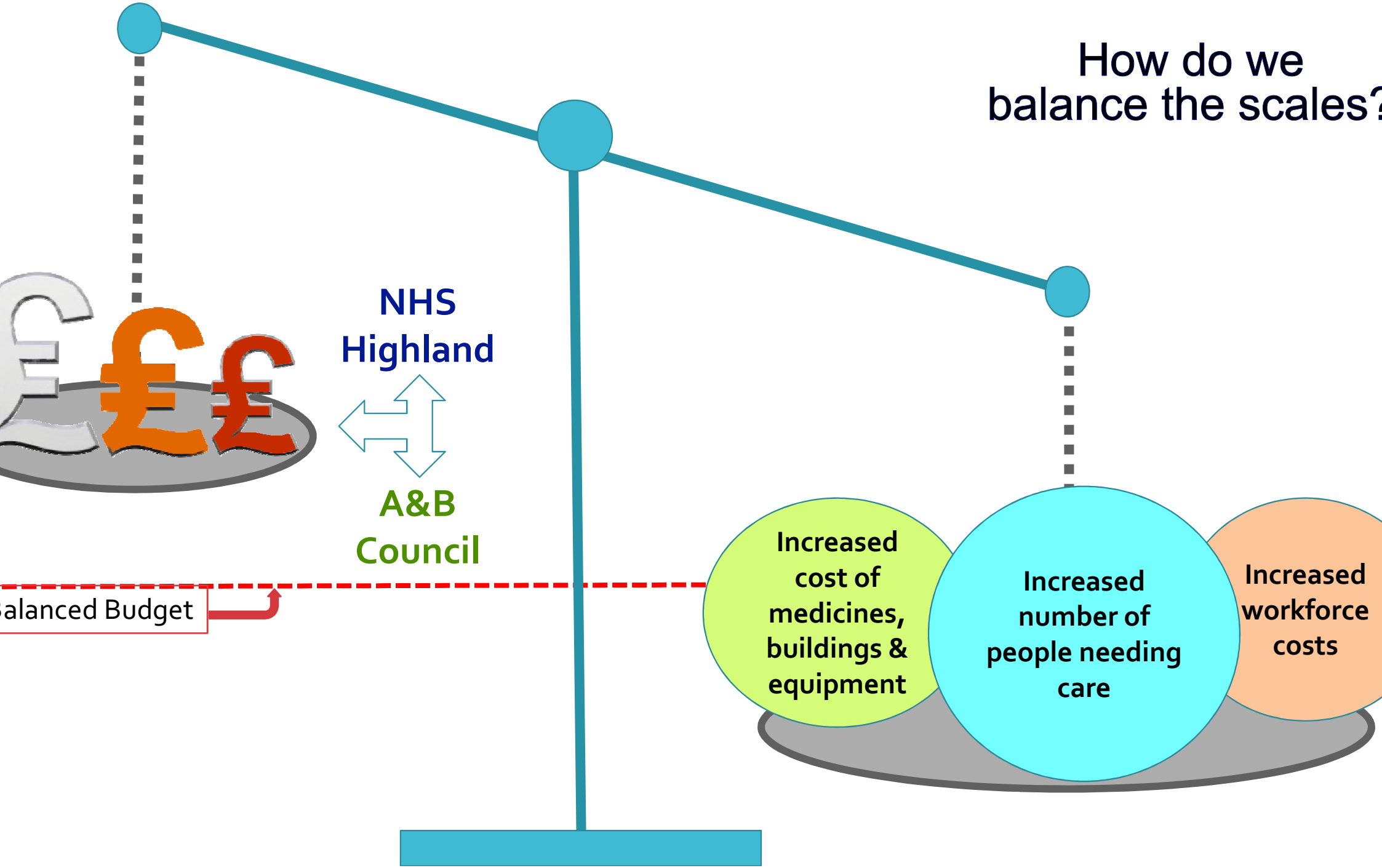
➢ Stage 2 – Involving and Collaborating on service redesign

- Developing the areas of work around the 8 key areas for service change
- Involve staff, citizens and partners as we take forward this work
- Publicise what we have found out and how this information will be used to make service changes

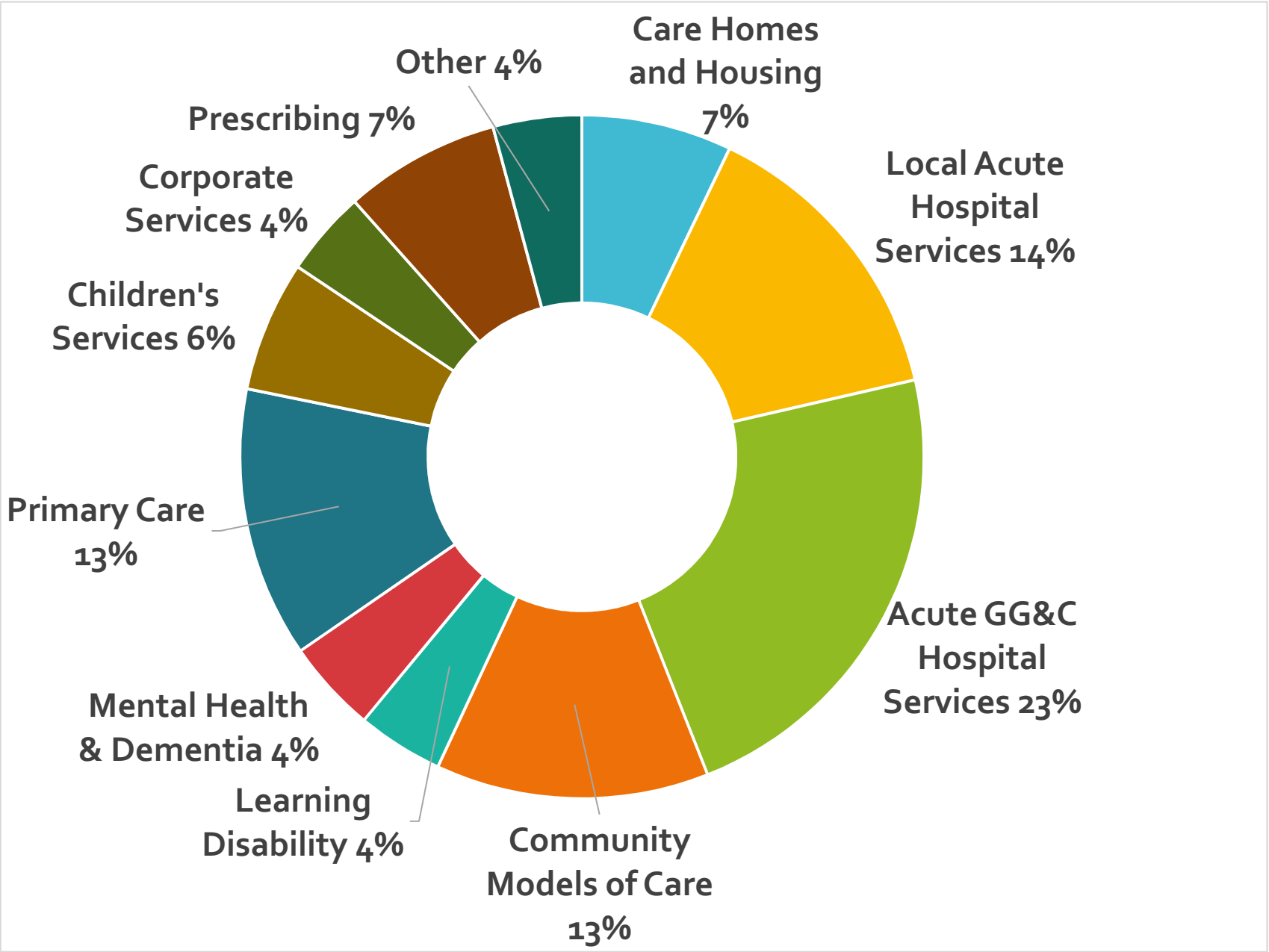
➢ Stage 3 – Involving and Collaborating on implementing service change

- Involve people who use services, carers, staff and partners in how we implement service change.

How do we balance the scales?



Current Spending



Spending Shortfall

2017/18	Income	£258.9m	£6.4m shortfall
	Spending	£265.3m	
2018/19	Income	£263.1m	£5.2m shortfall
	Spending	£268.3m	
2019/20 (estimated)	Income	£265.7m	£6.2m shortfall
	Spending	£271.9m	

High Level Service Changes

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

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

1. Children's Services

Population Profile

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

Service Demand

The number of children with complex needs is increasing.

Challenges

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

Evidence Base

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

Current Service Cost

£19.1 million

Estimated Savings

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

Service change

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

2. Care Homes & Housing Services

Population Profile

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

Service Demand

Increasing demand for adapted properties as more older people are enabled to stay at home.

Long-term sustainable solutions for high level needs (24 hour care).

Challenges

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

Evidence Base

A Health and care housing needs assessment has been undertaken to inform need.

A Care & Nursing Home Modelling Tool is being developed to better assess future needs.

Current Service Cost

£18.8 million

Estimated Savings

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

Service change

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

3. Learning Disability Services

Population Profile

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

Service Demand

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

Challenges

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

Evidence Base

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

Current Service Cost

£10.8 million

Estimated Savings

Required to make
£1.4 million
savings over the next year

Service change

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

4. Community Model of Care

Population Profile

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

Evidence Base

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

Service Demand

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

Current Service Cost

£34.2 million

Challenges

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

Estimated Savings

Required to make
£1.7 million
savings over the next year

Service change

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

5. Mental Health Services

Population Profile

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

Evidence Base

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

Service Demand

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

Challenges

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

Current Service Cost

£11.6 million

Estimated Savings

Required to make
£0.6 million
savings over the next year

Service change

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

6. Primary Care Services

Population Profile

33 GP practices in Argyll and Bute, with a registered patient population of 88,657 as at 1 April 2018.
Practice populations range from 11,200 in Oban to 130 on the Isle of Colonsay

Service Demand

To reduce the future workload on GPs and practices, services will be provided by other clinicians such as Pharmacy, Physiotherapy, Advanced Nurse Practitioners.

Challenges

GP Practices across Scotland provide Out Of Hours Cover, in Argyll and Bute.
Vacancies and turnover GPs
Transfer of GP work to HSCP.

Evidence Base

New GP Contract Implementation (April 18).
Sustainable services delivered by wider teams in the context of Primary Care Service Redesign.

Service Investment

New GP contract will see extra funding over the next 3 years- £848,000 to £2.9 Million in Argyll and Bute.

Changes

The HSCP is to take over some services currently provided by GPs e.g. Vaccinations, prescribing, Practice nursing tasks .

Service change

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

7. Hospital Services

Population Profile

One Rural general Hospital in Oban.
Six Community Hospitals all with Accident & Emergency departments.

Contract with NHS GG&C for acute health services and specialities .

Service Demand

More care now being delivered in Community.

Hospital used for more day care services.

Number of A&E attendances increasing.

Challenges

People living longer, more demand on services.

Population decline mirrored in workforce.

Recruitment difficulties.

Increasing costs of acute health care and negotiation with NHS GG&C to reduce payment.

Evidence Base

People have said they want to receive care as close to home where it is safe and possible to do so.

Hospital services there when needed.

A&E departments should only be for urgent care .

Current Service Cost

Local Hospitals
£37.8 million

GG&C Hospitals
£60million

Estimated Savings

Required to make
£2.1 million
savings over the next year from local hospitals

£1.2million
reduction in use of GG&C services

Service Change

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

8. Corporate Services

Profile

Corporate services teams – including finance, planning, IT, HR, pharmacy management, medical management and estates
Includes all IT and corporate asset infrastructure.

Evidence Base

Audit Scotland - integrating support services will provide efficiencies.
Evidence of corporate efficiencies in Council services can be replicable within the Partnership.
National health and wellbeing outcome indicator to use resources effectively and efficiently.

Service Demand

Customers of support services are front line health and social care services
Demands are increasing, new corporate demands of health and social care integration alongside requirements of Council and Health organisations
requirement to make corporate services more efficient and integrated for front line managers.

Future Budget

Recurring budget is expected to reduce, but non-recurring investment may be required.

Challenges

Inevitably less people and buildings
Not all corporate support services from Council delegated to the partnership
Balance between efficiencies and reduced level of service
More efficient use of technology and systems may require significant investment.

Estimated Savings

The HSCP is required to make £1.3m of saving over the next year.

Service change

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

Stakeholder Engagement

The HSCP is engaging service users, carer, partners and staff on the development of the 2nd Strategic Plan (April 2019- March 2022). Your views are important and we welcome your feedback specifically on the 8 key service changes required to deliver the ambitions of the Partnership over the life of the Plan.

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