A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

PEOPLE IN ARGYLL AND BUTE WILL LIVE LONGER, HEALTHIER INDEPENDENT LIVES

Argyll & Bute Health & Social Care Partnership Annual Performance Report 2018/19

Contents

Foreword

We are pleased to present Argyll and Bute HSCP's third Annual Performance report for 2018/19.

This report continues to illustrate the significant progress we are making on providing integrated services which focus on keeping people healthy, safe and well, but also providing care and treatment quickly when needed.

Our services continue to transform and change to meet increasing demand within the continuing backdrop of workforce and demographic pressures and on-going financial austerity.

Our staff and health and care partners continue to rise to these challenges as shown in the high quality of services we provide and the improved outcomes people are experiencing.

We, however, recognise that we must do more, and we are committed to continuing to improve in the areas where we are not meeting targets for example waiting times. We must also increase the rate of change on our integration journey, supporting our staff to bring services together and improve health and care pathways.

Within this we are working hard to actively listen to our patients, carers and service users, as their feedback is essential to drive improvement and are pleased to see our engagement processes strengthened to achieve this.

Finally, we would like to thank all HSCP staff, partners, carers and volunteers for their continued dedication and commitment, going the extra mile when most needed.

Joanna MacDonald, Chief Officer Argyll & Bute HSCP

Kieron Green, Chair of Argyll & Bute Integration Joint Board

Introduction

Welcome to the third Annual Performance Report from Argyll and Bute Health and Social Care Partnership (HSCP). This report summarises what we have achieved in the last financial year from 1st April 2018 to 31st March 2019.

The Partnership has responsibility for the planning and delivery of all health and social care services to adults and children within Argyll and Bute. We routinely monitor our performance to ensure we are delivering services that meet the needs of our residents, and also which identifies areas where require improvement is required. All Health and Social Care Partnerships are required by the Public Bodies (Joint Working) (Scotland) Act 2014 to publish an Annual Performance Report.

Our report aims to measure the progress we have made, specifically in relation to

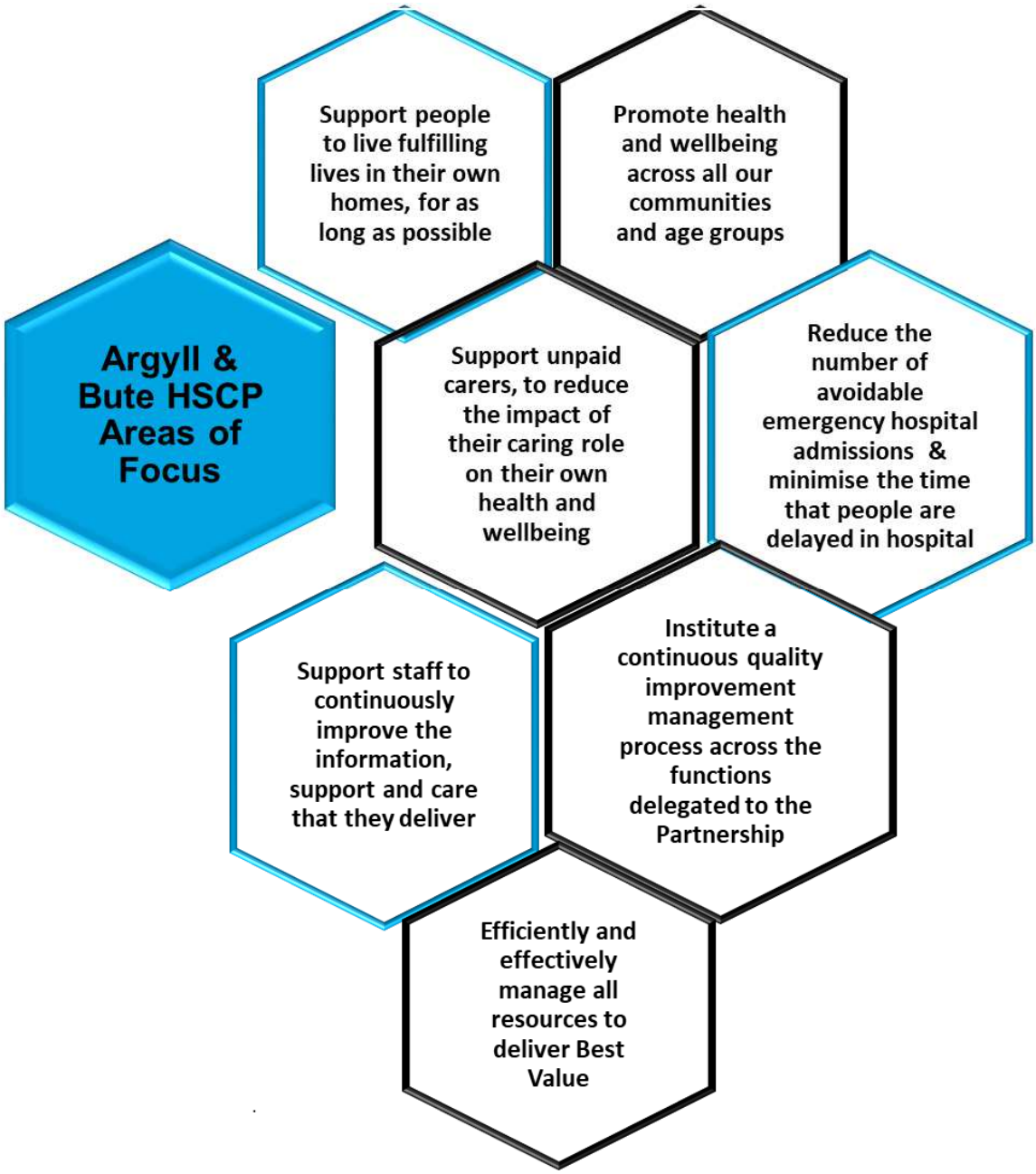
- Key priority areas as detailed in the Argyll and Bute HSCP Strategic Plan 2017/18 including our seven areas of focus (see page 6);
- The Integration Delivery Principles
- The nine National Health and Wellbeing Outcomes (NHWBO), and
- National and local performance indicators.

The full breakdown of our performance against the nine National Health and Wellbeing Outcomes over the past 4 years is available in Appendix 1. This includes all national and local indicators which we have used to measure progress. How our performance compares against other HSCP areas is documented in Appendix 2.

We have also included some good practice highlights and case studies describing service developments and improvements which have occurred within Argyll and Bute over the last year, which demonstrate the work of the Partnership and the impact it has had on our communities.

Section 1: Strategic Plan, Vision and Key Achievements in 2018/19

The Partnership's vision and priorities for health and social care in Argyll and Bute were developed for our first Strategic Plan 2016-2019. This describes how we intend to deliver integrated health and social care services to the communities within Argyll and Bute and identified seven key areas of focus for us as a partnership. These are shown in the diagram below.



Our Vision:

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

The Public Bodies (Scotland) Act 2014 requires Integration Authorities (IA's) to review their strategic plan at least once every three years. We have therefore reviewed our strategic plan. This involved a robust three month engagement programme where we sought the views of public, service users, carers, partner agencies and staff.

Our learning over the period of the last plan, together with the results of our recent engagement and consultation exercise, has confirmed that our objectives remain current and relevant to our communities, staff, partners and stakeholders.

1.1 Our Key achievements in 2018/19

Over the last year we have strived to deliver health and social care services to our communities. Our key achievements over the past year are documented below**:**

- **Review of Argyll and Bute Health and Social Care Partnership Strategic Plan**
  In 2018/19 a full review of our strategic plan was carried out. Our planning intentions for 2019/20 – 2021/21 are described in the document. A copy of our **strategic** plan is available at: www.bit.ly/ABStratPlan and appendices are available on: www.bit.ly/ABStratPlanApp

- **Published our new Carers Strategy and implementation Plan, and our Short Breaks Statement and created a new multi-agency Carers Act Planning Group**

- **Completed a review of our Community Mental Health Services**
  We have reviewed our Community Mental Health Services in 2018/19 with partner agencies, communities, service users and staff.

- **Completed a care housing needs assessment**
  A Health and care housing needs assessment has been undertaken to inform need as well as developing a Care and Nursing Home Modelling Tool to better assess future care needs.

- **The Joint Inspection of Services for Children and Young People in Need of Care and Protection**
  The inspectors evaluated the quality and effectiveness of services in Argyll and Bute provided by the Partnership. The findings of the inspection showed that children and young people in need of care and protection are being kept safe thanks to effective intervention by representatives from a range of organisations that make up Argyll and Bute's Community Planning Partnership. Our Inspection Reports for adults and children for the period 2018/19 are available in Appendix 3a and 3b, respectively.

- **Re-established our Locality Planning Groups**
  We have re-established our locality planning groups, in partnership with our communities, and we look forward to developing the groups as we move forward.

- **Development of a new Engagement Framework for Argyll and Bute**
  We developed a new engagement framework in 2018/19, establishing new engagement processes with our public, service users, carers, partner agencies and staff.

Section 2 - Performance Management and Governance

The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. These suites of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families.

Currently there are 9 key National Health and Wellbeing Outcomes (NHWBO) and 23 sub-indicators. These form the basis of the reporting requirement for Health and Social Care Partnerships across Scotland. A full breakdown of all the Outcomes, Indicators and our local indicators is available in Appendix 1.

Our Performance for 2018/19

There are currently 65 indicators against which we measure our performance. 38 measures are reported as meeting our targets. Further analysis of the trends across the outcomes notes 34 measures showing no change in trend against the previous quarter, 18 measures showing an improvement in performance trend and 14 measures showing a worsening trend.

Benchmarking against other Health and Social Care Partnerships

We regularly benchmark our performance against similar Health and Social Care Partnerships in order to compare our performance and identify any areas of potential improvement. Health Improvement Scotland has identified Moray, Stirling, East Lothian, Angus, Scottish Borders and Highland as areas which are similar in terms of population size, relative deprivation or affluence and rurality of area. Our performance against 23 National Indicators is presented in **Appendix 2** in comparison to these areas.

Performance Governance development over the last year

- **Review of Performance Scorecard**
  As part of the ongoing review of the current Integrated Joint Board (IJB) a number of duplicated measures have been removed, bringing the total number down from 102 to 66 measures.

- **Performance management in Mental Health**
  We are working alongside the Government's Information Services Division (ISD) to establish a performance measurement systems for Mental Health Services so we can clearly see outcomes for service users.

- **Performance management Carers**
  With the establishment of the Carers Strategy in Argyll and Bute we have been working with our local partners to identify additional performance measures. The coalition of Carers Network is also working on suggesting additional measures so there is a consistency of measures throughout Scotland. These new measures will be put in place in 2019/20.

Section 2.1 – How have we performed in 2018/19 - Ministerial Steering Group Indicators

The Ministerial Steering Group (MSG) Performance Measures have been developed **in addition to** the National Health and Wellbeing Outcome Indicators. These are intended to measure the improved outcomes resulting from the integration of HSCP services.

Our performance for 2018/19 against the Ministerial Group Indicators is shown in the table below:

Ministerial Steering Group Indicators; 2015/16 - 2018/19P					
	2015/16	**2016/17**	**2017/18**	**2018/19[p]**	**Target 2018/19**
Emergency admissions (All Ages)	8,638	8,715	9,018	8,659	8,332
A&E attendances (All Ages)	15,113	16,105	16,026	17,060	16,194
Unplanned bed days (All Ages)	65,847	65,705	64,800	58,941	56,687
Unplanned bed days MH (All Ages)	13,421	12,631	12,774	14,424	-
Delayed discharge bed days (18+)	8,857	6,803	8,414	9,561	7,037

Emergency Admissions Performance

An overall reduction of 3.98% (n=359) in the number of Emergency Admissions was noted over the last year (2017/18 - 2018/19) within Argyll and Bute HSCP area. Unfortunately, despite the noted decrease since last year, the overall target (n=8,332) was slightly missed.

Accident & Emergency (A&E) attendances

This year across Argyll and Bute HSCP area, there has been a significant rise in the number of A&E attendances compared to previous years. As a result, we did not achieve our target in this area.

Unplanned bed days

It is important to note that the number of unplanned bed days within Argyll and Bute HSCP has been decreasing year on year since 2015/16 and in the last year this has continued. Unfortunately, despite this, we narrowly missed the overall target for 2018/19 (n=56,687).

Delayed Discharge Bed days

Delayed discharges remain a key challenge across the Argyll and Bute HSCP area and this year we have missed our target in relation to Delayed Discharge Bed Days. Despite an initial reduction in delayed discharge bed days between 2015/16 and 2016/17, there has been a

steady increase in the number of delayed discharge bed days reported since 2016/17. This is due primarily to the availability of care at home or care home placement. Issues around Adults with Incapacity also have an impact on the delays.

All localities are working towards an integrated community team approach by implementing the Argyll and Bute Community Standards for every team. These include, single point of access, multi-disciplinary triage, lead professional, reablement, community medication support, anticipatory approaches with a focus on avoiding unnecessary admissions, generic workforce skill set, advanced nursing workforce within the teams and a self-management and self-directed support (SDS) approach to care and assessment.

Our achievements this year include:

- A continuing decrease in the number of days patients are staying in Cowal Community Hospital
- Development of virtual wards across the Partnership have allowed us to monitor both individuals in Glasgow Hospitals, and those being supported at home, to prevent in-patient stays
- Embedding reablement into all our community teams and ensuring routine and swift homecare review processes are in place
- Successful bed modelling exercises conducted throughout Argyll and Bute which have realised more efficient models of care.

Where we need to do more…

- Continue to expand our use of technology such as telecare, health and home monitoring systems, and health assistance equipment
- Support our communities to develop activities using of income from Self Directed Support
- Work with communities to develop local provision of care at home
- Develop our prevention services including support for anticipatory care, identifying local networks of support, and facilitating carer support
- Work with GPs and other services to co-ordinate care and minimise unexpected problems or admissions
- Work with partners in the voluntary and housing sector and with our communities to develop a range of suitable accommodation options

Section 3. National Health and Wellbeing Indicators Performance

In this section we aim to demonstrate our performance against each of the National Health and Wellbeing Indicators over the last year.

3.1 National Health and Wellbeing indicator 1

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

National Health and Wellbeing Indicator 1 aligns directly to Argyll and Bute HSCP Strategic Plan area of focus:

Within Argyll & Bute we are committed to supporting individuals to look after their own health and wellbeing in their communities. We aim to support individuals to prevent illness and focus on wellbeing and health improvement and have identified **14** targets by which we measure our performance in relation to National Health and Wellbeing Outcome 1.

These are listed in **Appendix 1** and this year we have achieved target in **6** of the **14** identified indicators.

This chapter described the work we have done over the last year, and areas where we recognise that more work is required in order to achieve our targets.

3.1.1 Falls Prevention and reducing hospital admissions

Over the last year we have been involved in a wide range of initiatives aimed at improving our performance in relation to falls reduction and achieving the national target for reduction of admission to hospital.

3.1.2 Falls in the Community

We have developed a local action plan aligned to the national falls framework. Each locality in Argyll and Bute (A&B) has a falls action plan which is regularly reviewed by the locality and A&B Falls Lead Officer. Closer links are also being established with our Technology Enabled Care team (TEC), Scottish Ambulance Services (SAS) and NHS 24 enabling us to understand local data in relation to falls. Examples of this include:

- **NHS Highland**
  We are working with NHS Highland in relation to the revision of their Policy for Prevention of Falls.

- **Integrated Response and Support Technology (FIRST) project**
  We are working with University of Strathclyde, NHS24 and Scottish Ambulance Service (SAS) in relation to the Falls Integrated Response and Support Technology (FIRST) project, which is funded by the Scottish Government's Technology Enabled Care (TEC) Programme.

- **Falls prevention with National Education Scotland (NES)**
  We are working with National Education Scotland in 2019 to develop a short film for health and social care staff to improve awareness and to encourage staff to discuss the benefits of exercise to prevent falls. This links directly to community exercise classes in each area and staff aim to encourage increased referrals to community-based programmes.

- **Community exercise classes with Live Argyll**
  Programmes are currently delivered by 'Live Argyll' and other providers who have trained instructors. They can deliver evidence-based exercise programmes to prevent falls, working closely with NHS colleagues. There were over 7,000 attendances at these classes across Argyll and Bute last year.

3.1.3 Inpatient Falls

Older hospital patients are more likely to fall, and work has been continuing to reduce these. The Scottish Patient Safety Programme set a target of a 25% reduction, and we have achieved this.

Hospital Campaign - 'Get Up, Get Dressed, Get Moving' The 'Get Up, Get Dressed, Get Moving' campaign builds on the good work undertaken in our hospitals so that people who need to go in to our hospitals, and their families, are aware that we encourage people to bring in their day clothes and foot wear, to get out of bed, to get dressed and to move around the ward as much as possible. Even short periods of being inactive lead to muscle loss, increased risk of falls, increased confusion, reduced independence, delays in getting home and increased risk of needing help when leaving hospital. The key message of the campaign is to 'Get

Up, Get Dressed, Get Moving'. If we increase physical activity we can enhance recovery and help people to get back to their home/homely setting sooner to live as independently as possible.

3.1.4 Alcohol and Drug Services

The Argyll & Bute Alcohol and Drug Partnership (ADP) have oversight of the delivery of the drug and alcohol treatment waiting times target and the Alcohol Brief Intervention target.

The recovery support services (Argyll & Bute Addiction Team and Addaction) continue to meet the current target of 90% of people who need help with their drug or alcohol problem will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

The Partnership did not meet the delivery target for Alcohol Brief Interventions (ABI) and have put in place an improvement plan involving a range of partners for the next financial year. Some of our planned actions include:

- Identification of staff with capacity to deliver ABI in short term
- Drink Wise Age Well (Addaction) to deliver ABI and alcohol awareness raising programmes in Argyll & Bute
- Support the embedding of ABI across all HSCP staff groups and work to incorporate ABI screening within the CareFirst information system

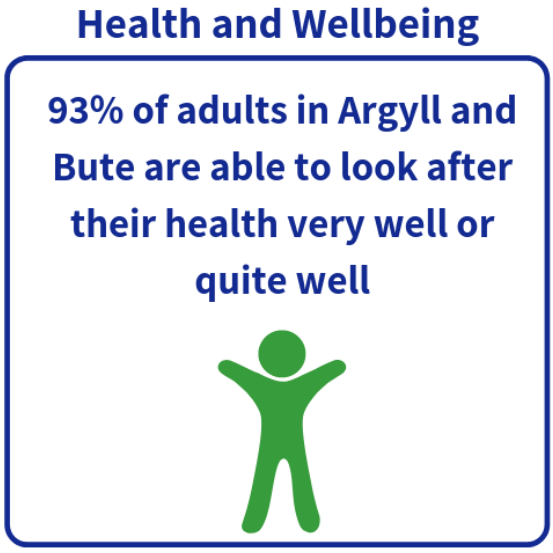
3.1.5 National Health and Wellbeing Outcome Additional Achievements in 2018/19:

Some additional highlights of the Partnership supporting communities to look after their own health and wellbeing across Argyll and Bute this year include:

- **Self-management classes - Chronic Obstructive Pulmonary Disease (COPD)**
  Establishment of a series of 6-week classes to educate and support people with Chronic Obstructive Pulmonary Disease (COPD). The classes developed by our COPD nurse and physiotherapy team encourage people to manage their condition and prevent unnecessary hospital admission. Classes are held in various areas of the Partnership to ensure fair and equitable access for people.
- **Self-management classes - Diabetes**
  Establishment of education and awareness sessions for people with diabetes. The sessions, developed by Dietician and Specialist Diabetic Nurses, are delivered across the Partnership area.
- **Advanced Nurse Practitioners**
  Introduction of 3 Advanced Nurse Practitioners (ANP) based in a local GP Practice in Helensburgh. The nurses work across five local GP Practices to prevent unnecessary hospital admissions and ensure alternative care pathways are in place for people.
- **'First Contact Practitioner'**
  As part of the new national GP contract, we have developed a new 'First Contact Practitioner' model which is being delivered in partnership with GP surgeries. First appointments are issued at local GP surgeries with Specialist Physiotherapists for

people reporting musculoskeletal problems and it is anticipated this will reduce treatment times for people ensuring they are seen, given self-management advice or referred onto appropriate services timeously.

- **'Food First Approach'**
  'Food First Approach' is an approach to treating poor dietary intake and unintentional weight loss using every-day nourishing foods and drinks. Over the last year, our Dietetics Team have worked hard to support our communities and their focus on this has resulted in a reduction in use of Oral Nutritional Supplements and won the Advancing Healthcare Award 2019.
- **Delivering mental health interventions in partnership within our local communities**
  We have initiated a project aimed at wellbeing and prevention delivering mental health interventions within local GP surgeries. The interventions will be delivered jointly by nurses, occupational therapists and primary mental health workers.



Community Practice Highlight - Strachur Hub Exercise Classes and falls prevention

The Strachur Hub was set up in March 2016 and is run in association with the GP practice's Patient Participation Group. A range of opportunities for participating in evidence-based strength and balance exercise programmes are available within the hub and are delivered by two trained instructors.

An independent assessment conducted at the Strachur Hub in 2018 found that by providing a falls prevention programme through the new exercise, strength and balance improvement programmes, they have achieved remarkable results. In a local study, the number of falls reduced by more than 90 percent.

Supported by its management committee and dedicated volunteers in partnerships with others like Interloch Transport, the Strachur Hub is held every Thursday from 10:30am to 1:30pm. Participants of the groups average 81 years and travel from a wide geographical area within Argyll and Bute. An average of 37 people attend the hub each Thursday.

The Hub also runs a wide variety of courses including: Diabetes management, chronic pain management, conversational French and German classes working with 'Takeaway Creative', defibrillator training and CPR with the Scottish Ambulance Service, first aid, country dancing and contributed choir for the Lauder Memorial Concert.

3.2 National Health and Wellbeing indicator 2

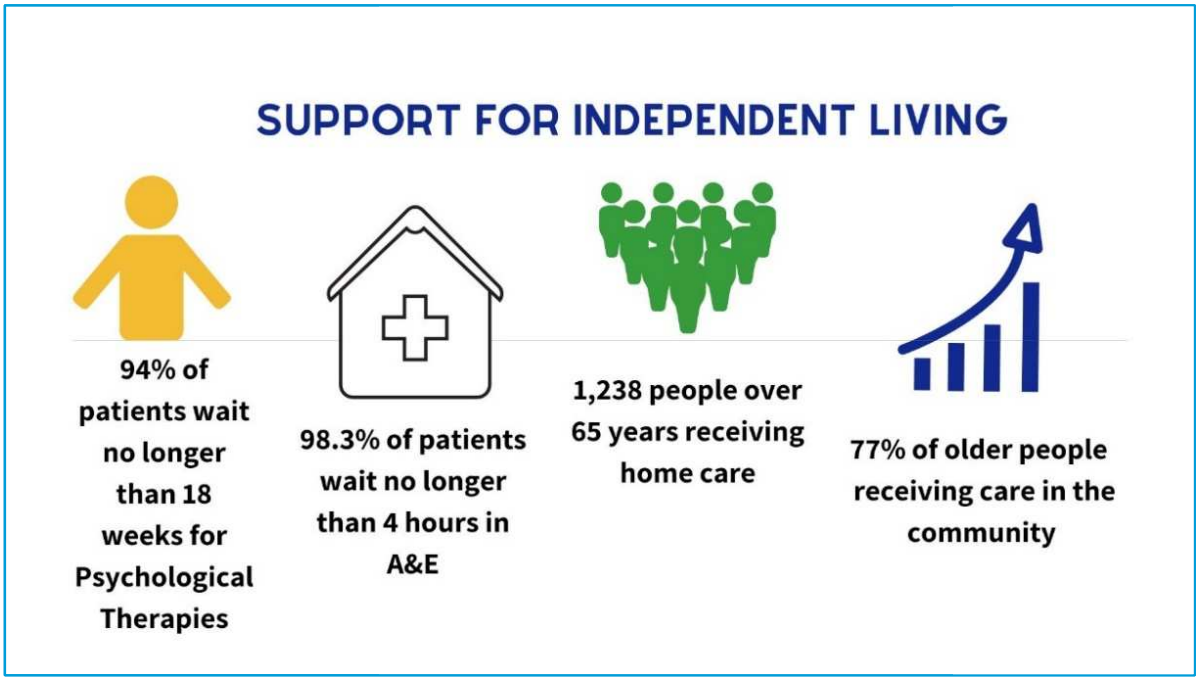
People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

National Health and Wellbeing Indicator 2 aligns directly to the Argyll and Bute HSCP Strategic Plan area of focus:

Our Community teams work across disciplines to ensure that people with intensive needs are cared for within their homes, and that chronic conditions are managed within the community where possible. Over the last year we have worked hard to further develop our community care teams to ensure that reablement is at the centre of our work. This has shown to be effective in reducing the need for long term care packages and in ensuring that essential home care services are matched to needs.

We have identified **17** targets by which we measure our performance in relation to National Health and Wellbeing Outcome 2. These are listed in **Appendix 1** and this year we have achieved the target in **14** of the **17** identified indicators.

This chapter describes the work we have done over the last year, and areas where we recognise that more work is still required in order to achieve our targets.



3.2.1 Community Mental Health Review 2018/19

This year we completed a review of our Adult Community Mental Health Service which highlighted many strengths in our current service provision, but also identified areas for improvement and development towards a future model. The recommendations from the review aim to provide care with an emphasis on prevention and wellbeing, on providing support for people in crisis and distress and enabling and encouraging recovery and wellness.

Our Mental Health and Dementia steering group continues to drive a redesign for future service provision and we continue to work with NHS Highland to test and implement the 'From Observation to Intervention' framework: (December 2018) launched by HealthCare Improvement Scotland and The Scottish Patient Safety Programme (Mental Health).

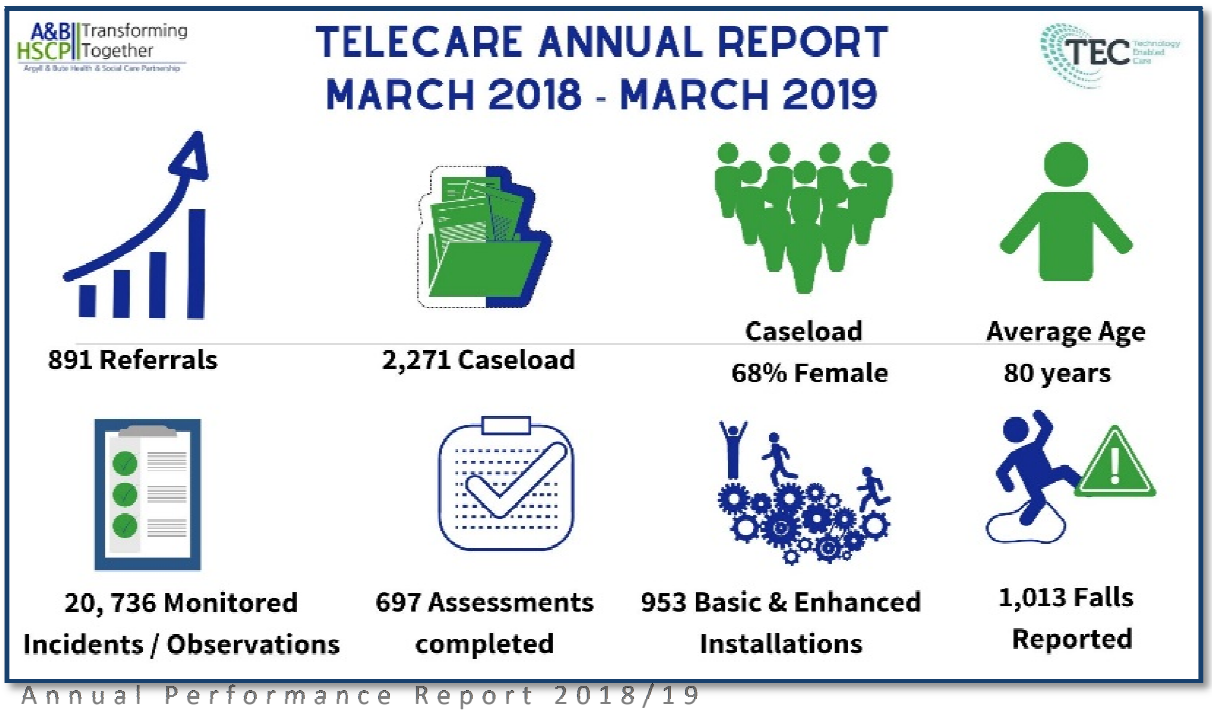
3.2.2 Argyll & Bute Care Homes & Housing Project

A review of care home provision is underway across Argyll and Bute, aimed at developing care home provision in the future. A specialised simulation modelling tool developed by Information Services Division (ISD) has been used to identify seven potential scenarios for future care home provision. The simulation model allows care home and housing groups to understand the change in potential demand for care home places for older people. It has created seven potential scenarios on the basis of projected changes in population within our area. Localities are using the results to inform local redesign of service provision.

3.2.3 Technology Enabled Care in Argyll and Bute

Over the last year we have strived to develop our Technology Enabled Care service. Our achievements include:

- **Telecare**
  We have continued to develop our telecare service and by the end of 2018/19 we were supporting 2,271 individuals across the partnership area. A full breakdown of telecare activity over the last financial year is shown in diagram below. Telecare is now centrally



managed and virtual working processes have been developed. This has enabled cross cover across all localities and work is almost complete in bringing the island telecare provision into the team work load which will ensure continuity of the service and for the island data to be accurately recorded.

- **Switching from an Analogue to Digital platform**

  We are working with Scottish Government towards switching current provision of Telecare from an analogue to digital platform. We have developed an implementation plan this year in partnership with the Scottish Government and continue to make steady progress. There are issues regarding unspent funds allocated by Scottish Government and matched by Argyll and Bute HSCP. No clear solution is available at present until the digital platform is ready so that the correct solution can be identified.

- **TEC Housing Charter**

  The Technology Enabled Care (TEC) in Housing Charter was developed as part of the TEC Ready Programme funded by the Scottish Government's TEC Programme and hosted by the Scottish Federation of Housing Associations (SFHA). We have committed to the 7 pledges required of the charter and this will provide a vital link to housing, and help to promote partnership working in addressing the exciting new challenges we face to ensure a successful transfer from an analogue to digital solution.

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- **Psychological Therapies: 'Beating the Blues'**

  The 'Beating the Blues' computerised Cognitive Behavioural Therapy (CBT) programme has been introduced over the last year. Following the appointment of a permanent coordinator, we have experienced a rise in the number of referrals of over 45%.

- **'Near Me' Clinics**

  NHS 'Near Me' is the brand developed by NHS Highland to support the development of video consulting clinics using the Attend Anywhere platform. The aim of 'Near Me' is to:

- Provide remote access to specialist services in Argyll and Bute improving access to services and prevent patient travel and unnecessary attendance at follow up clinics
- Reduce the time lost by NHSGG&C consultants and clinicians travelling to deliver clinics in Argyll and Bute thereby enhancing productivity
- Redesign services to enhance sustainability of specialist clinics e.g. dermatology, respiratory services
- Better manage demand and reduce waiting times for clinics in Argyll and Bute
- Increase productivity, save money and reduce duplication of work

The use of 'Near Me' is growing across the Partnership area. Rooms are being upgraded to the appropriate 'Near Me' specification. Clinics in Obstetrics, Paediatrics, CBT, Oncology, and Orthopaedics have been established and are now up and running. The team is currently working on developing Respiratory and Sleep studies and developing Dermatology clinics using the 'Near Me' technology.

- **Psychological Therapies using Near Me**
  We have started a new project in collaboration with Primary Mental Health Care Workers from Mid Argyll Community Mental Health Service. This supports the delivery of psychological therapies to Islay residents using digital technology. Established within the Islay Hospital, it has increased appointments/frequency of delivery and potential for greater efficiency while reducing travel for staff and service users.

- **Wellbeing Monitors/ Activity Monitoring systems ('Just Checking')**
  These have now been rolled out across all localities on a trial basis for 18 months funded by the Scottish Government TEC Program. They have been shown to greatly support long term independence and quality of life, save hours in home care provision, and ensure enhanced reablement. However the uptake of the 'Just Checking' system has been slow across Argyll and Bute and the potential of this project has not yet been maximised.

Case Study – Wellbeing Monitors (Just Checking)

Wellbeing Monitors (Just Checking) are wireless movement sensors that are placed in homes and used to detect movement around the property. They give an insight into the daily activities of individuals in their homes by recording a sequences of motion around the property. They help describe a persons daily routine. Sensors were placed within an elderly woman's home to determine her pattern of activity. It was quickly recognised that the individual was leaving the property at various times of day and night without the knowledge of her family. This contributed and confirmed to her family that a decision for 24 hour care was necessary.

3.2.4 National Health and Wellbeing Outcome 2 - Additional Achievements in 2018/19:

- **Palliative care at home**
  We have been working with people requiring palliative care to identify their needs and to support them to remain at home until end of life, if they wish.
- **Housing and Health Joint working with Occupational Therapists**
  This is a joint initiative with Council Housing Services and local Registered Social Landlords to provide training about housing options, to improve links between sectors particularly around people with complex housing needs and to support timeous appropriate allocation of housing for people with high level of need. The role also supports the planning of new housing developments for people with special needs.

- **Delivering mental health interventions in partnership within our local communities**
  An initiation of a project aimed at mental health wellbeing by delivering one stop shop interventions within local GP surgeries.
- **Jean's Bothy in Helensburgh**
  Ongoing provision of help and support for people with mental health issues in Helensburgh.
- **New Urgent Care Practitioner Posts**
  Development of Urgent Care Practitioner roles for each locality. These posts are now being advertised and will provide urgent care from 12 – 8pm, 7 days per week

Practice Highlight: Home Care Procurement Officer Pilot (Cowal and Bute)

The Home Care Procurement Officer (HCPO) pilot aims to put HCPO at the heart of service centres enabling them to be available to jointly plan home care services for those who need them. The pilot scheme has introduced 3 new Home Care Procurement Officers who aim to review all care packages within 6 weeks.

These officers now attend hospital discharge meetings, and virtual ward meetings, daily. This work has significantly improved partnership working with health colleagues, reduced duplication in health and social care systems/pathways and resulted in a very much improved service. The work of these professionals within the 'Virtual Ward' has resulted in smooth and timeous transitions for those who require an enabling home care service following a period of reablement. This vital work also prevents unnecessary admissions to care homes and hospitals, by being responsive to peoples and having home care services available when required.

The service is much more people focused, ensuring they receive the right service by the right person at the right time. Our targets for reviews are on track and we have not experienced any waiting times for our service for some time now.

3.3 National Health and Wellbeing Indicator 3

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

National Health and Wellbeing Indicator 3 aligns directly to the Argyll and Bute area of focus:

Within Argyll & Bute Partnership it is important to us that our citizens have a positive experience when using our services. We endeavour to ensure we enable them to give feedback about their experiences of health and social care services in a range of ways. This feedback supports us to improve and develop services in line with the needs of our local communities. We have identified **6** targets by which we measure our performance in relation to **National Health and Wellbeing Outcome 3.**

These are listed in **Appendix 1** and this year we have achieved target in **4** of the **6** identified indicators. This chapter described the work we have done over the last year and areas where we recognise that more work is required in order to achieve our targets.

3.3.1 Argyll and Bute Engagement Framework

Argyll and Bute Health and Social Care Partnership (HSCP) recognises that effective engagement is essential to the delivery of health and social care services and fundamental in supporting the HSCP to achieve its vision, ambitions and deliver on its key strategic objectives.

In 2018/19 we developed a new Engagement Framework. The framework sets out the intentions of the HSCP to continue to work with people in Argyll & Bute who have an interest in health and social care. It also provides a comprehensive overview of how engagement will be approached. It describes several complimentary documents and processes that support the delivery and monitoring of

engagement activity that can be used by HSCP staff, partners, communities and wider stakeholders alike.

We have also developed an Engagement Leaflet which describes our strategic engagement structures (shown below) and how individuals can become involved in health and social care services. It also describes the various feedback mechanisms by which our communities can contact us and share their health and social care experiences.

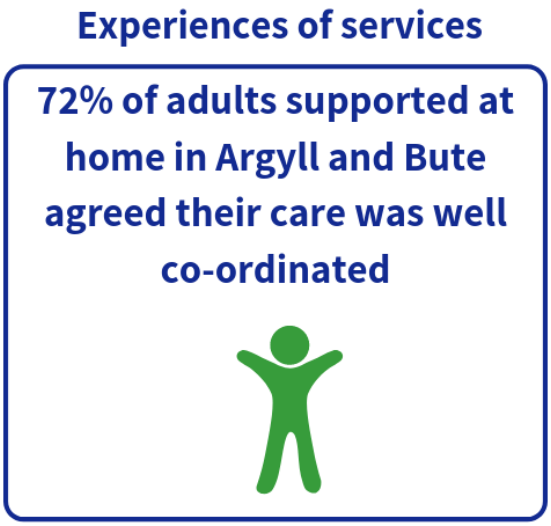
A copy of our Engagement Framework is available on: www.bit.ly/ABEngFram

A copy of our Engagement Leaflet is available on: www.bit.ly/ABEngLeaflet

3.3.2 Experiencing services within Argyll & Bute

We aim to incorporate patient experience and feedback in the operation of our services, and when planning and developing new services. Over the past year, we have been involved in several patient experience exercises including:

- **Experience within Accident and Emergency**
  A qualitative review of the patient experience for those suffering mental health crises when attending Accident and Emergency aimed at improving the patient pathway. This review was supported by Acumen - a network that enables mental health service users and carers to participate as equal partners in the development of services and the promotion of well-being and recovery.
- **Care Home Resident Experience**
  Quarterly meetings are now established across all localities where managers of care homes are invited individually to meet with a wide range of senior personnel covering Adult Protection, Local Area management, Commissioning, Health, Independent Sector, Social Care and a representative from the Care Inspectorate to discuss and receive feedback on the quality of care within their establishments.
- **Improving experience of services in Cowal**
  A focus group has been established in Cowal to gather information from a range of professionals including GPs, clinical services, nursing and social work staff about how services can change to improve patient experience, identify possible impact of change on community services and develop ideas for future service delivery from the local hospital.



Practice Highlight - Community Mental Health Review Experience Workshops

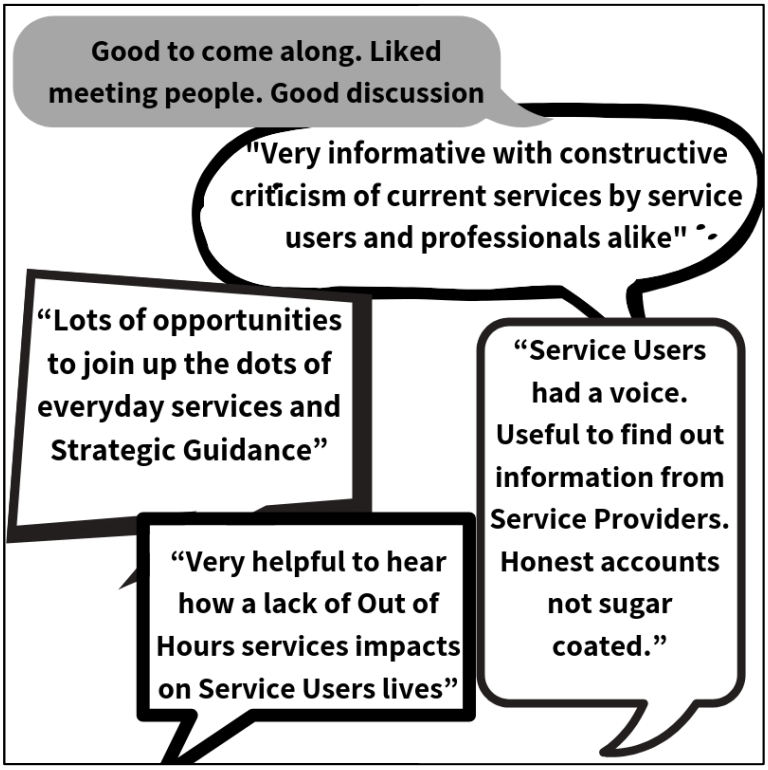
Seven lived experience workshops were held in communities across Argyll & Bute in 2018/19 aimed at gathering service user perspectives of community mental health services across Argyll and Bute.

The joint workshop with members of the community, Acumen, HSCP and Scottish Health Council was an opportunity to hear the voices of people with lived experience of Community Mental Health Services in Argyll & Bute. Between 7 and 18 individuals attended each workshop.

The workshops delivered by Acumen and Scottish Health Council and were well attended.

These workshops proved to be very popular with service users and staff from the HSCP's mental health services. It was identified that the workshops allowed for honest discussions between staff and service users and provided an opportunity for identifying common solutions to existing issues.

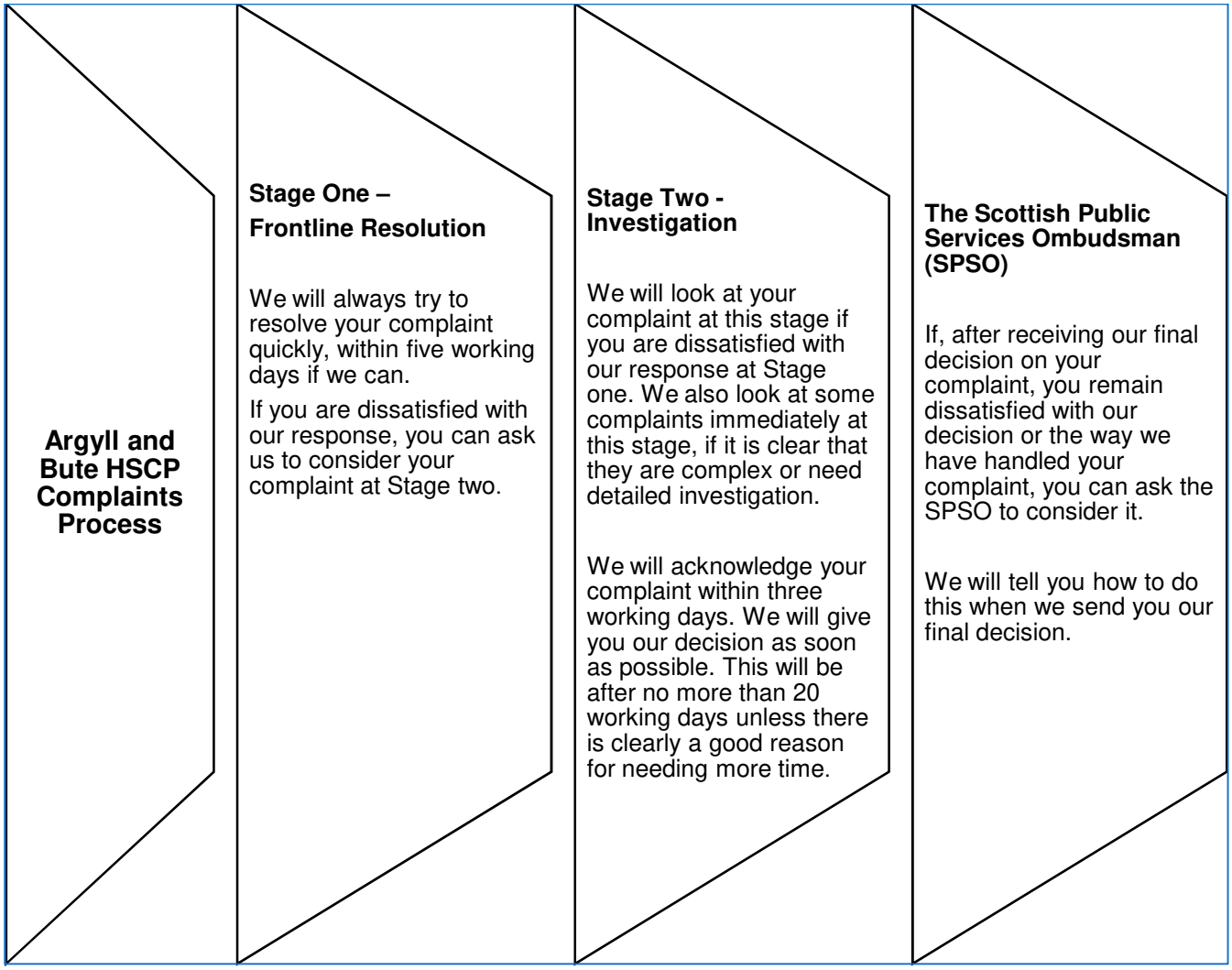
Feedback received from participants of the workshops is shown in picture to the right.



3.3.3 Making a complaint in Argyll and Bute

Understanding the experiences of the individuals we support is important to us. Complaints and feedback help us to identify areas where we need to improve. Aligned to national requirements, there is a single point of contact for all complaints made to the Argyll and Bute HSCP.

We have a two-stage complaints procedure (described overleaf) and we will always try to deal with your complaint quickly. Each complaint is reviewed in terms of content and complexity and handled in line with Argyll and Bute Health and Social Care Partnership and Integration Joint Board Complaints Handling Procedure. (Available on: https://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Pages/CommentonOurServices.aspx)



The table below presents the number of complaints relating to health and social care and our performance in meeting national targets during 2018/19.

Argyll & Bute HSCP Complaints; 2018/19		
	Health	**Social Care**
Stage 1 complaints	Total	Total
Number Received	34	7
Number Withdrawn	1	0
Number Investigated	33	7
Number Closed with 5 Working Days	22	5
% Closed with 5 working Days	**67%**	**71%**
Stage 2 complaints		
Number Received	81	71
Number Withdrawn	9	7
Number Investigated	72	63
Number Closed with 20 Working Days	7	14
% Closed with 20 Working Days	**10%**	**22%**

Where we need to do more…

We accept that the performance particularly in relation to response times for Stage 2 complaints needs to improve. Plans to achieve improved response times and more detailed reporting are being developed and will be a focus during 2019/20.

3.4 National Health and Wellbeing Indicator 4

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

National Health and Wellbeing Indicator 4 aligns directly to all our areas of focus.

Within Argyll & Bute Partnership we recognise the importance of supporting people to maintain or improve their quality of life. We have identified **9** targets by which we measure our performance in relation to **National Health and Wellbeing Outcome 4.**

These are listed in **Appendix 1** and this year we have achieved targets in **4** of the **9** identified indicators.

This chapter describes the work we have done over the last year and areas where we recognise that more work is still required.

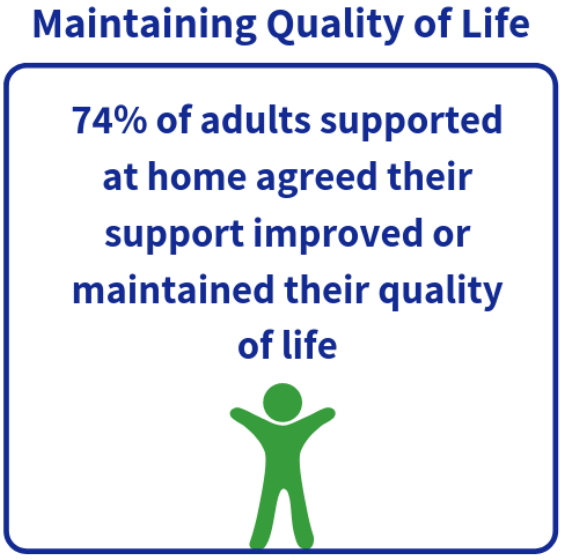
Several of our targets relate to waiting times performance and achievement of the 12 week waiting times targets. We recognise the importance of providing quick access to specialist services when needed to support quality of life and we need to improve services in this area.

This year we have been working with NHS Greater Glasgow and Clyde (NHSGGC) to redesign services and to agree a plan to provide more services locally by recruiting specialist nursing, physiotherapy and other staff. This will improve access to specialist services like Ear Nose and Throat (ENT), Orthopaedics, Dermatology, Chronic Pain and many more.

We are expecting our local waiting times to reduce in 2019/20 and 2020/21. This is part of a 3-year plan to bring waiting times down and achieve the target set by Scottish Government.

Within our Children's and Adolescent Mental Health service (CAMHS), the waiting time for referral to treatment has reduced and waiting times targets are being met. We now have additional staff and services in Argyll and Bute. This will ensure our vulnerable young people are promptly assessed and provided with the most appropriate evidenced based treatment services.

The external (outside Argyll and Bute) placement of children has been kept to a minimum by effective reviews and multi-agency working. The Children's' Resource Panel and the Joint Service Management Group have a strengthened remit and focus. The three residential houses for children and young people (Dunclutha, Shellach View and East King Street) have worked at full capacity throughout the year. Core and cluster housing method is currently being developed to increase this capacity so that we can continue to provide support to children sustaining family, friend links and relationships.



This has been a very successful year for our Through and Aftercare Team and this was noted in the Joint Inspection Report that stated:

"Care experienced young people told us that the support they had received, particularly from staff working in the through care and aftercare team, had helped them to achieve positive outcomes in relation to housing, employment and education."

Also, on the 11th March 2019, two of these young adults were invited to an audience with the First Minister, Nicola Sturgeon. This invitation came about as a result of research being carried out by The Scottish Through and After Care Forum (STAF) entitled, "Relationships Matter', to which a group of our young people from Argyll and Bute had contributed.

The Throughcare and Aftercare team continues to work closely with The Housing Consortium with 100% of care leavers are being offered appropriate housing. In addition all care experienced young people applying for a college course are guaranteed an interview.

Where we recognise we need to do more…

- To further develop palliative care provision within all our localities
- To further develop provision for people with life limiting conditions e.g. Motor Neurone Disease, Multiple Sclerosis, Parkinson's disease and others
- To continue to strive for improvement and excellence even though all of our Children's Houses are presently graded 5 (Very Good)
- To continue to improve our support for Adoption and Fostering services (graded 5 (with one 4)) with a focus on our support to adopters and our engagement with our children and young people. The inspection reports for children in 2018/19 are available in Appendix 3b
- To continue to strive to improve our performance in relation to the percentage of children and young people who had a permanency decision made, building on our considerable success in completing adoptions and permanent placements

3.5 National Health and Wellbeing Indicator 5

Health and social care services contribute to reducing health inequalities

National Health and Wellbeing Indicator 5 aligns directly to the Argyll and Bute HSCP Strategic Plan area of focus:

Within Argyll & Bute Partnership we recognise the importance of supporting our service users to maintain or improve their quality of life. We have identified **2** indicators by which we measure our performance in relation to **National Health and Wellbeing Outcome 5.** These are listed in **Appendix 1** and this year **we have marginally missed both our targets in this area.**

This chapter describes the work we have done over the last year and areas where we recognise work is still required in order to achieve our targets.

3.5.1 Treatment time waiting times

The challenge of ensuring waiting times targets are met in the HSCP has been recognised nationally and the Scottish Government has provided additional funding, over 3 years, for the NHS in Scotland. Our local treatment time targets were just over the standard this year.

Where we have identified that we need to do more:

- Focus on people with the longest waits over 12 weeks.

3.5.2 Health Improvement

We recognise the importance of preventing health and social care problems from arising. We invest in a wide-ranging programme to support people to lead active and healthy lives in Argyll and Bute. Our comprehensive Health and Wellbeing Annual Report is published here – http://healthyargyllandbute.co.uk/category/news/

Some Health and Wellbeing highlights from 2018 – 19 include:

- Continuing to raise awareness of the impact of childhood trauma on health and wellbeing outcomes, this programme included:
    - 230 staff and partners attending events in Argyll and Bute
    - Publication of the 2018 NHS Highland Public Health Annual Report on Adverse Childhood Experiences, Resilience and Trauma Informed Care
    - Multi-agency Steering Group to plan future activity
- Engaging with staff, partners and community members to investigate how people with long term conditions can be supported to live full and able lives in their community – more than 450 people in Argyll and Bute have informed this work

- Eight Health and Wellbeing Networks held 32 meetings to support community led health improvement activity in our local areas. These meetings are attended by HSCP staff, partners and community members and supported 98 groups to deliver initiatives that promoted physical activity and long-term health condition management.

Additional outputs this year include:

- 30 clients supported with HIV and LGBT issues
- 160 new clients accessed free condoms by post
- 851 secondary third year pupils attended drama workshops covering sexual health, alcohol and wellbeing themes
- 1,070 primary 7 pupils attended a 'Smoke Free' drama
- 35 people trained in Scotland's Mental Health First Aid
- 303 walkers participated in three walking groups
- 13 self-management courses delivered
- 15,638 sexual health materials issued

3.5.3 Health Inequalities:

We continue to promote equality of opportunity, access and delivery for the people of Argyll and Bute in the following ways:

- Legal duties under the Equalities Act in Scotland are fulfilled with a published Equalities Outcomes Framework. Specific activity under this banner in 2018-19 included the development of a British Sign Language action plan (for both the council and NHS) and a joint Child Poverty Strategy for Argyll and Bute
- Conducted a review of Equality Impact Assessments and ratified a joint approach in March 2019
- We participated in joint equalities activity in Argyll and Bute via the Argyll and Bute Community Planning Partnership's Equalities Steering Group. Some outcomes from this group included supporting Argyll and Bute's LGBT+ Pride events and the provision of free sanitary protection to eliminate period poverty

3.6 National Health and Wellbeing Indicator 6

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

National Health and Wellbeing Indicator 6 aligns directly to the Argyll and Bute HSCP Strategic Plan area of focus:

Within Argyll and Bute HSCP, 17% of adults are reported as being providers of unpaid care.

We are committed to supporting carers of all ages across Argyll and Bute in their caring role especially by recognising the importance of their own wellbeing. We currently still have **1** indicator by which we measure our performance in relation to **National Health and Wellbeing Outcome 6.** This is listed in **Appendix 1** and this year we have marginally missed this target.

Below we describe our support to carers over the last year and areas where we recognise that more work is required in order to achieve our target.

3.6.1 Carers Strategy

We have worked hard over the past three years to develop our new Argyll and Bute Carers Strategy and Implementation Plan 2018 - 2023, available on: http://bit.ly/ABCarersStrategy and our Short Breaks Statement, available on: www.bit.ly/CarersShortBreak.

The Strategy identifies commitments and actions designed to help us achieve our desired outcomes, which are:

- All Carers are identified at the earliest opportunity and offered support to assist them in their caring role
- Young Carers are supported with their caring roles and enabled to be children and young people first
- Mental and physical health of carers is promoted by ensuring that they can access or be signposted to appropriate advice, support and services to enable them to enjoy a life outside their caring role
- Carers have access to information and advice about their rights and entitlements to ensure they are free from disadvantage or discrimination in relation to their caring role
- People who provide care are supported to look after their own health and wellbeing which includes reducing any negative impact of their caring role on their own health and wellbeing

We created a multi-agency Carers Act Planning Group and we also work closely with the 4 Carers Centres in a 'Carers Partnership'. These have been hugely successful and responsible

for the development of Carer Assessment Templates and Carer Pathways designed to ensure that carers within Argyll and Bute receive appropriate and timely support.

Case Study: Support to Carers

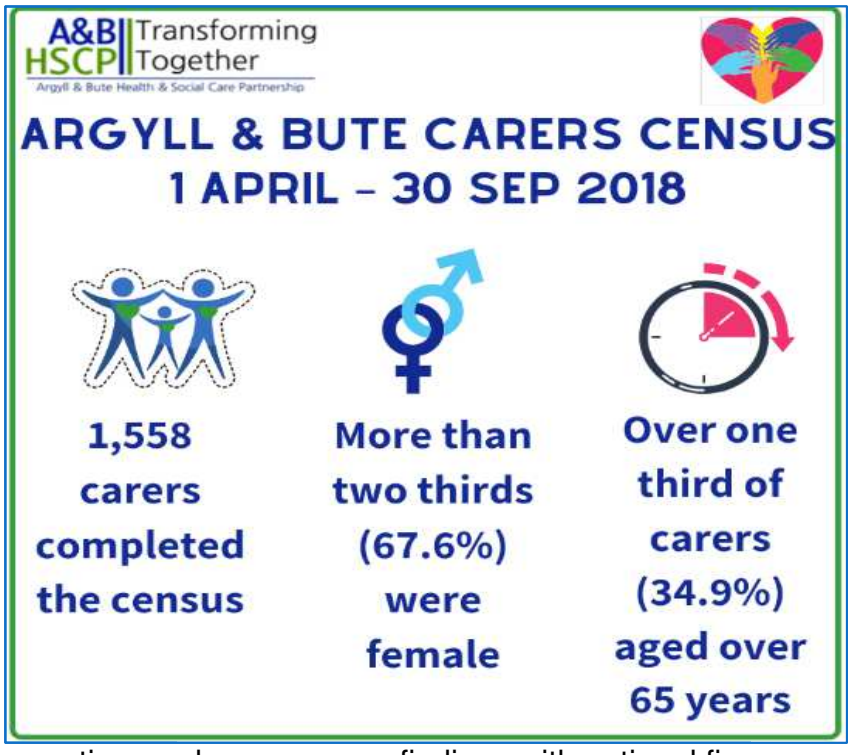
Elderly client living at home with her son who is her primary carer. Without his support she would require a care home placement. Son has a Learning Disability and is mother's main carer.

Following Review of the client's care, and of the carer's assessment, the son was referred to third sector organisation Crossroads for carer support and respite. This allowed him to attend a weekly walking group and to feel much more supported in his role.

The Case Manager maintained regular contact with son to assist with relieving his anxieties by discussing his mother's care provision in detail and providing reassurance.

3.6.2 Carers Census

In 2018/19 we began to collect information for the new baseline Carers Census created by Scottish Government. This reporting is still being developed fully in each of the carers services in conjunction with our Performance Team across Argyll and Bute and as such we currently have preliminary reports on carer support activity. The census is a bi-annual report so we will



gather more data over time and compare our findings with national figures.

3.6.3 Young Carers

We support young carers to complete their Young Carer Statements. This helps us to identify their needs and helps to reduce the negative impact that their caring role has on their own wellbeing. We also aim to support young carers to have normal childhood experiences.

Young carer achievements in 2018/19:

- Young Carers in Cowal and Bute developed a new twitter account - 'Crossroads Young Carers Cowal & Bute' @yccowalandbute and a new young carers website launched March 2019. Available on: http://www.cyccb.org.uk/
- In Mid Argyll, a simple information pack has been developed for young carers, parents and guardians to help them understand the process following referral, including young carers' statements. Local media have been involved too, promoting young carers and signposting individuals to local services for initial support, referrals and information
- In Kintyre and island communities such as Islay, carer support services have worked hard to link local services such as Islay and Jura Youth Action, Cyber Café, Kintyre Youth Café /Young Carers and Befrienders to help support and provide activities for young carers of primary and secondary school ages within island communities.
- North Argyll Carers have been using their Facebook page to encourage young carers to engage with consultations and encourage them to take up the offer of joining the national young carers' forums or youth parliament

All areas have worked hard to ensure young carers can attend various residential breaks throughout the year. During our day trips and residential adventures young carers are challenged to try new activities and to step outside of their comfort zones, which increases their confidence and self-esteem. These activities also develop social skills through team building challenges and outdoor activities.

Practice Highlight – Young Carers visit NHS24 Emergency Call Centre

Twelve young carers from Helensburgh Young Carers visited NHS24. This enabled them to view first-hand the emergency call process and to experience live calls.

This was positively received by individuals. One young carer highlighted, ***"I now feel much more confident about making these calls.***"

Work is continuing with Helensburgh & Lomond GP practices to explore how we can share information and 'flag up' that young carers are calling for assistance.

3.7 National Health and Wellbeing Indicator 7

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

National Health and Wellbeing Indicator 7 aligns directly to the Argyll and Bute HSCP Strategic Plan area of focus:

We have identified **6** indicators by which we measure our performance in relation to National Health and Wellbeing Outcome 7 This is listed in **Appendix 1** and this year we have achieved **2** of the **6** identified targets. This chapter describe the work we have done over the last year to support the most vulnerable individuals within our communities and keep them safe from harm.

3.7.1 Adult Support and Protection

Within Argyll and Bute, we have developed a robust Adult Support and Protection (ASP) Framework. Specifically, the Adult Support and Protection Committee, the independent chair and lead officer support and lead on an overarching strategic plan, which provides a framework for consistency in promoting and delivering the adult protection agenda across Argyll and Bute.

Key Adult Support and Protection priorities are further supported through local ASP operational groups lead by local area managers. These focus on delivery of outcomes for individuals and maintaining service standards.

3.7.2 Children Support and Protection

The HSCP actively contributes to the work of the Interagency Child Protection Committee (ICPC) to continuously improve our multi agency responded to children and young people at risk of significant harm. These services were inspected in 2019 by the Care Inspectorate who identified that processes for recognising and responding to children and young people in need of protection were well established within Argyll and Bute. The inspectors also highlighted that the wellbeing of children in need of care and protection was improving and that children and young people enjoyed positive and caring relationships with staff and carers. It was also noted that children and young people felt respected and listened to.

The target for the percentage of children on the child protection register with no change of Social Worker, has not been met. This is largely due to the turnover of staff, but we take great care ensuring continuity of support to children and the safe handover of cases.

We did not meet our target for Child Protection investigations relating to interagency planning and decision making procedures for responding to allegations or concerns about children at risk, specifically the number of Interagency Referral Tri-partite Discussions (IRTD) held within 24 hours. We are working hard to improve in this area.

In a very few instances an IRTD does not take place within 24 hours, this is often due to the lack of availability of multi-agency partners. In these cases plans are put in place to ensure the child's safety until the meeting has taken place.

We are focussed on improving our performance in relation to the number of children on the Child Protection Register with a completed Child Protection Plan. We are currently preparing an improvement plan which will be monitored by the Child Protection Committee in 2019/20.

Where we have identified that we need to do more:

- Improve the quality and consistency of our risk assessments
- Improve the systems to record and evidence and performance manage child protection plan completion
- Reduce the change in social workers to ensure continuity of service in children's services

3.8 National Health and Wellbeing Indicator 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

National Health and Wellbeing Indicator 8 aligns directly to the Argyll and Bute HSCP Strategic Plan area of focus:

We have identified **4** indicators by which we measure our performance in relation to **National Health and Wellbeing Outcome 8** This is listed in **Appendix 1** and this year we have achieved **1** of the **4** identified targets

This chapter describe the work we have done over the last year to support our staff to deliver services across the communities of Argyll and Bute.

3.8.1 Our Values & Culture

Our new HSCP Shared Values (CIRCLE) were designed following several staff and community partnership focus groups held in 2018. Each of the 6 new values has an associated set of Practices (Behaviours) which can be customised to ensure they are relevant for specific teams/services. Our Values are now part of staff appraisal conversations and are integrated into our HSCP Annual Staff Awards.

We have an agreed plan for spreading & further embedding CIRCLE, together with related work to measure our organisational culture, to strengthen integration and to create a positive workplace experience for all staff. This work will commence later in 2019 to support agreed recommendations arising from the Sturrock Review - an independent review report looking at cultural issues related to bullying and harassment in NHS Highland by John Sturrock, QC and mediator.

3.8.2 How we engage with our Staff

I Matter is a staff experience continuous improvement tool designed with staff in NHSScotland to help individuals, teams and Health Boards understand and improve staff experience. Our participation in iMatter reduced in May 2018, with a corresponding reduction in team-level action planning.

We have taken time to explore the barriers to engaging with iMatter and have evidence that those teams who action-planned saw a rise in engagement scores.

Heading into a repeat of the iMatter staff survey (May 2019) we have put effort into encouraging managers to ensure that all staff engage with the process and have a voice. We are confident this will see an increase in response rates and so more local team action plans.

3.8.3 Staff Wellbeing

Our Staff Health & Wellbeing working group has analysed recent survey data and developed a series of recommendations that will strengthen well-being and help reduce sickness absence levels across the HSCP. The recommendations are multi-faceted and will be implemented during the remainder of 2019. The quality of the staff experience, including staff wellbeing, is an important theme; external research in other health & social care organisations demonstrates the links between a high-quality staff experience and an enhanced service user experience.

3.8.4 Workforce Planning

Following the publication of our first HSCP Workforce Plan in May 2018, we are working on the next version which will include all HSCP and third/independent-sector services. We will publish this plan in October 2019 and it will be aligned with our new HSCP 3-year Strategic Plan.

We are also aligning our workforce planning approach across NHS and Argyll & Bute Council, following the new national workforce planning guidelines. We have several 'hard to fill' vacancies and so we are looking at innovative ways to attract staff to our remote & rural setting, whilst also exploring opportunities for Modern Apprentices across the HSCP.

3.8.5 Co-location & Integration

A strategic decision has been taken to adopt a 'shared services' approach for related corporate functions across the NHS and Council within Argyll & Bute. We are working to implement this for our HR services during 2019.

A parallel programme of co-location of related functions across Argyll and Bute is also underway. This will enable NHS and Council staff to work more effectively together and develop synergies. This will also strengthen our local integration approach.

3.8.6 Training our staff

A range of training programmes were completed this year by staff across the Partnership. They include:

- **Cognitive Behavioral (CBT) Therapy Diploma in partnership with University West of Scotland**
  Funded by National Education Scotland, four nurses have graduated this year with this diploma in Argyll and Bute HSCP. This is a significant development and has real benefits for people living in Argyll and Bute. We were very fortunate to obtain funding for this 2-year programme.

- **Lived Experience training for staff and volunteers**
  In-house training with staff and lived experience volunteers in relation to the Scottish government target for those presenting with first episode of psychosis.
- **E-Learning**
  LEON (Learning Electronically and On-line) is our e-learning system through which employees can access a wide range of online courses. It is available to all employees. The Argyll & Bute Council Talent Management team are working towards providing a variety of easily accessible courses which will give employees the information, knowledge and skills required to enhance their job.

Workforce Performance

- **Growing Our Own - OU BA (Hons) Social Work (Scotland)**
  Within Argyll and Bute there is difficulty recruiting social workers. For this reason a "growing our own" scheme was developed. Each year the council sponsor two applicants to undertake the degree in social work. The "growing our own" scheme is an opportunity for Argyll and Bute to support talented individuals to undertake their social work qualification and increase the number of qualified social workers across Argyll & Bute.

Where we need to do more…

- Reduce % of NHS and Social Work Sickness Absence rates
- Complete outstanding HSCP staff personal development plans

3.9 National Health and Wellbeing Indicator 9

Resources are used effectively and efficiently in the provision of health and social care services

National Health and Wellbeing Indicator 9 aligns directly to the Argyll and Bute area of focus:

We have identified **6** indicators by which we measure our performance in relation to **National Health and Wellbeing Outcome 9.** This is listed in **Appendix 1** and this year we have achieved **4** of the **6** identified targets.

This chapter describe the work we have done over the last year to support and encourage continuous improvement throughout services and directly with our staff.

3.9.1 How we Reduce Harm, Eliminate Waste and Manage Variation

The Highland Quality Approach (HQA) continues to be used as our quality and continuous improvement methodology. We are consistently trying to reduce harm, to eliminate waste and to manage variation.

3.9.2 Improvement Workshops

There have been 3 Kaizen Workshops and 1 Rapid Process Improvement Workshop (RPIW) this year. Kaizen is a Japanese word which means “change for the better” or “continuous improvement”. Workshops are held over two to three days.

RPIW is a rigorous five day Lean improvement event that aims to reduce harm, eliminate waste, and improves flow (speed of a system) through the redesign of ineffective processes. Each workshop involves frontline staff learning about quality improvement tools and then being supported to apply the tools in their own area of work to make improvements and over the following months, to monitor and measure the impact of the changes made.

The events held in Argyll and Bute during 2018/2019 included:

- Home Commissioning to Review Process RPIW held in Oban Lorn & Isles,
- Admission to Discharge Kaizen held in Islay Hospital,
- Mental Health In-Patients Kaizen
- Integrated Equipment Service Kaizen
- Improvement methodology workshop for Independent Providers held in conjunction with Care Inspectorate; included all HSCP staff
- Musculo-skeletal team Kaizen event held in Mid Argyll

3.9.3 Realising Improvement

These workshops have delivered a range of improvements for both the people receiving services and also for the staff delivering care, including:

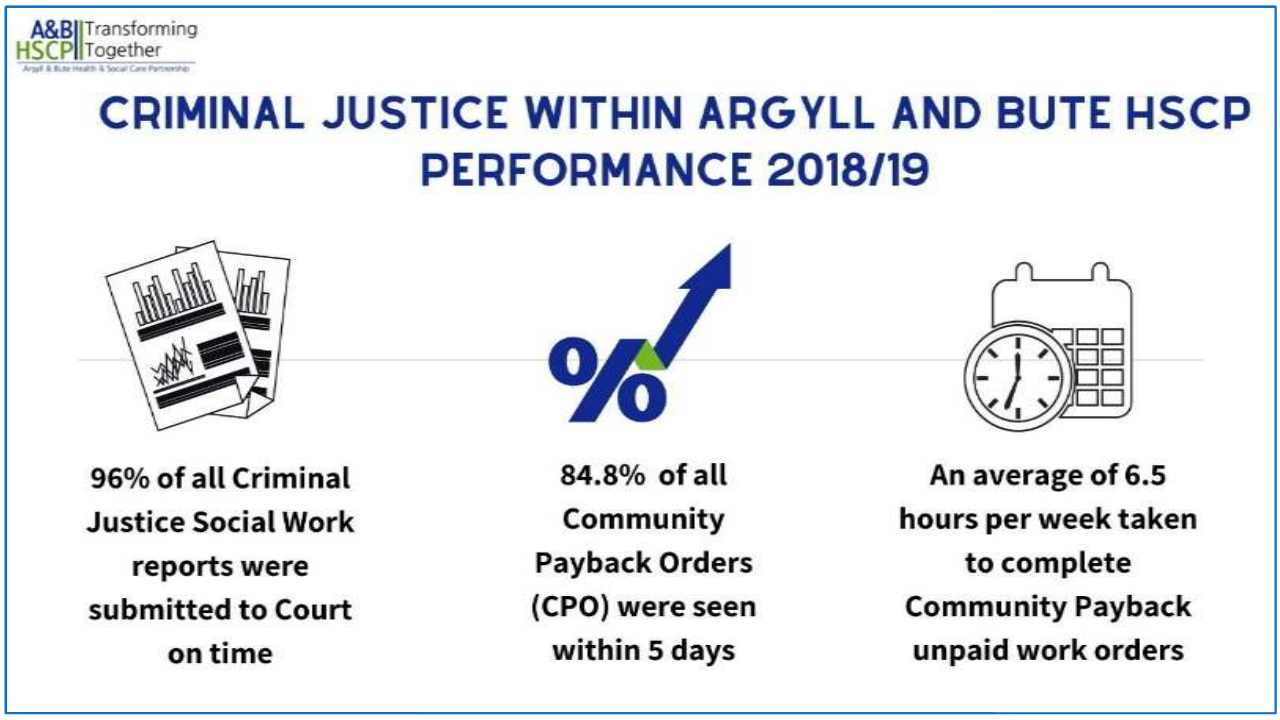
- A reduction in the time it takes for an assessment for a care at home package to be completed from 38 to 7 days, meaning a more timely response for people in need of care
- Implementing a system to gather feedback from people about their experiences, when previously none had been in place, resulting in the team having information with which they can continually improve the service.
- Reducing the number of documents and administration processes for nurses in the mental health in-patient setting, meaning nurses are spending less time on paperwork, enabling them to spend more time in direct patient care.
- In Islay Community Hospital there is an increased focus on discharge planning and improving communication. This is being achieved through the development of a hospital welcome pack for families, the use of a discharge planning checklist and a review of communication between the community and hospital teams.

Other initiatives which we have been involved in this year include:

- **Streamlining our patient and care information systems**
  Allied Health Professionals (AHP's), Community Nurses and Mental Health teams have moved onto a single IT system shared with Social Work "Care First". In the next few months we should see developments in shared information, reduced duplication and simpler processes in accessing community care patient records.

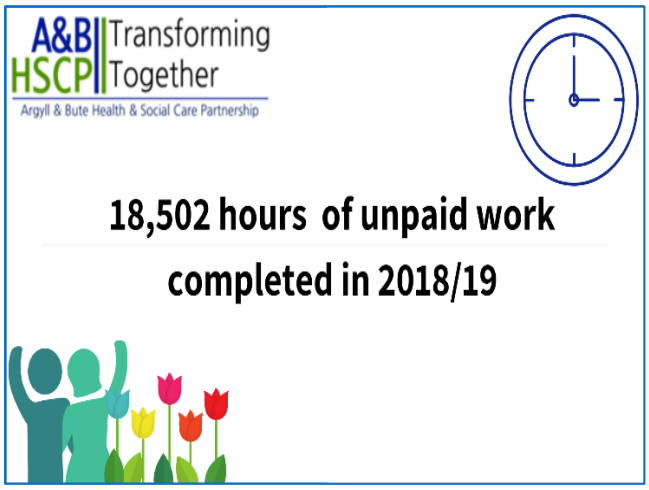
3.9.4 Criminal Justice

Over the last year there has been a significant amount of work completed by our Criminal Justice services ensuring that our statutory responsibilities and performance indicators were achieved. Our three local indicators are shown in the graphic and it is important to note that we exceeded target on all three indicators. We did not achieve our SCRA report target of 75% being submitted on time (Hearings/Looked after Children). We will take action to improve our processes and recording systems to achieve this in 2019/20.



3.9.5 Community Payback Orders

In Argyll and Bute, we seek to prioritise projects that offer the most benefit to the people in the local community. We work with local community projects to improve the area where offenders live, and aim to make the local community a more accessible, safer and attractive environment. For orders completed in the last year (2018/19) a total of **18,502** hours of unpaid work was accomplished.



Our Unpaid Work Co-ordinator assesses all requests for support from Community Payback Squads and prioritises projects that benefit most of the community. The Co-ordinator is also in regular contact with Operational Services within Argyll and Bute Council to offer help

and meets regularly with communities, local charities and councillors who share information on projects with their local Community Councils and groups.

We undertake annual consultation with service users and partners and this year, we have had a good response. From this, we have developed a programme of work to pursue within local communities in 2019/20.

Practice Highlight: Community Payback Order Unpaid Work Projects and training

There is a wide variety of unpaid work projects and activities which have been carried out this year. They include:

- Assisting Argyll and Bute Council Operational Services in gritting footpaths, cleaning railings, washing down walls and generally tidying up the community footpaths and litter picking across Argyll and Bute.

- Snow clearance - our squads routinely cleared the paths to the local hospitals, ambulance depots, fire depots, police stations, old folk's homes and any steep incline around housing estates.

- Developing a sensory garden aimed at stimulating senses and laying paths benefitting both locals and tourists in Glenfinnart Walled Garden, Ardentinny, We have also developed a plot of land within the garden and are now growing vegetables.

- Creating footpaths and play areas at Blairmore Community Trust near Dunoon. The Trust recently won a Gold award from Beautiful Scotland and they also received a trophy for winners in the Coastal Village category.

- We are helping develop waste ground at the rear of Bute Community Hospital. This project aims to create a garden for palliative care patients where they can sit out in the summer.

- Completion of the external refurbishment of Sandbank Community Village Hall.

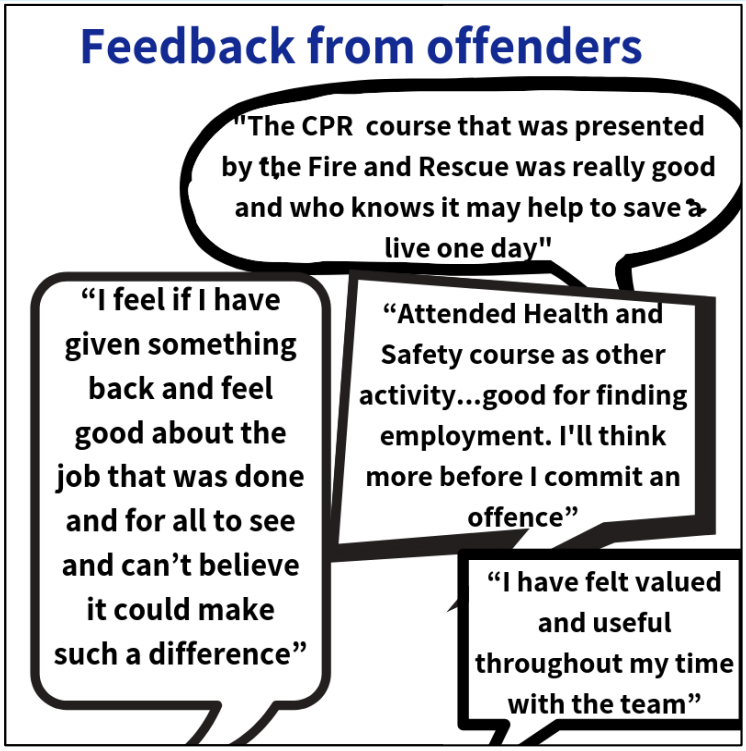
- Supporting individuals to develop health and wellbeing life skills

- Delivering cardiopulmonary resuscitation (CPR) courses with Scottish Fire and Rescue Service throughout the whole of Argyll and Bute.

Case Study: Support to Offenders

Mr B, a 57 year old man was convicted of careless driving, whilst under the influence of alcohol and also failing to provide details to the police. He was sentenced to a 1-year Community Payback Order with supervision requirement. Mr B had been in the army for a considerable part of his life, joining when he was 16 and leaving aged 43. On leaving the army, Mr B had worked as a HGV Driver until he was convicted of these offences.

Mr B found life out with the army difficult to adjust to and had for many years self- medicated with binge drinking to cope. Due to this criminal conviction Mr B also lost his HGV licence and this impacted on his capacity to earn a living.



Mr B was encouraged to view his Community Payback Order as an opportunity to invest in himself and he was encouraged to attend COMBAT STRESS - The Veterans Mental Health Charity based in Ayrshire to help him address his drinking, PTSD Symptoms and anger management issues. He was supported to attend for two separate residential courses to address his issues and these were considered to be successful in giving Mr B the skills to manage his alcohol use and conflict resolution.

Mr B also attended regular supervision appointments with his Criminal Justice Social Worker and he accepted full responsibility for his offending and the public safety issues inherent in driving offences.

As Mr B had complied fully with his Community Payback Order, had addressed all aspects of his offending behaviour, and was managing the underlying causes of this i.e. his own mental health and alcohol use and had an offer of employment through his army contacts, an application was made to the Court for an early discharge of his CPO. The Court recognised the progress that Mr B had made in his life and granted the early discharge.

Section 4: Localities - Locality Planning, Owning and Delivery

Over the last year we have continued to work with localities to plan and improve services and ensure that we work with communities. Until this year, a 'nine locality planning group model' was in operational within Argyll and Bute arranged into the following geographical groupings: Bute; Cowal; Helensburgh and Lomond; Islay and Jura; The Isles; Kintyre; Mid Argyll; Mull and Iona; and Oban and Lorn.

It was widely recognised that the groups were not operating to their potential and during the last year we have worked with our communities to re-establish these groups, ensuring they fulfil their potential of developing and implementing a locality plan which matches the needs of the community it represents.

4.1 Locality Planning Group Option Appraisal Event – October 2018

Locality planning group (LPG) members were invited to attend a half day Option Appraisal Workshop in October 2018 with a view to evaluating the current model against other models in order to influence an improved and sustainable model for the future.

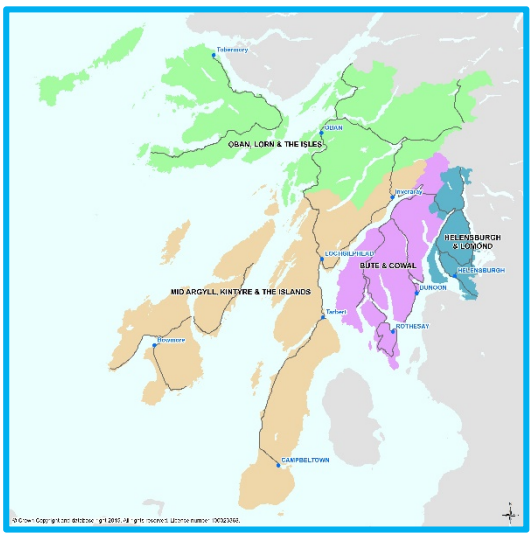
Thirty-three individuals participated in the workshop and were provided with background information pertaining to the legislative context for LPGs and the strategic planning constructs within Argyll and Bute HSCP benchmarked against other locality planning arrangements across Scotland.

Participants were supported in facilitator led groups to evaluate three options using a SWOT analysis to systematically, identify the strengths, weaknesses, opportunities and threats as they related to each of the three models.

A four-locality model was identified as the preferred model for locality planning groups in Argyll and Bute. It was considered this model provided the best opportunity to plan at scale and align with partners' organisational level. Participants highlighted that success of this model hinged on the development of effective engagement methods at a community level.

4.2 Four Locality Planning Group Model

In November 2018, the Integration Joint Board (IJB) approved a new four locality model for locality planning arrangements within Argyll and Bute HSCP. The four localities were identified as,



- Oban, Lorn and the Islands,
- Mid Argyll, Kintyre and Islay
- Cowal and Bute
- Helensburgh and Lomond

Existing locality planning groups were formally dissolved between February and March 2019. The dissolution meetings allowed the existing members to shape the format and function of the new groups considering the revised purpose, terms of

reference, nomination for membership and Induction materials for all members. The meetings also provided an opportunity for the groups to celebrate their collective achievements over the preceding two-year period.

4.3 Implementation of new model

Four new locality planning groups were developed, and representation was achieved from all required groups as directed by the legislative framework. Representative groups include - Third Sector, Families & Carers, Community Representatives, GP's, HSCP practitioners and representatives from the Independent Sector.

Additionally, within Argyll and Bute, it was deemed appropriate to include Elected Members and Community Councillors as members of the groups.

4.4 Next steps

The first locality planning meetings under the new arrangement took place in June 2019.

Based on the Argyll and Bute HSCP Strategic Plan, each locality will be supported to: -

- Create an Implementation Plan for each locality based on the HSCP strategic priorities
- Take account of the local needs, demographics and geography of each area
- Align each locality plan to local needs, focussing on delivering outcomes for individuals and localities

4.5 Achievements in each of the localities

The table below presents the achievements as described by locality planning group members over 2018/19 prior to the reestablishment of the groups.

Mid Argyll and Kintyre
▪ Positive and worthwhile contribution of the volunteers. ▪ Conversations between LPG and the Health Care Forum have been positive. ▪ Strong relationships established across the localities. ▪ Great functioning group – good communication and information which was shared and huge support.
Islay
▪ Met for 5 years and learned a lot from each other's disciplines. Members in the LPG sharing their experiences for the benefit of the communities. ▪ Development of relationships which have benefitted their communities. ▪ Lots of good practice and learning to date – need to ensure we build on the successes of the group to date and ensure this is not lost.

Cowal and Bute
▪ Experience of working with the LPG had been a positive experience although had at times been frustrating and difficult mainly around the lack of clarity of purpose, function and individual roles of the groups. ▪ Mixed experiences were conveyed from Cowal with individuals highlighting that they enjoyed being part of the group. ▪ One individual felt that being a member of the group enabled them to keep in touch with their previous role and felt this to be beneficial.
Oban Lorn and Isles
▪ Understanding the "*stakeholder vs shareholders*" relationship in the group was deemed worthwhile by the group. ▪ Communal working, agreeing purpose and direction. ▪ Recognising a real shift in the group from combative to collaborative but also understanding the reasons for combative behaviour when individuals feel so passionately about their community and have a real commitment to change for the better.
Helensburgh and Lomond
▪ The development of Jeans Bothy - a great community success to date. ▪ Joint development of Advanced Nurse Practitioner and Anticipatory Care Nurses with local GP. ▪ Working with Enable to develop funding for 2 year development worker post.

Section 5: Financial Performance and Best Value

5.1 Financial Performance

Financial management and performance is regularly reported to the IJB during the financial year, for the financial performance during the year and also the budget outlook for future years. This includes the monitoring and development of the Quality and Finance Plan which outlines the service changes required to deliver financial balance and the Strategic Plan objectives.

NHS Highland and Argyll and Bute Council delegate funding to the Integration Joint Board. The IJB then determines how to deploy these resources to achieve the objectives and outcomes in the Strategic Plan. The IJB then directs the Health Board and Council to deliver services in line with these plans.

This section summarises the main elements of our financial performance for 2018-19 and highlights the financial position and risks going forward into future years.

5.1.1 Financial Performance 2018-19:

The Integration Joint Board approved the budget for 2018-19 on 28 March 2018. At that time £7.7m of previously identified savings had still to be delivered, and there was a remaining budget gap of £5.3m. Further savings of £2.95m were identified leaving a gap of £2.39m to be addressed through service changes in year. This was reduced at the end of May to £1.6m following agreement of a reduced repayment to the Council of £100k following the overspend on Social Work in 2017-18 of £1.155m. The health related overspends for that year of £1.373m was covered by Scottish Government brokerage (in the form of funds which they do not need to pay back) given to NHS Highland.

There were significant financial challenges during the year across a range of services reflecting high levels of demand, the cost of supplementary staffing and the non-delivery of savings. Throughout the financial year there was a projected overspend position. At the end of May, an Investment Fund of £1.5m was agreed along with a savings plan for £10.6m to be monitored through the Transformation Board across 8 work streams. This was subsequently reduced to £10.2m following the decision to remove the closure of Struan Lodge from the Quality & Finance Plan.

At the end of the first quarter, the projected year end outturn was an overspend of £4.4m mainly due to a lack of confidence in delivering the agreed savings. The final outturn was an overspend of £6.681m. The main reason for the deterioration of the outturn was the requirement to make a further provision of £1.854m relating to disputed charges from NHS Greater Glasgow & Clyde. These charges remain in dispute but accounting rules require full provision to be made in the year end accounts.

NHS Highland has received brokerage from the Scottish Government that doesn't require to be repaid which covers the Health overspend of £3.554m. The overspend on Social Work does require to be repaid to Argyll and Bute Council and repayment arrangements have been put in place for both the 2017-18 overspend and the 2018-19 overspend of £3.127m.

The difficulties with delivering savings highlights the significant challenge facing the HSCP in delivering further savings in future years and the requirement to implement service change at scale and pace to ensure the ongoing financial sustainability of the partnership.

The main service areas contributing to the overall overspend position are noted below:

- Chief Officer – The variance is a combination of the unidentified savings total, slippage on identified efficiency savings and higher than expected bad debt provision charge partially offset by additional vacancy savings, slippage on the Community Services Investment Fund expenditure and the recognition that additional funding provided for superannuation costs related to auto-enrolment were not required.
- Looked After Children - Overspend arises mainly due to the high cost of meeting demand for expensive external care home placements and slippage on efficiency savings designed to reduce this cost as well as on legal costs within the Adoption service and agency staffing costs within the Care and Reviewing Officer service. These were partially offset by under spends on the foster care, supporting young people leaving care and children's houses budgets.
- Physical Disability - Overspend arises mainly due to higher than budgeted demand as well as slippage on the delivery of efficiency savings for supported living services, higher demand for residential care placements and the purchase of equipment by the Integrated Equipment Store.
- Learning Disability - Overspend arises due to a combination of higher than budgeted demand for supported living and care home services and slippage on savings developed to reduce both commitments partially offset by under spends in assessment and care management, respite and resource/day centres.
- Adult Services West and East - Savings not being achieved and several budget overspends, including; Psychiatric medical services - locums, Lorn and the Isles Hospital (LIH) Day Bed Unit - oncology drugs, Mull Medical Group - GP locums, LIH wards - agency nurses, LIH Laboratory - agency staffing and non-pay costs, GP prescribing.
- Commissioned Services – NHS GG&C - Savings not being achieved and increased charges for; mental health in-patient services, oncology drugs and other high cost services not included within the main patients services SLA.

The table overleaf summarises the overall financial performance:

Service	Actual £000	Budget £000	Variance £000	% Variance
COUNCIL SERVICES:				
Chief Officer	839	(232)	(1,071)	461.6%
Service Development	385	383	(2)	-0.5%
Looked After Children	7,506	6,859	(647)	-9.4%
Child Protection	3,218	3,285	67	2.0%
Children with a Disability	802	848	46	5.4%
Criminal Justice	(35)	100	135	135.0%
Children and Families Central Management Costs	2,421	2,415	(6)	-0.2%
Older People	29,367	29,462	95	0.3%
Physical Disability	1,880	1,316	(564)	-42.9%
Learning Disability	10,874	9,446	(1,428)	-15.1%
Mental Health	1,624	1,901	277	14.6%
Adult Services Central Management Costs	463	434	(29)	-6.7%
COUNCIL SERVICES TOTAL	**59,344**	**56,217**	**(3,127)**	**-5.6%**
HEALTH SERVICES:				
Adult Services - West	53,232	50,776	(2,456)	-4.8%
Adult Services - East	29,125	28,532	(593)	-2.1%
Children & Families Services	6,201	6,656	455	6.8%
Commissioned Services - NHS GG&C	64,370	61,391	(2,979)	-4.9%
Commissioned Services - Other	4,230	3,653	(577)	-15.8%
General Medical Services	16,723	16,674	(49)	-0.3%
Community and Salaried Dental Services	3,540	3,923	383	9.8%
Other Primary Care Services	8,806	8,806	0	0.0%
Public Health	1,714	2,018	304	15.1%
Management and Corporate Services	4,905	5,210	305	5.9%
Health Board Provided Services	2,206	2,206	0	0.0%
Depreciation	2,441	2,524	83	3.3%
Estates	5,538	5,099	(439)	-8.6%
Budget Reserves	0	2,009	2,009	100.0%
HEALTH SERVICES TOTAL	**203,031**	**199,477**	**(3,554)**	**-1.8%**
GRAND TOTAL	**262,375**	**255,694**	**(6,681)**	**-2.6%**

In summary financial balance was not achieved in 2018-19 for several reasons:

- Unidentified savings at the start of the financial year of £1.6m, for which no recurring savings were identified in-year to offset
- Delay in delivering recurring savings included in the Quality and Finance Plan
- Ongoing service pressures and budget overspends in areas which have historically been budget pressure areas, including medical agency and locum costs, GP prescribing costs, high cost care packages and demand for social care services (including supported living and care home placements)
- The full benefit of the financial recovery plan not being fully recognised in the financial outturn as service pressures and demands partly offset any benefits

During 2018-19, both the Chief Officer and Chief Financial Officer left the organisation. This resulted in reduced focus on the pursuit of additional savings to balance the budget and on

delivering the approved savings. A new Chief Officer was appointed in October 2018 and a new Chief Financial Officer was appointed in June 2019 on a fixed term secondment from the Council. The Chief Financial Officer post was covered by an interim between July 2018 and November 2018 and the Council's Head of Strategic Finance (in addition to her Council post) between December 2018 and June 2019. Enhanced budgetary control arrangements are now in place and comprehensive financial reports are now being presented to the IJB on a regular basis. Although unable to break even at the end of 2018/19, there is now greater control and transparency over the partnership's financial position.

The Scheme of Integration states that any overspend is funded from additional payments in-year by the IJB partners, i.e. Argyll and Bute Council and NHS Highland. The Health overspend is covered by brokerage from the Scottish Government. The Council has allocated additional funding to the IJB, however this additional resource impacts on the future financial position of the IJB as this will require to be repaid in future years as follows:

- 2020-21 - £0.800m
- 2021-22 - £1.000m
- 2022-23 - £1.327m

This is additional to the repayment of the 2017-18 overspend of £1.155m, which has been deferred and is now agreed as follows:

- 2019-20 - £0.100m
- 2020-21 - £0.300m
- 2021-22 - £0.755m

Financial Outlook, Risks and Plans for the Future

The IJB has a responsibility to make decisions to direct service delivery in a way which ensure services can be delivered within the finite financial resources available.

Considering the estimated available funding and the pressures in relation to costs, demand and inflationary increases the budget gap for the Partnership for 2019-20 is summarised below:

	2019-20 £m
Baseline Budget	264.2
Cost and Demand Pressures	5.7
Inflation (employee and non-pay)	8.6
Adjustment for undelivered savings	4.6
Total Expenditure	283.1
Total Funding	(276.3)
In-Year Budget Gap	**6.8**

There are significant cost and demand pressures across health and social care services, and these are expected to outstrip any available funding uplifts and have a significant contribution to the overall budget gap. The main pressures relate to demographic and volume pressures including amongst other areas healthcare packages, growth in prescribing, growth in adult social care services, younger adult supported living services and acute health services. There are also significant costs of the uplift in the Living Wage rate, pay inflation costs for HSCP employees, inflationary increases for drugs and prescribing costs and for commissioned services.

A savings plan for the budget gap shortfall of £6.8m has been agreed by the Integrated Joint Board comprising management / operational savings of £5.058m and policy savings of £1.736m. Many of these savings involve right sizing of existing budgets and there is much more confidence that these can be delivered. A copy of the Savings Plan can be found here: https://www.argyll-bute.gov.uk/sites/default/files/ab_hscp_ijb_27-3-19.pdf starting at page 85.

There were significant shortfalls in delivering the service changes included in the Quality and Finance Plan for 2018-19, and this highlights the significant challenge in delivering savings in future years. The IJB at its meeting of 30 January 2019 removed or reduced savings from its budget to the value of £3.9m as there was no confidence in delivering these. There were however additional under spends which reduced the overall overspend at the end of the year. Lessons continue to be learned and the approach to setting budgets along with the necessary savings plans will be adapted in future years.

There is a significant financial risk associated with the 2019-20 budgets, particularly the areas of overspend in 2018-19 which may continue into 2019-20 and the scale of savings planned to be delivered. We are working to proactively to address the financial challenges, while at the same time, providing high-quality health and social care services for the communities in Argyll and Bute.

There is likely to be a picture of a continuing budget gap for the partnership in future years and this will remain the case while cost and demand pressures and inflationary cost increases continue to outstrip the funding available. Many pressures in relation to Health and Social Care services are based on trends of continuing service demand increases which reflect our increasing elderly population, for example for care home placements and home care services and the expectations of ongoing cost increases for example in relation to staff pay awards and living wage costs.

A high-level estimate of the budget gap for the three years from 2020-21 is presented below based on a mid-range scenario:

	2020-21 £m	**2021-22 £m**	**2022-23 £m**
Baseline Budget	276.6	276.8	277.0
Cost and Demand Pressures	3.0	5.6	8.1
Inflation (employee and non-pay)	6.4	12.6	19.1
Savings agreed	(0.8)	(1.4)	(1.4)
Total Expenditure	285.0	293.6	302.8
Total Funding	(278.6)	(281.1)	(284.7)

	2020-21 £m	2021-22 £m	2022-23 £m
Estimated Budget Gap	**6.4**	**12.5**	**18.1**

The most significant financial risks facing the IJB over the medium term can be summarised as follows:

- delays in the delivery of the programme of service redesign resulting in inefficient use of resources, lack of sustainability, provision of poor quality services and a failure to meet the partnership shared vision and outcomes
- the ability to release resource from acute health services to allow investment and growth in community based services
- increasing demand for services alongside reducing resources
- the wider public sector financial environment, which continues to be challenging
- the impact of demographic changes
- the impact of the Living Wage and other nationally agreed policies which have financial consequences to deliver

5.2 Best Value

NHS Highland and Argyll and Bute Council delegate funding to the Integration Joint Board (IJB). The IJB decides how to use these resources to achieve the objectives of the strategic plan. The IJB then directs the Partnership to deliver services in line with this plan.

The governance framework is the rules and practices by which the IJB ensures that decision making is accountable, transparent and carried out with integrity. The IJB has legal responsibilities and obligations to its stakeholders, staff and residents of Argyll and Bute.

The Health and Social Care Partnership ensures proper administration of its financial affairs by having an appointed Chief Financial Officer (section 95 of the Local Government (Scotland) Act 1973). The Chief Financial Officer is required to keep proper accounting records and take reasonable steps to ensure the propriety and regularity of the finances of the Integration Joint Board.

The Integration Joint Board aligned the service changes outlined in the Quality and Finance Plan with the objectives of the Strategic Plan to ensure that resources are directed to deliver the planned performance levels and desired outcomes.

The ‘Transforming Together’ programme included service changes planned to deliver £10.4m of budget reductions through 8 transformational work streams. Most of these have not yet progressed to delivering savings. The ongoing workstream programmes are as follows:

- Children’s services
- Care homes and housing
- Learning disability services
- Community model of care
- Mental health services
- Primary care services
- Acute Hospital services
- Corporate services

These align with the Strategic Plan 2019/20 – 2021/22. There is evidence of transformation taking place at a strategic and operational level within the Partnership. However there remains a real challenge in disinvesting from expensive institutional based services. The IJB are focussed on directing the finite resources available to achieve Best Value, however there are challenges in achieving this in all areas due to the current arrangements for service delivery and the inherent cost of providing services in rural and remote areas. The continued investment in community services in 2019-20 will build capacity in communities and support the delivery of these service changes in the future.

Appendices

Appendix 1	Progress against National Health and Wellbeing Targets 2015/16 - 2018/19
Appendix 2	Benchmarking against Scotland and other HSCPs; Quarter 3 2018/19
Appendix 3a	Inspection Findings: Adult Services Inspection Reports 2018/19
Appendix 3b	Inspection Findings: Children & Families Inspection Reports 2018/19

Appendix 1 - Progress against National Health and Wellbeing Targets 2015/16 - 2018/19

National Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Suite	Indicator	Argyll & Bute HSCP						
		15/16	16/17	17/18	18/19	Target	Variance Against Target	Data Trend (17/18 to 18/19)
Core National Indicators	% of adults able to look after their health very well or quite well (Quarterly Conversions)	96%	96%	93.0 %	93%	93%	0%	→
	Rate of emergency admissions per 100,000 population for adults (Quarterly Conversions)	12103	12145	12,617	12678	12256	422	↑
	Rate of premature mortality per 100,000 population (Quarterly Conversions)	392	418	380.0	380	425	45	→
	NHS-H7 - Proportion of new-born children breastfed - STANDARD (Quarterly Conversions)	30	30	31.9 %	31.9	33	1.4	→
Health and Social Care Partnership Data	No of alcohol brief interventions in line with SIGN 74 guidelines (Health & Social Care Partner Data)	809	857	397	29	511	482	↓
	No of ongoing waits >4 weeks for the 8 key diagnostic tests (Health & Social Care Partner Data)	5	41	368	134	0	134	↓
	% of MMR1 uptake rates at 5 years old (Health & Social Care Partner Data)	94%	97%	95.8 %	97.2%	95%	2.2 %	↑
	% <18 type 1 Diabetics with an insulin pump (Health & Social Care Partner Data)	42%	42%	38 %	44%	25%	19%	↑
	% >18 type 1 Diabetics with an insulin pump (Health & Social Care Partner Data)	5%	7%	11 %	7%	12%	5%	↓
Local	AC1 - % of Older People receiving Care in the Community (Joint Planning & Performance)	76%	74%	74.2 %	77%	86%	9%	↑
	AC15 - No waiting more than 12 weeks for homecare service - assessment authorised (Home Care & Day Support Services)	35	13	6	4	6	2	↑
	A&B - % of Learning Disability Service Users with a Personal Care Plan (Learning Disability Care Management)	92%	90%	90 %	89%	90%	1%	↓
	CA15B - % Looked After and Accommodated Children in Family Placements - A&B (Adoption, Foster Care & Kinship Care)	86%	86%	79 %	77%	75%	2%	↓
	CA17 - No of External Looked After and Accommodated Children (Care Homes & Hostels)	5	7	8	9	10	1	↑

National Outcome 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.								
		Argyll & Bute HSCP						
Suite	Indicator	15/16	16/17	17/18	18/19	Target	Variance Against Target	Data Trend (17/18 to 18/19)
Core National Indicators	No of days people spend in hospital when ready to be discharged, per 1,000 population (Quarterly Conversions)	673	597	634	634	772	138	→
	% of health & care resource spend on hospital stays, patient admitted in an emergency (Quarterly Conversions)	24%	24%	22.0 %	22%	24%	2%	→
	Readmission to hospital within 28 days per 1,000 admissions (Quarterly Conversions)	71	80	87	87	101	14	→
	Falls rate per 1,000 population aged 65+ (Quarterly Conversions)	22	26	26	26	22	4	→
	% of adults supported at home who agree they are supported to live as independently (Quarterly Conversions)	84%	84%	79.0 %	79%	81%	2%	→
	% of adults supported at home who agree they had a say in how their support was provided (Quarterly Conversions)	82%	82%	76.0 %	76%	76%	0%	→
	Emergency Admissions bed day rate (Quarterly Conversions)	119930	107343	107,548	108883	121516	12633	↑
	Proportion of last 6 months of life spent at home or in a community setting (Quarterly Conversions)	89	90	90.0 %	90%	88%	2%	→
	% of adults with intensive needs receiving care at home (Quarterly Conversions)	67%	67%	67.0 %	67%	61%	6%	→
Health and Social Care Partnership Data	% of patients wait no longer than 4 hours in Accident & Emergency (Health & Social Care Partner Data)	99%	99%	98.3 %	98.3%	95%	3. 3%	→
	% of patients who wait no longer than 18 weeks for Psychological therapies (Health & Social Care Partner Data)	51%	98%	50 %	94%	90%	4%	↑
Local	A&B - Number of people 65+ receiving homecare - FQ stats (Home Care & Day Support Services)	1309	1212	1,241	1238	1180	58	↓
	AC14 - Total No. of Enhanced Telecare Packages (Telehealthcare)	553	630	726	978	500	478	↑
	AC2 - % of MH Clients receiving Care in the Community (Mental Health Admissions & Care)	99%	98%	98 %	98%	98%	0%	→
	AC21 <=3 weeks wait between Substance Misuse referral & 1st treatment (Substance Misuse)	93%	93%	95 %	90.50%	90%	0.5%	↑

	AC5 - Total No of Delayed Discharge Clients from A&B (Delayed Discharge)	18	17	28	23	12	11	↓
	CPC01.4.4 - % Waiting time from a patient's referral to treatment from Community Adolescent Mental Health Service (CAMHS) (C&F Plans - PIs)	91%	95%	89 %	91%	90%	1%	↑

National Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected.								
Suite	Indicator	Argyll & Bute HSCP					Variance Against Target	Data Trend (17/18 to 18/19)
		15/16	16/17	17/18	18/19	Target		
Core National Indicators	% of adults receiving any care or support who rate it as excellent or good (Quarterly Conversions)	82%	82%	80.0 %	80%	80%	0%	→
	% of adults supported at home who agree that their health and care services seemed to be well co-ordinated(Quarterly Conversions)	81%	81%	72.0 %	72%	74%	2%	→
	% of people with positive experience of their GP practice (Quarterly Conversions)	91%	91%	85.0 %	85%	83%	2%	→
	% of Social Work care services graded 'good' '4' or better in Care Inspectorate inspections (Quarterly Conversions)	86%	84%	86 %	86%	83%	3%	→
Health and Social Care Partnership Data	No of patients with early diagnosis & management of dementia (Health & Social Care Partner Data)	815	804	806	795	890	95	↓
Local Indicators	AC16 - No of abbreviated customer service questionnaire sent to AC users- bi-monthly (Performance Framework)	17	20	13	10	5	5	↓

National Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of service users.

Suite	Indicator	Argyll & Bute HSCP					Variance Against Target	Data Trend (17/18 to 18/19)
		15/16	16/17	17/18	18/19	Target		
Core National Indicators	% of adults supported at home who agree their support had impact improving/maintaining quality of li (Quarterly Conversions)	87%	87%	74.0 %	74%	80%	6%	→
Health and Social Care Partnership Data	No of outpatient ongoing waits >12 wks (Health & Social Care Partner Data)	38	196	482	498	0	498	↑
	% of outpatients on the waiting lists with medical unavailability (Health & Social Care Partner Data)	2%	0%	0 %	0%	0%	0%	→
	% of outpatients on the waiting lists with social unavailability (Health & Social Care Partner Data)	5%	4%	1.0 %	1.7%	4%	2%	↑
	% of patients on the admissions waiting lists with medical unavailability (Health & Social Care Partner Data)	2%	3%	1.5 %	3.4%	2%	1.4%	↑
	% of patients on the admissions waiting lists with social unavailability (Health & Social Care Partner Data)	13%	14%	8.4 %	10.5%	16%	6%	↑
Local Indicators	AC11 - Average working days between Referral & Initial AP Case Conference (Adult Protection)	19	12	14	25	15	10	↑
	CA72 - % LAAC >1yr with a plan for permanence (C&F Placement Process)	85	88	100 %	65%	81%	16%	↓
	CA34 - % of Care Leavers with a Pathway Plan (C&F After Care)	75	100	97 %	95%	74%	21%	↓

National Outcome 5: Health and social care services contribute to reducing health inequalities

Suite	Indicator	Argyll & Bute HSCP					Variance Against Target	Data Trend (17/18 to 18/19)
		15/16	16/17	17/18	18/19	Target		
Health and Social Care Partnership Data	No of treatment time guarantee completed waits >12 wks (Health & Social Care Partner Data)	0	0	0	2	0	2	↑
	No of treatment time guarantee ongoing waits >12 wks (Health & Social Care Partner Data)	1	0	0	6	0	6	↑

National Outcome 6: People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing

Suite	Indicator	Argyll & Bute HSCP					Variance Against Target	Data Trend (17/18 to 18/19)
		15/16	16/17	17/18	18/19	Target		
Core National Indicators	% of carers who feel supported to continue in their caring role (Quarterly Conversions)	41%	41%	33.0 %	33%	37%	4%	→

National Outcome 7: People who use health and social care services are safe from harm.

Suite	Indicator	Argyll & Bute HSCP					Variance Against Target	Data Trend (17/18 to 18/19)
		15/16	16/17	17/18	18/19	Target		
Core National Indicators	% of adults supported at home who agree they felt safe (Quarterly Conversions)	84%	84%	83.0 %	83%	83%	0%	→
Local Indicators	AC17 - % of Adult Care users reporting they feel safe at assessment (Performance Framework)	71%	80%	82 %	83%	70%	13%	↑
	CP15 - % of Children on Child Protection Register with no Change of Social Worker (Child Protection)	93%	76%	60 %	53%	80%	27%	↓
	CP7 - % of Children on Child Protection Register with a current Risk Assessment (Child Protection)	100%	100%	100 %	87%	100%	13%	↓
	CP16 - % of Children on Child Protection Register with a completed CP plan (Child Protection)	100%	91%	99 %	91%	100%	9%	↓
	CP17 - % of Child Protection investigations with IRTD within 24 hours (Child Protection)	97%	100%	100 %	93%	95%	2%	↓

National Outcome 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.

Suite	Indicator	Argyll & Bute HSCP					Variance Against Target	Data Trend (17/18 to 18/19)
		15/16	16/17	17/18	18/19	Target		
Core National Indicators	% of staff who say they would recommend their workplace as a good place to work (Quarterly Conversions)	0%	71%	71.0 %	71%	67%	4%	→
Health and Social Care Partnership Data	% of NHS sickness absence (Health & Social Care Partner Data)	5%	5%	5.36 %	5.64%	4%	1.64%	↑
Local Indicators	Health & Social Care Partnership % of PDPs/PRDs completed (HR2 - PRDs A&B Council)	0%	52%	30%	37%	90%	53%	↑
	Social Work staff attendance	0	3.9	5.7	5.20%	3.80%	1.4	↓

National Outcome 9: Resources are used effectively in the provision of health and social care services

Suite	Indicator	Argyll & Bute HSCP					Variance Against Target	Data Trend (17/18 to 18/19)
		15/16	16/17	17/18	18/19	Target		
Health and Social Care Partnership Data	% of SMR1 returns received (Health & Social Care Partner Data)	90%	93%	96 %	95%	95%	0%	↓
	% of new outpatient appointments DNA rates (Health & Social Care Partner Data)	10%	10%	9%	8.8%	7%	1.8%	↓
Local Indicators	CJ61 - % Criminal Justice Social Work Reports submitted to Court on time (CJ Court Reports)	100%	99%	98%	96%	92%	4%	↓
	CJ63 - % Community Payback Orders cases seen without delay - 5 days (Supervision of Offenders)	82%	86%	94 %	84.8%	80%	5%	↓
	CJ65 - Average hrs per week taken to complete Community Payback Orders Unpaid Work/CS Orders (Unpaid Work Requirement)	6.3	4.7	6.0	6.5	6	1	↑
	SCRA43 - % of SCRA reports submitted on time (Hearings/Looked After Children)	90%	64%	53 %	54%	75%	0	↑

Appendix 2 - Benchmarking against Scotland and other HSCPs; Quarter 3 2018/19										
Indicator	**Title**	**Comparative areas**								
		Argyll & Bute	**Angus**	**East Lothian**	**Highland**	**Midlothian**	**Moray**	**Scot Borders**	**Stirling**	**Scotland**
NI - 1	Percentage of adults able to look after their health very well or quite well	93%	95%	94%	94%	92%	93%	94%	94%	**93%**
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	79%	76%	71%	86%	86%	83%	83%	84%	**81%**
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	76%	71%	68%	79%	80%	75%	74%	73%	**76%**
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	72%	71%	66%	76%	71%	73%	75%	76%	**74%**
NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	80%	77%	75%	83%	71%	80%	83%	79%	**80%**
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	85%	78%	80%	87%	76%	80%	88%	86%	**83%**
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	74%	77%	75%	86%	73%	79%	80%	81%	**80%**
NI - 8	Total combined % carers who feel supported to continue in their caring role	33%	34%	36%	38%	32%	39%	36%	38%	**37%**

Indicator	Title	Comparative Areas								
		Argyll & Bute	Angus	East Lothian	Highland	Midlothian	Moray	Scot Borders	Stirling	Scotland
NI – 9	Percentage of adults supported at home who agreed they felt safe	83%	80%	81%	84%	79%	84%	86%	88%	**83%**
NI – 10	Percentage of staff who say they would recommend their workplace as a good place to work	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	***NA***
NI – 11	Premature mortality rate per 100,000 persons	380	384	372	373	389	372	324	360	**425**
NI – 12	Emergency admission rate (per 100,000 population)	12,678	11,060	10,325	10,666	11,563	9,198	12,366	10,045	**12,183**
NI – 13	Emergency bed day rate (per 100,000 population)	108,883	111,941	120,782	106870	123,372	95,356	134,823	106,781	**123,035**
NI – 14	Readmission to hospital within 28 days (per 1,000 population)	87	103	105	107	114	83	104	102	**102**
NI – 15	Proportion of last 6 months of life spent at home or in a community setting	90%	90%	86%	90%	87%	90%	87%	87%	**88%**
NI – 16	Falls rate per 1,000 population aged 65+	26	21	19	15	20	15	22	20	**22**
NI – 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	77%	84%	85%	86%	89%	85%	81%	95%	**85%**
NI – 18	Percentage of adults with intensive care needs receiving care at home	67%	51%	64%	50%	70%	65%	62%	66%	**61%**

Indicator	Title	Comparative Areas								
		Argyll & Bute	Angus	East Lothian	Highland	Midlothian	Moray	Scot Borders	Stirling	Scotland
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	625	419	775	1,300	1,422	936	855	566	**762**
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23%	28%	24%	21%	25%	22%	23%	21%	**25%**
NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	***NA***
NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	***NA***
NI - 23	Expenditure on end of life care, cost in last 6 months per death	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	***NA***

Appendix 3a: Adult Services – Inspection Reports for 2018/19

Internal Care Home Provision				
Care Homes	**Care & Support**	**Staffing**	**Management & Leadership**	**Environment**
Struan Lodge	4	5	4	4
Tigh a Rhuda	4	4	4	3
Gortanvogie	3	3	3	3

Rated by New System

Care Homes	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is care and support planned?
Thomson Court	5	Not Assessed	Not Assessed	Not Assessed	4
Eadar Glinn	5	Not Assessed	Not Assessed	4	4
Ardfenaig	4	4	4	4	4

External Care Home Provision

Care Homes	Care & Support	Staffing	Management & Leadership	Environment
Invereck	4	4	4	4
Argyle Care Centre	4	3	4	3
Ardnahein	3	3	3	3
Lochside Care Home	4	3	4	4
Morar Lodge Nursing Home	5	5	5	5
Palm Court	3	3	3	3
North Argyll House	5	4	5	5
Northwood House	4	4	5	4

Rated by New System

Care Homes	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is care and support planned?
Kintyre Care Centre	2	3	3	3	3
Ardenlee	4	4	5	4	4
Ashgrove	4	Not	Not	Not	5

		Assessed	Assessed	Assessed	
Etive Care Home	3	3	3	3	3

Internal Home Care & Day Centre Provision

Care Homes	Care & Support	Staffing	Management & Leadership	Environment
Mid Argyll , Jura, Islay, and Kintyre Homecare	3	4	3	NA
Mull & Iona, Tiree and Colonsay Homecare	3	4	1	NA
Lynnside Day Centre	5	5	4	5
Struan Lodge Day Care	4	5	4	5
Thomson Court Day Care	5	5	4	4
Mid Argyll Day Care	3	4	4	3
Greenwood	4	4	4	NA
ASIST	3	4	3	4
Community Resource Team	5	4	3	NA
Lochgilphead Resource centre	6	4	5	4
Lorne Resource Centre	4	4	3	4
Woodlands Centre	5	5	5	4

External Home Care & Day Centre Provision				
Care Homes	**Care & Support**	**Staffing**	**Management & Leadership**	**Environment**
Allied Health Care (Helensburgh & Cowal)	5	5	5	NA
Allied (Isle of Bute)	5	5	4	NA
Argyll Homecare	5	5	4	NA
Care+ (Oban)	4	3	3	NA
Careplus	5	5	5	NA
Carers Direct	4	4	4	NA
Carewatch	3	3	3	NA
Carr Gomm Argyll & Bute	4	4	5	NA
Oasis Day Centre	6	6	5	6
Cowal Care Services	5	5	5	NA
Crossroads (Cowal & Bute)	5	5	4	NA
Joans Carers	4	4	3	NA
Highland Home Carers	5	5	4	
Mears Homecare	4	4	4	NA
Mears Care Ltd	4	4	3	NA
Premier Healthcare	5	5	4	NA
Quality Care	5	5	4	NA
Crossroads North Argyll	4	5	3	NA
Clyde Carers	3	3	2	NA
Blue Triangle Oban Housing	4	3	3	NA
Affinity Trust	4	4	4	NA
Enable Scotland (Dunoon)	5	4	4	NA
Enable Scotland (Helensburgh)	5	5	6	NA
Enable Scotland (Lorn & Isles)	5	5	5	NA
Enable Scotland (Helensburgh Day Services)	5	5	5	NA
Enable Scotland (Mid Argyll & Kintyre)	5	5	4	NA
Key Community	5	5	4	NA
Mariner Homecare	5	5	5	NA
South Peak	4	4	4	4
Addaction Scotland Recovery Service Old Registration (most recent grades)	5	5	5	NA
Maxie Richards Foundation	5	5	5	NA

Appendix 3b: Children & Families Inspection Reports 2018/19

The latest inspection grading for Children and Families services registered with the Care Inspectorate are as below.

Children and Families - Quality Theme Care Inspectorate Grades (1-6)					
Care Inspectorate Number	**Name**	**Care & Support**	**Environment**	**Staffing**	**Management & Leadership**
CS2005091229	Achievement Bute	5	N/A	5	4
CS2012307560	Cornerstone	5	N/A	5	5
CS2006129195	Scottish Autism – Oban autism Resources	5	N/A	4	5
CS2010249688	Ardlui Respite House – Sense Scotland	5	4	4	4
CS2003000426	Helensburgh Children's Unit (Argyll and Bute Council)	5	5	5	5
CS2003000461	Shellach View (Argyll and Bute Council)	5	5	5	5
CS2003000451	Dunclutha Residential Home (Argyll and Bute Council)	5	5	5	5
CS2006115758	Dunoon School Hostel (Argyll and Bute Council)	4	5	4	3
Cs2006130205	Glencruitten Hostel (Argyll and Bute Council)	4	5	4	4
CS2004082322	Argyll and Bute Adoption Service	4	N/A	5	5
CS2004082341	Argyll and Bute Fostering Service	5	N/A	5	5
CS2004079237	Kintyre Community Support Network	4	N/A	4	3

Appendix 4: Glossary of terms	
Advanced Nurse Practitioners (ANP)	**Advanced Nurse Practitioners** are Registered Nurses who have done extra training and academic qualifications to be able to examine, assess, make diagnoses, treat, prescribe and make referrals for patients who present with undiagnosed/undifferentiated problems.
Alcohol and Drug Partnership (ADP)	A multi-agency group tasked by the Scottish Government with tackling alcohol and drug issues through partnership working. There are 30 ADPs in Scotland.
Analogue to Digital	The Technology Enabled Care (TEC) Programme has been exploring the scope of benefits of switching the current Telecare provision from a analogue based system via traditional telephony connections, to a digital service.
Allied Health Professionals (AHPs)	**Allied Health Professionals (AHPs)** are a diverse group of professionals supporting people of all ages focusing on personal outcomes. They provide preventative interventions in such areas as supported self-management, diagnostic, therapeutic, rehabilitation and enablement services to support people to live healthy, active and independent lives. The Active and Independent Living Programme (AILP) supports AHPs, working in partnership with multi-disciplinary teams and agencies to improve the health and wellbeing of the population throughout the life-course. For the full list of AHP professions please see: https://www2.gov.scot/Topics/Health/NHS-Workforce/Allied-Health-Professionals
Alternative Care Pathways (ACP)	Community or primary **care pathways**; Self-**care** and are an effective **alternative pathway** of **care** for patients with long term conditions that enables health professionals to identify when referral to expert community teams may be a better option for the patient.
Anticipatory Care/ Anticipatory Care Planning	**An Anticipatory Care Plan** is a dynamic record that should be developed over time through an evolving conversation, collaborative interactions and shared decision making. It is a summary of Thinking Ahead discussions between the person, those close to them and the practitioner. More information is available on: https://www.gov.scot/publications/anticipatory-care-planning-frequently-asked-questions/
Attend Anywhere	**Attend Anywhere** is a web-based platform that helps health care providers offer video call access to their services as part of their 'business as usual', day-to-day operations
Beating the Blues	**Beating the Blues®** is a computerised cognitive behavioural therapy (CBT) programme for depression and anxiety.
Benchmarking	The process of comparing quantitative or qualitative information, often related to practices, performance or prices, against a point(s) of reference. A point(s) of reference might be, for example, an agreed standard, established targets, or the performance of other organisations.

CareFirst information system	**CareFirst** is a web based, multi modular Case Management system commonly used by local authorities for recording care arrangements, statutory interventions and related events pertaining to Social Care Service Users.
Cardiopulmonary resuscitation (CPR)	**Cardiopulmonary resuscitation** is an emergency procedure that combines chest compressions often with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person who is in cardiac arrest.
Child Protection Register (CPR)	In Scotland the **child protection register (CPR)** is a confidential list of all children in the local area who have been identified as being at risk of significant harm. It allows authorised individuals to check if a child they are working with is known to beat risk.
Chronic Obstructive Pulmonary Disease (COPD)	**Chronic Obstructive Pulmonary Disease** (**COPD**) is an umbrella term used to describe progressive lung diseases including emphysema, chronic bronchitis, and refractory (non-reversible) asthma. This disease is characterized by increasing breathlessness.
Cognitive Behavioural Therapy (CBT)	**Cognitive behavioural therapy (CBT)** is a talking therapy that can help you manage your problems by changing the way you think and behave. It is most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems.
Core and Cluster Housing	The term 'cluster accommodation' refers to shared accommodation, in which people have their own private bedroom, or other single person accommodation units, but they share communal facilities such as kitchens, bathrooms and so on
Health and Social Care Partnership (HSCP)	**Health and Social Care Partnerships, (HSCPs**) are the organisations formed as part of the integration of services provided by Health Boards and Councils in Scotland. Each partnership is jointly run by the NHS and local authority. HSCPs manage community health services and create closer partnerships between health, social care and hospital-based services.
Information Services Division (ISD)	**The Information Services Division (ISD)** is a division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care and facilitates robust planning and decision making.
Integration Authority (IA)	The Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to work together to form new partnerships, known as integration authorities (IAs).
Integration Delivery	The integration planning and delivery principles are the lens

Principles	through which all integration activity should be focused to achieve the national health and wellbeing outcomes. More information is available on: https://www2.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Principles
Integration Joint Board (IJB)	The Argyll and Bute Integration Joint Board is responsible for the planning, performance, resourcing, and operational management of health and social care services delivered through the Argyll & Bute Health & Social Care Partnership (HSCP).
iMatter	**Imatter** is a staff experience continuous improvement tool designed with staff in NHSScotland to help individuals, teams and Health Boards understand and improve staff experience.
Interagency Referral Tri-partite Discussions (IRTD)	Interagency planning and decision making procedures for responding to allegations or concerns about children at risk.
Just Checking	**Just Checking** is an activity monitoring system that helps people live in their own homes for longer by showing family and professionals their day-to-day capabilities — or where support is needed.
Lean	**Lean Process Improvement** is the process of continually reviewing a process identifying waste or areas in a process map that can be improved. It is an ongoing feedback process of loop that over time improves the business through better processes.
Local Intelligence Support Team (LIST Team ISD)	**Local Intelligence Support Team (LIST Team ISD)** have staff with a wide skill set who can assist GP Clusters and Practices to gain a better understanding of their own data and with data linkage give a broader picture of how patients are interacting across a complex landscape. Profiling local populations, projecting future demand and looking at alternative models of service delivery and care can help find potential answers to complex problems
Locality Planning Group (LPG)	A **Locality Planning Group (LPG)** brings together NHS and Council staff, community members, carers, representatives from third and independent sectors and community based groups. These individuals collectively work together to improve the health and wellbeing of the community in which they live. LPGs develop a locality plan, influence priorities in their local area, agree mechanisms for all members to contribute to the delivery of actions at a local level and review and regularly report progress to the Strategic Planning Group.
Looked After Children	Under the Children (Scotland) Act 1995, **'looked after children'**

(LAC)	are defined as those in the care of their local authority – sometimes referred to as a 'corporate parent'.
National Health and Wellbeing Outcomes (NHWBO)	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.
NHSGGC	This refers to **NHS Greater Glasgow and Clyde** from whom we buy acute health services.
Options Appraisal	**Options Appraisal** is a technique for setting objectives, creating and reviewing options and analysing their relative costs and benefits.
Out of Hours Services (OOH)	Across Scotland, NHS Boards provide **Primary Care Out of Hours (OOH)** services for patients' when their registered GP practice is closed.
The Partnership	**The Partnership** means the Health and Social Care Partnership, also referred to as the HSCP.
Psychological Therapies	A range of interventions, based on psychological concepts and theory, which are designed to help people understand, and make changes to, their thinking, behaviour and relationships in order to relieve distress and to improve functioning.
Reablement	**Reablement** is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury.
Scotland Excel	**Scotland Excel** is the Centre of Procurement Expertise for the local government sector and offers training and provides assessment, consultancy and improvement services to help councils transform their procurement capability.
Scottish Children's Reporter Administration (SCRA)	**The Scottish Children's Reporter Administration (SCRA)** is a national body focused on children and young people most at risk. SCRA was formed under the Local Government (Scotland) Act 1994 and became fully operational on 1st April 1996**.**
Self-Directed Support	**Self-Directed Support** is a way of providing social care support that empowers individuals to have informed choice about how support is provided to them with a focus on working together to achieve individual outcomes.
Self-management	**Self-management** is the name often given to a set of approaches which aim to enable people living with long term conditions to take control and manage their own health and put them in the "driving seat" of their care.
SOURCE Team ISD	The Source Tableau Platform is a tableau visualisation tool with interactive features aimed at Health and Social Care

	Partnerships (HSCPs) or Integrating Authorities (AI). It contains a wide range of information on health activities, expenditure and linked data to support HSCPs with understanding local activities, decision making, planning and performance management.
Strategic Planning Group (SPG)	The Strategic Planning Group is responsible for advising the Integration Joint Board, the development and review of the HSCP Strategic Plan and Commissioning Plan ensuring the alignment of service strategies. This group is also responsible for monitoring progress against the strategic priorities and National Health and Wellbeing Outcomes (NHWBO).
SWOT analysis	SWOT Analysis is a useful technique for understanding your Strengths and Weaknesses, and for identifying both the Opportunities and the Threats of particular options
Wellbeing Monitoring System (Activity Monitoring System)	These systems are designed to automatically check your wellbeing on a regular basis. Some rely on you pressing a button once or twice a day. If you do not press the button a call centre will ring you to check you are ok. Just Checking is an example of one type of activity monitoring system.

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Social Care

are-partnership