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
Strategic Commissioning and Market Facilitation Plan
2019 - 2022

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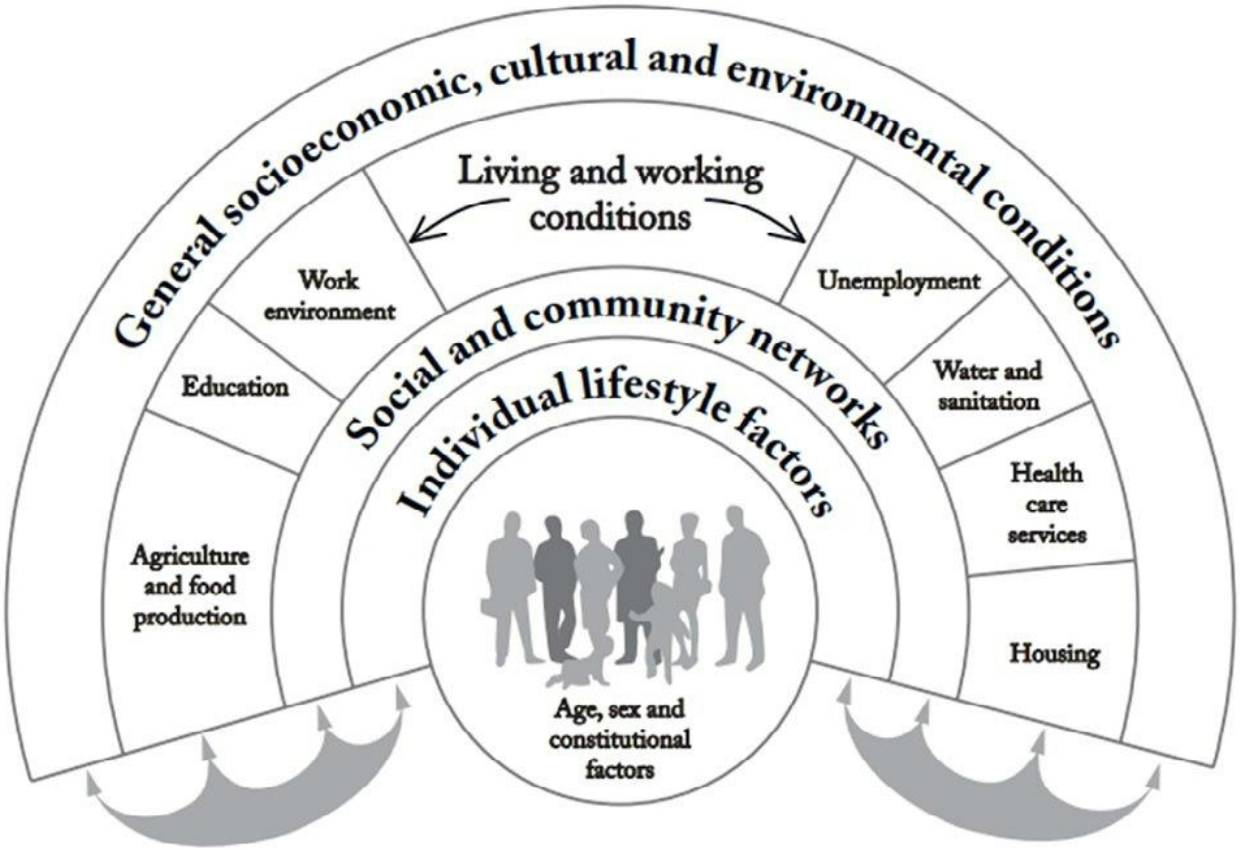
Section 1 Foreword

This is the Strategic Commissioning and Market Facilitation Plan for the Adult population of Argyll and Bute Health and Social Care Partnership (A&B HSCP). The plan sets out how our Argyll & Bute Strategic Plan 2019-2022 to integrate health and social care services will be implemented and how we will encourage people to improve their health and wellbeing.

We believe everyone has the right to live a long, healthy and happy independent life and to be supported to live at home when it is safe to do so. We know we cannot achieve this on our own. The biggest difference in health and social care in our communities will come from the things we can do for ourselves by taking control of our own health and wellbeing.

We know the wider issues of poverty, housing and social isolation can have an impact on a person's health and wellbeing. We have spent the last 10 months working with our partners to undertake a Joint Strategic Needs Assessment of Health and Social Care; this is a systematic approach including consideration of the wider determinants of health and wellbeing



Dahlgred and Whitehead (1993) model of the determinants of health (and Wellbeing

Working with our partners we have identified our priorities for this Strategic Commissioning and Market Facilitation Plan. This plan also details how we intend to meet these priorities so we can support, facilitate and provide equitable health and social care services for all our communities.

Section 2: Background

Argyll & Bute Health and Social Care Partnership (HSCP) is responsible for the planning and delivery of all community based health and social care services for adults and children in Argyll and Bute. Services are delivered by the Partnership in a variety of ways; this includes in house provision, co-production with our communities, and a variety of purchased/ commissioned services.

In 2019 we published the Argyll and Bute HSCP Strategic Plan 2019 - 2021 in which we stated our commitment to developing a Strategic Commissioning and Market Facilitation Plan. In doing this, we recognise that health and social care services which meet the varied and expansive needs of our communities are best delivered in partnership with service providers, service users and carers.

We recognise by working collaboratively together, we can draw on the extensive skills, knowledge and experience of our stakeholders to deliver on our strategic intentions, and develop services which are responsive to the needs of the communities within Argyll and Bute.

This Argyll and Bute HSCP Strategic Commissioning and Market Facilitation Plan aim is to clearly describe how we aim to work with providers and potential providers of adult social care in order to:

- Ensure we deliver the best services available with the resources which available to us.
- give clarity for services providers regarding our approach to the health and social care market within Argyll and Bute and how we aim to deliver a balanced market through our commissioning and procurement arrangements
- Provide our communities with more information regarding the cost, availability and quality of services to help them to make informed choices to meet their health and social care needs. This will include providing current and potential providers with intelligence drawn from our recently completed Joint Strategic Needs Assessment (JSNA).
- Describe what we think future demand in health and social care might look like within Argyll and Bute. This includes describing how we think our services should change in future to meet the needs and expectations of our communities, national strategies and demographic change.

This document aims to present a snapshot of the key emerging themes in relation to the Argyll and Bute landscape. A full Joint Strategic Needs Assessment aimed at identifying the needs and characteristics of our populations across the whole of Argyll and Bute is available and includes:

  - current population demographics within Argyll and Bute including population change
  - health and wellbeing of our communities
  - current service caseloads
  - our current workforce

The full document can be found here: http://healthyargyllandbute.co.uk/joint-strategic-needs-assessment-jsna/

Who is this plan for?

This plan is for all providers and potential providers of adult health and social care support. Specifically;

- Providers of adult health and social care
- Voluntary and community organisations
- People who use adult health and social care services
- Families and carers of people who use adult health and social care

- Individuals interested in local business development and social enterprise

Ongoing Engagement with our partners

Argyll and Bute Health & Social Care Partnership has developed this plan as the first stage in the development of market facilitation and commissioning process within Argyll and Bute. Following the publication of this plan, the future development and implementation of the plan will be directed by a Strategic Commissioning and Market Facilitation Steering Group with representation from all our key partners. This group will be responsible for the ongoing direction, implementation and engagement with our partners in relation to strategic commissioning and market facilitation.

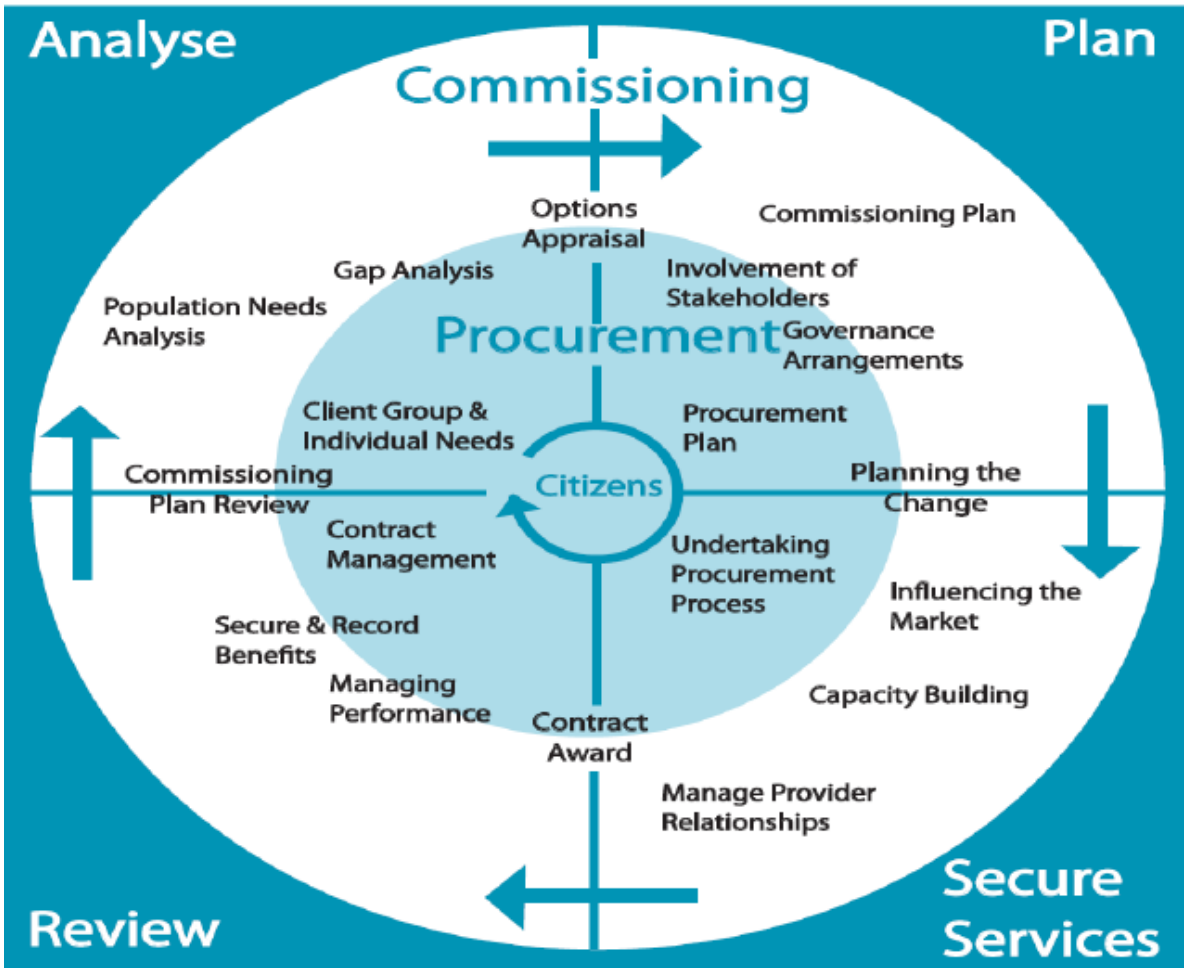
The HSCP is committed to the ongoing engagement with our partners to ensure we can jointly respond to the health and social care needs of our communities.

Section 3: What is Strategic Commissioning and Market Facilitation?

3.1 **Strategic Commissioning in Argyll and Bute**

Strategic commissioning is the main process for understanding, planning and delivering better health and wellbeing outcomes, but it is recognised a substantial amount of work can be needed to deliver this process effectively.

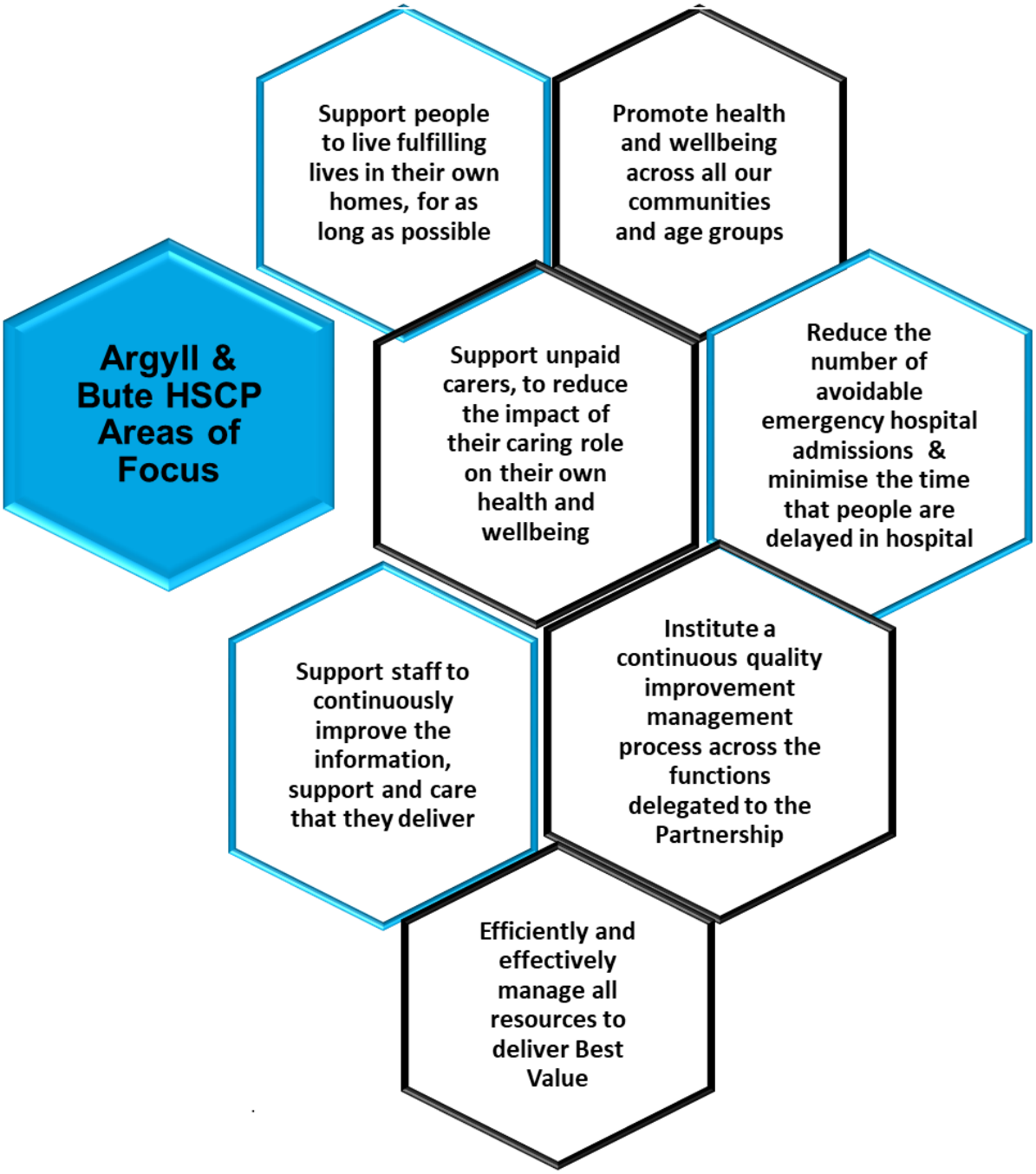
Within Argyll and Bute, we intend to deliver strategic commissioning using the cyclical process described by the Institute of Public Care Commissioning Framework. This is a comprehensive and detailed process comprising of four steps: **Analyse**, **Plan**, **Deliver** and **Review**.



Ref:
https://www.scie.org.uk/publications/guides/guide45/files/Workshop_Handout_1_IP__Commissioning_Framework[1].pdf?res=true

Figure 1: The Institute Public Care Commissioning Framework

The Partnership's vision and priorities for health and social care in Argyll and Bute are described in our Strategic Plan 2019-2021. This describes how we intend to deliver integrated health and social care services to the communities within Argyll and Bute over the next three years. It also identified seven key areas of focus for us as a partnership. These are shown in the diagram below:



3.2 What is Market Facilitation?

"Market facilitation means commissioners working closely with providers, supported people, carers and their internal colleagues (procurement, legal and financial) to encourage the flourishing of a sustainable, effective range of providers and types of support in an area." – iHub

Argyll and Bute Health and Social Care Partnership is committed to providing their communities with "***the right support at the right time***". This means the provision of varied, sustainable services while ensuring quality of service, best value and choice.

We also aim to make information available to our communities which detail the range of support on offer and the providers that are available to deliver this support.

In order to achieve this, we recognise it is important that we -

- Work with our partners, sharing information and intelligence on current demand and service provision within our area
- Consider jointly what future demand might look like in Argyll and Bute
- Describe how we think the market needs to change in our area to this meet demand
- Describe how we will intervene in the market to achieve balance and demand for services

We recognise that this is an iterative process which will involve working closely with all our partners to ensure health and social care in Argyll and Bute is responsive to the needs of its residents.

Section 4: The Changing Landscape within Argyll and Bute

Our recent Joint strategic Needs Assessment highlighted key themes which we need to take into consideration when commissioning health and social care services. A summary of the significant findings and associated implications for services and service providers are documented below.

4.1 Argyll and Bute Population and Population Change

In 2017, the population of Argyll and Bute was estimated to be 86,810, a 3.7% decrease from 90,790 in 2007 and the largest percentage decrease out of all Council areas in Scotland.

Argyll and Bute is divided into four locality areas: Mid Argyll, Kintyre & Islay, Oban, Lorn & the Isles, Cowal & Bute; and Helensburgh & Lomond. The table 1 below details the population of Argyll and Bute in each of the four localities by age.

Table 1 - Population estimates in 2017 and % population by age band

Age Band	B&C		H&L		MAKI		OLI		Argyll & Bute		Scotland
	no.	%	no.	%	no.	%	no.	%	no.	%	%
0-15	2,842	14%	4,096	16%	3024	15%	3,201	16%	13,163	15%	17%
16-24	1,685	8%	3,224	12%	1,685	8%	1,987	10%	8,581	10%	11%
25-44	3,435	17%	5,624	21%	3,793	19%	4,256	21%	17,108	20%	26%
45-64	6,249	31%	7,533	29%	6,178	31%	6,161	31%	26,121	30%	28%
65-74	3,489	17%	3,279	13%	2,975	15%	2,627	13%	12,370	14%	10%
75-84	2,069	10%	1,734	7%	1,750	9%	1,418	7%	6,971	8%	6%
85+	704	3%	674	3%	591	3%	527	3%	2,496	3%	2%
Total	**20,473**	**100%**	**26,164**	**100%**	**19,996**	**100%**	**20,177**	**100%**	**86,810**	**100%**	**100%**

Source: NRS, 2017 mid-year population estimates

4.1.1 An increasing number of people aged 75+

Key population trends indicate that the Argyll and Bute population is set to decrease in forthcoming years, specifically, between 2019 and 2021, population 3-year projections estimate:

- **1% decrease overall in the population of Argyll and Bute**
- **7% increase in population aged 85+ years**
- **11%increase in the population aged 75-84 years**

Between 2019 and 2029, 10-year projections estimate a 31% increase in the number of people aged between 75 – 84 years and a 24% decrease in those aged 16 – 24 years.

In 2017, over one quarter of all people in Argyll and Bute were of pensionable age and given the population projections identified, this is set to increase. As people age they use health and social care services more frequently.

4.1.2 A decrease in the working age population

The implications of an increasing elderly population and a falling overall population include a decreasing pool from which to recruit our workforce from. There will also be a detrimental impact on the number of people available to volunteer. Currently the percentage of people volunteering, by age, is lower in those aged 75+.

4.1.3 Natural population change – increased numbers of deaths

The number of deaths in Argyll and Bute is also projected to increase with 146 additional deaths in 2021-2026 compared to 2016-2021. This equates to an average of 29 additional deaths per year, which will in turn place pressure on the delivery of health and social care services due to increasing demand. It is likely this will result in the need for more end of life care and palliative care provision.

Argyll and Bute Population and Population Change

Implications for services and service providers

- The increasing older adult population coupled with the decreasing working age population highlights a real challenge for the recruitment of staff moving forward. The increase in national retirement age compounds this as there is real potential for fewer volunteers.

- The increase in older adult population and the projected increase in deaths represent a potential increased demand on services for home care provision and palliative care provision in the future.

4.2 Living and Working in Argyll and Bute

Argyll and Bute has a significant remote and rural geography, with 23 inhabited islands and remote small towns. Specifically, 47% of the population of Argyll and Bute live in rural areas and 69% live in "very remote" areas, compared to 17% rural and 4% very remote in Scotland as a whole. 45% of small areas within Argyll and Bute are within the 20% most access deprived in Scotland.

4.2.1 Deprivation and poverty

One in 10 individuals resident in Argyll and Bute (8,775 people) are income deprived and 9% of those of working age (aged 16 to 64) are employment deprived (4,730 people). There is a higher than average reliance on part- time and seasonal employment within Argyll and Bute which may be unstable.

The data zones that fall within the most deprived in Scotland are located within Campbeltown, Helensburgh, Hunter's Quay, Dunoon, Rothesay and Oban. Cowal and Bute has the highest number and proportion of people within the most deprived two quintiles within Scotland. Helensburgh and Lomond is the only locality within Argyll and Bute with data zones within the most and least deprived within Argyll and Bute.

It is important to note that 80% of those identified within Argyll and Bute as being income deprived do not live in the most deprived areas and deprivation within rural areas is likely to be hidden by the mixed socioeconomic status of small rural areas.

The cost of living in remote rural areas is higher than in accessible and urban areas and consistent with this fuel poverty rates are high within Argyll and Bute.

4.2.2 Seasonal fluctuations in service demand

High levels of seasonal tourism and high numbers of second homes impact on health and social care service demand in summer months. There is also a noted increase in mortality over the winter months which are consistent with the national Scottish trend.

4.2.3 Unpaid Carers

It is estimated that 12,677 people aged 16+ currently provide unpaid care in Argyll and Bute with highest proportion identified as residing in Bute, Cowal and Kintyre. Local figures suggest a disproportionate amount of familial carers are aged 65+ and that unpaid carers do not always identify as being a carer. Recent survey data from Argyll and Bute on rates of unpaid carers who feel 'supported to continue in their caring role' are low'.

4.2.4 Housing

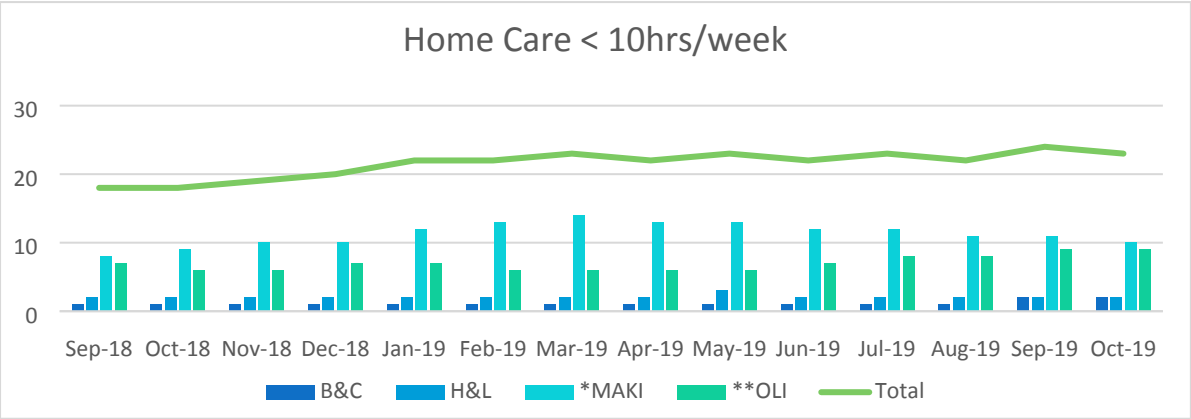
More than 1 in 5 individuals within Argyll and Bute currently live alone and projections indicate that the population of individuals aged 75+ who are living alone, is increasing. Additionally, there are an estimated 100 homeless applications per year, the majority of which have support needs.

Argyll and Bute also have an older housing stock with a need for adaptations and there are a high number of vacant and second homes which are occupied more in the summer months. The table below provides a summary of the number of Single Adult Dwellings, vacant homes and second homes across the four localities in Argyll and Bute.

Percentage of adults 18+ in Argyll and Bute live in a single adult dwelling, 2017				
Locality	**Dwellings with a 'single adult' Council Tax discount**	**% of those 18+ living alone**	**% of vacant homes**	**% second homes**
B&C	4404	26%	6%	10%
H&L	3714	17%	3%	2%
MAKI	3855	23%	6%	8%
OLI	3408	21%	3%	8%
A&B HSCP	**15381**	**21%**	**4%**	**7%**

4.2.5 Personal Care at Home

The number of people across Argyll and Bute receiving personal care at home is increasing while there is a general trend in the number of long stay home residents decreasing; this mirrors national objectives to shift the balance of care to support more adults within the community. As at October 2019, a total of 475 individuals were receiving homecare across Argyll and Bute. The graphs below show the trends over the past year in each of the four localities within Argyll and Bute by home care hours offered.


Home Care < 10hrs/week
30
20
10
0
Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19
B&C
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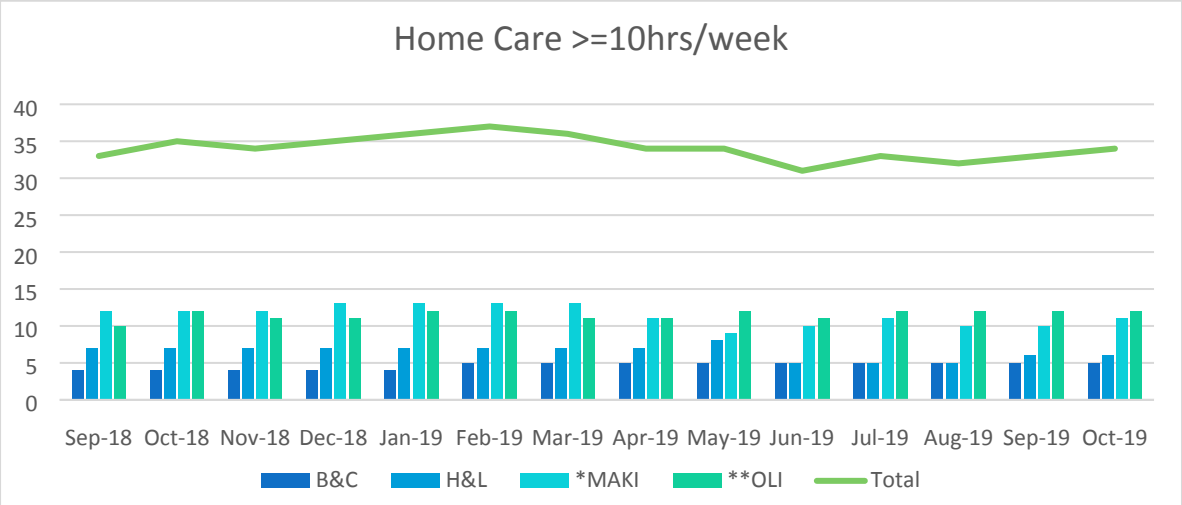
Home Care >=10hrs/week
40
35
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25
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15
10
5
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Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19
B&C
H&L
*MAKI
**OLI
Total

Living and Working in Argyll and Bute

Implications for Argyll and Bute services and service providers:

- The rural and remote geography of Argyll and Bute presents difficulties for communities accessing services out with their local area. There is a high reliance on transport to reach health and social care services.
- Services across the area need to consider other innovative ways of ensuring equality of access to support and treatment across all areas
- Deprivation is evident within Argyll and Bute and often hidden within small pockets of rural communities. Services must consider the accessibility of services for those in hidden deprivation and support those income or employment deprived to maximise their income where appropriate e.g. signposting to welfare support.
- Argyll & Bute Health and Social Care services need to be responsive to the seasonal requirements of its population and manage demand in its services at peak times throughout the year.
- There is a reliance on individuals who provide unpaid health and social care support others across Argyll and Bute. It is essential to ensure that networks are available to support carers within our community.
- A high proportion of the population in Argyll and Bute live alone which is projected to increase in future years. Aligned to this, there is an increasing demand for home care services which is likely to continue.
- Argyll and Bute's older housing stock requires ongoing adaptations to ensure individuals can live in their own homes safely moving forward. This includes the ongoing use of community alarms and telecare services such as day time first responder services**.**

4.3 Health and Wellbeing Status and Support

Those living in the most deprived areas of Argyll and Bute have poorer physical and mental health outcomes than those living in the least deprived areas within Argyll and Bute. Women within Argyll and Bute have a greater life expectancy compared to the rest of Scotland and compared to their male counterparts. Nationally, increases in life expectancy have plateaued and this is replicated in Argyll and Bute. Emerging evidence suggest this may be linked to austerity with those experiencing deprivation disproportionately affected. Issues which have been identified as having an impact of on the health and wellbeing status of the communities of Argyll and Bute include:

4.3.1 Long Term Conditions

It is recognised that nationally around one third of adults are living with a limiting long term condition. Within Argyll and Bute, there is a prevalence of deaths and burden of disease due to cancers and circulatory disease. There is an additional high burden of disease due to low back and neck pain, depression, sensory conditions (e.g. deafness), migraine, anxiety disorders, Alzheimer's disease and other dementias and COPD. Some conditions e.g. hypertension, dementia, type 2 diabetes, are known to be under diagnosed. As the elderly population continues to increase it is expected that there will be an increase in the number of elderly people with complex long term conditions.

4.3.2 Dementia

Recent figures estimate that there are currently 1,869 individuals aged over 60 years living with dementia in Argyll and Bute. Over the next ten years this is expected to rise by almost 30%. The table below described the dementia prevalence projections by severity in Argyll and Bute for 2019 and 2029:

Dementia prevalence projections by severity in Argyll and Bute for 2019 and 2029								
	2019				2029			
Age Band	Mild	Moderate	Severe	Total	Mild	Moderate	Severe	Total
60-70	76	44	17	137	85	50	19	154
70-80	286	166	65	516	317	184	72	573
80-90	494	286	111	892	678	393	153	1,225
90+	180	104	41	324	262	152	59	473
All	1,036	600	234	1,869	1,344	779	303	2,425

Source: NRS Population projections (2016 based) and Alzheimer Scotland Dementia UK Update Severity of dementia rates estimates (2014).

4.3.3 Frailty

Frailty is related to the ageing process, that is, simply getting older. It describes how our bodies gradually lose their in-built reserves, leaving us vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment. In medicine, frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care.

It is estimated around 1,500 people in Argyll and Bute is identified with frailty through either an episode with geriatric medicine or with a home care/care home care package (not due to learning or physical disabilities). With the expected increase in the older adult population over the next 10 years this figure is also expected to rise.

4.3.4 Care Home Placements in Argyll and Bute

There are 18 adult care homes within Argyll and Bute, 6 of which are run by the HSCP. As of October 2019, there were 399 individuals resident within in area care homes and a further 193 (48%) out with the area. Three quarters of out of area placements across Argyll and Bute were for Older People (75%, n=145) and the highest percentage out of area placements were recorded within Helensburgh and Lomond locality.

The breakdown across all localities and client categories is displayed in the tables below.

Care Home-Out of area placements			
AREA	****In Area**	*****Out of Area**	**% Out of Area**
B&C	132	63	48%
H&L	106	65	61%
MAKI	80	27	34%
OLI	81	38	47%
TOTAL	**399**	**193**	**48%**

* As at end October 2019, based on open service agreements

** In area-placement is within Argyll & Bute area and includes Local Authority run care homes

***Out of area-placement is out with Argyll and Bute area

Care Home-Out of area placements by client category					
Client Category	**B&C**	**H&L**	**MAKI**	**OLI**	**TOTAL**
Learning Disability	12	11	9	9	**41**
Mental Health	0	3	1	0	**4**
Older People	49	50	17	29	**145**
Physical Disability	2	1	0	0	**3**
TOTAL	**63**	**65**	**27**	**38**	**193**

4.3.5 Self-Directed Support (SDS)

Self-directed Support is about giving adults who are eligible for services, more choice and control over how their support services are designed and making sure they receive support that meets their assessed needs. It allows people to choose how their support is provided to them by giving them as much ongoing control as they want over the money spent on their support. Using SDS individuals can buy a range of services, including respite, transport or day care provided through voluntary and private organisations.

Health and Wellbeing Status and Support
Implications for Argyll and Bute services and service providers:

- An increase in demand for dementia related support is projected over the next ten years for sufferers and carers alike.
- There is limited availability of services for specialised complex long term conditions within Argyll and Bute often resulting in out of area placements to accommodate need
- An increasing demand for support in relation to long term conditions is projected across the Partnership area requiring services to support and community based support (including day care and supported living services) to prevent avoidable emergency admissions to hospital
- An increasing demand for services which are tailored to the needs of individuals and the utilisation of Self Directed Support

4.4 Health Behaviours and Risk Factors

There is an overall need to enable and support behaviour change across health behaviours and risks within our communities. The Health Improvement team within Argyll and Bute work with various partners including health and wellbeing networks to promote healthy behaviours across our communities. There is limited information available within Argyll and Bute relating to health risk behaviours, however national figures suggest that in the main Argyll and Bute aligns to the National trends. These are identified as:

4.4.1 Healthy diet, physical activity and healthy weight

Over a quarter (27%) of adults within the Highland Health Board area, of which Argyll and Bute is a constituent part, are obese (BMI 30 or higher). Additionally, it is reported that within Argyll and Bute less than one in four adults eat the recommended 5 or more portions of fruit and vegetables as day. This is recognised as being lower than for Scotland as a whole.

4.4.2 Smoking

Around one in five adults across Argyll and Bute smoke and this is recorded as being higher in younger age groupings and in those staying in deprived areas.

4.4.3 Substance misuse

Hospital stays due to illicit drug use or drug misuse? in Argyll and Bute have increased in recent years and are more likely in the most deprived areas. Rates of alcohol-related hospital stays are similar in Argyll and Bute than for Scotland as a whole where it is recognised that one in five adults are estimated to drink at hazardous/harmful levels.

4.4.4 Suicide

There has been an average of 12 deaths per year due to probable suicide within Argyll and Bute

4.4.5 Sexual Health

Very little information is available locally with regard to sexual health in Argyll and Bute. However national reports highlight that sexually transmitted infections have increased in recent years.

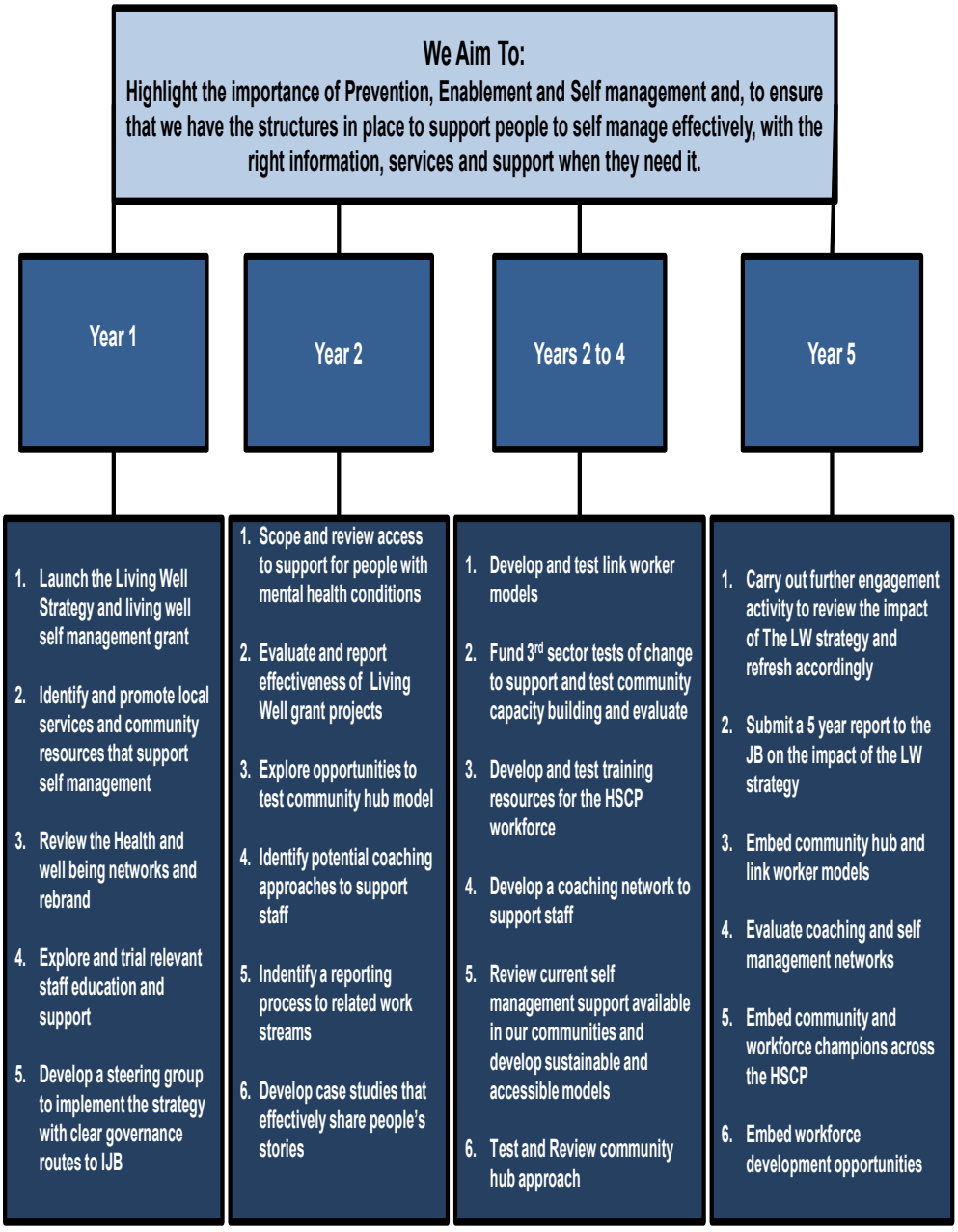
Health Behaviours and Risk Factors
Implications for Argyll and Bute services and service providers:

- Treating people with long term health conditions, such as cancer, type 2 diabetes and heart disease, places high demands on front line health and social care services.
- Their incidence is forecast to increase significantly due to better treatment options that keep people living for longer following diagnosis.
- Our higher proportion of older people creates an additional burden on services due to the association of long term health conditions with age.
- There is a link between people with long term health conditions self-managing their symptoms and lifestyle, with better health and wellbeing outcomes.
- Health and social care staff have a key role in promoting the concept of self-management and incorporating in daily interactions.
- Self-management includes the following:
    - Promoting the benefits of physical activity and signposting to community based activity.
    - Empowering people to understand their symptoms and how to manage them.
    - Non-medical pain management techniques.
    - Linking people with community based support such as money advice, carer support services, and social support or volunteering for people who are isolated.
    - Anticipating how long term conditions might progress and planning for this, for example using tele-care equipment, having a Power of Attorney, or anticipatory care plans.
    - Understanding the links between past trauma and physical conditions and listening/responding in a person centred way.

Argyll and Bute has a strategic approach to self-management called Living Well in Argyll and Bute. This includes the following aims:

People- People living in Argyll and Bute have the tools and support they need to support them to Live Well
Community- There are a wide range of local services to support people to Live Well
Workforce- Staff are able and motivated to support the people they see to Live well
Leadership – Effective Leadership is in place to support the delivery of the Living well strategy

The Living Well strategy has a 5 year implementation plan in place that aims to ensure we have the structures in place to support people to Live Well in their communities and this is illustrated in the diagram below.



4.5 Our Workforce

The Argyll and Bute Health and Social Care Partnership as a statutory body employs individuals under the umbrella of its parent organisations Argyll and Bute Council and NHS Highland.

The other significant workforce in health and care are our partner's workforce i.e. the Independent sector, Third sector, Volunteers and Unpaid Carers. Partnership working between all areas of this workforce is fundamental in order to enable the delivery of good care and ultimately better outcomes for people in our communities.

Currently there is around **2,500** staff directly employed by the Partnership and a combined wider workforce of **4,000** individuals including partners across Argyll and Bute.

Workforce issues identified across Argyll and Bute include:

- **An ageing population and workforce** - Workforce planning figures estimate that around 1/3 of the Partnerships direct workforce is aged 55+ and this is consistent with the wider population and workforce trend throughout Scotland. It is likely this will result in a decreasing pool from which to recruit staff and a need for services to ensure planning
- **Difficulties recruiting and retaining staff** - there is a particular challenge in relation to staff recruitment and retention across Argyll and Bute which may result in gaps in service provision, particularly specialist services across Argyll and Bute
- **Decreasing pool of volunteers -** With increases in the age of retirement and changes to pensions there is likely to be a reduction in the number of volunteers available to support community groups and organisations.
- **Affordable housing –** It has been identified that the lack of affordable housing, particularly in Oban and Mid Kintyre is having a detrimental impact on the recruitment and retention of staff in these areas
- **Sustainability of Third Sector organisations** – A significant contribution is made by the Third Sector in supporting the delivery of health and social care services across Argyll and Bute. An identified risk to the sustainability of these services and organisations is linked to unpredictable funding streams.
-

4.6 Service Activity

4.6.1 Current Adult Social Work Caseloads

As at 31st August 2019, there were 2,801 adults known to be in contact with Social Work Services across Argyll and Bute. Almost two thirds (63%) of all individuals were over 71 years and the majority of individuals were aged over 80 years of age (44%, n=1,229).

Individuals recorded on CareFirst as being in contact with social work services as at 31st August 2019 by age grouping						
	18-60 years	61-70 years	71-80 years	> 80 years	Age not yet recorded	Total:
Number of people	755	278	531	1,229	8	2,801
% by age grouping	27%	10%	19%	44%	0%	100%

Source: Carefirst

4.6.2 Emergency Admissions for individuals within Argyll and Bute

Over the last 5 years emergency admissions within Argyll and Bute were consistently higher than the set target. In 2018/19 there were 8,659 emergency admissions 57% (n=4963) of which were individuals aged over 65 years.

In 2018/19, there were 4,963 emergency admissions of individuals over 65 to Scottish Hospitals from within Argyll and Bute and increase of 1.2% (n=60) from the previous year. Just over half (53% (n=2,657) of all >65 years admissions were made to hospitals within the Highland Health Board area and just under half were made to Glasgow hospitals (45%, (n=2.254). The majority of emergency admissions are made from the Cowal and Bute locality.

Argyll & Bute Residents Admissions to Hospital by Patient Locality, over 65s; All hospital sites in Scotland				
	2017/18		2018/19	
	No.	%	No.	%
Cowal & Bute	1,404	29%	1,433	29%
Helensburgh & Lomond	1,146	23%	1,237	25%
Mid Argyll, Kintyre & Islay	1,212	25%	1,191	24%
Oban, Lorn & Isles	1,141	23%	1,103	22%
Total	4,903	100%	4,964	100%

4.6.3 Delayed Discharges

The number of delayed discharges in Argyll and Bute has consistently risen over the last five years. Last year (2018/19) there were 9,561 delayed discharges for individuals aged 18+.

4.6.4 Attendance at A&E

The number of attendances at A&E by residents of Argyll and Bute has consistently risen over the last 5 years. Last year (2018/19), there were 17, 060 which constitutes a 6.45% (n=1,034) rise from the previous year).

4.7 Spending plans

Key areas of adult commissioned services currently fall within the following areas of spend:

	Budget 2019/20	Forecast outturn 2019/20
	£000s	£000s
Older People Care Home placements	7,333	7,671
Care at Home for Older People	11,308	11,140
Supported Living: Physical Disability	1,078	1,576
Supported Living: Learning Disability	5,381	6,030
Supported Living: Mental Health	514	553
Looked after children: residential placements	813	1,303

Key trends highlighted have included growth in care at home demand in response to our ageing population, with more people living at home. Whilst numbers of residential care home placements are not increasing, the cost of these is increasing as the levels of frailty of client's increases and more are likely to be living with dementia. In addition, we are expecting continuing cost pressures for high cost treatments such as oncology and cystic fibrosis.

We have included growth in our financial projections as follows for 2020/21 to 2022/23 as follows:

	2020/21	2021/22	2022/23	
Cost & demand pressure area	**£000s**	**£000s**	**£000s**	**Commentary**
Oncology treatments	450	450	450	
Cystic Fibrosis treatments	581			New treatments introduced during 2019/20
Older People – care at home	640	340	345	1.5% p.a. assumed
Older People residential care home placements	326	339	352	0.5% p.a.
Care Services for Younger People	539	278	270	1.5% p.a. assumed
Continuing care	250	250	250	Reflects one new expensive placement p.a.

The commissioning and procurement of adult services is therefore framed currently within this financial resource framework.

Section 5: Key Market Messages

- **Care at Home**

  Population Projections show that there will be an increasing demand for 'Care at Home' services for older adults. We will need everyone in the Partnership to help us develop a Care at Home strategy to meet this need. This strategy will be based on re-ablement after illness, requiring increasingly flexible care services.

- **Unpaid Carers**

  Accessible support to Unpaid Carers is at the core of our work throughout Argyll and Bute. We will continue to work with our Carers Implementation Group to develop our plans.

- **Health improvement**

  We expect a continuing increase in the numbers of people with (multiple) long-term conditions, including dementia. The focus here is on prevention, and we need all our partners, in every community, to help us to build communities which promote health, independence, and self-management, enabling people to remain in their own homes for as long as possible.

- **Housing**
  Having a suitable and affordable place to live is at the very core of addressing every individual's health and social care needs and in meeting one of the National Outcomes for Health & Social Care regarding 'Independent Living' . The partnership Working with our local Registered Social Landlords and Argyll and Bute Council Housing department, will plan and implement special needs housing, work with partners to strengthen and increase the resource available to support housing adaptations allowing people to remain in their own home

- **Accessing Transport**

  In spite of digital technology, many services can only be delivered in person. There will be a continuing need to support the transport needed to access such services.

- **Self-Directed Support**

  The HSCP is committed to allowing people to choose how their care is organised. We will work with providers to identify and overcome any barriers to this, so that they can respond to the changing needs of individuals who control their own care budgets.

- **Hospital Avoidance and Discharge**

  We need our partners to help us develop services which are able to respond quickly at any time to, if possible, prevent hospital admissions, but also to enable people to return to their own home as soon as they can be supported there. Central to this will be effective systems in every community to monitor the Frail Elderly.

- **Digital Technology**

  We already use digital technology wherever possible, to support individuals within their local communities. This includes our Attend Anywhere virtual appointments, to reduce travel to Glasgow Hospitals.

  We will continue to develop this Technology-enabled Care Service. We need our partners to help us, by developing novel ideas to use such technology to support people to live as

independent a life as possible in their own homes and communities, and to reduce their dependence on carers. This would include the prevention of falls, and support to live well with dementia.

- **A sustainable workforce**

  We cannot deliver quality support to individuals and communities without a suitably-skilled and sustainable workforce. All our partners need to work together to develop the training plans needed to make the best use of everyone's staff and help us attract people to Argyll and Bute to work.

- **Engaging with our communities**

  We continue to work with local communities via our Locality Planning Groups to develop their local plans. We need to develop new ways for our communities to tell us what they think about our services and how they believe they should develop. During service change we will ensure we take a planned approach to engage with those who may be affected.

- **Best Value**

  Ensure we make best use of all our resources (buildings, staff and £) so we have the most advantageous combination of cost, quality (in this context means meeting a specification which is fit for purpose and sufficient and sustainable) to meet customer requirements.

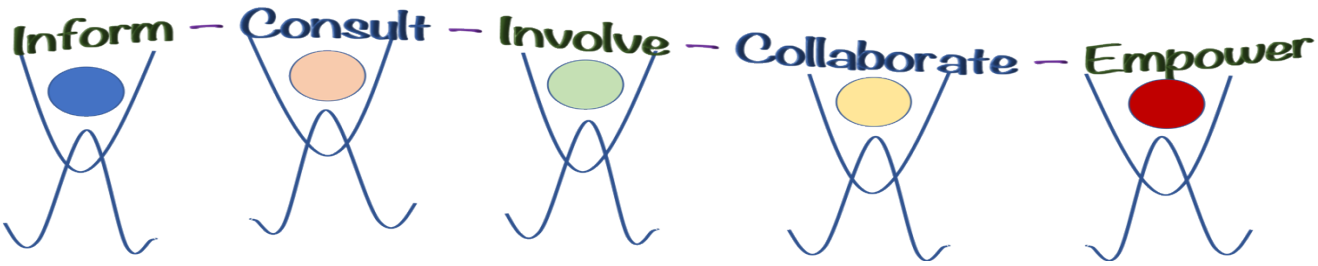
Section 6: Working together to meet the needs of our communities

Argyll and Bute HSCP is committed to ensure partnership working with all partners including Independent, Third Sector, Service users and Carers to deliver the right services to people at the right time.

6.1 Engagement with our communities

The HSCP has responsibilities to engage effectively with the people who will be affected by our business. This includes our staff, partners, people who use our services, carers and the wider community. Our intentions to meet these responsibilities are set out in an Engagement Framework. This can be viewed here:

https://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/PPF/Pages/PublicEngagementinArgyllandBute.aspx



This work includes:

- HSCP **Engagement Framework** providing a comprehensive overview and strategic direction for engagement work.
- An **Annual Engagement Plan** to proactively plan and record engagement activity.
- An **Engagement Quality Standards Framework** to evidence how the HSCP is delivering best practice.
- A **Strategic Engagement Advisory Group** with key partner involvement to advise the Integrated Joint Board on engagement policy, strategy and best practice.
- Revised model of **Locality Planning Groups** to strengthening planning at scale and to better align with Community Planning arrangements.
- New **Guide to Engaging** to widely publicise the range of ways that people can engage with the HSCP.
- New mechanisms to engage with people with an interest in health and social care services called '**Community Conversation Cafes**'.
- An **engagement pathway and tools** to support managers responsible for local services to engage with people in a systematic and consistent way.

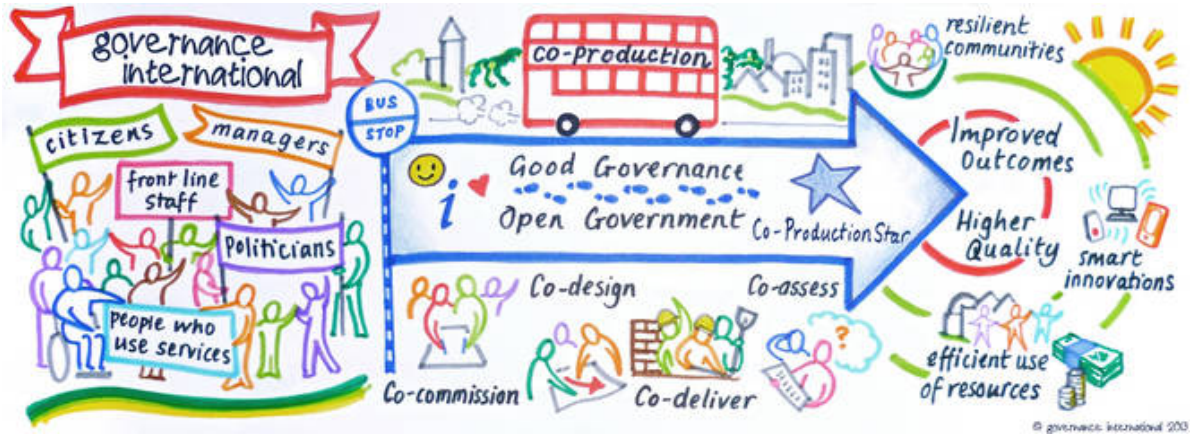
6.2 Co-production with our communities

Health and Social Care services are valued by communities across Argyll and Bute and feedback from communities highlights the importance of service continuity and public desire to have and protect local services.

Co-production is a term used to describe people who deliver services and people who use these services working collaboratively together in order to achieve better outcomes in local communities, for example **doing with, rather than doing to**. In addition to commissioning services directly, there is a role for the HSCP in adopting principles of co-production to enable communities to realise the level of community based support they aspire to.

In short, co-production can promote good relations across our communities and ensure that services delivered are relevant to the needs of our communities. Co-production can take place at different levels and includes:

- **Co-design** – working together to develop plans for new services
- **Co-deliver** – working together to implement services
- **Co-assess** – working together to evaluate the effectiveness of services
- **Co-commission** – working together to develop commissioning plans and procure services



The legislative landscape in Scotland is supportive of empowering communities. This has evolved during the current decade with the publication of the Christie Commission review of public services in Scotland in 2011[1] and in the implementation of the The Community Empowerment (Scotland) Act 2015[2] and The Public Sector (Joint Working) (Scotland) Act 2014[3].

Co-production in Argyll and Bute

Throughout Argyll and Bute there are lots of community networks which exist to produce a rich and vibrant third and voluntary sector. There are many exemplars of community led activity including

[1] Christie, C. (2011). 'Commission on the Future Delivery of Public Services'. Scottish Government. http://www.gov.scot/Publications/2011/06/27154527/18
[2] Scottish Government (2015). 'Community Empowerment (Scotland) Act 2015'. https://www.gov.scot/policies/community-empowerment/
[3] Scottish Government (2014). 'Public Sector (Joint Working) (Scotland) Act 2014'. http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf

setting up new services and taking over local assets into community control. Notwithstanding this apparent empowerment, there are ongoing challenges to co-production within Argyll and Bute which require to be addressed including bureaucracy, fragile funding streams and finite numbers of people available for community action.

Example of co-production in Argyll and Bute:

The Lade Centre in Rothesay, Isle of Bute is community project to support people with, or caring for people with, life-limiting illnesses or long-term conditions. The idea for the centre originated from a survey of local residents which identified a need for a drop-in centre for adults which people could easily access, and which could help with issues of social isolation.

In the latter half of 2017 a steering group was formed following a series of workshops, lead and facilitated through collaboration between the Locality Planning Group and Fyne Futures Ltd. These workshops developed the thinking on how best to use the offer of rent-free premises and the group worked in close cooperation with the HSCP local manager to bring the development of the centre to fruition.

The steering group, over a period of six months, was able to form a charitable organisation, a SCIO, which developed the aspiration into a fully-fledged organisation capable of opening the centre. Pump priming funding by way of the Integrated Care Fund was crucial to enabling the development.

Jean's Bothy in Helensburgh is a community centre with a focus on mental health and wellbeing. It provides a space for people to meet, as well as an advice centre and classes, activities, and support for people struggling with mental health and wellbeing.

In the development stages, a steering group was set up with local interested parties from the local community including, Enable, Navy, Helensburgh and Lomond locality planning group members, Third Sector and Service Users. Enable "hosted" the funding application which resulted in a 2 year fund from which a project manager was employed. The centre was officially opened in August, 2018 and continues to support the local community.

More information on co-production is available on:
http://www.coproductionscotland.org.uk/learning/section/guides/

6.3 Procurement of health and social care services

Under direction of the Partnership, a variety of health and social care services in Argyll and Bute are procured by either Argyll and Bute Council or NHS Highland. The process is aligned to both partner organisations procurement strategy.

Argyll and Bute Council Procurement Strategy and other associated documents are available on:
https://www.argyll-bute.gov.uk/business-and-trade/procurement-useful-links-and-documents

Argyll and Bute also work in partnership with various organisations to ensure effective and efficient procurement and commissioned services. These include:

6.3.1 Partnership with Scotland Excel

Scotland Excel was established in 2008 as non-profit shared service which is funded by Scotland's 32 local authorities including Argyll and Bute Council.

As the Centre of Procurement Expertise for the local government sector, it aims to develop collaborative procurement solutions which support better outcomes for Scotland's people and communities through early intervention and the delivery of sustainable public services.

Argyll and Bute HSCP is an active participant in the review and development of all relevant Scotland Excel care contracts. All new placements for providers that are on Scotland Excel frameworks will be commissioned from the framework.

More information is available on: http://www.scotland-excel.org.uk/

6.3.2 National Care Home Contract (NCHC)

Argyll and Bute HSCP utilise the National Care Home Contract (NCHC) to support the commissioning of older people's residential and nursing care in partnership with Scotland Excel. This supports the procurement and contract management functions relating to care home services for older people.

More information is available on: http://www.scotland-excel.org.uk/contract.aspx?contract=0100&pageNumber=1

6.3.3 Public Contract Scotland

Argyll and Bute HSCP works in partnership with the Public Contract Scotland portal to advertise new contract opportunities to suppliers.

More information available on: https://www.publiccontractsscotland.gov.uk/

6.4 Contract Monitoring and types of Contractual Arrangements

Contracted services which are commissioned by the Partnership are jointly monitored by HSCP service managers and the Argyll and Bute Procurement and Contract Management Team. This follows review on a quarterly basis to ensure delivery to contractual requirements.

Various types of contractual arrangements exist across the partnership. These are summarised in the table below:

Contract Type	Definition
Framework Agreements	Established following a procurement process, a Framework is an agreement between one or more public bodies and one or more service providers which sets out the terms and conditions under which specific contracts (usually called 'call-off' contracts) can be entered into. In a framework agreement the volume of the service or goods and the timing of the requirement is often unknown when the agreement is established and is only specified at the time of the 'call-off'. An example of this in Argyll and Bute would be the agreements for provision of Care at Home services to older people.
Collaborative Agreement	Established following a procurement process, a collaborative agreement is usually developed nationally (by another local authority/HSCP, Scotland Excel or Scottish Procurement) with key stakeholders for use by local authorities. There is an example of this lead by Scotland Excel for the provision of Residential Care and Education Services to children and young people.
Grants	Payments made by the Partnership to Third Sector Organisations to support their activities, an example of this could be one-off funding for the delivery of a community event or other time limited activity that the partnership values but that would not be viable without this funding. Grants should be allocated following a proportionate grant application/approval process.
Contracts for services/ Supplies	Established following a procurement process, a contract for services or supplies is an arrangement between 2 or more parties for the delivery of specified services/goods under set terms and conditions and in return for the agreed price.
Spot Purchase	Spot purchasing (or spot contracting) happens when a service is purchased by or on behalf of (for example, by a local authority) an individual. Services are purchased as and when they are needed, and are purchased on an individual basis for a single user. A framework contract as described in box 2 above, often sets the terms for spot purchase arrangements to be made on behalf of individuals, for example – Care at Home Services to older people.
Bespoke Arrangements	Bespoke contracts are contracts that are tailored to fit the specific requirements of a project. Bespoke contracts are often used when boilerplate or standard form contracts are not suitable. The complexity of the project is one of the main factors that determines which type of contract makes the most sense.

6.5 Current Contractual Arrangements by Service grouping

A summary of all the current Argyll and Bute Health and Social Care Partnership contractual arrangements by care group is summarised in the table below.

Adult Residential	
Estimated Annual Spend	To Be Confirmed
Contract Description	There are a number of contracts in place to provide support to Adults in a Care Home environment. The HSCP makes use of the available options when it comes to these contracts, including: • National Framework (Scotland Excel – Care Homes for Adults with Learning Disabilities including Autism); • Argyll & Bute Spot Purchase arrangements for Adults with Learning Disabilities and • Other bespoke contract arrangements for Adults with a physical or severe and enduring mental health problems.
Contract Periods	The Scotland Excel Framework introduced the Care Homes for Adults with Learning Disabilities including Autism contract which is now on its second generation. Most of the current arrangements were made under the first contract (End date May 2019). The new contract 'Care Homes for Adults with Learning Disabilities Including Autism' started 14th October 2019 and ends 15th September 2023. Individual placements made under any iteration of the contract are ongoing unless terminated by either the provider or purchaser. Spot Purchase and other bespoke arrangements are ongoing and the period of the contract is linked specifically to the needs of the individual.
Contract Development	All new placements for providers that are on the Scotland Excel framework will be commissioned from the framework.
Contract Management	Management and review of individual placements is undertaken by the relevant lead officer in Adult Care aligned to care plan needs of the individual. The lead officer has support from Argyll and Bute Council's Procurement and Contract Management Team and Scotland Excel with regards to any matters of concern.

Supported Living Services	
Estimated Annual Spend	Approx. £9m per annum- To be confirmed
Contract Description	Argyll and Bute has its own framework arrangement in place with 6 providers for the provision of Supported Living Services to Adults living with a learning disability. Supported Living Services aim to support adults to have a level of independence in their communities. A small number of clients with Mental Health support needs are placed under this contract. There are a small number of adults with placements outside of Argyll and Bute.
Contract Periods	The contract ends on 31st March 2021.
Contract Development	Contracts were awarded following a procurement process that was proportionate and recognised the nature of the market for these services in Argyll and Bute. When this contract expires, there are 2 options, as follows: 1. Scotland Excel are developing a framework for the Provision of Care and Support Services (Care at Home and Supported Living). Argyll and Bute HSCP will consider using the framework when the current contract ends. 2. The alternative will be to develop a local and proportionate procurement process that meets the needs of Argyll and Bute.
Contract Management	Argyll and Bute Council's Procurement and Contract Management Team actively manage these contracts. This includes KPI reporting and review at quarterly provider meetings. Individual placements are managed and reviewed by the lead officer in Adult Care.

Care at Home Services

Estimated Annual Spend	Approx. £9m per annum- To be confirmed
Contract Description	Argyll and Bute has its own framework arrangement in place with several providers for the provision of Care at Home Services to Older People throughout Argyll and Bute. There is also in-house provision in the Mid Argyll, Kintyre and Islay area as well as the Lorn Isles.
Contract Periods	The contract expires on 31st March 2021.
Contract Development	Contracts were awarded following a procurement process that was proportionate and recognised the nature of the market for these services in Argyll and Bute. When this contract expires, there are 2 options, as follows: 1. Scotland Excel are developing a framework for the Provision of Care and Support Services (Care at Home and Supported Living). Argyll and Bute HSCP are considering using the framework when the current contract ends. 2. The alternative will be to develop a local and proportionate procurement process that meets the needs of Argyll and Bute.
Contract Management	Argyll and Bute Council's Procurement and Contract Management Team actively manage the contracts. This includes KPI reporting and review at quarterly provider meetings. Individual placements are managed and reviewed by the lead officer in Adult Care.

Residential and Nursing Homes (Older Adults)	
Estimated Annual Spend	To be confirmed
Contract Description	Older People are placed in Care Homes under the terms of the National Care Home Contract (NCHC). Care Homes provide either Residential Care, Nursing Care or both. There are 17 care homes in Argyll and Bute, 6 of which are operated by the HSCP and the remainder are under contract, together they have capacity to cater to 503 residents in total. The HSCP has some placements with homes under the NCHC outside of Argyll and Bute.
Contract Periods	The contract has been reviewed annually for the past 5-6 years. The current NCHC terms are valid to 7th April 2020 from which time new terms, or updated terms are expected.
Contract Development	Scotland Excel and COSLA are currently working on the development of a new national contract. It would be the intention of the HSCP to continue making use of any available national arrangement.
Contract Management	Argyll and Bute Council's Procurement and Contract Management Team actively manage these contracts. This includes KPI reporting and review at quarterly provider meetings. Individual placements are managed and reviewed by the lead officer in Adult Care.

Addiction Recovery Support	
Estimated Annual Spend	Approx. £450,000.00
Contract Description	The aim of this service is to provide a recovery oriented service to people with drug and/or alcohol dependence in Argyll and Bute in a way that improves health and well-being and enables them to live healthier lives in their community. There is one provider of this service for Argyll and Bute.
Contract Periods	This contract started on 16th December 2019 and will be in place for 3 years with the option to extend for up to a further 2 years.
Contract Development	This contract was awarded following a competitive tendering process carried out by Argyll and Bute Council on behalf of the Alcohol and Drugs Partnership (ADP).
Contract Management	This contract is actively managed by the ADP, this includes KPI reporting and review at quarterly provider meetings. Support is provided by the Council's Procurement and Contract Management Team as and when required.

Carers Support	
Estimated Annual Spend	Approx. £720,000 per annum- To be confirmed
Contract Description	These contract are for the purpose of providing a range of appropriate, relevant and person centred information, advice and support to individuals identified as Carers in line with the statutory obligation as set out in the Carers (Scotland) Act 2016.

Contract Periods	These contracts started on 1st January 2020 and run for a period of between 1 and 3 years.
Contract Development	New contracts have recently been developed and will be subject to ongoing review in light of the requirements of the new act.
Contract Management	Argyll and Bute Council's Procurement and Contract Management Team actively manage these contracts. This includes KPI reporting and review at quarterly provider meetings. Individual placements are managed and reviewed by the lead officer in Adult Care.

Independent Advocacy	
Estimated Annual Spend	Approx. £175,000 per annum- To be confirmed
Contract Description	This contract is for the provision of an Independent Advocacy Service (the Service) to Adults and Older People resident in the Argyll and Bute local authority area. The Service will primarily be available to people who have a statutory entitlement to advocacy.
Contract Periods	The contract ends 31st January 2021 with the option to extend for up to 2 further years.
Contract Development	This contract will be reviewed on an ongoing basis.
Contract Management	Argyll and Bute Council's Procurement and Contract Management Team actively manage these contracts. This includes KPI reporting and review at quarterly provider meetings.

Day Care Older Adults	
Estimated Annual Spend	Approx. £115000 per annum- To be confirmed
Contract Description	Day Care Services for Older People are mostly provided by the HSCP with the exception of in the Helensburgh and Lomond area, where there is one contracted provider.
Contract Periods	The contract ends on 30th November 2020.
Contract Development	This contract will be reviewed on an ongoing basis.
Contract Management	Argyll and Bute Council's Procurement and Contract Management Team actively manage these contracts. This includes KPI reporting and review at quarterly provider meetings.

Health	
Estimated Annual Spend	£65 - £70million
Contract Description	The HSCP currently has a number of NHS SLA contract for health and care services at local, board level and regional arrangements. They are specific health care services e.g. dialysis or Ambulance Service or emergency care etc.

Contract Periods	This varies from cost per case to 3 year contracts.
Contract Development	Informed from NHS Scotland Service level agreement process and are developed at: • HSCP wide • Locality • Service specific
Contract Management	HSCP Planning and Contracting and finance team with operational management input as appropriate

Grants	
Estimated Annual Spend	To be confirmed
Contract Description	The HSCP currently has a number of grant agreements with the third sector across all care sectors. These contracts are often linked with coproduction projects.
Contract Periods	Varied/ bespoke
Contract Development	Some of these are issued by the locality teams. Examples include: • Befriending support • Transport provision for communities • Community hub provision within localities • Community health initiatives in partnership with Argyll and Bute HSCP Health Improvement Team
Contract Management	HSCP Planning and Contracting and finance team

8 Commissioning Plan- Theme Prioritisation

Informed from the JSNA by assessing the service issues & gaps, equity and life circumstances etc and examining this against the HSCP Strategic Plan Objectives 2019/20-2021/22 the following themes have been identified for commissioning activity.

1b) An increasing number of people aged 75+

2f) Unpaid Care

3b) Long term conditions

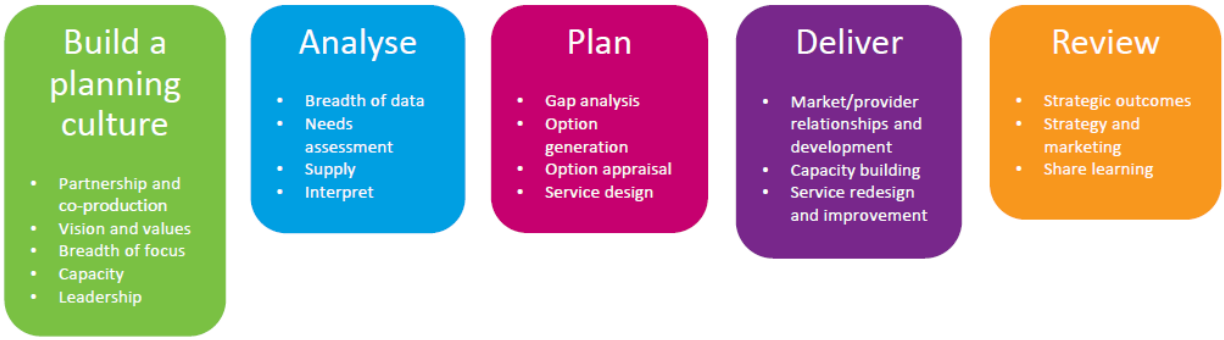
3c) Dementia and Frailty

4a) Overall health related behaviours and risk factors

- Smoking
- Healthy diet, physical activity and healthy weight
- Substance misuse
- Suicide
- Sexual health

The detail of these themes are captured in the matrix in Appendix 1 and work will now commence to progress the development of our partnership commissioning intentions following the Health Improvement Scotland Best Practice Guidelines Dec 2019.

The steps involved in this are illustrated in the diagram below:



9 Conclusion/Next Steps

Strategic commissioning for health and social care is: “the main process for understanding, planning and delivering better health and wellbeing outcomes”

The aim of our commissioning plan– better use of significant resources for health and social care provision ensuring - Right Care, Right Place, Right Time for the needs of our population aligned with the HSCP strategic plan objectives.

The needs of the HSCP adult population have been captured by undertaking a Joint Strategic Needs Assessment (JSNA) which has followed an approach outlined by NHS NSS ISD and encompass:

- Part A: Current and future levels of need
- Part B: Current supply of services
- Part C: Gaps between need and provision of services

The HSCP has spent the last 10 months progressing the understanding of the needs of its Adult population and this work has now progressed whereby it has been captured in its Joint Strategic Needs Assessment (JSNA).

The JSNA have now been presented to the Strategic Planning Group (SPG) in November and January and also at the development session of the IJB in January 2020.

The SPG has also assessed the JSNA findings re issues, gaps in provision and impact on demographic groups and identified:

- The key service/market enabling messages
- Identification of the initial priority areas for commissioning activity in 2020/21

The IHub division of Health Improvement Scotland of the Scottish Government Health Department has just published its guide, “Good Practice Framework for Strategic Plans ” published on 16th December 2019. The HSCP has obtained HIS support as a critical friend to support the commissioning and market facilitation process adopting the guidelines.

The Health Improvement Scotland framework is aimed at confirming and strengthening the commissioning and procurement process/stages to be followed. It is also acknowledged that the commissioning process will require developing a new partnership and provider relationship, which will take time.

The next steps of the process include:

- Communicating the key service/market enabling messages
- Confirmation of the initial priority areas for commissioning activity in 2020/21
- Engagement planning and process with providers, stakeholders and communities to design future service models and specification in 2020/21
- Option assess future models including financial modelling to meet HSCP objectives
- Informing workforce planning, financial planning and procurement activity from 2021/22 onwards

The HSCP Strategic Planning group (SPG) is remitted to progress this work and report back to the IJB in 2020/21 and going forward. The SPG has established a project group to undertake this work with representation from all partners, stakeholders, carers and the public.

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Argyll & Bute Health & Social Care Partnership

Appendix 1 – Key Commissioning Themes from Joint Strategic Needs Assessment

Part A – Current and future level of need 1. Demographic Profile		**Part B – Current levels of supply of services**	**Part C – Future impact and potential requirements**		**Part D – Links to ABHSCP Strategic Areas of focus**	**Part E – Key message to our Providers**
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
1b) An increasing number of people aged 75+	- places a pressure on delivery of health and social care service due to increasing demand	- 83% of adult social care clients are aged 65 and over - Older people are more likely to be high-resource individuals for healthcare services. - Waiting times for services have increased - Rates of people over 65 years of with multiple emergency admissions lower than Scotland as a whole but highest in Oban and Lorn, Kintyre and Islay and Jura. - There is a gap in the JSNA in data from community services and around anticipatory care planning	- Continued increases in demand for health and social care services - Finite health and social care resources stretched to accommodate higher demand in older peoples services - Risk of continued increased waiting times for planned	- Promotion of self-management - Pre-ablement e.g. increasing strength and physical activity - Preventative measures e.g. flu vaccination - Anticipatory Care Planning to avoid unnecessary admissions - Reduction of waiting lists.	**Promote health and wellbeing across all our communities and age groups** **Reduce the number of emergency admissions to hospital and minimise the time people are delayed in hospital**	- **Promotion of health enabling and co-production** - **Hospital avoidance and prevention** - **Increasing care at home provision**

Part A – Current and future level of need 1. Demographic Profile		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key message to our Providers
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
			services - Impact across multiple other themes including remote and rural geography (2a), social support for older people (2d) and provision of unpaid care (2f).			

Part A – Current and future level of need 2. Life Circumstances		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to providers
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
2f) Unpaid Care	- People providing unpaid care may not always identify as doing so - Proportion of unpaid carers estimated to be highest in Bute, Cowal and Kintyre -	- Carers centres in all areas receive HSCP funding - Initial local figures suggest that a disproportionate amount of familial carers are aged 65+ - Low numbers of registered unpaid carers in MAKI and Bute and Cowal - Survey data from Argyll and Bute on rates of unpaid carers who feel 'supported to continue in their caring role' are low	- Decreasing availability of familial unpaid carers of working age (1a) and increasing number of older people (1b) - Less support given from within family with a resulting increase service demand	- Identification of and support to unpaid carers to maintain wellbeing -	**Support unpaid carers to reduce the impact of their caring role on their own health and wellbeing**	- **Support to unpaid carers**

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
3b) Long term conditions	- Around 1/3 of adults are living with a limiting long term condition and rates are increasing - High prevalence of deaths and burden of disease due to cancers and circulatory disease - This is also high burden of disease due to low back and neck pain, depression, sensory	- Prescribing costs have increased over time. - The highest number of potentially preventable bed days from Argyll and Bute residents are associated with COPD, heart failure, diabetes complications, 'influenza and pneumonia', cellulitis and 'convulsions and epilepsy' - Local variation in numbers of admissions for some long-term conditions e.g.	- Likely to increase demand as rates increase with increase in numbers and proportion of older people (1b) - Supported living services are provided through partners (2d) - Need for transport services (2a) - Health literacy and engagement with public to identify conditions at earlier stages	- Support to self-manage and access community support - Community-based support to prevent avoidable emergency admissions - Ensure equality of access to support services in all local areas, with transport as required. - Effective engagement with public -	**Promoting health and wellbeing across all our communities and age groups** **Reduce the number of emergency admissions to hospital and minimise the time that people are delayed in hospital**	- **Promotion of health enabling and co-production** - **Self-Directed Care** - **A shift to digital technology and increase use in telecare and telehealth** - **Availability of Transport** - **Engaging**

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
	conditions (e.g. deafness), migraine, anxiety disorders, Alzheimer's disease and other dementias and COPD - Over 300 people in Argyll and Bute have learning disability - Some conditions e.g. hypertension , dementia, type 2 diabetes, are known to be under diagnosed	COPD admissions in Kintyre. - SLAs are in place with NHS GGC for managed clinical networks (MCN) for stroke and for coronary heart disease (CHD) in Helensburgh and Lomond where services do not link with NHS Highland MCNs but to NHS GCC - Heart start is funded to deliver training in CPR across Argyll and Bute. - X-PERT diabetes education is provided	(5a)			**with Communities**

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		although a recent needs assessment identified insufficient capacity to deliver this across all areas of Argyll and Bute. Scottish Government non-core funding has been used to increase capacity to deliver diabetes education. - An Argyll and Bute mental health strategy is under development. -				
	-	- There is a SLA for provision of community mental health	-	-		-

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		services by NHS GGC in Helensburgh and Lomond including community mental health services, primary mental health care, crisis support and dementia services. - Mental Health support groups/link clubs exist across Argyll and Bute with Kintyre Link Club receiving HSCP funding. - Lomond and Argyll Advocacy Services and Acumen are contracted to provide				

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		advocacy services. - Public Health services that target prevention of health and social conditions, and aim to improve health and wellbeing, can save Health and Social Care expenditure. - Health and Wellbeing Networks aim to promote health and wellbeing within communities. - Specialist support for Long Term Conditions, within the third sector, appears				

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		to be most concentrated in Helensburgh with organisations such as the MS centre in Lochgilphead, Lorn and Oban Health Options (LOHO) and Strachur Hub acting to support self-management of different long-term conditions. - As part of the recent living well strategy for people living with long-term conditions, organisations across Argyll and Bute have been invited to bid for up to				

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		£15,000 to support people in their local communities				
3c) Dementia and Frailty	- Numbers of people with dementia is likely to increase. - Frailty generally affects older people and is resource-intensive for health and social care. - Numbers of people with frailty is likely to increase.	- Dementia support is contracted from Alzheimer's Scotland with activities focussed in Helensburgh and Oban. - There is a gap in Care Inspectorate registered day care support services for older people across MAKI and on the islands (with the exception of Bute). - There is ongoing dementia	- Likely to increase with increase in older population (1b) - Increasing numbers of unpaid carers (2f) - Challenges within social care workforce within OLI and Mid Argyll (1a)	- Challenge variation in Care Home use across Argyll and Bute - Challenge variation in Home Care waits and delayed discharges - Increase early diagnosis of dementia - Implement redesign of dementia services - Support for those with dementia and their unpaid carers - Reduction of falls rates - Realistic use of medicine and interventions	**Support people to live fulfilling lives in their own homes for as long as possible**	- **Hospital avoidance and prevention** -

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		services redesign and reallocation of resources - Target not met on numbers of patients with early diagnosis & management of dementia - The most common adult social services client group is the frail elderly (1,780) - High use of 'Triple whammy' medications - High falls rates per 1,000 population aged 65+ and target not met - Longest waits for home care and highest				

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		days delayed in hospital in OLI and Mid Argyll - Home Care review completed. Variation in Care Home use across areas with high rates of use in Cowal - Hanover (Scotland) Housing Association Ltd are contracted to provide a telecare response service. A day-time first responder service is contracted to Carr-Gomm throughout Argyll and Bute which aims to				

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		prevent emergency admissions to hospital.				
3d) Inequalities across the HSCP area	- Those living in the most deprived areas have poorer physical and mental health outcomes than those living in the least deprived areas within Argyll and Bute	- Smoking cessation services currently targeted in deprived areas. - Alcohol Brief Interventions (ABI) target not being met - An SLA with NHS GGC provides screening services (e.g. newborn blood testing, bowel cancer screening) to people across Argyll and Bute - Bowel and Abdominal Aortic	- Life expectancy increases have stalled (3a) - Deprivation across found in towns and more hidden in rural areas (2b) - Planned development of link working will take an inequalities sensitive approach (2b).	- Consider whether services may be inadvertently increasing inequalities e.g. Use of Equality Impact Assessments - Use of proportionate universalism (targeting services to deprived communities of those experiencing deprivation) - Work with communities (including those experiencing deprivation) to coproduce	**Promote health and wellbeing across all our communities and age groups**	• **Promotion of health enabling and co-production**

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		Aneurysm (AAA) Screening uptake is lower in deprived areas. Breast screening targets are not being met. - The Health Improvement Team (HIT) within public health commissions 8 people to coordinate 8 local health and wellbeing networks which work with communities and aim to improve health and wellbeing and reduce inequalities - The HSCP has		services or interventions - Ensure services are open to all populations within A&B HSCP including those with physical and mental health disabilities (e.g. deaf or hearing impaired, those with dementia, autism or mental illness) and all minority populations (e.g. those from non-white ethnic backgrounds and travelling communities)		

Part A – Current and future level of need 3. Health and Wellbeing status		Part B – Current levels of supply of services	Part C – Future impact and potential requirements		Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key Message to provider
Identified theme	**Issues**	**Current supply of services (and issues identified)**	**Likely future impact and links to other themes**	**Summary of Potential Needs**	**Strategic area of focus/ transformational theme**	
		an updated approach to equality impact assessments implemented in 2019 - Staff training in Equalities and Human rights is compulsory for all staff				

Part A – Current and future level of need 4. Health behaviours and risk factors	Part B – Current levels of supply of services	Part C – Future impact and potential requirements	Part D – Links to ABHSCP Strategic Areas of focus	Part E – Key message to providers

Identified theme	Issues	Current supply of services (and issues identified)	Likely future impact and links to other themes	Summary of Potential Needs	Strategic area of focus/ transformational theme	
4a) Overall health related behaviours and risk factors	- Overall need to enable and support behaviour change across health behaviours and risks	- Implementation of new self-management strategy - MAP of behaviour change training promoted by Health Improvement Team	- Links to deprivation (2b), experience of trauma (2e) and inequalities in health (3d). - Also links with need to Public engagement (5a)	- Role of all service contacts in promoting health behaviour change - Health psychology knowledge to support behaviour change - Health promotion activities within communities - Implementation of self-management strategy	**Promote health and wellbeing across all our communities and age groups**	• **Promotion of health enabling and co-production** • **Hospital avoidance and prevention** • **Target resources to deprived areas** • **Identify gaps in weight management service/diabetes prevalence**
4b) Smoking	- Although the percentage of adults smoking in Argyll and Bute has decreased, it is still estimated that just under 20% of adults smoke, with	- Smoking cessation services are provided by pharmacies and specialist advisors targeted to the most deprived areas - Targets for smoking cessation	- Smoking rates higher in more deprived areas (2b and 3d)	- Meet smoking cessation targets for deprived areas		

	higher rates at younger ages and in the most deprived areas.	are currently not met.				
4c) Healthy diet, physical activity and healthy weight	- Around 30% of men and 40% of women in Scotland do not meet 2011 moderate/vigorous physical activity guidelines - Less than 25% of adults eat the recommended 5 or more portions of fruit and vegetables as day (rates are lower for NHS Highland than for Scotland as a whole) - An estimated 27% of adults are obese (BMI 30 or higher) in NHS Highland area.	- Dieticians provide services to all areas of Argyll and Bute. - Dieticians provided tier 3 weight management services across Argyll and Bute with tier 4 services and bariatric surgery provided outside Argyll and Bute. - Scottish Government, non-core outcomes funding for adult healthy weight money is provided to the weight management dietician to increase provision of tier 2 and tier 3 adult weight management services. - A recent needs assessments	- If trends continue, rates of overweight and obesity will increase - Links to deprivation (2b) and inequalities in health (2d).	- Equality of weight management services in all areas		• **Promotion of health enabling and co-production** • **Hospital avoidance and prevention**

		around type 2 diabetes identified gaps in tier 2 weight management services and further non-core funding has been used to increase provision.				
4d) Substance misuse	- Over 20% of adults in Scotland are estimated to drink at hazardous/harmful levels. - Rates of alcohol-related hospital stays are similar in Argyll and Bute than for Scotland as a whole. Scotland as a whole has higher rates of alcohol-related harm than other parts of the UK. - Hospital stays due to drug use in Argyll and Bute have increased in recent years and	- Community-based addictions support is contracted via the Alcohol and Drug Partnership from Addaction - Targets for alcohol brief interventions (ABI) not met	- Links to deprivation (2b), experience of trauma (2e) and inequalities in health (3d)	- Trauma informed services - Meet ABI targets - Harm reduction		

	are more likely in the most deprived areas.					
4e) Suicide	- There have been an average of 12 deaths per year due to probable suicide.	- Suicide prevention training within frontline and Mental Health Services is a former target. - There is a gap in current information around this in the JSNA.	- Links to deprivation (2b), experience of trauma (2e) and inequalities in health (3d)	- All services should be suicide-aware, trained and confident.	**Promote health and wellbeing across all our communities and age groups**	
4f) Sexual Health	- Sexually transmitted infections have increased in recent years in National reports	- Business to business contracts for specialist sexual health services are held with three GP practices across Argyll and Bute where specialist staff are not otherwise available: Campbeltown Medical Practice, Lochgilphead Medical Centre and Lorn Medical centre. - Waverly Care are contracted to provide support	- Links to deprivation (2b), experience of trauma (2e) and inequalities in health (3d) - Provision of specialist services challenging across remote and rural areas (2a)	- Ensure sexual health services accessible in all areas		

		services for those with HIV and other blood-borne viruses				