A&B HSCP | Transforming Together

Argyll & Bute Health & Social Care Partnership

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

Strategic Plan 2019/20 – 2021/22

FOREWORD FROM OUR CHIEF OFFICER

Welcome to the Argyll & Bute Health and Social Care Partnership's second Strategic Plan. Our previous plan supported us to continue to deliver your services during a challenging period of change, whilst ensuring that we maintained the focus on supporting the people of Argyll & Bute to lead long, healthy and independent lives.

Over the next three years we will build on the success of bringing a multi-disciplinary team of health and social care staff together with a continuing focus on integrated services and practices.

We are working with staff to progress a shared understanding of best practices and importantly develop a new health and social care practice that will allow us to deliver services that protect and keep people safe.

As a rural health and social care partnership, our geography and demographic can at times be perceived as challenging but it should also be perceived as an opportunity to develop innovative community based practices throughout health and social care. We are seeking best practices in rural medicine and social care and are seeking to innovate with the independent and third sector to strengthen and enhance the breadth of service delivery in our remote and rural areas.

We are also actively working with our key partners, NHS Highland and Argyll & Bute Council, to plan a workforce that will support Argyll & Bute's population and the diverse range of health and social care needs.

We continue to support the approach of 'right service, right place and right time' to ensure that Argyll & Bute residents are able to access the range of health and social care services they require. 'Shifting the Balance of Care' is progressing, with an added focus on reducing health inequalities and the prevention of poor health and social outcomes.

We are strengthening the governance of the Integration Joint Board to ensure strategic and operational accountability.

A revised communication and engagement structure is being introduced to support the involvement of communities to participate and inform the work of the Health & Social Care Partnership.

Working with our partners, stakeholders and specifically the residents across Argyll & Bute is key to progressing our Strategic Plan. I would like to express my sincere appreciation and thanks to all who contributed to the development of the Strategic Plan and I look forward to seeing your planning becoming a reality in Argyll & Bute.

Joanna MacDonald

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APPENDICES

SECTION 1 - OUR PARTNERSHIP: VISION AND OBJECTIVES

Argyll and Bute Health and Social Care Partnership is responsible for the planning and delivery of all community based health and social care services for adults and children in Argyll and Bute. This includes services which are purchased from external providers including NHS Greater Glasgow and Clyde.

The Partnership has been established as a separate legal entity from both the Council and the Health Board, with a new board of governance the (Integration Joint Board (IJB)) which has responsibility for the planning, resourcing and overseeing the operational delivery of integrated services, as identified in its Strategic Plan. This includes the services, staff, and resources (budget of circa £276.327m). IJB membership comprises elected councillors, NHS Highland non- executive Board members and a number of other members from a range of sectors and stakeholder groups including the Third Sector, Independent Sector, patients/service users, trade unions, staff and carers.

A full breakdown of the scheme of integration, including membership of the IJB and services provided by the HSCP can be found within the Argyll and Bute HSCP Integration Scheme (Revised 2018): www.bit.ly/ABIntegrationScheme

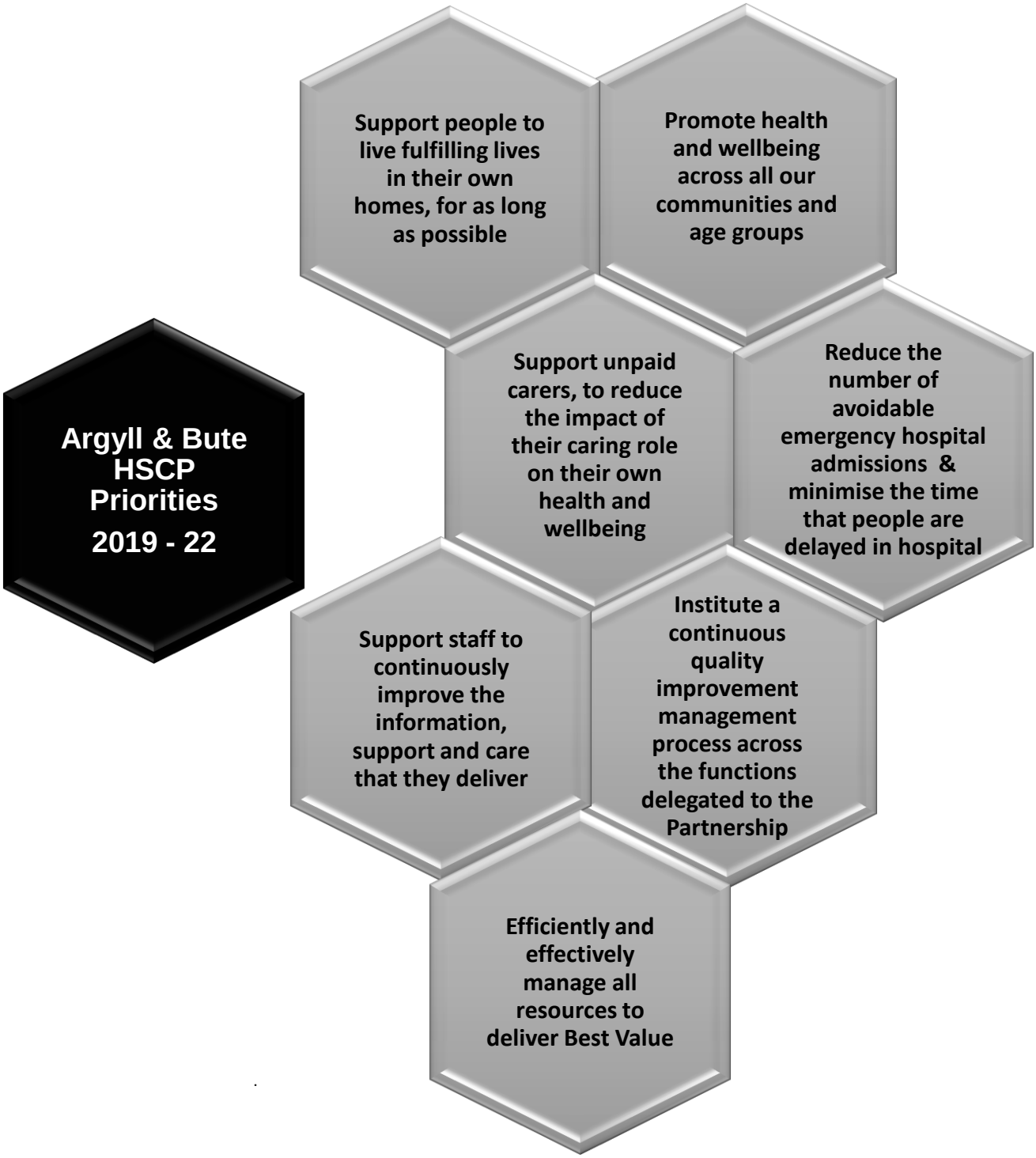
Vision and Objectives

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

The Partnership's (HSCP) vision and priorities for health and social care in Argyll and Bute were developed for our first Strategic Plan 2016-2019.

Our learning over the period of the last plan, together with the results of our recent 3 month engagement and consultation exercise has confirmed they still remain current and relevant for our communities, staff, partners and stakeholders.

Argyll and Bute HSCP seven areas of focus/priorities for the next 3 years are:



Our values which underpin our vision and objectives are:

All employees and stakeholders in Argyll and Bute Health and Social Care Partnership are expected to adhere to our newly developed HSCP Shared Values and Practices (CIRCLE) which are:

Compassion ▪ Integrity ▪ Respect ▪ Continuous Learning ▪ Leadership ▪ Excellence

These shared values together with our Vision for health and social care provide the foundation for the aims and objectives of how we operate and relate to our patients and users of our service, our staff and our partners and stakeholders.

Argyll and Bute Health and Social Care Partnership aims to work in partnership with our local communities to offer services which are

- Easily understood
- Accessible, timely and of high quality
- Well-co-ordinated
- High quality , safe, compassionate and person centred
- Effective and efficient, providing best value.

These priorities and values are reflected within our Strategic Objectives (**Appendix 1**) and are designed to deliver the National Health and Wellbeing Outcomes (NHWBO) for Adults, Older People and Children (**Appendix 2**).

Equalities

Argyll and Bute Health and Social Care Partnership (as with all public organisations) are required to meet the requirements of the Equality Act 2010.The protected characteristics under the Equality Act 2010 are: Age, Gender, Disability, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief and Sexual Orientation. An Equality and Socio-Economic Impact Assessment (EqSEIA) in relation to this Strategic Plan has been carried out and is available on: www.bit.ly/StratPlanEQIA .

SECTION 2 – ENGAGEMENT

In the last year within Argyll and Bute we have worked hard to develop an engagement strategy and build robust arrangements to ensure effective engagement with our public, service users, carers, partner agencies and staff.

The HSCP engagement process involves three stages:

Stage 1 – Informing and Consulting on the Strategic Plan

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

Stage 2 – Involving and Collaborating on service redesign

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

Stage 3 – Involving and Collaborating on implementing service change

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

The second Argyll and Bute Health and Social Care Strategic Plan development has been informed through engagement events.

The process involved presentations to service user and carer representatives and partner organisations through a range of groups/forums as well as a wide range of health and social care staff. The feedback from this process was captured in a report to inform the shaping of our Strategic Plan. This report was presented and approved by the IJB in November 2018. This report provides a full breakdown of the Argyll and Bute Strategic Plan Engagement Programme with communities, staff, multiagency and public representative groups (Available on: www.bit.ly/StratPlanFeedRep).

Feedback received from communities, staff, multiagency and public representative groups regarding our draft Strategic Plan was captured in further report submitted to IJB in March 2019.

SECTION 3 – A PROFILE OF ARGYLL AND BUTES POPULATION

This section provides a profile of the population of Argyll and Bute. It highlights characteristics of the population which can impact on the provision of health and social care services and identifies the key challenges that are faced. We continue to develop these profiles ensuring that we can assess the future needs in each of the services we provide.

2019 Population size

86, 863 people

Age	Number	%A&B	%Scotland
0-15	**13,086**	**15%**	17%
16-44	**25,111**	**29%**	37%
45-64	**25,834**	**30%**	27%
65-74	**12,349**	**14%**	11%
75-84	**7,388**	**9%**	6%
85+	**2,595**	**3%**	2%

Argyll and Bute has a higher proportion of older people than Scotland as a whole, with **11.6% aged 75+** compared to 8.5% in Scotland.

Source: National Records of Scotland (NRS) 2016-based population projections

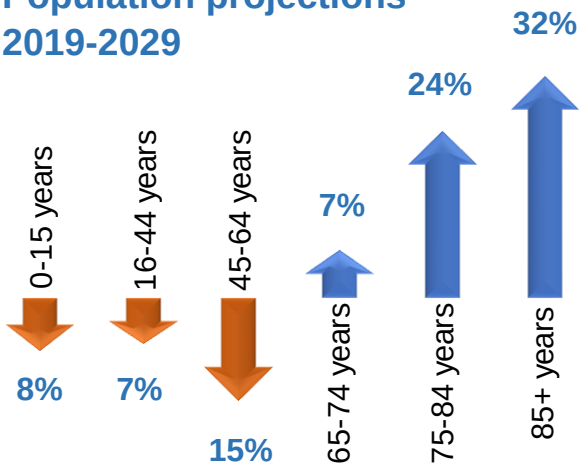
Remote and Rural

73% live in remote or very remote areas

47% live in areas in the 20% most deprived for geographic access to services (derived from travel times)

Source: Scottish Government Urban-Rural (UR) Classification 2016, SIMD 2016 and NRS population estimates (2017) and Census 2011

Population projections 2019-2029



Over 10 years, the population is projected to **decrease overall by 4%** to 83,120 people. The population is projected to **increase by 32% for those 85+** to a total of 3,437 people in 2029, with an increase to 2,715 people by 2021.

The decrease in population overall and increases in numbers of the oldest in society represents a challenge to the model of how care is delivered.

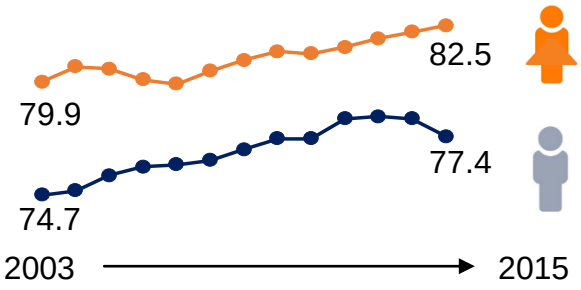
People report that they wish to remain in their own homes if possible.

21% of those aged 18+ live alone.

Source: NRS 2016-based population projections NRS 2017-household and population estimates

All needs assessment information sources are detailed in **Appendix 3.**

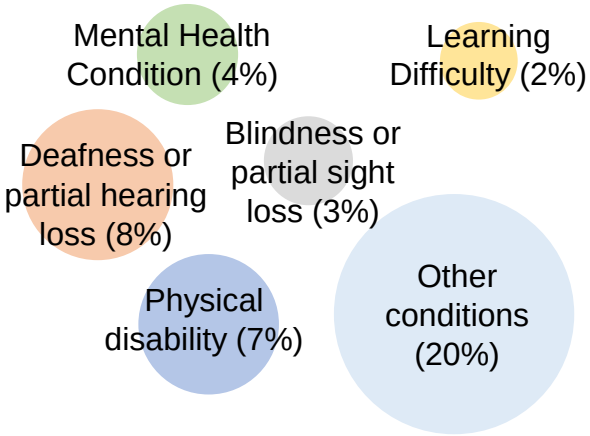
Life expectancy



Source: Scottish Public Health Observatory
(3-year mid-point) life expectancy from birth

Life expectancy in Argyll and Bute has increased but remains lower for **males (77.4 years)** than for **females (82.5 years)**. Male life expectancy is close to Scotland as a whole (77.1 years). Female life expectancy is **higher than for Scotland** as a whole (82.1 years).

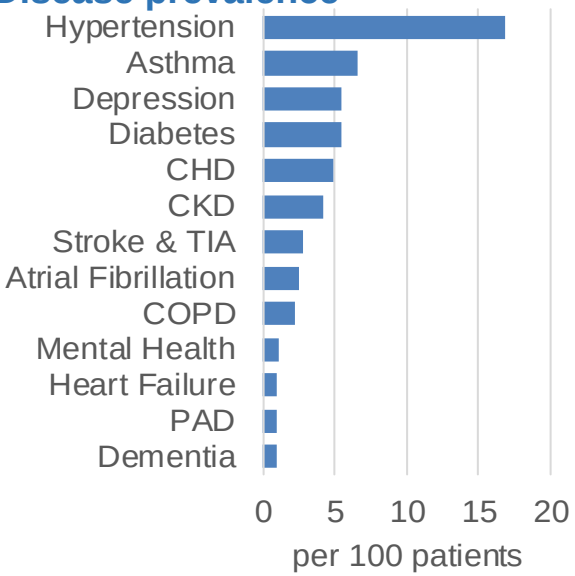
Health Conditions



Overall, **32%** said they had **one or more health conditions**. This rose from 10% in those aged 0-15 to **86% in those aged 85+**. The most common conditions were **deafness or partial hearing loss** (25% of those aged 65+) and **physical disabilities**.

Source: Census 2011 Note that people could select more than one type of condition

Disease prevalence



CHD = Coronary Heart Disease
CKD = Chronic Kidney Disease
TIA = Transient Ischaemic Attack
Mental Health = Serious mental health conditions e.g. schizophrenia
PAD = Peripheral Arterial Disease

Common diseases tend to be long-term, lasting more than a year.

Conditions associated with aging e.g. dementia are likely to become more prevalent.

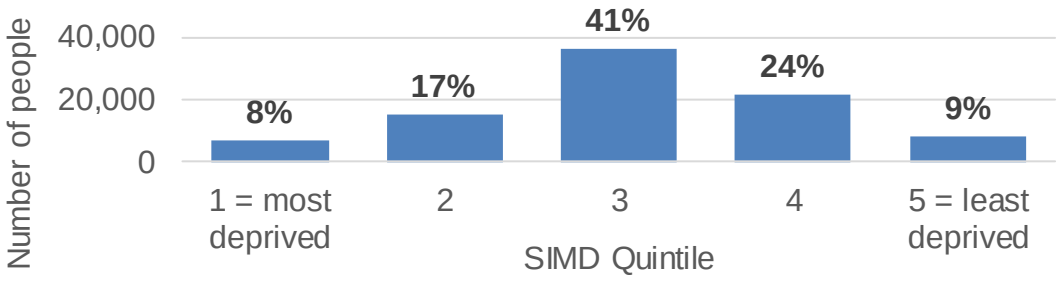
Many people are living with more than one condition and this is more likely as people age. Evidence shows that awareness of the other disabilities people are living with can improve care provision.

It has been demonstrated that lifestyle changes (e.g. healthier eating) can reduce the risk of developing some conditions e.g. type 2 diabetes and coronary heart disease.

Source: GP registers 2015/16, NHS NSS Information Services Division (ISD)

Inequalities in Argyll and Bute

Scottish Index of Multiple Deprivation (SIMD) classifies small areas in Scotland according to 7 different domains: income, employment, education, housing, crime, health and access to services. Areas are ranked and divided into 5 groups, or quintiles.



Small areas in the most deprived quintile are within the towns of Campbeltown, Helensburgh, Dunoon, Hunter's Quay, Oban and Rothesay. The areas in the least deprived quintile are all in or around Helensburgh and Garelochhead. Small rural areas more likely to be mixed with regards to socioeconomic status, e.g. the housing available is more likely to represent a range of Council Tax bands, and they tend to fall into the middle quintiles. Note that not all people living in the most deprived quintile experience relative deprivation and similarly, there may be people living in the least deprived quintile who do experience relative deprivation. Overall, **10 %** of people in Argyll and Bute are estimated to be **income deprived***. * In receipt of or dependent on someone else in receipt of one or more of a number of in or out of work benefits, tax credits or pension credits

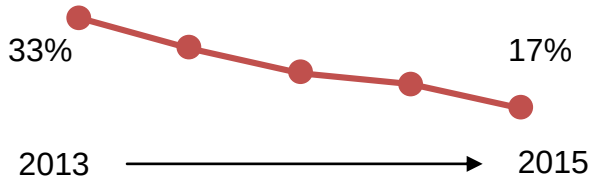
		SIMD quintile				
		1 = most deprived	2	3	4	5 = least deprived
Income deprived		21%	11%	8%	7%	4%
Children living in poverty		22%	12%	8%	6%	4%
Rate neighbourhood as 'very good' place to live		36%	Data not published			71%
Patients with emergency hospitalisations (age-sex standardised rate per 100,000 population)		8,767	1,263	1,211	1,094	1,086
Life expectancy (years)	Male	72.8	77.7	77.8	80.5	81.3
	Female	77.9	81.4	81.4	84.3	83.2

People living in SIMD quintile 1 are more likely to be income deprived that those living in SIMD quintile 5, and children are more likely to be living in poverty. Average life expectancy is lower in SIMD quintile 1 than SIMD quintile 5 and people are more likely to have had an emergency hospitalisation. People living in SIMD quintile 1 are less likely to rate their areas as a good place to live.

Sources: SIMD 2016: NHS NSS ISD (Population-weighted) and Scottish Government. 2017 Scottish Household Survey: perception of neighbourhood. ScotPHO deprivation profile: Income (2015), Child poverty (2012), Patients with emergency hospitalisations (2013-2015) Life expectancy (2009-2013)

Healthy Lifestyles

Smoking



Smoking rates in Argyll and Bute have decreased, but 1 in 6 adults were still estimated to be smokers in 2016.

Source: Scottish Core Survey Questions.

Child health	A&B	Scotland
Babies exclusively breastfed at 6-8 weeks	**33%**	30%
P1 children of healthy weight (compared to 90% in 1990 UK reference)	**74%**	77%

Although breast feeding rates in Argyll and Bute are higher than in Scotland as a whole, rates are low compared to other countries.

There are significantly less children of healthy weight than in the 1990 UK reference, with relatively high rates of children who are overweight or obese.

Source: ScotPHO: breast-feeding (2015/6 to 2017/8), P1 health weight (2017).

Although improvements can be seen, e.g. in lower rates of smoking and reduced alcohol consumption in adolescents (SALSUS survey), there is evidence that healthier lifestyle choices could reduce and help to manage long-term conditions e.g. hypertension and give children the best start possible.

Community resilience

	A&B	Scotland
neighbourhood a 'very good' place to live	**70%**	57%
'strongly agreed' they could rely on friends/relatives in neighbourhood for help	**73%**	63%

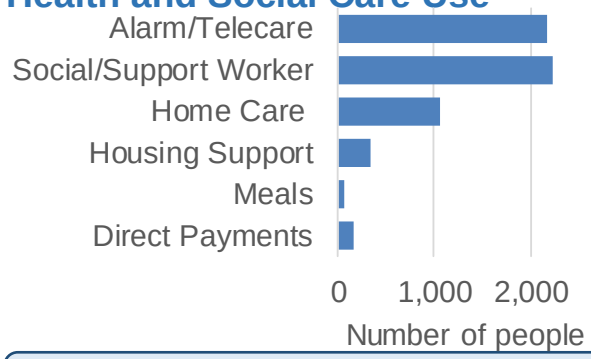
A high proportion of people feel Argyll and Bute is a very good place to live and can rely on people in their neighbourhood for help.

'not at all strongly' belong to community	**15%**	5%

Isolation and loneliness can have a large impact on health and wellbeing. A&B has a high proportion of secondary homes and holiday accommodation which may affect communities. A&B also has high rates of migration of people into and out of the area; mainly between other areas in Scotland and the UK. 'Faslane' military base, in Helensburgh and Lomond, likely accounts for some of this. Local survey evidence suggests that community cohesion is lower in Helensburgh and Lomond. However, there are communities in A&B that are very strong, including many that are small and remote. NRS estimate that **21% of those aged 18+ live in single person households**.

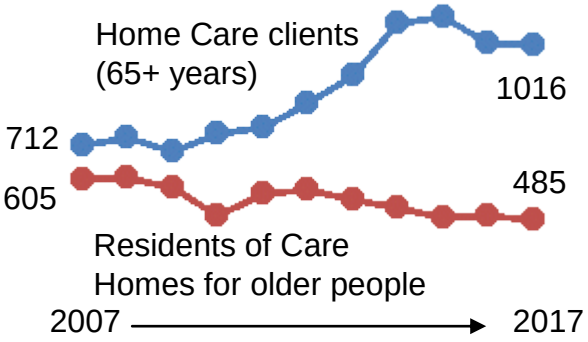
Sources: Scottish Household Survey 2017 (based on a small sample of 250 people in A&B)
Migration: NRS. A&B Citizens panel survey

Health and Social Care Use



3,690 people (4.3%) in A&B receive social care, of which 83% are aged 65+. 330 people of all ages are known to have a Learning Disability.

Source: Scottish Government Social care Survey 2017: People can receive more than one service



Provision of Home Care has increased over the past 10 years whereas the number of Care Home residents has decreased. 95% of those receiving Home Care are aged 65+. The median length of Care Home stay has decreased but the complexity of care required has increased.

Source: Care Home Census 2017: NHS NSS ISD

Unpaid Care

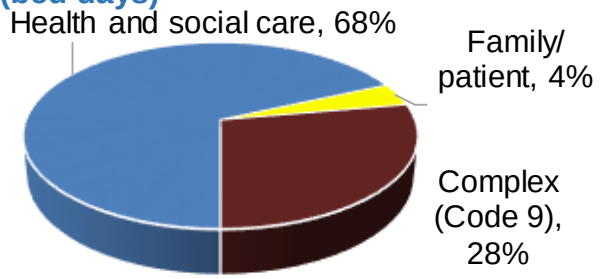
17% of adults reported providing unpaid care. Caring may impact on the health and wellbeing of unpaid carers themselves (including young carers).

Source: SSCQ 2017

Delayed Discharges

Delayed discharges occur when people do not need to be in hospital for medical reasons but they cannot yet be discharged. In the first half of 2018/19, an average of **27 beds a day** were taken up by delayed discharge patients from Argyll and Bute across Scotland.

Reasons for delayed discharges (bed days)



Source: NHS NSS ISD (April – Sept 2019) Code 9: complex and considered out of the immediate control of HSCP staff (e.g. requirement for specialist facilities that do not exist in A&B).

Awaiting appropriate arrangements for safe discharge to be made by health and social care accounted for most bed days. Providing increased care at home presents a challenge in the context of a decreasing working age population and the remote and rural geography of Argyll and Bute.

Child Protection

There were 175 looked after children in A&B at July 2017, 87% of which were looked after in a community setting. 31 children were on the child protection register. Concerns include domestic abuse, neglect and parental substance misuse.

Source: Scottish Government Children's social work statistics (at 31st 2017)

SECTION 4 - PARTNERSHIP ACHIEVEMENTS

Over the last 3 years the HSCP has made some significant progress in achieving the vision for Health and Social Care in Argyll and Bute and integrating services. The following pages describe a few of our key achievements.

Community Capacity building	Community Care
• Robust community led structures for health improvement with eight Health and Wellbeing Networks and a small grant fund to support community activity. • Health and wellbeing grant funding supporting a wide range of health improving activities, for example, 98 projects funded during 2018 – 19 with an average investment of £1,124.39 • Joint Health Improvement plan evaluated in 2016 and refreshed for 2017 – 2022. This includes the following new strategic priorities: getting the best start in life; working to ensure fairness; connecting people with support in their community; and focusing on wellness not illness. • Promoting understanding of self-management of long term health conditions amongst front line staff and commissioning services to support self-management. Examples include the pain management toolkit, type 2 diabetes framework, link working and tai chi for health. • Wide range of population health improvement programmes underway, for example, smoking cessation, sexual health, mental health improvement and alcohol & drugs.	• Developed Community Care Teams with a single point of access in Kintyre and Mid-Argyll • Developed a single point of access for health community referrals in Dunoon • Embedding across Argyll and Bute a re-ablement approach to care that enables people to reach their highest level of independence, reducing the need for continued care at home • In the process of simplifying referral pathways into community teams ensuring a quicker referral and allocation process to support quicker access to services • Day Responder Service – this is a rapid response service and the team role is to support people to stay at home and avoid hospital admission – e.g. deliver or collect medication, attend the person's home to supply prescribed medication, encourage them to drink regular fluids for adequate hydration. • Development of an Equalities Outcome Framework to assist the HSCP meeting the Scottish requirements of the Equalities Act 2010.

Children Services	Housing and Social Care
• Graded 'very good' in 100% of our children's residential services. Fostering services also graded as 'very good'. • Increased the numbers of looked after children placed in family type placements. • Implementing video conferencing 'Attend anywhere' for Maternity Services ensuring reduced travel for patients in the Argyll and Bute area, starting on Islay	• Working in partnership with our communities and local housing association we developed extra care housing unit in Lorn Campbell Court. • Undertook a housing and health care Health Need profile with Argyll and Bute Council and Local Housing Associations to plan for future specialist housing care to meet need
Technology Enabled Care and IT	
• Created a fully integrated Technology Enabled Care Hub with single point of referral, dedicated staff and a standardised pathway across all localities. • Provided telecare monitoring and home health monitoring support for people to maintain their independence and prevent illness or worsening of their condition. • Personalised text reminder service for people with chronic health and other conditions to support them with medication or monitoring. We now have over 800 users in Argyll and Bute. • Delivered the migration of Telecare information from existing standalone database into social care system to improve service to patients and ensure best use of resources.	• Migrated Criminal Justice data from West Dunbartonshire Council to Argyll and Bute HSCP as required by the new model for community justice. • Transferring 300+ community based health staff onto the social care system providing a single IT (Information Technology) community system by March 2019. • Successfully obtained further national funding to further increase the use of 'Attend Anywhere' virtual clinics within Oncology and Maternity services. • Planning and buying a new IT "Portal" system which will allow clinicians to view patient's records across Argyll and Bute and NHS Greater Glasgow and Clyde Hospitals by March 2019. • Development of a single community care assessment system across the HSCP.

Health and Social Care Partnership Engagement and Communication	
▪ Developed the HSCP Engagement Framework May 2018 which draws on the International Association for Public Participation and the Scottish Health Councils Participation Toolkit. ▪ Developed an Engagement Quality Assurance Framework as a means of evidencing engagement activity and achievement against acknowledged good practice. ▪ Established a Strategic Engagement Advisory Group comprising of the Scottish Health Council; service User/Carer, 3rd Sector and HSCP engagement, health improvement and planning officer. ▪ Used 'Emotional Touch Points' approaches 'to demonstrate how personal stories can contribute to improvement and ensure that care is effective, relevant and high quality during integration of health and social care.	▪ Feedback was invited from citizens, service user and carer representatives, partners and staff to inform the development of the 2nd Strategic Plan. The consultation received feedback on the proposed strategic areas of change as well as suggestions about what the HSCP needs to do to make sure people are involved in the process of change ▪ Developed an Engagement Specification which provides guidance for managers and teams on the steps to be considered when planning effective engagement with citizens, partners and staff. These steps reflect the approach outlined in the HSCP Engagement Framework and provides a recommended approach to engagement which is based on recognised best practice. ▪ Developed and strengthened our use of social media with dedicated Facebook and Twitter accounts to inform and engage with our communities and staff

Carers	Adult Services
• Established a multi-agency Carers Act Planning Group in Argyll and Bute with representation from all our partners. • Developed a local Carers strategy and Short Breaks Statement in response to the Carers Act 2016. • Agreed Argyll and Bute eligibility criteria for Carers. • Developed assessment templates and pathways for Carers describing how to access and receive support from centres and local teams. • Working with carers centres and respite providers to implement the Carers Act which gives carers the right to be assessed and supported in their caring role. • Increased support to carers during hospital discharge planning.	• Continued focussed work has been delivered to care home staff aimed at reducing the number of falls and improving quality of life for residents. • Implemented '***Take the Balance Challenge***' in partnership with Police Scotland and Scottish Fire and Rescue Service aimed at spreading key messages about staying active to reduce falls. A short video is available with subtitles and can be downloaded here - https://vimeo.com/234691208/7a79ab7be1 • Reduced length of stay and readmission rates for patients in our community hospitals. • We have maintained our A&E waiting time performance in Argyll and Bute with 98% of patients seen and treated within the 4 hour waiting time target. • Enhanced funding to local existing young carer service.
Mental Health Services	
• Continued to strengthen and invest in our community mental health services to provide a more responsive service. • Moved the mental health inpatient ward to the new Mid Argyll Hospital after a £500,0000 refurbishment and upgrade to 21st century standards	

The Argyll and Bute HSCP Annual performance report 2017/18 provides more information on the achievements, progress and performance of the organisation in improving health and social outcomes and delivering services for our communities – it can be found at: www.bit.ly/StratPlanPerfRep

SECTION 5 - STRATEGIC PLANNING WITHIN THE HEALTH AND SOCIAL CARE PARTNERSHIP

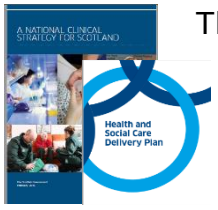
The following describe what has shaped and informed the production of our Strategic Plan and what arrangements we have in place to implement our Strategic Plan.

5.1 The Strategic Plan

Argyll and Bute Health and Social Care Partnership are required, under the auspices of the Public Bodies (Joint Working) (Scotland) Act 2014, to produce a Strategic Plan. The Strategic Plan sets out the services which the Partnership has responsibility for and how these services will be delivered within Argyll and Bute. The plan will also demonstrate how we intend to measure progress in relation to local service delivery and in relation to the National Health and Wellbeing Outcomes (NHWBO) which promote quality health improvement across integrated health and social care services, these are available to view in **Appendix 2**.

This Strategic Plan has been developed within the context of the wider Health and Social Care national strategic planning and policy arena and in consideration of both host organisations and partners existing strategies and policies. **Appendix 4** displays a map of National and local policies and strategies which have been taken into consideration in the development of this plan and in the delivery and redesign of services throughout the Health and Social Care Partnership.

Some key developments over the past three years which have informed the shaping of this plan include:



The Scottish Government **Health and Social Care Delivery Plan** and the **National Clinical Strategy** were both published in 2016 and set out the expectations for a modern health and care system for Scotland. This includes a requirement for organisations to come together and focus on regional planning of services where appropriate.

West of Scotland (WoS) Regional Plan for Health and Social Care - The West of Scotland Health and Integrated Joint Boards (and all other Boards in Scotland) have been directed by the Scottish Government to produce a Regional Delivery Plan to implement the National Health and Social Care Delivery Plan. This is to fulfil the collective ambition of the West of Scotland Boards to improve the health and care of the 2.7 million people who live within our communities.

The intention is to do this by providing care for and with individuals and their carers that foster independence; are sustainable; and are safe, effective, equitable and proportionate to their needs. It also details the guiding principles, vision, aims and direction of travel which will inform redesign and development of regional services.

National Workforce plans for Health and Social Care – Scottish Government

The Scottish Government has developed and issued 3 national workforce plans to facilitate and support the strategic delivery of integrated health and social care services:

2017/18 National Health and Social Care Workforce Plan: part one. Published: 28 Jun 2017. Focussing on NHS Scotland aims to support NHS Scotland organisations, including independent NHS contractors in the community, to identify, develop, retain and support the workforce they need to deliver safe and sustainable services to Scotland's people;

It aims to enable NHS Scotland organisations to work together over time to help deliver a whole system approach to health and social care.

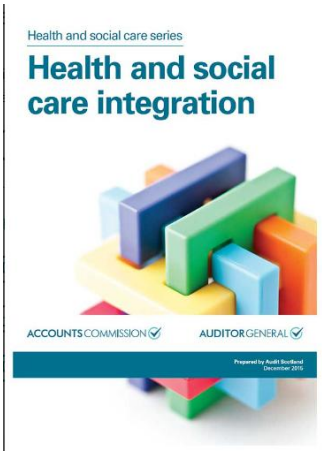
Framework for improving workforce planning across NHS Scotland, including the establishment of a National Workforce Planning Group.

2017/18 National health and social care workforce plan: part two. Published: 15 Dec 2017. Part two of the plan will enable a move towards improved workforce planning in Social Care.

Workforce planning in respect of social care faces distinct challenges. The social care workforce is the largest publicly funded workforce in Scotland, including the independent, public and third sectors who are working with citizens who need support - ranging from vulnerability in older people to those with disabilities, mental ill-health and homelessness, children's services and criminal justice.

Looking to the future, Integration Authorities will need to be able to draw on a more integrated and multidisciplinary workforce and so the workforce we currently have and our approach to recruitment and retention, training and education has to be supported to respond to that challenge.

National health and social care workforce plan: part three "Primary Care". Published: 30 Apr 2018. This sets out the Scottish Government's vision for the future of primary care - enhanced and expanded multi-disciplinary community care teams, made up of a variety of professionals each contributing their unique skills towards delivering person-centred care and integrated services improving outcomes for individuals and local communities.



Integration of Health and Social Care – Audit Scotland

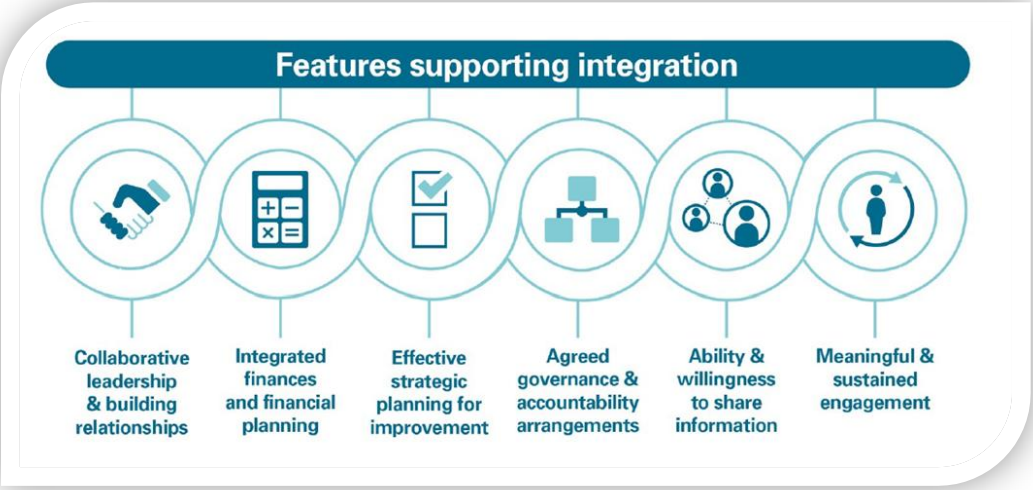
Audit Scotland have also conducted a number of investigations into how integration of health and social care is progressing. These reports have provided an objective focus on the success and challenges to be overcome for IJB's to achieve their objectives. The latest report **Health and Social care integration: update on progress Nov 2018**

http://www.audit-scotland.gov.uk/report/health-and-social-care-integration-update-on-progress

This short video produced by Audit Scotland "How We Can Transform Health and Care Services", explains the challenges we are facing and what we must do to get us back on track https://www.youtube.com/watch?v=2nqp9bZzK28

Ministerial Strategic Group for Health and Community Care Review of Progress with Integration of Health and Social Care. Final Report. Published February 2019.

The strategic group for health and community care has been involved in an ongoing review of the progress made by integration authorities across Scotland. This report summarises the key features which are critical to support and develop integrated services (shown in diagram below)



The report also explorers each of the four key areas in the diagram above which require focussed improvement across Scotland. Each have associated proposals for action and expected timelines.

The full report is available on:
https://www.gov.scot/binaries/content/documents/govscot/publications/report/2019/02/ministerial-strategic-group-health-community-care-review-progress-integration-health-social-care-final-report/documents/00545762-pdf/00545762-pdf/govscot%3Adocument

European Union (EU) Exit Planning

The uncertainty caused by **EU Exit Planning** and its impact on Health and Care over the 3 years of this Strategic Plan is also an important factor. There are a number of macro-economic and social implications. The areas which will have the most direct impact on Health and Care services subject to either an agreement or no agreement are generally considered to be:

- Staffing - The EU's policy of freedom of movement and mutual recognition of professional qualifications within the EU means that many health and social care professionals currently working in the UK have come from other EU countries

- Regulation - These include:
    - The working time directive
    - Procurement and competition law and consequent stockpiling and costs
    - Regulation of medicines and medical devices
    - Regulation to enable common professional standards and medical education between European Economic Area (EEA) countries.

- Cross-border cooperation - As well as playing an important role in a range of public health issues, the EU operates systems for the surveillance and early warning of communicable diseases, These facilitate the rapid sharing of information and technical expertise in response to potential pandemics, communicable diseases and other cross-border health threats e.g. H1N1 pandemic and efforts to tackle anti-microbial resistance (AMR).

- Funding and finance - HM Treasury has stated in the longer term the UK 'will be poorer' with a reduced economy. If these warnings prove to be correct and cuts in public spending follow, then the implications for a health and care service already struggling to live within its existing budget would be significant.

5.2 Strategic Planning Arrangements

5.2.1 Strategic Planning Group

The Strategic Planning Group includes representation from the service users, the public, Carers and organisations that deliver, or have an interest in, adult health and social care. It has the responsibility to develop the Strategic Plan including the strategic commissioning plan while ensuring progress is regularly measured against the outcomes for health and wellbeing, and associated local and national indicators.

What we intend to do…
Over the next three years we intend to revisit the role mechanisms and structure of the HSCP Strategic Planning Group to ensure it is operating as effectively as possible.

Its role will also include guiding, supporting and reviewing the arrangements and work of our locality planning groups

The Strategic Planning Group will also look to put in place effective governance and reporting structures to identify how we best shape and deliver our strategic commissioning priorities.

5.2.2 Locality Planning Groups

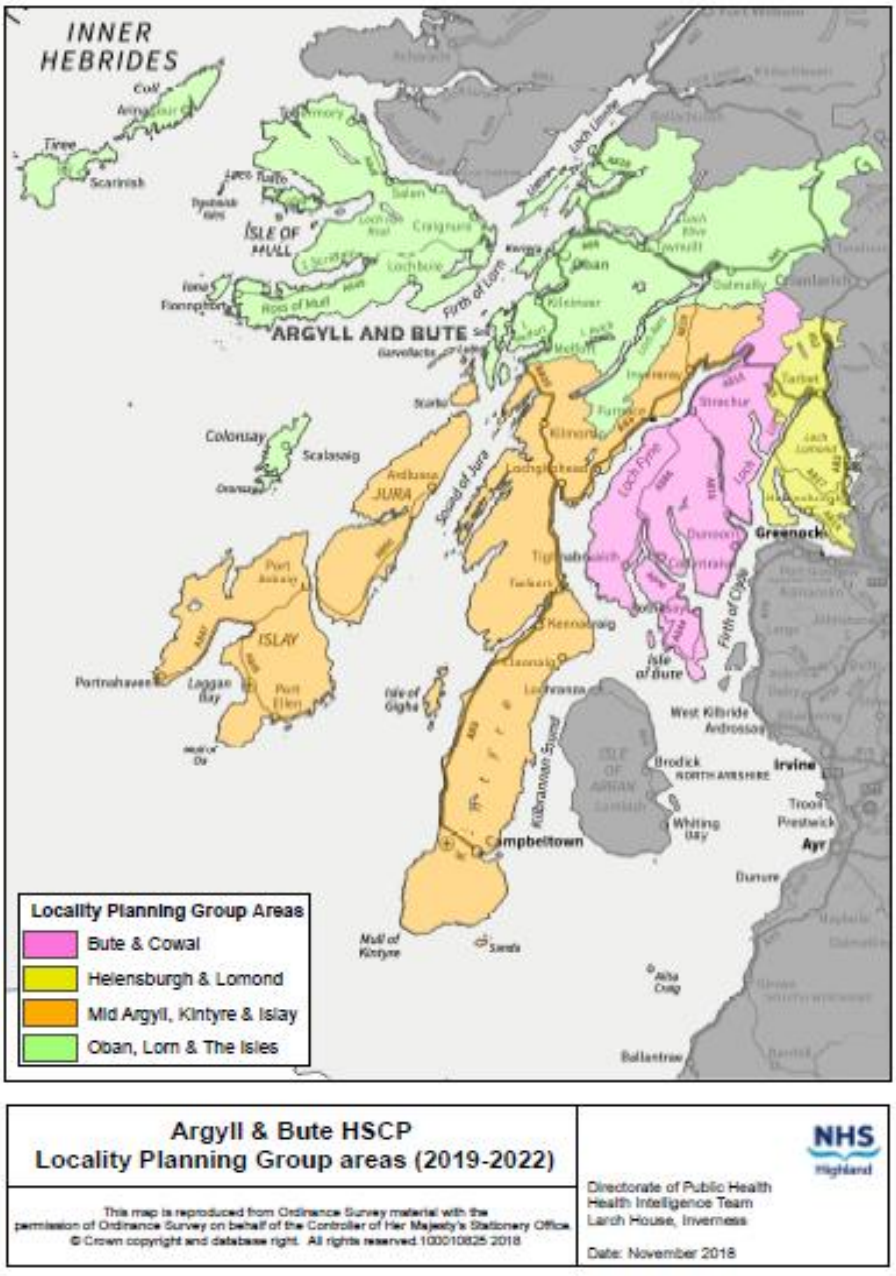
Locality Planning Groups (LPGs) are required to develop, engage, communicate and enact the implementation of the 3 year Strategic Plan, at locality level, by developing their own annual Locality implementation plan. This plan is required to:

- Support the 7 areas of focus and strategic transformation objectives of the Argyll & Bute HSCP
- Deliver against the road map of "what we expect to look like in 2019 - 2022
- Review the locality plan on an annual basis to ensure it is meeting identified need
- Assess progress against the locality plan and provide an annual report to the Strategic Planning Group

Following an Option Appraisal Workshop in October 2018 attended by Locality planning group members, participants' agreed that the current model of locality planning groups was not working and required urgent revision to achieve more efficient and effective shared planning across Argyll & Bute. A 'Four Locality Planning Group Model' overwhelmingly emerged as the preferred model for future locality planning arrangements in Argyll and Bute.

The new preferred localities (shown in the map below) were identified as:

- Bute & Cowal
- Helensburgh & Lomond
- Oban, Lorn & Isles
- Mid-Argyll, Kintyre & Islands



Argyll & Bute HSCP
Locality Planning Group areas (2019-2022)

NHS Highland
Directorate of Public Health
Health Intelligence Team
Larch House, Inverness
Date: November 2018

The health needs profiles for each of the Locality Planning Group areas are available in the following pages:

Health Need profile Bute & Cowal (B&C) Locality Planning Group Area

Population size

Age	Number	%B&C	%A&B
0-15	2842	14%	15%
16-44	5120	25%	30%
45-64	6249	31%	30%
65-74	3489	17%	14%
75-84	2069	10%	8%
85+	704	3%	3%

20,473 people

B&C has the highest proportion of older people of all LPG areas with **13.5% aged 75+** compared to 10.9% in A&B.

Source: NRS 2017-population estimates

Built and rural environment

B&C has 5 settlements (of 500 people or more): Dunoon (9,140), Rothesay (4,390), Innellan (1,210), Port Bannatyne (1,140) and Tighnabruaich (520).

33% live in rural areas that are remote or very remote

30% (6,144) people live on the island of Bute and **14,329** within Cowal.

34% live in areas in the 20% most deprived for geographic access to services (derived from travel times)

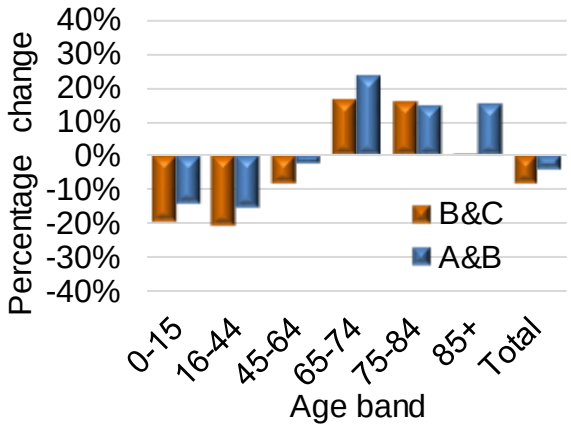
26% of those aged 18+ live alone.

10% of dwellings are second homes (compared to 1% nationally).

6% of dwellings are vacant (compared to 3% nationally)

Sources: Scottish Government UR 2016 SIMD 2016, NRS 2017 population and household estimates and 2016 settlement estimates

Population change (2007-2017)



There was an **overall 8% decrease** in the population of B&C between 2007 and 2017 whereas the number of **people aged 75+ increased by 11%**. Local population projections from 2019 to 2024 and 2029, suggest there could be a **continued decrease in the overall population** of B&C along with a **continued increase in the number of people aged 75+** and a greater proportional increase in those aged 85+.

Source: NRS population estimates (2007 – 2017)
A&B Council local population projections (2013)

Deprivation

14.3% of the population are income deprived

14.1% live in one of the 20% most deprived areas in Scotland. These areas are within Rothesay, Dunoon and Hunter's Quay. Note that the majority (72%) of those income deprived live in other areas of B&C.

Source: SIMD 2016

Health Need profile Helensburgh & Lomond (H&L) Locality Planning Group Area

Population size

Age	Number	% H&L	%A&B
0-15	4096	16%	15%
16-44	8848	34%	30%
45-64	7533	29%	30%
65-74	3279	13%	14%
75-84	1734	7%	8%
85+	674	3%	3%

26,164 people

H&L has a lower proportion of older people than Argyll and Bute as a whole, with **9.2% aged 75+** compared to 10.9% in Argyll and Bute. The higher proportion of those aged 16-44 reflects the presence of Faslane in the locality which employs a high proportion of males of this age.

Source: NRS 2017-population estimates

Built and rural environment

H&L has 5 settlements (of 500 people or more): Helensburgh (15,610), Garelochhead (3,700), Cardross (2,110), Kilcreggan (1,270) and Rosneath (1,240).

H&L is the only locality in to have an 'urban' area (Helensburgh).

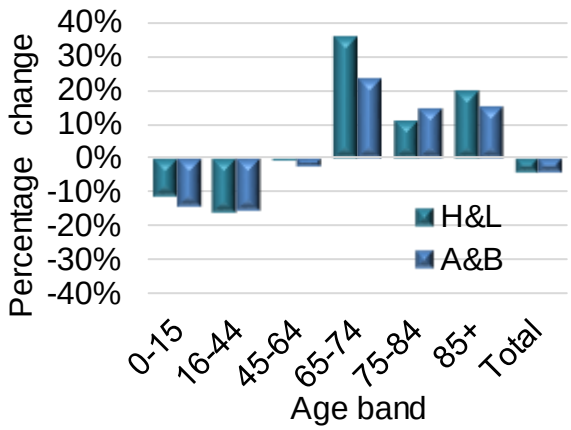
11% live in rural areas that are also remote or very remote**.**

47% live in areas in the 20% most deprived for geographic access to services (derived from travel times)

17% of those aged 18+ live alone.

Sources: Scottish Government UR 2016, SIMD 2016, NRS 2017 population and household estimates and 2016 settlement estimates

Population change (2007-2017)



There was an **overall 4% decrease** in the population of Helensburgh and Lomond between 2007 and 2017 whereas the number of **people aged 75+ increased by 14%**. Local population projections from 2019 to 2024 and 2029, suggest there could be a **continued decrease in the overall population** of H&L with a **continued increase in the number of people aged 75+** and a greater proportional increase in those aged 85+.

Source: NRS population estimates (2007 – 2017)
A&B Council local population projections (2013)

Deprivation

8.0% of people are income deprived

7.6% of the population live in one of the 20% most deprived areas in Scotland. These areas are within Helensburgh. Note that the majority (75%) of those income deprived live in other areas of H&L.

Source: SIMD 2016

Health Need profile Oban, Lorn and the Isles (OLI) Locality Planning Group Area

Population size

Age	Number	% OLI	%A&B
0-15	3201	16%	15%
16-44	6243	31%	30%
45-64	6161	31%	30%
65-74	2627	13%	14%
75-84	1418	7%	8%
85+	527	3%	3%

20,177 people

OLI has a lower proportion of older people than A&B, with **9.6% aged 75+** compared to 10.9% in A&B.

Source: NRS 2017-population estimates

Build and rural environment

OLI has 3 settlements (of 500 people or more):

Oban (8,790), Tobermory (1,010) and Dunbeg (610).

58% live in rural areas that are remote or very remote

56% live in areas in the 20% most deprived for geographic access to services (derived from travel times)

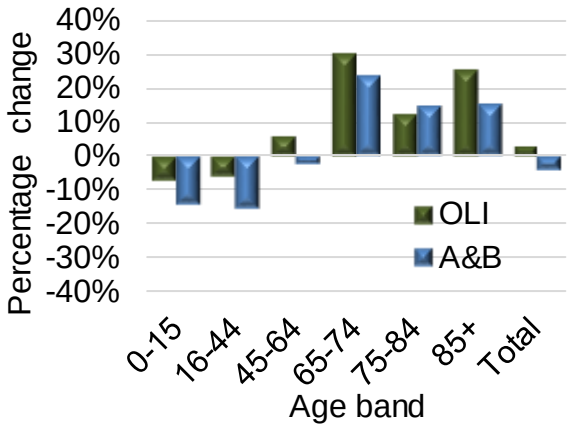
25% live on one of 16 inhabited islands (2011 census population), the largest populations are on Mull (2,800), Tiree (653), Seil (551), Coll (195), Luing (195), Lismore (192), Iona (177), Colonsay (124), Easdale (59) and Kerrera (34).

21% of those aged 18+ live alone.

8% of dwellings are second homes (compared to 1% nationally).

Source: Scottish Government UR 2016, SIMD 2016 NRS 2017 population and households NRS 2016 settlements and Census 2011

Population change (2007-2017)



There was an **overall 3% increase** in the population of OLI between 2007 and 2017 whereas the number of **people aged 75+ increased by 16%.** Local population projections from 2019 to 2024 and 2029, suggest there could be a **continued increase in the overall population** of OLI with a greater proportional **increase in the number of people aged 75+** and particularly in those aged 85+.

Source: NRS population estimates (2007 – 2017)
A&B Council local population projections (2013)

Deprivation

7.9% of people are income deprived

2.4% of the population live in one of the 20% most deprived areas in Scotland. These areas are within Oban. Note that the majority (91%) of those income deprived live in other areas of OLI.

Source: SIMD 2016

Health Need profile Mid Argyll, Kintyre and Islay (MAKI) Locality Planning Group Area

Population size

Age	Number	% MAKI	%A&B
0-15	3024	15%	15%
16-44	5478	27%	30%
45-64	6178	31%	30%
65-74	2975	15%	14%
75-84	1750	9%	8%
85+	591	3%	3%

19,996 people

MAKI has a higher proportion of older people than A&B, with **11.7% aged 75+** compared to 10.9% in A&B.

Source: NRS 2017-population estimates

Built and rural environment

MAKI has 7 settlements (of 500 people or more): Campbeltown (4,670), Lochgilphead (2,300), Ardrishaig (1,290), Tarbert (1,130), Port Ellen (810), Bowmore (720) and Inverarary (560).

77% live in remote or very remote and rural areas

51% live in areas in the 20% most deprived for geographic access to services (derived from travel times)

17% live on an island (2011 census population), the largest populations are on Islay (3,228), Jura (196) and Gigha (163).

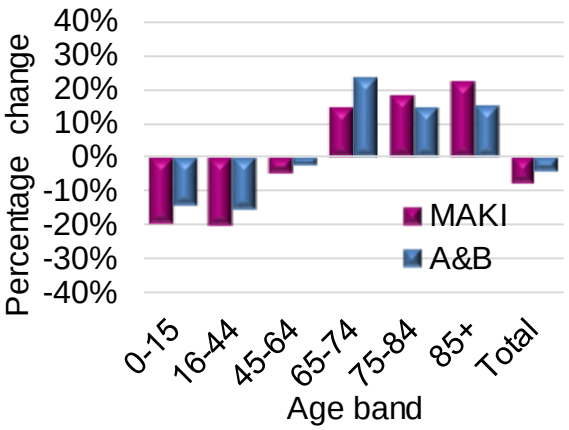
23% of those aged 18+ live alone.

8% of dwellings are second homes (compared to 1% nationally).

6% of dwellings are vacant (compared to 3% nationally)

Source: Scottish Government UR 2016, SIMD 2016 NRS 2017 population and households NRS 2016 settlements and Census 2011

Population change 2007- 2017



There was an **overall 8% decrease** in the population of MAKI between 2007 and 2017 whereas the number of **people aged 75+ increased by 19%**. Local population projections from 2019 to 2024 and 2029, suggest there could be a **continued decrease in the overall population** of MAKI with a **continued increase in the number of people aged 75+** and a greater proportional increase in those aged 85+.

Source: NRS population estimates (2007 – 2017) A&B Council local population projections (2013)

Deprivation

10.3% of people are income deprived

5.9% of the population live in one of the 20% most deprived areas in Scotland. These areas are within Campbeltown. Note that the majority (86%) of those income deprived live in other areas of MAKI.

Source: SIMD 2016

What we intend to do…

- Implement the new model of locality planning groups by April 2019.
- Review community engagement groups to support this new model of locality planning groups
- Develop a locality plan for each of the new locality areas based on the Strategic Plan.

5.2.3 Strategic Commissioning Intentions

Our commissioning priorities for the next three years will be informed by our eight programmes of transformational change. The output from each programme will define our future requirements with regard to the procurement and development of services that are necessary to meet the strategic objectives of our plan.

This work will inform the development of our Strategic Commissioning and Market Facilitation Plan in 2019/20 which will be created in conjunction with our Partners including Argyll and Bute Council, Highland and Greater Glasgow and Clyde Health Boards, Third and Independent sector and our Locality Planning Groups.

What we intend to do…

We intend to create a new **Strategic Commissioning and Market Facilitation plan** informed by the outputs from our transformational work streams, including undertaking a gap analysis and reviewing current delivery and performance.

5.2.4 Community Planning Partnership

The main purpose of the Community Planning Partnership (CPP) in Argyll and Bute is to address population decline and grow the economy via **Argyll and Bute Outcome Improvement Plan (OIP) 2013 - 2023** The purpose of the plan is to detail strategic or high level priorities, identify the outcomes which will be delivered by the partners either individually or jointly, and show how those outcomes will contribute to Argyll and Bute CPP purpose and one or more of the Scottish Government national outcomes

Outcome 1 - The economy is diverse and thriving

Outcome 2 - We have infrastructure that supports sustainable growth

Outcome 3 - Education, skills and training

Outcome 4 - Children and young people have the best possible start

Outcome 5 - People live active, healthier and more independent lives

Outcome 6 - People live in safer and stronger communities

Of the six outcomes the HSCP takes the lead and has significant influence on outcomes 4 and 5 and our Strategic Plan and planning arrangements are aimed at achieving our partnership aims and aspirations and improve the quality of life for communities throughout Argyll and Bute.

The Community Planning Partnerships website is available on: https://www.argyll-bute.gov.uk/council-and-government/community-planning-partnership

5.2.5 Performance

The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. Together these outcomes focus on improving the experiences and quality of services for people using these services, carers and their families, as well as, the difference that integrated health and social care services should make, for individuals. Currently there are 9 key National Health and Wellbeing Outcomes (NHWBO) and 23 sub indicators which form the basis of the reporting requirement for the HSCP.

The Argyll and Bute Integration Joint Board has the responsibility to oversee the performance of the services for which it is responsible, progress against these indicators is reported quarterly to the IJB at a locality and Argyll and Bute wide level. The Public Bodies (Joint Working) (Scotland) Act 2014 also requires partnerships to produce an Annual Performance Report. The latest performance report (2017/18) can be found on the Argyll and Bute Council website at: www.bit.ly/StratPlanPerfRep .

5.3 Clinical and Care Governance

The Argyll and Bute Clinical and Care Governance and Professional Governance Frameworks sets out the systems and structures through which the Integrated Joint Board can receive assurance regarding the care delivered in Argyll and Bute HSCP.

The Clinical and Care Governance structure is firmly embedded within the HSCP and is threaded through all our health and social care delivery and supporting structures and encompasses the following themes;

- Quality and Effectiveness of Care
- Safety
- Experience
- Professional regulation and workforce development.

- Social Justice
- Information governance

The IJB receives regular reports on care and clinical governance at its meetings and these can be found:

https://www.nhshighland.scot.nhs.uk/Meetings/ArgyllBute/Pages/Welcome.aspx

SECTION 6 – HEALTH AND SOCIAL CARE PARTNERSHIP

This section, outlines what we do, who our key partners in health and care are and what we are planning to do over the next 3 years.

6.1 Local Health and Care Facilities and Services

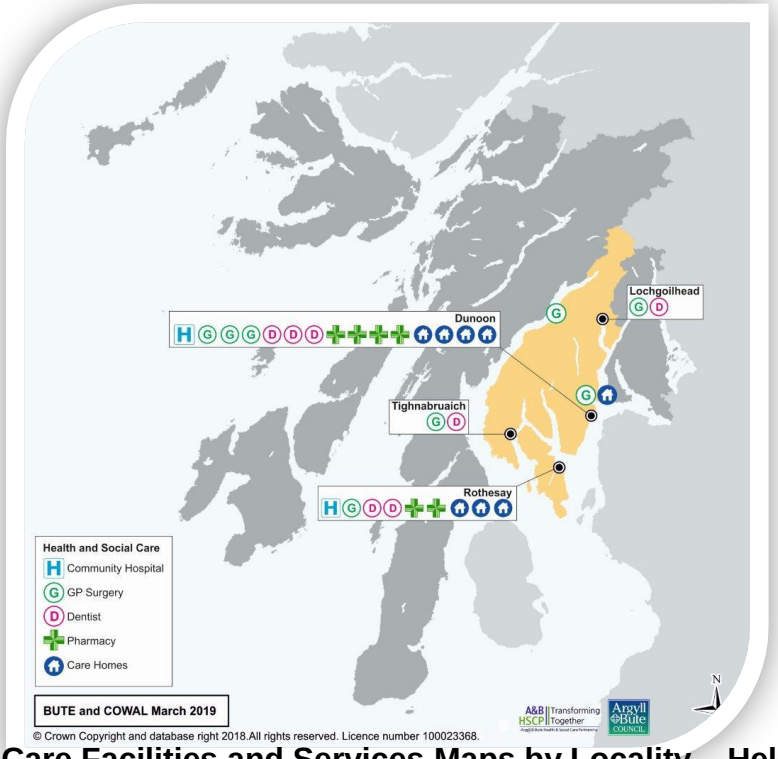
Argyll and Bute Health and Social Care Partnership is responsible for the planning and delivery of all hospital and community based health and social care services for adults and children in Argyll and Bute. Our main health and care facilities in Argyll and Bute are overleaf in maps describing the services within each locality planning group area.

Argyll and Bute geography covers some 2,500 square miles and encompasses a range of rural, very remote rural and populated islands. This presents a variety of challenges to the sustainability of health and care services as well as an increase in the cost of service delivery. Working with our communities and staff we have striven to maintain local service so as to provide the vast majority of our health and care services within Argyll and Bute close to people's communities.

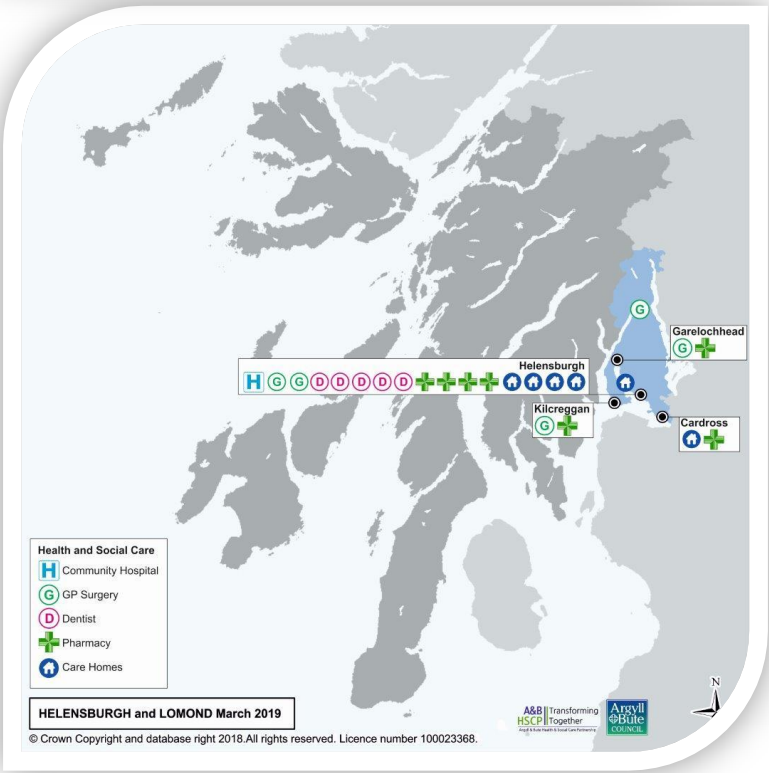
What we intend to do…

Over the next three years we will be progressing actions to meet our strategic areas of focus enhancing the quality and sustainability of local services. We will also progress the redesign and transformation of services as detailed in Section 7.

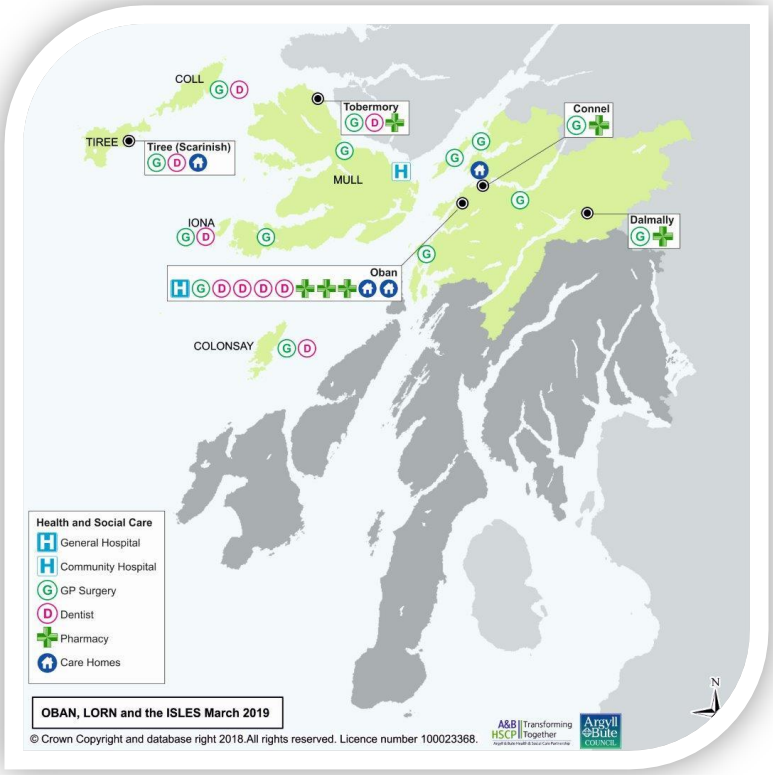
Local Health and Care Facilities and Services Maps by Locality – Bute and Cowal



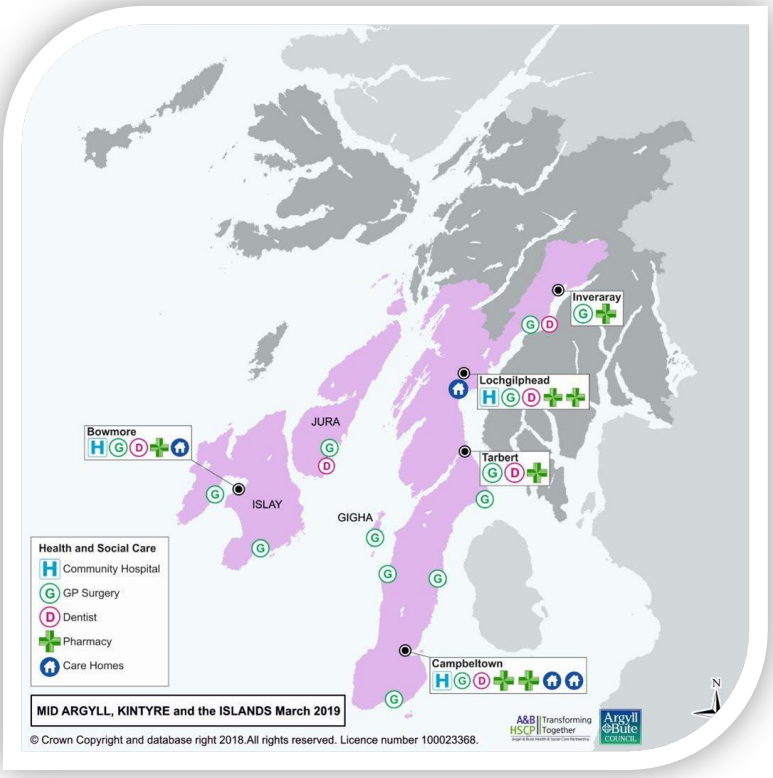
Local Health and Care Facilities and Services Maps by Locality – Helensburgh and Lomond



Local Health and Care Facilities and Services Maps by Locality – Oban, Lorn and Islands



Local Health and Care Facilities and Services Maps by Locality – Mid Argyll, Kintyre and Isles



6.2 Technology Enabled Care (TEC)

Scotland's Digital Health and Care Strategy: “enabling, connecting and empowering” was released in April 2018 and directs Partnerships to maximise the use of technology in reshaping and improving services, with a view to supporting person-centred care, and improving outcomes for individuals. It is available on: https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/

The issue is not whether digital technology has a role to play in addressing the challenges we face in health and care, and in improving health and wellbeing: the issue is that it must be central, integral and underpin the necessary transformational change in services in order to improve outcomes for people. Over the next decade digital services will become not only the first point of contact with health and care services for many people, but also how they will choose to use health and care services on an on- going basis.

Within Argyll and Bute, Technology Enabled Care is used to help people manage their own health, and stay happy, safe and independent in their own homes. It involves using different systems such as alarms, sensors, home health monitoring or text messaging services, which are used in your own home and connect you directly to health services providers.

Following a review of our TEC service in 2018, we have created a TEC integrated hub which is now managed centrally with outreach workers based in each locality. This newly developed, integrated team has a single point of referral and a clear pathway for all clients allowing for supported discharge from services with dedicated staff to provide follow up care. The TEC service also delivers regular training for partnership services enabling them to tap into the TEC support available.

What we intend to do…

Over the next three years we intend to increase the use of digital services and further develop TEC services within Community Teams to ensure it is a core service. We will also further develop ‘Attend Anywhere’ clinics in Dermatology, Respiratory and Gynaecology pressure specialities significantly reducing travel for appointments. The use of home health monitoring will be expanded to help for example titrate medication to clients, freeing up staffs time to offer more direct patient care. We will also complete our new Argyll and Bute TEC strategy, which will include the shift from Analogue to Digital technology.

More information in relation to our TEC service is available on our website at: https://www.argyll-bute.gov.uk/social-care-and-health/argyll-and-bute-telecare-service

6.3 Partnership arrangements with other NHS boards covering adults and children

Argyll and Bute HSCP works very closely with NHS Greater Glasgow and Clyde Health Board, from whom we commission acute hospital and specialist services for emergency, elective and outpatient services. Under this arrangement 11,500 Inpatient, 7,600 Day case 17,100 consultant outpatient and 22,500 nurse led outpatient appointments are provided to residents of Argyll and Bute per year.

The trend over the last few years has seen an expected shift from planned inpatient activity to day case procedures while emergency inpatient activity has remained broadly the same.

What we intend to do…

The HSCP has established regular service planning and operational liaison meetings to consider service and cost issues. We continue to develop excellent working relationships to ensure seamless service provision. Over the next three years our focus will be to increase value and reduce the overall spend on this contract finding other ways to deliver these services within our communities.

6.4 Partnership with the Independent Sector

Argyll and Bute HSCP also commission a wide range of services from the Independent Sector. We continue to work in partnership with these organisations and with Scottish Care (which represents a large section of independent sector health & social care providers across Scotland). This enables the delivery of services throughout our area and create opportunities for improvement.

There is representation from Independent Sector organisations on our Integrated Joint Board (IJB), Strategic Planning Group (SPG) and other working groups within Argyll and Bute HSCP. We value their ongoing contribution and expect their ongoing support moving forward.

What we intend to do….

We are committed to developing a programme of works with Scottish Care and Independent providers and recognise the value of working with them on our Transforming Together objectives (as detailed in Section 7). We aim to work with them to create opportunities for collaboration as we continue to develop our HSCP commissioning plan and work together to develop the service and workforce, capacity and capability to meet our communities' future needs.

6.5 Partnership with Third Sector

Third sector providers encompasses social enterprises, small community groups and voluntary organisations. They essential contributors to the mixed economy of care, providing a wide range of contracted services across all care groups in Argyll and Bute. They play an invaluable role in developing community resilience, engaging people and reducing social isolation. **Argyll and Bute Third Sector Interface (TSI)** is the organisation that enables the third sector voice to be heard in local decision-making.

The Third Sectors is a key partner in the planning, creating, reviewing and delivering of services within Argyll and Bute each partner may have different support needs and will link into different strategies providing shared learning and shared governance. There is representation from the Third Sector organisations on our Integrated Joint Board (IJB) and our Strategic Planning Group (SPG) and Locality Planning Groups (LPGs).

What we intend to do…

Again the importance of our 3rd sector partners in helping achieve our Transforming Together objectives is key. This builds on the success we have achieved to date. It requires to be strengthened and will require us to work closely together to develop our service commissioning plan and the workforce, capacity and capability to meet our communities' future needs.

6.6 Self-Directed Support in Argyll and Bute

The Social Care (Self-directed Support) (Scotland) Act was enacted in 2013 and aims to give people full opportunity to take control of their support and their lives. It is for people of all ages, who after assessment with the HSCP, are identified as eligible for social care and support. Self-Directed Support (SDS) is delivered in line with Scottish Government legislation to ensure everyone, including people who require social care are:

- Respected
- Treated with fairness
- Able as possible, to enjoy the same Freedoms as everyone else
- Able confident that their Safety is a priority
- Able to live with as much Independence as possible

In Argyll and Bute it is often a challenge to deliver the full range of choices for everyone because, for example, there are not care providing services in all communities. This means that we have to work together to find the best possible solution for people to meet their social care needs and outcomes.

What we intend to do…

The HSCP has worked closely with individuals, agencies, the third sector services to enable people to realise the full potential of SDS. We will continue to strengthen and improve this over the next 3 years.

6.7 Criminal Justice Services

The Argyll and Bute Criminal Justice Service has offices in Dunoon, Rothesay, Campbeltown, Lochgilphead, Oban and Helensburgh with responsibility for assessment and supervision of service users, working with partners to deliver public protection, risk management, and interventions with a view to reducing reoffending.

The implementation of the Community Justice (Scotland) Act in 2016 led to the dissolution of Community Justice Authorities in Scotland. Previously, Criminal Justice Services in Argyll and Bute were provided via a partnership arrangement with East and West Dunbartonshire Councils. Since the implementation of the new model for community justice on 1st April 2017, the governance arrangements of Criminal Justice Services in Argyll and Bute have changed. Criminal justice Strategic Planning and service delivery is now the responsibility of local community justice partners which include the Argyll and Bute Council and Argyll and Bute Community Planning Partnership. The statutory partners are required to produce a local plan for community justice (known as a 'Community Justice Outcomes and Improvement Plan') and are required to engage and involve the Third Sector partners in the planning, delivery and reporting of services and improved outcomes.

We are in the process of strengthening relationships with local partners including Argyll and Bute Alcohol and Drug Partnership (ADP) while developing our local Criminal Justice strategy to implement the new arrangements. One key aspect of the new arrangements has been to review effective means of developing resilience for both management and frontline staff within a small and geographically diverse team.

What we intend to do…

Over the next three years our priorities are focussed on building on our achievements by developing a competent and skilled workforce which assists service users to have access to high quality services and interventions, developing and implementing our Youth Justice Strategy and engaging and consulting with our communities and partners to improve and strengthen our services. In addition we intend to:

- prioritise the completion of Service Review to ensure service has sufficient resilience and resources to deliver on national and local outcomes, including the extension of Presumption Against Short Sentences
- Continue to develop links via the Argyll and Bute Alcohol and Drug Partnership (ADP) to create an integrated support service for women with addictions, jointly provided by local

Drug and Alcohol and Criminal Justice Social Work staff offering focussed support on a 1-1 basis to enable women offenders to remain in the community.

- Staff training and implementation of nationally accredited programmes to deliver effective treatment programmes for domestic abuse and sexual offenders to reduce the impact of these crimes in our communities.
- Continue to strengthen partnerships to deliver Community Justice Model.
- Implement new audit and performance improvement frameworks to ensure a high quality service

6.8 Alcohol and Drug Partnership

The Argyll and Bute Alcohol and Drug Partnership (ADP) is a partnership of statutory and voluntary organisations working together to achieve a reduction in the harmful effects of alcohol and drugs on both individuals and the wider community. Alcohol and drug support is available in all localities throughout Argyll and Bute provided by our integrated Argyll and Bute Addiction Team (ABAT) and by Addaction an external provider of community based adult addiction recovery services.

We have worked over the past three years to strengthen our presence throughout the partnership ensuring there is support for all individuals', including young people across the wider geographical area. Currently we have offices in all localities across the Partnership area including Helensburgh, Cowal, Bute, Mid Argyll, Kintyre, Oban and Islay.

More information is available on our website: https://www.argyllandbuteadp.info/

What we intend to do…

- We are in the process of developing our ADP governance structure and will further develop this structure over the next three years ensuring it is aligned to the wider structure of the Integrated Joint Board (IJB).
- We will begin a commissioning exercise for Addiction Support Service provision across all localities.
- In line with the recent release of the new National drug and alcohol strategy, Rights, Respect and Recovery (Available on: https://www2.gov.scot/Resource/0054/00543437.pdf) we intend to develop a new local drug and alcohol strategy for Argyll and Bute.

6.8 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' – namely that *"people, including those*

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

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

The HSCP together with the Council and the Argyll and Bute Housing Associations completed in 2018 a Health and Social Care Housing Health Need profile to inform the Strategic Housing Improvement Plan for Argyll and Bute.

The outcomes of which form the basis of our revised housing contribution statement which is available in **Appendix 5.**

What we intend to do…

- Support implementation of the housing contribution statement
- Working with our local Registered Social Landlords and Argyll and Bute Council Housing department, plan and implement special needs housing that aligns to the requirement defined for each locality from our housing and care Health Need profile.
- Continue to work with partners to strengthen and increase the resource available to support housing adaptations allowing people to remain in their own home
- Working in partnership, progress the outcomes of the care home and housing programme in Section 7.

6.9 Carers

The maintenance of lives that are as healthy, independent and happy as possible relies hugely on the efforts of many in the statutory and voluntary sectors.

Even more than this, the support and care provided by Carers has never been more extensive and more essential. Without their input, the health and social care systems would be unable to function.

The Carers' Strategy for Argyll and Bute recognises this and has been developed as a result of discussion and feedback with a wide range of stakeholders, of whom our Carers have been the most important.

The consultation process has identified the following priority outcomes and commitments.

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

During this time we have also created a multi-agency Carers Act Planning Group which has been hugely successful and responsible for the development of Carer Assessment Templates and Carer Pathways aimed at ensuring that Carers within Argyll and Bute receive appropriate and timely support.

We realise that our staff need to be supported to deliver services to Carers and consequently we have developed guidance in relation to the new Carers Act for our staff, raising awareness and resulting in increased numbers of carers receiving support during the hospital discharge stage. We also recognise the numbers of young carers within Argyll and Bute who care for adults and family members and we have increased our funding to support our existing Young Carers Service.

What we intend to do…

- We intend to deliver on all of our 5 priority outcomes, fulfilling our 30 key commitments by completion of a wide actions over the next three years as detailed in our Carers Strategy Implementation Plan available on: http://bit.ly/ABCarersStrategy

SECTION 7 – TRANSFORMING TOGETHER PROGRAMME

As detailed in our previous plan and further strengthened in this plan there remains an urgent need to continue and accelerate the change in health and social care services from a treatment only, to a health and well-being focused service.

7.1 Our Drivers for Change

The drivers for this change are now well known and understood by the public and stakeholders (see Figure 1 overleaf).

These drivers provide the context for the objectives and policy priorities detailed in this Strategic Plan, which when considered with our Locality Health Need profile and Area Profile has led us to conclude that doing the same things, will not be sufficient to meet future need, hence we must change and transform services and support people to make changes to their life style.

Therefore we need to prioritise investment and transform our services and resources to:

- Preventative measures
- Anticipatory care
- Maintenance of health and well being

Achieving this transformation of services requires the following:

- National and local policy development and application
- Strategic approach to planning and delivery of service at locality, HSCP and regional level
- A focus on quality, safety and sustainability
- Evidence and robust performance management
- A workforce plan that details the skills and roles required to meet need
- A commissioning plan which identifies the gaps in current services, designs new service models and supports market and provider development to meet the health and well-being needs of all of our Communities.
- An organisation that has at its core a continuous improvement system of operation and culture

Figure 1- Drivers for Service Change

7.2 Healthy Argyll and Bute - Health Improvement

Argyll and Bute has a good track record for prioritising working in a preventative way to identify and solve health problems before they arise. In April 2017 the Joint Health Improvement Plan (JHIP) was published and covers a 5-year period to 2022 - http://healthyargyllandbute.co.uk/wp-content/uploads/2013/03/JHIP-2017-22.pdf

It was developed by the Health & Wellbeing Partnership in consultation with partners and also members of the eight Health and Wellbeing Networks. This JHIP is purposely short and should be viewed as a "call to action" for communities and organisations with an interest in enabling the people of Argyll and Bute to lead the healthiest lives possible, thereby contributing to the success of Argyll and Bute.

It sets out how improving health should be approached and gives some practical examples of how this has worked in our local communities. The health improvement approach favoured in Argyll and Bute, centres on building better communities with a wide range of services and activities in these communities.

This is in the knowledge that people live good lives in vibrant communities. We call this an "asset based approach" (see glossary for definition) to health which is different to a "deficits approach" i.e. looking for a health problem and then trying to find the solution. Experience over many years of promoting health has shown that a deficits approach does not work.

Front line staff can help to prevent health and social care problems from getting worse or from arising in the first place. Working in a preventative way can include:

- Educating people on their symptoms and what to do to better manage these symptoms or stop them getting worse – this is known as "self management".

- Talking to people about how to keep well and how to make small changes, for example be more active, drink less alcohol or stop smoking.

- Consider underlying reasons why people are unwell like loneliness, childhood trauma, caring responsibilities or debt and linking them up with practical support in the community.

- Working in a person centred way and having kindness and compassion at the heart of service delivery.

- Recognising the interplay of mental and physical health and the importance of wellbeing, confidence and motivation in improving health outcomes.

Following these principles of prevention and anticipation has the potential to deliver wide ranging benefits for the HSCP and the population we serve, for example, we can improve

quality of life for people, limit further deterioration and frailty, maximise independence and minimise reliance on carers and services.

7.3 What will services look like in 2022?

We expect the service characteristics we outlined in our previous plan to be more prevalent so:

- You will only need to contact one person for all Health and Social Care in your community.
- A single Health and Social Care team will provide more services in your home, all day, every day – and night.
- Everyone has a personal responsibility to look after their own health and wellbeing, however, we recognise that life circumstances can have an impact on this ability for some people.
- Our staff will work with people to enable them to access support, advice and help so everyone can stay healthy and well in their community.
- More people will choose self - directed support to design and deliver services that meet their personal needs and objectives.
- GP and other 'front-line' services will continue to be provided locally through at least as many local surgery buildings (also known as Primary Care Centres) as at present.
- We expect that, through mergers and federations there will be fewer GP practices, each with several GPs working together, supported by a larger multidisciplinary community team. This team of health care professionals will take over some of the care currently provided by GPs e.g. Vaccinations, pharmacotherapy services, community mental health etc., allowing GPs to use their skills to help patients with more complex conditions.
- There will still be local access to primary and community care services via local surgeries as well as through the appropriate use of technology and home visits.
- Most hospital treatments will not require a stay in hospital, with hospital beds being used only for those needing more complex medical care, meaning we will need fewer inpatient beds.
- With more care delivered in the home, and with more support for carers (especially family and friends), nursing and care home beds will be used for those who need a higher level of care.

- Your local hospital will continue to co-ordinate and deliver emergency medical care, with fast access to Glasgow hospitals when necessary.
- Re-ablement, getting you as well, independent and mobile as possible will be the norm for everyone.
- Technology Enabled Care will be viewed as the norm in helping you, your family and professionals support you to remain at home and anticipate any changes in your health or care needs including remote consultations with trained staff.

7.3 What will we be doing over the next three years…?

The IJB has put in place a "Transforming Together" programme with 8 work streams to strengthen and build on our achievements to date and continue the changes required to meet our vision, priorities and objectives. These are detailed below:

The following sections provide detail on each of the programmes, they detail the current situation, outline what we have been doing, what we intend to do and how we intend to do it over the next 3 years.

Transforming Together Work streams	
1	**Children's Services**
2	**Care Homes and Housing**
3	**Learning Disability Services**
4	**Community Model of Care**
5	**Mental Health Services**
6	**Primary Care – GP, Pharmacy etc.**
7	**Hospital Services**
8	**Corporate Services**

Transformational Area 1 - Children's Services

Current Situation

There are currently 13,163 children aged 0-15 years resident within Argyll and Bute HSCP area. Although the population of children is projected to decrease over future years, the number of children with complex needs is increasing. Evidence tells us that being exposed to adverse and stressful experiences (ACEs) can have a negative impact on children throughout their lives. Trauma informed and resilience-building practices is being embedded within services.

Challenges

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

What have we done so far?

- We have established robust multi-agency arrangements through which to deliver the Children and Young People's Service Plan. This includes multi-agency locality Practitioner Forums.
- Our 3 Children's Houses as well as our Adoption and Fostering Services are graded 5 (Very Good).
- The number of our Looked After and Accommodated Children (LAAC) cared for in family type placements continues to increase vis-à-vis institutional type care.
- 100% of our Young People leaving care in the last year were offered appropriate housing.
- In line with "Best Start" we provide continuity of Midwifery care to women across Argyll and Bute.
- We have fully embedded all elements of the Universal Health Visitor Pathway.
- We have delivered a health drama to 820 S3 pupils across Argyll and Bute in 2017 which included information on smoking.
- We are using the Model for Improvement to test the use of assessment tools and interventions aimed at supporting Children to reach their developmental milestones at 13 – 15 months and 27 – 30 months
- We are also using the Model for Improvement to test methods to ensure multi-agency chronologies are in place for Children and Young People following an Initial Referral Discussion (IRD) where the decision is to progress to child protection procedures
- We have initiated a redesign of the Child and Adolescent Mental Health Services (CAMHS) including the deployment of additional staffing which will ensure a clear and accessible pathway is available to all young people in secondary school
- We have developed GIRFEC (Getting It Right For Every Child) infomercials by young people for use in schools to promote understanding of the Named Person role and the National Well-being indicators

What do we plan to do?

- We will ensure Children and Young People are provided with opportunities to evaluate current services and influence the planning of future services.
- We are developing a Children and Young People's Wellbeing Survey to be circulated to S2 and S4 school pupils.
- We will make greater use of the Model of Improvement to ensure long term sustainable changes are embedded in practice.
- We will prevent Children and Young People coming into care through prevention, early intervention and effective alternatives.
- We will ensure Children and Young People's views are listened to.
- We will reduce youth and adult reoffending rates.
- We will implement the redesign of CAMHS (Child and Adolescent Mental Health Services) to improve access to and the responsiveness of local community based services.
- We will oversee and align the self-evaluation of services involving Children and Young People under the Children and Young Peoples Services Plan to provide greater uniformity when identifying multiagency and single agency performance measures.
- We will place Looked After and Accommodated Children (LAAC) closer to their families and communities.
- We will further develop the Joint Needs Assessment to strengthen and build on the existing good work in conjunction with the Children and Young People wellbeing survey.

Priorities Year 1:	Priorities Year 2:	Priorities Year 3:
• Strengthen Early Intervention and Support	• Use of logic modelling to help define and separate strategic and operational performance measures. • Align all self-evaluation involving children and young people's services under the Children and Young People's Service Plan to provide more uniformity when identifying multiagency and single agency performance measures • Deliver the Children and Young People's wellbeing survey. • Develop the 2020 – 2023 Children and Young People's Service Plan	• Launch 2020 – 2023 Children and Young People's Service Plan

How will we measure our progress?
We will monitor outcomes against our plan objectives, service inspections and feedback.

Transformational Area 2- Care Home and Housing

Current Situation

There is an increasing demand for care at home placements as people live longer with more complex needs and for adapted properties as older people are enabled to stay at home. The number of older people is set to rise significantly in the coming years, with the steepest rises being in the over 75 year age group. Currently, 10.7% of the population in Argyll and Bute is aged 75 and over. The Care Homes and Housing transformation work aims to establish future need and provide a multi-agency platform for planning how our future care home and specialist housing requirements are met, work is already underway and

Phase 1:	Developing the current scale and profile of "24/7" Nursing & residential care and supported accommodation for older people.
Phase 2:	Health Need profile
Phase 3:	Model future demand
Phase 4:	Provision of new models of care homes and housing

comprises four distinct phases of work which include:

Challenges

The challenge is to provide suitable housing and sustainable 24 hour care and care at home services for people with high levels of need in the context of workforce recruitment difficulties.

What have we done so far?

- Completion of a Health Need profile of specialist housing. (Phase 1).
- Completed a benchmarking exercise on care home and housing provision compared to other areas throughout Scotland.
- Established local working groups to deliver the requirements of the project with representation from all relevant stakeholders and partners.

What do we plan to do?

- Understand the current scale and profile of nursing, residential care & supported accommodation for older people.
- Plan future provision around 24 hour care and housing.
- Develop a Care & Nursing Home Modelling Tool to better assess future needs.
- Understand and develop diversity and equality impacts.
- Determine future demand in health, social care, housing and independent sector.
- Encompass this within our commissioning strategy.
- Develop a staff communication programme
- Develop a public and stakeholder communication programme highlighting the need to change perceptions of the "historical/expected" service provision.

Priorities Year 1:	Priorities Year 2:	Priorities Year 3:
• Scoping of future needs and planning future care homes and housing models (Phase 2/3)	• Agree the future shape of service provision at locality and Argyll and Bute level for the cohort of care provision required (Phase 3/4) • Develop a commissioning strategy (Phase 3/4)	• Working in partnership with Argyll & Bute Council Housing Services, local Registered Social landlords and care home providers to fulfil the future requirement of care homes or housing from existing or new stock. (Phase 4)

How will we measure our progress?

Set targets and objectives including:

- Reduce out of area placements
- Provision of care home or specialist housing at the time required, without delay

The full Argyll and Bute Housing Contribution Statement is available in Appendix 5.

Transformational Area 3 - Learning Disability Services

Current Situation

Argyll and Bute has 330 people living with learning disabilities. There is a changing demand for learning disability services, both internal and external. Those with learning disabilities are living longer, with some indication of increasing complexity of need.

Alternative models of care will be required which will involve moving away from individual tenancies which are unsustainable. Campus style engagement models will support the development of new opportunities for supported living with a view to delivering alternative models of care and support.

Our shrinking population presents workforce challenges and building strong relationships with our Third Sector providers will enable the delivery of new care models for people with learning disabilities.

Challenges

Providing effective support for people with learning disabilities in ways that address their personal outcomes is a priority for the Argyll & Bute Health and Social Care Partnership (HSCP). Whenever possible, we will work to support people to live healthily and well within their local communities, with their families and friends. We will seek to enable people with learning disabilities to enjoy good physical and mental health, making use of facilities and activities available locally, in partnership with local groups and organisations from across the sectors.

We recognise that the ways in which we have traditionally supported people needs to change. We will seek to provide people with greater choice and control and offer maximum

flexibility which best meets their personal aspirations.

What have we done so far?

- Developed a new Learning Disability Strategy for Argyll and Bute HSCP (currently at consultation stage).
- Completed a structural review of our service (currently at consultation stage).
- Improved management of care transitions via our wider Disability Transitions Group.
- Reviewed our Autism Strategy and developed an implementation plan.
- Initiated reviews of current care packages in relation to Resettlement, Supported Living and Reduce the number of professionals so provide a single service with a single point of contact.
- Improved our communication and engagement with communities and service users, through the newly established HSCP Engagement Framework.
- Developing residential care and campus style support models that do not rely on individual tenancies

What do we plan to do?

- Further develop service and resources that will support individuals to return from out of area placements.
- Develop HSCP internal services that are able to support individuals with complex needs.
- Review and evaluate current 'sleepover' services and increase usage of Telecare, whilst maintaining service user safety and wellbeing.
- Working with Autism Network Scotland to develop realistic and effective implementation plan objectives.
- Sustain and further improve on the positive feedback from external regulators regarding the quality of service provision.
- Support the co-production of community based services for families living with learning disabilities.
- Work with housing services to develop 'Core and Cluster' models of care.
- Review our day service provision working with day service managers and locality teams to outline options for future provision aligned to campus style support models.
- Increase the uptake of Self Directed Support

Priorities Year 1:	**Priorities Year 2:**	**Priorities Year 3:**
• Develop 'Care Campus' approaches to services that will be designed, commissioned, and delivered in a way that meets the identified needs of individuals and groups, rather than assigning provision in	• Fully utilise opportunities offered through Self-directed Support to influence the variety of providers and support available to meet personal outcomes for people with learning disabilities • Work with people with Learning Disabilities and their carers	• Deliver training focused on identifying risk, prevention, choice and rights to our staff and those of partner organisations • Further embed and strengthen links made between

‘categories’ of care needs. • Reduce the number of people cared for ‘out of area’, by making provision available within Argyll & Bute.	when devising packages of care to incorporate carers’ needs and expertise in the design and delivery of these packages. Examples of this will include: ○ Involving carers of people with learning disabilities when identifying potential services that meet the outcomes of the person with a learning disability as part of the approach to developing new commissioning plans.	services (e.g. child to adult, adult to older people’s care) to ensure that all transitions are well planned and managed whether due to age or change of needs or health. People will be supported and be fully involved at periods of transition across all Services.
Priorities Year 1 cont.d	**Priorities Year 2 cont.d**	
• Use approaches such as ‘Strategic Change through Person Centred Thinking’ to obtain qualitative and quantitative information from those receiving services and use it to shape our plans to help them achieve their objectives.	○ Asking carers how best to support caring relationships and make sure the wellbeing of carers themselves will be supported and enhanced. ○ Invest in the asset based/community capacity building approach to ensure people with learning disabilities have access to a choice of community resources, lifelong learning and employment opportunities.	

How will we measure our progress?
In order to ratify strategic outcomes/priorities and ensure that they are met, immediate next steps will include: • Establishing a steering group with responsibility to deliver the Implementation Plan, with representation from partners, including provider organisations; Dec 2019 • Devising and delivering an outcomes-based implementation plan for this Strategy by Jan 2019 • Setting out funding priorities and ambitions within the implementation plan (identifying

clearly the opportunities and need for savings to be made); by Jan 2019

- Putting in place robust monitoring and reporting arrangements (i.e. a performance framework, consistent with strategic and corporate requirements); by Apr 2019
- Identifying risks to achieving the strategic outcomes and propose mitigation measures; by Jan 2019
- Developing Commissioning Plans for all services to be provided;
- Establishing consultation plans (using the Engagement Specification) with people with learning disabilities and their carers' as part of the process to set our strategic objectives; by Feb 2019
- Utilising feedback from professionals and those affected by our plans through a Health Impact Assessment and Equality and Socio-Economic Impact Assessment; by Mar 2019

Transformational Area 4 – Community Model of Care

Current Situation

There are more elderly people living in Argyll and Bute and it is anticipated this will increase significantly in future years. There will be more people living with care needs in our communities and some of these care needs will be complex. It is also predicted that more people will be living with dementia, requiring support and care in our communities.

There are a number of challenges to meeting service demand including recruiting care workers; high public expectation of care provision; the availability of appropriate homes/housing for people with care needs; and the delivery of care across a large geographical area.

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

Challenges

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

What have we done so far?	
• Co-location opportunities of multi-agency teams continue to be explored and developed across the Partnership area. • Reviewed our Community Teams across A&B HSCP. Developed proposals for redesign of our services and are currently engaging with staff on the proposed changes • Established a Resource Manager network across the Partnership with a view to further developing our homecare and re-ablement services	• Established Single Points of Access and 'daily huddles' in each of our community teams as a means of highlighting pressure points in our service provision. This is having a positive effect on delayed discharges across the area. • Reviewed and reduced the need for on-going care packages allowing this resource to be transferred to other users. • Undertaken team caseload reviews including acuity assessment to determine appropriate team size.

What have we done so far? Cont.d	
• Developed a Generic Support worker role within the multi-agency team.	• Undertaken HQA (Highland Quality Assurance) Improvement methodologies to team processes and shared standard work.
What do we plan to do?	
• Prioritise prevention e.g. empower people to self-manage long term health conditions • Connect people with sources of support in their community, such as opportunities to be more physically active. • Fully embed the rapid response and reablement approach within all teams. • Develop the role of the advanced nurse practitioner within the teams. • Further develop the use of technology to support people living at home who have health and care needs. • Provide care with an 'asset based approach'.	• Build on the implementation of multi-disciplinary community care teams. • Further develop the generic support worker role within the teams. • Extend the working hours of the teams to ensure equity of care delivery. • Ensure IT supports the teams to maximise service delivery. • Implement agreed standard outcome measures for the teams. • Ensure anticipatory care planning is adopted to reduce the incidence of emergency hospital admissions. • Embed the frailty pathway within all teams

Priorities Year 1:
• Multi-disciplinary teams will be established across all Argyll and Bute. • All teams have a Single Point of Access. • All teams have a daily huddle with referral and caseload allocation. • All teams are working appropriately and where necessary, extended hours to deliver care. • All teams are working to the agreed standards for community teams in Argyll and Bute. • Generic workers will be a key role within the teams
Priorities Year 2:
• All teams will be working on an ‘asset based approach’. • The use of TEC will be fully embedded in the assessment and care in the community. • IT will support mobile and agile working for the community teams. • The teams will be working to a single record and data system. • Advanced nurse practitioners will be developing in the teams. • Anticipatory care planning will be fully embedded within the team.
Priorities Year 3:
• Advanced nurse practitioners will be embedded in the teams. • A frailty pathway will have been developed and implemented in all teams. • Improvement work will be shared and implemented as standard work. • Agreed outcome measures will have been tested and implemented.

How will we measure our progress?
• Reduced delayed discharges in Argyll and Bute.

- Improved discharge planning with Greater Glasgow and Clyde.
- Reduced number of unnecessary emergency admissions to hospital.
- Reduced length of stay in hospitals.
- More people will be looked after at home rather than hospital or care home.
- Reduced number of professionals involved with a person in receipt of care.

Transformational Area 5 - Mental Health Services

Current Situation

There are increasing numbers of people living with mental health problems in our communities and an increasing demand for support and care services centred on all areas of mental health. Specifically,

- in-patient beds for people with severe and acute episodes of mental ill health
- Community services to support people living at home.

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

Recruitment to specialist mental health professionals and care support workers remains challenging. The nature of the large geographical area presents difficulties in delivering care and support, particularly responding to acute episodes of care out with normal working hours.

Challenges

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

What have we done so far?

- Completed a review of our Community Mental Health Teams recommendations of which (still subject to approval) will be actioned via our Mental Health and Dementia Steering group.
- Identified resource to deliver the Wellness Recovery Action Planning (WRAP) approach to enable people to self-manage their mental wellbeing.
- recent Islay trial of 'Near Me' the use of video consultation to support primary care mental health workers and clients
- Agreed a new locality based consultant model of care
- Establishment of inpatient beds within Mid Argyll Community Hospital (July 2018)

What do we plan to do?

- Continue to support the statutory requirement of Mental Health Officer duties within services.
- Ensure consistency of agreed method of engagement with service users, carers and other relevant representatives.
- Refine and implement local Mental Health and Dementia Services Strategies.
- Implement the locality based consultant model of care and work to resolve recruitment difficulties.
- Further monitor the Link Worker initiative for progression through Primary Care Implementation Plan via NHS Highland pilot with a view to applying similar approach to mitigating the impact of problems such as debt and loneliness on mental health.
- Further develop the review and implementation of Community Mental Health Teams across Argyll and Bute.
- Review and development of dementia care, including in patient and community services.
- Increase crisis interventions in the community to reduce risk and to manage hospital admissions safely, if required.
- Continue to explore new technological ways of delivering therapy and support.
- Work with Primary Care colleagues to help support the roll out of anticipatory and preventative care strategies associated with the new GP contract.

Priorities Year 1:	**Priorities Year 2:**	**Priorities Year 3:**
• Progress planned developments associated with Transforming Together agenda for mental health : - • Community Mental Health Services review and outcomes • Psychological Therapies • Care Reviews • Inpatient services • Dementia services, including development of a local dementia strategy	• Establish clear pathways to keep patients in local hospitals before transferring to acute units and further develop community supports and strategies, aimed at supporting individuals to remain at home and in their community and ensure effective admission and discharge planning.	• Consider and consolidate standardisation of processes; roles and responsibilities; care and support co-ordination and utilisation of effective training and delivery models (i.e. specialist / generic), as appropriate to support mental health and dementia services locally.

How will we measure our progress?
• Monitor the number of acute admissions, year on year to assess the effectiveness of community supports and strategies which support individuals at home. • Evaluate and monitor reductions in demand and spend for out of hour's services; Police Scotland and interventions by other emergencies services. • Realise reductions in acute hospital admissions and / or use of compulsory measures in terms of detention under Mental Health legislation. • Monitor the number of crisis interventions provided by practitioners. • Monitor the number of service users requiring detentions in community hospitals. • Evaluate service and carer satisfaction levels relating to above outcomes.

Transformational Area 6 - Primary Care

Current Situation

There are 33 GP practices in Argyll and Bute, with a registered patient population of 88,657 as at 1 April 2018. The national priority is to reduce the workload of GPs and practices by the HSCP delivering services. These services will be delivered by clinicians such as Pharmacists, Physiotherapists, and Advanced Nurse Practitioners.

The new GP Contract was implemented in April 2018 and currently, sustainable services delivered by wider teams are being planned within the context of Primary Care Service Redesign. There are 6 main streams to this work:

- **Vaccination Transformation Programme**
- **Pharmacotherapy Services**
- **Community Treatment and Care Services**
- **Urgent Care (Advanced Practitioners)**
- **Additional Professional Roles**
- **Community Link Workers**

It is anticipated there will still be access to primary and community care service via local surgeries as well as through the appropriate use of technology and home visits. This will see extra funding over the next 3 years in Argyll and Bute - £848,000 in the first year, expected to rise to £2.9 Million.

It is recognised that there are challenges in implementing the new GP contract in Argyll and Bute within a remote rural and island context and we await the outcome of the **Scottish Government Short Life Working Group** to help us further refine our future plans.

The new contract does not require GPs to provide out of hours services to their practice population and this means the HSCP has to provide an alternative service.

Challenges

- We cannot sustain all GP practice provided “Out of Hours” (OOHs) services in their current form particularly in our isolated and remote island communities.
- The ageing workforce and increasing vacancies in our GP practices, when considered alongside the need to provide GP OOHs, means it is more difficult to recruit GPs
- Developing new service models and recruiting other clinical staff to allow the transfer of work from GP practices to HSCP staff
- Using technology to offer support and provide a service to staff and patients

What have we done so far?

- Developed the Argyll and Bute HSCP Primary Care Improvement Plan (PCIP) 2018 – 2021.
- Facilitated the federation, merger and closer working between GP practices across Argyll and Bute including Lochgilphead and Inveraray, Helensburgh and Garelochhead and Islay practices.
- Established locality wide GP Out of Hours (OOHs) services in all mainland areas, centred on the local hospital. Continued to support the single island service on Islay
- Developed a Primary Care Modernisation Group reporting to the IJB via the HSCP senior leadership team and the Service Transformation Board.
- Creation and implementation of 3 Whole Time Equivalent (WTE) Advanced Practice Anticipatory/Emergency Care Nurses working in partnership across 5 GP Practices within Helensburgh and Lomond Locality.
- Developed a network of GP cluster Leads in each locality.

What do we plan to do?

- Employ more physiotherapists so that patients can benefit from quicker access and treatment, reducing unnecessary referrals to GPs.
- Increase the number of community mental health nurses better placed to support up to 25% of patients who currently see GPs.
- Set up a local Community Treatment and Care Service providing support to General Practice for minor injuries, chronic disease monitoring and other services suitable for delivery within the community.
- Increase the pharmacists and pharmacy technicians working within GP practices to provide a new medicines management service, referred to as the Pharmacotherapy service
- Free up GP time and support the changing role of the GP so they can concentrate on patients with more complex health and care conditions.
- Working with the community, provide a single GP practice covering the Islands of Mull and Iona for in and out of hours services.
- Support delivery of the Vaccination Transformation Programme within the Partnership area, removing the requirement for GP involvement
- Assess local need with regard to Community Link Workers and develop this role in response to local need and priorities.
- Continue to develop the Advanced Practitioner role within communities throughout the Argyll and Bute area.

Priorities Year 1:	Priorities Year 2 and Year 3:
• Establish immunisation teams to administer vaccines in Oban, Lorn & Mull, Cowal & Bute and Mid Argyll areas. • Expand pharmacy teams and introduce the Pharmacotherapy service in a phased approach across the HSCP. • Agree, finalise and deliver a midwifery model for pertussis delivery across Argyll and Bute. • Recruit GPs and other staff to the Island of Mull and Iona practice • Establish a sustainable GP out of hours service for Jura, linking it with Islay and building community resilience	• Establish immunisation teams to administer vaccines in Kintyre and Islay and in Tiree, Coll and Colonsay areas. • Agree and finalise Influenza Vaccine delivery. • Expand provision of pharmacotherapy service. • Test, agree and deliver Shingles vaccination delivery model. • Test, agree and deliver 'at risk' programme delivery model. • Travel Health and travel vaccinations

How will we measure our progress?

We have established a 3 year implementation plan against these various priorities and will manage and monitor progress against these objectives and milestones. These will include such measures as:

- Establish a baseline of current practice and measure new activity against the baseline, for example spend on antidepressant therapy as opposed to medication, number of referrals to Centre for Mental Health Service (CMHS) for primary care,
- Use and satisfaction with Technology Enabled Care and Home Health monitoring for example psychological therapy, blood pressure monitoring.
- Treatment related specific outcomes (patient and practitioner)
- Increase in activity for physiotherapy and reduced expenditure on pain medication

Transformational Area 7 – Hospital Services

Current Situation

There is one Rural General Hospital in Oban and six Community Hospitals all with Accident & Emergency departments; these are the Victoria Hospital on Bute, Campbeltown Hospital, Cowal Community Hospital, Dunoon, Mid Argyll Community Hospital and Integrated Care Centre, Lochgilphead and Mull and Iona Hospital.

Argyll and Bute HSCP also has a contract in place with NHS GG&C for delivery of specialist acute hospital services.

As more people live longer there is more demand on health services. We do not have the physical capacity, staff numbers or funding to provide more hospital based services, and we cannot continue to provide services in the same way. More care is now being delivered in the community and hospitals are being used for more day case treatment services.

International and national evidence advises that people have better outcomes when they receive care as close to home when it is safe and possible to do so; hospital and A&E care should only be used when needed for acute care; The focus of our hospital service needs to be one of a networked service that supports maintaining people's health and well-being, by diagnosis and planned treatment and not an emergency ill health treatment service.

Challenges

- People living longer, more demand on services
- Population ageing is mirrored in the workforce
- Recruitment difficulties
- Increasing costs of acute health care and negotiation with NHS GG&C to enhance local care and provide better value for money

What have we done so far?

• Developed an action plan for redesign of Community Hospitals • Reviewed Medical Model in Lorn and Islands Hospital • Successfully ran improvement events in each community hospital with a view to streamlining processes and improving efficiency.	• Completed a scoping study of inpatient and unscheduled activity within all our hospitals • Participated in the National Day of Care survey • Established the Argyll and Bute "6 Essential Actions" Group working NHS wide to embed best practice around unscheduled care.

What do we plan to do?	
• Standardise the role and function of each of our community hospitals, developing a service specification for each. • Continue working with stakeholders to further develop our Community Hospital specification • Bed model (see glossary for definition) each in-patient area to ensure we make best use of all resources • Map clinical standards against current practice • Scrutinise emergency NHSGG&C patient activity with the aim of reducing. • Implement standardised day case services • Map current workforce including development of a skills matrix to support the new model of care and develop the required workforce.	• Review hospital admissions to both A&B and GG&C hospitals • Negotiation with NHS GG&C to review how specialist services are provided to maximise local provision and obtain best value for money • Workforce review to ensure we are utilising the full potential of all individuals • Further improve discharge planning to reduce readmissions • Work with community services to identify alternatives to hospital admissions • Continue with our Quality Improvement (QI) initiatives and fully implement 6EA, Daily Dynamic Discharge and falls programmes and roll out to ensure quality improvement initiatives are fully embedded within all hospitals.

Priorities Year 1:	**Priorities Year 2:**	**Priorities Year 3:**
• Moderate reduction in the number of hospital beds. • Begin service specification for all community hospitals. • Complete bed modelling exercise across all inpatient areas.	• Completion of service specification for Community Hospitals and Lorn and Islands Rural General Hospital. • Increase day case services in all hospitals. • Fully embed Quality Improvement initiatives across all hospitals. • Reduction in unscheduled activity into NHS GG&C Hospitals	• Continue to deliver more care in the community, less inpatient care and appropriate use of our A&E Departments, reducing unscheduled activity into Glasgow.

How will we measure our progress?
• We will monitor and manage the level of acute activity delivered locally • Reduce the increase in emergency activity into NHS GG&C Hospitals • Incorporate into our patient outcomes and experience of services patient/user feedback • Monitor and manage services to ensure consistent high quality standards of care.

Transformational Area 8 – Corporate Services

Current Situation

Corporate services include finance, planning, IT, HR, pharmacy management, medical management and estates, as well as all our buildings and vehicles. There is a requirement to make corporate services more cost efficient and to provide an integrated service (NHS and Council) to ease the burden of work for our front line managers.

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

Challenges

- Not all corporate support services from the Health Board are delegated to the partnership and none are delegated from the Council to the Partnership
- Operational managers and team leaders are having to use 2 systems (NHS or Council) and processes to manage staff, budgets, information and order supplies. This causes duplication and delay and is a waste of time and resources
- National IT systems and local systems between health and care cannot be joined up e.g. Payroll NHS employed staff national system, council payroll system for council employed staff
- Increased efficiency and productivity will require more use of digital services and IT systems may require significant investment
- Co-locating health and social care staff has not happened quickly enough to support integrated working
- Must reduce the cost and increase the productivity of corporate services

What have we done so far?

• In December 2019 established a secure and permanent IT network link between both NHS and Council. Allowing staff to access some of the NHS & Council systems from either location. Critical step forward for integrated working for integrated teams	• Transferring 300+ community health staff onto the Care First system providing a single health and care system for the community. • Co-located health and social care staff in Campbeltown, Oban, and Mid Argyll Hospitals

What do we plan to do?	
• . Approved a plan and agreed a timetable to co-locate corporate IT, Finance, Planning & Performance and HR staff in council offices in Lochgilphead May 2019 • Continue with co-location of health and social care corporate staff to work together in the same locations and in the same teams • Integrate health and social work administration and implement digital technology • Provide new IT system to allow clinical and care professionals to share information to improve care and treatment for patients • Facilitate and support mobile working for community based staff across the health and social car partnership including the independent sector	• Explore opportunities to provide a single health, social care, and education catering service in Argyll and Bute • Benchmark the standards, productivity and cost of hospital cleaning services across the HSCP • Close the old Argyll and Bute hospital and old Aros offices reducing estate size and running costs • Explore further opportunities to rationalise estates and properties by co-location of staff • Examine the cost and use of Health and Social care business fleet to improve service to users and reduce cost and CO_2 footprint

Priorities Year 1:	**Priorities Year 2 and 3:**
• Implement co-location plans and arrangements as identified • Identify other estate rationalisation and co-location opportunities • Increase the number of health staff using the single health and social care IT system- “CareFirst”	• Provide single integrated corporate services for health and social care staff in Finance, HR etc. • Put in place a single unified telephone and IT system between the NHS and the council saving money and increasing productivity of staff • Establish and operate a single catering

• Pilot mobile App for staff using the "CareFirst" IT system	service for Education, NHS and Social Care within Argyll and Bute
How will we measure our progress?	
• Reduced number of buildings and estate • Productivity benchmark targets improved • Significant cost reduction in corporate services of between 10-20% (To be confirmed)	

SECTION 8 - OUR WORKFORCE

Why is this important?

Our workforce is vital to support the HSCP to deliver our vision and need to feel valued and be skilled, motivated and flexible to support the HSCP. New ways of working and doing things are needed. The HSCP workforce includes employees of two different organisations, Argyll and Bute Council and NHS Highland, as well as people in many organisations and individuals that contribute as part of an overall workforce delivering health and social care. These include unpaid carers and volunteers and third and independent sector providers that together enable the delivery of good care and ultimately better outcomes for people in our communities.

The HSCP need to support staff as we transform together the way we deliver our services for the future. We need to attract and retain our workforce and invest in training and development, and involve our workforce in shaping how our future services look. There are a range of national and local workforce challenges and workforce planning is more critical for success than ever before, it also dynamic, evolving and success depends on being integrated with financial and service planning.

Cultures are created by people within organisations through shared values and the development of and embedding of accepted behaviours, as well as respecting and valuing each other's values and beliefs.

Where are we now?

- We have a workforce that is skilled and highly experienced with the majority over the age of 50. At the end of March 2018 there were 2,406 staff within Argyll & Bute HSCP:
    - 851 Council or Local Authority (LA) employees, of which the head count for social work is 621
    - 1,555 NHS employees

- Health and social integration is much wider than these organisations and includes our Primary Care service providers, Care at Home and Care Home providers in the independent sector, and third sector providers and volunteers.

- Our initial Workforce Plan for 2018/19 focused on Adult Services, the largest area of staff who are direct employees of Argyll and Bute Council and NHS Highland. This Plan included key challenges and what is needed to Bridge the Gap from where we are to where we want to be with an Action Plan for this.

- Work was completed in July 2018 with Healthcare Improvement Scotland's Improvement Hub (iHub) and its associates to test a change-based planning approach to support workforce change and development, introducing and utilising systems modelling at locality level. The approach was designed to support localities in evaluating the potential effect of decisions relating to workforce change allowing the effect of workforce change hypotheses to be examined and tested by means of computer simulation – without risk to operational activity, prior to recruitment or redeployment actions.

- Further consideration will need to be given to how this modelling approach could be used in the future as part of workforce planning, investment would be needed to support software, capacity and skills. At present there are other more value added priorities.

- The next iteration of our Workforce Plan in 2019 will include information about other HSCP services; Children & Families, Mental Health, Learning Disabilities, Sexual Health, Public Health, Dental and Corporate services. There will also be more about the role of the third-sector; voluntary organisations, community networks and other commissioned providers who support the HSCP achieve our Vision and key Objectives. Workforce planning is iterative and emerging as we transform our services together.

- Effective workforce planning is complex and the future is at national, regional, board, HSCP and local level with recommendations for improving workforce planning at all levels in Parts 1 and 2 and 3 of the National Workforce plans already published and the Integrated Health and Social Care Workforce Plan due for publication in 2019.

- The Six Step methodology is a requirement by the Scottish Government's CEL (2011)32 for workforce planning. The HSCP is part of the West of Scotland Regional Planning Group; we contribute to NHS Highland Board's annual workforce plan, who are part of the North of Scotland Regional Planning group.

- Workforce planning is an integral part of service redesign and requires detailed workforce plans as part of the transformation programme.

- HSCP Shared Values & Practices Framework (CIRCLE) was approved by the IJB in August.

- IMatter is a continuous improvement tool designed with staff in NHS Scotland to help individuals, teams and Boards understand and improve staff experience. In 2017 Council and NHS employees participated for the first time.

- Work is in progress around improving Staff/Employee Health & Wellbeing and draft recommendations have been developed following a survey utilising healthy working lives initiatives and the NHS Highland Staff Health and Wellbeing Framework. Staff have been asked to review the results and recommendations and contribute ideas to improve the wellbeing of our workforce.

- Challenges exist across all partners around recruiting the right people to a range of roles with health and social (NHS and Council employers) as well as with the Third and Independent sectors. Other opportunities in local areas can often appear more attractive and offer more competitive salaries, public sector pay increases also differ from those in other sectors. As part of the commissioning process the investment in partners needs to be reflected. The HSCP needs to invest in the workforce to attract, retain and develop it for the future.

- The ageing workforce is also affecting all partners so whilst we may want to look towards utilising volunteers more in the future, this group as also ageing and reducing in number, with the increased working age and caring responsibilities having an impact.

Where do we want to be?

- As a Partnership in Argyll & Bute we would like Health and Social Care to be a career of choice so we need to look at how we attract, retain and develop the right people

- Having a valued, skilled, motivated, flexible workforce to transform together to deliver the changes required.

- Provide better and more efficient services, building stronger working and collaborative partnerships across health and social care, primary care and our independent and third sector partners, service users and carers to provide better and more efficient services. Using the Engagement Framework so that all our partners play their part in designing and delivering future services.

- Making the best use of people's skills and capabilities.

- Prevention/early intervention is paramount and is fundamental as part of Transforming Together – working in a preventative way – using every contact to provide health and well-being support, advice and signposting, and utilising technology and Technology Enabled Care (TEC)

- Supporting the workforce through service redesign, new ways of working and the transformational changes required, an organisational development approach is

fundamental to building a culture of shared values and objectives and close partnership working. Areas of focus include:

- Staff Experience and Engagement
- Culture
- Service improvement and change
- Leadership and Management Development
- Workforce and team development

This includes:

- Supporting the health and wellbeing and resilience of our workforce
- Promoting and supporting the HSCP values and practices and building on integrated working to date from senior level throughout the organisation
- Working collaboratively across the whole workforce to prepare for and deliver on new, effective and efficient models of care, including with our third and independent sector partners.
- Raise awareness and provide opportunities which enable people to move into a career with health and social care at any stage of their career, from school leavers to those looking for a career change.
- Develop career pathways into health and social care at any stage, working with education providers
- Develop career pathways by investing in our personal development review processes and nurture and develop the talent within the workforce for future succession planning

How do we get there?

- Our approach to workforce planning needs to take account of the workforce contributions and we need to understand what our baseline workforce is across the whole partnership
- Implement the National Health & Social Care Workforce Plans
- Progress our 2018/19 Workforce Plan
- Develop the next iteration of the HSCP Workforce Plan
- Develop education, training and development plans to support the workforce, developing and investing in opportunities for shared learning and development.
- The workforce implications of service change and redesign should be set out clearly in the Service Transformation plans. Any Service redesign/organisational change planned should outline workforce implications from the outset and each should have

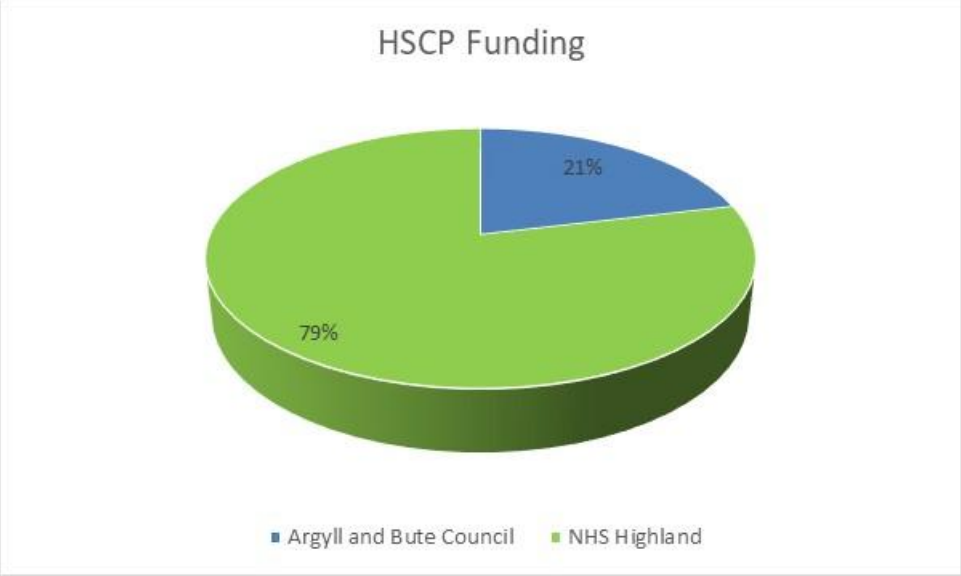
a fully developed and integrated workforce plan utilising the Six Steps Approach – bringing service, financial and workforce planning together.

- Review the Organisational Development Strategy and develop a plan to support the workforce

SECTION 9 – FINANCE

2019-20 Approved Budget

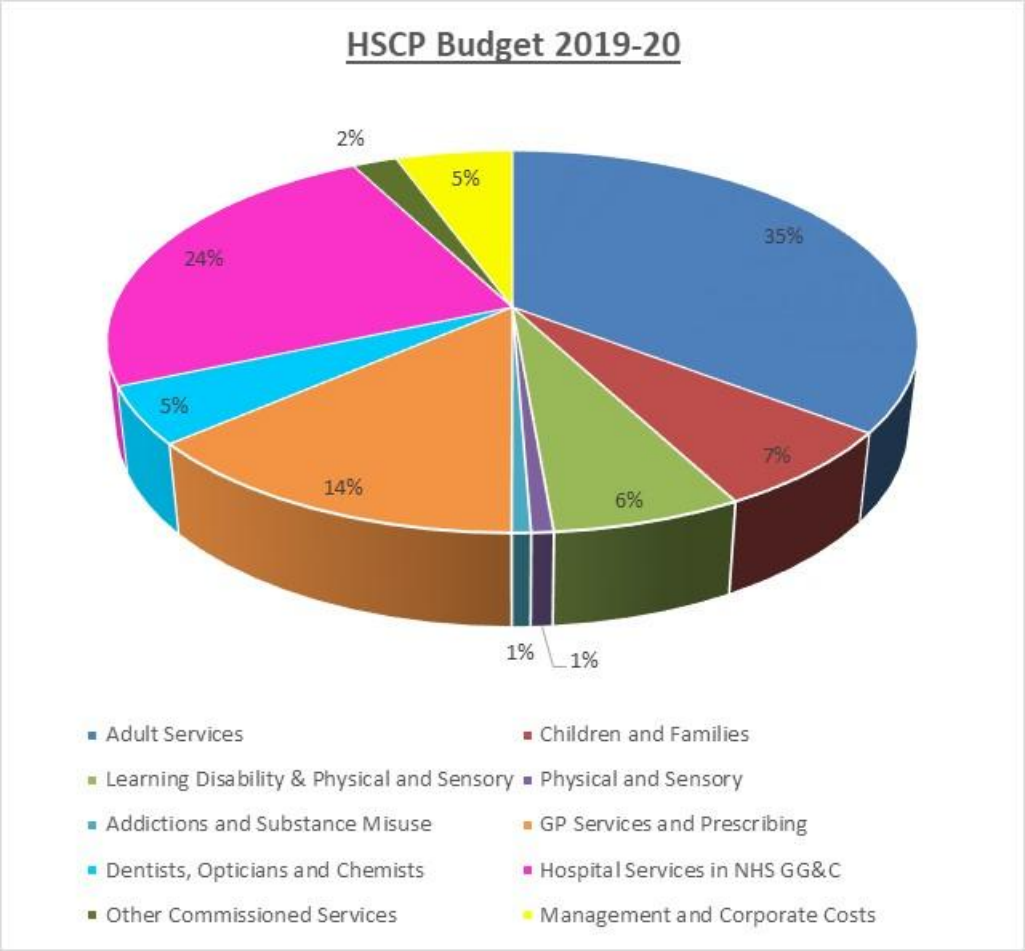
The Argyll and Bute Health and Social Care Partnership approved budget for 2019-20 amounts to £276.327m. All funding comes from the two partner bodies, NHS Highland and Argyll and Bute Council. The chart below shows that NHS Highland provides 79% of the funding with 21% provided by Argyll and Bute Council.



A balanced budget has been set for 2019-20 which requires £6.794m savings to be delivered to cover a range of cost and demand pressures. The bulk of these are management / operational savings and there is a high degree of confidence that they will be delivered. However, the outturn for 2018-19 was an overspend of £6.681m and the overspend areas need to be addressed in 2019-20 as well as delivering the new savings that have been identified. This is a challenging position.

Local management has instigated weekly grip and control meetings to review all proposed spend on supplies and services and all requests to fill staff vacancies to ensure that only essential spend is incurred and all wastage is removed. In addition, Argyll and Bute Health & Social Care Partnership is actively participating in a wide range of workstreams led by NHS Highland which aim to produce further savings for Health areas within 2019-20 and beyond.

This budget is spent across a range of services. 35% of the budget (£94.324m) is spent on Adult related services and 24% of the budget (£63.713m) is spent on Hospital Services in NHS Greater Glasgow and Clyde. The chart below shows the breakdown of the budget across the various service areas.



For Health, the key areas being focussed on are the reduction of the use of agency staff and locums, replacing these with permanent members of staff or independent GP practices where possible, and further negotiation of the costs charged by NHS Greater Glasgow and Clyde under the service level agreement where patient activity levels have been largely flat but charges have increased by substantially more than inflation.

For Social Care, the aim is to reduce the use of expensive agency staff, and to reduce the level of overspend on Learning Disability and Physical Disability through implementation of care campus support models of care, and reduction of out of area placements where appropriate to client needs.

Progress is being monitored closely with regular formal reporting to the Quality and Finance Plan Programme Board and the Integrated Joint Board.

Medium Term Financial Outlook

It is anticipated that the public sector in Scotland will continue to face a very challenging short and medium term financial outlook. Both NHS Highland and Argyll and Bute Council

are also faced with significant financial challenges over the next three years and there is uncertainty over what the scale of any reduction in available funding will be.

A medium term financial outlook has been prepared covering the period 2020-21 to 2022-23. The outlook has been prepared based on a number of assumptions and estimating three different scenarios, best case, worst case and mid-range. Relatively small variations in assumptions can lead to fairly significant changes in the outcome.

The current estimated budget gap, as reported to the Integrated Joint Board on 29 May 2019 is noted in the table below:

	2020-21 £000	**2021-22 £000**	**2022-23 £000**
Best Case	2,835	5,467	7,582
Mid-Range	**6,403**	**12,521**	**18,074**
Worst Case	9,948	19,595	28,830

Detailed Planning is being undertaken based on the Mid-Range scenario for 2020-21 and beyond whilst recognising that there are still a number of uncertainties which will need careful monitoring.

Progress on delivery of the 8 Transforming Together workstreams will be key in meeting these future budget gaps. In particular, increasing use of Technology Enabled Care is planned to enable people to stay in their own homes longer and to ensure that increasing levels of demand can be met safely and appropriately within the funding available. Use of core and cluster care models are demonstrated to be more cost effective and will be deployed further. GP practices are being encouraged to ensure that prescribing is as cost effective as possible through using scrip switch software which helps GPs consider lower cost alternative drugs which are equally effective.

In March 2019 the Integrated Joint Board endorsed that further work be undertaken on these areas which may assist in delivering savings in future years:

- Potential for cost reduction in co-location General Practitioner services including hospital out of hours and rural out of hours services.
- Decommission of dementia inpatient services and reinvest in community services in line with government policy. There is also reduced demand for inpatient dementia services and increasing pressure on community dementia teams.
- Review of Radiography service to establish if 24/7 provision is necessary. Radiography was previously reviewed in 2014 with the selected option being implemented. There is a desire to review the service again by both clinical and professional service leads based on evidenced need.
- Continued Review of Community Hospitals. Review to be undertaken with parallel challenges in terms of workforce resource, provision of health care services in a rural

environment and the development of integrated services delivered from the hospital premises.

Fundamentally this will require us to develop revenue and capital financial plans that reflect improved pathways of care for services that are delivered through community services, in patient services, care homes and supported accommodation including Mental Health and Children's services.

This additional work is required to ensure that a balanced budget is achieved over the next three years.

Financial Risks and Challenges

There are significant financial risks in relation to the 2019-20 budget, and these risks may continue into future years. A report was presented to the Integrated Joint Board on 27 March 2019 which introduced a process of identifying and reporting financial risks to the Board on a regular basis. The risk analysis identified a total of 34 risks and classified 26 as possible and 8 as likely.

Only 3 of the risks have been classified as having a potential impact in excess of £0.500m as follows, and these are being addressed as outlined above:

Health or Social Work	**Identified Risk**	**Likelihood**
Health	Continued use of agency medical staff in psychiatry	Possible
Health	NHS Greater Glasgow and Clyde seek to correct historic undercharging on the main patients' services SLA	Possible
Social Work	Potential increase in the number of children and young people who need to be taken into care and supported/accommodated by the HSCP.	Possible

The financial risks will be monitored and mitigating actions put in place to reduce both the likelihood and potential impact. New or changed risks will also be identified and managed, and reported to the Integrated Joint Board.

If you would like a copy of this document in Gaelic or another language or format, or if you require the services of an interpreter, please contact Argyll and Bute Health and Social Care Partnership on 01546 605664 or email nhs.abhscp@nhs.net

A&B HSCP Transforming Together
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