

**DRAFT MINUTE OF  
ARGYLL & BUTE HEALTH & SOCIAL CARE PARTNERSHIP (HSCP)  
INTEGRATION JOINT BOARD  
WEDNESDAY 25 JANUARY 2017, COUNCIL CHAMBERS, KILMORY**

**Present :**

Councillor Kieron Green	Argyll & Bute Council (Chair)
Robin Creelman	NHS Highland Non-Executive Board Member (Vice Chair)
Christina West	Chief Officer, Argyll & Bute HSCP
David Alston	NHS Highland Chair
Elaine Wilkinson	NHS Highland Non-Executive Board Member (VC)
Dr Michael Hall	Associate Medical Director, Argyll & Bute HSCP
Caroline Whyte	Chief Financial Officer, Argyll & Bute HSCP
Louise Long	Chief Social Work Officer
Dr Richard Wilson	GP Representative
Dr Peter Thorpe	Secondary Care Adviser, Argyll & Bute HSCP
Liz Higgins	Lead Nurse, Argyll & Bute HSCP
Elaine Garman	Public Health Specialist, Argyll & Bute HSCP
Denis McGlennon	Independent Sector Representative
Glenn Heritage	Argyll & Bute Third Sector Interface
Elizabeth Rhodick	Public Representative
Maggie McCowan	Public Representative
Catriona Spink	Unpaid Carer Representative
Heather Grier	Unpaid Carer Representative
Councillor Mary-Jean Devon	Argyll & Bute Council
Councillor Anne Horn	Argyll & Bute Council
Councillor Elaine Robertson	Argyll & Bute Council
Dawn MacDonald	Staff Representative (NHS)
Stephen Whiston	Head of Strategic Planning & Performance
Lorraine Paterson	Head of Adult Services (West)
Allen Stevenson	Head of Adult Services (East)
David Ritchie	Communications Manager (Health)

**Attending :**

Melanie Newdick	NHS Highland Vice-Chair
Sheena Clark	PA to Chief Officer (Minutes)

**Apologies :**

Anne Gent	Director of Human Resources, NHS Highland
Linda Currie	AHP Lead

ITEM	DETAIL	ACTION
1	<b>WELCOME</b>	
	The Chair welcomed everyone to the meeting.	

<b>2</b>	<b>APOLOGIES</b>	
	Apologies were as noted.	
<b>3</b>	<b>DECLARATIONS OF INTEREST</b>	
	Agenda item 5.2 - Councillor Devon advised that she is an ordained Elder of the Church of Scotland.	
<b>4</b>	<b>DRAFT MINUTE OF INTEGRATION JOINT BOARD 30-11-16 &amp; ACTION LOG</b>	
	<p>The Chief Officer reported that on 15 December 2016 the Policy &amp; Resource Committee :</p> <ul style="list-style-type: none"> <li>• Approved the additional £0.110m funding in respect of the Living Wage, to be added to the IJB's 2016-17 recurring baseline allocation.</li> <li>• Did not support the IJB's request for an additional payment of £0.185m to support the implementation of the pause to the proposals at Struan Lodge and Thomson Court, requesting that the IJB looks for alternative savings and report back to the Council later in the financial year as required within the Scheme of Integration.</li> </ul>	
<b>5</b>	<b>BUSINESS</b>	
	<p><b>5.1 Finance</b></p> <p>The Chief Financial Officer presented the reports.</p> <p>a) <u>Budget Monitoring</u> - robust budget monitoring processes are key to ensure the expenditure incurred by the IJB partners is contained within the approved budget for 2016-17 and overall the partnership delivers a balanced year-end outturn position. The projected year-end outturn position is an overspend of £1.1m and the IJB requires assurance this position can be brought back into line with the available budget by financial year-end. There are significant financial risks in terms of service delivery for 2016-17 and mitigating actions are in place to reduce or minimise these.</p> <p><i>The IJB noted the overall Integrated Budget Monitoring Report for the December 2016 period and the projected year-end overspend of £1.1m; noted the progress with the delivery of the Quality &amp; Financial Plan and agreed the previously approved financial recovery plan requires to continue to be implemented to ensure delivery of a balanced integrated budget for the 2016-17 financial year.</i></p> <p>b) <u>Budget Outlook 2017-18 and 2018-19</u> – the IJB is facing a challenging financial outlook with an estimated budget gap for integrated services of £16.3m and £5.7m for the remaining 2 years of the Strategic Plan. The outlook position has deteriorated significantly since the report to the IJB on 30 November 2016 following the Local Government and Health budget settlements. There is a particular</p>	

	<p>challenge for the IJB in producing a balanced budget by 31 March 2017, with the budget gap being very heavily weighted to 2017-18, with estimated reductions of 6.4% and 2.2% in each of the years. Indications are that one year financial offers will be submitted by both Health and Council partners. There remains a degree of uncertainty around the financial offers from the Health Board and Council and this budget outlook has been based on indicative information provided. Financial assumptions and budget outlook will be updated when there is more certainty around the budget allocations available and the cost and demand pressures.</p> <p>Councillor Devon highlighted the impact of a reduced resource allocation on the children who are currently in a continuing care setting.</p> <p>Heather Grier enquired about the availability of information on the detail of the resource allocation for all departments within the Council. The Chair advised that the information would be publicly available following the outcome of the Council's budget setting meeting.</p> <p>The Vice-Chair requested that following the announcement of the Council's funding settlement to the IJB, a rationale is requested for any reduction in funding for integrated care.</p> <p>Councillor Devon expressed concern regarding the Health &amp; Social Care Partnership's ability to comply with the delivery of statutory services due to the financial challenges.</p> <p>Enquiring about the impact of patient travel costs, Councillor Robertson was advised that reimbursement costs are now capped, irrespective of the cost to NHS Highland.</p> <p>Elaine Wilkinson enquired about the opportunity for apprenticeship levis. Caroline Whyte agreed to check the process for accessing funding for apprenticeships.</p> <p><i>The IJB noted the indicative budgets and resulting budget gap for 2017-18 of £16.3m and for 2018-19 of £5.7m, and noted that this position has materially change from previous estimates following Local Government and Health funding settlement announcements. Noted that this is not the final position and there is still further clarity required around cost and demand pressures and the funding offers from both partners. Noted the requirement for the IJB to approve a balanced Integrated Budget by 31-3-17 and noted the ongoing requirement for development of the Quality &amp; Financial Plan for the next two years in line with the updated estimated budget gap and the previously agreed timeline.</i></p> <p>c) <u>Audit Committee – Minutes of 3-8-16</u></p> <p><i>The IJB noted the Minutes of the quarterly meeting.</i></p>	<p><b>CWh</b></p> <p><b>CWh</b></p>
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	<p><b>5.2 Auchinlee Care Home Update</b></p> <p>Following the decision by the IJB in November 2016, the HSCP has continued their engagement with CrossReach and interested parties in an attempt to agree a viable and sustainable arrangement to retain Auchinlee Care Home. Formal notification from CrossReach in January 2017 indicated their proposal to keep the care home open for a further 3 months to March 2017, with the losses incurred to be shared between CrossReach and the HSCP.</p> <p>The HSCP Strategic Management Team (SMT) continues to be thoughtful and mindful of the impact the closure of Auchinlee Care Home would have on the residents, their families and the community. However, following further engagement and discussions with CrossReach and community bodies, the SMT have confirmed their view that the proposal from CrossReach will expose the HSCP to a significant risk in terms of resident safety and quality of care, service sustainability and financial impact. In view of this the SMT have recommended that they are unable to support the funding request of £60k to CrossReach to underwrite their losses in January-March 2017. The HSCP continue to work to develop a proposal which is safe and sustainable to keep the service locally.</p> <p>The IJB discussed the recommendations in the report and supported the SMT's conclusion regarding the funding request of £60k. The IJB acknowledged the impact the closure of Auchinlee Care Home will have on residents, families and the community.</p> <p>Councillor Anne Horn dissented at the IJB's decision to support the SMT's recommendation.</p> <p><i>The IJB noted the update on the further meeting of the HSCP with Crossreach following the recommendation of the IJB to enter further discussions. The IJB considered the implications of the revised proposal from CrossReach and supported the recommendations from the Strategic Management Team as detailed in the paper and noted the HSCP are continuing to work on alternative provision for existing residents of Auchinlee within and outwith Kintyre. The proposal to undertake a care summit to develop a future model of care for Elderly care for the West of Argyll was noted.</i></p>	
	<p><b>5.3 Public Health – Update on Suicide Prevention &amp; Mental Health Improvement Work</b></p> <p>The Public Health Specialist provided a report summary, outlining the work undertaken in 2016 and the planned work in 2017 and beyond. She advised on the changes and the work planned on suicide prevention and prevention of self harm which has now been</p>	

	<p>mainstreamed into work within mental health and public health. It is expected that the changes will support a mentally healthy Argyll &amp; Bute, with awareness to be raised through work streams in other areas of integrated working.</p> <p>Glenn Heritage highlighted the 'Breathing Space' initiative, which is being supported by the Third Sector Interface, and the importance of the use of social media to communicate a positive message to young people.</p> <p><i>The IJB noted the paper and supported agreement to access free training venues across community planning partners to minimise training costs.</i></p>	
	<p><b>5.4 Clinical &amp; Care Governance</b></p> <p>The report presented by the Lead Nurse provided updates on :</p> <p>HSCP Complaints - work is continuing to develop reporting for HSCP Health complaints and Social Work complaints. Improvement work is being tested and support is being provided to identify the key points of a complaint which requires to be investigated and a plan provided.</p> <p>Scottish Inpatient Experience Survey – hospitals have been asked to consider their particular reports. Local Teams have developed an improvement plan which is being monitored.</p> <p>Mandatory Training Compliance – HR and Clinical Governance teams are working to develop a system to provide the required compliance information.</p> <p>Delayed Discharges – the report should differentiate between East and West areas, with the focus on the number of bed days, not the number of delayed discharges.</p> <p>Oban Laboratories – a significant amount of work has been undertaken to ensure appropriate governance arrangements are in place and to ensure compliance with Clinical Pathology Accreditation.</p> <p><i>The IJB noted the content of the report, the risks identified and the risk management plans.</i></p>	
	<p><b>5.5 Infection Control</b></p> <p>The report presented by the Lead Nurse provided an update on the current status of Healthcare Associated Infections and Infection Control measures in NHS Highland, including Argyll &amp; Bute HSCP.</p> <p>In Argyll &amp; Bute, during the reporting period of 1/4/16–4/12/16 there</p>	

	<p>were 4 community onset cases of Staphyococcus aureus (SAB), 9 cases (4 healthcare associated and 5 community associated) of Clostridium difficile infection (CDI) and 16 cases of Escherichia coli (E.Coli) admitted to hospital in Argyll &amp; Bute.</p> <p><i>The IJB noted the performance position for the HSCP and noted the progress to reduce and manage healthcare associated infections.</i></p>	
	<p><b>5.6 Staff Governance</b></p> <p>The paper set out and provided an overview of performance data and current issues for staff governance in the Health &amp; Social Care Partnership.</p> <p>The IJB expressed some concern in relation to the NHS and Council rate of staff absence. This was acknowledged as a key area of work, with liaison between Managers and Occupational Health to support employees to return to work.</p> <p>There are some key challenges in terms of statutory and mandatory training and both Health and the Council are undertaking a plan of work to address these issues.</p> <p>The IJB requested additional information on the number of staff on fixed term contracts.</p> <p><i>The IJB noted the content of the quarterly report on the staff governance status in the HSCP.</i></p>	<p><b>MN/JF</b></p>
	<p><b>5.7 Chief Officer Report</b></p> <p>The Chief Officer briefed the IJB on a telecare pilot in the Ross of Mull; a successful pilot of the Kintyre Dialysis Unit and an associated scoping exercise to investigate viability of a dialysis unit on Bute; the Strategic Review of Lorn &amp; Islands Hospital; a self management course for people with diabetes; an Integrated Care Fund update and an update on the interim relocation of inpatient mental health services.</p> <p><i>The IJB noted the content of the report.</i></p>	
	<p><b>Date of Next Meeting :</b></p> <p><b>Wednesday 29 March 2017 at 1.30pm</b>  <b>Council Chambers, Kilmory, Lochgilphead</b></p>	

## ACTION LOG

### – INTEGRATION JOINT BOARD 25-01-17

	<b>ACTION</b>	<b>LEAD</b>	<b>TIMESCALE</b>	<b>STATUS</b>
1	IT support to be looked at regarding Webex use for IJB meetings.	Christina West		Ongoing
3	Progress service redesign proposals as detailed in the templates.	Heads of Service		Ongoing
4	Equality Impact Assessments as noted.	Heads of Service		Ongoing
5	Engagement & Consultation Feedback to the IJB	Allen Stevenson	March 17	
6	Staff Governance report to include additional information on the number of staff on fixed term contracts.	Moira Newiss / Jane Fowler	March 17	
7	Following the announcement of the Council's funding settlement to the IJB, submit a request for the rationale of any reduction in funding for integrated care.	Caroline Whyte	March 17	
8	Check the process for accessing funding for apprenticeships.	Caroline Whyte	March 17	







# Argyll & Bute Health & Social Care Partnership

## Integration Joint Board

Agenda item : 5.1a

**Date of Meeting:** 29 March 2017

**Title of Report:** Struan Lodge Re-Design

**Presented by:** Allen Stevenson Head of Adult Service (East)

### The Integration Joint Board is asked to :

- Note the completion of communication and engagement events planned and delivered between December 2016 and the end of February 2017.
- Note the key themes identified within the report compiled by the Public Involvement Manager on behalf of the Head of Adult Services (East).
- Note the contribution by the Cowal Communication and Engagement Group formed specifically to plan and deliver conversation café / drop in events.
- Note the content of a report by Struan Lodge Development Group (SLDG) - A Strategy for Integrated Adult Care.
- Note a further report will be presented to the Integration Joint Board (IJB) in May 2017. The report in May will include recommendations and identify key milestones.

## 1. EXECUTIVE SUMMARY

1.1 The Integration Joint Board (IJB) agreed to a pause period in relation to the re-design of Struan Lodge for a period of three months. This pause was put in place to allow individuals, groups or organisations the opportunity to come forward with their views and ideas regarding the future re-design of Struan Lodge.

1.2 A series of public events were planned and delivered by a new Communication and Engagement Group made up of community reps, staff and a variety of key stakeholders during December 2016 and the end of February 2017. The proposal for Struan Lodge involved the creation of a Cowal Hub that would provide a range of enhanced day services/support to a wider group of frail/elderly older people. The proposal also included ceasing residential care at the site.

- 1.3 A separate Community Feedback Report was completed by the HSCP Public Involvement Manager. This report captures all the feedback from conversation café / drop in events, survey monkey and hard copy questionnaires returned by members of the community. Submissions were received up to the last day of the engagement period.
- 1.4 The formation of a new Communication and Engagement Group made up of key stakeholders planned and delivered a series of events during the agreed timescale to secure feedback from the Dunoon and Cowal communities in relation to the re-design proposal for Struan Lodge.
- 1.5 Feedback from the community engagements events has been captured and the feedback has been different at each event. The full detail of the feedback is set out in the Community Feedback report.
- 1.6 The SLDG strategy was launched at a Dunoon Community Council (DCC) public meeting on Monday 6<sup>th</sup> March 2017.
- 1.7 The SLDG Strategy needs to be considered further within the context of the HSCP strategic plan aims and objectives. Consideration also needs to be given to the affordability of the proposals within the SLDG strategy. Potential opportunities to develop innovative service development ideas also need to be considered and explored further to determine what can be taken forward.

## **2. INTRODUCTION**

- 2.1 Argyll and Bute Health and Social Care Partnership (HSCP) are actively working to deliver the transformational change required across Argyll and Bute to meet the future needs of an ageing population, as demand grows within an increasingly challenging financial climate across public services. The scale of the challenges ahead is unprecedented and will require everyone to work smarter in the future by using our resources more efficiently and effectively.
- 2.2 The current health and social care system needs to change. We need to shift the balance of care by supporting people to stay at home longer to live healthier happier and independent lives. To do this we need to develop our approach to preventative interventions delivered increasingly in peoples own home or more homely settings.
- 2.3 Our Strategic Plan (2016-2019) identified 6 key areas of focus and set out our locality priorities in response to the national policies of the Scottish Government. Feedback from communities during the consultation period on the strategic plan identified that our communities want the HSCP to reduce the need for emergency or urgent care by improving our approach to anticipatory care. Our communities also identified the need for us to prevent ill-health, increase levels of confidence and ensure our staff were able to help people to improve their skills and confidence to remain at home.
- 2.4 The Argyll and Bute Integration Joint Board (IJB) agreed to a pause in work relating to service re-design at Struan Lodge in November 2016 due to concerns raised by the community. A move to ceasing 24 hour care residential placements was rejected by various people and groups

including the Struan Lodge Development Group. A pause between December 2016 and February 2017 has allowed the community to take part in a series of conversation café /drop in events about the future design of services for people living in Dunoon and Cowal.

### 3. DETAIL OF REPORT

- 3.1 During the pause period agreed by the IJB in November 2016, Officers supported work by the Communication and Engagement Group to develop a community redesign leaflet which set out the current service model in Cowal, the proposed changes and the process that would be followed during the pause. The leaflet was then distributed widely. A set of questions were also developed to ensure we asked the community the same questions which could then be collated at the end of the process.
- 3.2 The Communication and Engagement Group in Cowal was populated by a mixed group of people with varying degrees of experience in developing and delivering community events.
- 3.3 The Community Feedback report captures the key themes from the Cowal engagement events. It is a thorough report which sets out the detail of all the conversations that took place as well as the content of survey monkey and hard copy responses to the questionnaires submitted to the team.
- 3.4 The key themes / general points are captured on a table within the report and include the following:

	Key Themes / General Points
1	Promotion of good health and well being
2	Support to maintain independence at home for as long as possible
3	More services for people with mental ill health, including services for people with a diagnosis of dementia
4	More support for carers including respite care and overnight care
5	Strachur Hub – fabulous model, replicate in other outlying areas (spokes) with Struan Lodge as the hub
6	Day centre / day care – including activities
7	More should be done to tackle loneliness and isolation
8	Need convalescence type facility for everyone
9	Reliable and accessible transport
10	NHS Greater Glasgow & Clyde : more service provided locally, less in Inverclyde / Paisley / Glasgow; better communication; discharges from hospital better co-ordinated; better arrangements for appointments
11	Out of Hours services very limited
12	Concern this is just about cutting costs which will impact on quality of care
13	People want more choice
14	Crossroads & Befrienders – fantastic services, need more money to expand
15	Sheltered housing
16	Struan lodge should retain residential care – anxieties about

	capacity within the private sector; need to work with provide homes to support improvement in standards of care; future increased need for residential care; fear what will happen if residents are moved from Struan Lodge
17	Concern about reducing the number of beds at Cowal Community Hospital
18	Care at Home – more needed locally based on individual need

3.5 The Struan Lodge Development Group (SLDG) strategy was launched at a Dunoon Community Council (DCC) public meeting on Monday 6<sup>th</sup> March 2017. Approximately 90 members of the community attended. A number of IJB members attended the meeting at the invitation of DCC. At this meeting it was noted that a live petition was available for members of the public to sign in relation to Struan Lodge.

3.6 The SLDG Strategy needs to be considered further within the context of the wider feedback obtained in the HSCP strategic plan aims and objectives. The HSCP Strategic Plan sets out the strategic direction of travel and our key areas of focus 2016-2019. Consideration also needs to be given to the affordability of the proposals within the SLDG strategy. Potential opportunities to develop innovative service development ideas need to be considered and explored further to determine what can be taken forward.

3.7 A further detailed report will be presented to the IJB in May 2017 which sets out a clear set of recommendations and key milestones. The recommendations will be based on all available information taking account of the aims and objectives of the Strategic Plan.

#### **4. CONTRIBUTION TO STRATEGIC PRIORITIES**

4.1 The final set of recommendations will align with the Strategic Plan in terms of the 6 key areas of focus.

#### **5. GOVERNANCE IMPLICATIONS**

##### **5.1 Financial Impact**

The final set of recommendations will need to fit within the financial envelope available to the HSCP.

##### **5.2 Staff Governance**

The final recommendations will take appropriate account of staff governance.

##### **5.3 Clinical Governance**

The final recommendations will take account of the appropriate care standards.

## **6. EQUALITY & DIVERSITY IMPLICATIONS**

- 6.1 This work draws on a series of public engagement events planned and delivered across Dunoon and Cowal between December 2016 and the end of February 2017.

## **7. RISK ASSESSMENT**

- 7.1 The IJB agreed to a pause in the re-design work relating to Struan Lodge following feedback from the local community indicated a lack of communication and engagement relating to the proposal relating to the future use of Struan Lodge.

## **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT**

- 8.1 A programme of conversation café/drop in events were organised during December 2016 and February 2017 to secure feedback from communities across Dunoon and Cowal regarding proposed changes to the services delivered at Struan Lodge.

## **9. CONCLUSIONS**

- 9.1 The period of communication and engagement in relation to the re-design proposals for Struan lodge has now been completed. The community feedback report sets out the key themes that have emerged from this process.
- 9.2 A further report will be prepared for the IJB meeting in May 2017 which sets out key recommendations and milestones which fit with the aims and objectives of the Strategic Plan.

Allen Stevenson  
Head of Adult Services (East)



Argyll and Bute Health and Social Care Partnership (HSCP)

# STRUAN & COWAL COMMUNITY REDESIGN



## COMMUNITY & STAFF FEEDBACK REPORT

FINAL

12<sup>th</sup> March 2017

Struan & Cowal Community Redesign Website : [www.tinyurl.com/hcqszzg](http://www.tinyurl.com/hcqszzg)

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## Background

The Argyll and Bute Health and Social Care Partnership (A&B HSCP) Strategic Plan 2016 – 2019 outlines our priorities for health and social care services across Argyll and Bute

<http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/SP%202016-2019%20%20Final.pdf>

Our priorities are in response to national policies as set out by the Scottish Government, for example Shifting the Balance of Care, but also based on what our communities and staff have said is important to them.

People have said **“We want to live a long, healthy, happy and independent life supported by health and social care services when we need them.”**

They have said **“We want to stay at home for as long as possible.”**

We need to redesign health and social care services in Cowal to meet these priorities. **It is important that you have the right service, in the right place, at the right time.**

### What does this mean?

This means that we can no longer provide services as we do now. If we carry on as we are, we will not be able to support the ever growing number of people who will need our support in the future.

Communities have told us they want to be supported to live in their homes for as long as possible. To achieve this, we need to provide more community based services. We need to make sure the services provided at Struan Lodge and within the community meet the needs of our population now and in the future, are flexible in response to changes in demand and that they are sustainable for many years to come.

We are committed to keeping Cowal Community Hospital at the heart of the community. We want to retain the high quality level of care which it provides, when people need it. As we are looking to provide more services in the community it means we feel we can reduce the number of beds in the local hospital.

### What is being proposed?

The service change identified for the Struan Lodge and community care across Cowal has been informed by previous reviews of residential care and care in the community over the last three years. We also need to take account of working within the current level of residential care provided by private care companies and increased use of our community based services and interventions.



**The vision we have discussed with communities and staff is to consider provision of :**

- **Community Support Hub / Centre of Excellence** – the vision would allow Struan Lodge to be used as a multi-purpose facility, providing a range of high quality flexible services for the community
- **Reablement Service** – this would enable us to increase confidence and improve skills to support people to live their lives to the full and maximise independence. This is what people have said is important to them.
- **Drop in Advice Centre** - Struan Lodge would be a key central point where people can receive advice and point people in the right direction
- **Social Day Hub** – people could use Struan Lodge as a place to get help and advice, and build strong working relationships with other local community services such as Befrienders Service and Carers Centre
- **Community Transport** – people have said that transport and providing the means to access both hospital and other health and social care services is vital within rural communities. We will work hard with partners to ensure that transport is available

Our vision has been informed from previous Struan Lodge Development Group proposals. We would like to work through a co-production model to design and develop a progressive, fit for purpose service model strengthening links with the neighbouring Cowal Community Hospital to become a single health and care campus.

The vision fits well with the HSCP three year Strategic Plan. The Strategic Plan was developed with all partners and taken through an extensive involvement and engagement process to agree the shape, objectives, outcomes the people of Argyll wanted to experience for health and social care.

The creation of the Cowal Hub could provide a wide range of services which will improve our co-ordinated approach, tailored to the individual needs and improved health and care outcomes of adults who require our support. It also means that we can expand the day service to help a greater number of older people, people who otherwise would not have access to such services.

## **Communication and Engagement**

**The Cowal Communications and Engagement Group** has responsibility for supporting the Locality Planning Group (LPG) to ensure the approach to engagement activities is in line with Statutory Guidance CEL 4 (2010)<sup>1</sup>.

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<sup>1</sup> CEL 4 (2010) Informing, Engaging and Consulting People in Developing Health and Community Care Services, Scottish Government, February 2010

The Communications and Engagement Group is made up of public, third sector, union, NHS and Council Staff. The Scottish Health Council provides guidance and support.

A summary Communications and Engagement Plan was presented to the Integrated Joint Board at its special meeting on 2<sup>nd</sup> November 2016 and endorsed. A copy of the Plan, which was developed by the Cowal Communications and Engagement Group, can be found at Appendix 10.

### **Struan and Cowal Community Redesign Leaflet**

In November 2016, the Struan & Cowal Community Redesign leaflet was produced which was then distributed during the first week of December in advance of the first community engagement event. The leaflet provided an outline of why services need to change, diagram of what services are currently available for Cowal citizens, proposed Cowal Hub model, communications and engagement that would be followed, and the schedule of engagement activities before Christmas.

A total of 2,500 information leaflets were printed in advance of the engagement events. These were distributed to various key locations including hospital waiting areas / reception, GP surgeries, dental surgeries, library, village shops / Post Offices, Service Point, and Third Sector groups. The remainder were made available for people to take away with them at the engagement events.

### **Feedback “We Want Your Views!”**

A “We Want Your Views!” feedback form was developed and produced (Appendix 1). The feedback form was made available at all events during the engagement period (December – February). Local people were encouraged to complete and return the feedback form by post using the Freepost envelope supplied. 27 feedback forms were returned by post. Appendix 2 provides the detailed unedited responses for information.

People were also given the option to complete the feedback form online through Survey Monkey. The same questions were used to ensure consistency. A total of 9 responses were received and these have been included in the report.

The HSCP generic email address was provided for anyone wishing to share their views, comments or put forward alternative ideas. 3 people used the generic email address to provide feedback, 1 official complaints form was used and 1 person emailed Locality Management office directly. These have been included (Appendix 7) in the overall feedback report but do not include names to maintain anonymity of the authors.

The deadline for submitting the “We Want Your Views!” Feedback Form was Tuesday 28<sup>th</sup> February 2017.

## Community and Staff Engagement 2016 / 17

The HSCP held a series of engagement activities during the period December 2016 to February 2017. The Schedule of Community Engagement Activities has been included at Appendix 9. Representatives of the HSCP along with members of the Communications & Engagement Group attended and supported the various activities.

Approximately 124 people attended these events, broken down as follows :

Location	Date	Number of Attendees
Cowal Community Hospital, Dunoon	12 <sup>th</sup> December	23
Kirn & Hunters Quay Bowling Club, Kirn	13 <sup>th</sup> December	6
Village Hall, Innellan	19 <sup>th</sup> December	2
Village Hall, Lochgoilhead	10 <sup>th</sup> January	7
Kames Church Hall (Lunch Club)	18 <sup>th</sup> January	16
Village Hall, Tighnabruaich	18 <sup>th</sup> January	12
Village Hall, Strachur	24 <sup>th</sup> January	5
Village Hall, Ardentinny	1 <sup>st</sup> February	23
Village Hall, Colintrave	9 <sup>th</sup> February	2
Village Hall, Sandbank	15 <sup>th</sup> February	1
St Muns Church Hall, Dunoon	21 <sup>st</sup> February	2
Cowal Community Hospital, Dunoon	22 <sup>nd</sup> February	6
Village Hall, Kilmun	23 <sup>rd</sup> February	16
Cowal Community Hospital, Dunoon *	3 <sup>rd</sup> March	3

\*Feedback event where key themes from all the feedback received was available for anyone to see.

Most of the engagement activities were based around the Community Café method. People were invited to come along for a 'chat and a cuppa' and share their views about what is being proposed.

In addition to the engagement events, members of the HSCP attended staff and local group meetings / activities. The following table provides details of these additional activities along with number of people engaged in discussion :

Location	Date	Numbers
Lunch Club, Kames Village Hall	18 <sup>th</sup> January	16
Sandbank Community Council	19 <sup>th</sup> January	16
Sewing Club, Strachur	24 <sup>th</sup> January	9
Co-Op, Dunoon	27 <sup>th</sup> January	10
Lochgoilhead Lunch Club	5 <sup>th</sup> February	15

At some engagement events, in particular where conversation cafés were run, people were encouraged to record their views, comments, ideas / suggestions on tablecloths. Where tablecloths were used in this way, the information has been included in this report (Appendix 3) and included in the overall analysis.

## **“We Want Your Views!” Feedback Results**

The evaluation of the feedback received has provided qualitative feedback only. Feedback has not been ranked in any order of priority as we did not ask people to do that. A breakdown of how the feedback has been received is as follows :

<b>Feedback Method</b>	<b>Number Received</b>
Feedback Form	30
Survey Monkey	9
Email	4
Letter	1
Other	1

Given the volume of responses received, a summary of the main issues or points provided have been included in the main body of this report. Appendix 2 provides the detailed unedited written feedback received from all responses received (“We Want Your Views!” feedback form, Survey Monkey, emails and letters). Appendix 3 provides the full details recorded on tablecloths and Appendix 4 includes ideas put forward for what day care could look like for Cowal. Appendix 5 provides details of discussion themes / comments captured by event facilitators.

### **Summary**

A total of 45 responses have been received, either by post, online using Survey Monkey, emailing to the generic email address, by letter or alternative format. The response rate is lower than anticipated.

Based on the feedback received, a number of key themes / general points have emerged. There is divided opinion within the central Dunoon area and the outlying rural communities. There are some who would like to see services at Struan Lodge continue as currently provided, some people have stated they feel the proposed model for Struan and Cowal Community Redesign is good, acknowledging the benefits. Rural communities, however, are interested in developing their own local services.

The table below lists the key themes / general points that emerged from the feedback received.

Key Themes / General Points	
1	Promotion of good health and well being
2	Support to maintain independence at home for as long as possible
3	More services for people with mental ill health, including services for people with a diagnosis of dementia
4	More support for carers including respite care and overnight care
5	Strachur Hub – fabulous model, replicate in other outlying areas (spokes) with Struan Lodge as the hub
6	Day centre / day care – including activities
7	More should be done to tackle loneliness and isolation
8	Need convalescence type facility for everyone
9	Reliable and accessible transport
10	NHS Greater Glasgow & Clyde : more service provided locally, less in Inverclyde / Paisley / Glasgow; better communication; discharges from hospital better co-ordinated; better arrangements for appointments
11	Out of Hours services very limited
12	Concern this is just about cutting costs which will impact on quality of care
13	People want more choice
14	Crossroads & Befrienders – fantastic services, need more money to expand
15	Sheltered housing
16	Struan lodge should retain residential care – anxieties about capacity within the private sector; need to work with provide homes to support improvement in standards of care; future increased need for residential care; fear what will happen if residents are moved from Struan Lodge
17	Concern about reducing the number of beds at Cowal Community Hospital
18	Care at Home – more needed locally based on individual need

Discussions at the community engagement activities have echoed these key themes.

Feedback prior to implementing any proposed change in how services will be delivered is crucial to ensure the local population is given the opportunity to share their views and have their ‘voice’ heard, this is in line with Statutory Guidance CEL (4) 2010.

All feedback received has been very important and of great value. Many thanks to all those who returned their completed “We Want Your Views!” feedback forms, attended our engagement events or responded using other methods.

The full Your Views! Feedback Report will be presented to the Integration Joint Board (IJB) on 29<sup>th</sup> March 2017 as a supplement to the strategic management report by Allen Stevenson, Head of Adult Services (East).

This feedback report will become a public document and available on the HSCP webpage at [www.tinyurl.com/hcgszzg](http://www.tinyurl.com/hcgszzg)

Caroline Champion  
Public Involvement Manager  
Argyll & Bute Health & Social Care Partnership

(on behalf of Allen Stevenson, Head of Adult Services (East))

12<sup>th</sup> March 2017



Argyll and Bute Health and Social Care Partnership  
(HSCP)



## STRUAN & COWAL COMMUNITY CARE REDESIGN



### WE WANT YOUR VIEWS!

#### Why?

You said "We want to live a long, healthy, happy and independent life supported by health and social care services when you need them"

You said "We want to stay at home for as long as possible"

We want to support you to achieve this

You said "We want public involvement in service redesign"

We want to do that and have put in place a series of events and ways to gather your views

We can no longer provide services as we do now. We need to provide more community based services. We need to make sure the services provided at Struan Lodge and within the community meet the needs of our population now and in the future, are flexible in response to changes in demand and that they are sustainable for many years to come.

Your feedback is important. We will use what you say to help us redesign and improve *your* local services so they are fit for the future.

#### How can you do this?

Complete this feedback form and return it to the FREEPOST address on page 2



complete the form online <https://www.surveymonkey.co.uk/r/WQ7FC8S>



email us your story / views to [nhs.abhscp@nhs.net](mailto:nhs.abhscp@nhs.net)

Your feedback will be confidential. By that we mean :

- ✓ we will not name you in the document
- ✓ if you share your views but you do not want these to be part of the public record of the feedback we receive, we will respect that and your views will not be included.

Please tick this box if you do not want your views included in the feedback report

Q1 Thinking about yourself, what would enable you to live a long, healthy, happy and independent life?

Please turn over

**Q2 What support might you need to achieve this?**

What could services look like in 3 years?

**Q3 We would like to develop a centre of excellence at Struan Lodge which will provide a range of community services to support people to stay at home for as long as possible. What services would you like to see developed?**

**Q4 How do we increase confidence in community services to ensure they meet your needs?**

What do you need to have in place to be confident in community services?

**Q5 Do you have any ideas, concerns or questions about how we redesign services to move away from hospital to community based services?**  
(Please continue on a separate sheet if necessary)

**We welcome your more detailed comments, ideas, concerns or questions. Please attach them to this sheet**

Please return this feedback form **no later than Tuesday 28<sup>th</sup> February 2017** to :

Caroline Champion, Public Involvement Manager  
FREEPOST RRYT-TKEE-RHBZ  
NHS Highland (Argyll and Bute HSCP)  
Blarbuie Road, LOCHGILPHEAD, Argyll, PA31 8LD

If you need help completing this form or to receive a copy in a different language / format (e.g. large print) contact Caroline ☎ 01546 605680 or [caroline.champion1@nhs.net](mailto:caroline.champion1@nhs.net)

*Thank you*

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# STRUAN & COWAL COMMUNITY REDESIGN

## FEEDBACK

*The following provides detailed unedited written feedback received from all forms received by post, online survey monkey and email. Each has been given a unique reference as part of the overall analysis of responses.*

### **Q1 Thinking about yourself, what would enable you to live a long, healthy, happy and independent life?**

- Have a healthy diet, be sociable, do things that make you happy [sccr001/12dec16]
- Support of family and friends. Constant activities to do [sccr002/12dec16]
- Stimulation. People. Interaction [sccr003/12dec16]
- Family genct [sccr004/12dec16]
- By being able to carry on doing the things I enjoy [sccr005/12dec16]
- Support if required to maintain independence at home and able to socialise with family and friends [sccr006/12dec16]
- To continue to live my life the way I want to and gain support when & how I want to [sccr007/12dec16]
- Staying in Dunoon with more local treatments in the hospital here near one's friends & family [sccr008/13dec16]
- The promotion of good mental & physical health in later life [sccr009/20dec16]
- Maintaining a good physical and mental health [sccr011/10jan17]
- I think the question is not well worded. You can't predetermine if a life will be long, nor do much to ensure it is healthy, happy and independent. Community care needs to be appropriate [sccr013/06feb17]
- PUBLIC SUPORT WHEN IN NEED – PERSONAL FITNESS AND DIET TO AVOID BEING IN NEED. AFFORDABLE CARE IN QUALITY HOMES [sccr014/06feb17]
- I have macular degeneration and it would be helpful to meet with other people with sight loss occasionally. I know there used to be meetings in Dunoon, but as I am unable to drive and the buses are infrequent, it means hanging around Dunoon waiting for buses, and at 84 this is not an attractive option. [sccr015/06feb17]
- I am 81, and getting older every day. But so are those who make the closures [sccr016/01feb17]
- Support when needed – either at home or if necessary in care – the important thing is choice [sccr017/01feb17]
- Remaining healthy and being independent as long as possible [sccr018/01feb17]
- Rhetorical question. Who knows what may occur and our choice is irrelevant. Managements' brief is "care in the community" Now dismantle what should be available [sccr019/06feb17]
- Of course I would like to stay at home as long as possible – as long as I could look after myself, but there comes a time that this would not be possible, I would

- rather go into a good care home – like Struan Lodge – than having absolute strangers in & out of my house. [sccr020/13feb17]
- A PLACE NEARBY TO MEET PEOPLE AND TAKE PART IN NEIGHBOURHOOD GET-TOGETHERS. AND EVENTS. – WALKING DISTANCE FROM MY HOME. I AM A NON DRIVER [sccr021/16feb17]
  - Knowing that properly funded care will be available if I need it, that the appropriate professional people are in charge, not uncaring bureaucrats such as the IJB [sccr022/16feb17]
  - Fewer clerks & administration staff telling me what I want or need, and more nurses & doctors locally. Reinstatement of home care staff. Knowing that there are properly paid care home staff with the skills and temperament to do the job to a high standard. And that I would not be dependant on the private sector. [sccr023/16feb17]
  - Ideally care at home with the same carers plus a Home Help. I wouldn't want my home to deteriorate from lack of care – it would depress me – I'd rather be in Struan Lodge [sccr025/20feb17]
  - ABLE TO KEEP MY CAR FOR AS LONG AS POSSIBLE. I AM LUCKY TO LIVE OPPOSITE A BUS STOP & 5 MINUTES FROM A POST OFFICE, PAYPOINT & SHOP. I HAVE AN EXCELLENT G.P. SURGERY WHO ALSO DISPENSE MY MEDICATION. JUST ALONG THE ROAD. I WOULD NEED HELP WITH THE GARDEN [sccr026/23feb17]
  - GOOD HEALTH & LOCAL SERVICES [sccr027/24feb17]
  - Access to food shops, books (library services), exercise, opportunity to meet other people, exercise, useful advice, and sufficient warmth. [sccr028/28feb17]
  - Reliable transport so that I can get to Dunoon when I no longer drive. Being able to attend clubs / drop ins for social contact preferably in halls along the shore. The emergency service and physio / clinics at Cowal Community Hospital. Trained and mentored care staff. Mentoring is an ideal as two weeks of training is great but needs support in practice in my view. [sccr029/28feb17]
  - Truly local services, provided rather than “delivered” – (an unfortunate term, as if a package dumped on the doorstep!) You can help with healthy, but “happy”?? I wish” Luck & money. [sccr030/01mar17]
  - Proper health care at local hospital [sccr001/09dec16sm]
  - Good, local health care [sccr002/09dec16sm]
  - Good social life to avoid loneliness and depression, keeping active and involved in the community , access to good quality and appropriate health and social care. [sccr003/09dec16sm]
  - knowing that i had a local hospital when i needed it [sccr005/17jan17sm]
  - having access to other providers for the elderly allowing independence for as long as possible [sccr006/07feb17sm]
  - To have a local hospital that is there when I need it so I don't have to travel and family don't have to travel miles to visit me. [sccr007/21feb17sm]
  - To know that there is a choice of public and private care homes as I don't want to leave this area because there is no availability of care home beds . Not everyone is able to be cared for at home. [sccr009/23feb17sm]

**Q2 What support might you need to achieve this? What could services look like in 3 years?**

- More up to date [sccr002/12dec16]
- A lot more modern [sccr004/12dec16]
- Having support to allow going out and about and staying in contact with people [sccr005/12dec16]
- At present none required. Will be still studying in 3 years [sccr006/12dec16]
- Easily accessible in community. That I can dip in and out depending on whats going on for me [sccr007/12dec16]
- At the present rate there won't be any! There should be more locally provided [sccr008/13dec16]
- Information on how to stay healthy in later life [sccr009/20dec16]
- What ever it takes to ensure Q1 It is what I have paid for throughout my working life [sccr011/10jan17]
- Carers who go in to homes several times a day need to do more than dash in and out, and need adequate time to travel between 'patients'. This is not always happening, but is important and basic to 'community care'. [sccr013/06feb17]
- THERE SHOULD BE A MIX OF public SERVICES & PRIVATE services based on need in the community – DO NOT RELINQUISH ALL PUBLICALLY OWNED SERVICES [sccr014/06feb17]
- We have an excellent health centre with access to doctors, a dentist and chiropodist in Tighnabruaich and I would like to see it being used for exercises for the elderly once a week which would increase mobility and be a chance to socialise I would like to see Dunoon hosp[ital used for medical consultations instead of ferrying aged people across the Clyde for often a few minutes consultation. Surely it would be cheaper than providing transport for so many patients. The patient transport doesn't leave Duoon to come over here till 9am which means that we are often late for morning appointments. I know of one 90yearold who arrived late and they refused to see her so she was taken home without being attended to and required another appointment to be made. [sccr015/06feb17]
- No hospital, no money, empathy [sccr017/01feb17]
- adequate support in the Community, and if necessary Residential care [sccr018/01feb17]
- It will no longer be "free" Either those "managing" must prove to the public that their cost cutting is successful or patients must pay for some services [sccr019/06feb17]
- Who knows, everything is being changed, but not for the better. [sccr020/13feb17]
- A PLACE TO DO THIS. TRANSPORT / A LIFT (IN THE FUTURE) [sccr021/16feb17]
- That the public hold the decision makes to account. Appalling if IJB gets it way, maybe even non-existent [sccr022/16feb17]
- If people who know what they are doing (ie not the IJB) and given proper funding, there could be big improvements. Otherwise it could be much worse or event extinct. [sccr023/16feb17]
- Sufficient Home Carers able to attend those discharged from Hospital with no delays [sccr025/20feb17]
- WHO KNOWS!! AT PRESENT, THE RULES & REGULATIONS CHANGE CONSTANTLY WITHOUT SUFFICIENT CONSULTATION WITH THE PEOPLE WHO MIGHT REQUIRE CARE AT HOME OR DAY-CARE FACILITIES [sccr026/23feb17]

- AS NOW [sccr027/24feb17]
- I live in Tighnabruaich, 2 miles from the bus stop to Dunoon. If I were no longer driving I would need sufficient daily transport to get to the village shops, the village ahll, the doctor's surgery – and back. Relying on 'lifts' is not an option here. [sccr028/28feb17]
- I would like you to refer to my answer in Q1. I could need a person whose role was to assess my overall situation and help me organise my social, medical care and personal care. More monitoring in the home that link people with medical staff electronically. I have seen news of people in more isolated spots having phone call / skype appointments. All sorts of electronic supports linked to a medical centre to alert them of unexpected changes. These supports would keep people independent and hopefully prevent hospital admissions. [sccr029/28feb17]
- Impossible to look ahead without authoritative information. Use of telecare seems to be in conflict with "reduce loneliness" – people, contact is needed. [sccr030/01mar17]
- More services in Cowal [sccr001/09dec16sm]
- Support to stay in own home but not if it means I was isolated and lonely. Need better support for lonely people, who cannot get out and about. [sccr002/09dec16sm]
- If the current rate of cutbacks continue, Struan lodge will have closed, Dunoon Hospital will be down to two beds, Palliative care will be a classroom for the burgeoning number of managers and personal assistants. This trend has to be stopped. Care in the community was never meant to be an excuse to cast the needy elderly out of the system and into isolation, trapped in their own homes. [sccr003/09dec16sm]
- don't cut beds at CCH! [sccr005/17jan17sm]
- knowledge of whats available, not having to jump through hops to get the simplest service. Is it possible for providers to speak to one another without there being underlining rifts between them and not make me feel unfomforatble for ccessing them if required. maybe gaining access to services prior to becoming a crisis situation. in 3 yrs time services should be well established [sccr006/07feb17sm]
- Continued investement in local services, including in patient and residential care so all the services I may need are available locally. [sccr007/21feb17sm]
- We need to make sure that there is a balanced care plan for both care home and home care . Every strand on health and social care and under tremendous pressure they need to be supported with the right trained staff. [sccr009/23feb17sm]

**Q3 We would like to develop a centre of excellence at Struan Lodge which will provide a range of community services to support people to stay at home for as long as possible. What services would you like to see developed?**

- Things for patients with dementia. Use pets for therapy more [sccr001/12dec16]
- Carers to come and give support. Have more information for family and friends [sccr002/12dec16]
- More mental health support [sccr004/12dec16]

- Activities to allow people to meet new people and carry on doing what they enjoy to avoid loneliness + depression [sccr005/12dec16]
- Carers (home). Meals (eg on wheels). Day centres – activities. Dressings. Bathing service. Therapies [sccr006/12dec16]
- Café, take away, Bistro type service that can deliver a range of foods, widely inc Cowal not just Dunoon. Active, purposeful groups (not Bingo!). That people will enjoy & get a lot out of it [sccr007/12dec16]
- The opposite of what is proposed – we need a convalescence type facility – not just for elderly or dementia patients [sccr008/13dec16]
- I would like to see day care, sheltered housing and an expansion of residential care at Struan Lodge allowing a seamless transition should people require this [sccr009/20dec16]
- I think this is stupid – people are living longer there will always be those who require care home places and they will be more ?? than ?? [sccr011/10jan17]
- I think it is wrong to shut Struan Lodge as a residential service for people who need extra care, especially as it is reputed to offer better service than the other care homes. So I don't think it should be the place for offering a variety of community services for those able to stay at home. [sccr013/06feb17]
- I would first of all like to see public care Beds for LONG-Term provision AND respite beds for short-term provision – OUTREACH services for public care could also operate here [sccr014/06feb17]
- I imagine there will be some expense adapting Struan Lodge when. You have empty wards doing nothing, and would make it a suitable day centre. Why aren't you using the wards that have been closed in the hospital, and keep Struan Lodge as the excellent care home that it is at the moment. [sccr015/06feb17]
- Struan is excellent compared with private. Do not describe them as excellent. They are not medically trained in this includes seniors and cannot interpret medical health signs eg. signs [sccr017/01feb17]
- Day Centre transport for elderly – already provided by Interloch. Meals & support at Home [sccr018/01feb17]
- Computerising has proved inefficient and unhelpful Centralising ambulances patient transport, hospital appointment systems, transfer of patient notes, test reports etc. have not benefitted vulnerable patients [sccr019/06feb17]
- Use the old building for your so called Hub of excellence and leave the frail residents in the 24 hour residential care home [sccr020/13feb17]
- What about when its no longer possible? More residential care beds, more help for convalescing patients. Help for young carers and young people with serious health issues so that they are cared for in Dunoon rather than being separated from their families [sccr022/16feb17]
- More residential services and respite beds. All the research available supports this need. Have you listened to what is happening nationally? Less centralisation, more local resources. I do not like having to go to Greenock or Paisley for treatment or taking my 91 year old relative. (Referring to the second part of the question) Why is this question tagged on to this statement? [sccr023/16feb17]
- Home Help Services ... as we used to have. The continued 24hr residential care at Struan Lodge [sccr025/20feb17]
- I WOULD DEFINITELY EXPECT THE 24HR. CARE TO CONTINUE FOR THE PRESENT RESIDENTS, AS STRUAN LODGE IS THE BEST CARE HOME IN DUNOON. HOPEFULLY CONTINUE AS BEFORE FOR THOSE WHO

CONNOT STAY AT HOME & NEED CONSTANT CARE. NO AMOUNT OF SAY SERVICES WILL MAKE UP FOR LOSING 24HR. CARE [sccr026/23feb17]

- Services at Struan Lodge are no use for upcountry patients [sccr027/24feb17]
- Struan Lodge is a 50-mile round trip away from here and the roads can be very unreliable (and wearing). However, it would be useful to have a centre for advice concerning welfare provisions, informal medical advice, & help with modern technology (ie ipad, phones, computers etc) to be useful to the area & from or even ten-fold increase in voluntary and community transport is needed. [sccr028/28feb17]
- A social hub would benefit those in Dunoon but Shore people will find it far to go. I have visited the hospice where you have an opportunity to meet others and take up a range of support services. This model is working well except that one lady I know was told she'd had her time with one activity and had to stop just when she needed it most. [sccr029/28feb17]
- See Q5. [sccr030/01mar17]
- Overnight respite care [sccr001/09dec16sm]
- There are already a lot of community services, but still people are lonely - 4 x per day care package can mean being on your own all day apart from 4 x 15mins. This is not good enough. Patients need stimulation and company. [sccr002/09dec16sm]
- Speed up the decision making process. We notified them that my Mother was in crisis and would need access to their facilities two weeks before the situation became so bad she moved in with us. About three weeks later she fell and broke her hip. She never did come home, but a month or so after her accident, Struan Lodge got round to replying. Struan Lodge should already be a centre of excellence, how much of the budget will be devoted to achieving this accolade for the council? The range of services should include reliable transport to and fro, appropriate activities during the clients stay, medical backup if required. [sccr003/09dec16sm]
- lots of people don't want to stay at home! They want a local in patient/care services [sccr005/17jan17sm]
- It would be EXCELLENT if the residential side wasn't being made extinct to make way for the development of Centre of Excellence which no one knows how this will turn out and how much it will cost to keep people in their own homes who should really be in a residential placement due to health/safety issues but the council think it better to make cost cuts on the short term fix, what else will be cut to the detriment of others safety or lives? [sccr006/07feb17sm]
- Day services with stimulating activities, services for people of all abilities, good services in the community and in people's homes not just at Struan. [sccr007/21feb17sm]
- The 24 hour residential care expanded to cover the need for future care beds which will be required within the town. A fit for purpose day centre which will have a more flexiable approach , not Monday to Friday 9 to 4 , this needs to be a 7 day service to deliver appropriate respite day care to allow careers to get much needed respite . A meals and wheels service that will meet the needs of the community providing lunches , evening meals 7 days per week , a lunch club to allow the elderly to drop in and have an oppurtunity to access other services like bathing service , podiatry, physiotherapy, OT, an information centre to direct people to access services required. [sccr008/22feb17sm]

- This question as most are trying to lead people to say we don't need care beds this is not true we need more care home beds as the aging population [sccr009/23feb17sm]

**Q4 How do we increase confidence in community services to ensure they meet your needs? What do you need to have in place to be confident in community services?**

- To be able to rely on Dunoon Community Hospital and not be sent to Inverclyde ect, have a hospital which we can actually use [sccr001/12dec16]
- Be more open – provide more information to people [sccr002/12dec16]
- Improve communication [sccr003/12dec16]
- A working hospital [sccr004/12dec16]
- Regular updates of care for patients and relatives [sccr005/12dec16]
- Good communications. Advertising. Letting people know whats available. Using Care Commission rating to let others know [sccr006/12dec16]
- Communicating saying what they need & not assuming everyone want to be in a care home – I want to die in my own bed in my own home! [sccr007/12dec16]
- A competent group of people running the show. Obviously those in charge now are not up to the job [sccr008/13dec16]
- Less focus on cost and profit and greater focus on quality provision [sccr009/20dec16]
- It is a pie in the sky concept so you will need an army of trained community carers to achieve it [sccr011/10jan17]
- To have some certainty that those managing community services are more prepared to listen to the community. [sccr013/06feb17]
- A proper consultation process on public provision of services – councillors should also consult their constituents B4 making drastic decisions [sccr014/06feb17]
- I think I have already answered this question. [sccr015/06feb17]
- Be polite, listen, take note of comment, action them, report back, and reflect. [sccr017/01feb17]
- I think Dunoon Hospital and Struan Lodge should be available to provide interim stay for people being discharged from main line Hospitals [sccr018/01feb17]
- Stop closing our hospital beds:!! Replaced by terminal care ward – (shicking). Clerical service using empty accommodation A “HUB” (viz a computer & desk) to take over [sccr019/06feb17]
- I have no confidence [sccr020/13feb17]
- THE HOSPITAL WITH MORE CLINICAL / SOCIAL WORK STAFF. IT HAS A LOT OF SPACE! [sccr021/16feb17]
- Stop tampering with services proven to work. A system where accountability is in evidence. Properly trained staff at grass roots level, fewer bureaucrats. We need nurses, doctors and carers – not those primarily concerned with cost. [sccr022/16feb17]
- If ever something needed redesigning it's the IJB, and not Struan Lodge. A complete change in leadership of our community services would help. We need people we can trust to have our welfare as their priority. What qualifications do the current incumbents have? Membership of the human race would be helpful [sccr023/16feb17]

- Punctual carers who have a vocation for the job. They should have adequate time to provide the necessary care so are not rushing to finish [sccr025/20feb17]
- A RELIABLE, PROPERLY TRAINED CARER SYSTEM WHO VISIT FOR MORE THAN 15 MINUTES [sccr026/23feb17]
- Have services for all patients not only Dunoon based patients. [sccr027/24feb17]
- Our doctors surgery is very good in my opinion. But social care doesn't seem to be very evident, particularly for people who don't have much money. I haven't needed anything up till now, but observation of other people seem to indicate (perhaps wrongly) that there doesn't seem to be any solution for minor disabilities. [sccr028/28feb17]
- Information that is readily available on whatever is available on the internet, but also in printed form for the many people who are not computer comfortable. Best of all trained people who can join up you needs face to face. [sccr029/28feb17]
- I need to know what is available in my area – perhaps not needed now but building confidence for the future. You can only be confident in something you see working. What is “3<sup>rd</sup> sector?” [sccr030/01mar17]
- Staff!!!! [sccr001/09dec16sm]
- Need more staff - there are waiting lists for a lot of the community services, such as befrienders. The patients were being charged too much for Struan day care so stopped going. [sccr002/09dec16sm]
- Less of the relentless cutbacks. Less of the political manouevreing and more attention to the needs of the people for whom the service was intended. [sccr003/09dec16sm]
- increase public confidence by listening to them! [sccr005/17jan17sm]
- It would be good to get people from the council to speak to us in the community that have a background knowledge of the area and what is needed to exband and develop the needs of people instead of looking at ££ figures and trying to make quick but detrimental fix. instead of cutting out things in the community that matter because of budget cuts, why doesnt the council try and track those people/individuals down that actually owe monies, why is it always those that have paid their dues throughout their life get the raw end of the deal?? Home Care services that work for the elderly, that are able to reach the out of area homes, how are they going to be looked after when a provier(s) doesnt cover that area or they dont have availability to cover for 3months, does that person sit at home with no one coming in to care of them or do they have to sit in a hospital bed wishing they no longer existed because they are made to feel they are blocking a bed for someone else. [sccr006/07feb17sm]
- ? [sccr007/21feb17sm]
- Service providers who will deliver quality services and not be profit lead.take the time to listen to the needs of the community, work closer with staff members who are front line delivering services to listen to concerns being raised, ensure that services commissioned are complying with mandatory staff training , like moving and handling , food hygiene , adult protection , dementia awareness, unless these measure are in place you are putting clients at risk. [sccr008/22feb17sm]
- These questions are loaded trying to push the resident of Cowal down your way [sccr009/23feb17sm]



## **Q5 Do you have any ideas, concerns or questions about how we redesign services to move away from hospital to community based services?**

- Keep everyone informed and listen to all feedback [sccr002/12dec16]
- Create a base in Dunoon for the mentally ill [sccr004/12dec16]
- If moving away from hospital services then the standards may begin to change due to the easy going environment [sccr005/12dec16]
- Using steer groups. Public information. Using social media platforms to spread information [sccr006/12dec16]
- Responsive Health Service. In a Rural communities where I stay a 999 call could take 50 mins – hour from Dunoon. I'm fed up having to go across the water for various clinics. I'd much rather use Skype & my GP practice [sccr007/12dec16]
- Increase the number of beds in the hospital + Struan Lodge. Stop shunting people off over the water to Inverclyde. Provide more clinics & consultant visits in Dunoon. Rename the hospital to Dunoon hospital so people know where it is [sccr008/13dec16]
- Most people would like to stay at home, however for a growing number this is not possible. I would therefore like to see an increase in the number of places in Struan Lodge, equalling the cost of excellent care to that of the private [sccr009/20dec16]
- There are limited services out of hours. This concerns me particularly for palliative care patients. As part of the anticipatory discussions to devise care planning we are unable to provide reassurance that they will be able to access help. In Cowal there is no provision for nursing cover between 8pm and 8.30am There is often a considerable wait for NHS24 and the on call doctors have varying knowledge and skills re palliative care. Often, therefore patients choose to request end of life care in the Hospice and supported care ward. The ward has been affected by staff shortages and is closed intermittently. To reduce beds further in the hospital will also reduce the availability of this option for our dying relatives. [sccr010/04jan17]
- See Q4 It all sounds good on paper but will never achieve what it sets out to do as a growing number of elderly people are alone or distant from relatives and will need 24/7 care. If, as I suspect. This is an attempt at saving money at the expense of the most vulnerable in society then it is inhumane. The over-paid, underperforming bureaucracy that haemorrhages funds from patient care should follow the example of the oil industry workers and accept a 30% reduction in pay before any closure of this essential service which would be better expanded with proper investment in increased beds and a better use of the campus. The health and social service in all its forms should be given back to the professionals, the working doctors, nurses and trained social workers with some junior administration staff employed to assist them with inputting records into computers from which the Scottish Health Department can see the trends and needs etc.. The Trak-Care system should be universal across all the health boards with all of them using the same instances so that patient's records can be accessed throughout Scotland. This would arrest the empire building mentality at least within the IT departments. Finally all employees in the Scottish NHS should be made to sign a legally binding pledge that all their actions and decision will be for the good of the patient, and not their own career or that their staff and, where found not to be so, subject to instant dismissal and loss of pension rights. [sccr011/10jan17]

- BIG concern re. Home Care is the difficulty in . accessing carers – especially rurally ... AND ... the “self-directed” route and the huge responsibility on families to deal with the admin. and worse ... the self-employed carers .... and keeping an eye on . accurate figures ..... This is a heavy . enough burden on a family member .. but also, for some ‘staff’ ... great carers – but not book-keepers. [sccr012/31jan17]
- I don’t think there should be a move away from hospital. Given the relatively isolated position of Dunoon a hospital and hospital based services are very important. [sccr013/06feb17]
- WE STILL NEED HOSPITAL SERVICES SO I DON’T AGREE WITH THE QUESTION However community base services should target Discharge care / elderly care & vulnerable people Also ASK people what support they have at home. [sccr014/06feb17]
- A day centre, no matter how excellent, in Dunoon does not answer the needs of the people who live in all the outlying areas in Cowal, [sccr015/06feb17]
- The transport costs will be quite substantial for the people to be taken to and from the centre. Where will this money come from. If there is no overnight care at the Lodge how can that reduce beds in community hospital. IT Does not add up. [sccr016/01feb17]
- Make an outreach Hub, ensure there is transport make sure you inform the community. Don’t be a stranger – meet & talk. Wear a catheter or pad for experience Know what you are Know & experience what you are presented [sccr017/01feb17]
- More people on the ground for home support with adequate pay for home helpers and enough time to spend at each stop so not rushed from one house to the other, also unblock main line hospital beds [sccr018/01feb17]
- an expensive building, too expensive to provide long term care for those who want to stay in their own community. Or how long patients are prevented to occupy hospital beds. Or doctors told how long an appointment should last!! [sccr019/06feb17]
- We need our hospital, we are an ageing population in this area – we do not wish to be transferred across to Inverclyde or Paisley where nobody can visit. [sccr020/13feb17]
- NO WE NEED THE HOSPITAL TO STAY! STRUAN LODGE SHOULD BE KEPT FOR PEOPLE WHO CAN NOT STAY IN THEIR OWN HOMES! [sccr021/16feb17]
- “.. to move away from hospital to community based services?” Why would you think that is a good idea? I oppose any plans to further reduce hospital services. I am shocked at what has been done to the hospice – I want it reinstated. Its time to redesign the funding process not to reduce services. Elections are on the way – keep ignoring the wishes of the public at your peril. (Other comments written on feedback form page 1 – The Public gave their views in no uncertain terms already! “You ..” – Who? “You said “We want public involvement in service redesign” – You were told that you had failed to consult, hence this exercise. “We can no longer provide services as we do now” – Why not? “We need to provide more community based services.” – Based on what evidence? So why do away with residential care?) [sccr022/16feb17]
- I don’t believe that it should be either hospital or community based service. We need a combination of both plus residential care. Whoever designed the current system of fifteen minute visits to people at home should be ashamed of themselves. This is totally inadequate, and doesn’t help either clients or staff.

(Other comments written on feedback form page 1 – When, Who, Circumstances? Indeed “Why”, and why now and not before? “*You said “We want public involvement in service redesign” and you decided without it “We can no longer provide services as we do now”* Belatedly I am glad you realise that the current services are inadequate. Why are you obliterating something that works? “*We will use what you say to help us redesign and improve your local services...*” Don’t forget this fact [sccr023/16feb17]

- Comments on Feedback Form page 1 “We want your views!” – SO THAT YOU CAN FIND WAYS OF AVOIDING THEM? “Why?” HAVE YOU IGNORED WHAT YOU WERE TOLD AT PUBLIC MEETINGS “We want to do that and ...” YOUR CREDIBILITY HAD BEEN QUESTIONABLE SINCE INCEPTION. REDESIGN THIS FORM FOR A START – ASK THE QUESTIONS THE PUBLIC WANT ANSWERS TO [sccr024/16feb17]
- Besides personal care at home there is a need for additional help from Home Helps to provide care for the home too – cleaning, ironing, vacuuming, changing beds / curtains. Also the garden needs attention plus window cleaning etc [sccr025/20feb17]
- NOBODY WANT TO STAY IN HOSPITAL ANY LONGER THAN NECESSARY, SO MANY MORE HOME CARERS ARE NEEDED, WITH PROPER HOURS & PAY. [sccr026/23feb17]
- Have more services returned to Dunoon Hospital rather than virtually closing it. [sccr027/24feb17]
- We have an Abbyfield building in this village that seems only to be used for occasional, informal accommodation. This seems an awful waste of potentially useful social care space, eg day or part-day care. Even meals occasionally. Demonstration on useful subjects – exercise for older people, etc. [sccr028/28feb17]
- The care of those who need care day and night is of concern to me. Those in Struan Lodge right now care the example right now. I think it would be hard on elderly carers and family to have their relatives moved further away. [sccr029/28feb17]
- All planned services seem to relate to the Dunoon area – extension to rural area is essential. We cannot “drop in” to Dunoon. Other areas have more local clinics – eg. physio on a regular basis. Strong local hospital. [sccr030/01mar17]
- If you have the appropriate amount of staff with the back up they require i.e. a half decent local hospital, then community care should be hospital. Having read your report I am extremely concerned when you talk of cutting beds from Cowal Hospital, are there any beds left? Used to be medicine for the elderly, and 2 wards with proper staffing when it was GP led, now it is a shambles. Having had an elderly relative thrown out on a Friday to be readmitted 2 days later. The service is poor, the care is poor and I am disgusted that you think cutting the services further will improve anything. And the elderly relative I speak of was bed blocked at IRH for 2 weeks before a bed became available at Cowal. Cut beds what a joke. Increase capacity, as the population ages you cannot expect community based care to work without the appropriate back up [sccr001/09dec16sm]
- The emphasis is on community based living, but this is not always the best for the elderly, confused patients. Admission to a care home can change the patient's life, once they have company and feel secure. There are many people left in their own homes who are lonely so call the GP or press their telecare alarm as they

feel anxious on their own. You can put as many community services in as you like, but if the people are housebound and unable to access these services it will not help this group. The hospital beds have been reduced so far that each time we have tried to admit a patient to the hospital we are told there are no beds. This is not good enough and patients who could be looked after in Dunoon are being sent across the water to acute beds. You MUST take into consideration that all this care on the community is placing a huge burden on the GP's. The time required for house visits has increased enormously, but there are no extra GP's to undertake this. Many of the visits are not due to medical reasons but are a cry for help from lonely people. House visits can be 15 miles away so can take the GP up to an hour, and if there are other visits in the opposite direction it means the GP is run ragged with no break. [sccr002/09dec16sm]

- I am very worried that it will be a politically motivated stitch up. As with the continual hospital bed closures (from about 80 twenty years ago) the process will be expensive and not transparent. I believe all the hospital beds are full all the time, so provision is clearly inadequate. I am fully in favour of care in the community, but it has to be funded in order to care for people in the community (especially those who are housebound) rather than abandoning them. They then spend their time at the GP surgery or A and E. The ones who are housebound are continually on the phone to the emergency services because they are so lonely and abandoned. 4 carer visits of 5 minutes each does not begin to address the social and loneliness issue. The GPs who are already under enormous pressure, have to deal with innumerable phone calls every day and make many unnecessary house calls to folk who are simply lonely or anxious. [sccr003/09dec16sm]
- Government policy advocates that patients should be involved in planning their care. In particular the aim is that palliative care patients have the opportunity to discuss options for their end of life care. In Cowal there is no nursing support from 8pm till 8.30am, Marie Curie are great but there are little to no trained staff, NHS 24 responses can be delayed and the doctors on call have varying levels of knowledge and skills around palliative care. Therefore increasingly the choice of patients and their families, particularly when faced with unstable symptoms, is to be admitted in to the Cowal Hospice and Supported Care Ward. However there have been issues with bed availability, in part due to staffing shortages. What options do we have to support members of our community in their last days of life? The government advocate choice but in reality there is little choice available! [sccr004/19dec16sm]
- DON'T move away from hospital to community! Will the hospital still be there when I need it?? [sccr005/17jan17sm]
- I do not believe 5 questions on a Survey Monkey is sufficient enough to put across the feelings of people and closing a long established residential home with high quality inspection results. How come the council cannot get its house in order when other private care homes manage this perfectly well, maybe the cuts need to be made higher up the chain within the council, are all the managers and chief executives really required to run a small rural council? Why can't Struan Lodge be used to its full capacity regarding other services joining in, there is a large part of Struan that isn't in use by anyone and has not been in use for approx 5yrs, how much of other services will take up permanent space, I do not believe the situation has been thought through correctly, again people making decisions that don't have a clue what is required and what the community need. Do any of you really think the NHS and Council will really work together to get the best outcome

for me? You are both different organisations how will youn all gel together to ensure the person comes first instead of cost of spending? [sccr00607feb17sm]

- To remember that people will still need care in hospital and that it is an important part of care for people in our community. I didn't know Struan Lodge residential was part of the hospital so not sure why closing it will help move services away from hospitals, there will always be a need for residential care and some of it in Dunoon is not good so improving the alternatives before shutting the best would be prefered. [sccr007/21feb17sm]
- We can not lose track of the need for care beds for the most vulnerable who are at risk to themselves and others, how can we keep clients safe , at present there isn't the resources to provide 24 hour care at home and with an ageing population we are going to need Struan Lodge to meet demand , keeping people at home is not always the cheaper option also [sccr008/22feb17sm]
- Once again loaded question you should be ashamed [sccr009/23feb17sm]

### EVENT TABLECLOTHS

**Kirn & Hunters Quay Bowling Club, Kirn, Tuesday 13<sup>th</sup> December 2016  
(2pm – 5pm, 6pm – 8pm)**

- 1 bed unit for people who go into mental health crisis – not used because no CPN willing to work overnight. Is this correct? What happens to people who go into crisis?
- Fear that people resident in Struan Lodge will be moved back into the community
- Lack of training for home carers
- Lack of support for patients with diagnosis of dementia – no CPN to call on, no safety in home (no advice), carer assessment hit 'n' miss
- No respite facility for people with dementia – bad experience
- Carers need more time for people they are caring for
- Care for elderly should be in the hands of the NHS, not in the hands of private providers
- Issue with discharge planning & meals on wheels service not being promoted
- Who monitors home carers? Commissioning & Procurement (all agencies registered with Care Inspectorate)
- Need : community podiatry, community dental, OT & physiotherapy
- This is a very difficult period of time for people who are resident in Struan Lodge - do families move their loved one now or wait for the outcome of the "pause" period?
- More support required for carers
- Home carers not being treated well
- Informal set up within the community v. good
- Should we have more sheltered housing? A ½ way between home & nursing home?
- We need more : CPNs, psychology input, dementia link worker
- What will happen to staff?
- Query re ambulance being used in another area
- Patient Transport Service – patients being left at hospital – appts / clinics running behind
- Time bank ceased?
- Concern about the long term viability of private providers
- Crossroads and befrienders excellent – increase funding to service / expansion
- What would really make a difference is the ability to phone a CPN directly for help
- We need more – CPNs, psychologist input, dementia link worker
- Issue with discharge planning
- Meals on wheels not being promoted

## Kames Village Hall, Tighnabruaich, Wednesday 18<sup>th</sup> January (2pm – 5pm)

- Mobile pharmacy for remote / rural areas / communities – commercial opportunity supported by HSCP
- Rapid response for rural areas
- Access to Out of Hours services
- Extending access to GO hours inc. weekends
- Full understanding of what health & social care services provide in my area
- Delayed discharges an issue? Being discharged (late at night) ie in appropriate with no transport
- Care at Home – not enough information widely known – what is current model? More publicity needed
- All these comments repeated by 3 other tables 16 people
- Want services locally, where possible. Good having local carers
- All consultants (ie hospitals) not available here ie Dunoon – over the water
- Public awareness of current services eg O.O.H. / home care
- People being able to rent in village are coming from outside area before locals
- More of these events to inform & communicate
- Transport a big issue in remote areas
- Podiatry always full. Need to travel to Dunoon
- Not heard of Struan Lodge. What happens there? Is it value for money? How many people live there?
- Would people travel from here?
- Agree in principle with care at home expanding
- GP contact – locum? Rural fellows good. Practice not involved in community
- Negative experience of Inverclyde Hospital
- System didn't allow my husband to return to Dunoon Comm Hosp from Inverclyde Hosp (advised long waiting list)
- Statistics re hospital beds needs to be clearer to allow informed decisions
- Don't believe Struan Lodge & residential under occupancy
- Transport to Dunoon an issue especially in dark
- Local MacMillan / Marie Curie service excellent (gentleman supported to stay at home to end of life)
- IRH – too rigid, does not treat patients as individuals
- Better discharge planning for patients who go into hospital in GG&C (Inverclyde)
- Getting hold of GP OOHs – really important to be able to get hold of a doctor; NHS 24 ok but don't always understand a doctor isn't required in person, most times just a conversation is all this is needed
- GP service Mon – Fri good
- Ideas for tackling isolation & loneliness (challenge for rural communities) – “telephone buddy” at least once a week (phone pal); club to have activities (game related); outings such as those organised by Interloch Transport
- Logistic decision to reduce bed numbers – as long as statistics are right

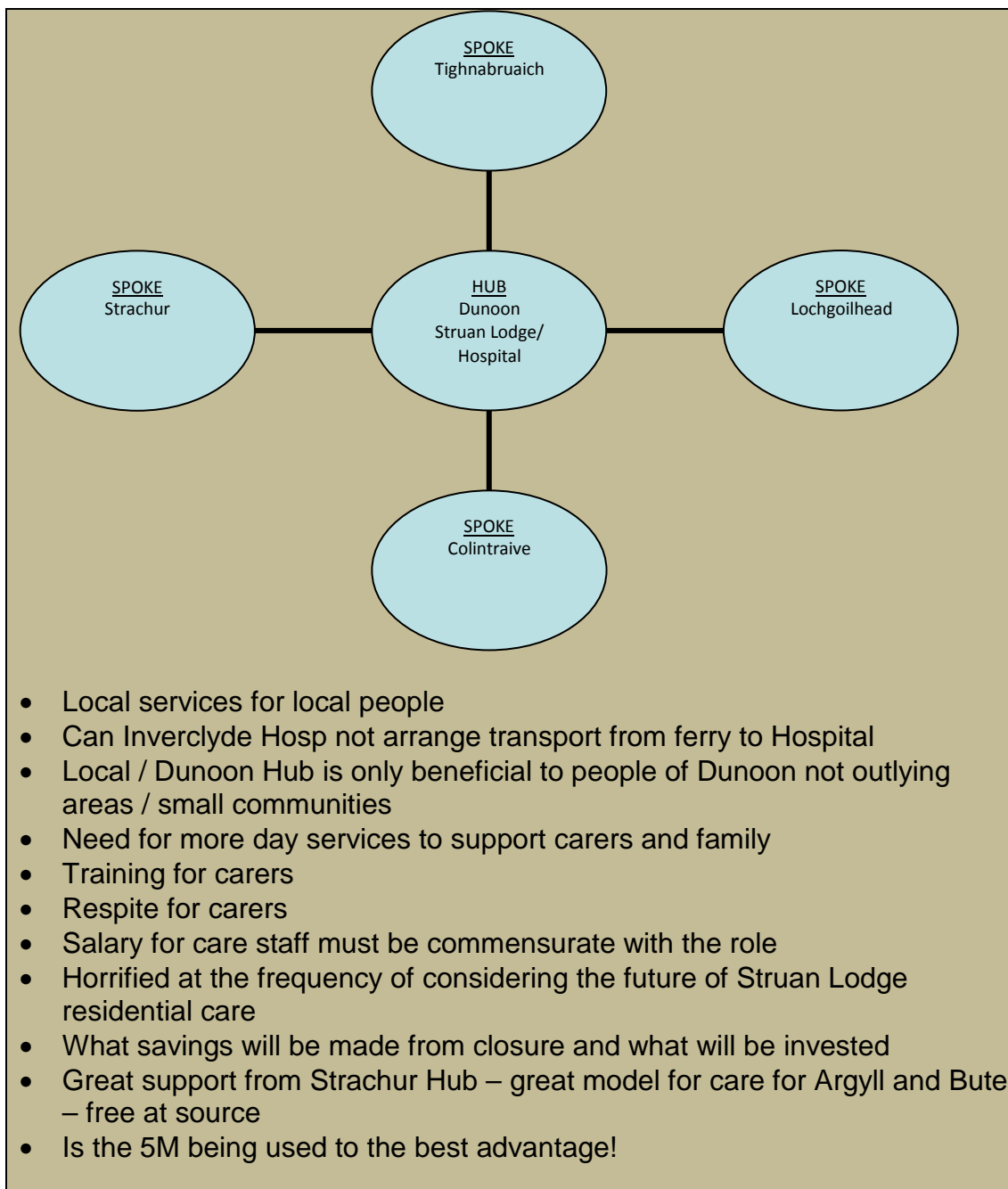
- Better use of technology – why do x-rays need to go to Oban for a specialist – surely a better & more modern method – put patients first
- Concerned about capacity figures in the residential homes
- Can we ensure that there will be enough beds in the future
- It is financial prudent to stop residential services in struan Lodge – too costly
- Where are our supplementary / services such as District Nurses
- Outpatient Dept at Dunoon Hospital to increase to stop so many trips to INVERCLYDE & other hospitals
- Continuity of carers, needs to be improved
- Transport to outpatients dept.
- Hospital discharge transport.
- Carers need a better career structure
- Care needs to be fairer (means tested)
- Want to stay at home as long as possible but both residential & nursing home placements when needed
- Sheltered & Very Sheltered Housing provision
- Appointments too early at GGC – Do Not Dovetail with Patient transport start time
- Do we have the Rural Fellow here now?
- Befrienders are Excellent as is Interloch
- Transport big issue
- Not heard of STRUAN Lodge!
- Assessment proves for care Difficult. Could have done with some overnight support
- SSAS issue – ½ hr late (Ambulance)
- Patient Transport is sometimes cancelled at very short notice ie Day of outpatient appointment which is then cancelled

### **New Hall, Strachur, Tuesday 24<sup>th</sup> January 2017, (2pm – 5pm)**

- Educating young people about care as a career needs to be promoted in school
- We must continue to have 24 hour residential care as part of the range of services provided
- Self sustaining and self reliant communities
- Great community spirit!
- Good range of services locally
- Hall committee since 1923 on war memorial
- Back to traditional values (look after one another and older family members)
- New people coming in have re-organised the Hall activities – it has always been good
- Challenge to recruit to key clinical posts (GPs, Consultants)
- Positive use of technology
- Saturday and night service could be better
- Strachur Hub very positive!!



- Adequate transport links
- Family support is important (but not so many people have their family)
- Only 1 school, only 42 children (concerning)
- Marvel at the care that's provided at the hospital
- Events where all providers, vols are together – will dispel confusion re who does what, working together in partnership
- Dutch Model which is nurse led – might not “fit” with Scotland but a model that could be considered & adapted – carers need to respond to individual needs
- So many services in Scotland are free – just how sustainable is this situation?
- Need to provide training for a career in care, especially for people who are looking for a change of direction in their working lives
- Great shortage of carers & care providers (recruitment challenges)
- Support, training & co-ordination of volunteers – organised by ?? Carers Centre? Third Sector (TSI)? How would this work if we go down the route of a hub & spoke model (where Struan Lodge is the hub)?
- We need our European friends to meet increasing need for providing home care & increasing demand for home care
- Self directed support – having to cover gaps myself – on paper it looked different to how it panned out in reality
- How can any service cover everything?
- We need more carers
- Positive story – care package in place within a week
- Hub attendance circa 30 people – piggy back onto this for another event in Strachur (Thu mornings)
- Tuesday mornings? Take Away Creative
- “Volunteers” need to be better branded
- Local Hub – (Good) – exercise & diet; extend Hub; mainly women; mental health; transport (inpatients)
- Unpaid / hidden carers need a stronger voice
- Increase body of volunteers in our rural communities to support carers (sitting service)
- Why pay for care? If you can afford to pay?
- Practice Nurse excellent
- Equipment required to support people at home
- Care and repair excellent
- Excellent care – O/T; Practice; SDS advisor – free
- Dementia & loneliness a big issue
- More respite required
- More rural Hub's
- Dementia increasing and more complex
- Speed up SDS
- Is TSI working?
- Hub Model



**Village Hall, Ardentinny, Wednesday 1<sup>st</sup> February 2017, (2pm – 5pm)**

- “It’s all about communication”
- Better response from Social Work
- Perception is that services are worse not better
- The number of beds to be closed in the hospital? plus the beds at Struan Lodge. Doesn’t add up
- Night services ?? for Ardentinny
- SHELTERED HOUSING
- Will day services cost?
- What about transport
- How does closing Struan Lodge meet your (HSCP) objective of improving

and building on excellent services

- Community concern about move to centres of excellence
- Limited falls responder service - Ardentinny is 12 miles - only covers 10 miles
- Joined up care I know what each other provides
- Look at opportunity for people to use more of the empty beds in the local hospital
- Need a range of services
- Short-term funding is short-sighted
- Timing of appointments for Greater Glasgow Hospital
- Must improve communication – everyone at this meeting is here because they were asked by 2 members of the community. Community Councils were not informed – best way to spread the word. Small advert in paper is not enough
- Must make allowance of choice – yes I want to stay at home as long as possible, but there must be care if you need it
- Figures given on board do not make sense – not representative. Also, where is the spare bed capacity for the future – given the forecast of demographic position. Are there any plans to encourage private companies to open more homes if the need arises, given that the council is not going to and we are going to have a lot of old people with complex needs
- Ideal scenario for me – small sheltered housing complex with warden in Ardentinny. I know his is cloud cuckoo land!
- Care packages much more difficult to deliver in rural areas. Not always enough carers, private companies not interested, not enough money involved
- Why can't we have a social hub in Struan Lodge and some residential – at least until the present residents no longer have need. There is plenty of room in it
- “We only found out by accident – very poor publicity”
- If I can't go to Struan Lodge I don't want to go anywhere
- 1. BEFRIENDING HOUSEBOUND 2. TRANSPORT FOR SOCIAL OUTINGS (VITAL FOR MENTAL WELLBEING) 3. TRANSPORT FOR HOSPITAL APPT
- Centre of excellence? The conversion of Struan Lodge to a Centre of Excellence run by Argyll & Bute Council seems a contradiction in terms. Little else they are engaged in provides anything approaching Excellence
- The Hub – great for people near it – but sub-hubs are needed for other, more remote, centres
- Have you read “Soyalent Green”
- Difficulties in attending “mainland” hospitals – timings of appointments – parking when you get there – difficulty in letting immobile passengers off
- We need more clinics back in Dunoon
- It is really important that people can remain in in their own community
- It would be best to keep both day and residential services
- Changing the model of care
- Need a full range of care services
- All people attending Ardentinny were invited by the community council not widely advertised

- Concerned there will be no hospital in Dunoon in time
- Can we improve the hospice / palliative care in Hospital
- Ensure that our Hospice Care remains in order that people do not have to be cared for in their end of life off the Dunoon / Cowal area
- Takes too long to develop and put in place Care Packages – delayed discharge – spending too much time off Cowal – Inverclyde is Glasgow
- Would we come back to meet Ardentinny Group
- ½ hour visits to those living at home is not enough x 4 times a day
- Feel comfortable if those leaving SL to remain in Cowal. This would be dependent on the other providers upping their game / better rates. How is this going to be achieved
- Worrying and bleak outlook for older people – selling houses
- How are going to ensure that we have sufficient capacity for residential care in the future
- Can you tell us how much will be saved & reinvested into a community Hub
- Care in the Community is great but unworkable – too much isolation
- Would like to see more to supplement – ie Residential Care – Struan Lodge is setting the best standard
- Would like to see what you are going to do to raise the grades and standards of all the private providers
- If I was living in Ardentinny and wanted to access the new Hub would transport be provided
- The Hub seems a good idea
- Better and more realistic appointments – no cognisance of Postcodes & difficulties in transport

**Village Hall, Colintrave, Thursday 9<sup>th</sup> February 2017 (2pm – 5pm)**

- transport problems for reaching “mainland” hospitals – eg 9a.m. appointments in Glasgow
- currently 20 beds
- patients returning home from Inverclyde / Glasgow should have someone at home to ensure environment incl services appropriate and able to ensure that not a cycle of readmissions (OT is required)
- better assessments required to allow person being hospitalised to safely & timeously return home
- Will there be enough residential placements if SL. No longer offers residential care? – how will you ensure this for the increasing O.P. population
- insufficient levels of care available (convalescent)
- better internet is required for feelings of safety for more rural communities
- better complaints procedures
- better access to information re advise + guidance – how does the system work
- how can people access services better publicity
- improved communication if move people to remain at home longer → link to GP’s consultations via internet

- How do we (ABHSCP) address the skill / numbers of staff in both Health and Social Care – attract staff for our future

**Village Hall, Sandbank, Wednesday 15<sup>th</sup> February 2017 (2pm – 5pm)**

- Worry about the A and E ? will it close? - glad it will not close
- How will Meals on Wheels be provided if Struan Lodge closes?
- WRVS? how are these services going to be provided as the Hospital provides less beds?

**St Mun's Church Hall, Dunoon, Tuesday 21<sup>st</sup> February 2017 (2pm – 5pm, 6pm – 8pm)**

- Not enough alternative care home placements available
- Struan Lodge only place in Dunoon that had respite bed available when it was needed
- Will realise they (IJB) made mistake if close Struan Lodge
- people in crisis taking up Hospital beds as no care home beds available. Hospital beds far more expensive
- why not sell Struan Lodge to another provider?
- Better care in care home than in community (care @ home) (\* private provider)

**Village Hall, Kilmun, Thursday 23<sup>rd</sup> February 2017 (2pm – 6pm)**

- Home Care staff – too young, poorly trained not supervised
- We need to stop using the terminology of “burden” – Older People are contributing and should be valued and services to be fit for purpose
- People trust Struan Lodge – as grades are high / quality
- how are you going to ensure that private homes can reach SL. standard / grades
- get all residential home should be getting 5s whether consider private
- joint up services / recieved from Dunoon Hosp – A+E was excellent. – good link with Inverclyde
- Dunoon Hosp requires to have a maternity unit and better medical services – negative impact on regeneration
- We need reassurance that we never lose our A&E
- improved Ferry services would benefit our community – improved links to mainland
- I would save the Hospital, not reduce bed number, but actually increase health care offered at hospital
- A Day Centre is only a valuable resource if good transport – why can't we have a hub in our community Hall with workers / staff coming to us
- We need our Hospital to grow not too reduce – we need to recognise that Dunoon / Cowal has an aging population
- Can you ensure that no one will need leave Dunoon residential care

- can see the point of beds reductions as long as there is never any move to close our A and E
  - Improve terms + conditions for Health / Social Care workers
  - We need better paid social care staff to provide community based support – better paid staff vital if people to remain in their homes
  - We need reassurance that Home Care is not a 15 minute service – this Home Care service needs to be improved
  - better transport when need to go to Inverclyde / Glasgow for Health appointments
- I volunteer at Inverreck and the quality of care is outstanding – delivered at a fraction of the cost of Struan Lodge



Argyll and Bute  
Health and Social Care Partnership (HSCP)  
Cowal Locality Planning Group (LPG)



## DAY CARE - YOUR IDEAS

“Day care is for older people who prefer to continue living in their own homes but need some support during the day, possibly adding to the support they already have”

What might day care look like locally?  
What would you like to see included?

*Ideas?  
Write them  
down & post  
here*

# DAY CARE - YOUR VIEWS

## FEEDBACK

Take onboard the Netherlands Model of elderly care. Please look at what actually works in other places & implement here

Day care is currently limited to short visits and a changing number of carers. Time would be better set by daily need around a fixed set of times. At some point day care no longer provides the level of care required necessitating provision of residential care. Day care involves time spent with the person in a social context going beyond just enough time to prepare a meal for instance

Community engagement in this matter is not good. This event is not well publicised for the public to attend

Companionship  
Community  
Transport  
1 hot meal a day (at least)

Volunteer drivers

More funding to Crossroads / Befrienders service – to increase scope of current service

The HUB would be a safe and convenient recourse for multi agency / professionals to offer services & support

- Increased dementia to agencies / professionals
- Increased respite for carers in the family home
- Telephone helpline for CPN support / dementia



### DISCUSSION THEMES / COMMENTS CAPTURED BY EVENT FACILITATORS

#### 12<sup>th</sup> December 2016, Cowal Community Hospital, Dunoon

- Care Inspectorate gradings – how do we raise these for private providers?
- Home care – need adequate training and career structure
- Pension contribution – difference between LA and Private sector
- Terms and Conditions – disparity
- Training, recruitment and retention
- Group to talk to Struan Lodge staff
- Need mechanism for “blue sky thinking” for Struan Lodge staff
- Finances – helpful discussion with Caroline White. Reps now feel more confident speaking to people.
- Reps from pupils from DGS to be asked to join C&E group and LPG.
- Ask pupils to use social media to seek views etc.
- Need relationship with care providers to encourage people tin care sector.
- Hospital beds – issues with discharge planning @ Inverclyde.
- Number of conversations were not in relation to Struan Lodge.
- More local services – not having to go the Inverclyde for small/routine ops
- Need to manage people’s expectations.
- Need more work on out-patient clinics /pre-op checks.
- 

#### 13<sup>th</sup> December 2016, Kirn & Hunters Quay Bowling Club, Kirn

- 24 / 7 mental health services
- Better home help
- Hospital should promote “Meals on Wheels”
- Permanent psychiatrist
- Keep on top of home help
- More funding for XRoads & Befrienders
- Stimulation / Entertainment needed for care homes
- Lack of support from dementia team. Only two people employed therefore can only respond to crisis.
- No CPN support or advice given to keep mum safe.
- Not offered carers assessment
- Dementia specialist unit unable to support people with dementia.
- Not advised meals on Wheels service available (hospital discharge)
- SAS – prioritisation of ambulance calls.
- No psychologist in CMHT.
- Crossroads and befrienders fantastic – need extra funding to expand.
- Need community chiropodist, OT, physio and specialist dental services.
- Struan Lodge – ideal location for “hub” to capture above services.

- Family best placed to look after relative at home, not safe to be admitted into care.
- Need care staff to be able to provide time and support plus carers need respite.
- Support needed – be able to speak to CPN when you need advice.
- Consider more sheltered housing and use as interim step from own home to residential care?
- Have GPs been consulted, invited to events? Also Inverslyde Hospital?
- Day service is under used at present due to charging policy – how will that change? How will more people use day service in the future?
- Concerns around visiting Inverclyde for clinic visits
- Costs of transport to Inverclyde ie ambulance / Interloch
- Enough people to bring clinic here
- Difficulties getting public transport to Inverclyde
- Use of clinics at Vale of Leven difficult to get to!!
- What clinics do we have that come to Dunoon?
- Care should not be profit lead should be NHS run
- Outstanding care in Struan Lodge
- Why cost so high in Struan Lodge?
- Raise Council Tax
- No CPN, can't get hold of dementia team
- No advice on safety
- Can't leave mum alone
- No carers assessment offered
- Lack of dementia service, contacted Councillor
- Lack of beds
- Struan Lodge Day Care 'appalling'
- Time constraints for care staff in community
- Lack of training for carers in community
- Not aware that meals on wheels available
- ?utilising our ambulances when taking patient to Inverclyde, used in Inverclyde area. Having to wait for ambulance to come from other area
- People being left at Inverclyde as ambulance left before they had been to their appointment
- ?dementia link worker is
- Would want to stay home as long as possible to enable this I would need carers who are trained & no time constraints
- Support for carers
- Crossroads & Befrienders are excellent. Need more funding to expand
- Help would be able to pick up phone and get advice – can't get a hold of dementia team
- What is the intention for Struan Lodge?
- What will happen to residents? If decision if made to close?
- Would more sheltered housing be beneficial?

### **10<sup>th</sup> January 2017, Lochgoilhead**

- Advertise in local shop / Wee Goil to employ staff to work in our rural communities (Carrick)

- Have staff employed in area & via SDS – brokerage
- Local staff – flexible hours would be a possible spin off (TSI) able to offer assistance
- Alan (TSI) to get information re Bureau
- Appin (Highland) Social Enterprise – good to find out how this is organised and how they are able to meet the needs of the community
- Flexible carers
- There is a lunch club (Mondays) and community transport
- Asda deliver
- Advertise Care and Repair better
- Single point of access for services / resources
- More activities in local community
- Lost the Befrienders service in rural area but still operating in Dunoon
- Carrick (77 pop) – holiday homes (interlopers) – people look out for each other
- There's a mini bus – limited access
- Easier access to health services – District Nurses
- Annual health test – problem would be that older people have to travel to GP
- Better transport – bus service (can be more available during school term time)
- Better co-ordinated transport & links to services (pick up points & no co-ordinated drop offs)
- Exercise classes
- Better links with Lochgoilhead & Carrick
- Health & Social Care Needs :
  - Practice nurse – retired two years – not replaced – has in the past resulted in bed blocking – not set days – no chiropody services
  - Day responder service – assist with provisions home from hospital services – not looking for free service and would be willing to pay – Red Cross previous involvement
- GP practice could be more a part of the community and make better use of facilities
- Needs are there but perhaps too hard to admit that they require some level of support
- Should Monday Club be extended? Very much enjoyed and great for social interaction
- Advertising via Practice Manager (Lorna Alexander) is good way to get out the message
- Struachur hub extends invitation
- TAG on to Monday Club (11.30 – 1.30pm)
- The Wee Gail

#### **24<sup>th</sup> January 2017, Memorial Hall, Strachur**

- Re Hospital bed closures – hospital no longer does surgery or a fracture clinic. If you have a fracture then you have to travel to Inverclyde to get a cast. Problematic if you cannot drive as no public transport and taxis are expensive. People are unable to visit.
- Local “hub” only beneficial to people of Dunoon, not outlying areas.
- Beds needed in Struan Lodge.

- How do you get to Struan Lodge if you can't drive? Transport issues.
- Need residential care.
- From Strachur it's difficult to visit patients in Inverclyde.
- People are being brought from Inverclyde to home for an assessment (OT) and then if they are unable to manage they have to return to Inverclyde.
- Better communication needed between discharge and care planning.
- (Strachur) "Hub" needs continuing funding.
- Local services needed.
- Better dental services.

### **27<sup>th</sup> January – Co-Op, Dunoon**

- Don't close Struan – if doing so well, why close it? Close somewhere else instead.
- Keep Struan open. I'm currently in sheltered housing and will need residential care one day. There's nowhere else to go as no beds available.
- If (residential) beds close, concerned that day services will eventually close too.
- Reduction of hospital beds. This was due to staffing issues, no lack of people needing to use them so you're providing false figures.
- Struan Lodge is an excellent facility. If about enhancing services, should enhance current facility, not close it.
- Would like to see all staff based together instead of all over town. A "one stop shop" where you can see all the professionals you need to in one place.
- Families are being told not to place relatives in Struan in case it closes.
- Provide home carers with cars to encourage people become carers instead of them having to use their own cars at their own expense.

### **5<sup>th</sup> February – Lochgoilhead Lunch Club**

- How do we get a service in Lochgoilhead (LG) – What is the referral process
- What services are currently available in LG
- Can we employ local people to provide local services and support.  
Advertise locally for staff
- We need better health services in LG. Why does GP not take blood
- Too much central services in Dunoon – rural villages are forgotten about
- GP doesn't make home visits
- Good service from the GP – happy with the GP
- Health services and locally provided home care are essential to our community if it is to be sustainable
- Been here before in terms of this type of event and nothing gets done. Hope this time you will listen to those residing in LG. We know best.
- Enhanced Day service Hub not any use to those living in LG. A local provision would be of better for LG. More akin to Strachur
- Not too concerned about Dunoon Hospital as LG mainly is dealt with by Vale of Leven. Easier to get to and have better health services – more treatments undertaken.
- Many people do not have access to internet. Can LG Community Council have access to hard copies of Allan's IJB report.

- How Much for Struan Lodge residential care? It costs a fraction of that cost at Ashgrove and my sisters care is great. Ashgrove is improving greatly since the new manage came in

## **22<sup>nd</sup> February – Cowal Community Hospital, Dunoon**

- Hate to see residents moved
- Keep staff group together
- Third time in 20 years Struan threatened with closure
- No redeployment opportunities for staff locally
- Staff great and it's a beautiful place
- Redesign of day care structure needed
- Need for step up / step down service – lack of facilities and health staff
- Lack of alternative beds
- Have rehab beds in Struan Lodge
- Expand Struan Lodge residential care and close day service
- Emotional impact on residents and family if they need to leave the area.
- Care at home services chaotic
- Changes to care at home service will reduce people's choice which is against SDS principles.
- Struan Lodge is predominantly dementia clients and numbers are increasing.
- Needs of day service have changed
- Found details of today's event hard to find. Not published on Council website.
- What about out of hours Mental Health services?
- Lack of trust in IJB and process.
- No respite provision for learning disability within Argyll and Bute.
- If put befriending service in, will local service (Cowal Befrienders) cease?
- Should have dementia friendly villages / super sheltered housing
- Community Care team have not been given the opportunity to discuss, raise concerns or voice their opinions until today.

## **23<sup>rd</sup> February – Village Hall, Kilmun**

- Issues – transport and isolation
- Struan Lodge – should be made a community resource
- Keep Struan Lodge residential
- Reduce senior management to make savings
- Services should be for more than one client group
- Has a cost benefit analysis been undertaken (if residential service closes and redesigned into community services) – there will be hidden costs and not necessarily a saving.
- NHS compensation costs to people who suffer as a result of wrong decisions being taken are huge (£1 billion)
- Should “create” services, not “cut”
- Proposal not cost-effective
- Cost analysis should be undertaken of knock on costs if losing residential care and hospital beds.

- Accountants make decisions based on figures, emotional costs are not considered.
- No ferry subsidy so costs are high to travel to Inverclyde.
- Why are Councillors employed and not volunteers?
- Should be a mixture of housing available – sheltered, residential, nursing care.
- Need local resources – communities look out for each other
- Care staff are paid poorly
- Not everyone wants to be cared for in their own home with different carers coming in.
- Not everyone's home is suitable for having long term care provided
- Need community beds as travel out with area is costly and can be difficult to get to if can't drive
- Should look at producing radar map showing radius of area each hospital covers across Argyll & Bute.
- Other cuts will impact on Cowal services.
- Not enough community services to allow people to be discharged from hospital.
- What is the cost of providing 24/7 care within someone's own home?
- Large number of unpaid carers/hidden care not acknowledged.
- No convalescent care facility
- Need joined up services
- Dunoon hospital should be regenerated not closed down. It's underutilised.
- Residential care missing from the diagram of current provision in the leaflet
- Feedback form needs redesigned
- Befriender Service not consulted and don't want to be based there (Struan Lodge).

### DISCUSSION THEMES / COMMENTS

#### MEETINGS WITH STAFF

**26<sup>th</sup> January 2016, Cowal Community Hospital, Dunoon – COWAL GPs**

Suggestions for future provision

- Nurse practitioners
- More Skilled District Nurses
- Out of Hours District Nursing Service
- Lead Professional Model fully embedded
- Specialist Acute Dementia beds
- Consistent Anticipatory Care Planning Model
- Single point of access to support interface between Hospital and Community

**3<sup>rd</sup> February 2016, Struan Lodge, Dunoon – STRUAN LODGE STAFF**

- Better promotion of SDS
- What are the implications of sending people out of there own area
- How are the private sector going to maintain the standard of care, and staff to run there the private sector /business in Dunoon is shambolick, carers been paid the minimum working from morning till night to make a decent wage
- When the times comes for 24 hour care, why has the choice of the Dunoon Residents been taken away, where they want to end there DAYS
- 99% of Dunoon people do not want to Die in a care home in a different area with no family around them
- good quality of care
- Are there enough good carers to make staying at home possible
- Good quality care home should not be the exeption to the rule
- Better Promotion of S.D.S. in the community
- Volunteers will there always be people willing to do this very important job
- Someone who lives in a family atmosphere when Residential are is needed having to travel, money, emotional, and social aspects have to be considered
- I don't think the Residents of Cowal will have any choices about where they will be able to stay
- I would like to see a model of the Hub
- Where will our residents fo if Struan Lodge closes do the have choices
- CLOSING RESIDENTIAL SERVICE OFFERED BY STRUAN LODGE WILL LIMIT THE CHOICES AVAILABLE TO EPOLE REQUIRING 24-HR CARE IN COMMUNITY. THIS WILL HAVE A NEGATIVE IMPACT ON FAMILIES WHO MAY HAVE TO TRAVEL TO SEE THEIR LOVED ONES (IF THEY ARE WELL ENOUGH)

- WE REGULARLY RECEIVE PHONE CALLS AT STRUAN LODGE FROM SOCIAL WORK STATING THAT SOMEBODY REQUIRES AN URGENT PLACE TO STAY WHAT WILL HAPPEN TO PEOPLE SUCH AS THIS WHEN 24 HR SERVICE IS CLOSED
- DAY CARE NEEDS TO BE EXPENDED MORE FROM COMMUNITY NEEDS TO ATTEND TO ATTEND DO AWAY WITH CHARGING POLICY MAKE IT AFFRODABLE FOR ELDERLY TO ATTEND / ALLOW APPROPRIATE RESPITE CARE
- DO NOT MOVE OUR RESIDENTS THEY ARE HAPPY, SAFE & CONTENT HERE IN DUNOON DO NOT TAKE THEIR CHOICE OF WHERE THEY WANT TO STAY TAKEN AWAY FROM THEM
- Struan Lodge Residential Care Home Has to Remain open Dunoon is lacking in Care Beds 3 years ago we had 48 vacant Care Beds today (3/2/17) we have 3 vacant Care Beds People in Dunoon DO NOT want to leave the area to get a provision of care
- STEP UP / STEP DOWN IS NEEDED WITH THE PROPOSED REDUCTION IN BEDS AT COWAL COMMUNITY HOSPITAL
- There needs to be good quality Residential Care in the community of Dunoon & beyond. The standard of care needs to be maintained and improved. The Residents of Struan need to stay in their own home where they have lived happily for many years close to family & friends. The trend for the coming years is a prediction for a older population with more individuals with complex illnessess including Dementia. A skilled workforce is required with more beds in residential care. A local good quality provision of residential care is urgently needed in Dunoon
- Step up & step down from hospital is proposed this could assist with empty hospital beds and assisting people to stay at home
- Good quality residential care will always be required. Care in the community is great and needs improved but at some point some people require 24 hour residential care in the areas that they live (Cowal) and choose to stay in
- Telecare – links needs to be made 24 hour care. – improve resources to allow people to stay at home
- Assessments
- lack of suitable beds / vacancies in Cowal – demand outstripping need at present time
- telecare needs to be improved trackers to reduce risk / wandering
- is there a waiting list for residential care? – lack of transparency
- Concerned about hospital + residential beds – no capacity presently – what are the contingencies in the future
- how will we improve community care services
- 24 / 7 Home Care does not exist or work. How will this be addressed



### **3<sup>rd</sup> March 2017, Struan Lodge, Dunoon – TRADE UNIONS**

- Did timings of events result in attendance being lower than anticipated?
- Good qualitative feedback more important than quantity
- Need to ensure peace of mind for employees
- Ensure pathways for employees
- Staff feel that they are soft targets again
- Enhance step up / step down services
- Priority is preserving jobs
- Business case needs to evidence staff are protected

### LETTERS / EMAILS RECEIVED

*(names and addresses have not been included to protect the identify of individuals)*

Hi - I have just read the Community Redesign leaflet and it appears to contradict its self. In one bit there is talk of closing hospital beds in Cowal Community Hospital and in another section it is stated that the hospital will be central to care.

The closing of beds in the hospital accross Scotland and England has caused hold ups in operations as people have no where to go if the require rehabilitation before going home.

A friend of mine's husband was 5th in the que for a bed in Dunoon so as so many beds have been closed here over the past few years they have to wait in Inverclyde or go home earlier than they should thus causing bed blocking or readmission again as they are not fit to go home.

I also have serious concerens about the training/knowledge of the home carers and the time they have to spend with clients.

[email received 25<sup>th</sup> January 2017]

I have been reading the leaflet which accompanies the local consultation meeting being held. I will be attending a meeting at Kilmun Hall on 23<sup>rd</sup> February. I would like to have more detail available at the meeting than is provided by the leaflet. The overall strategy is well presented but many of the statements are vague.

What will happen to those in Struan Lodge at the moment? What will happen to people who need 24 hour care in future?

For those who naturally want to live in their homes with support as long as they can what can be realistically be done with the cuts to the budget?

Looking forward to more answers

[email received 20<sup>th</sup> February 2017]

I have just attended an event at Ardentenny Village Hall, at which we were asked for our views on the redesign of community care in our area. It seems that the closure of Struan Lodge as a residential care facility is inevitable. However, I cannot see how providing more community based services will reduce the need for the number of beds in the community hospital, surely that need will increase when people can no longer cope without appropriate 24 hour care?

Care in the community is commendable and I am all for people being able to stay at home for as long as is possible and a centre of excellence provided locally could provide people with the tools to stay physically and mentally well. What should be made clear is how local is local? Cowal is an area of small rural communities strung out over large distances often accessed by single-track roads. As people get older, travel becomes more problematic. Will the centre of excellence provide outreach services for the elderly in more rural communities, or will people be expected to travel to the centre? I would not revel in the prospect of having to sit on a mini-bus for a couple of hours each way to attend a day centre facility when I am incontinent and confused, for example.

In redesigning your services, please be mindful that not all elderly people will be able or better off staying in their own homes. What they need is secure, safe accommodation that will provide them with good quality health care, preferably in an area where they can continue contact with family and friends.

[email received 2<sup>nd</sup> February 2017]

When I phoned to ask for a feedback form, as invited in the Struan and Cowal Community Redesign leaflet, I expected a form for that purpose. However I trust it is in order for me to use this one for the purpose of making my views on that issue known.

I am opposed to any further transfer of care services from the public to the private sector. I do not think the profit motive has any place in the provision of caring services. The private sector faced with increase in the National Minimum wage is finding it very difficult to provide satisfactory levels of service and still be able to make a profit. Recent events in Rothesay just highlight the problem. I genuinely wonder if the private sector can provide an adequate service any more cheaply than the NHS / Council can. There is no evidence of a surplus of places for overnight care in the area to the best of my knowledge and I believe this should continue to be provided at Struan Lodge as long as any of the present residents desire this. Any new admissions should have it made very clear to them that there may be a possibility that they would have to move at a later date. Struan Lodge should continue ideally, but if it has to close as a care home, but should be gradually run down as the number of residents decreases. If this involves staff redundancies over a period of time, these should as far as possible be voluntary. The various uses proposed for Struan Lodge may well be desirable but there is already talk of building a GP practice building in the hospital grounds. Could this not be extended to provide the accommodation desired instead of closing Struan Lodge.

As regards even future running down of Dunoon Hospital, I would ask that very serious thoughts be given to the disadvantages of further use of Inverclyde. As we are constantly reminded the majority of patients tend to be elderly and so are their partners. Visiting during hospitalisation tends to be good for moral but the effort of making them journey to Inverclyde (bus, ferry, bus) is very wearing for those of us who are getting on in years. When active medical intervention does not seem to be called for, adequate provision of beds at Dunoon could save an awful lot of effort. I speak with feeling on this matter as my 82 year old wife is currently at Inverclyde and at 87 I am beginning to feel the strain of daily visits / less need for ambulances to have to make the ferry crossing with the time it takes would improve the efficiency of the ambulance service in Cowal and probably save some money.

[A&B HSCP Complaints Form received 12<sup>th</sup> February 2017]

I am in my mid-70s, as is my husband, and we are fortunate to be in good health so far.

I have little direct experience to form my views, but have seen the problems of some other friends.

Q1. The only thing to say here is that it would be good to die suddenly (or after a short illness), having been in good health up until then. The local Medical Centre provides good services.

Q2. Thinking about the availability of hospital consultants. If they won't come to Dunoon Hospital, perhaps they could have regular "office hours" during which they would be available for online meetings with GPs and patients in the GPs' surgeries, via Skype or similar.

Q3. Struan Lodge is too far from West Cowal to be of daily use to us.

Q4. There should be some caring and nursing support living in the Tighnabruaich area.

Q5. There needs to be the possibility of residential care for those who will benefit from it. And there should be sheltered housing also. Not everyone can be cared for at home.

PS You may include my views in your feedback report.

[email received 1st March 2017]

## Re. changes/ consultation on Health and Social Care.



Dear Caroline Champion,

Here are some thoughts on the development of care in Cowal.

1. I understand the heavy cost of running Struan Lodge Residential unit. Like many other people, I was totally unaware that there is also Day Care involved. Thus the basic statement that "We will not close Struan Lodge" does not ring true.
2. Project is Dunoon centric – there is no mention of how the proposed "Centre of Excellence" will affect anywhere other than Dunoon and its immediate area.
3. I cannot see any evidence that better home care will seriously reduce the number of people who need hospitalisation. Of course people wish to stay at home while they are fit to do so; but "for as long as possible" may not be very long. Home care can only reduce the demand for a time. Battling on as things get more and more difficult is not necessarily an attractive prospect.
4. From the graphs presented, I understand that demand for elderly care can only increase as the population ages. Where is the plan for the future? Funds are short but the whole exercise seems to be a limited, short-term, money saving exercise. Closing S.L. residential unit makes things worse in the short term. I feel that it would only make sense as part of a project to increase the future provision of residential elderly care – we will surely need more rather than fewer Care Homes. I see nothing in the "vision" of a miraculously healthier population to support this. Though individual interventions, sooner rather than later, can obviously help, they seem unlikely to counteract the demographic trends..
5. Hospital beds : we have had little information in the public domain on the workings of the hospital, which is vitally important to possible confidence. Compared with the ongoing S.L. debate, the public is only in a position to object to any reduction of beds. This should not have been included in the SL meetings.

We have seen many idealistic, aspirational statements but regrettably few hard facts on future costings especially for home care services. Until this is remedied it is hard to feel confident in a safe service in the future.

I hope these comments are helpful.



Argyll and Bute  
Health and Social Care Partnership (HSCP)  
Cowal Locality Planning Group (LPG)



## STRUAN & COWAL COMMUNITY REDESIGN

### What is happening?

Our Strategic Plan outlines our priorities for health and social care services across Argyll and Bute

<http://www.nshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/SP%202016-2019%20Final.pdf>

Our priorities are in response to national policies as set out by the Scottish Government, e.g. Shifting the Balance of Care (page 2), but also based on what you have said is important to you.

You said **"We want to live a long, healthy, happy and independent life supported by health and social care services when we need them."**

You said **"We want to stay at home for as long as possible."**

We need to redesign health and social care services in Cowal to meet these priorities.

**It is important that you have the right service, in the right place, at the right time.**

### What does this mean for you?

This means that we can no longer provide services as we do now. If we carry on as we are, we will not be able to support the ever growing number of people who will need our support in the future.

### Is Struan Lodge included in the redesign?

Yes. The vision for services provided at Struan Lodge is to build on the excellent care it currently provides. We need to be able to care for many more people through its day care service.

To support people to live in their homes for as long as they wish,

we need to provide more community based services.

It also means we can reduce the number of beds in the community hospital.

What we would like to do is develop Struan Lodge as a day centre of excellence.

This does mean we need to stop providing overnight care.

### Will Struan Lodge close completely?

No. We want to assure you that there is no intention to close Struan Lodge. We do need to change how services are provided in the future to ensure we meet the needs of more and more people.

### What Now?

We understand how anxious communities and staff are about the changes proposed for



Struan Lodge.

It is really important that we listen to you and give you the opportunity to share your views. If you have any suggestions on what services could be provided from Struan Lodge and within the community, we want to hear from you.

### Is this just about saving money?

We do need to get value for money and use our resources more efficiently and effectively. We need to be honest about that.

We must make sure the services we provide not only meet the future needs of our population but are flexible as demand changes and they are sustainable well into the future.

## We Want Your Views!

Our vision is to build on the excellent services currently provided in Cowal. We must make sure your local services will support you to live a long, healthy, happy and independent life.

**We want to hear what your views are on the proposed changes to local services.** Do you have any alternative ideas? Come along to one of our events, see back page or look out for adverts in your area.

**Your feedback is important.** We will use what you say to consider how to redesign and improve services so they are fit for the future.

## WHAT SERVICES DO WE CURRENTLY HAVE IN COWAL?

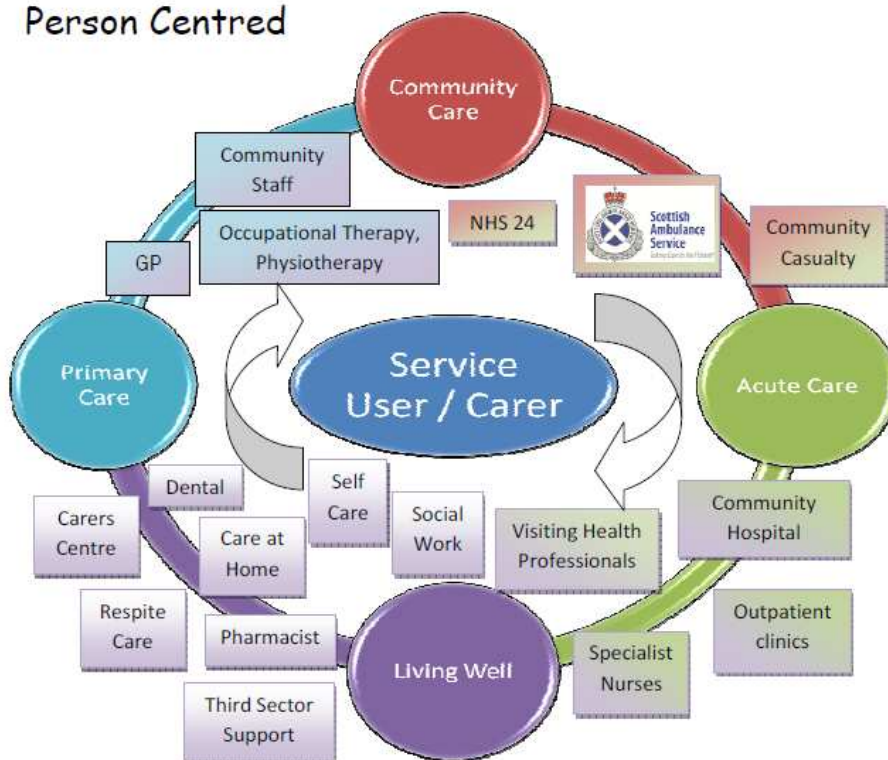


Dunoon Pier

We provide a range of services. Our aim is to support **you to live a long, healthy, happy and independent life**. This is what you have said is important to you.

The diagram below shows you what health and social care services are currently available to you, with you at the heart of what we do.

### Person Centred



### WHAT IS THE BALANCE OF CARE?

We hear the term 'Shifting the Balance of Care' when describing why services need to change. This means that we need to improve the health and wellbeing of the people. We aim to do this by increasing our emphasis towards improving health and anticipating care needs. This will provide continuous care and more support for people closer to home. We can't do this alone. We need to work together with you to make this happen and this does mean we need to make changes.



## STRUAN LODGE- WHAT IS BEING PROPOSED?

**A Community Support Hub / Centre of Excellence** – the vision will allow Struan Lodge to be used as a multi-purpose facility, providing a range of high quality flexible services to the community.

**Reablement Service** – this will enable us to increase confidence and improve skills to support you to live your life to the full and maximize independence. This is what you have said is important to you.

**Drop In Advice Centre** – Struan Lodge will be a key central point where you can receive advice and point people in the right direction.

**Social Day Hub** – people can use Struan Lodge as a place to get help and advice, which will allow us to build strong working relationships with other local community services such as the Befrienders service and Carers Centre.

**Community Transport** – you have said that transport and providing the means to access both hospital and other health and social care services is vital within rural communities. We will work hard with partners to ensure that transport is available.

## REVIEW OF BEDS AT COWAL COMMUNITY HOSPITAL

We are committed to keeping your local hospital at the heart of your community. We want to ensure we retain the high quality level of care which it provides, when people need it. We also know we can no longer provide services as we do now.

Come along to one of the engagement events, find out more about what is being proposed.

Share your views with us. Your feedback will be used to help us redesign and improve your local services so they are fit for the future.

## COMMUNICATION & ENGAGEMENT WITH YOU

**The Cowal Communications and Engagement Group** is responsible for the engagement plan for the Cowal Service Redesign. We are made up of public, third sector, union, NHS and Council Staff. The Scottish Health Council provide guidance and support. Our engagement plan for the next few months is :

**Informing you** - we need to share information about the services we have in Cowal, their costs, the needs our communities have now and in the future, our resources, and other background information

**Engage with you** - we need the chance to discuss all that information with you. We will be holding a number of events across Cowal between mid-December and the end of February for both our citizens and staff. See back page for details of the events already planned before Christmas.

**Reporting on what you say** - we need to gather what people say and report that back to the Integrated Joint Board (IJB)

If there are other ideas about how to develop services according to good practice, but within the budget of the Health and Social Care Partnership, we need to listen.

## INVOLVING YOU

**Email**. You can email us at [nhs.abhscp@nhs.net](mailto:nhs.abhscp@nhs.net)

**Feedback forms** will be widely available in your communities or you can phone for one. You can also complete the feedback form online at <https://www.surveymonkey.co.uk/r/WQ7FC8S>

**Information & Engagement events** Feedback forms will be available at the events.

**Ask us to your meetings**

We can come to you - phone us! Telephone 01369 708345



Glendaruel



Toward Light, South Cowal

If you have any questions, would like to receive this leaflet in an alternative format or a different language, please contact

Lana Lyddon

PA to  
Locality Manager  
(Cowal)



01369 708345 or



lana.lyddon@nhs.net

For more information  
visit our webpage

[www.tinyurl.com/hcqszzq](http://www.tinyurl.com/hcqszzq)



Holy Loch

## DROP IN EVENTS / CONVERSATION CAFÉS

We are holding a number of drop in events or conversation cafés for local communities and staff to come and join us in discussion.

Here you can share your views, tell us if you have any alternative ideas and ask questions. Events for December have been arranged as follows :

LOCATION	DATE	DETAILS
Conservatory, Cowal Community Hospital, Dunoon	Monday 12th December	2pm — 5pm
Kirn & Hunters Quay Bowling Club, Kirn	Tuesday 13th December	2pm — 5pm 6pm — 8pm
Village Hall, Innellan	Monday 19th December	2pm — 5pm

Other events will be held across Cowal during January and February. Look out for details in the local press or on public notice boards.

**Remember, you can ask us to come to you!**

Specific events are being organised for staff but anyone is welcome to attend the drop in / conversation cafés to give their views. Look out for details or contact your union representative for more details.

*" WE WILL LISTEN TO YOU, LEARN FROM YOUR EXPERIENCES  
AND USE THIS INSIGHT TO GUIDE WHAT WE DO"*



Kyles of Bute, West Cowal

## APPENDIX 9

### SCHEDULE OF ENGAGEMENT EVENTS 2016 / 17 COMMUNITIES & STAFF

Location / Venue	Date	Details
Conservatory, Cowal Community Hospital, <b>Dunoon</b>	Monday 12 <sup>th</sup> December	2pm – 5pm 6pm – 8pm
Kirn & Hunters Quay Bowling Club, <b>Kirn</b>	Tuesday 13 <sup>th</sup> December	2pm – 5pm 6pm – 8pm
Village Hall, <b>Innellan</b>	Monday 19 <sup>th</sup> December	2pm – 5pm
Village Hall, <b>Lochgoilhead</b>	Tuesday 10 <sup>th</sup> January	2pm – 5pm
Kames & District Recreational Hall, <b>Tighnabraich</b>	Wednesday 18 <sup>th</sup> January	2pm – 5pm
Village Hall, <b>Sandbank</b> (Community Council Meeting)	Thursday 19 <sup>th</sup> January	7pm
Memorial / New Hall, <b>Strachur</b>	Tuesday 24 <sup>th</sup> January	2pm – 5pm
Cowal Community Hospital, Dunoon ( <b>GPs</b> )	Thursday 26 <sup>th</sup> January	7pm
Co-Op, <b>Dunoon</b>	Friday 27 <sup>th</sup> January	10am – 3pm
Struan Lodge, Dunoon ( <b>Residents Group</b> )	Tuesday 31 <sup>st</sup> January	11.30am – 1pm
Village Hall, <b>Ardentinny</b>	Wednesday 1 <sup>st</sup> February	2pm – 5pm
Struan Lodge, Dunoon ( <b>Staff Group</b> )	Friday 3 <sup>rd</sup> February	2pm – 4pm
Village Hall, <b>Lochgoilhead</b> (Lunch Club)	Monday 6 <sup>th</sup> February	12noon
Village Hall, <b>Colintraive</b>	Thursday 9 <sup>th</sup> February	2pm – 5pm
Village Hall, <b>Sandbank</b>	Wednesday 15 <sup>th</sup> February	2pm – 5pm
St Mun's Church Hall, <b>Dunoon</b>	Tuesday 21 <sup>st</sup> February	2pm – 5pm 6pm – 8pm
Conservatory, Cowal Community Hospital, <b>Dunoon</b>	Wednesday 22 <sup>nd</sup> February	2pm – 5pm
Village Hall, <b>Kilmun</b>	Thursday 23 <sup>rd</sup> February	2pm – 6pm
Conservatory, Cowal Community Hospital, <b>Dunoon (Feedback Event)</b>	Friday 3 <sup>rd</sup> March	2pm – 4pm

**Cowal Locality**

**Struan Lodge and Cowal Hub**

**Communications & Engagement Process**

**SUMMARY**

It is essential to have in place a robust comprehensive Communications and Engagement Plan to ensure the Argyll and Bute Health and Social Care Partnership carries out its responsibility for public involvement and engagement in accordance with Statutory Guidance<sup>i</sup>, relevant Legislation and Code of Practice. This is also in line with the HSCP Communications and Engagement Strategy agreed by the Integrated Joint Board in June 2016.

The Cowal Communications and Engagement Group will be responsible for developing and implementing the Communications and Engagement Plan for the Cowal Hub. The Group held an extraordinary meeting on 20<sup>th</sup> October 2016 to specifically to develop an outline plan. The Group will meet fortnightly over the next few weeks to drive the Plan forward within agreed timescales.

An outline Communications and Engagement Plan has been agreed by the Group. Based on previous community and staff engagement processes that have worked well, it is proposed to use a model of engagement that has four distinct stages. The four stage are :

**Stage 1** : (now until mid November) obtaining all the relevant detailed information about both the current service and proposed Cowal Hub model then 'crafting' how this information will be presented to communities and staff. Information required includes proposed service specification, financial costs including cost of beds, activity date / occupancy levels, capacity available in the private sector, population profile (current and projected). This is to ensure people have the right information to be in a position to compare the current service at Struan Lodge and what is proposed with the Cowal Hub model.

It is at this stage that the Cowal Communications and Engagement Group will consider best mechanisms for encouraging and obtaining feedback / views. It is anticipated we will use a variety of methods including online (Survey Monkey), feedback forms and feedback obtained through the engagement process.

**Stage 2** : (mid - late November) key information about both the current service provided at Struan Lodge and the proposed Cowal Hub model out into the community and encourages communities to discuss it (to hold 'community conversations').

This will encourage people to start talking about and generating better informed views for Stage 3. It means people will have time to digest the initial information, become familiar with it and not be overloaded with information all at once.

**Stage 3** : (end November – end February) series of engagement activities will be held across Cowal. A comprehensive programme of events will be developed by the Cowal Communications and Engagement Group over the next 2 – 3 weeks. It is anticipated that the programme will include a series of ‘conversation cafés’ which have proved effective in the past. In addition, invitations to attend community council / community group meetings will be encouraged and added to the programme. It is essential to ensure that the proposed involvement / engagement framework includes different methods to meet varying needs.

**Stage 4** : (end February – mid March) preparation of feedback report outlining what people have told us. This report will form the basis of a recommendation report to Locality Planning Group, Locality Management Team, Operational Management Group. This report will be presented to the Senior Management Team and IJB at its meeting in March 2017.

The feedback report will become a public document. Key findings will be communicated to communities and staff ensuring the HSCP adopts the “You Said, We Did” philosophy.

It is recommended that once the HSCP moves to implementation stage that communities and staff are kept up to date on progress.

The full Communications and Engagement Plan will be further developed over the next few weeks and a copy will be posted on the HSCP webpage demonstrating that clear and transparent processes are being adopted and that Statutory Guidance is being duly followed.

A timeline with key milestones of the communications and engagement process is attached with this document.

Caroline Champion  
Public Involvement Manager  
A&B HSCP

22<sup>nd</sup> October 2016

(on behalf of Allen Stevenson, Head of Service (East))

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<sup>1</sup> CEL 4 (2010) Informing, engaging and Consulting People in Developing Health and Community Care Services, Scottish Government, February 2010





# Argyll & Bute Health & Social Care Partnership

## Integration Joint Board

Agenda item : 5.1b

**Date of Meeting:** 29 March 2017

**Title of Report:** Thomson Court Day Service

**Presented by:** Allen Stevenson, Head of Adult Services (East)

### The Integration Joint Board is asked to :

- Note the completion of engagement events planned and delivered between December 2016 and the end of February 2017.
- Note the key themes identified within the report compiled by the Public Involvement Manager on behalf of the Head of Adult Services (East).
- Note the positive contribution by the Bute Communication Group formed specifically to plan and deliver conversation café/drop in events.
- Agree a new enhanced model of day service is developed to meet the needs of a growing frail/elderly population. The new model retains the existing day service and will enhance the support available to dementia and frail/elderly people.
- Note a new service specification will be developed in partnership with local managers, the Communication Group and Locality Planning Group by the end of June 2017.
- Note the savings target attached to the original proposal (£20k) will be met from a review of management cover within the new re-designed service.

## 1. EXECUTIVE SUMMARY

- 1.1 A series of public events were planned and delivered by a new Communication Group made up of community reps, staff and a variety of key stakeholders during December 2016 and the end of February 2017. The events were set up to give the community an opportunity to air their views and consider any other alternative options in relation to the redesign of services at Thomson Day Care Service. The proposal was to move from a small dementia day service to a befriender model to meet the

increasing demand for services for a growing number of frail elderly people on Bute.

- 1.2 A separate Community Feedback Report was completed by the HSCP Public Involvement Manager. This report captures all the feedback from conversation café/ drop in events, survey monkey and hard copy questionnaires returned by members of the community. Submissions were received up to the last day of the engagement period.
- 1.3 The formation of a new Communication Group made up of key stakeholders planned and delivered a series of events during the agreed timescale to secure feedback from the Bute community in relation to the re-design of Thomson Court Day service. The group accepted the challenge of engaging with the community and developed a very positive approach to the community engagement process. This was a new group formed for this specific role made up of experienced community reps and a variety of other key stakeholders with a very good knowledge of the local community.
- 1.4 Feedback from the community engagements events strongly supports the need to retain and enhance the current day service model which operates from the Thomson Court campus. The current model supports a small number of people with dementia. The community have strongly reported the need to retain services for people with dementia. However they also wish to see the service extended to include the growing number of frail elderly people.
- 1.5 A new service specification needs to be developed to enhance the work already being delivered at the current day service. The re-design will be developed by managers, members of the communication group and Locality Planning Group. This work will be completed by the end of June 2017. This will allow for a detailed service specification to be developed and then shared with the community before sign off and implementation of the new model.

## **2. INTRODUCTION**

- 2.1 Argyll and Bute Health and Social Care Partnership (HSCP) are actively working to deliver the transformational change required across Argyll and Bute to meet the future needs of an ageing population and as demand grows within an increasingly challenging financial climate across public services. The scale of the challenges ahead is unprecedented and will require everyone to work smarter in the future by using our resources more efficiently and effectively.
- 2.2 The current health and social care system needs to change. We need to shift the balance of care by supporting people to stay at home longer to live healthier happier and independent lives. To do this we need to develop our approach to preventative interventions delivered increasingly in peoples own home or more homely settings.
- 2.3 Our Strategic Plan (2016-2019) identified 6 key areas of focus and set out our locality priorities in response to the national policies of the Scottish Government. Feedback from communities during the consultation period



on the strategic plan identified that our communities want the HSCP to reduce the need for emergency or urgent care by improving our approach to anticipatory care. Our communities also identified the need for us to prevent ill-health, increase levels of confidence and ensure our staff were able to help people to improve their skills and confidence to remain at home.

- 2.4 The Argyll and Bute Integration Joint Board (IJB) agreed to a pause in work relating to service re-design at Thomson Court Day service in November 2016 due to concerns raised by the community. A move to a befriender model of service delivery was rejected by the community. A pause between December 2016 and February 2017 has allowed the community to take part in conversations about the future design of services for people with dementia and the growing number of frail / elderly adults living on Bute.

### 3. DETAIL OF REPORT

- 3.1 During the pause agreed by the IJB in November 2016, Officers supported work by the Communication Group to develop a community redesign leaflet which set out the current service model on Bute, the proposed changes and the process that would be followed during the pause. The leaflet was then distributed widely. A set of questions were also developed to ensure we asked the community the same questions which could then be collated at the end of the process.
- 3.2 The way in which the Communication Group approached this task was excellent. The level of enthusiasm by the group members was exceptional throughout the communication and engagement period.
- 3.3 The Community Feedback report captures the key themes from the Bute engagement events. It is a thorough report which sets out the detail of all the conversations that took place as well as the content of survey monkey and hard copy responses to the questionnaires submitted to the team.
- 3.4 The key themes / general points are captured on a table within the report and include the following:

Key Themes / General Points	
1	Need to expand day care centre for everyone, to include physical & mental stimulating activities / exercise, entertainment, social interaction; centre of excellence; hub
2	More services for people with mental ill health, including services for people with a diagnosis of dementia
3	Fear Thomson Court Day Centre will close & ramifications; fear the closure will result in depletion in services for people with a diagnosis of dementia; much valued service
4	Sheltered housing needed
5	More support for carers (respite care, training)
6	More should be done to tackle loneliness & isolation
7	Return to original home help concept
8	Provision of nursing & social care for people at home
9	More home visits

10	Retain existing hospital beds
11	Promotion of good health & wellbeing; support to maintain independence at home for as long as possible; encouragement to stay well
12	More information on benefits, health care
13	Progressive care
14	Regular assessments
15	Red Cross, Meals on Wheels, Befrienders – excellent services
16	Transport – access to social activities; access to appointments
17	Increase Care & Repair service
18	Value people as individuals
19	Recognition that not everyone wants to remain at home, some may wish to go into residential care

3.5 The work in relation to the new enhanced service will be developed by local managers, members of the communication group and locality planning group. The work will be led by the Local Area Manager Jane Williams. A draft service specification will outline the way the service will work with a wider group of service users and describe how other services will work more closely with the day service. Tackling isolation and loneliness and a focus on re-ablement and retaining skills and improved confidence will all be developed within the service specification.

#### **4. CONTRIBUTION TO STRATEGIC PRIORITIES**

4.1 The re-design work at Thomson Court day service is aligned to our strategic plan. Improving support by co-ordinating statutory services and third sector activity in Bute will ensure we support older adults to remain at home independently. It will also tackle the issue of loneliness which is now a significant issue for older people living at home.

#### **5. GOVERNANCE IMPLICATIONS**

##### **5.1 Financial Impact**

The savings target of £20k will be met from a review of management cover within the new redesigned service.

##### **5.2 Staff Governance**

Further work will be developed to address issues relating to staff governance within the new enhanced service,

##### **5.3 Clinical Governance**

The Council's standards relating to the staff supervision policy will be fully met within the enhanced service.

## **6. EQUALITY & DIVERSITY IMPLICATIONS**

- 6.1 The new enhanced service will further protect the most vulnerable in the community. This will include people with long term conditions, dementia and the frail/elderly.

## **7. RISK ASSESSMENT**

- 7.1 The re-design will extend the reach of the current service to offer support to a wider group of older adults who are frail/ elderly.

## **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT**

- 8.1 This work was based on a series of public engagement events planned and delivered on Bute between December and the end of February 2017.

## **9. CONCLUSIONS**

- 9.1 The period of engagement agreed by the IJB at the end of 2016 has ensured the proposal to enhance the current service at Thomson Court is based on robust community engagement on Bute between November 2016 and February 2017. This has resulted in a clear direction of travel to enhance the current supports on offer at Thomson Court Day service.
- 9.2 The re-designed service will ensure closer partnership working by HSCP staff and other partner agencies as well as on-going active involvement of the wider community in Bute. Tackling the challenge of providing personalised local care for older adults with dementia and a growing frail /elderly population will continue to be a significant issue as we move beyond the current cycle of the strategic plan. By delivering this re-design we will start to meet the challenges ahead.

Allen Stevenson  
Head of Adult Services (East)



Argyll and Bute Health and Social Care Partnership (HSCP)

# THOMSON COURT DAY CENTRE & BUTE COMMUNITY REDESIGN



**WE WANT YOUR VIEWS!**

**Community Feedback**

**REPORT**

FINAL

12<sup>th</sup> March 2017

Thomson Court Day Centre & Bute Community Redesign Website :  
[www.tinyurl.com/zlsvmmp](http://www.tinyurl.com/zlsvmmp)

## Summary

A total of 95 responses have been received, either by post, online using Survey Monkey, emailing to the generic email address or by letter. This represents a good response rate.

Based on the feedback, a number of key themes / general points have emerged. Some people have stated they feel Thomson Court Day Centre should be developed to provide a much wider range of services and activities for a greater number of people who are frail and elderly, and would greatly benefit from a day care service. There are, as anticipated, a number of people who are worried about what is being proposed, both for Thomson Court, Thomson Court Day Centre and the Victoria Hospital.

The table below lists the key themes / general points that emerged from the feedback received.

Key Themes / General Points	
1	Need to expand day care centre for everyone, to include physical & mental stimulating activities / exercise, entertainment, social interaction; centre of excellence; hub; 7 day a week service
2	More services for people with mental ill health, including services for people with a diagnosis of dementia
3	Fear Thomson Court Day Centre will close & ramifications; fear the closure will result in depletion in services for people with a diagnosis of dementia; much valued service
4	Sheltered housing needed
5	More support for carers (respite care, training)
6	More should be done to tackle loneliness & isolation
7	Return to original home help concept
8	Provision of nursing & social care for people at home
9	More home visits
10	Retain existing hospital beds
11	Promotion of good health & well being; support to maintain independence at home for as long as possible; encouragement to stay well
12	More information on benefits, health care
13	Progressive care – care can be ‘stepped up’ or ‘stepped down’ according to the level of care people require
14	Regular assessments
15	Red Cross, Meals on Wheels, Befrienders – excellent services
16	Transport – access to social activities; access to appointments
17	Increase Care & Repair service
18	Value people as individuals
19	Recognition that not everyone wants to remain at home, some may wish to go into residential care

Discussions at the community engagement activities have echoed these key themes. The feedback event held on 27<sup>th</sup> February was an opportunity for people to see what we had been told, this also provided a useful 'validation' of the key themes by the local community.

Feedback prior to implementing any proposed change in how services will be delivered is crucial to ensure the local population is given the opportunity to share their views and have their 'voice' heard, this is in line with Statutory Guidance CEL (4) 2010.

The engagement period carried out has been done with the support and guidance of the Bute Communications and Engagement Group, and in line with Statutory Guidance.

All feedback received has been very important and of great value. Many thanks to all those who returned their completed "We Want Your Views!" feedback forms, attended our engagement events or responded using other methods.

The full Your Views! Feedback Report will be presented to the Integration Joint Board (IJB) on 29<sup>th</sup> March 2017. As a supplement to the strategic management paper by Allen Stevenson, Head of adult Services (East).

This feedback report will become a public document and available on the HSCP webpage at [www.tinyurl.com/zlsvmmp](http://www.tinyurl.com/zlsvmmp)

## Background

The Argyll and Bute Health and Social Care Partnership (A&B HSCP) Strategic Plan 2016 – 2019 outlines our priorities for health and social care services across Argyll and Bute

<http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/SP%202016-2019%20%20Final.pdf>

Our priorities are in response to national policies as set out by the Scottish Government, for example Shifting the Balance of Care, but also based on what our communities and staff have said is important to them.

People have said **"We want to live a long, healthy, happy and independent life supported by health and social care services when we need them."**

They have said **"We want to stay at home for as long as possible."**

We need to redesign health and social care services on the Isle of Bute to meet these priorities. **It is important that you have the right service, in the right place, at the right time.**

## **What does this mean?**

This means that we can no longer provide services as we do now. If we carry on as we are, we will not be able to support the ever growing number of people who will need our support in the future.

Communities have told us they want to be supported to live in their homes for as long as possible. To achieve this, we need to provide more community based services. We need to make sure that health and social care services meet the needs of the local population now and in the future, are flexible in response to changes in demand and that they are sustainable for many years to come.

We are committed to keeping the Victoria Hospital in Rothesay at the heart of the community and we want to retain the high quality level of care which it provides, when people need it. As we are looking to provide more services in the community it means we can reduce the number of beds in the local hospital.

## **What is being proposed?**

The vision for services provided at Thomson Court Day Centre is to build on the excellent care it currently provides. We need to be able to care for many more people through day care services and to support people to live in their homes for as long as they wish.

The service change proposed for Thomson Court Day centre and community care on Bute has been informed by previous reviews of residential care and Balance of Care provision over the last three years and the need to further develop the community and partnership services.

The aim is to redesign the existing dementia day service with registered capacity (by the Care Inspectorate) for 12 people at any one time. The current model of service is limited to people with dementia, this therefore excludes a large number of frail and elderly people with long term conditions in the community.

What we would like to do is provide a wider range of community based services for a greater number of people who are frail and elderly within the community. This will include a service that meets the needs of dementia patients and their carers.

We would like the new service to be flexible and to help a greater number of vulnerable people who require different levels of support. An enablement service will allow us to increase confidence and improve skills to support people to live their lives to the full and maximise independence. This is what people have said is important to them.

The proposed changes mirror the HSCP three year Strategic Plan, which was developed with all partners and taken through an extensive involvement and engagement process to finalise and agree the shape, objectives, outcomes the people of Argyll wanted to experience for health and social care.



## Communication and Engagement

**The Bute Communications and Engagement Group** has responsibility for supporting the Locality Planning Group (LPG) to ensure the approach to engagement activities is in line with Statutory Guidance CEL 4 (2010)<sup>1</sup>.

The Communications and Engagement Group is made up of public, third sector, union, NHS and Council Staff. The Scottish Health Council provides guidance and support.

A summary Communications and Engagement Plan was presented to the Integration Joint Board (IJB) at its special meeting on 2<sup>nd</sup> November 2016 and endorsed. A copy of the Plan, which was developed by the Cowal Communications and Engagement Group, can be found at Appendix 10.

### **Thomson Court Day Centre & Bute Community Redesign Leaflet**

In December 2016, the Communications and Engagement Group developed the Thomson Court Day Centre & Bute Community redesign leaflet which was distributed at the beginning of January 2017 and in advance of the first community engagement event. The leaflet provided an outline of why services need to change, diagram of what services are currently available for Bute citizens, proposed change for the dementia day service at Thomson Court Day Centre, communications and engagement process followed, and the schedule of engagement activities for January and February.

A total of 1,500 leaflets were printed and distributed to key locations across the island. The remainder were made available for people attending the engagement events.

### **Feedback “We Want Your Views!”**

The Communications and Engagement Group developed a feedback form “We Want Your Views!” (Appendix 1). The feedback form was made available at all events during the engagement period (January and February). Local people were encouraged to complete and return the feedback form by post using the Freepost envelope supplied. 46 feedback forms were returned by post. Appendix 2 provides the detailed unedited responses for information.

People were also given the option to complete the feedback form online through Survey Monkey. The same questions were used to ensure consistency. A total of 47 responses were received and these have been included in the report.

The HSCP generic email address was provided for anyone wishing to share their views, comments or put forward alternative ideas. No one used the generic email address to provide feedback. 2 letters were received, one of these has been included (Appendix 6) in the overall feedback report but names have been excluded to maintain anonymity of the authors. The remaining letter

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<sup>1</sup> CEL 4 (2010) Informing, Engaging and Consulting People in Developing Health and Community Care Services, Scottish Government, February 2010

contained specific details which would identify individuals therefore this was not included in the feedback report.

The deadline for submitting the “We Want Your Views!” Feedback Form was Tuesday 28<sup>th</sup> February 2017.

## Community and Staff Engagement

The HSCP held a series of engagement activities during January and February 2017. The Schedule of Community Engagement Activities has been included at Appendix 9. Representatives of the HSCP along with members of the Communications & Engagement Group attended and supported the various activities.

Approximately 155 people attended the four events, broken down as follows :

Location	Date	Number of Attendees
Baptish Church, Rothesay	12 <sup>th</sup> January	60+
Village Hall, Port Bannatyne	26 <sup>th</sup> January	33
Moat Hall, Rothesay	20 <sup>th</sup> February	48
Discovery Centre, Rothesay *	27 <sup>th</sup> February	14

\* Feedback event

Most of the engagement activities were based around the Conversation Café method where people were invited to come along for a ‘chat and a cuppa’ and share their views about what is being proposed.

In addition to the engagement events, members of Locality Management and the Bute Communications & Engagement Group attended local group meetings / activities. The following table provides details of these additional activities along with approximate number of people engaged in discussion :

Meeting / Group	Date	Approx Numbers
Rotary	5 <sup>th</sup> January	20
North Bute Literary Society	17 <sup>th</sup> January	30
Craigmore Bowling & Social Club	13 <sup>th</sup> January	14
Bute Community Council	18 <sup>th</sup> January	28
Bute Kidney Dialysis Group	18 <sup>th</sup> January	8
Bute Island Radio	20 <sup>th</sup> January	unknown
Bute Natural History Society	24 <sup>th</sup> January	20
Bute Health & Care Forum	25 <sup>th</sup> January	8
Ballianlay (SWI)	6 <sup>th</sup> February	41
Bute Forum for Older Voices	8 <sup>th</sup> February	8
Stroke Club	16 <sup>th</sup> February	14

Staff were invited to attend community engagement events but to ensure staff were kept up to date and encouraged to participate, the Local Area Manager (Bute) attended a number of staff meetings.

At the engagement events, people were encouraged to record their views, comments, ideas / suggestions on tablecloths or flip chart paper. Where tablecloths or flip chart paper was used in this way, the information has been included in this report (Appendix 3). In addition, the Community Development Officer (Cowal and Bute) provided the Wishing Well, facilitating discussions around day care (Appendix 4). All feedback has been included in the overall analysis.

### **“We Want Your Views!” Feedback Results**

The evaluation of the feedback received has provided qualitative feedback only. A total of 59 responses were received, a breakdown of how the feedback has been received is as follows :

<b>Feedback Method</b>	<b>Number Received</b>
Feedback Form	46
Survey Monkey	47
Email	0
Letter *	2
Other	0

\*letter not included in the feedback report to protect anonymity

In addition, where local groups / clubs held meeting (e.g. Stroke Club, Memory Group) were held a record of the key points have also been recorded and included in this report. Again, the key points have been in the overall analysis (Appendix 5).

Given the volume of responses received, a summary of the main issues or points provided have been included in the main body of this report. Appendix 2 provides the detailed unedited written feedback received from all responses received (“We Want Your Views!” feedback form, Survey Monkey and letters). Appendix 3 provides the full details recorded on tablecloths / flip chart paper and Appendix 4 includes points recorded at public meetings. Appendix 5 includes ideas put forward for what day care could look like for Bute.

Caroline Champion  
Public Involvement Manager  
Argyll & Bute Health & Social Care Partnership

(on behalf of Allen Stevenson, Head of Adult Services (East))

12<sup>th</sup> March 2017



Argyll and Bute Health and Social Care Partnership  
(HSCP)



# THOMSON COURT DAY CENTRE & BUTE COMMUNITY CARE REDESIGN



## WE WANT YOUR VIEWS!

### Why?

You said "We want to live a long, healthy, happy and independent life supported by health and social care services when you need them"

You said "We want to stay at home for as long as possible"

We want to support you to achieve this

You said "We want public involvement in service redesign"

We want to do that and have put in place a series of events and ways to gather your views

We can no longer provide services as we do now. We need to provide more community based services. We need to make sure the services provided on Bute meet the needs of our population now and in the future, are flexible in response to changes in demand and that they are sustainable for many years to come.

Your feedback is important. We will use what you say to help us redesign and improve *your* local services so they are fit for the future.

### How can you do this?

Complete this feedback form and return it to the FREEPOST address on page 2



complete the form online <https://www.surveymonkey.co.uk/r/ButeRedesign>



email us your story / views to [nhs.abhscp@nhs.net](mailto:nhs.abhscp@nhs.net)

Your feedback will be confidential. By that we mean :

- ✓ we will not name you in the document
- ✓ if you share your views but you do **not** want these to be part of the public record of the feedback we receive, we will respect that and your views will not be included.

Please tick this box if you **do not** want your views included in the feedback report

**Q1 Thinking about yourself, what would enable you to live a long, healthy, happy and independent life?**

Please turn over

**Q2 What support might you need to achieve this?**

What could services look like in 3 years?

**Q3 We would like to develop a range of community services to support people to stay at home for as long as possible. What services would you like to see developed?**

**Q4 What day care services would you like to see developed on Bute?**

**Q5 How do we increase confidence in community services to ensure they meet your needs?**

What do you need to have in place to be confident in community services?

**Q6 Do you have any ideas, concerns or questions about how we redesign services to move away from hospital to community based services?**  
(Please continue on a separate sheet if necessary)

**We welcome your more detailed comments, ideas, concerns or questions. Please attach them to this sheet**

Please return this feedback form **no later than Tuesday 28<sup>th</sup> February 2017** to :

**Caroline Champion, Public Involvement Manager, FREEPOST RRYT-TKEE-RHBZ, NHS Highland (Argyll & Bute HSCP), Blarbuie Road, LOCHGILPHEAD, Argyll, PA31 8LD**

If you need help completing this form or to receive a copy in a different language / format (e.g. large print) contact Caroline ☎ 01546 605680 or [caroline.champion1@nhs.net](mailto:caroline.champion1@nhs.net)

*Thank you*

# THOMSON COURT DAY CENTRE & BUTE COMMUNITY REDESIGN

## FEEDBACK

*The following provides detailed unedited written feedback received from all forms received by post, online survey monkey and email. Each has been given a unique reference as part of the overall analysis of responses.*

### **Q1 Thinking about yourself, what would enable you to live a long, healthy, happy and independent life?**

- TO HAVE THE HEALTH FACILITIES IN SITU TO PROVIDE ME WITH FUTURE HEALTH PROBLEMS SUCH AS DEMENTIA CARE, GERIATRIC CARE, WHICH IS AN ESSENTIAL NEED ON AN IDLANDS OF ELDERELY PEOPLE [tcdcbr001/12jan17]
- Keeping busy – going out doing things on a volunteer basis [tcdcbr002/12jan17]
- VOLUNTARY HELP. SOMEONE TO PLAY GOLF WITH ME. SOMEONE TO GO TOT THE CINEMA WITH ME. SOMEONE TO PLAY MUSIC WITH ME [tcdcbr004/12jan17]
- GOOD HEALTHCARE SERVICES. AVAILABILITY OF PATIENT TRANPSORT TO HOSPITAL ON OR OFF ISLAND FOR THOSE WHO REQUIRE IT. REQUIRE MORE RESIDENTIAL CARE ON ISLAND ESPECIALLY FOR DEMENTIA PATIENTS [tcdcbr005/12jan17]
- SERVICES ON BUTE [tcdcbr006/12jan17]
- SERVICES ON BUTE [tcdcbr007/12jan17]
- A MIX OF PROFESSIONALS AND TRAINED VOLUNTEERS BEFRIENDERS A DAY CENTRE THAT I CAN GO TO ONCE RO TWICE A WEEK TO MEET PEOPLE OR ENJOY MUSIX OR SIMILAR. VOLUNTEER BEFREINDERS WHO'S TRAINED TRANSPORT TO GET ME OUT► SERVICES THAT COME TO ME MY HOME VARIOUS CLUBS – LUNCH CLUB – TEA CLUB – SINGING [tcdcbr009/12jan17]
- Mental & physical health, my home life continued my pension to be continued and the knowledge that should dementia occur my family would have help [tcdcbr010/12jan17]
- PHYSICAL AND MENTAL CAPABILITY – I KNOW THIS CANNOT BE GUARANTEED BUT GENERALLY – PROFESSIONAL, NON PATRONISING, ASSISTANCE – AT EACH STEP [tcdcbr011/12jan17]
- Occasional help around the house [tcdcbr012/12jan17]
- GOOD PROVISION OF NHS AND SOCIAL SERVICES. THRO' CARE PARTNERSHIP? [tcdcbr013/12jan17]
- DEPENDS WHAT'S WRONG WITH ME. IF I HAD DEMENTIA THOMSON DAY CENTRE WOULD BE IDEAL IF IT OPERATES AS IT IS JUST NOW [tcdcbr014/16jan17]
- Information about preventative measures to ensure good health. Access to leasure / health facilities eg gym / swimming pool. These need to affordable for elderly population. Good health care available. Encouragement to lead healthy

lifestyle. Small group activities generally promote well being. Place value on individuals [tcdcbr015/26jan17]

- I HAVE LIVED MOST OF MY ADULT LIFE ON BUTE. I WOULD LIKE TO SPEND MY REMAINING YEARS ON THE ISLAND SAFE IN THE KNOWLEDGE THAT I HAVE FRIENDS AND FAMILY AROUND ME [tcdcbr016/26jan17]
- Good HEALTH CARE from Professionals. A HEALTHY LIFESTYLE. CARE IN THE COMMUNITY AS NECESSARY. PREVENTATIVE MEASURES TO ENSURE GOOD HEALTH [tcdcbr017/26jan17]
- THE SUPPORT OF THE SOCIAL SERVICES e.g. CARE VISITS + THE FACILITY OF A DAY CENTRE TO MEET WITH PEOPLE + TAKE PART IN ACTIVITIES TO STIMULATE THE MIND. THIS WOULD BE BY STAYING IN MY OWN HOME [tcdcbr018/26jan17]
- Firstly to be in good health. Have my close family nearby. Knowing that I would have people to care for me should I need any assistance. Be in my own home [tcdcbr019/26jan17]
- To be reassured that care in the community would be just that, with care / carers given ample time to attend those in need, therefore more staff required [tcdcbr020/26jan17]
- I'M VERY LUCKY TO BE ABLE TO LIVE A HAPPY, MOSTLY HEALTHY HOPEFULLY LONG LIFE – I WOULD LIKE TO HELP AS MANY PEOPLE AS I CAN BUT I DO NOT KNOW HOW OR WHAT TO DO [tcdcbr021/31jan17]
- CONTINUOUS PACKAGE OF SUPPORT SERVICE 7 DAYS A WEEK WITH 4 VISITS DAILY. PROVISION OF DEMENTIA CENTRE FOR HUSBAND WITH DEMENTIA. AS CARER FOR HIM I NEED DAILY RESPITE [tcdcbr022/13feb17]
- GOOD SOCIAL LIFE WITH LIKE MINDED PEOPLE AND CENTRAL HUB FOR STIMULATING CHAT WITH FRIENDS. GOOD HEALTH AND MAYBE HELP FROM INSPIRING OCCUPATIONAL THERAPIST AND “ON THE DAY” APPOINTMENTS AVAILABLE AT HEALTH CENTRE [tcdcbr023/13feb17]
- Hopefully good health. Plenty of Social Stimulus. Community Transport with interesting trips away. Meeting places to chat with friends [tcdcbr024/14feb17]
- Good Health + plenty of exercise + friends [tcdcbr025/20feb17]
- The care we are receiving at the moment. [tcdcbr026/20feb17]
- A good care facility that supported independant living for as long as possible. [tcdcbr027/20feb17]
- To live at home & have care in the community as well as social care out with the home. [tcdcbr028/20feb17]
- Home Care – Family able to remain on island if one member in care – dislocation of family has dreadful effect on health. [tcdcbr029/20feb17]
- Having the health & community service readily available to me my needs. [tcdcbr030/20feb17]
- Wholistic approach to all aspects of humanity starting with Education, so that all essential principles are applied to all aspects of life eg. The periodic table of how all numerals can be applied to health inc. Nutrition construction, surgery manufacture etc etc etc [tcdcbr031/20feb17]
- A good balance between independence (supported if necessary) in my own home and hospital / hospice or other when medical opinion deems it necessary [tcdcbr032/20feb17]
- SECURITY, PEOPLE WHO CARE, CONFIDENCE IN THE STRUCTURE & SYSTEM OF WELFARE CARE [tcdcbr033/20feb17]

- Interaction with other people, adequate medical support, good transport links Occupational Therapists able to assess my needs [tcdabr034/20feb17]
- Being in my own home knowing that there were adequate health service / care arrangements on the Island to deal with most non-critical Medical situations [tcdabr035/20feb17]
- FLEXIBLE SUPPORT AT HOME DURING THE DAY AND NIGHT TO MEET MY CHANGING NEEDS AS MOBILITY BECOMES RESTRICTED OR MY MIND BECOMES LESS COHERANT [tcdabr036/23feb17]
- IF IMPAIRMENT IS PHYSICAL, WOULD PREFER TO STAY AT OWN HOUSE. IF IT IS MENTAL I WOULD BE SAFER TO SELF & OTHERS, UNDER 24HR SUPERVISION IN A LOCAL CARE HOME [tcdabr037/23feb17]
- If only physically struggling I would be happy to remain in my own home. If mentally impaired I would definitely want a care home [tcdabr038/23feb17]
- Feeling secure I home environment with support from community if needed (at any time of day). [tcdabr039/23feb17]
- COMMUNICATIONS IS VERY IMPORTANT. DECISIONS MUST NOT BE MADE WITHOUT DISCUSSION WITH USERS AND THE COMMUNITY. [tcdabr041/27feb17]
- A friendly community with various services available on the island whether they are NHS, Council or HSCP. [tcdabr042/27feb17]
- By being able to keep going, physically mentally and spiritually, making contributions to the community [tcdabr044/28feb17]
- The very best of LUCK. [tcdabr045/01mar17]
- Support which allows people to stay in their own homes. [tcdabr046/01mar17]
- Good health - mobility/transport - social interaction [tcdabr001/16jan17sm]
- Regular health checks by my GP. Exercise and fresh air. Keeping up hobbies and interests. Avoiding loneliness. Enjoying my home and garden. Having one or more proper holiday breaks every year. Keeping mobile. Being able to walk and to drive. [tcdabr002/18jan17sm]
- Keeping fit, eating a balanced diet and keeping weight under control. [tcdabr003/19jan17sm]
- Local health and social services that respond to my needs when I need them. [tcdabr004/23jan17sm]
- Living well in my own home with my close family knowing that there is a caring community around me. It would be a comfort if I knew that people knew ME and my needs. [tcdabr005/26jan17sm]
- Remain at home as long as possible. Access to day care services both at home and at day centre, to alleviate and combat loneliness. Good GP services. Consultants visiting the island. Robust dementia care services. [tcdabr006/27jansm]
- An excellent support network for when I am no longer able to care for myself. The same excellent support network which my family currently use at Thomson day centre [tcdabr007/27jan17sm]
- comfortable home that doesn't hamper me going out, doesn't increase my social isolation, affordable heating, suitable public transport, advice to help me help myself early enough so that I maintain my health and fitness. Access to help re say fading hearing and sight - eg aides to help continuance of independence [tcdabr008/28jan17sm]
- Good wife, good friends, good life-style, good social and medical care when needed [tcdabr009/30jan17sm]



- Sadly an enablement to live a long, healthy and independent life is not down to me or anyone else. However, a wish to enjoy a happy one is very much dependent upon an ability to continue to experience the company of other members of the community and if a day care centre no longer exists on the island I envisage a far lonelier existence than might otherwise be possible. [tcdabr010/30jan17sm]
- Affordable public transport to and from the island. Good medical & Nursing services, easily accessible (community based where appropriate) which \*offering continuity\* - too often the GP practice dictates the doctor I can see. Good social services when I become frail Services that can be delivered locally actually delivered locally rather than I travel [tcdabr011/06feb17sm]
- Support in the community [tcdabr012/13feb17sm]
- Free exercises classes suited to age group and daily with free rural transport where needed. [tcdabr013/13feb17sm]
- Good medical and social support available on the island (Bute) [tcdabr014/15feb17sm]
- Prompt access to health care Regular contact with other people Stimulating activities to participate in and contribute to [tcdabr015/16feb17sm]
- Having health care and social services readily available [tcdabr016/20feb17sm]
- A satisfactory income and/or a good pension. A supportive community, health monitoring protecting oneself e.g. flu jabs, treble AAA screening, good social networks, no smoking, a moderate alcohol intake. [tcdabr017/21feb17sm]
- Most importantly I would like to be able to have a centre to go to as often as I wished where I would have like minded company and be able to spend, what could be a long day if at home alone, a good part of that day in company doing craft work, drawing or even just chatting. I would wish for the good health to enable me to do this. [tcdabr018/21feb17sm]
- Good environment, i.e my own home (owned or rented) in an area where I do not feel threatened by other people or by total neglect of the infrastructure, dirty streets, potholes in streets and pavements, many closed down buildings etc. Shops, especially groceries, not too far away and some kind of public transport to get to Glasgow and beyond. [tcdabr019/22feb17sm]
- Being able to remain part of the community, socialise with others my age. [tcdabr020/25feb17sm]
- Free health care [tcdabr021/25feb17sm]
- Knowing there is a good support on the island when its my time to grow old [tcdabr022/25feb17sm]
- Be able to remain part of the community and socialise with others my age [tcdabr023/25feb17sm]
- Being part of the community, being able to socialise with others of similar ages. Dedicated health services. [tcdabr024/25feb17sm]
- Meeting people in a warm safe place to chat, have lunch, and talk about concerns. [tcdabr025/25feb17sm]
- Being able to get the type of care I need in the proper environment [tcdabr026/25feb17sm]
- Living where my individual needs are best met. If this is not possible in my own home, I wish to have the choice to live in a local residential home where my family and friends can visit on a regular basis and I will have the company of other local residents who can discuss events, places and people that I can relate to. [tcdabr027/25feb17sm]

- Having family friends around me. [tcdcbr028/25feb17sm]
- To be able to remain part of the community and socialise with others my age in a relaxed, familiar and safe environment. [tcdcbr029/25feb17sm]
- If I was of sound mind having support in my home however if I was unable to look after myself having professionals look after me so I am not a burden to my family. [tcdcbr030/25feb17sm]
- Buckie and haggis [tcdcbr031/25feb17sm]
- Access to free health care at point of need; affordable fresh local produce; employment and/or voluntary occupation; opportunities for social engagement [tcdcbr032/25feb17sm]
- Have the support of my family and to be able to remain part of the community and socialise with others my age. [tcdcbr033/25feb17sm]
- Family and Friends to give plenty of support. [tcdcbr034/25feb17sm]
- Be able to remain part of the community [tcdcbr035/25feb17sm]
- good health, looking after my health [tcdcbr036/25feb17sm]
- Surrounding yourself with positivity and good people [tcdcbr037/25feb17sm]
- To be able to remain part of the community and socialise with others my age. [tcdcbr038/25feb17sm]
- A good health and social care service. Continuity of care while still being able to attend a day service to allow my family to continue to work and enjoy their own life etc and this would also give me social interaction with people around my own age, while allowing me to be independant under supervision of the carers to ensure my safety. Without the use of day services this may not be possible for many people and may end with families having to give up their own jobs to be at home and care for family members. [tcdcbr039/25feb17sm]
- I want to be able to socialise with others my age in a secure warm welcoming environment [tcdcbr040/26feb17sm]
- Family and friends close by. [tcdcbr041/26feb17sm]
- To know I am being properly cared for if I can no longer look after myself. [tcdcbr042/26feb17sm]
- To remain safely in my own home, having my own space within the community I was brought up in, near the people and places I know. [tcdcbr043/26feb17sm]
- Access to social and healthcare services. Assistance with day to day living. Access to services including rest bite and dementia services in local areas. [tcdcbr044/26feb17sm]
- Good care and support [tcdcbr045/26feb17sm]
- A decent care system [tcdcbr046/26feb17sm]
- In the Future I would like to feel reassured If I needed help to continue to live an independent life . Help would be there. [tcdcbr047/28feb17sm]

## **Q2 What support might you need to achieve this?**

- A FULLY SERVICED THOMSON COURT. MORE FACILITIES WITH LOCAL HOSPITAL BEDS. PROMOTING HEALTH RATHER THAN CURING HEALTH PROBLEMS. ENCOURAGING PEOPLE TO BE MORE ACTIVE SO THEY ARE FTTER IN OLD AGE [tcdcbr001/12jan17]
- Meals on Wheels provided by Thomson Court essential. Must be a focus on the carer as well [tcdcbr002/12jan17]

- THAT THERE WOULD BE PROGRESSIVE CARE. WHERE YOU START OF IN EG SHELTERED HOSUING & AS YOU NEED EXTRA CARE YOU CAN PROGRESS AT EACH STAGE & IT MUST BE ON THE ISLAND [tcdcbr003/12jan17]
- SOMEONE TO ACCOMPANY ME [tcdcbr004/12jan17]
- WE TRUST THAT THERE WILL NEW FACILITIES ON THE ISLAND TO COPE WITH ALL MEDICAL CARE [tcdcbr005/12jan17]
- BETTER DAY CARE. MORE SOCIAL INTERACTION [tcdcbr006/12jan17]
- BETTER DAY CARE. INFORMAL MEETINGS [tcdcbr007/12jan17]
- Carer service is good. Could do with more time (for their sake). Naturally watching time [tcdcbr008/12jan17]
- FUNDING FROM VARIOUS ORGANSIATIONS – TRAINING FOR PAID EMPLOYEES OR VOLUNTEERS. IN 3 YRS A CENTRE OF EXCELLENCE FOR THE OLDER GENERATION WHATEVER THERE NEEDS. [tcdcbr009/12jan17]
- Hopefully – the day centre would still be in place and even enlarged thus taking more than 12 persons [tcdcbr010/12jan17]
- KNOWING THAT MONEY IS THE MAIN CONCERN / RPBLEM. I WOULD EXPECT WE MIGHT BE BACK TO MORE GROUP RATHER THAN INDIVIDUAL SUPPORT [tcdcbr011/12jan17]
- More home helps? [tcdcbr012/12jan17]
- PROVISION OF GOOD NURSING CARE AND SOCIAL CARE AT HOME WITHOUT DEPLETION OF EXISTING HOSPITAL BEDS [tcdcbr013/12jan17]
- IF THERE IS A DEPETION OF RESOURCES DEMENTIA SUFFERES WILL HAVE NO QUALITY OF LIFE/ THEIR RELATIVES WILL SUFFER WITHOUT RESPITE [tcdcbr014/16jan17]
- Good health professionals interested in prevention and supportive measures. Care in the community needs caring individuals to support it. Cost is important, but many people feel it is the priority – the only way to think! [tcdcbr015/26jan17]
- SOCIAL CARE NEEDS TO BECOME AS MUCH OF A PRIORITY AS THE NHS. (MORE FUNDING) [tcdcbr017/26jan17]
- LOOKING TO MORE CARE IN THE COMMUNITY LONGER TIME GIVEN TO CARERS TO BE ABLE TO SPEND SOCIAL TIME WITH THEIR CLIENTS [tcdcbr018/26jan17]
- Not enough funds and personnel to look after people who need any help [tcdcbr019/26jan17]
- an improvement in all the facilities now in place. More staff on call & more time to socialise with housebound People [tcdcbr020/26jan17]
- AT THE MOMENT I DON'T NEED HELP, AS LONG AS I KEEP TAKING MY MEDICATION BUT OTHER PEOPLE NEED ALL THE HELP THEY CAN GET [tcdcbr021/31jan17]
- PROVISION OF EXERCISE CLASSES IN GENERAL CARE CENTRE AT LEAST 3 TIMES PER WEEK [tcdcbr022/13feb17]
- GOOD COMMUNITY NURSE SYSTEM PREVENTATIVE MEDICINE (ie. For osteoporosis etc) CARE TO HELP WITH WASH & DRESS. PREPARE FOOD AND WASH CLOTHES IF REQUIRED. CARE & REPAIR SERVICE [tcdcbr023/13feb17]
- Health Centre that is interested in Preventative measure. Good community Nurse system. Help from the wonderful Care & Repair [tcdcbr024/14feb17]

- More than 1 Care Home + Nursing Home [tcdcbr025/20feb17]
- Similar as the present. [tcdcbr026/20feb17]
- At the moment this is difficult to imagine, however looking at the support my parents receive, I would hope similar Carer packages and Day Centre facilities would help. [tcdcbr027/20feb17]
- At the moment I have no idea!! but spoken to those who have support, I hope then to have care in the community and Day Centre facilities would be very important. [tcdcbr028/20feb17]
- up-date of buildings. One stop clinic. [tcdcbr029/20feb17]
- Keep Thomson Court Day Centre open for the increasing number of people who will need it in the future for dementia and other debilitating diseases where it would be beneficial. [tcdcbr030/20feb17]
- No idea of budget, people, services etc etc [tcdcbr031/20feb17]
- I suspect lack of money will ensure that new ideas (or old, good ideas) will prevent any changes for the better care of those in need. [tcdcbr032/20feb17]
- SUPPORTIVE, PROVIDING AN EXCELLENT SERVICE. [tcdcbr033/20feb17]
- Services should be community, not home based. People do not need to be isolated in their homes reliant on carers. They need to be able to attend events & centres outwith their own home [tcdcbr034/20feb17]
- VISITING CARERS WHO ARE ABLE TO COME REGULARLY (FOR MEALS, SHOPPING, CLEANING) AND ON CALL TO HELP OVERNIGHT AS NECESSARY –NEEDS A ‘BANK’ OF CARERS TO CALL ON [tcdcbr036/23feb17]
- WOULD HOPE THAT THE ELDERLY COULD ANTICIPATE BEING CARED FOR IN A LOCAL CARE HOME. OT AS AT PRESENT, DREADING THE DAY WHEN THEY ARE REMOVED TO AN UNFAMILIAR MAINLAND FACILITY [tcdcbr037/23feb17]
- Very definitely a suitable Care Home able to take all those needing proper care. [tcdcbr038/23feb17]
- VISITING CARERS TO HOME – TO UNDERTAKE ANY TASKS FOOD DELIVERED (LIKE MEALS ON WHEELS) GARDEN CARE [tcdcbr039/23feb17]
- I hope that they will still be on the island with hospital + clinics + day centre + lunch clubs. [tcdcbr042/27feb17]
- Hopefully a new care home will exist offering a high standard of care [tcdcbr043/28feb17]
- I do not know – but read on. [tcdcbr044/28feb17]
- Seeing the same GP / nurse at every medical intervention. Easily accessed / affordable transport provision (i.e. to health and social appointments). Day Centre / drop in informal Community Centre / clubs and organisations. [tcdcbr001/16jan17sm]
- will soon be 65. I have a daughter (and grandchildren) but she lives near London. The main worry is of a physical or mental decline setting in and starting to lose the ability to look after myself properly. [tcdcbr002/18jan17sm]
- Ready access to fitness/activity classes. Ready access to professional advice/reassurance on inevitable issues that will arise. [tcdcbr003/19jan17sm]
- This is two questions. My answer to the first is that if local services that respond to my needs when I need them were available, then I would self evidently not need any further support to achieve this. My response to the second is what a stupid question. [tcdcbr004/23jan17sm]

- Again knowing that people knew ME! Poorer due to lack of funding and the training of personnel who would be at the chalkface/the ones who would be directly in contact with me. [tcdabr005/26jan17sm]
- These should be focused on the service user/patient and take account of our needs. Respite services, therapeutic input, appropriate nursing care to enable people to stay on the island in the final few years of their lives. [tcdabr006/27jan17sm]
- I feel services should be expanded to cover 7 days. I believe Thomson is registered for 7 days at present but can only open 5 days due to staff level. Befrienders and other voluntary lunch clubs should also be developed however I feel they would be of more benefit to ladies and gents without a complex dementia [tcdabr007/27jan17sm]
- accessible office where one can "walk in" and discuss needs and where to access whatever the appropriate support is. need range of highly skilled staff who can work appropriately with wide range of service users, community facilities for social contact and mental and physical stimulation, transport to get there, suitable housing [tcdabr008/28jan17sm]
- GP appointments readily available. Minor treatments here without needing to go off-island. [tcdabr009/30jan17sm]
- It's completely impossible to determine what support I might need in the future, being unaware of what health issues might befall me, but I would like to think day care facilities outside of the home would remain available. [tcdabr010/30jan17sm]
- Day centre offering company, contact with professional services, respite for me and my family, signposting & point of contact to other service. Community care (nurses for routine bloods, blood pressure etc) would visit me. High standard of GP / hospital so that I would only leave the island if necessary - in the 21st century that means outpatient clinics with specialists , a scanner available on the island (either permanent or visiting on a lorry like the breast screen) dialysis [tcdabr011/06feb17sm]
- Appointments being available at doctors ,advice on health issues and being supported by qualified and experienced care providers [tcdabr012/13feb17sm]
- More speedy consultant appointments ,including scans etc. [tcdabr013/13feb17sm]
- Seven day emergency cover and the social cover necessary to provide essential cover when required [tcdabr014/15feb17sm]
- I am currently only 70, healthy and independent. See above for support needed. I would hope there could be a varied range of services available both in the home and at day and residential centres in order to offer the 'person-centred' care that policy talks about. [tcdabr015/16feb17sm]
- In the future I might need the services of Thomson Court Day Centre to help me live better and to give respite time to my spouse. [tcdabr016/20feb17sm]
- Increasing home visits especially support for dementia. Encouraging community involvement to combat isolation. Activity based approach may be expensive financially and in staff time but much needed. A range of provision is required. [tcdabr017/21feb17sm]
- I might require transport if I am no longer able to drive. I may also [tcdabr018/21feb17sm]
- I have very little or no experience with services as I have been reasonably healthy (my parents have died but did not need many services either) so I cannot

say. Basic services like GP, dentist, chemist and emergency overnight stay in a place where there is medical help if I need it. A service of homehelps if I need them. [tcdabr019/22feb17sm]

- Daycare support, any service . In 3 years time will probably need to meet the needs of the clients. [tcdabr020/25feb17sm]
- Local health care clinicians, local hospitals, local care home [tcdabr021/25feb17sm]
- I would need the support of the thomson court [tcdabr022/25feb17sm]
- Day care support.. like any service in 3 years time will properly need to meet the needs of the clients [tcdabr023/25feb17sm]
- Day care support meeting the needs of the clients who use it. [tcdabr024/25feb17sm]
- A place that is run properly by proper paid staff and not for profit. A place where all older people can meet in a warm, safe environment. This is a place that would make older people feel human and not a drain on society. In 3 years it would be a 7day a week service and if the district nurses, dentist, doctors, chiropodist, etc could have 1 day a week and see all the people under one roof, this would improve the health & wellbeing of our ageing people [tcdabr025/25feb17sm]
- There should be a variety of ways care is given. Just in the home does not suit everyone [tcdabr026/25feb17sm]
- Might need full time care in a local residential home as I have no one locally to care for me and there is no local transport network available to go shopping, attend appointments, etc [tcdabr027/25feb17sm]
- Not been stuck in house 247. [tcdabr028/25feb17sm]
- Day care support. In 3 years, services should look like our community cares for dementia patients by maintaining the current level of support- within a designated day centre specific to this need. [tcdabr029/25feb17sm]
- If I am well enough to live on my own then care workers to help me when needed. If I have a condition I would want to be in a place where I can receive specialist care. [tcdabr030/25feb17sm]
- Dole money and tax credits [tcdabr031/25feb17sm]
- Preventative services such as well women/well man clinics; public services and private enterprises that procure food locally supporting local supply chains; investment in business growth/diversification and skills development opportunities; funding support for community transport and local voluntary sector offering engagement opportunities [tcdabr032/25feb17sm]
- Day care services designed to meet my needs [tcdabr033/25feb17sm]
- Warm safe environment that is disability friendly and additional needs friendly. [tcdabr034/25feb17sm]
- Day care support and somewhere to socialise with people [tcdabr035/25feb17sm]
- more health checks regularly at gp [tcdabr036/25feb17sm]
- None [tcdabr037/25feb17sm]
- Day care support, like any service in 3 years time will properly need to meet the needs of the clients. [tcdabr038/25feb17sm]
- A day service, getting me out my house. In 3 years time the possibility of the service being extended to 7 days per week and longer hours to allow more people to attend and also meet the continued needs of the service users which is of vital importance. [tcdabr039/25feb17sm]

- I need a structures service to be available where I can go to recieved company structure routine stimulation and friendship [tcdcbr040/26feb17sm]
- Interaction with othersome and support to keep in touch with the outside world. [tcdcbr041/26feb17sm]
- A care home where I would be with like minded people and not being a burden on my family or friends. I would like to know that the correct support is out there and not just leaving me to rot in my own home as seems to be the case now. In 3 years time I would like to see all pensioners being given better care and support if needed. [tcdcbr042/26feb17sm]
- I may daily or other ad hoc help with certain tasks if my mobility decreases or I experience other difficulties such as loss of sight or hearing. I would also like to be able to interact with my peers regularly but at times of my own choosing. [tcdcbr043/26feb17sm]
- Will simply not be able cope with the already increasingly high demand if these services were to go into community settings. e.g peoples houses [tcdcbr044/26feb17sm]
- The way things are there isn't going to be any care and support. [tcdcbr045/26feb17sm]
- With the present strain on services things will only be worse [tcdcbr046/26feb17sm]
- Personally , at the age of 63 now, and fortunately in Good Health and Work Full Time and will continue to until at least aged 66 - 70 The support I might need will be further ahead than 3 years [tcdcbr047/28feb17sm]

**Q3 We would like to develop a range of community services to support people to stay at home for as long as possible. What services would you like to see developed?**

- A GOOD DEMENTIA CARE TEAM AND RESPITE FACILITIES FOR CARERS ie RELATIVES + FRIENDS + ENIGHBOURS – CARERS CANNOT COPE 24 HOURS 7 DAYS A WEEK WITHOUT SOME RESPITE FROM FULLY QUALIFIED + TRAINED STAFF [tcdcbr001/12jan17]
- Meals on Wheels. Red Cross. Wheelchair Service – all good services [tcdcbr002/12jan17]
- CARERS A PROPERLY TRAINED & THAT THEY HAVE SOME MEDICAL CARE TRAINING [tcdcbr003/12jan17]
- I WOULD LIKE TO SEE THE DAY CENTRE KEPT OPEN, KEEPS PEOPLE TOGETHER & GIVES PEOPLE COMPANY [tcdcbr004/12jan17]
- TO EXTEND THE TIME GIVEN BY CARERS TO INDIVIDUALS AND ALSO THAT THEY ARE PROPERLY TRAINED FOR THEIR DUTIES [tcdcbr005/12jan17]
- CARE IN THE COMMUNITY [tcdcbr006/12jan17]
- CARE IN THE COMMUNITY [tcdcbr007/12jan17]
- A HUB FOR PEOPLE TO VOLUNTEER – OPPORUNTIES FOR PEOPLE TO TRAIN IN DEMENTIA AND WORKING WITH OLDER PEOPLE. TRANSPORT MADE AVAILABLE TO THOSE WHO CANNOT GET AROUND [tcdcbr009/12jan17]
- I can't help thinking that for bed bound folk needing care support at home is not the answer. Who sees to window washing, curtain washing – keeping kitchens

free of insects / vermin. For the bed – bound who cannot afford home clearing help – surely the Annexe should be updated and used and a rise in council tax would help [tcdabr010/12jan17]

- REGULAR ASSESSMENTS OF INDIVIDUAL NEEDS. INCREASE IN LUNCH / SOCIAL CLUBS WHILE PEOPLE CAN ATTEND [tcdabr011/12jan17]
- More accurate info by phone. Home visits [tcdabr012/12jan17]
- AS IN Q2 AND HOME SERVICES SUCH AS PRESENTLY PROVIDED BY ARGYLL CARE AND REPAIR = TRNAPSORT? [tcdabr013/12jan17]
- LOOK AT Q4 SAME ANSWER [tcdabr014/16jan17]
- Preventative measures in place to promote good health. This needs health professionals to communicate / demonstrate these measures. Many individuals need support here, but the long terms value could be considerable [tcdabr015/26jan17]
- TRANSPORT DAY CENTR” [tcdabr017/26jan17]
- KEEP THE THOMSON COURT DAY CENTRE [tcdabr018/26jan17]
- More time given to each individual & a morning call for those who are left alone during the night and are very vulnerable [tcdabr020/26jan17]
- ALL OF THEM – I CANNOT CHOOSE ONE SERVICE ABOVE ANOTHER – THE OUTLYING DISTRICTS NEED HELP AS WELL AS THE MAIN TOWN [tcdabr021/31jan17]
- VISITATION OF OLDER PEOPLE REGULARLY FOR THOSE UNABLE TO LEAVE THEIR HOMES DUE TO INFIRMITY. THIS WOULD HELP TO PREVENT LONLINESS + ISOLATION [tcdabr022/13feb17]
- DEMENTIA DAY CENTRE ON THE ISLAND WITH STAFF WHO HAVE HAD DEMENTIA TRAINING. ALSO MORE HOSPITAL BEDS FOR OUR AGEING POPULATION INSTEAD OF TAKING OFF THE ISLAND RESIDENTS WHO HAVE SPENT THEIR LIFE HERE A GOOD CARE HOME WOULD BE WELCOME HER TOO [tcdabr023/13feb17]
- Social stimulus – Day Centre with staff both at the centre and Home Care receiving Dementia training. Good O.T. service. Home carers to spend time with meal preparation, as well as wash & dress. Also clothes wash [tcdabr024/14feb17]
- New Care Home + Nursing Home adequately staffed + Care Home for Dementia Sufferers [tcdabr025/20feb17]
- The same as present. [tcdabr026/20feb17]
- As above! [tcdabr027/20feb17]
- Some care in the home depending on needs and again much social care out with the home to meet & communicate with people. [tcdabr028/20feb17]
- District nurse expansion & support. Carer support groups & respite facilities [tcdabr029/20feb17]
- Home visits for healthcare & social services when required and more social activity groups to help the infirm and frail people in the community [tcdabr030/20feb17]
- Chosen friendships, depending on individual conditions, requirements, knowledge so that it can be shared [tcdabr031/20feb17]
- Day hospital (perhaps as previously in Vic. Annexe) Day centre (as in Thomson Court) extension of time available to care Plus etc carers during home visits. [tcdabr032/20feb17]
- AS MUCH WELFARE CARE AT HOME AS POSSIBLE [tcdabr033/20feb17]



- Transport. Day Centres with events geared towards people with different physical & mental health needs. Fitness classes, lunch clubs, support groups [tcdcbr034/20feb17]
- Medical care visits as necessary. Regular transport to cover shopping / visits to local amenities [tcdcbr035/20feb17]
- THE 'BANK' OF CARERS SO THERE IS PLENTY OF SUPPORT AVAILBLE TO COVER DEMAND [tcdcbr036/23feb17]
- HAVE RESERVATIONS ABOUT CARE IN THE COMMUNITY, BELIEVING IT IS AN INEFFICIENT METHOD OF PROVIDING THE SERVICES REQUIRED BY THE ELDERLY. WE NEED A NEW PURPOSE BUILT FACILITY TO REPLACE THOMSON COURT [tcdcbr037/23feb17]
- I would rather see the money being spent on providing full care rather than lots of ancillary care services [tcdcbr038/23feb17]
- AS Q2 [tcdcbr039/23feb17]
- I would like to see more services based on the island with Consultants' clinics etc retained at the Victoria Hospital. [tcdcbr042/27feb17]
- Possibly encouragements to stay active. For instance, perhaps help to produce own meals from raw materials. Not microwaving pre-processed food. – tcdcbr044/28feb17]
- The respite services provided by the Thomson Day Care Centre is vital to keeping certain patients in their own home. [tcdcbr046/01mar17]
- A return to the original concept of a 'Home Help' - a service where individual workers could use a bit of initiative, maintain a set hygiene standard but allow time to support well being e.g. sitting with someone while they eat their meal, time to simply socialise, escort to shops, discuss the daily news - only limited by the imagination (and supervisory support) of the worker. [tcdcbr001/16jan17sm]
- Ideally I'd like my daughter to be around to make sure I'm safe and sound in my old age. We can speak by phone or even use 'FaceTime' but she cannot be physically present other than on holiday visits. I don't relish the idea of ever having to leave Bute to go and live near her. I doubt if she fancies that idea much either. So that's the worry. I don't know what format of 'services' do or could exist to respond to that. [tcdcbr002/18jan17sm]
- Someone who will have time to chat and who can be trusted. [tcdcbr003/19jan17sm]
- Pay care staff decent wages and allow them to spend more that 10 minutes a visit to care for elderly people in their own homes. Care at home services need to be properly funded to attract good carers. Care at home is more than just a quick visit to do the bare minimum of personal care. When unpaid carers need a break they need residential services for their loved ones here on the island close to home. [tcdcbr004/23jan17sm]
- Transport to and from day care centres where I would be in contact with others to participate in social activities. [tcdcbr005/26jan17sm]
- Nursing care Dementia care Respite care Access to day centres out of the house [tcdcbr006/27jan17sm]
- early identification before social isolation and reduced mobility set in, invitation to join in a range of provision that assists folk to keep going as long as possible - clubs, transport to shops, exercise facilities, opportunity and assistance to move to more suitable accomodation [tcdcbr008/28jan17sm]
- Day centres with activities to stimulate both mind and body. Not just for those with fully developed dementia but for all who wish to attend (including those attending

as volunteer assistants). No objection to a payment being required for these services, though preferably with some form of means-tested assistance.  
[tcdcbr009/30jan17sm]

- Not knowing what range of services already exist makes it impossible for me to comment. [tcdcbr010/30jan17sm]
- In addition to above, carers with enough time and availability to make visits through the day and even night [tcdcbr011/06feb17sm]
- Social and educational facilities being available more collaboration with college ,health board and schools [tcdcbr012/13feb17sm]
- Diet and exercise,conveying one elderly old friend until another old friend. [tcdcbr013/13feb17sm]
- Depending on the degree of need - Grocery shopping, Home help, home care, (cooking/washing etc), dental, chiropody, regular visits [tcdcbr014/15feb17sm]
- I don't know enough about what is and is not currently available. But in my view, services should include the opportunity for socialising and not be confined to home visits to individuals. [tcdcbr015/16feb17sm]
- Home visits by a range of health service professionals, and more community-based activities for the elderly and infirm. [tcdcbr016/20feb17sm]
- Health Centre, Hospital, Thomson Home and other centres required. These services should be island based where possible. A Hub and Spoke system. [tcdcbr017/21feb17sm]
- Day centre is a must. Specially trained staff for dementia patients should be considered and perhaps a separate area for those who are well to meet and have group discussions, keep fit classes etc. [tcdcbr018/21feb17sm]
- Homehelps to assist with day to day living, i.e help with keeping the home clean, including washing of clothes etc and probably personal care. Perhaps a person who can help with all the form filling, including tax forms or gas/electric billing. [tcdcbr019/22feb17sm]
- Thomson court dementia daycare.. expand this service to be open 7 days outreach if required. [tcdcbr020/25feb17sm]
- Proper qualified people taking care of vulnerable people in their homes, more money invested into these services. Respite care [tcdcbr021/25feb17sm]
- I would like the respite for the carer at home [tcdcbr022/25feb17sm]
- Thompson Court Dementia Day Centre... expand this service, open 7 days, outreach if required [tcdcbr023/25feb17sm]
- Thomson court dementia day care centre, expand to 7 days a week, have an outreach programme. Trained qualified staff. [tcdcbr024/25feb17sm]
- People need to socialise and sure it must be more cost effective to have them all in one place for lunch & ,dinner than have people running all round the island sometimes 4 times a day [tcdcbr025/25feb17sm]
- Services to get people out of their homes, more befriending [tcdcbr026/25feb17sm]
- Living in a remote area of Argyll & Bute, the geography of the area does not allow for affordable community services to be adequately provided. It would cost a lot more to develop a range of community services in my local area than it would to keep people all together in a home. Most of the service developers would spend their time travelling instead of using it to support people. [tcdcbr027/25feb17sm]
- Would like to see these people taken out and being in company of other. If it's a tea dance. Bingo. Day center. People need this [tcdcbr028/25feb17sm]

- People who stay at home become isolated, so unless the community services plan is to provide the same amount of hours support per person that a day centre can, this idea falls flat! A few minutes per day is no substitute for what is currently on offer. It is much more economical to have all service users in one place, less isolated and with people their own age. Residential schools for the disabled were shut down and the residents "integrated" into society where a lot of them swiftly removed themselves again by breaking the law and being sentenced to a term in prison suggesting that even being in jail is better than being stuck at home just living for the next visit. Thomson court dementia day centre..expand this service, open 7 days, out reach if required. [tcdcbr029/25feb17sm]
- Groups for elderly people to meet up to help combat loneliness and carers going to see an elderly person everyday who is able to help and give support. [tcdcbr030/25feb17sm]
- The shelters back for drinking in [tcdcbr031/25feb17sm]
- learning & development in local professionals so that they are more confident in making decisions locally; community transport for on island events and activities; and off island non-medical services; family services that support increased awareness, access and engagement in successful transitions from school to work; from healthy to critical illness; from work to retirement; from unemployment to work; crucially services that empower people to retain decision making about their own circumstances. [tcdcbr032/25feb17sm]
- Thomson day care services expanded to 7 days a week [tcdcbr033/25feb17sm]
- More carers visiting homes, more day activities for elderly, more activities that are elderly friendly. [tcdcbr034/25feb17sm]
- Keep Thomson court dementia day centre...expand the service and provide 7 days a week [tcdcbr035/25feb17sm]
- more help for the elderly in their own home or a local hospital for the elderly [tcdcbr036/25feb17sm]
- More child support [tcdcbr037/25feb17sm]
- Thomson court dementia day centre, expand this service open 7 days, and out reach if required [tcdcbr038/25feb17sm]
- Thompson Court Dementia Day Centre. Day services are vital for social interaction and mental stimulation as opposed to a few drop ins per day at home which is not sufficient to the needs of the service users. [tcdcbr039/25feb17sm]
- I want to see thomson dementia day centre expanded. I want to be able to enjoy the sensory garden. I want the option of 7 days and I would like the option of outreach with fully trained registered staff who are working within the national care standards and accountable to the care inspection team [tcdcbr040/26feb17sm]
- More personal time with each person. [tcdcbr041/26feb17sm]
- The ones where the carers don't just pop in and out and fill in a form to say they have been there, even though they have a time slot of 1/2 - 1hrs and don't take the patient to the toilet, instead the patient is left in dirty nappies until the next shift, and God help them if the next shift can't be bothered either. [tcdcbr042/26feb17sm]
- I would like to see personal support at home for those who need it but not just for the necessities. I would like to see an element of social support built in to help in situations where there are no family members or friends to provide that social interaction. [tcdcbr043/26feb17sm]

- Keeping services such as dementia services in day centres and not a few hours a week at home will enable to keep rest bite for carers. More rest bite days for carers, access to health services, befriender schemes ect [tcdabr044/26feb17sm]
- Care in the community. Care and support in home. Place for when care in home no longer viable but local for family and visitation. [cdabr045/26feb17sm]
- Dementia care and general care for the elderly [tcdabr046/26feb17sm]
- See Question 4 [tcdabr047/28feb17sm]

#### **Q4 What day care services would you like to see developed on Bute?**

- DEMENTIA CARE FACILITIES. MEALS ON WHEELS – These could be made at the local schools LUNCH CLUBS FOR THOSE FIT ENOUGH TO ATTEND. DAY CENTRE TO HELP SLOW DOWN THE DELINE IN BRAIN CELLS. MORE WEEKEND FACILITIES [tcdabr001/12jan17]
- Day care centre needs to be expanded. Staff are specialised and know how to deal with dementia. Brilliant staff. Befrienders good but different [tcdabr002/12jan17]
- AS ABOVE & A DEMENTIA UNIT WHERE YOU ARE NOT JUST PUT IN & FORGOTTEN ABOUT. WHERE PEOPLE ARE STIMULATED [tcdabr003/12jan17]
- MUSIC GROUP WITH INSTRUMENTS. SINGING. RANGE OF ACTIVITIES. GET YOUR FEET DONE, COOKING, SOMETHING TO STIMULATE MIND, DANCE, EXERCISE [tcdabr004/12jan17]
- WANT TO AT LEAST KEEP WHAT WE HAVE AND EXTEND IT [tcdabr005/12jan17]
- VOLUNTEERING [tcdabr006/12jan17]
- VOLUNTEERING [tcdabr007/12jan17]
- Happy with Thomson Court. Gives confidence that he will be looked after when wife goes out shopping etc. Must be a centre [tcdabr008/12jan17]
- A STATE OF THE ART DAY CARE CENTRE. WITH TRAINED STAFF. HOME BEFRIENDERS – POSS TRAINED VOLUNTEERS. RESIDENTIAL CARE HOME FOR RESTBITE ETC ON BUTE [tcdabr009/12jan17]
- Perhaps people at different stages of dementia could be catered for in different rooms – with different programmes [tcdabr010/12jan17]
- AS ABOVE. FIRSTLY DAY CLUBS TO RELIEVE CARERS OF VERY DEMANDING RELATVES, BUT ALSO FROM SOCIAL POINT FOR THOSE WITH NO RELATIVES, THOUGH NOT DEMENTED [tcdabr011/12jan17]
- COMFORT OF A DAY CARE CENTRE FOR SOCIAL INTEGRATION, ENTERTAINMENT AND EXERCISE ACTIVITIES PHYSICAL AND MENTAL
- A BETTER SYSTEM BY WHICH DEMENTIA SUFFERERS ARE NOT IGNORED OR MISSED [tcdabr014/16jan17]
- Day care for dementia sufferers. Some form of meeting place for the elderly population where they can socialise / learn new skills / pen on their own skills – or take some form of pleasurable exercise [tcdabr015/26jan17]
- This service is most important both to the person attending the centre and equally to the carer who has some valuable 'me' time [tcdabr016/26jan17]

- DAY CARE (eg THOMSON COURT) for sufferer of dementia. A CENTRE FOR PEOPLE TO MEET OTHERS FOR SOCIAL / RECREATIONAL ACTIVITIES / WALKING GROUPS / SWIMMING / CINEMA [tcdcbr017/26jan17]
- MORE OPPORTUNITY FOR OUTINGS TO ENABLE PEOPLE TO INTEGRATE WITH THE LOCAL COMMUNITY eg. TO BE TAKEN SHOPPING TO ENABLE THEM TO ORGANISE THEIR OWN DIET [tcdcbr018/26jan17]
- Provision for mental health [tcdcbr019/26jan17]
- More places for people to spend time out of their homes during the day respite for family [tcdcbr020/26jan17]
- THE CARE HOME THAT WAS TO BE BUILT ON BUTE BUT WAS NEVER FINISHED [tcdcbr021/31jan17]
- PROVISION OF GENERAL CARE CENTRE FOR ALL OLDER PEOPLE AT LEAST 5 DAYS PER WEEK. PROVISION OF TRANSPORT TO THE CENTRE [tcdcbr022/13feb17]
- DEMENTIA DAY CENTRE LOCALLY TO GIVE STIMULUS TO PATIENTS AND RESPITE FOR CARERS. MAYBE WEEKEND ART & CRAFT THERAPY. SINGING AND SPECIAL SHOWER & TOILET FACILITY AVAILABLE FOR SAY RESIDENTS WITH A QUIET ROOM [tcdcbr023/13feb17]
- Special dementia Day Care Centre to give stimulus to patients and respite for carers. Perhaps with weekend art & craft therapy. Special shower & toilet facility available for day Patients [tcdcbr024/14feb17]
- larger dementia service essential [tcdcbr025/20feb17]
- Further develop of the Day Care Centre at Thomson Court [tcdcbr026/20feb17]
- A development of the current Day Care Centre at Thomson Court which offers a great facility for both patient and carer! [tcdcbr027/20feb17]
- The Thomson Court Day Centre offers a fantastic service to people on Bute for both the patient & their carers. [tcdcbr028/20feb17]
- Care of elderly Care of Carers Palliative care [tcdcbr029/20feb17]
- Day care for dementia sufferers that provide mental & physical stimulation & give respite to carers, also mental health services & day care for people with other debilitating conditions [tcdcbr030/20feb17]
- Have a large room which can be divided into applied subject requirements Games, music, quiz, singing, etc. etc [tcdcbr031/20feb17]
- See Q3. Old ideas e.g. Friendship Club, Lunch clubs. (Probably too many groups are currently relying on Volunteers.) [tcdcbr032/20feb17]
- DAY CENTRES LUNCH CLUBS EXERCISE CLASSES [tcdcbr033/20feb17]
- Services which allow people to go to things outwith their own home. As above, exercise classes, lunch clubs, dancing, card game meetings. Parkinson's support [tcdcbr034/20feb17]
- Visiting arrangements for those who don't have immediate family / friends on the Island & spend many hours with no company [tcdcbr035/20feb17]
- DAY CENTRES ARE REQUIRED TO STIMULATE THE MIND AND PROVIDE LIGHT EXERCISE TO KEEP ELDERLY PEOPLE ACTIVE [tcdcbr036/23feb17]
- SEE ABOVE. IT IS IMPERATIVE TO REMEMBER THAT BUTE IS AN ISLAND BEING IN CARE IN A MAINLAND HOME, NO MATTER HOW GOOD IT MAY BE, POSES PROBLEMS OF VISITING FOR RELATIVES, DEPENDING ON FERRY SERVICES & THE WEATHER MEANS THAT IN THE EVENT OF AN EMERGENCY, THEY MAY BE PROHIBITED FROM VISITING FOR MANY HOURS [tcdcbr037/23feb17]
- Continued day care at the Thomson Court [tcdcbr038/23feb17]

- DAY CARE CENTRE WHERE PEOPLE CAN COME TO MEET MAYBE WITH A CUP OF TEA TO CHAT AND SOCIALISE. LONLINESS IS A VERY REAL FEELING IN OLDER PEOPLE WHO LIVE AT HOME ON THEIR OWN. [tcdabr039/23feb17]
- I would like to see dementia services, wellness clinics and lunch clubs for people who need supported. [tcdabr042/27feb17]
- Possibly central day care where minds are still challenged and physical activity is encouraged [tcdabr044/28feb17]
- Transport from your house to go and meet up with others who live alone. [tcdabr045/01mar17]
- Respite for dementia patients. These are ill patients who need most supervision. They cannot be left unsupervised. [tcdabr046/01mar17]
- It is vitally important that whatever day care is provided there should be separate days / facilities for the physically frail and those with dementia. Basics needed - warmth, company, transport and accessibility, benefit checks, bathing / hairdressing / chiropody, opportunity for socialising / learning / activity, a place where the older person's voice can be heard. The services need to be flexible in their content - over time the needs and abilities of individuals and groups will change. All day care should be provided on 7 days per week - depending on an individual's needs and choices most people would choose only a few days attendance. It is essential that the carers of people with dementia should be able to access day respite on weekends as well as weekdays. [tcdabr001/16jan17sm]
- If, like me, you have no personal or family experience of what you mean by 'day care services' it's difficult to come up with a list of the people and skills that would help. Call the services whatever you health & social care language practitioners prefer - it's how they all add up to a response to the above problem that counts. [tcdabr002/18jan17sm]
- Group sessions that focus on both physical and mental activity. [tcdabr003/19jan17sm]
- Thomson Court should remain available to the people of Bute. It is a lifeline for unpaid carers and those we look after. A safe, well-staffed local resource is essential. Care at home services only work if there are opportunities for unpaid carers to have short breaks too. People with dementia and people who have high physical care needs should have choice and so should their unpaid carers and family members. [tcdabr004/23jan17sm]
- A large enough building to accommodate the various activities under the one roof. No need for a new build as there are various empty buildings on Bute to cover this. With space to have outdoor activities in the summer. [tcdabr005/26jan17sm]
- A combination of home based services (home visits) but also at day centre to encourage/support people to get out of their houses, a change of scenery, alleviate loneliness.. [tcdabr006/27jan17sm]
- I would like to see dementia day care provided 7 days per week at thomson which is an environment where my mother can socialise with peers and also recieved the care, support and stimulation she needs to help her stay at home for as long as possible. I feel a befriending service is very good and has its place for those who wish some company and to get out and about with assistance for a few hours here and there and get some company however I feel for families like mine who are struggling to hold down jobs, kids at school and care for a family member who has very complex needs day care in its existing format should be

developed not reduced. The staff are extremely well trained and experienced. The voluntary sector do not have to conform to the same regulations as this local authority service which greatly worries me. I know the care inspectorate inspect such services regularly. How would the voluntary sector be regulated?  
[tcdabr007/27jan17sm]

- activities that are of genuine interest to people but also allow for whatever is the purpose of the daycare - meals, social contact, exercise, good staff who can identify as early as possible the signs that someone may need help so attendance at the activities needs to be for a range of needs - from someone saying they feel lonely (maybe on the death of a long time partner before depression and neglect sets in )or are first diagnosed with a degenerative condition. Places where people can relax and have support.  
[tcdabr008/28jan17sm]
- See 3 above [tcdabr009/30jan17sm]
- As Q.3. [tcdabr010/30jan17sm]
- Mental health, dementia and palliative care are all significant health / social problems. I would like to see day care services developed to support patients and their carers with these problems. A 'treatment centre' might allow interventions e.g. some less invasive chemotherapy regimes, less invasive diagnostic procedures - to be carried out on the island [tcdabr011/06feb17sm]
- Phoenix centre ,thomson court ,more clubs for educational uses and for all ages and abilities .more community care homes and centres .Too many elderly people are isolated [tcdabr012/13feb17sm]
- Workshops for the elderly and outside playground for elderly.  
[tcdabr013/13feb17sm]
- Encourage mental stimulation in providing a place for the elderly and lonely to meet and have something to look forward to on a regular basis. Provide a centre for dementia patients to meet and most of all to give carers respite from 24/7 care duties [tcdabr014/15feb17sm]
- The continuation of the excellent work done at Thomson Court. I take the point that there is a wish to offer services to all potentially isolated elderly whether or not experiencing dementia. I would want to be assured that any savings made by closing the day centre would be used to enhance the level of care provided in the home. 15 minute visits for example are totally unacceptable.  
[tcdabr015/16feb17sm]
- Thomson Court Day Centre should be developed and expanded rather than closed. In future years there will be more and more people on Bute who will require and benefit from this service for sufferers of dementia. It could be expanded to also help people with other conditions like stroke, Parkinson's Disease and other disabling conditions that affect the mind and body. The benefits of getting together with other people in a caring and professional setting and sharing in activities or getting necessary help for living a better life far outweigh the funds saved by cutting out this service. [tcdabr016/20feb17sm]
- An ageing and longer-living population needs support with regard to independent life. The increase in older people with dementia problems will need considerable investment in developing the skills of support staff and crucially in supporting carers. [tcdabr017/21febsm]
- Transport for the elderly to take in any appointments. Lunch Club. Day trips away or short Island trip for those who are unable to be away for an extended period.  
[tcdabr018/21feb17sm]

- I am sorry but I have no idea, I do not really know what day care is apart from what Thomson Court provides. [tcdcbr019/22feb17sm]
- Thomson court dementia day centre [tcdcbr020/25feb17sm]
- Respite care, dementia care, daycare for lonely people, daycare for frail people [tcdcbr021.25feb17sm]
- Daily clubs [tcdcbr022/25feb17sm]
- Thompson Court Dementia Day Centre [tcdcbr023/25feb17sm]
- Thomson court dementia day centre [tcdcbr024/25feb17sm]
- Day care for all who want to attend. This would give people a social life. [tcdcbr025/25feb17sm]
- A local place where any person not just with dementia can go [tcdcbr026/25feb17sm]
- Continue with Thomson Court as it stands and if you have funds you can provide extra day care services. If it works well, Thomson Court, why change it!! What day care services are available to be developed? [tcdcbr027/25feb17sm]
- Thomson home not to be shut. This has been a great asset to bute take that away ur as well locking all the old dears up in a cell as that's what it would be like for them not seeing friends n people who care for them weather they remember them or not it's getting them out of being stuck in there home. Not a way to live. [tcdcbr028/25feb17sm]
- Thomson Court dementia day centre. [tcdcbr029/25feb17sm]
- Centre for elderly people to meet up and be able to speak to each other and health professionals should they have queries about their health. Exercise classes for elderly people. Mental health nurses in the community who can help people with dementia or alzheimers. [tcdcbr030/25feb17sm]
- Home brew delivery service [tcdcbr031/25feb17sm]
- Community transport utilising mini buses currently on island; lunch clubs based at the schools to support crossgeneration interaction and make best use of existing resource; social clubs that recognise real habits based in enterprises such as Printpoint (readers group); Black Bull (pint and a punt); Bute Produce (grow your own) [tcdcbr032/25feb17sm]
- Thomson court dementia day care & day care centres for autism [tcdcbr033/25feb17sm]
- Activities [tcdcbr034/25feb17sm]
- Thomson court day centre [tcdcbr035/25feb17sm]
- day centres for the elderly [tcdcbr036/25feb17sm]
- Anything as there is not a thing to bring people to the island [tcdcbr037/25feb17sm]
- Thomson Court Dementia Day Centre. [tcdcbr038/25feb17sm]
- Thompson court Dementia Day Service. [tcdcbr039/25feb17sm]
- Thomson court dementia day service. I feel there should also be services for isolated elderly people who do not have dementia. This should not be at the expense of the dementia day centre [tcdcbr040/26feb17sm]
- More community involvement. Outings and visits to a meeting place to see other people to socialise. [tcdcbr041/26feb17sm]
- Day care for all pensioners [tcdcbr042/26feb17sm]
- See my previous answer. I would like to see more provision for social interaction which is responsive to the changing needs of users. [tcdcbr043/26feb17sm]



- Continued day care dementia centre and disability day centre. More focus on respite days for carers. Information centres held locally for family and friends of sufferers of dementia ect. [tcdcbr044/26feb17sm]
- Lunch clubs. Counselling. Company for elderly in the community. Possibility of outings for patients and own home patients. [tcdcbr045/26feb17sm]
- Dementia care have [tcdcbr046/26feb17sm]
- Total expansion of existing services. I think it is vital for ones self esteem and mental health . That there are facilities to take people out of there own homes for a day or even a few hours. Many people , due to an illness , or just natural ageing , begin to loose contact with the " outside world" I feel it is vital that when that happens " we " offer then transport to help them get there and a place to go , whether to give then the opportunity to chat and have a cuppa, or help because of a medical condition. [tcdcbr047/28feb17sm]

**Q5 How do we increase confidence in community services to ensure they meet your needs?**

- A FULLY WORKING THOMSON COURT INCLUDING DEMENTIA CARE, RESIDENTIAL CARE, MENTAL HEALTH FACILITIES THOSE IN CHARGE NEED TO REMEMBER THAT THIS ELDERLY COMMUNITY IS GETTING OLDER + OLDER AS WE ARE LIVING LONGER [tcdcbr001/12jan17]
- Respite to carers is pivotal to the carers. Have a greater capacity to cope as carer [tcdcbr002/12jan17]
- THAT PEOPLE ARE PROFITIENLY TRAINED TO MEET PEOPLES NEEDS [tcdcbr003/12jan17]
- SUPPORT. INFORMATION GIVEN TO YOU VERBALLY NOT LEAFLETS [tcdcbr004/12jan17]
- TO REALISE THAT THERE COMES A TIME WHEN PEOPLE REQUIRE MORE THAN COMMUNITY SERVICES AND WLL REQUIRE RESIDENTIAL CARE ON THE ISLAND NOT TRANSFERRED OFF ISLAND [tcdcbr005/12jan17]
- LEADERSHIP / CO-ORDINATION [tcdcbr006/12jan17]
- LEADERSHIP / CO-ORDINATION [tcdcbr007/12jan17]
- Confident in current services [tcdcbr008/12jan17]
- INFORMED PEOPLE / TRAINED PEOPLE / A PURPOSE BUILT DAY CARE CENTRE [tcdcbr009/12jan17]
- The people working in community services must be assured that their jobs and pay would be secure/ From that clients would receive the best care – and by word of mouth – the Bute community’s confidence would be positive [tcdcbr010/12jan17]
- MORE TRAINING FO CARERS, NOT JUST TO DEAL WITH PHYSICAL NEEDS, BUT TO BE AWARE THEIR CLIENTS ARE ADULTS [tcdcbr011/12jan17]
- Accurate reliable info – on benefits + health care [tcdcbr012/12jan17]
- THE COMFORT OF KNWOING FACILITIES AVAILABLE IF REQUIRED – BOTH DAY AND \*TWENTY FOUR HOUR CENTRES [tcdcbr013/12jan17]
- WE NEED DAY CARE CENTRE FOR PEOPLE WHO ARE NOT SUFFERING FROM DEMENTIA BUT HAVE PHYSICAL DISABILITIES COULD GO TO. A CENTRE FOR COMPANY. THEY NEED SOCIAL CONTACTS [tcdcbr014/16jan17]

- They need to be seen to work. They need to reflect what the use finds useful. Time restraints and money often restrain good caring people from giving the service they would like to give [tcdabr015/26jan17]
- Consult families about proposed plans – not just final notice given via local paper [tcdabr016/26jan17]
- THEY NEED TO MEET THE NEEDS EXPRESSED BY THE COMMUNITY. THE SERVICE PROVIDERS NEED TO LISTEN [tcdabr017/26jan17]
- THAT OUR VOICES WILL BE HEARD [tcdabr018/26jan17]
- Updates on what is available example escort to hospital appointments, and help maybe to reassure one is being listened to, more care beds available on the island [tcdabr020/26jan17]
- HEALTH CENTRE SHOULD MAKE OLDER PEOPLE AWARE OF WHAT SERVICES ARE AVAILABLE. RESPITE CARE FOR DEMENTIA PATIENTS TO GIVE CARERS A BREAK [tcdabr022/13feb17]
- DISCUSS PROBLEMS AND TOGETHER COME UP WITH SOLUTIONS. THE PRESENT 3 WK BIN COLLECTION IS UNPLEASANT IN WINTER BUT WILL BE HORRENDOUS IN SUMMER [tcdabr023/13feb17]
- A good meeting place to discuss problems with others and a good link worker to come up with a solution [tcdabr024/14feb17]
- Well trained Care Staff [tcdabr025/20feb17]
- What we are receiving at the moment. [tcdabr026/20feb17]
- Similar to what my parents receive at present from both Care Plus and Thomson Court Centre which give great confidence in these services. [tcdabr027/20feb17]
- Both Care Plus and Thomson Court Day Centre, also the Befrienders depending on the Patients needs. [tcdabr028/20feb17]
- Health Board – accessibility [tcdabr029/20feb17]
- That the public are consulted and informed and elected councillors are consulted. [tcdabr030/20feb17]
- Too big a subject to write here. We would need to have a list, + comments [tcdabr031/20feb17]
- Adequate respite care, residential care, medical assistance in addition to home / family carers ... Adequate assistance with adaptations in people's homes. [tcdabr032/20feb17]
- AS MUCH INVESTMENT AS POSSIBLE WE MUST CARE FOR OUR ELDERLY [tcdabr033/20feb17]
- Actual support not totally or mainly reliant on volunteers. Any volunteers being used need to be fully trained & regulated. [tcdabr034/20feb17]
- Regular information about the proposals for changes [tcdabr035/20feb17]
- BY PROVIDING A RELIABLE TEAM OF CARERS IN SUFFICIENT NUMBERS TO COVER THOSE IN NEED [tcdabr036/23feb17]
- IN THE NATURE OF THINGS, CARE WORKERS OPERATE UNSEEN MAY BE GOOD, BAD OR INDIFFERENT. WORKING IN A CARE HOME SITUATION HOWEVER, UNDER PROFESSIONAL MANAGEMENT, ANY DEFICIENCIES WOULD SOON BECOME APPARENT. THESE COULD EITHER BE RECTIFIED OR THEIR APPOINTMENT TERMINATED [tcdabr037/23feb17]
- Despite all the care services there is still an urgent need for care round the clock – as in a home. [tcdabr038/23feb17]
- A RELIABLE TEAM OF CARERS WHO CAN VISIT REGULARLY AND FOR A TIME NECESSARY TO HELP THE INDIVIDUAL [tcdabr039/23feb17]

- Need to be sure that services will continue and not be stopped for budgetary reasons. [tcdcbr042/27feb17]
- A care home on the model of the Annexe which should not have been closed. [tcdcbr043/28feb17]
- Whatever scheme is implemented, there must be a safety net in existence, so that the elderly with multiple health problems are left in unsuitable accommodation for most of the day and night. An accident with bad consequences will happen. There must be some form of 24 hour care at a stage. [tcdcbr044/28feb17]
- Listen!!! and be seen to adapt to particular local needs. Where there is only one day care service on an island the decision to close that is appalling and totally perverse. The offer of replacement with a 'befriender service' is risible. [tcdcbr001/16jan17sm]
- If I routinely heard good reports that elderly people were well looked after on Bute I'd certainly be reassured. [tcdcbr002/18jan17sm]
- Publish and shout about success! [tcdcbr003/19jan17sm]
- Long term funding. Better wages for care staff, better assessment and management processes. [tcdcbr004/23jan17sm]
- Try to take on board all the suggestions that have been put to you in your open days and act on them. [tcdcbr005/26jan17sm]
- Firstly, have some respect for the community you serve! Consult properly, listen to the views of the community, and tailor services to meet the needs of the community. No more of these sham "consultations" and then lots of waffle from staff/board members/councillors trying to justify the unjustifiable. [tcdcbr006/27jan17sm]
- By expanding services which are essential instead of threatening to reduce and replace with a few hours a week befrienders. [tcdcbr007/27jan17sm]
- If the finances only allow the total package of care to be a few very short visits a day to attend to the bare necessities of life that is all the confidence I will ever have in the services. We need a great deal more spent on the whole provision for me to think that community services will be able to offer any more and meet more than being fed and changed [tcdcbr008/28jan17sm]
- Co-ordination of services (including voluntary). Easily-accessible information about what is available. Locally-based control of services. [tcdcbr009/30jan17sm]
- Ensuring carers are provided with respite opportunities themselves, made available via the existence of a day care centre, is essential to both the carers' well-being and the well-being of the individuals they care for. That provision would most certainly help maintain "confidence in community services". [tcdcbr010/30jan17sm]
- Meaningful patient involvement. Joined up service management with protected time for professionals to meet and communicate. Open governance mechanisms - to ensure this is happening and patients or even services are not sidelined for 'professional' convenience. [tcdcbr011/06feb17sm]
- Have more beds available locally ,doctor surgeries being open till 6 [tcdcbr012/13feb17sm]
- Put more moneys and staff in NHS,who can happily go to peoples houses. [tcdcbr013/13feb17sm]
- This consultation exercise is a start but certainly we do not want to be closing facilities down until good alternatives are in place. You need to give assurances

that any existing services will not be diluted or moved off the island..

[tcdabr014/15feb17sm]

- Avoid jargon and PR. The 'redesign' document says 'we need to be honest' about 'value for money' etc. It is not possible for a person not directly involved in policy to know whether this is in fact the main driver. [tcdabr015/16feb17sm]
- By thinking about the needs of the community now and in the future rather than on how to cut the budget, and by consulting with elected officials, the public and medical professional before making final decisions with long-term consequences. [tcdabr016/20feb17sm]
- Good information and easy communication. People have to be confident they will be listened to and action is as fast and responsive as possible. [tcdabr017/21feb17sm]
- I would like to have at hand a printed detail of all help available with detailed cost for each service. Respite is very very important for carers and I would like to see this expanded. [tcdabr018/21feb17sm]
- Easy to contact, no long waiting times or lists, working efficiently. [tcdabr019/22feb17sm]
- Listen to the community carers professionals & clients families [tcdabr020/25feb17sm]
- Save the services that are already in place and working well. Investing money and dedicated trained qualified staff. [tcdabr021/25feb17sm]
- Put your plans into action [tcdabr022/25feb17sm]
- Listen to the community carers professionals and the clients families [tcdabr023/25feb17sm]
- Listen to the clients, carers, families and professionals who use this centre. [tcdabr024/25feb17sm]
- Stop having people on crap wages and give them time to do their job. Having a place available 7 days a week for the elderly to go and have hot meals and be cared for must be at the forefront of the survey [tcdabr025/25feb17sm]
- Not just decide to stop a service that is needed in the community and assume befriending suits all situations [tcdabr026/25feb17sm]
- Carry out a trial period providing community services, while still keeping Thomson Court open to residents, and assess its success honestly. No cover ups with results as happens too often. [tcdabr027/25feb17sm]
- Help more stop doing cuts . Find cuts in the big people s pockets cut their wages see more into helping these people. [tcdabr028/25feb17sm]
- Listen to the community, care professionals and the clients' families. [tcdabr029/25feb17sm]
- The only way to increase confidence is for the services to do what they say they are going to do. Stop closing care homes and sending people off the island when all their family lives on the island. [tcdabr030/25feb17sm]
- Get white lightning and eldorado back [tcdabr031/25feb17sm]
- More time listening, accepting feedback and reflecting back; [tcdabr032/25feb17sm]
- Listen to clients and carers and professionals involved and ensure decisions are not solely based on finance! [tcdabr033/25feb17sm]
- Unsure [tcdabr034/25feb17sm]
- Listen to what the community, carers and service users want [tcdabr035/25feb17sm]
- by keeping and improving the services we have [tcdabr036/25feb17sm]

- Encourage less laziness in the community [tcdabr037/25feb17sm]
- Listen to the community carers, professionals and the clients families. [tcdabr038/25feb17sm]
- By listening to the concerns from community carers, service users families and other health professionals. [tcdabr039/25feb17sm]
- By being truthful instead of being underhand. This whole episode has been a disgrace. The figures used have been twisted to provide the public with false information to allow the ijb to close this service [tcdabr040/26feb17sm]
- Keep asking the people who care. [tcdabr041/26feb17sm]
- Employ the correct people with the right qualifications. [tcdabr042/26feb17sm]
- By engaging with service users at each stage in the process and then simply delivering what they need. [tcdabr043/26feb17sm]
- As a community worker I strongly believe that there is no confidence and will not be any confidence in community services in the future. I also believe that to increase confidence in these services all plans need to be scrapped and looked at again with full public involvement. [tcdabr044/26feb17sm]
- They need more money and support to run efficiently for proper care and support. [tcdabr045/26feb17sm]
- Have honest discussions concerning any plans regarding local care needs [tcdabr046/26feb17sm]
- By listening to the concerns of community , then physically being seen to do something about them. [tcdabr047/28feb17sm]

**Q6 Do you have any ideas, concerns or questions about how we redesign services to move away from hospital to community based services?**

- MORE TRAINED COMMUNITY STAFF. MORE TRAINED MENTAL HEALTH STAFF. TOP PEOPLE SHOULD LISTEN TO WHAT THE WORKERS AT GROUND LEVEL KNOW IS NEEDED – CONSULTATION IS REQUIRED BEFORE ACTION! WHICH IS INVARIABLY WRONG  
BEFRIENDERS ARE HELPFUL BUT ARE NOT TRAINED IN DEMENTIA CARE  
[tcdabr001/12jan17]
- Concerns about losing the centre. Pivotal in the care of dementia sufferers without question. Interacting with others is beneficial. House visits would not fit the bill. Interaction with many people is the key benefit. Plus getting out of their home environment. Enjoyed the activities [tcdabr002/12jan17]
- SO MANY SERVICES HAVE BEEN CUT & EVERY TIME THIS IS DONE IT HAS A KNOCK ON EFFECT ON OTHER SERVICES. WHEN NEEDED A “HOSPITAL OR CARE BED” WOULD BE AVAILABLE [tcdabr003/12jan17]
- WE WANT MORE HOSPITAL BEDS. A LOT OF OLDER PEOPLE DON'T THEIR INDEPENDENCE TAKEN AWAY. CONVALESCENT HOMES NEEDED [tcdabr004/12jan17]
- DON'T THINK COMMUNITY BASED SERVICES ON ITS OWN IS WONDERFUL. I MAY NOT WANT TO DIE IN MY OWN BED [tcdabr005/12jan17]
- BETTER LIASON BETWEEN SOCIAL SERVICES [tcdabr006/12jan17]
- BETTER LIASON BETWEEN / HEALTH SOCIAL SERVICES [tcdabr007/12jan17]

- Where would folk who use it currently go? What kind of service. Value the opportunity to meet and mix with other folk including old friends. Also goes to memory club. Also uses befrienders service [tcdabr008/12jan17]
- TRAIN MORE PEOPLE (MAKING MORE JOBS). START FROM SCRATCH WE ARE A NEW GENERATION OF OLD PEOPLE – CONSULT WITH US MORE. ESPECIALLY THOSE OF US THAT LIVE ON BUTE [tcdabr009/12jan17]
- It is unfortunate if a spouse has to go to the Merino Court, Greenock – could a group help with transport if the remaining spouse was unfit to make the journey [tcdabr010/12jan17]
- NOT TOTALLY CONVINCED OF CORRECTNESS OF MOVEMENT COMPLETELY TO COMMUNITY. BUT – CO-ORDINATION OF ALL VOLUNTARY / SOCIAL ORGANISATIONS AVAILABLE. MORE COMMUNITY HOUSING LIKE SHELTERED [tcdabr011/12jan17]
- Pay more attention to elected reps [tcdabr012/12jan17]
- EXISTING HOSPITAL BEDS TO BE RETAINED ALONG WITH EXISTING DAY CARE FACILITIES EXPANDED WHERE NECESSARY [tcdabr013/12jan17]
- I FEAR THAT PEOPLE WILL NOT BE ABLE TO MEET WITH OTHERS AND WILL BE LEFT LONELY AND ISOLATED IN THEIR OWN HOUSES AND FAMILIES WILL NOT HAVE ANY RESPITE [tcdabr014/16jan17]
- Transport needs. The elderly (especially those with mobility needs) love to “go out”. The elderly community needs to feel valued – as is their right. Their service is as much as priority as that for the young and for the mentally ill. All are vulnerable. [tcdabr015/26jan17]
- People who have served this island will deserve some day or residential care here on Bute [tcdabr016/26jan17]
- There is a need for transport for elderly people who are isolated in their homes due to them being less mobile. They still would improve their wellbeing by social activity [tcdabr017/26jan17]
- MORE CARE HOME ON THE ISLAND. TO ENABLE PEOPLE TO STAY NEAR THEIR FAMILIES [tcdabr018/26jan17]
- Much of the above to be available and if possible The same carers as much as possible To attend, if needed [tcdabr020/26jan17]
- WHAT EVER YOU DO – PLEASE KEEP THOMSON COURT DAY CENTRE + BUTE COMMUNITY CARE CENTRE RUNNING [tcdabr021/31jan17]
- PERHAPS REGULAR DROP IN VISITS FROM COMMUNITY NURSES FOR VULNERABLE ELDERLY PATIENTS WHO COULD ADVISE DOCTOR IF HOME VISIT IS REQUIRED. GET WELL CLINICS WITH ADVICE ON HOW TO STAY WELL [tcdabr023/13feb17]
- Do we still have home visits from doctors when patients are too old or unwell to come to the Health Centre? or could Community Nurses visit the most fragile on a regular drop in basis [tcdabr024/14feb17]
- The main concern is for local people (Brans?) being able to stay on the Island and be cared for here near family + friends [tcdabr025/20feb17]
- no. [tcdabr026/20feb17]
- Personally, I believe Bute requires both hospital and community based services as received at present with further development of the Day Care Centre and an appreciation of the excellent home care provided by Care Plus. [tcdabr027/20feb17]
- Our hospital plays a big part in our community young or old and at present we need both it and Thomson Court and our excellent care from Care Plus. Don't

close them as well. We all want to stay on Bute, Young or Old  
[tcdcbr028/20feb17]

- Push recruitment & packages for island living [tcdcbr029/20feb17]
- Concern that money savings will undermine health services that will be required more & more as Bute's population gets older [tcdcbr030/20feb17]
- Education Education Education & new ideas. I found a book recently called "The Intuitive Practitioner" My subject is "WHOLISTIC HEALTH" [tcdcbr031/20feb17]
- Concerns Not everyone wants to remain alone in his / her own home. Sometimes it is not medically appropriate – where do people go now? [tcdcbr032/20feb17]
- INVEST IN WELFARE CARE, PROVIDE ELERLY OR SICK PEOPLE FACILITIES AT HOME & THE COMMUNITY. IN ORDER TO LIVE INDEPENDENT LIFES. [tcdcbr033/20feb17]
- A volunteer based service will not work if that is all that is provided. People with physical limitations need to be supported so that they are not isolated in their homes ∴ transport links to take them places are essential [tcdcbr034/20feb17]
- Concerns about the provision of care home places on Bute when staying at home is no longer a viable option [tcdcbr035/20feb17]
- INCREASE COUNCIL TAX TO STOP CUTTING THESE SERVICES [tcdcbr036/23feb17]
- \*WHY NOT? IS IT LACK OF FINANCE? IF SO THIS IS A PRODUCT OF YEARS OF COUNCIL TAX FREEZE. USED AS A VOTE WINNER BUT INEVITABLY YEARLY EXACERBATING PROBLEMS IN THE LONGER TERM. I DISAGREE IN GENERAL TERMS WITH CARE IN THE COMMUNITY, BELIEVING THERE SOULD BE INVESTMENT IN A LOCAL CARE HOME PROVIDING 24 HOUR SUPERVISION. [tcdcbr037/23feb17]
- I think it is most important that the hospital here on Bute is maintained instead of designing services to put people home when they still require care [tcdcbr038/23feb17]
- I WOULD HOPE THAT STAFF FROM THE DAY CENTRE WOULD BE RETAINED – SO THERE EXPERTISE & SKILLS WOULD NOT BE LOST [tcdcbr040/27feb17]
- I know this will be difficult as people want to sue existing buildings. We need to invest in people and reward & support carers. [tcdcbr042/27feb17]
- I have a number of concerns and questions regarding "moving away from hospital to community based services". FIRSTLY – how is it possible to keep people with dementia in their own homes? This would demand 24 hour care from experienced and highly trained carers. Such people are thin on the ground! SECONDLY – In cases where there is no question of dementia but here the elderly person is housebound the care provided is inevitably far short of satisfactory. Carers look in for a maximum of ½ hour 4 times a day. This leaves 22 hours possibly to be spent alone. In spite of the desire to remain at home there clearly comes a time when the company of others and the care provided by trained professionals outweighs other considerations. THIRDLY Who is going to ensure that the elderly person's house is kept clean. Carers cannot be expected also to be cleaners but it is essential to keep the house in good order. FINALLY There is a very strong feeling locally that it is quite wrong that so many Bute residents – many natives of the island – have been forced to move to the mainland to find a care home. Provision of such a facility on the island should be a top priority. [tcdcbr043/28feb17]

- Hospitals can be good at healing the results of accidents, but by their nature they do not offer much stimulus, so the patient can quickly become institutionalised. Bute's population is decreasing. The Island could have a growth industry based on the elderly. Why should folk who have lived many years – maybe all their life – on Bute have to be shipped off...with a £750 - £1000/week cost... being a loss to the Island. If there was a Nursing home of excellence, then there would be more work, both due to the home, and in earlier years. (note at bottom of the page – Thinking the site could be on part of the Thomson Home land.) [tcdcbr044/28feb17]
- If you are alone at home you need to be able to contact somebody. Hopefully you get to know each other. [tcdcbr045/01mar17]
- Yes!! Don't shut the day care centre!!! If you want to move away from hospital / residential care home models, it would be madness to close the day care centre. [tcdcbr046/01mar17]
- This is not a new situation and the ageing demographic has been well forecast for the last 20 years. To achieve a solution to particular local needs does not need expensive 'reinventing the wheel' exercises. There are a myriad of very well documented and researched day care models already in existence throughout Scotland - go pinch other people's ideas and adapt them, not forgetting the huge input available from the voluntary sector, especially in the area of dementia day care. [tcdcbr001/16jan17sm]
- The move from Hospital services to Community seems a good idea to me. I've never ever been in hospital for any procedure and I don't find it a welcome prospect. There is a perception around that it's all about cutting budgets rather than finding ways of working smarter and better for patients. Whatever the changes to services are, if they are shown to be working then we'll all gradually be more relaxed about change. I'm afraid I can't come up with specific suggestions because I simply don't have the experience of having to care for a sick or elderly person. Both my parents died at age 61 from heart attacks so I never experienced the problem of caring for parents gradually getting old and frail. Frankly, I'm happy to trust the health and care experts as to what actually works well - provided that we don't start to get news reports of neglect, poor service, waiting lists and so on. [tcdcbr002/18jan17sm]
- Continue to develop a 'joined up and seamless service' from doctor through to home support; one which will also have hospitalisation as part of the service. [tcdcbr003/19jan17sm]
- Yes. (I am being pedantic, if you want to know what these ideas are, then you really ought to ask a different question). You may want to think more carefully about how to ask good questions that elicit the information you seek. This has not
- been a very good questionnaire. [tcdcbr004/23jan17sm]
- I have stated that there are various places that can be turned into a centre which have all activities under the one roof. Make the register listing people in need of community care. Hopefully confidentiality rights need to be addressed on this list. My husband and I don't object to our names on any suggestions that we have given. [tcdcbr005/26jan17sm]
- Consult the community. [tcdcbr006/27jan17sm]
- A Community based model is certainly how I want to my family to continue to receive the support which is vital to us. If we did not receive the level of support from Thomson that we do my mother would not be able to remain at home with us. There is only a handful of beds now on Bute....where will my mother end up if Thomson day centre is closed? [tcdcbr007/27jan17sm]



- I can't believe that we will make any great progress when the housing on the island is so inappropriate for such an elderly population, it exacerbates the pace of social isolation and becoming housebound and fuel poverty. How do we get round that? [tcdabr008/28jan17sm]
- "Care in the community" means so much more than regular home visits. See 3 above. Volunteering should be encouraged, without the obstacle of excessive bureaucracy. [tcdabr009/30jan17sm]
- From past experience, when caring for my own elderly parents elsewhere in the UK, my primary concern is very much that those able to continue living in their own homes should not be expected to withdraw altogether from the island community which they would be in danger of doing in the event a day care centre facility on the island was denied them in the future. This is particularly pertinent in the case of people whose families do not themselves live on the island or who have no family at all. [tcdabr010/30jan17sm]
- Yes! A fundamental step is to move to a 'hospital on the island not on the mainland' service where this is possible. That means improved diagnostic services and the ability to provide high dependancy medical and psychiatric beds plus a treatment centre. Then improved district nursing and social services to allow patients to be monitored (e.g. bloods, pain, oxygen level) at home. Currently care workers frequently take the view that the patient needs to be moved to hospital for 'monitoring' in many cases this is not accurate but they are either insufficiently trained or experienced to accept that the patient can be managed at home - this needs to be addressed likely with better supervision / escalation arrangements and in service training. [tcdabr011/06feb17sm]
- Staff have to be trained and qualified and not young girls on minimum wage [tcdabr012/13feb17sm]
- Don't think this entirely possible with Rothesay's aging population who have earned right to be nursed when necessary ,on the island. [tcdabr013/13feb17sm]
- It is essential that joint working/meeting/liaison between medical and social/community staff is the norm. It is also vital that ALL community based services are retained on the Island of Bute. [tcdabr014/15feb17sm]
- This question illustrates the fact that the main direction of the 'redesign' is decided. The document claims that the partnerships are seeking to address the expressed wish to 'stay at home for as long as possible'. Most people would wish that but that shouldn't be taken to mean that all care takes place in the home. Loneliness is I understand a major cause of ill health so regular provision of social contact is essential. Voluntary befriending is not enough of an answer in my view. Day care provides the opportunity to eat with others, to be offered activities and to be under the eye of a team of professionals who will keep an eye on you. In other words, being part of a community if family are not local or unable to provide a high level of care. [tcdabr015/16feb17sm]
- Not everything can be done in the home. It is not possible for volunteer "befrienders" in the community to be a replacement for the professional and knowledgeable care that dementia patients require to help them and their carers live a better life. The best way to keep people from being forced to leave for the mainland where they can get better services is to offer the required services on Bute. [tcdabr016/20feb17sm]
- A supportive local health centre and hospital is as essential as community based services. Care in the community is fine in theory but has in the past failed because of inadequate funding and limited resources. [tcdabr017/21feb17sm]

- We are lucky to have such a good service at our local Health Centre. Could the Community Nurses be funded to do more for patients for whom it is difficult to get out for an appointment, or perhaps be available at a Community Centre for the elderly. [tcdabr018/21feb17sm]
- I think it is important that if you are a carer that the cared-for-person can be looked after somewhere else periodically so that the carer can 'refuel' in their own home. Also, people get constantly warned that they should be careful who they allow into their home, so a very good system should be in place to make sure only the right people will have access. I also believe in professional care, see previous remark, as you can set standards of care and insist that these will be followed while working with volunteers is very different. Volunteers have to be asked to do things, not ordered, and they also may not follow the guidelines. I am a voluntary worker and have realised that volunteers will at times use their own interpretation of rules etc. [tcdabr019/22feb17sm]
- If services were to move to community based how would it be ensured that the correct care required would be given to each individual especially those with dementia [tcdabr020/25feb17sm]
- Community care homes, sheltered housing with trained wardens on site 24hours a day, investing time and money into specialised day services. [tcdabr021/25feb17sm]
- If services were to be moved to community based, how would it be ensured that the correct care required will be given to each individual especially dementia patients [tcdabr023/25feb17sm]
- If services were to move to community based, how would it be ensured that the correct care required will be given to each individual especially dementia patients. Lonely vulnerable elderly people living a very sad life staring at 4 walls 24/7, confused people hurting/injuring themselves or others. [tcdabr024/25feb17sm]
- By providing care and wellbeing 7 days per week this would help people see the doctor ect before the person was so ILL that the only option is hospital [tcdabr025/25feb17sm]
- Stop assuming that everyone wants or should be looked after in their home care at home is nice but we are having people being looked after at home who would be much better off in a different environment [tcdabr026/25feb17sm]
- Most of the time would be spent travelling. It is already very difficult to recruit people to work in Argyll & Bute as is evidenced in the lack of teachers, doctors, etc applying for jobs in the area. [tcdabr027/25feb17sm]
- U move these services from Rothesay u are stopping these people from sign there family day in day out. U cut the day center as I said u would be as well putting them in a cell as that's it would be like for them and there family's. Save Thomson home [tcdabr028/25feb17sm]
- If services were to move to community based, how would it be ensured that the correct care required will be given to each individual; especially dementia patients. [tcdabr029/25feb17sm]
- There are many people who have lived on Rothesay all their lives who have been moved off the island due to their care homes being shut down. Instead of shutting down the service adapt it. E.g. Thomson Court by having a day centre in there it provides well needed respite and support. By having people stay at home it can be hard for families so more support is needed to educate family members about how to take care of their loved ones and providing respite to allow the loved ones a break from their caring responsibility. [tcdabr030/25feb17sm]
- Big carry out lock-in Booz sesh [tcdabr031/25feb17sm]

- With particular view on elderly - People die, community based services should be about how we help folk live while still here. Preparing their own meals or at least the menu; passing on experiences, skills and knowledge to younger generations; meeting up with friends or peers in familiar settings - coffee shop or pub; transitioning from independent living to supported living with dignity [tcdabr032/25feb17sm]
- I'm concerned that we are dealing with finance instead of real people with real issues, efficiency should not be measured in £ saved!!! [tcdabr033/25feb17sm]
- No [tcdabr034/25feb17sm]
- If this were to happen how could you ensure the correct care is provided and that standards are kept. [tcdabr035/25feb17sm]
- A lot more child services, e.g. Soft play, indoor activities, and a lot more help from the council [tcdabr037/25feb17sm]
- If services were to move to community based how would it be ensured that the correct care required will be given to each individual, especially dementia patients. [tcdabr038/25feb17sm]
- Extend the hours of day services. My concern is that by moving to solely community based, how can you ensure that each individual, especially with dementia is receiving the correct care and stimulation that they need and deserve. And how can you ensure that the service users are going to remain safely in their own home during the times when carers are not in attendance? [tcdabr039/25feb17sm]
- I feel Thomson court needs. To be developed as a whole. It needs to become more of a facility which can be utilised to keep people at home if that is their wish. Instead of being in hospital they could have a small period of recuperation either in respite with nursing support or at day care also with nursing support [tcdabr040/26feb17sm]
- Ask volunteers to help within the community. [tcdabr041/26feb17sm]
- Do what other communities have done to accommodate their pensioners with dementia. Build a care home with the facilities and shops they remember from years ago. These aged people have paid their dues all their lives and need some support and respect. [tcdabr042/26feb17sm]
- My main concern is that whilst community based services can work and indeed be better for some individuals there will still be some who need more intense, hospital based care. One size doesn't fit all. [tcdabr043/26feb17sm]
- Closing dementia day care centre at Thomson court will ultimately lead to more problems for dementia sufferers and their carers. This has already been proved by the closure of the Victoria hospital annexe a few years ago. There are simply not enough suitable places on Bute for the elderly to be housed safely. This means in the end that island residents will be shipped off the Island to spend their final days away from the place they have lived all their lives and away from family and friends. Why is there no plan to re open the annexe? Foley court is at less than half capacity, why is foley court not used as more of a nursing home with trained staff on site 24 hours a day for people with illnesses that cannot stay in their own homes anymore. [tcdabr044/26feb17sm]
- I have no experience either professional or personal in this area. But I do know there are elderly people sitting in their homes that have no visitors for days and have no access to social amenities as they are full or under funded. [tcdabr045/26feb17sm]

- Invest in the available facilities and insure that all departments concerned with local healthcare can work together efficiently [tcdabr046/26feb17sm]
- No I do not, but I sincerely hope that the worker at all levels , and areas of Social Care, who have vast experience and knowledge, and who do know what to do, are listened too, and followed . [tcdabr047/28feb17sm]

### EVENT TABLECLOTHS

Village Hall, Port Bannatyne, Thursday 26<sup>th</sup> January 2017 (2pm – 5pm)

- Help with mail, paying bills etc. – service required for this
- MORE SUPPORT FOR CARERS who cant earn more £110/wk & get carer's allowance they have travel & other extra costs
- FOR PEOPLE WITH DEMENTIA MORE TIME IS REQUIRED FOR HOME CARE VISITS
- THE DAY SERVICE AFFORDS RESPITE FOR CARERS
- TRANSPORT THAT'S ACCESSIBLE
- HOME CARE WORKERS NEED MORE TIME e.g. TO PREPARE FOOD
- CONVALESCENT HOMES – MORE 'STEP UP' or 'STEP DOWN' BEDS
- A RANGE of DIFFERENT ACTIVITIES
- CARE HOMES + Respite facilities weekends
- OPPORTUNITIES FOR SOCIAL INTERACTION – MEETING PEOPLE
- DON'T WANT CONFINED TO MY HOUSE!!
- A DAY CARE CENTRE FOR EVERYONE IS MOST ESSENTIAL, TO GIVE CARERS A LITTLE RESPITE & ALSO TO STIMULATE THE PATIENTS WHO GO TO THE CENTRE
- Mobile HOME visits for – eyes, podiatry, hearing tests, physio / OT, for housebound
- NEED FOR PEOPLE WHO WOULD COME IN & SIT WITH LOVED ONES – DEMENTIA TRAINED
- BEFRIENDER SERVICE IN EVENING & ADEQUATE TRAINING
- CARE PLANS FOR EACH 'CLIENT' DRAWN UP IN CONJUNCTION WITH CARER THAT BEFRIDNER CAN REFER
- OPEN UP THOMSON COURT DAY CENTRE TO MORE PEOPLE eg. VULNERABLE ELDERLY, TO GIVE MORE CARERS RESPITE
- DISABLED ACCESS IN ALL PUBLIC FACILITIES
- FLEXIBILITY IN HOURS eg. DROP IN CENTRE TO ALLOW CARERS TO HAVE RESPITE
- Day care – offer respite, entertainment
- Refurbish Annexe & Thomson Court & make a facility for older people
- One point of call for alerting
- What happens if there is a major incident – only 1 ambulance – is there a vulnerable persons list?
- Thomson Home was given to the community
- Island so important to the community
- No of care homes has diminished over a number of years
- Accept things have to change but not at a cost
- Annexe was a great facility – missed – wonderful care, everyone loved it – had a day centre where facilities could be used e.g. kitchen for cooking, garden
- Reason for Craighard closing not 100% accurate

- What happens to patients after a stay in hospital, especially for people who live at home? – better discharge planning, people need to have more support with the appropriate service in place
- Befriending used as a scheme with support – must be trained
- Meals on Wheels – way of identifying problems before they become critical
- Staff in the community need better understanding of where people live
- More needs to be done to support people who live alone – better care required, not for living but “caring” aspect
- More support for people with a diagnosis of dementia – there is a growing number of people who will need help – more support for carers as it can be very lonely
- Old school (academy / secondary school, owned by Fyne Homes) built in 1938, why can't it be used for the purpose it was meant for? Lovely building! elderly people facility – could be used for day care; community base; start with a clean sheet; funded by health & social care but run privately

**Moat Hall, Rothesay, Monday 20<sup>th</sup> February 2017 (2pm – 5pm, 6pm - 8pm)**

*What Would Enable You To Live A Long, Healthy, Happy and Independent Life on Bute?*

- GOOD PUBLIC TRANSPORT
- HOME HEALTH VISITORS
- Care for dementia etc. which may be in the form of Care Home / within people's own homes
- Appropriate support for me and my needs as I get older. Respite care on day / residential basis if I or a member of my family requires it
- A MORE 'FLEXIBLE' RESIDENTIAL CARE HOME PROVISION ON THE ISLAND. SUFFICIENT RESIDENTIAL CARE HOME PROVISION TO MEET NEEDS ON THE ISLAND
- Lots of capable, well qualified health visitors
- Bus service to outlying farms ie like a public taxi
- Day Care Day Centre Respite
- Permanent weight watchers group run by health centre
- KEEP THE DAY CENTRE – REQUIRED FOR CARERS FOR RESPITE
- MUST HAVE A NURING HOME & RESIDENTIAL DEMENTIA CARE HERE. MAYBE A NOT-FOR-PROFIT PROJECT
- Trained Care Workers – paid properly - Specialised Services for the elderly - Lunch Clubs - Keep Fit Clubs - Opportunities to socialise – with the funding to secure services – Elderly being cared for in the community NOT at home as this leads to isolation for patients & carers – option to choose home or community care
- better community transport for accessing services
- Care Homes on the Island
- Improved + Local Dental services on Rothesay

*What Support Might You Need?*

- MEALS ON WHEELS

- DAY CARE CENTRE
- HOME HELPERS
- Transport to get to community events (minibuses)
- Transport Ability to attend community events – to be organised I don't want to feel stuck at home & isolated Community events
- IT IS ESSENTIAL THAT WE MAINTAIN OUR HEALTH CENTRE AND A&E FACILITY. AND THE HOSPITAL DENTAL SERVICE NEEDS TO BE EXPANDED FOR NEW PATIENTS (CLOSED TO THEM NOW)
- Local GP's Day Care Day Centre Access to major hospitals
- CARE IN THE COMMUNITY IS INEQUATE TO COPE WITH THE NEEDS IN THE COMMUNITY – IT'S NOT WORKING
- TRANSPORT FOR HEALTH APPTS EVEN ON ISLAND – FOR PEOPLE WHO NEED A HELPER WITH THEM
- Day Centre with qualified staff and a stimulating programme to keep Health & well being high
- WE NEED MORE RESIDENTIAL CARE HOMES & A NURSING HOME
- LACK of CARE PROVISION MEANS PEOPLE ARE STUCK IN HOSPITAL
- Places for Patients to go for respite to keep family Healthy
- Family In the case of total dependency 4 x 10/15 minutes will not be enough, where will you go than?
- A Community is as human as it treats its most vulnerable members

*Any Ideas, Concerns, Questions About Hospital or Community Based Services?*

- Being in hospital is not great fun. Perhaps being at home, but health visitors checking regularly, not carers, with input from home visits from a GB
- NEED BIGGER DENTAL PRACTICE – I have to go to Inverkip!
- It should be ensured that the services are provided by professionals who are specifically trained to meet peoples needs
- Concern : What happens when I get older & want to stay on the island, rather than have to go the mainland for appropriate care
- Is there enough Care? Do they get enough time? People feel lonely
- 1-2 hours a week befrienders service cannot possibly replace the supervision provided by Thomson Day Care Centre. Many / most dementia patients cannot be left unsupervised for even 5 mins
- FOR DEMENTIA FAMILIARITY IS IMPORTANT AND
- DAY CENTRE FOR OLDER PEOPLE IN GENERAL
- What would be the demand in the future for Dementia services?? NHS figures suggests that there are close to 100 Dementia patients in Bute. There are only 12 spaces available at the day care centre. Surely that would not be enough in the future. Could you comment on that?
- Where are all these volunteers / befrienders going to come from? There are not enough volunteers on the island as it is.
- Where is the capacity in terms of residential care given that Craigard has closed – residential care required to stop people leaving the island
- WE MUST HAVE MORE HOMES AS OUR ELDERLY POPULATION IS INCREASING
- AN INNOVATIVE POLICY ON ISLAND CARE & RURAL HOMES

- Think of other users of TCDS when not fully occupied – exercise class for those without dementia
- Victoria Hospital concerns that residents have to go off island due to reduced bed usage
- increased settings in community for older people to tackle loneliness + isolation – friendships
- WE NEED ENOUGH LOCAL CARE HOMES SO PEOPLE DON'T HAVE TO LEAVE THE ISLAND
- Mental Health support – as Art therapies as Different therapies not just medication and labelling
- HOW DO YOU TREAT your most vulnerable people a society / can be judged by that To have people “locked up” and feed them 4 x a day How does that keep them stimulated and not isolated and lonely
- a professional local newspaper to keep community involved and informed
- RESIDENTIAL CARE UNDER ONE ROOF BUT FOR THOSE MORE AWARE OR MORE ABLE SUCH THAT AN INTERMEDIATE LEVEL OF CARE HOME REGISTRATION IS APPROPRIATE

*What Services Would You Like To See Developed?*

- Better Dental Care we need another Dentist
- Regular visitors / befrienders (loneliness)
- Support for adults & the possibility of earlier diagnosis of illnesses like dementia, alzheimers & Parkinsons
- Community Hub / drop in
- RESPITE DAY CARE FOR PARTNERS
- Better access to dental services
- SUNDAY or WEEKENDS NEED SERVICES THEN. NO DAY SERVICE
- EXERCISE GARDENING FLEXIBILITY OF CARE OPTIONS
- TRANSPORT TO ATTEND SOCIAL GROUPS
- Utilise existing resources flexibly & with imagination 7 day services
- Needs are not only 5 days – we need to have more weekend activities / clubs
- WE NEED DEMENTIA SPECIFIC SERVICES FOR FUTURE
- More respite care Care Home to be built A.SP Purpose built
- Help with transport to get me to a Day Centre or Lunch Club meeting with others – shopping service
- WE NEED A NURSING HOME – WHY CAN THE H&SPC NOT RUN HOMES
- RESPITE FOR CARERS REQUIRED
- Develop old “Salvation Army” Hall into a health & wellbeing centre
- Can transport be improved to ensure that assistance is available on mainland for families & patients (Victoria Hospital)
- TCDC – needs to stay open – but open to more people and not just dementia
- District Nurses are already struggling to keep up and meet demands. Capacity issues
- A COMMUNITY IS AS HUMAN AS IT TREATS ITS MOST VULNERABLE MEMBERS.



*What Day Services Would You Like To See Developed On Bute?*

- Imperative to have an old peoples' home on the island. Appalling most people have to travel to the mainland to visit close family
- COMMUNITY BUS SERVICE O ENABLE ELDERLY FOLKS GET TO COMMUNITY CENTRE & ACTIVITIES
- Activities that enable to young & the more mature (!) to mix & help each other ROTARY
- Develop an 'adopt' an elderly person scheme whereby younger people can include elderly people as part of their lives
- One course (in the form of online + non-online) of information on what's on on Bute so that everyone's aware of activities they could be involved in
- THE DAY CENTRE OFFERS CONTINUITY & FAMILIARITY WHICH IS ESSENTIAL WHEN SOMEONE HAS DEMENTIA
- IF THE DAY CENTRE IT WOULD BE A DISASTER FOR ME. IT WOULD PROBABLY ACCELERATE ACCESS TO RESIDENTIAL CARE WHICH WOULD COST MORE
- THE POLICE WOULD BE INVOLVED LOOKING FOR PEOPLE WITH DEMENTIA AND THAT WOULD IMPACT ON THEIR BUDGET
- CENTRAL HUB
- Opportunities to meet to combat isolation
- MEMORY GROUPS
- Day services which enable people to leave their homes even for short periods so that they do not feel isolated. Different generations should be involved so that community spirit & involvement is maintained / expanded
- Older people without dementia would benefit from services which involve meeting up – social stimulation – tackling isolation + loneliness
- More physical exercise at the Thomson Day Care Centre YES AGREE
- NURSING HOME
- OUTREACH (FROM CENTER) – SERVICE INSTEAD of DAY SERVICES – for STIMULATION – e.g. VOLUNTEERS for a COFFEE THIS IS IN ADDITIONON TO DAY CENTRE
- Increased scope for both residential and community / home respite
- WITHOUT THE DAY CENTRE MY HUSBAND WOULD HAVE TO GO INTO CARE AND THIS WOULD DISLOCATE THE FAMILY WE HAVE BEEN MARRIED FOR 53YRS
- THE DAY CENTRE GIVES PEOPLE A PURPOSE – ON DAYS IT'S NOT ON MY MUM IS RESTLESS
- IT'S SOMEWHERE YOU CAN FIT IN – YOU'RE NOT DIFFERENT OR STAND OUT. FAMILIARITY – IMPORTANT
- DAY SERVICE – IF YOU COULD USE IT AS A 'SITTING' SERVICE IF YOU NEED TO GO SOMEHWERE FOR 2 HOURS FOR EXAMPLE & YOU WOULD PAY FOR THIS CARE
- Combination of children Nurseries and daycare for elderly
- DEMENTIA TRAINING FOR WIDER COMMUNITY – TO UNDERSTAND THE ILLNESS
- WE SHOULD HAVE A CHARITY SHOP FOR DEMENTIA SERVICES – SOCIAL ENTERPRISE – TIME BANKING
- WE NEED TO RETAIN A DAY SERVICE FOR PEOPLE WITH DEMENTIA
- Community groups for Older People to have activities – Lunch Clubs

memory groups music groups

- Identifiable Community Hub with volunteers and staff providing a space for people to meet
- +Elderly Day Care Services especially for Dementia Patients who need to socialise + Thomson Day Care Services
- Thomson C.D.S. – needs to remain to provide respite for partner
- THE DAY CENTRE IS ESSENTIAL FOR THE ISLAND

*What Do You Need To Have In Place To Be Confident In Community Services?*

- Absolutely imperative to have 24/7 medical availability. Again, to have the Victoria Hospital open 24/7 with A&E
- HEALTH CENTRE
- Support in both the Health Centre & the local Hospital to assess people's needs & good transport links
- FAMILIES SHOULD BE KEPT TOGETHER. IF SOMEONE NEEDS TO MOVE OFF ISLAND IT'S NOT EASY FOR FAMILIES TO VISIT & STIMULATE THEIR LOVED ONES
- SPEEDING UP OF PAPERWORK FROM SOCIAL WORK
- A HUB FOR RESPITE CARE OF MY ELDERLY PARENT
- More group work for vulnerable old people under supervision – (company as well as interest)
- Respite opportunities for carers
- Outreach whilst vital it should not be viewed as a replacement for T.C. Day Service – supplement
- Flexible Respite Care
- Essentially Local Nursing Home
- Regular respite on outreach basis to keep people at home and avoid ?? into Care / Residential
- HOW DO YOU ACCESS SERVICES? WHERE DO YOU GO? THIS NEEDS TO BE MADE CLEAR TO THE PUBLIC
- Less levels of managers in NHS (safes money)
- IF THERE IS NO DAY CENTRE PEOPLE WILL BE SOCIALLY ISOLATED AT HOEM & THEY & THEIR CARERS HEALTH WILL DETERIORATE
- Community Services Need Secure ring fenced index linked funding

*WHAT GROUPS WE HAVE ALREADY PLEASE PLACE COLOURED STIKERS NEXT TO THE ONES YOU THINK ARE IMPORTANT OR YOU WOULD LIKE TO SEE EXPANDED*

- LUNCH CLUBS – TRINITY (2 hearts), FERFADD COURT (2 hearts)
- EXERCISE GROUPS – FIT FOR LIFE (5 hearts), CHI BALL (4 hearts) BUTE STROKE GROUP (5 hearts)
- MEMORY GROUP (4 hearts)
- CROSSROADS FOR CARERS ( 3 hearts)
- YOUNG CARERS (4 hearts)
- BUTE BEFRIENDERS (4 hearts)
- INTERLOCH TRANSPORT ( 5 hearts)
- WALKING GROUPS (4 hearts)

- CHURCH GROUPS (no hearts)
- PARKINSONS GROUP (5 hearts)
- BUTE OLDER VOICES (5 hearts)
- AFFINITY TRUST (1 heart)
- STEPPING STONES (5 hearts)
- CARD GROUPS (1 heart)
- BOOK CLUBS (no hearts)

## WISHING WELL

**“WHAT DAY CARE SERVICES WOULD YOU LIKE TO SEE DEVELOPED ON BUTE?”**



**Ardbeg Baptist Church Hall, Rothesay – Thursday 12<sup>th</sup> January 2017**

**Responses in the Wishing Well :**

- Something like the Day Hospital which used to be used for frail elderly up to the year 2000. GP was in attendance and Physio or OT.
- More Day Care Services similar to Thomson Court Day Centre
- More access to Outreach Services- drop in, have visits and group meetings
- Day Care Service which meets the needs of the specific people who use it
- A variety of activities maybe from one building, so people can pick an mix; I feel we need a day care service for people in advance stages of Dementia
- Develop existing or create new multi-agency group to look at specific service eg Day Care Service
- Seven days a week service, not just Monday to Friday
- Keep People/Carers informed of what is available.
- More financial information available to make decisions
- A more diverse service to include frail elderly – a drop in centre
- Rather than close the Thomson Court Day Centre , this service should be extended into other premises if necessary. Care in the community is an excellent concept, but will never be adequate because of lack of funding for personnel.

**Responses on the Graffiti Wall :**

- Similar Service that is provided at Thomson Court Day Centre
- Would like to see the Day Centre continue as it is- maybe expand current service
- Carers support group
- Bute hub, lunch, exercise and themes?
- Leave well alone, minimum change to existing service
- Day Care Service increase
- Day Care , central point and easy access
- Drop in Day Care Centres – Pop up Centres
- Looking to future – younger people (under 65) need support, stokes, Dementia, Mental Health
- Seven day services and nights

- Looks forward to some privacy when person goes to club
- Concerned about respite bed in Struan Lodge being under threat
- People need to get out of their homes to meet other people and then carers can then get a rest
- Open service to all other adults (not just some)

**Other Question on Wall :**

What groups we have? (Community asked to stick coloured dots to the services that they like and would like to see expanded)

- Lunch clubs
- Exercise groups
- Memory group
- Crossroads – Carers and Young Carers
- Bute Befrienders
- Interloch Transport
- Walking groups
- Churches groups and premises
- Parkinson's group
- Bute forum for older voices
- Affinity Trust

Attendees to the event would like to see lunch clubs. Exercise groups, memory group, Bute Befrienders and Interloch Transport expanded as Day Care Services.

**Village Hall, Port Bannatyne – Thursday 26<sup>th</sup> January 2017**

**Responses in the Wishing Well:**

- Old Rothesay Academy building could be used as Nursing Home, day care centre for craft etc
- Similar service that the Victoria Annexe used to provide for frail/elderly people
- More residential and nursing beds, too many Bute people in residential care in Greenock
- Thomson Court – similar service but to take more people and not only those diagnosed with dementia
- As we already have Thomson Court, extend one or two other places with a mix of services, community music or singing
- More services like befriending and Interloch
- Rural areas of Bute to have their share of services. Most are in the town centre; better use of community halls, pop up services
- Interloch transport, befrienders transport, carer group, Mental health – need for social group and support group
- More 24 hours care beds are needed on Bute

- Charging policy for Social Work services is too complex, some charges are too costly; charge for day care plus transport plus telecare
- One partnership but we pay for social work services and not Health services – scrap charges
- Easier access to health appointments on Bute rather than travel on ferry
- More carers support at home to keep carer well, not enough services like Crossroads
- Easy information and access to process if concerned about a loved one's care requirements

#### **Responses on the Graffiti Wall :**

- More support like Crossroads for carers
- All day care staff to have a development plan to SVQ levels
- More places available in day support- building based service
- Preventative health, investment in trained staff, care and composition
- Drop in somewhere central to support all adults

#### **Other Question on Wall :**

What groups we have? (Community asked to stick coloured dots to the services that they like and would like to see expanded)

- Lunch clubs
- Exercise groups
- Memory group
- Crossroads – Carers and Young Carers
- Bute Befrienders
- Interloch Transport
- Walking groups
- Churches groups and premises
- Parkinson's group
- Bute forum for older voices
- Affinity Trust
- Stepping stones – chronic pain, long term illness support group
- Card groups - suggested

Most of coloured dots were at Interloch Transport. The attendees thought transport was essential to allow those who are mobility impaired access to Health Centre, hospital appointments also social appointment to groups, hairdressers etc

### **Moat Centre, Rothesay – Monday 20<sup>th</sup> February 2017**

#### **Responses in the Wishing Well :**

Interesting to note the comments that were signed did not answer the question re day care redesign but concentrated on the concerns of long term residential care on Bute.

**I feel this is important to include as these people have strong views and have signed their comments.**

(Names removed to ensure anonymity)

*“A purpose built building on the Island with beds and care staff. Translating old persons in need to a home eg in Greenock (no matter how excellent) is inevitably the trigger for terminal decline”*

*“It is deplorable that natives of this Island are having to go to homes on the mainland for care in their latter years.*

*It is vital that people who currently being looked after in Thomson Court continue to get the same centralised care on this Island”*

*“A Care home on the Island is absolutely essential. It is criminal the number of people born on Bute, who have spent all their days here, who now find themselves having to go to a care home off the Island”*

*“At least one old peoples home, probably 2!”*

### **Anonymous Comments**

Answering the question on what day care services would you like to see developed on Bute?

- Transport
- Support groups for people with specific conditions eg dementia
- A hub for people with physical and mental disabilities : (a) so they are not isolated in their homes (b) their families can have respite and continue to work without constant worrying

With grateful thanks to Sharon MacDonald, Community Development Officer for Bute and Cowal for providing the Wishing Well, facilitating discussions and providing a report with the feedback received.

### OTHER FEEDBACK

#### MEMORY GROUP, 31<sup>st</sup> January 2017

(Dot Gordon, Alzheimers Scotland)

##### Feedback Form Q1 / Q2

- Someone to look after me at home
- I would like to be able to go out & have company
- I would like to get out to meet other people
- I would like have something of interest to do eg. singing / keeping my brain active / facility to use technology eg. a computer
- Access to transport is vital – volunteers & reliable vehicle
- Care & Repair
- HEALTH – for elderly people there should be more health checks as routine practice. Heavily dependent on carers / family phoning
- G.Ps – no continuity – no follow up after hospital discharge
- Patient required 3 intravenous dosage of anti biotic per day for 3 week period – no community nurses available patient had to travel to health centre, hospital & sometimes wait for hours
- More community resources – enough nurses; enough care workers; realistic times for home care visits
- Dementia training for care workers
- Investing in home care – training / paying for time between visits / paying a decent wage

##### Feedback Form Q3

- A regular uplift of general waste bin – eg. 2 weekly. Believe it will be a health hazard
- Specialist dementia trainer for volunteers / community
- Volunteer gardeners eg. Fyne Futures

##### Feedback Form Q4

- Lunch Clubs
- Tea dances
- Exercise groups
- Quiet space
- Facilities for showering / bathing
- Range of different times eg. morning, afternoons, evenings, weekends so that people could attend eg. for a morning or afternoon
- Art therapy
- Food – important that it is good quality (as it currently is)
- Trips / outings – on island
- Home visits for social stimulus
- Day services opened up for people who do not have a diagnosis of dementia as at present they cannot access the day centre



## LETTERS / EMAILS RECEIVED

*(names and addresses have not been included to protect the identify of individuals)*

## THOMSON COURT DAY CENTRE &amp; BUTE COMMUNITY CARE REDESIGN

What does 'Community based' services mean?

More services provided by volunteers? Or paid staff without a fixed base to operate from? Or?

I guess the overall aim is to reduce costs but this becomes more difficult as the numbers of elderly and elderly-confused grow. And this increase in numbers has to be recognised and included in plans.

I think it **essential that Thomson Court Day Centre remains open** and I think there is a very good case for increasing the number of places.

According to 'Population Size Bute' (available at the consultation meeting), there are around 1000 residents in Bute aged 65-74, 600 aged 75-84, and 200+aged 85 and over. This totals around 1800 over 65. I think there are 8 (or is it 10?) places available for dementia sufferers at the Day Centre. This is not enough with demand/need likely to increase.

I looked after my mother who suffered from Alzheimer's for some 12 years. I desperately needed the time she was taken care of at the Day Centre to allow me to do some normal socialising. A paid carer coming into one's house for half an hour or so, helps the 'unpaid carer' but gives her/him no respite, just to relax.

I think for the frail /lonely/ housebound, some form of **afternoon club** a couple of times a week with a cup of tea and various activities/ interests available would be a great help. I think it is quite uplifting to the spirit to have a change of scene and some company, meet new people, and have someone take an interest in what you do/think. I appreciate that transport would be an issue/cost – perhaps some help from recently retired people?

I wondered if the old hospital annexe could be brought back into use? Or isn't there a large lounge in one of the sheltered housing complexes?

Certainly were I to become housebound, any chance to get out of the house and meet other people would be a huge benefit. Interesting and stimulating activities would be a plus – not all 90-year-olds are confused!

I also think that this requirement to PVG (Protection of Vulnerable Groups) all volunteers needs to be considered – it is expensive and time-consuming (and I am unsure what is done other than to check if the volunteer has a criminal conviction?). Very few, if any, recently retired volunteers are likely to abuse the position.

I think many people would welcome a **well-run care home** on the island. Taking a whole day to 'pop in' to see a relative in care on the mainland means they don't get nearly as many visits and feel more isolated.

[letter received 17<sup>th</sup> January 2017]



Argyll and Bute  
Health and Social Care Partnership (HSCP)  
Bute Locality Planning Group (LPG)



## THOMSON COURT DAY CENTRE & BUTE COMMUNITY REDESIGN



### What is happening?

Our Strategic Plan outlines our priorities for health and social care services across Argyll and Bute

<http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/SP%202016-2019%20Final.pdf>

Our priorities are in response to national policies as set out by the Scottish Government, e.g. Shifting the Balance of Care (page 2), but also based on what you have said is important to you.

When we consulted with you in the past,

You said **“We want to live a long, healthy, happy and independent life supported by health and social care services when we need them.”**

You said **“We want to stay at home for as long as possible.”**

We need to redesign health and social care services on Bute to meet these priorities.

**It is important that you have the right service, in the right place, at the right time.**

### What does this mean for you?

This means that we can no longer provide services as they currently exist. If we carry on as we are, we will not be able to support the ever growing number of people who will need our support in the future.

### Is Thomson Court Day Centre included in the redesign?

Yes. The vision for services provided at Thomson Court Day Centre is to build on

the excellent care it currently provides. We need to be able to care for many more people through day care services and to support people to live in their homes for as long as they wish.

We need to provide more community based services and to review the number of beds in the Victoria Hospital.

### Will Thomson Court Day Centre close?

This is under review. We do need to change how services are provided in the future to ensure we meet the needs of more and more people including respite needs for carers.

### Will Thomson Court residential care home close?

No. We want to assure you that there is no intention to close Thomson Court residential care home.

### What Now?

We understand how anxious communities and staff are about the changes proposed for Thomson Court Day Centre.

It is really important that we listen to you and give you the opportunity to share your views. If you have any suggestions on what services could be provided from within the community, we want to hear from you.

### Is this just about saving money?

We do need to get value for money and use our resources more efficiently and effectively. We need to be honest about that.

We must make sure the services we provide not only meet the future needs of our population but are flexible as demand changes and they are sustainable well into the future.

## We Want Your Views!

Our vision is to build on the excellent services currently provided on Bute. We must make sure your local services will support you to live a long, healthy, happy and independent life.

**We want to hear what your views are on the proposed changes to local services.** Do you have any alternative ideas? Come along to one of our events, see back page or look out for adverts in your area.

**Your feedback is important.** We will use what you say to consider how to redesign and improve services so they are fit for the future.

## WHAT SERVICES DO WE CURRENTLY HAVE ON BUTE?

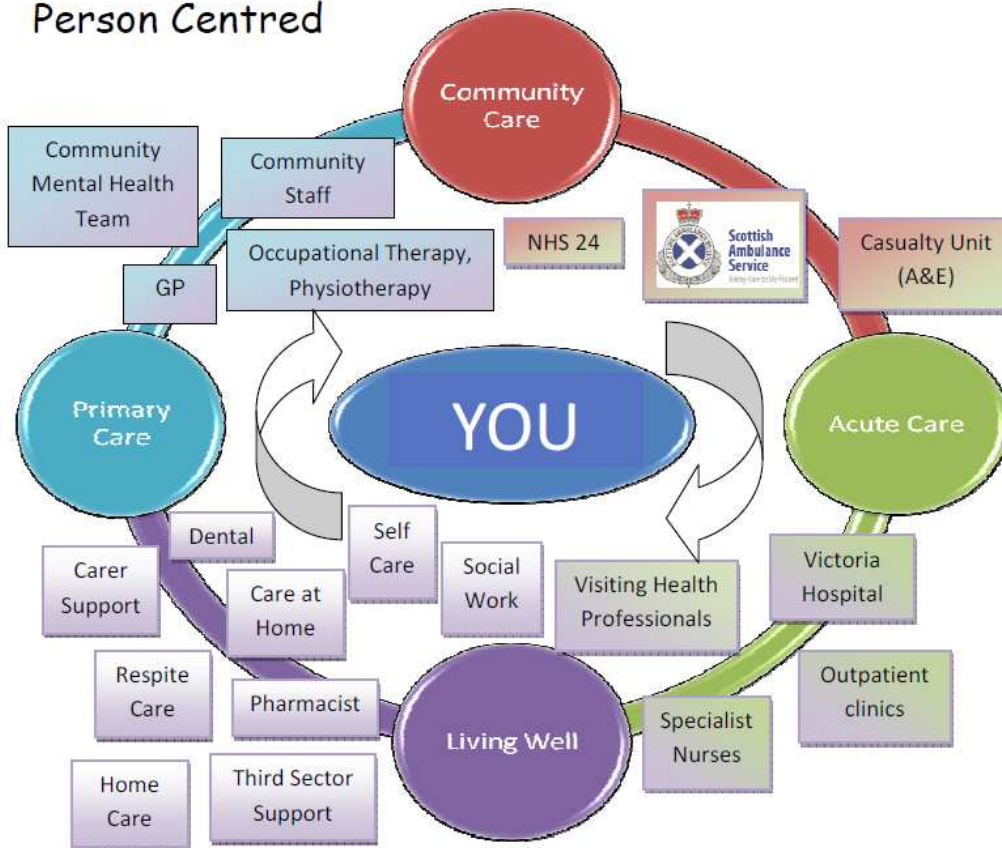


Rhubodach Ferry

We provide a range of services. Our aim is to support you to live a long, healthy, happy and independent life. This is what you have said is important to you.

The diagram below shows you what health and social care services are currently available, with you at the heart of what we do.

### Person Centred



### WHAT IS THE BALANCE OF CARE?

We hear the term 'Shifting the Balance of Care' when describing why services need to change. This means that we need to improve the health and wellbeing of the people. We aim to do this by increasing our emphasis towards improving health and anticipating care needs. This will provide continuous care and more support for people closer to home. We can't do this alone. We need to work together with you to make this happen and this does mean we need to make changes.

## THOMSON COURT DAY CENTRE (DEMENTIA) - WHAT IS BEING PROPOSED?

The aim is to redesign the existing small dementia day service, registered for 12 people. The current model of service is limited to people with dementia, this therefore excludes a large number of frail and elderly people with long term conditions in the community.

What we would like to do is provide a wider range of community based services for a greater number of people who are frail and elderly within the community. This will include a service that meets the needs of dementia patients and their carers.

We would like the new service to be flexible and to help a greater number of vulnerable people who require different levels of support. An enablement service will allow us to increase confidence and improve skills to support you to live your life to the full and maximize independence. This is what you have said is important to you.

This is where we need your help. To ensure we have the right service in the right place at the right time, we would like you to tell us what you need to help you live a long, healthy, happy and independent life.

## REVIEW OF BEDS AT VICTORIA HOSPITAL

We are committed to keeping your local hospital at the heart of your community. We want to ensure we retain the high quality level of care it provides, when people need it. We also know we can no longer provide services as we do now.

Come along to one of the engagement events, find out more about what is being proposed.

Share your views with us. Your feedback will be used to help us redesign and improve your local services so they are fit for the future.

## COMMUNICATION & ENGAGEMENT WITH YOU

**The Bute Communications and Engagement Group** is responsible for the engagement plan for the Bute Service Redesign. We are made up of public, third sector, union, NHS and Council Staff. The Scottish Health Council provide guidance and support. Our engagement plan for the next few months is :

**Informing you** - we need to share information about the services we have on Bute, their costs, the needs our communities have now and in the future, our resources, and other background information

**Engage with you** - we need the chance to discuss all that information with you. We will be holding a number of events on Bute between January and the end of February for both our citizens and staff. See back page for details of the events already planned.

**Reporting on what you say** - we need to gather what people say and report that back to the Integrated Joint Board (IJB)

If there are other ideas about how to develop services according to good practice, but within the budget of the Health and Social Care Partnership, we want to hear about them.

## INVOLVING You

**Email** You can email us at [nhs.abhscp@nhs.net](mailto:nhs.abhscp@nhs.net)

**Feedback forms** will be widely available in your communities or you can phone for one. You can also complete the feedback form online at <https://www.surveymonkey.co.uk/r/ButeRedesign>

**Information & Engagement events** Feedback forms will be available at the events.

**Ask us to your meetings** We can come to you - phone us! Telephone **01700 501540**



Rothesay



Isle of Bute



Bute

## DROP IN EVENTS

If you have any questions, would like to receive this leaflet in an alternative format or a different language, please contact

Margaret Thompson

PA to Local Area Manager (Bute)



01700 501540

or



margaret.thompson4  
@ nhs.net

For more information visit our webpage

[www.tinyurl.com/zlsvmmp](http://www.tinyurl.com/zlsvmmp)

We are holding a number of drop in events for local communities and staff to come and join us in discussion.

Here you can share your views, tell us if you have any alternative ideas and ask questions. Events for January and February have been arranged as follows :

LOCATION	DATE	DETAILS
Baptist Church Rothesay	Thursday 12th January	2pm — 5pm 6pm—8pm
Village Hall Port Bannatyne	Thursday 26th January	2pm — 5pm
Moat Centre Rothesay	Monday 20th February	2pm — 5pm 6pm—8pm



Come and join us for a  
chat and a cuppa



**Remember, you can ask us to come to your group or meeting!**

Specific events are being organised for staff but anyone is welcome to attend one of our events to give their views. Look out for details or contact your union representative for more details.

*“ WE WILL LISTEN TO YOU, LEARN FROM YOUR EXPERIENCES  
AND USE THIS INSIGHT TO GUIDE WHAT WE DO ”*



Kyles of Bute

## APPENDIX 9

### SCHEDULE OF ENGAGEMENT EVENTS 2017 COMMUNITIES & STAFF

<b>Location / Venue</b>	<b>Date</b>	<b>Details</b>
Baptish Church Hall, <b>Rothesay</b>	Thursday 12 <sup>th</sup> January	2pm – 5pm 6pm – 8pm
Village Hall, <b>Port Bannatyne</b>	Thursday 26 <sup>th</sup> January	2pm – 5pm
Moat Hall, <b>Rothesay</b>	Monday 20 <sup>th</sup> February	2pm – 6pm 6pm – 8pm
Discovery Centre, <b>Rothesay (Feedback Event)</b>	Monday 27 <sup>th</sup> February	2pm – 4pm

**Bute Locality**

**Thomson Court Day Centre, Rothesay**

**Communications & Engagement Process**

**SUMMARY**

It is essential to have in place a robust comprehensive Communications and Engagement Plan to ensure the Argyll and Bute Health and Social Care Partnership carries out its responsibility for public involvement and engagement in accordance with Statutory Guidance<sup>1</sup>, relevant Legislation and Code of Practice. This is also in line with the HSCP Communications and Engagement Strategy agreed by the Integrated Joint Board in June 2016.

A Bute Communications and Engagement Group is now established. The Group will be responsible for developing and implementing the Communications and Engagement Plan for Thomson Court Day Centre.

At its inaugural meeting on 9<sup>th</sup> November, the Communications and engagement Group agreed to adopt the proposed outline Communications and Engagement Plan presented to the Integrated Joint Board (IJB) on 2<sup>nd</sup> November. The outline Plan has been based on previous community and staff engagement processes that have worked well.

The proposed Communications and Engagement Plan will use a model of engagement that has four distinct stages. The four stage are :

**Stage 1** : (now until end November) obtaining all the relevant detailed information about both the current service and proposed service change then 'crafting' how this information will be presented to communities and staff. Information required includes a service profile (current and future), financial costs, activity date / occupancy levels, capacity available in the private sector, population profile (current and projected). This is to ensure people have the right information to be in a position to compare what Thomson Court Day Centre currently provides and how the service will be provided in the future.

It is at this stage that the Bute Communications and Engagement Group will consider best mechanisms for encouraging and obtaining feedback / views. It is anticipated we will use a variety of methods including online (Survey Monkey), feedback forms and feedback obtained through the engagement process.

**Stage 2** : (early December) key information out into the community and encourages communities to discuss it (to hold 'community conversations').

This will encourage people to start talking about and generating better informed views for Stage 3. It means people will have time to digest the initial information, become familiar with it and not be overloaded with information all at once.

**Stage 3** : (mid December – end February) series of engagement activities will be held on Bute. A comprehensive programme of events will be developed by the Bute Communications and Engagement Group. It is anticipated that the programme will include a series of ‘conversation cafés’ which have proved effective in the past. In addition, invitations to attend community council / community group meetings will be encouraged and added to the programme. It is essential to ensure that the proposed involvement / engagement framework includes different methods to meet varying needs.

**Stage 4** : (end February – mid March) preparation of feedback report outlining what people have told us. This report will form the basis of a recommendation report to Locality Planning Group, Locality Management Team, Operational Management Group. This report will be presented to the Senior Management Team and IJB at its meeting in March 2017.

The report will become a public document. Key findings will be communicated to communities and staff ensuring the HSCP adopts the “You Said, We Did” philosophy.

It is recommended that once the HSCP moves to implementation stage that communities and staff are kept up to date on progress.

The full Communications and Engagement Plan will be further developed over the next few weeks and a copy will be posted on the HSCP webpage demonstrating that clear and transparent processes are being adopted and that Statutory Guidance is being duly followed.

A timeline with key milestones of the communications and engagement process is attached with this document.

Caroline Champion  
Public Involvement Manager  
A&B HSCP

18<sup>th</sup> November 2016

(on behalf of Allen Stevenson, Head of Service (East))

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<sup>1</sup> CEL 4 (2010) Informing, engaging and Consulting People in Developing Health and Community Care Services, Scottish Government, February 2010





# Argyll & Bute Health & Social Care Partnership

## Integration Joint Board

Agenda item: 5.2 (i)

Date of Meeting : 29 March 2017

Title of Report : Budget Monitoring – January 2017

Presented by : Caroline Whyte, Chief Financial Officer

### The Integration Joint Board is asked to :

- **Note** the overall Integrated Budget Monitoring report for the January 2017 period, including:
  - Integrated Budget Monitoring Summary
  - Quality and Finance Plan Progress
  - Financial Recovery Plan
  - Financial Risks
  - Reserves
  - Other Project Funding
- **Note** that as at the January period there is a projected year-end overspend of £0.7m primarily in relation to the deliverability of the Quality and Finance Plan, the cost of medial locums and increased demand for social care services.
- **Note** the progress with the delivery of the Quality and Finance Plan and the forecast shortfall in delivery of savings, these will be included as part of the budget planning process for 2017-18.
- **Agree** that the previously approved financial recovery plan requires to continue to be implemented to ensure the delivery of a balanced integrated budget for the 2016-17 financial year. The focus should be on achieving recurring savings, however an instruction has been issued to services that there should be a moratorium on non-essential expenditure for the remainder of the financial year, to limit the impact of the 2016-17 outturn on the 2017-18 budget position.

## 1. EXECUTIVE SUMMARY

1.1 The main summary points from the report are noted below:

- Robust budget monitoring processes are key to ensure that the expenditure incurred by the IJB partners is contained within the approved budget for 2016-17 and that overall the partnership delivers a balanced year-end outturn position.
- This report provides information on the financial position of the Integrated Budget as at the end of January 2016. The projected year-end outturn position is an overspend of £0.7m, the Integration Joint Board requires assurance that

this position can be brought back into line with the available budget by the financial year-end. A financial recovery plan was approved by the IJB on 4 August to address the then forecast £1.5m year-end overspend, this position had reduced and progress was being made with the projected outturn position, however additional demand for services was limiting progress with bringing this position back into line. An instruction was issued at the start of January to put in place a moratorium on non-essential expenditure and the forecast outturn position has reduced from a projected overspend of £1.1m at December to £0.7m at January.

- There are significant financial risks in terms of service delivery for 2016-17 and there are mitigating actions in place to reduce or minimise these, the likelihood of these occurring are reduced as the financial year end is closer, but they should continue to be closely monitored together with the delivery of the Quality and Finance Plan and financial recovery plan.

## **2. INTRODUCTION**

- 2.1 This report sets out the financial position for Integrated Services as at the end of January 2017. Budget information from both Council and Health partners has been consolidated into an Integrated Budget report for the SMT.

## **3. DETAIL OF REPORT**

### **3.1 INTEGRATED BUDGET MONITORING SUMMARY**

- 3.1.1 This main overall financial statement is included as Appendix 1. This contains an objective (service area) financial summary integrating both Health and Council services, with a reconciliation of the overall split of the budget allocation.

#### **Year to Date Position – YTD Overspend - £0.476m**

- 3.1.2 The main areas to note from this are:

- The overall Year to Date variance is an overspend of £0.476m. This consists of an overspend of £0.822m in Council delivered services and an underspend of £0.346m in Health delivered services.
- For both Health and Council delivered services the year to date positions are generally in line with the forecast outturn position detailed later in the report.

- 3.1.3 Council and Health partners use different financial systems and treatments for the monthly profiling of budgets and recording of actual costs which results in financial information relating to the year to date position for the integrated budget not being a reliable indicator of the year-end position. However later in the financial year, as expected, there is more of a direct correlation between the year to date position and the forecast outturn position.

## **Forecast Outturn Position – Projected Overspend - £0.721m**

3.1.4 The year-end forecast outturn position for the January period is a projected overspend of £0.721m. The main areas are noted below:

- Adult Care – projected overspend £5.5m:
  - Anticipated shortfall of £3.1m in the delivery of savings as part of the Quality and Finance Plan, further detail is included in section 3.2.
  - Budget overspends in relation to locum cover for vacancies and sickness absence, the spend on medical locums to January is £1.2m.
  - Projected overspends for additional demand for services including care home placements, home care and supported living, due to new clients and the increasing needs of existing clients. The projected overspend in adult social care services is £1m and is £0.9m for learning disability services. These areas are included in the areas of focus for the Quality and Finance Plan for 17-18 onwards, however any deliverable savings are reduced by the requirement to first reduce the current overspend position.
  
- Chief Officer – projected underspend £0.7m
  - Projected underspend in relation to the additional funding set aside for the investment in Community Based Care and the requirements of Continuing Care. These funds require to remain uncommitted to ensure the delivery of a balanced year-end budget position.
  
- Children and Families – projected underspend £0.7m:
  - Underspend of £0.3m in relation to vacancy savings in Health posts.
  - Projected underspends in relation to fostering and kinship care reflecting the level of demand on the budget and in supporting young people leaving care due to the delay in the development of a new multi-disciplinary team to support young people leaving care.
  - These are partly offset by projected overspends in children and families area teams due to agency staff, the criminal justice partnership share of the partnership shortfall and in residential placements where one new placement has been put into place. This reflects the demand led nature of the service and the high cost of some care packages.
  
- Budget Reserves – projected underspend £1.9m – represents the uncommitted element of budget reserves which can be utilised to offset the overall projected outturn position. There is an additional projected underspend of £0.5m from the Integrated Care Fund. These are non-recurring underspends and in some cases the funding will require to be re-instated for 2017-18.

3.1.5 The forecast outturn position is reliant on a number of assumptions around the current and expected level of service demand and costs, this is subject to change and is reported through routine monthly monitoring. Although there is an overall overspend of £0.721m currently projected this only represents 0.28% of the annual budget, therefore there remain opportunities before the end of the financial year to reduce or bring this position back into line.

3.1.6 There is an overall increase in funding of £1.774m compared to the approved budget. There is an increase in available funding from £256.001m to £257.775m, these in-year changes in funding are noted in Appendix 1. This relates to an overall increase in Health Funding, mainly relating to allocations of funding from the Scottish Government partly offset by a transfer to NHS Highland for centrally provided services. There is an overall increase in Council funding reflecting the amounts drawn down from reserve balances and the additional funding for the Living Wage implementation, these are partly offset by budget transferred out with Integration Services.

### 3.2 QUALITY AND FINANCE PLAN PROGRESS

3.2.1 There is a significant risk around the deliverability of the Quality and Finance Plan for 2016-17. There are significant budget savings to be delivered within an accelerated timescale and it is absolutely key that these remedial plans are delivered to produce a sustainable balanced budget for the partnership. The Integration Joint Board previously requested further detail on the progress with delivering savings, including the impact on the 2017-18 budget.

3.2.2 Progress with the individual budget reductions outlined in the Quality and Finance Plan is detailed in Appendix 2. This notes the savings delivered to date, an overall risk assessment of the deliverability of the individual savings, and an estimate of the amount to be delivered during 2016-17 and 2017-18. The risk category of the individual savings has been updated and this can be compared with the anticipated risk of delivery when the savings were approved in June 2016.

3.2.3 There are budget reductions totalling £8.498m required to produce a balanced partnership budget. These savings have all been previously approved by the Integration Joint Board for implementation.

3.2.4 Progress on the delivery of savings is summarised below:

Risk Category	Number	Budget Reduction £000	Achieved to January 2017 £000	Remaining £000	Forecast Shortfall 2016-17 £000	Forecast Shortfall 2017-18 £000
<b>RED</b>	20	3,625	924	2,701	2,578	2,352
<b>AMBER</b>	19	2,538	1,418	1,120	1,006	768
<b>GREEN</b>	24	2,335	2,166	169	123	15
<b>TOTAL</b>	<b>63</b>	<b>8,498</b>	<b>4,508</b>	<b>3,990</b>	<b>3,707</b>	<b>3,135</b>

- 3.2.5 As at the end of January 2017 recurring budget reductions of £4.508m have been achieved, this compares to a total of £4.395m at the December 2016 period, an increase of £0.113m. This demonstrates the progress in delivering savings.
- 3.2.6 Additional savings in social care services were approved by the Integration Joint Board on 22 June 2016. Plans to deliver these savings are in place however it is unlikely these will all be fully delivered in 2016-17 given the timescales around engagement and there are likely to be delays with releasing some of the savings. Progress with delivery of these savings is included within the overall savings monitoring in Appendix 2.
- 3.2.7 The update on progress includes an estimate of the recurring shortfall in delivery of savings on a recurring basis from 2017-18 onwards, this estimated total shortfall is £3.135m and this will be factored into the budget outlook for 2017-18. The removal of any of these previously approved savings from the Quality and Finance Plan from 2017-18 onwards will require approval from the Integration Joint Board. The majority of these savings will appear on the Quality and Finance Plan for 2017-18 and 2018-19, to ensure transparency of reporting when savings have been achieved. Where savings are removed completely the IJB would be provided with further information from services to challenge the deliverability of savings to ensure an informed decision can be taken before removing these from the savings plan.
- 3.2.8 The risk category attached to each of the savings is an assessment of the deliverability. The risk categories were updated at the October period. There were originally eight options assessed to be red risk which accounted for £2.250m of the total savings. With the risk category reviewed there were 20 options classed as red risk and these account for £3.625m of the total savings. This is indicative of the challenges and complexity with delivering service changes which were not foreseen when they were approved. The updated red risk savings are noted below:
- Prescribing
  - Rural Cowal Out of Hours Service
  - Re-design of community pathways and community hospital services to shift the balance of care as a result of reduced length of stay, reduced delayed discharges and reduced emergency admissions – Cowal, Bute, Kintyre and Islay
  - Closure of AROS
  - Kintyre Medical Group
  - Management and Corporate Staffing
  - IT and Telephony Re-provision
  - Ardlui Respite Facility
  - Consultation Support Forum
  - Homecare Review
  - Struan Lodge Service Re-design
  - Thomson Court Day Service
  - Bowman Court Progressive Care Centre
  - Mental Health Support Team
  - Support for Carers
  - Learning Disability Day Services
  - Homecare Packages

3.2.9 There is a reported forecast overspend of £0.7m as at the January 2017 period, this is primarily in relation to the expected shortfall in the delivery of the Quality and Finance Plan. The estimate is that £3.7m of the savings will not be deliverable in 2016-17, services are working to address this position and underspends in other service areas have been forecast to reduce this expected year-end overspend position.

### **3.3 FINANCIAL RECOVERY PLAN**

3.3.1 The Integration Joint Board has a responsibility to ensure a balanced year-end budget position and there will be financial consequences for the partner bodies and the IJB if this not delivered. Therefore a recovery plan was approved by the IJB on 4 August to address the reported forecast overspend of £1.5m as at the June period.

3.3.2 The plan included management actions to bring the projected spend back into line with budget. The actions do not have any policy implications, will have limited impact on the day to day delivery of services and can be delivered in the normal course of business. The areas identified included:

- Review of the payment to Greater Glasgow and Clyde – initial analysis of the most recent iteration of the financial model indicates that the saving in relation to this included in the Quality and Finance Plan is achievable. There may be a further opportunity to reduce the payment by negotiation.
- Review spending plans against non-recurring funding allocations with a view to removing uncommitted elements of any non-recurring resource allocations. Depending on the nature of the funding there may be a requirement to re-instate funding in 2017-18.
- Further efficiencies and cost reduction through vacancy management, management of sickness absence and standardisation of procurement processes.
- Drive forward the re-design of community pathways and community hospital services to shift the balance of care as a result of reduced length of stay, reduced delayed discharges and reduced emergency admissions.
- Review of future commitments on non-pay non-essential expenditure budgets, for example furniture replacement.
- Restricting new investment to core service delivery.

3.3.3 The Strategic Management Team has been adhering to this recovery plan, the forecast overspend position had reduced from £1.5m in June to £0.2m as at September and increased again to £1.2m as at the October financial monitoring period. The plan has recovered a proportion of the overspend, however an increase in the estimated non-delivery of savings and in demand for services has increased the projected overspend position, the projected overspend position as at January is £0.7m.

3.3.4 The IJB has two months to recover the £0.7m projected overspend position. In an attempt to bring the expenditure back into line within the delegated budget the Strategic Management Team agreed at the start of January 2017 to issue an instruction to all service managers and budget holders that a moratorium has been applied across the integrated budget, i.e. for both Health and Council budgets. There will be no commitment of discretionary budgets and any non-clinical or non-front line service delivery posts will not be filled until 1 April 2017. In the month following the issue of this instruction the forecast overspend

position has reduced from £1.1m to £0.7m, however not all of this reduction can be attributed to the moratorium on expenditure as there has been movement in demand for services and further underspends in project funds. The Scheme of Integration outlines that any overspend will require to be funded by the partners in-year, however that this will be repaid by the IJB in future years. The projected overspend position for 2016-17 should be brought into line with budget to limit the impact on the 2017-18 budget position.

3.3.5 The Strategic Management Team are clear that the focus should be directed to actions that will deliver recurring savings, the main area being the driving forward the delivery of the Quality and Finance Plan. Any other actions will assist in producing an overall balanced year-end position for 2016-17 but will lead to a greater budget gap to address on a recurring basis from 2017-18. The delivery of the recovery plan to date is mainly in relation to one-off actions that will not address the budget gap on a recurring basis. For example the removal of budget reserves, the non-committal of project funding and the additional budget allocations for community based care and continuing care. Some of these budgets will not be available in 2017-18 and in some cases by utilising these funds in this way this will add to the pressures for 2017-18 as the funding will require to be re-instated. The focus should be directed to actions that will deliver recurring savings, the main area being driving forward the Quality and Finance Plan.

### 3.4 FINANCIAL RISKS

3.4.1 An assessment of financial risks together with the likelihood and impact and the potential financial consequences for the Integrated Budget is included as Appendix 3. This only includes financial related risks and highlights areas where there are potential cost or demand pressures facing service delivery.

3.4.2 There are 5 financial risks with a potential financial impact of £1.8m noted at the January 2017 period. These are assessed in terms of likelihood and a summary of the risks is noted in the table below:

Likelihood	Number	Potential Financial Impact £000
Almost Certain	0	0
Likely	0	0
Possible	5	1,850
Unlikely	0	0
<b>TOTAL</b>	<b>5</b>	<b>1,850</b>

3.4.3 The potential financial impact represents the estimated full year impact on the budget, this value will reduce as we progress through the financial year. The financial risks have reduced throughout the year, mainly as a result of the risks materialising and being reported through the forecast outturn position, for example the risk of non-delivery of savings in the Quality and Finance Plan.

3.4.4 At January being 10 months through the financial year the financial risk exposure is significantly reduced. However the integrated budget is still

exposed to risks in relation to demand and in some service areas, for example children's services, a small increase in demand can result in a significant increase in cost. The level of financial risks has decreased throughout the year, however in some cases this is because the risk has materialised and has had a financial impact, for example medical locum costs.

### **3.5 RESERVES**

3.5.1 The Integration Joint Board does not have any opening reserve balances but there are inherited reserve balances from Council delivered services. These balances for 2016-17 total £0.4m. The balances are mainly in relation to unspent grant monies carried forward or funds the Council has earmarked from the general fund for service development. The funds are committed for specific projects previously approved by the Council, this includes funding for:

- Self Directed Support
- Sensory Impairment
- Autism Strategy
- Care at Home – Fairer Work Practices
- Integrated Care Fund
- Early Intervention (Early Years Change Fund)
- Criminal Justice Transformation

### **3.6 OTHER PROJECT FUNDING**

3.6.1 There are specific additional funding allocations to drive forward integration work including the Integrated Care Fund, Technology Enabled Care and Delayed Discharge. An Improving Care Programme Board has been put into place in terms of the governance arrangements for these funds and their role is to ensure that funds are directed to achieve the desired priorities.

3.6.2 These funds are time-limited and it is crucial they are used effectively to invest in the changes in service delivery required to deliver on the outcomes in the Strategic Plan. The funding available for 2016-17 totals £3.355m and Appendix 4 notes the allocations from these funds.

## **4. CONTRIBUTION TO STRATEGIC PRIORITIES**

4.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery, monitoring this budget through the financial year is key to ensuring a balanced budget position.

## **5. GOVERNANCE IMPLICATIONS**

### **5.1 Financial Impact**

5.1.1 The monitoring of the budget is key to ensure the delivery of the financial plans for 2016-17, as at the January 2017 monitoring period significant financial risks have been identified and services are forecasting a year-end overspend of £0.7m. The recovery plan requires to continue to be implemented and monitored to ensure this can be brought back into line with the delegated



budget. A moratorium on non-essential expenditure has also been implemented from January 2017.

## **5.2 Staff Governance**

None

## **5.3 Clinical Governance**

None

## **6. EQUALITY & DIVERSITY IMPLICATIONS**

None

## **7. RISK ASSESSMENT**

7.1 Financial risks are monitored as part of the budget monitoring process.

## **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT**

8.1 Where required as part of the delivery of the Quality and Finance Plan local stakeholder and community engagement will be carried out as appropriate in line with the re-design of service provision.

## **9. CONCLUSIONS**

9.1 This report summarises the financial position of the Integrated Budget as at January 2017. The forecast year-end outturn position is a projected overspend of £0.7m, the previously approved financial recovery plan requires to continue to be implemented and monitored to ensure the delivery of a year-end balanced budget. The focus should be placed on the delivery of the savings from the Quality and Finance Plan to reduce expenditure on a recurring basis. However in an attempt to bring in expenditure at the year-end within the delegated budget a moratorium on non-essential expenditure is in place, this includes the non-filling of posts which are not for front line delivery of services.

9.2 The forecast overspend position has decreased from the June period by £0.8m as a result of progress with the recovery plan and further one-off income or budget reductions which can be utilised to balance the overall budget position in 2016-17. These actions have however been partly offset by additional demand pressures and a forecast shortfall in the delivery of savings previously approved from social care services which has reduced the impact of these actions on the forecast overspend position.

9.3 The report also highlights the level of financial risk associated with delivering a year-end balanced Integrated Budget. There are significant financial risks in relation to the demands on service delivery and significant risks in relation to the delivery of the Quality and Finance Plan, although these risks are reducing as we move closer to the financial year-end. These risks and the projected outturn position will continue to be closely monitored and reported as part of the overall approach to budget monitoring.

**APPENDICES:**

Appendix 1 – Integrated Budget Monitoring Summary – January 2017

Appendix 2 – Quality and Finance Plan Progress – January 2017

Appendix 3 – Financial Risks – January 2017

Appendix 4 – Other Project Funding – January 2017

## INTEGRATED BUDGET MONITORING SUMMARY - JANUARY 2016

	Year to Date Position				Forecast Outturn			Previous Period	
	YTD Actual	YTD Budget	YTD Variance	Variance	Annual Budget	Forecast Outturn	Forecast Variance	Forecast Variance	Movement in month
	£000	£000	£000	%	£000	£000	£000	£000	£000
<b>Service Delegated Budgets:</b>									
Adult Care	105,838	101,835	(4,003)	-3.9%	126,603	132,097	(5,494)	(5,659)	165
Alcohol and Drugs Partnership	979	979	0	0.0%	1,314	1,314	0	0	0
Chief Officer	506	381	(125)	-32.8%	1,460	749	711	655	56
Children and Families	15,238	16,256	1,018	6.3%	19,838	19,146	692	661	31
Community and Dental Services	3,342	3,423	81	2.4%	4,108	4,008	100	100	0
Integrated Care Fund	784	1,209	425	35.2%	2,090	1,580	510	500	10
Lead Nurse	1,080	1,125	45	4.0%	1,348	1,278	70	80	(10)
Public Health	977	1,030	53	5.1%	1,268	1,188	80	60	20
Strategic Planning and Performance	2,910	2,981	71	2.4%	3,708	3,608	100	111	(11)
	131,654	129,219	(2,435)	-1.9%	161,737	164,968	(3,231)	(3,492)	261
<b>Centrally Held Budgets:</b>									
Budget Reserves	0	1,400	1,400	100.0%	2,050	150	1,900	1,900	0
Depreciation	2,166	2,203	37	1.7%	2,649	2,602	47	45	2
General Medical Services	12,810	12,798	(12)	-0.1%	15,449	15,449	0	0	0
Greater Glasgow & Clyde Commissioned Services	48,609	48,430	(179)	-0.4%	58,116	58,316	(200)	(220)	20
Income - Commissioning and Central Management and Corporate Services	(1,076)	(1,003)	73	-7.3%	(1,181)	(1,246)	65	50	15
NCL Primary Care Services	1,141	1,437	296	20.6%	1,847	1,479	368	354	14
Other Commissioned Services	2,874	3,218	344	10.7%	3,861	3,531	330	300	30
Resource Release	4,081	4,081	0	0.0%	4,897	4,897	0	0	0
	77,875	79,834	1,959	2.5%	96,038	93,528	2,510	2,429	81
<b>Grand Total</b>	<b>209,529</b>	<b>209,053</b>	<b>(476)</b>	<b>-0.2%</b>	<b>257,775</b>	<b>258,496</b>	<b>(721)</b>	<b>(1,063)</b>	<b>342</b>

## Reconciliation to Council and Health Partner Budget Allocations:

	Year to Date Position				Forecast Outturn			Previous Period	
	YTD Actual	YTD Budget	YTD Variance	Variance	Annual Budget	Forecast Outturn	Forecast Variance	Forecast Variance	Movement in month
	£000	£000	£000	%	£000	£000	£000	£000	£000
Argyll and Bute Council	46,775	45,953	(822)	-1.8%	55,966	57,187	(1,221)	(1,563)	342
NHS Highland	162,754	163,100	346	0.2%	201,809	201,309	500	500	0
<b>Grand Total</b>	<b>209,529</b>	<b>209,053</b>	<b>(476)</b>	<b>-0.2%</b>	<b>257,775</b>	<b>258,496</b>	<b>(721)</b>	<b>(1,063)</b>	<b>342</b>

FUNDING RECONCILIATION - JANUARY 2016

Partner	£000	£000	£000
<p><b>Argyll and Bute Council:</b>                      Opening Funding Approved                      Annual Budget at December 2016  <b>Movement</b>  <i>Details:</i>                      Non-recurring drawdown of budget from Reserves                      Reduction due to re-alignment of Utility Budgets across the Council                      Transfer of Budget outwith Integration for Helensburgh Office receptionist                      Additional Funding approved by Council for the Living Wage</p>		55,553 55,966 <hr/> 413	332 (21) (8) 110 <hr/> 413
<p><b>NHS Highland:</b>  <b>Opening Funding Approved:</b>                      Core NHS Funding                      Additional SG Funding                      Opening Funding Approved                      Annual Budget at December 2016  <b>Movement</b>  <i>Details:</i>                      Budget Carry Forwards (ICT, TEC &amp; ADP)                      New Medicines Funding                      Other SG funding increases/decreases                      Transfer to Health Board for Central Services</p>	195,868 4,580	200,448 201,809 <hr/> 1,361	716 1,000 1,717 (2,072) <hr/> 1,361

QUALITY AND FINANCE PLAN PROGRESS - JANUARY 2016

New Ref	Service Area	Description	Lead	TARGET 2016-17		Achieved	Remaining	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
				Budget Reduction £000	FTE Reduction	£000						
1	Prescribing	Targeted focus on safe, effective, appropriate cost effective prescribing, as well as reducing waste. Argyll and Bute Medicines Management Group re-established to take forward actions.	Fiona Thomson	500	0.0	400	100	High risk area in terms of delivery of savings as there have been failures in the past in delivering savings in prescribing. Savings achieved include use of scriptswitch, dose optimisation, change to generics, patient access scheme rebates, primary care rebate scheme, formulation changes and implementation of pharmacists advice by practices.	RED	RED	100	100
2	NHS GG&C Service Level Agreement	Participate in a review of the costing and activity model to review tariff and activity levels. Take action to reduce admission rates and speed discharge up to local services and reduce outpatient follow up appointments.	Stephen Whiston	500	0.0	500	0	Full saving achieved through impact of the West of Scotland Cross Boundary Flow in terms of the fluctuations in patient activity.	AMBER	GREEN	0	0
3	Commissioned Services	Review individual placements out of the area and where possible re-negotiate tariffs/contracts.	Stephen Whiston	250	0.0	250	0	Achieved.	GREEN	GREEN	0	0
4	Speech & Language Therapy Services	Re-align services to focus on delivering capacity building and a universal approach in partnership with Education.	Linda Currie	140	3.2	125	15	Unlikely that balance of £15k will be delivered.	GREEN	GREEN	15	15
5	Rural Cowal Out of Hours Service	Carry out review of service delivery model and implement service re-design.	Allen Stevenson	300	2.9	0	300	No evidence of progress being made to release savings. Requires the co-operation of GPs, delivery of the saving is not fully within the control of the service.	RED	RED	300	300
6	Re-design Community Hospital - Cowal	Re-design provision of services across the Argyll and Bute area, with a focus on quality outcomes and aligning service provision to capacity and current service delivery requirements. By shifting the balance of care as a result of reduced length of stay, reduced Delayed Discharges and reduced energy admissions.	Allen Stevenson	500	6.7	0	500	A review of in-patient services has concluded that it is possible to reduce the number of beds in Cowal Community Hospital by 6 from 20 to 14, achieving a recurring saving on nurse staff costs of £123k. A proposal is being presented to the LPG for agreement prior to implementation. Bed numbers would require to reduce further to deliver the full saving. No saving has been declared to date for 2016-17 but there are underspends in nursing staff costs.	RED	RED	377	377
7	Re-design Community Hospital - Victoria Hospital, Bute		Allen Stevenson	250	4.1	0	250	The current plan is to reduce the number of beds in Rothesay Victoria Hospital by 5 from 13 to 8. This could achieve a recurring saving of £33k in nursing staff costs. However no commitment has been provided by the locality to achieve any saving and to date the budget is overspent.	RED	RED	250	250
8	Re-design - Lorn and Islands Hospital		Lorraine Paterson	500	11.5	288	212	The current plan is to re-design the medical unit reducing the bed compliment from 42 to 34, a reduction of 8. This will achieve savings of £288k on nursing pay costs, savings declared to date for 2016-17 relate to reductions in one ward.	AMBER	AMBER	212	212
9	Re-design Community Hospital - Mid Argyll		Lorraine Paterson	500	22.0	350	150	This target relates to savings on nurse staff costs from a reduction of 17 beds in the lower ground floor dementia ward. This savings should be achievable in the longer term as the delay in implementation for 2016-17 is due to low staff turnover.	GREEN	AMBER	150	150

QUALITY AND FINANCE PLAN PROGRESS - JANUARY 2016

New Ref	Service Area	Description	Lead	TARGET 2016-17		Achieved January 2016	Remaining	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
				Budget Reduction £000	FTE Reduction	£000	£000					
10	Re-design Community Hospital - Kintyre	Re-design provision of services across the Argyll and Bute area, with a focus on quality outcomes and aligning service provision to capacity and current service delivery requirements. By shifting the balance of care as a result of reduced length of stay, reduced Delayed Discharges and reduced energy admissions.	Lorraine Paterson	250	3.8	18	232	The initial plan was to reduce by 4 beds, this has now been changed to reduce staffing levels while maintaining the existing bed complement. To deliver additional savings in 2017-18 there would need to be a willingness and a plan to reduce bed numbers and the staffing levels further.	RED	RED	232	232
11	Re-design Community Hospital - Islay		Lorraine Paterson	250	5.5	20	230	A review of nurse staffing has produced a small saving, it is difficult to see how further savings can be achieved while an in-patient facility remains open. Staffing levels are now 3 per shift and there is no support to reduce this any further.	RED	RED	230	230
12	Argyll and Bute Hospital Staffing	Transfer of inpatient mental health services from Argyll and Bute Hospital to MACHICC.	Lorraine Paterson	300	8.4	245	55	On track to be fully delivered.	GREEN	GREEN	0	0
13	Closure of West House	A number of support services for Argyll and Bute Hospital are provided from this building, staff would be relocated to other available accommodation.	David Ross	500	0.0	131	369	In progress. Full saving will not be realised until building fully closes. Much work has still to be done to re-locate staff and services from West House and Succoth.	AMBER	AMBER	270	100
14	Closure of AROS	A number of support services including HR and Finance are provided from this building, staff would be relocated to other available accommodation.	David Ross	150	0.0	0	150	High risk as substantial amount of work remaining to arrange re-location of staff and services from the building. Unlikely that any saving will be achieved in 2016-17. Work to re-locate staff will have to be pushed forward to ensure the full saving can be achieved in 2017-18.	RED	RED	150	150
15	Kintyre Medical Group	In the longer term it is anticipated that the operation of the services will be taken on by Campbeltown Medical Practice, a transitional plan is in development to support this change.	Lorraine Paterson	75	2.0	0	75	No saving achieved to date. No certainty over delivering this service and the costs associated with the service transferring.	GREEN	RED	75	25
16	Management & Corporate Staffing	Level of staffing review, reduced with no or limited impact on service delivery.	George Morrison	200	5.0	127	73	Savings achieved to date are the removal of a post from the finance team and reductions to legal and consultancy costs. Unlikely that full saving will be achieved in 2016-17 on an recurring basis going forward.	AMBER	RED	73	73
17-20	Locality General Savings 1%	Efficiency savings target applied across localities.	Allen Stevenson/ Lorraine Paterson/ Louise Long	602	0.0	602	0	Achieved.	AMBER	AMBER	0	0
21	Review Day Hospital Services for Older People with Dementia	Re-design of traditional day services.	Lorraine Paterson	25		0	25	No savings achieved as yet, dependant on the closure of the day hospital service in Campbeltown.	AMBER	AMBER	25	0
22	IT Services	Productivity gains and telephony cost reduction.	Stephen Whiston	50	0.0	0	50	Business case being developed for longer term savings in telephones and IT, unlikely that any savings will be delivered this financial year. The investment required to extend the Lync system across the HSCP is significant and could also deliver significant savings. Recommended that this saving is removed from the plan and replaced with savings in line with the business case when this has been developed.	RED	RED	50	50
23	AHP Service Redesign Helensburgh for Dietetics and Podiatry	Identify opportunities and deliver re-design within the community mental health team.	Allen Stevenson	42	0.0	15	27	Unlikely to fully achieve target, specifically in relation to Dietetics.	AMBER	AMBER	27	27
24	CMHT Nursing Redesign Helensburgh		Allen Stevenson	11		11	0	Achieved.	GREEN	GREEN	0	0
25	Islay - Reduction in Patient Travel	Investigate and where possible provide appropriate services locally to reduce travel.	Lorraine Paterson	30		30	0	Achieved.	GREEN	GREEN	0	0
26	Public Health Services Redesign		Elaine Garman	35		35	0	Achieved.	GREEN	GREEN	0	0

QUALITY AND FINANCE PLAN PROGRESS - JANUARY 2016

New Ref	Service Area	Description	Lead	TARGET 2016-17		Achieved January 2016	Remaining	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
				Budget Reduction £000	FTE Reduction	£000	£000					
27	Kintyre Patient Transport Redesign	Investigate and where possible provide appropriate services locally to reduce travel.	Lorraine Paterson	25		0	25	No evidence of progress to date and no plans in place to re-design the service. Savings would require reducing air travel and the number of patient escorts.	AMBER	AMBER	25	25
28	Mid Argyll/A&B Hospital Catering Services	Relocation and Conversion to Cook/Freeze	Lorraine Paterson	50		50	0	Achieved.	GREEN	GREEN	0	0
29	Mid Argyll Operational Teams Redesign	Re-design and restructure community teams to deliver single system approach to care delivery	Lorraine Paterson	20		0	20	In progress.	AMBER	AMBER	0	0
30	Child Health	Review of child health medical staffing levels.	Louise Long	10		10	0	Achieved.	GREEN	GREEN	0	0
31	Learning Disabilities	Review the provision of day services considering external provision.	Lorraine Paterson	25		0	25	In progress, not expected to be delivered in 2016-17.	AMBER	AMBER	25	25
32	Clinical Governance	Review of clinical governance team workload and staffing.	Liz Higgins	20		0	20	In progress, not expected to be delivered in 2016-17.	AMBER	AMBER	20	20
33	Infection Control	Review of infection control team workload and staffing.	Liz Higgins	10		10	0	Achieved.	AMBER	AMBER	0	0
34	Child Protection Services	Review of child protection services budget.	Liz Higgins	20		20	0	Achieved.	GREEN	GREEN	0	0
35	Medical Physics	Review provision of medical physics services to Argyll and Bute.	Lorraine Paterson	15		15	0	Achieved.	GREEN	GREEN	0	0
36	Community Dental Service	Review of community dental services and staffing levels.	Euan Thomson	25		25	0	Achieved.	GREEN	GREEN	0	0
37	Custodial Healthcare	Anticipated cost reduction in the provision of out of hours services in the Cowal and Helensburgh areas.	George Morrison	20		30	-10	Achieved.	GREEN	GREEN	0	0
38	Review of Budget Reserves	Review of uncommitted and discretionary spend budgets held in reserve. This relates to budgets where either Scottish Government funding has been received and not yet allocated or locally established budgets relating to forecast cost increases or service developments. For these monies the funds aren't released to managers until there is a clear spending plan, where these do not come forward the budget reserves can be undercommitted.	George Morrison	300		271	29	On track to be fully delivered.	GREEN	GREEN	0	0
39	Older People's Services	Undertake a longer term review of Council owned care homes across Argyll and Bute during 2016-17 with a view to reducing placement costs.	Allen Stevenson/ Lorraine Paterson			tbc	0	No specific target. References 55 to 57 are options to take this work forward.			0	0
40	Learning Disability Service	Undertake a longer term review of Council run Learning Disability Day Services/Resource Centres during 2016-17 to establish demand in each locality and develop options for person-centred service re-design.	Allen Stevenson/ Lorraine Paterson			tbc	0	No specific target.			0	0
41	Social Work Administration Staffing	Removal of vacant and temporary posts, will be implemented as part of a review of the administration services across the whole partnership.	Louise Long	100	5.0	100	0	Achieved.	GREEN	GREEN	0	0
42	Reduce Printing and Postage Costs	Will be delivered through increased use of electronic communication such as email	Stephen Whiston	18	0.0	18	0	Achieved.	GREEN	GREEN	0	0
43	Public Dental Service	Recurring allocations are included in the Health offer of funding. There has been a confirmed reduction to the Public Dental Service allocation which represents a 5% reduction. There has been a roll back of provision in advance of this reduction and the budget is forecast to be underspent by £205k in 2015-16. The reduction can be met through non-filling of vacant posts.	Euan Thomson	176	tbc	175	1	Achieved.	GREEN	GREEN	0	0
44	Reduction to Outcomes Framework Allocations	Recurring allocations are included in the Health offer of funding. A number of previous allocations issued separately have been rolled up into a new Outcomes Framework Allocation. This includes for example eHealth, Effective Prevention, GIRFEC, Policy Custody, Dental Services. The total funding was £2.2m in 2015-16 and the reduction represents a 5.5% reduction. A plan will be drafted for a targeted approach to a reduction from the Outcomes Framework allocations with a focus on reducing discretionary/non-recurring costs.	Liz Higgins Stephen Whiston Euan Thomson Elaine Garman	124		153	-29	Achieved.	GREEN	GREEN	0	0
45	Ardlui Respite Facility	Services at Ardlui have consistently been charged for at the intensive service cost rate. Cost reductions could be achieved by reviewing the rates paid to the supplier to ensure that the appropriate rate is paid for each child.	Louise Long	10	0.0	0	10	Following a review of the demands, pressures and savings identified in May, this saving has been reviewed and up-to-date commitment data suggests that this saving will not materialise. However, the saving is fully offset by reductions in the forecast demand/cost pressure previously assessed against the Children's Houses and children with a disability on a recurring basis.	GREEN	RED	10	10

QUALITY AND FINANCE PLAN PROGRESS - JANUARY 2016

New Ref	Service Area	Description	Lead	TARGET 2016-17		Achieved January 2016	Remaining	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
				Budget Reduction £000	FTE Reduction	£000	£000					
46	Other Residential Respite	Although an unpredictable budget, regular monitoring and control of services and costs could yield a cost saving over the year unless a high dependency case arises which uses up the funds available.	Louise Long	10	0.0	0	10	The 2016-17 saving will not be delivered due to demand for services for 2 high need clients. Expected to be delivered for 2017-18 as one of the two current high cost service users using this budget will transition to Adult Services.	GREEN	AMBER	10	0
47	Adoption	Review the payments made to adoptive parents where they are continuing to receive payments equivalent to the foster care rates in order to produce cost savings.	Louise Long	10	0.0	0	10	The 2016-17 saving will not be delivered due to increased demand for the service.	GREEN	AMBER	10	0
48	Children's Houses	Review the rotas operating in the children's houses to negate the affect of absence and assist with the additional support required by several high dependency young people. One area to consider is increasing the pool of staff to avoid anyone working beyond 37 hours per week drawing overtime costs.	Louise Long	30	0.0	30	0	Achieved.	GREEN	GREEN	0	0
49	Foster Care	Review one external foster care placement and move child to Shellach View/internal foster carer in order to reduce costs.	Louise Long	30	0.0	30	0	Achieved.	GREEN	GREEN	0	0
50	Residential Placements	Arrange to transfer three existing externally placed young people into the Council's children's houses at the earliest opportunity in order to reduce costs. Additional savings may be available within this activity but may be required to support Kinship Care Payments dependant upon the uptake of the new Kinship Care Orders.	Louise Long	22	0.0	0	22	Due to two new unplanned placements into external residential care this saving will not be realised in 2016-17. Plans are being developed to repatriate as many children back to Argyll as possible which could produce a saving in 2017-18.	GREEN	AMBER	22	0
51	Supporting Young People Leaving Care	Likely cost avoided from lead time to implement Alternatives to Care project.	Louise Long	17	0.0	22	-5	This saving will not be recurring in 2017-18 when the new team is in place.	GREEN	AMBER	0	17
52	Consultation Support Forum	Likely cost avoided from lead time to implement revised service model.	Louise Long	5	0.0	5	0	A delay in the Life Choices Initiative is likely to lead to this saving being delivered in 2016-17 but this is not likely on a recurring basis.	GREEN	RED	0	5
53	Children Affected by Disability	Cost avoided due to clients transferring to Adult Services.	Louise Long	15	0.0	15	0	Achieved.	GREEN	GREEN	0	0
54	Homecare Review	Comprehensive re-design to incorporate: - Integrating reablement services for assessment and care management - homecare procurement and external providers - change delivery model from time and task to outcome focussed - integrate external providers into assessment and care management process - delivering services on a patch basis to reduce unproductive time	Allen Stevenson/ Lorraine Paterson	375	0.0	193	182	The Commissioning Team have started to work on a patching model for service distribution across Argyll. £193k of this saving has been delivered in East Argyll but no progress has been made in West Argyll to date. It is unlikely that the remaining £182k will be delivered in 2016-17 from West Argyll, there is the possibility of East delivering a little more as patching arrangements kick in. It is likely that all of the savings will be achieved on a recurring basis.	AMBER	RED	182	125
55	Struan Lodge Service Re-design	Re-design the service provided by the teams at Struan Lodge Care Home and Struan Day Service to end residential care on the site and instead create a community support hub which provides reablement, drop-in, assessment and review and day/social support to older people, including people with dementia, in the Cowal area. This would include a review of the vehicles used by the new service to support the provision of a community transport service for all client groups across Cowal (for example taking patients home from hospital etc.). As staff turnover allows, divert funds to support befriender schemes in Cowal to improve services in the community, supported from the hub. The lead in time for delivering on this could be significant as the service is re-designed.	Allen Stevenson	175	14.0	0	175	Decision taken at Special IJB meeting on 2nd November to pause implementation. No saving will be achieved for 2016-17. Assume as decision has not been reversed that this saving will still be achieved for 2017-18, and an additional saving would be achieved as this represented a part-year saving.	AMBER	RED	175	0



QUALITY AND FINANCE PLAN PROGRESS - JANUARY 2016

New Ref	Service Area	Description	Lead	TARGET 2016-17		Achieved January 2016	Remaining	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
				Budget Reduction £000	FTE Reduction	£000	£000					
56	Thomson Court Day Service	Review model of dementia day service provision including the balance of funding to provide befriender services in and around Rothesay.	Allen Stevenson	10	3.0	0	10	Decision taken at Special IJB meeting on 2nd November to pause implementation. No saving will be achieved for 2016-17.	AMBER	RED	10	0
57	Tigh a Rudha Care Home	Realign capacity to match the level of service provision required, staffing is reduced in a stepped basis based on registration requirements. Review will look at usage of Hospital beds and will ensure that there is capacity for an element of growth.	Lorraine Paterson	18	1.5	18	0	Achieved.	AMBER	GREEN	0	0
58	Gortonvogie Care Home	Realign capacity to match the level of service provision required, staffing is reduced in a stepped basis based on registration requirements. Review will look at usage of Hospital beds and will ensure that there is capacity for an element of growth.	Lorraine Paterson	18	1.5	0	18	A review of the staffing structure is underway which is expected to deliver some savings most likely from 2017-18 onwards, the extent of which is still to be established. For 2016-17, the unit has over-recovered on income but this cannot be relied upon in future years.	GREEN	AMBER	18	0
59	Bowman Court Progressive Care Centre	Review overnight provision to share staffing resource across the progressive care centre and adjoining hospital. Increase the pool of bank staff based at the unit/work jointly with external providers to provide absence cover, eliminating unfunded overtime and mileage costs. Review grades and tasking of existing staff group to bring them into line with agreed homecare grades.	Lorraine Paterson	80	0.0	0	80	Discussions are ongoing regarding savings proposals put forward by the local management team. A staffing redesign is underway and although this will avoid excess costs, it will not facilitate a reduction in budget. Work remains outstanding in relation to the review of the grades of existing senior staff at the unit. The 2016-17 saving will not be delivered and it is doubtful that the full saving will be delivered during 2017-18.	AMBER	RED	80	80
60	Sleepover Provision	Review overnight support services where it is deemed safe to do so and replace with telecare equipment and the local responder provision.	Allen Stevenson/ Lorraine Paterson	150	0.0	0	150	Work has been ongoing to review existing sleepover packages with a view to replacing with alternative care. Additionally, the Commissioning Team are reviewing how sleepovers are delivered to high risk clients going forward with a view to sharing support/moving to block arrangements where possible. It is expected that changes to packages will commence in early December however, due to the late start in reducing packages and the cost implication of new sleepover rates which address the National Living Wage and European Working Time Directive, the 2016-17 saving will not be achieved. The 2017-18 saving is expected to be achieved, but a different approach will be required to achieve savings, therefore this full saving will be included on the Q&F plan for 2017-18.	AMBER	AMBER	150	150
61	Internal Mental Health Support Team	Review the level of provision available from the community support team and the role of the internal mental health support worker to consider if it meets the requirements of the service and provides best value. Proposed saving reflects the underspend produced in 2015/16, this is expected to be recurring.	Allen Stevenson/ Lorraine Paterson	60	0.0	0	60	At the moment, given the pressures on the service it is unlikely that the full £60k saving will be delivered in 2017-18.	GREEN	RED	60	60
62	Assessment and Care Management Financial Assessments	Replace four para-professional LGE8 care managers with four LGE6 finance assistants and transfer responsibility for the completion of all financial assessments to the new staff group. Review of current posts including opportunities for accommodating through vacancies or natural turnover.	Allen Stevenson/ Lorraine Paterson	12	0.0	0	12	There are currently no temporary posts available to provide an opportunity to deliver this saving and so it is extremely unlikely that it will be delivered during 2016-17. Unless the implementation of the UAA (Universal Adult Assessment) progresses dramatically over the next few months, it is unlikely that the 2017-18 saving will be delivered.	AMBER	AMBER	12	12

QUALITY AND FINANCE PLAN PROGRESS - JANUARY 2016

New Ref	Service Area	Description	Lead	TARGET 2016-17		Achieved	Remaining	Progress	ORIGINAL Risk of Delivery (RAG)	CURRENT Risk of Delivery (RAG)	Projected Shortfall 2016-17	Projected Shortfall 2017-18 onwards.
				Budget Reduction £000	FTE Reduction	January 2016 £000	£000					
63	Assessment and Care Management Reduction	Remove 2 FTE para-professional care managers across Argyll to reflect the increased pool of staff within the partnership available to undertake assessment and care management work. This would also allow us to protect professional grade staff to ensure that there is capacity to meet the partnership's obligations in relation to adult protection. This cost reduction would capitalise on the benefit of Integration and economies of scale in terms of the staff resource, there would be training requirements but these would be addressed during implementation.	Allen Stevenson/ Lorraine Paterson	30	2.0	0	30	There are currently no temporary posts available to provide an opportunity to deliver this saving and so it is extremely unlikely that it will be delivered during 2016-17. Unless the implementation of the UAA (Universal Adult Assessment) progresses dramatically over the next few months, it is unlikely that the 2017-18 saving will be delivered.	AMBER	AMBER	30	30
64	Mid Argyll Dementia Day Service	Review service management arrangements for the Dementia Day Service in Mid Argyll and transfer responsibility to the manager at Ardfenaig. This could be achieved by temporarily redeploying the postholder to the MAKI HCPO post to cover 1 year secondment or into the Kintyre HCO post - both have been advertised.	Lorraine Paterson	18	1.0	10	8	The service has a plan in place to deliver this saving.	AMBER	GREEN	8	0
65	Support for Carers	Review the allocation of funding to carers support groups, establish how the funding is used, identify what supports are provided, ensure resources are targeted to support vulnerable carers, establish if best value is being delivered, disinvest during 2016/17 to gather resources for use in 2017/18 to support the introduction of the Carers Act. This would be a review of how this money is currently invested to ensure that value for money is being achieved and potentially achieving efficiencies.	Allen Stevenson/ Lorraine Paterson	75	0.0	9	66	The Commissioning Team have identified slippage on the spending of at least one group and are reviewing the funding allocation. It is unlikely that the remaining saving of £66k will be delivered in 2016-17. This saving was always intended to be a non-recurring saving for 2016-17 as the budget is required for investment in support for carers from 2017-18 onwards.	AMBER	RED	66	75
66	Supported Living Services	Review existing supported living services to ensure that services are providing best value, are consistent with the partnership's priority of need eligibility criteria and that the non-residential care charging policy is being applied appropriately and consistently. Re-assessments would be carried out to ensure the appropriate level of service is being delivered, it is expected that this would deliver efficiencies and cost reductions.	Allen Stevenson/ Lorraine Paterson	100	0.0	0	100	The service is actively working with suppliers to review and reduce care packages where possible. The service and commissioning team are confident that they can achieve this saving going forward into 2017-18.	AMBER	GREEN	100	0
67	Learning Disability Day Services	Review internal day support provision for learning disabled clients.	Allen Stevenson/ Lorraine Paterson	110	0.0	49	61	The saving achieved for 2016-17 is as a result of vacant posts which will not be removed on a recurring basis. There review of the resource centres requires to be completed before the savings will be achieved on a recurring basis.	GREEN	RED	61	110
68	Homecare Packages	Review small number of high cost homecare packages to ensure that person centred care needs and outcomes are met but on an affordable basis through packages that provide value for money. This would involve looking at packages on a case by case basis and ensuring that processes are put in place to ensure best value whilst balancing this with meeting the need of individual clients.	Allen Stevenson/ Lorraine Paterson	200	0.0	103	97	Savings have been delivered in East Argyll, the remaining balance of £97k is not likely to be delivered in 2016-17. The ability to deliver the saving on a recurring basis will be dependent upon the success of service redesign work to intervene earlier in cases to prevent clients becoming high resource individuals.	AMBER	RED	97	100
<b>Total Budget Reduction</b>				<b>8,498</b>	<b>103.1</b>	<b>4,508</b>	<b>3,990</b>				<b>3,707</b>	<b>3,135</b>

INTEGRATION JOINT BOARD

APPENDIX 3

FINANCIAL RISKS - JANUARY 2016

Ref	TITLE OF RISK	DESCRIPTION OF RISK	MITIGATIONS/ACTIONS IN PLACE	LIKELIHOOD		POTENTIAL FINANCIAL IMPACT £000
				SCORE	OVERALL LIKELIHOOD	
1	Commissioned Services	The volume of high cost care packages increases	Closer scrutiny of applications for care packages.	3	Possible	250
2	Adult Care - Older People Service Demand	Demand for services for older people (ie over 65s) exceeds the demand pressure already factored into the budget.	Ongoing monitoring and reporting of service demand and provision costs to IJB management team.	3	Possible	600
3	Prescribing	Costs increase through national pricing agreements, new drugs are introduced, volumes dispensed increase.	Closer working with prescribers to ensure formulary compliance and Best Value.	3	Possible	500
4	Adult Care - Younger Adult Service Demand	Demand for services for younger adults (ie under 65s) exceeds the demand pressure already factored into the budget.	Ongoing monitoring and reporting of service demand and provision costs to IJB management team.	3	Possible	300
5	Local Healthcare Treatments	Activity levels of locally provided treatments are not contained and grow significantly	Management of volume of service provided locally and re-design of pathways.	3	Possible	200
<b>TOTAL</b>						<b>1,850</b>

OTHER PROJECT FUNDING

<b><u>Integrated Care Fund</u></b>				
Project	16-17 Budget	Spend to December 2016	Forecast Y/E Spend	Forecast Y/E Outturn
	£'000	£'000	£'000	£'000
Scottish Care Local Integration Leads	64	48	64	0
Business Transformation Manager (Split 50/50 with DD)	30	22	30	0
Project Manager	36	32	41	(5)
Agile Working (ICPB 21 Sept 2016)	5	0	5	0
Management and Prevention of Falls	41	20	41	0
Commissioning Posts x 2	96	70	96	0
Reablement Service	234	148	244	(10)
Public Health Post	52	31	52	0
Self Management Programme	14	0	14	0
Care & Repair Team	80	60	80	0
Preventative health improvement (ICPB 21 Sept 2016)	70	18	70	0
Helensburgh & Lomond Locality Allocation	254	42	216	38
Cowal & Bute Locality Allocation	298	83	228	70
Oban, Lorn & Isles Locality Allocation	221	8	123	98
Mid Argyll, Kintyre & Islay Locality Allocation	283	128	190	93
Integrated Equipment Store	138	103	138	0
Support Community Reablement & Intermediate Care	40	0	40	0
Helensburgh block purchase of care at home for reablement	20	0	20	0
Advanced Healthcare Monitoring System for Reablement Teams	31	0	31	0
X-PERT training programme for type 2 diabetes	9	3	9	0
<b>Sub Total</b>	<b>2,016</b>	<b>816</b>	<b>1,732</b>	<b>284</b>
Uncommitted funding	<b>212</b>			<b>212</b>
<b>Total Budget</b>	<b>2,228</b>			<b>496</b>

<b><u>Delayed Discharge</u></b>				
Project	16-17 Budget	Spend to December 2016	Forecast Y/E Spend	Forecast Y/E Outturn
	£'000	£'000	£'000	£'000
Helensburgh ICAT	141	63	112	29
Islay Overnight Service (Carr Gorm)	45	0	45	0
Mull Overnight Service	45	0	45	0
Business Transformation Manager (Split 50/50 with ICF)	29	22	29	0
Care First Enterprise License	75	75	75	0
Recruitment drive (email 7 Oct 16)	5	0	5	0
Uncommitted funding	212	0	0	212
<b>Total budget</b>	<b>552</b>	<b>160</b>	<b>311</b>	<b>241</b>

<b><u>Technology Enabled Care</u></b>				
Project	16-17 Budget	Spend to December 2016	Forecast Y/E Spend	Forecast Y/E Outturn
	£'000	£'000	£'000	£'000
TEC Management	77	67	77	0
Workstream 1 - Home Health Monitoring	95	22	95	0
Workstream 3 - Living it Up	51	30	51	0
Workstream 4 - Teleheath & Telecare	171	69	171	0
<b>Sub Total</b>	<b>394</b>	<b>188</b>	<b>394</b>	<b>0</b>
Uncommitted funding	<b>181</b>			<b>181</b>
<b>Total Budget</b>	<b>575</b>	<b>C/F to 17/18</b>		<b>181</b>



# Argyll & Bute Health & Social Care Partnership

**Strategic Management Team**

**Agenda item : 5.2 (ii)**

**Date of Meeting : 29 March 2017**

**Title of Report : IJB Reserves Policy**

**Presented by : Caroline Whyte, Chief Financial Officer**

**The Integration Joint Board is asked to :**

- Note the contents of the report
- Approve the Reserves Policy for Argyll and Bute Integration Joint Board

## **1. EXECUTIVE SUMMARY**

- 1.1 This report sets out a proposed Reserves Policy for the Integration Joint Board. It is a requirement to have this in place as the IJB is a section 106 body under the Local Government (Scotland) Act 1973. The IJB is able to hold reserves which should be accounted for in the financial accounts and records of the IJB.

## **2. INTRODUCTION**

- 2.1 A Reserves Policy requires to be put in place for the IJB, this will require to be in place when the IJB are asked to set the budget for 2017-18 and 2018-19.
- 2.2 The Financial Regulations for the IJB were approved at the IJB meeting in December 2015, these outlined that a policy on reserves will be prepared by the Chief Financial Officer and submitted to the IJB for approval. The proposed Reserves Policy has been drafted in consultation with the NHS Highland Director of Finance and the Council's Head of Strategic Finance.

## **3. DETAIL OF REPORT**

- 3.1 The proposed Reserves Policy is included as Appendix 1, this provides the full detail to support the governance for creating and holding revenue reserves for the IJB.
- 3.2 Reserves can be held for three main purposes:

- i. A working balance to cushion the impact of uneven cash flows and avoid unnecessary temporary borrowing – this forms part of general reserves;
  - ii. A contingency to cushion the impact of unexpected events of emergencies – this also forms part of general reserves;
  - iii. A means of building up funds, often referred to as earmarked reserves (or earmarked portion of the General Fund in Scotland), to meet known or predicted requirements; earmarked reserves are accounted for separately but remain legally part of the General Fund.
- 3.3 The IJB will allocate the resources it receives from the partner Health Board and Council in line with the Strategic Plan. In doing this it will be able to use its power to hold reserves so that in some years it may plan for a contribution to build up reserve balances, in others to break even, or use a contribution from reserves in line with the reserves policy. This will be integral to the medium to longer term financial plan.
- 3.4 It is important for the longer term financial sustainability of both the IJB and the parent bodies that sufficient usable reserves are held to manage unanticipated pressures from year to year. Similarly, it is also important that in-year funding available for specific projects and government priorities is able to be earmarked and carried forward into the following financial year, to allow for spend to be committed and managed in a way which represents best value for the IJB in the achievement of national outcomes.
- 3.5 The IJB has no opening reserves balance at the start of financial year 2016-17, however unless otherwise agreed any unspent funds from the delegated budget in year will be transferred into reserves of the IJB at the end of each financial year.
- 3.6 The proposed Reserves Policy suggests a prudent level of general reserve be set at 2% of the IJB net revenue budget, this would equate to around £5m. There is no guidance on the minimum level of reserves that should be held, however the 2% is in line with the position taken by a number of Integration Joint Boards facing similar strategic, operational and financial risks as Argyll and Bute and is also in line with the Council reserves policy.
- 3.7 Whilst this level of free general reserve would allow the IJB a degree of flexibility and assurance this must be proportionate and take cognisance of the level of savings required to be delivered. Given the unprecedented economic climate in which the IJB are facing this should be kept under review and the proposed 2% should be viewed as an optimum level of reserves to be built up over time, recognising the tensions between prudent financial planning and budgetary constraints.
- 3.8 Any earmarked reserves will relate to specific funds for specific purposes and will only be used for these purposes. Whilst these reserves will be fully committed and therefore not free to use they will be regularly monitored and any change of use or decisions relating to any remaining balances will require approval from the IJB.

#### **4. CONTRIBUTION TO STRATEGIC PRIORITIES**

The IJB is required to have a Reserves Policy in place to ensure that year-end flexibility and reserve balances are directed in line with the delivery of the Strategic Plan.

#### **5. GOVERNANCE IMPLICATIONS**

##### **5.1 Financial Impact**

The IJB is required to have its own Reserves Policy which sets out the framework under which reserves will be held. This policy will be linked to the budget setting process of the IJB. There are currently no reserve balances for the IJB, however any potential underspend at the end of the financial year will be credited to IJB reserves.

##### **5.2 Staff Governance**

None

##### **5.3 Clinical Governance**

None

#### **6. EQUALITY & DIVERSITY IMPLICATIONS**

None

#### **7. RISK ASSESSMENT**

Financial risk for the IJB if a Reserves Policy is not in place. The proposed 2% target for free reserves would limit financial risk exposure, however it is acknowledged that given the current financial climate that it would be an aspiration to achieve this level of reserves.

#### **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT**

None

#### **9. CONCLUSIONS**

9.1 The Reserves Policy supports the Financial Regulations which set out the financial framework that the IJB will operate in. The IJB do not currently have any reserve balances but the policy requires to be in place to be approved by the IJB together with the budget.





## ARGYLL AND BUTE INTEGRATION JOINT BOARD

### RESERVES POLICY

#### 1. Background

1.1 To assist local authorities (and similar bodies) in developing a framework for reserves, CIPFA have issued guidance in the form of the *Local Authority Accounting Panel (LAAP) Bulletin 55 – Guidance Note on Local Authority Reserves and Balances*. This guidance outlines the framework for reserves, the purpose of reserves and some key issues to be considered when determining the appropriate level of reserves. As the Argyll and Bute Integration Joint Board has the same legal status as a local authority, i.e. a section 106 body under the Local Government (Scotland) Act 1973 Act, and is classified as a local government body for accounts purposes by the Office of National Statistics (ONS), it is able to hold reserves which should be accounted for in the financial accounts and records of the Integration Joint Board.

1.2 The purpose of a reserves policy is to:

- outline the legislative and regulatory framework underpinning the creation, use or assessment of the adequacy of reserves;
- identify the principles to be employed by the Integration Joint Board in assessing the adequacy of the Integration Joint Board's reserves;
- indicate how frequently the adequacy of the Integration Joint Board's balances and reserves will be reviewed; and
- set out arrangements relating to the creation, amendment and use of reserves and balances.

1.3 In common with local authorities, the Integration Joint Board can hold reserves within a usable category.

#### 2. Statutory/Regulatory Framework for Reserves

##### Usable Reserves

2.1 Local Government bodies - which includes the Integration Joint Board for these purposes - may only hold usable reserves for which there is a statutory or regulatory power to do so. In Scotland, the legislative framework includes the General Fund, the power to hold this reserve is outlined in the Local Government Scotland Act 1973. The IJB has no power to hold any other usable reserves, including the Repairs and Renewals Fund and an Insurance Fund as the power to hold these is included in the Local Government Scotland Act 1975.

### **3. Operation of Reserves**

3.1 Reserves are generally held for three main purposes:

- a working balance to help cushion the impact of uneven cash flows and avoid unnecessary temporary borrowing – this forms part of general reserves;
- a contingency to cushion the impact of unexpected events or emergencies – this also forms part of general reserves; and
- a means of building up funds, often referred to as earmarked reserves (or earmarked portion of the General Fund in Scotland), to meet known or predicted requirements; earmarked reserves are accounted for separately but remain legally part of the General Fund.

3.2 The balance of the reserves will normally comprise of one of three elements:

1. Funds that are earmarked or set aside for specific purposes. In Scotland, under Local Government rules, earmarked reserves are accounted for separately but remain legally part of the General Fund. The identification of earmarked reserves may include:
  - future use of funds for a specific purpose, as agreed by the Integration Joint Board; or
  - reserves for unspent revenue grants or contributions.
2. Funds which are not earmarked for specific purposes, but are set aside to deal with unexpected events or emergencies; and
3. Funds held in excess of the target level of reserves and the identified earmarked sums. Reserves of this nature can be spent or earmarked at the discretion of the Integration Joint Board.

3.3 For effective financial management there is a need for clear, transparent reporting arrangements for reserves. For each earmarked reserve there should be a clear protocol setting out:

- the reason / purpose of the reserve;
- how and when the reserve can be used;
- procedures for the reserves management and control; and
- a process and timescale for review of the reserve to ensure continuing relevance and adequacy.

### **4. Role of the Chief Financial Officer**

4.1 The Chief Financial Officer is responsible for advising on the target level of reserves. The Integration Joint Board, based on this advice, should then approve the appropriate strategy as part of the budget process.

## **5. Adequacy of Reserves**

- 5.1 There is no guidance on the minimum level of reserves that should be held. In determining the reserve levels the Chief Financial Officer must take account of the strategic, operational and financial risks facing the Integration Joint Board over the medium and longer term and the Integration Joint Board's overall approach to risk management.
- 5.2 In determining the level of general reserves, the Chief Financial Officer should consider the Integration Joint Board's Strategic Plan, the medium term financial strategy and the overall financial environment. Guidance also recommends that the Chief Financial Officer reviews any earmarked reserves as part of the annual budget process.
- 5.3 In light of the size and scale of the Integration Joint Board's responsibilities, over the medium term it is proposed that a prudent level of general fund reserves will represent 2% of net expenditure. This value of reserves must be reviewed annually as part of the Integration Joint Board budget process to take into account the financial environment at that time. The level of other earmarked funds will be established as part of the annual financial year-end process.

## **6. Reporting Framework**

- 6.1 The Chief Financial Officer has a fiduciary duty to ensure proper stewardship of public funds.
- 6.2 The level and utilisation of reserves will be formally approved by the Integration Joint Board based on the advice of the Chief Financial Officer. To enable the Integration Joint Board to reach a decision, the Chief Financial Officer should clearly state the factors that influenced this advice.
- 6.3 As part of the budget report the Chief Financial Officer should state:
- the current value of general reserves, the movement proposed during the year and the estimated year-end balance and the extent that balances are being used to fund recurrent expenditure;
  - the adequacy of general reserves in light of the Integration Joint Board's medium term financial strategy;
  - an assessment of earmarked reserves and advice on appropriate levels and movements during the year and over the medium term; and
  - if the reserves held are under the prudential target, that the Integration Joint Board should be considering actions to meet the target through the budget process.

## **7. Accounting and Disclosure**

- 7.1 Note that while in a Local Authority context all receipts and payments are made via the General Fund, in respect of the Integration Joint Board all receipts and payments will be administered through the financial ledgers of the respective partners. Any overall General Fund reserve balance will be held by Argyll and Bute Council on behalf of the Integrated Joint Board, no

interest will be credited to the Integration Joint Board for balances held. It is not permitted to carry a negative reserve balance.

- 7.2 Expenditure should not be charged direct to any reserve. Any movement within Revenue Reserves is accounted for as an appropriation and is transparent. Entries within a reserve are specifically restricted to 'contributions to and from the revenue account' with expenditure charged to the service revenue account.

March 2017

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# Argyll & Bute Health & Social Care Partnership

## Integration Joint Board

Agenda item: 5.2 (iii)

Date of Meeting : 29 March 2017

Title of Report : Integrated Budget 2017-18 and 2018-19

Presented by : Caroline Whyte, Chief Financial Officer

### The Integration Joint Board is asked to :

- **Note** the overall budget position and resulting budget gap for 2017-18 of £11m and 2018-19 of £9m, a cumulative total of £20m, this position reflects the offers of funding from both NHS Highland and Argyll and Bute Council
- **Approve** the proposed Quality and Finance Plan for 2017-18 and 2018-19 delivering total savings of £11.6m across the two years, noting that £3.5m of these savings relate to new service delivery changes that specifically require IJB approval
- **Approve** the principles for monitoring and implementation of the Quality and Finance Plan
- **Approve** the investment plan to provide support to lever the service re-design changes
- **Note** the remaining budget gap of £2.8m and £5.6m, a total of £8.4m across the remaining two years of the Strategic Plan and the resulting financial risk of the unidentified savings
- **Note** the requirement to engage with the Council and Health Board partners in the financial position and the requirement to identify additional savings to produce a planned balanced budget position, savings proposals will be brought back to the IJB for approval in May 2017
- **Note** financial offers from the partners cannot be formally accepted at this stage as the IJB has not developed a financial plan which delivers a balanced budget.

## 1. EXECUTIVE SUMMARY

- 1.1 The IJB is facing a challenging financial outlook with an updated estimated budget gap of £11m and £9m for the remaining two years of the Strategic Plan. The budget outlook has changed over the planning period, with a notable improvement particularly in 2017-18, this is due to increased funding from both the Council and Health Board to assist with the smoothing of the budget gap.

- 1.2 It has been acknowledged that it was going to be challenging for the Integration Joint Board to produce a balanced budget by 31 March 2017, with significant savings required in both years. The Quality and Finance Plan has been in development over a period of time with plans initially being developed by Locality Planning Groups.
- 1.3 There are significant cost and demand pressures due to the nature of services delivered and this is likely to be a continuing trend in future years with an ongoing requirement to address a funding gap. The changes required to service delivery are significant and the transformational change can only be delivered if services have the appropriate time to plan and implement savings.
- 1.4 There has been a degree of uncertainty around the financial offers from the Health Board and Council and the budget position is now based on the financial offers for 2017-18 and estimates for 2018-19. The timing of having financial allocations agreed for the IJB makes it difficult for financial planning and identifying the final budget gap, hence the position has been relatively fluid over the planning period. The Scottish Government outlined requirements for Councils and Health Boards over the minimum level of delegated resources to be transferred to IJBs for 2017-18, the offers from both partners are in line with the Scottish Government requirements.
- 1.5 The proposed Quality and Finance Plan for 2017-18 and 2018-19 includes savings totalling £11.6m across the two year period, this is £8.4m short of the budget gap with £2.8m of unidentified savings in 2017-18. A further report will be presented to the IJB in May 2017 with additional savings proposals. The service changes outlined in the proposed Quality and Finance Plan have been assessed as being in line with delivering on the Strategic Plan and outcomes, the requirement to identify additional savings may result in service changes that are not line with the strategic objectives and priorities of the IJB.
- 1.6 There is a significant financial risk to the IJB and the Council and Health Board partners as a result of the shortfall in identified savings, this risk will increase if the Board take the decision not to approve any of the service changes on the proposed Quality and Finance Plan. The IJB will require to issue formal Directions to delegate resources back to the Council and Health Board for 2017-18, these will require to be caveated around the requirement to identify additional savings. Financial offers from the partners cannot be formally accepted at this stage as the IJB has not developed a financial plan which delivers a balanced budget.

## **2. INTRODUCTION**

- 2.1 The Integration Joint Board is required to allocate the delegated resources it receives from the Health Board and Council in line with the delivery of the Strategic Plan. The Board is able to use its power to build up reserves, the IJB currently don't have any balances held in reserves, a reserves policy is also being presented to the Board for approval.
- 2.2 The approach to budget planning for 2017-18 and 2018-19 is set out in the Scheme of Integration as an incremental approach using the 2016-17 budget as a baseline, taking into account cost and demand pressures, inflation and the impact of previously agreed budget savings. This approach to building up costs when compared with the funding available will inform the IJB on the overall budget gap to be addressed for the remaining period of the Strategic Plan.

- 2.3 The updated budget position for 2017-18 and 2018-19 is set out in the report. There are significant cost and demand pressures to be funded together with reductions in the funding available and these give rise to the overall budget gap. A proposed Quality and Finance Plan for 2017-18 and 2018-19 has been developed, building on the service re-designs that commenced during 2016-17.

### 3. DETAIL OF REPORT

#### 3.1 BASELINE BUDGET 2016-17

- 3.1.1 The starting point for developing the budget for 2017-18 is to use the 2016-17 budget allocation as a baseline position.

- 3.1.2 The base budget for 2016-17 is outlined in the table below:

Partner	2016-17		
	Approved Budget £m	Reported Position £m	Difference £m
Health	195.868	197.229	1.361
Council	55.663	55.966	0.303
Additional SG Funding	4.580	4.580	0.000
<b>Partnership Total</b>	<b>256.111</b>	<b>257.775</b>	<b>1.664</b>

- 3.1.3 The difference in the overall funding in 2016-17 is mainly due to the allocation of additional non-recurring budgets or funding during the year, therefore the starting point should be the original approved baseline budget for 2016-17.

- 3.1.4 The Integration Joint Board submitted a request to the Council for an additional £0.110m of funding in 2016-17 on a recurring basis to fund the shortfall in the cost of the Living Wage implementation for 2016-17, this has been approved by the Council and therefore this is included in the approved budget figure.

#### 3.2 FUNDING

- 3.2.1 The Scottish Government issued letters to both Councils and Health Boards outlining expectations around the minimum level of funding to be allocated to Integration Joint Boards for 2017-18. The Council approved their budget on 23 February 2017 which included a decision around the delegated budget for the IJB. The NHS Highland budget will be presented to their Board on 28 March 2017 for approval, the estimated funding outlined in this paper mirrors the recommendations made by the Health Board Director of Finance. We now have some certainty around the funding available from both partner organisations which allows the IJB to finalise the budget gap for 2017-18.

## Health Funding

3.2.2 The table below outlines the estimated funding available from NHS Highland:

Health	2017-18 £m	2018-19 £m
Baseline	165.229	167.306
Annual allocations	22.289	22.289
Non Discretionary Primary Care Services	8.350	8.350
NRAC Share Adjustment (from 29.27% to 28.87%)	(0.600)	(0.600)
<b>Total Baseline Funding</b>	<b>195.268</b>	<b>197.345</b>
1.5% Uplift	2.547	2.578
Share of £7m funding	0.130	0.000
<b>Total Health Funding</b>	<b>197.945</b>	<b>199.923</b>

3.2.3 The Scottish Government uplift to Health Board baseline budgets has been confirmed as being 1.5% for 2017-18, there is an assumption that the same level of uplift will be applied in 2018-19.

3.2.4 There are number of annual allocations, including non-recurring in-year allocations, the funding for 2017-18 onwards has not been confirmed at this stage, however these funds are targeted for specific issues and there would be an expectation that any changes in the level of funding would result in an offsetting increase or decrease to service budgets. An updated position on the allocation from these funds and any implications will be presented to the IJB when available. The funding in relation to Non-Discretionary Primary Care Services reflects a reimbursement of costs, rather than funding to be allocated to services, any change in this value would have no impact to the bottom line position.

3.2.5 There is a further adjustment to reduce the Argyll and Bute share of Health funding by £0.6m in 2017-18 and a further £0.6m in 2018-19, £1.2m in total. Argyll and Bute has historically been allocated an NRAC share of the totality of NHS Highland funding and an adjustment has been made to the baseline funding for Argyll and Bute on an annual basis to account for this. The NRAC share for Argyll and Bute will reduce from 29.27% to 28.87% in 2017-18, mainly as a result of the reducing population in Argyll and Bute and the increasing population in the rest of the NHS Highland area. The planning assumption from the Health Board is that this reduction of £1.2m will be phased over a 2 year period. This is a reasonable approach, as historically the NRAC share has been an acceptable basis for the allocation of funds to Argyll and Bute. There is an expectation that there will not be any further adjustment to the NRAC share until 2020-21 at the earliest, as the Scottish Government has issued a 3 year NRAC settlement.

3.2.6 There was an expectation that the £107m of funding announced by the Scottish Government would be additional funding allocated to Health Boards to be transferred over to social care services, in reality only £7m of this funding will be additional funding over and above the 1.5% baseline uplift. The Argyll and Bute share of the additional £7m is £0.130m and has been included as an increase to baseline funding.



3.2.7 The Scottish Government have stipulated to Health Boards that “NHS contributions to Integration Authorities for delegated health functions will be maintained at least at 2016-17 cash levels” and that “the £107 million funding from health budgets for supporting social care is to be treated as an additional allocation to this minimum budget”. The table below illustrates that the estimated Health funding meets this requirement:

	£m
Baseline Funding 2016-17	165.229
Share of £107m Funding	1.950
<b>Minimum Requirement 2017-18</b>	<b>167.179</b>
<b>Proposed Baseline Funding 2017-18</b>	<b>167.306</b>
<b>Difference</b>	<b>0.127</b>

3.2.8 The Health offer of funding is provisional until NHS Highland approve their budget on 28 March 2017, and the funding for 2018-19 is estimated at this stage.

### Council Funding

3.2.9 The Council approved their budget for 2017-18 on 23 February 2017 and a formal offer of funding has been received in line with this, this position is finalised for 2017-18 however the funding allocation for 2018-19 is indicative at this stage.

3.2.10 The table below outlines the estimated funding available from Argyll and Bute Council:

Council	2017-18 £m	2018-19 £m
Baseline Funding	55.663	54.223
Additional Finance Settlement Funding	0.010	0.000
Reduction (share of £80m)	(1.450)	(1.450)
<b>Total Baseline Council Funding</b>	<b>54.223</b>	<b>52.773</b>
One-off Funding	2.137	0.000
<b>In-year Council Funding</b>	<b>56.360</b>	<b>52.773</b>

3.2.11 The additional Finance Settlement Funding relates to additional funding to fund the cost of Continuing Care. There was additional funding totalling £2.4m Scotland wide to fund the costs of Continuing Care, this funding is insufficient and the full cost of implementation is included in as a cost pressure of £0.500m in 2017-18 with a further £0.735m cost in 2018-19.

3.2.12 The Local Government Finance Settlement outlines the Scottish Government expectations in respect of the funding levels from Councils to Integration Joint Boards in 2017-18 in light of the £107m investment in social care services, this is noted below:

*“to reflect this additional support local authorities will be able to adjust their allocations to Integration Authorities in 2017-18 by up to their share of £80m below the level of budget agreed with their Integration Authority for 2016-17 (as adjusted where agreed for any one-off items of expenditure which should not feature in the baseline).”*

3.2.13 This in effect means that the minimum budget allocation for social care services transferred to the IJB from the Council is the level of budget for 2016-17 less a share of a Scotland wide £80m maximum reduction. The Scottish Government further stipulated the share of this reduction for each IJB, the permitted share for Argyll and Bute is £1.450m and Argyll and Bute Council have transferred this reduction to the IJB. Therefore the approved delegated budget from the Council to the IJB in 2017-18 is compliant with the stipulations from the Scottish Government. The funding assumption for 2018-19 at this stage is that there would be a similar permitted reduction, however the Local Government Finance Settlement is for one year only and it is not clear if there will be further stipulations for the delegated budget.

3.2.14 There are significant cost and demand pressures and inflationary cost increases in the delivery of social care services, totalling £3.1m, and these are required to be met from within the delegated resource from the Council. When approving the Council budget for 2017-18 there was a recognition of the challenges faced by the IJB in meeting the cost and demand pressures in the short term and the Council decision was to allocate additional one-off transitional funding to the IJB of £2.137m, from the £2.361m they received from the Local Government settlement in February. This one-off funding will not be added to the baseline allocation for the IJB but will assist in smoothing the budget gap.

3.2.15 The overall total funding estimates are noted in the table below:

<b>All Funding</b>	<b>2017-18 £m</b>	<b>2018-19 £m</b>
Health	197.945	199.923
Council	56.360	52.773
Additional SG Funding (share of £250m)	4.580	4.580
<b>Total Estimated Funding</b>	<b>258.885</b>	<b>257.276</b>

### **3.3 COST AND DEMAND PRESSURES**

3.3.1 Cost and demand pressures in relation to both health and social care services are expected to outstrip any available funding uplifts and will have a significant contribution to the overall budget gap. There are cost and demand pressures totalling £7.924m in 2017-18 and a further £4.741m in 2018-19. These are detailed in Appendix 1. The main pressures for 2017-18 are in relation to:

- Healthcare Packages £0.4m
- Prescribing Growth £0.4m
- Apprenticeship Levy £0.4m
- New Medicines Funding £0.7m
- Living Wage £2.4m
- Demand pressure older people £0.6m
- Continuing Care £0.5m
- Establishment of Service at Lorn Campbell Court £0.4m

- 3.3.2 A number of cost pressures are offset by proposed savings in the Quality and Finance Plan, therefore any non-acceptance of cost or demand pressures may have an impact on the savings deliverability. For example there is a cost pressure in relation to prescribing, this has been included in the budget outlook for transparency as there will be an estimated 2% growth in prescribing demand, however the expectation is that this demand increase will be accommodated from savings in prescribing.
- 3.3.3 The cost and demand pressures have been subject to ongoing review and scrutiny by the Strategic Management Team, the pressures included are deemed to be unavoidable and therefore require to be provided for in the budget. The estimated pressures for 2018-19 are difficult to quantify and may be subject to change as they are reviewed.
- 3.3.4 Cost and demand pressures are one of the main contributing factors to the overall financial gap, as such the IJB should scrutinise these suitably to ensure that these are valid and necessary in terms of delivering the outcomes in the Strategic Plan.

### 3.4 INFLATION

- 3.4.1 The required inflationary increases to the baseline budget are noted below:

<b>Inflation</b>	<b>2017-18 £m</b>	<b>2018-19 £m</b>
Pay Inflation	1.085	1.085
Prescribing - cost growth 2%	0.386	0.386
Hospital Medication - cost growth 2%	0.050	0.050
GG&C SLA - 0.4% uplift 2017-18	0.218	0.820
Other Health SLAs - 1.0% uplift	0.110	0.110
Health - Energy Cost Increases	0.057	0.057
National Care Home Contract Increase	0.083	0.083
Other Social Care Increases	0.028	0.028
<b>TOTAL</b>	<b>2.017</b>	<b>2.619</b>

- 3.4.2 Inflation is only applied to service budgets where it is deemed to be unavoidable, therefore there are no general inflationary increases for costs applied to any service budgets. The inflation estimates for 2018-19 are provisional at this stage and will be kept under review.

### 3.5 IMPACT OF 2016-17 BUDGET POSITION

- 3.5.1 The financial position for 2016-17 is outlined in the January budget monitoring report which is also presented to the IJB. The financial position for 2016-17 impacts on the budget for future years as there are implications from not delivering previously approved recurring savings, the projected outturn position for the current year and the requirement to re-instate project funding.

- 3.5.2 There were savings of £8.498m approved for 2016-17. There has been a significant risk with the delivery of the level of savings in the Quality and Finance Plan and the routine monthly budget monitoring reports have been highlighting a projected shortfall in delivery of savings. A detailed assessment has been carried out for each of the savings included on the plan and it is estimated that £3.135m of savings approved in 2016-17 have not yet been delivered on a recurring basis, further detail is included in the budget monitoring report. As these savings have not yet been delivered on a recurring basis and these were required to balance the 2016-17 budget, this amount will require to be added to the overall budget gap for 2017-18 onwards. In most cases the savings will require to be re-instated on the Quality and Finance Plan.
- 3.5.3 The projected outturn position for the Integrated Budget at the January budget monitoring period is an overspend of £0.721m, further detail on this position is included in the budget monitoring report. The Scheme of Integration outlines that *“where recovery plans are unsuccessful and an overspend occurs at the financial year end, and there are insufficient reserves to meet the overspend, then the Parties will be required to make additional payments to Argyll and Bute Integrated Joint Board.....Any additional payments by the Council and NHS Highland will then be deducted from future years funding/payments”*. The position is only a projection at this stage, but for planning purposes it is prudent to assume that the current forecast overspend would result in a reduction in funding in 2017-18 and should factor into the overall budget gap. There is a recovery plan in place to address this position and there has been further improvement with the projected overspend reducing to £0.260m at the February period. The February budget monitoring report has not yet been finalised but further detail around the financial position for 2016-17 is included in the January monitoring report.
- 3.5.4 As part of the financial recovery plan it was agreed to review spending plans against non-recurring funding allocations with a view to removing uncommitted elements to bring the 2016-17 position back into balance. As a result of this there were underspends in relation to project funding which have not been fully committed. This funding totalling £0.451m will require to be re-provided in 2017-18. This includes funds specifically provided by the Scottish Government for specific projects and there is an expectation that the funds would be utilised as allocated, regardless of the timing of the expenditure.

The re-provisions include:

- Technology Enabled Care £0.208m
- Primary Care Development Fund £0.065m
- Mental Health Fund £0.066m
- Primary Care Transformation Fund £0.112m

- 3.5.5 As a result of the financial position for 2016-17 with the expectation that savings will not be fully delivered and that financial balance will not be achieved the overall impact is that £3.846m of additional savings will require to be added to the Quality and Finance Plan for 2017-18.

### 3.6 BUDGET GAP 2017-18 AND 2018-19

3.6.1 The Integration Joint Board has a responsibility to set a balanced budget and to delegate resources back to the Council and Health for the delivery of services in line with the Strategic Plan. The funding and cost estimates are prepared for each partner separately but these should be viewed by the Integration Joint Board as contributing to one Integrated Budget with one bottom line position. It will not necessarily be the case that the same level of resource will be delegated back to each of the partners and the development of the Quality and Finance Plan and the service changes included in that will determine the split of resources.

3.6.2 There are one-year offers of funding from Council and Health partners for 2017-18 with funding for 2018-19 based on estimates. The IJB have already agreed in principle to approve a two year budget and to take decisions about transformational changes to service delivery for a two year period in line with the Strategic Plan, this will facilitate the lead-in time for implementing the service changes and delivering the savings.

3.6.3 The Integrated Budget summary is noted below, together with the resulting overall budget gap for the next two years:

	<b>2017-18 £m</b>	<b>2018-19 £m</b>
Baseline Budget	256.111	258.885
Cost and Demand Pressures	7.924	4.741
Inflation	2.017	2.619
Total Expenditure	266.052	266.245
Total Funding	(258.885)	(257.276)
<b>Budget Gap</b>	<b>7.167</b>	<b>8.969</b>
Quality and Finance Plan 2016-17	3.135	0.000
Projected Outturn 2016-17	0.260	0.000
Reinstate Project Funds	0.451	0.000
<b>Updated Budget Gap</b>	<b>11.013</b>	<b>8.969</b>
<b>% age of Baseline Budget</b>	<b>4.3%</b>	<b>3.5%</b>
<b>Cumulative Budget Gap</b>	<b>11.013</b>	<b>19.982</b>

3.6.4 The Integrated Budget gap for 2017-18 is £11m and for 2018-19 is estimated to be a further £9m. The budget gap position for 2017-18 is near finalised, the only potential change to this would be a change to the outturn position for 2016-17 or other small changes to estimates, but it not expected that any of these would be material. There are a number of high level assumptions around the budget gap for 2018-19 and these will be subject to review, however this is the best estimate we have based on the information available. These are the planning assumptions that should be used for decision making when approving the Quality and Finance Plan for 2017-18 and 2018-19.

- 3.6.5 The budget outlook has been reported to the IJB on a regular basis and the position has changed considerably over the planning period. This is mainly as a result of uncertainties around funding, the Scottish Government intention was for funding to be confirmed to IJBs in time to allow for plans to be developed. It is clear that there is a significant impact to the IJB in terms of planning as a result of not having clarity around funding. This reinforces the importance for planning across the two year period to ensure we are prepared to deliver the savings required.
- 3.6.6 It is important that the Integration Joint Board view the budget gap as one bottom line position in terms of taking an integrated approach to plans to balance the budget. However it is also important to understand the implications of the financial settlements of both the Health and the Council partners in terms of the respective budget gap proposed to be transferred to the Integration Joint Board.
- 3.6.7 The tables below detail the estimated budget gap outlined above split between Health and Council delivered services:

<b>HEALTH</b>	<b>2017-18 £m</b>	<b>2018-19 £m</b>
Baseline Budget	195.868	197.945
Cost and Demand Pressures	5.276	1.586
Inflation	1.411	2.041
Total Expenditure	202.555	201.572
Total Funding	(197.945)	(199.923)
<b>Total Budget Gap</b>	<b>4.610</b>	<b>1.649</b>
2016-17 outturn	2.812	0.000
<b>Revised Budget Gap</b>	<b>7.422</b>	<b>1.649</b>
% reduction (before 16-17 outturn)	2.4%	0.8%

<b>COUNCIL</b>	<b>2017-18 £m</b>	<b>2018-19 £m</b>
Baseline Budget	55.663	56.360
Cost and Demand Pressures	2.648	3.155
Inflation	0.606	0.578
Total Expenditure	58.917	60.093
Total Funding	(56.360)	(52.773)
<b>Total Budget Gap</b>	<b>2.557</b>	<b>7.320</b>
2016-17 outturn	1.034	0.000
<b>Revised Budget Gap</b>	<b>3.591</b>	<b>7.320</b>
% reduction (before 16-17 outturn)	4.6%	13.0%

- 3.6.8 There is a significant impact from both sides of the budget in relation to the 2016-17 outturn as a result of the delay in the delivery of savings and the projected overspend. There would require to be negotiation at the financial year-end if there is an overspend on the integrated budget on the arrangements or agreement around the pay-back of any overspend in future years.

- 3.6.9 The position in relation to Health delivered services is an estimated overall reduction of 2.4% in 2017-18 and a further 0.8% in 2018-19. It is very difficult to forecast into future years for the Health position, as there is no formal indication of the funding uplift and there are significant emerging cost and demand pressures for Health delivered services which historically have not always been fully funded.
- 3.6.10 The position for Council delivered services is an estimated overall reduction of 4.6% in 2017-18 and a further 13% in 2018-19. As previously noted, the Scottish Government stipulated the minimum budget level to be transferred to Integration Joint Boards for social care services for 2017-18, it is not clear if similar requirements will apply in 2018-19 but for planning purposes it is assumed a similar reduction would be permitted. There is a historic pattern of significant cost and demand pressures in relation to the delivery of social care services and the impact of funding these costs from within the delegated budget level and the permitted reduction results in an increased budget gap and the requirement to deliver additional savings to balance the budget. The budget gap in 2018-19 is expected to be significantly higher which illustrates the impact of the additional one-off funding in 2017-18 to assist with smoothing the overall budget gap for the IJB.
- 3.6.11 The Integration Joint Board has agreed a process for the development of the Quality and Finance Plan for the two years from 2017-18 onwards. This will require to deliver estimated savings of £20m across the two years with £11m of the savings required to be delivered in the first year. The weighting of the savings requirement in 2017-18 has improved significantly due to improved funding offers from both the Health Board and Council and the improvement to the estimated 2016-17 year-end outturn position.

### **3.7 PROPOSED QUALITY AND FINANCE PLAN 2017-18 AND 2018-19**

- 3.7.1 The Quality and Finance Plan has been in development since October 2016 when the process started with Locality Planning Groups to develop priority areas for service change to deliver on the strategic objectives and the required savings to deliver a balanced integrated budget for the two years 2017-18 and 2018-19.
- 3.7.2 The proposed Quality and Finance Plan for 2017-18 and 2018-19 is included in Appendix 2. The document provides the context for the IJB in terms of strategic direction and performance expectations and includes the proposed Quality and Finance Plan and the proposed investment plan.

3.7.3 The proposed savings are summarised in the table below:

	2017-18 £m	2018-19 £m
<b>Quality and Finance Plan 2016-17:</b>		
Approved Still to be Delivered	3.010	3.135
Savings Not Achievable	(0.117)	(0.117)
Full Year Impact	0.022	0.207
Additional/Extensions to Savings	1.701	2.786
<b>Total Savings from 2016-17 Q&amp;F Plan</b>	<b>4.616</b>	<b>6.011</b>
NEW - Efficiency Savings	1.631	2.051
NEW - Policy savings	1.950	3.503
<b>TOTAL SAVINGS PROPOSED Q&amp;F PLAN</b>	<b>8.197</b>	<b>11.565</b>

3.7.4 The proposed Quality and Finance Plan includes a carry forward of undelivered savings from 2016-17, with £0.117m of these savings being identified as not deliverable on a recurring basis. In addition to this there is also the full year impact of savings approved in 2016-17. When developing the Quality and Finance Plan for 2017-18 and 2018-19 it became apparent that a number of the proposed service changes are extensions or additions to the savings approved for 2016-17. The Integration Joint Board has already taken a decision in principle to these service changes, therefore it is recommended that these do not require further approval to progress.

3.7.5 Efficiency savings have been identified that can be removed from service budgets without any impact on front line service delivery and can be delivered in the normal course of business.

3.7.6 There are additional new policy savings of £2.0m in 2017-18 which increase to £3.5m in 2018-19. These service changes may impact on service users and employees and therefore require approval from the IJB to implement.

3.7.7 The total savings identified on the Quality and Finance Plan compared to the overall budget gap is noted in the table below:

	2017-18 £m	2018-19 £m	Cumulative Total £m
Budget Gap	11.013	8.969	19.982
Total Savings Quality and Finance Plan	8.197	3.368	11.565
<b>Remaining Budget Gap</b>	<b>2.816</b>	<b>5.601</b>	<b>8.417</b>

3.7.8 If the proposed Quality and Finance Plan is approved by the IJB, there will remain unidentified savings of £2.8m for 2017-18 and a further £5.6m in 2018-19. There is time to develop further opportunities to deliver savings in 2018-19 which will allow for a lead-in time to implement, however there remains a significant financial risk for 2017-18 to identify additional savings in order to deliver a balanced budget position.



- 3.7.9 It is the assessment of the Strategic Management Team that the service changes outlined in the proposed Quality and Finance Plan are in line with the delivery of the Strategic Plan objectives. The requirement to deliver further savings in addition to this may impact on the delivery and safety of services and on the ability of the IJB to meet strategic objectives and national improvement targets. An assessment of the impact of any further savings would be carried out by the SMT.
- 3.7.10 There is a requirement for the IJB to approve a balanced budget, therefore at this stage it is recommended that a decision is made to approve the proposed Quality and Finance Plan and that further proposals to balance the 2017-18 budget are brought back to the IJB in May 2017.
- 3.7.11 The remaining budget gap and unidentified savings pose a significant financial risk for the partner bodies, i.e. the Health Board and Council, as any overspend from integration services will require to be funded by additional payments from the partners in the short term. It would not be the intention to develop the Quality and Finance Plan with a focus on balancing the position in terms of the same level of resource being allocated back to fund Health and Social Care services and that approach would not be taken to identifying any additional savings. It is however important to understand and quantify the risk for each of the partners of the remaining budget gap. If there was an assumption that the same level of resource was allocated back to each partner then the remaining unidentified budget gap would be split as follows:

	<b>2017-18 £m</b>	<b>2018-19 £m</b>	<b>Cumulative Total £m</b>
Health Services	0.921	0.069	0.990
Social Care Services	1.895	5.532	7.427
<b>Remaining Budget Gap</b>	<b>2.816</b>	<b>5.601</b>	<b>8.417</b>

- 3.7.12 A number of service re-designs are required in social care services to address the current overall overspend position, the savings expectation is therefore understated for these changes in the Quality and Finance Plan to ensure costs can be reduced in the first instance to accommodate current service demand. This provides an additional financial risk in terms of any decision not to approve these changes, this will lead to continued overspends for these areas where service changes are required to deliver financial balance before savings can be released.
- 3.7.13 The IJB are not in a position to formally accept or approve the funding offers from the Council and Health Board until it is clear whether additional savings can be delivered to produce a balanced budget position. The IJB require to consider whether the level of funding is adequate to deliver the delegated services in line with the objectives in the Strategic Plan and whether this level of savings is achievable, in light of the difficulties of achieving savings totalling £8.5m outlined in the Quality and Finance Plan for 2016-17. As acknowledged by the IJB previously the changes required to service delivery are significant and the transformational change can only be delivered if services have the appropriate time to plan and implement savings.

3.7.14 Directions will require to be formally issued to the Council and Health Board following the budget decisions made by the IJB, to formally advise on the level of delegated budget for service delivery, these will require to be caveated around further decisions required to balance the budget for 2017-18.

### **3.8 QUALITY AND FINANCE PLAN – MONITORING AND IMPLEMENTATION**

3.8.1 The Board is asked to approve the proposed Quality and Finance Plan for 2017-18 and 2018-19, this will allow operational management to commence the planning and implementation of service changes.

3.8.2 A monitoring process will be put in place during planning and implementation to enable progress on the delivery of the plan to be monitored both in operational and financial terms. Reports will be made to the IJB on a regular basis through the financial monitoring report. For each service change initiative this will clearly show an assessment of any impact on service, the risk of delivery, the projected savings for each year, a comparison to the target savings and the expected and planned timescales for delivery. Where a project is off track this will be reported to the IJB through the financial monitoring report and highlighted by exception. This will provide an assurance to the Board over the progress with delivering savings and ultimately delivering services within the overall level of resources available.

3.8.3 Some areas on the proposed Quality and Finance Plan will require to be subject to more detailed reviews before the detail of service changes can be set out fully. These include the reviews of Learning Disability Services, Lorn and the Islands Hospital, Cowal Out of Hours and care home provision in the West of Argyll & Bute. The outcome of the reviews will be brought back to the IJB for further consideration of recommendations and fit with strategic priorities.

3.8.4 The Integration Joint Board will require assurance from the Strategic Management Team that a process will be put in place to ensure that issues are brought back to the IJB for approval, if they are not in line with the safeguarding principles set out below:

- Safe Service – where any service change will compromise the requirement to provide safe services eg. safety and care of patients
- Sustainable Service – where a change will negatively impact on the sustainability of services or will implement a model which is viewed as having risks in terms of sustainability in the future eg. inability to recruit to posts, adverse impact on budget
- Equality Impact Assessment Outcome – where based on assessment the recommendation is to stop or to continue with justification
- Value for Money – where a change is not perceived as providing value for money from the finite resources we have available
- Community Engagement – where through engagement with communities it is identified that the service redesign is not appropriate or fit for purpose
- Redundancy Implications – where there is a requirement to make staff redundant to implement service change

3.8.5 It is the role of the management team to implement the strategic direction approved by the Integration Joint Board. In the event that any of the principles set out above are not met the Strategic Management Team will request approval from the Board at the earliest opportunity before proceeding.

### **3.9 INVESTMENT PLAN**

3.9.1 In order to lever the change and deliver the service re-designs included in the Quality and Finance Plan there are gaps that needs to be addressed in terms of project management capacity and a required investment in the delivery of community based services to facilitate the shift in the balance of care.

3.9.2 The proposed investment plan is included in Appendix 2. A total investment fund of £1.1m has been identified in 2017-18, with this expected to increase in 2018-19 to invest in leveraging the change. The IJB has an ambitious Strategic Plan which will require the transformation of health and social care services across Argyll and Bute to deliver on a number of national and local outcomes and service improvements, all at the same time as the requirement to deliver significant financial savings. It is crucial that this fund is protected and diverted to this investment to lever the change to ensure that all of the savings in the Quality and Finance Plan can be delivered, following on from lessons learned in 2016-17 where there were significant shortfalls in the delivery of savings.

### **3.10 RESERVES**

3.10.1 A Reserves Policy has been drafted for approval by the IJB. The IJB does not have any opening reserve balances but does have the ability to hold reserves. The position for reserves should be considered during the budget setting and year-end processes. During the budget setting process it is important to consider the adequacy of the reserves available to the IJB.

3.10.2 It is important for the longer term financial sustainability of both the IJB and the parent bodies that sufficient usable reserves are held to manage unanticipated pressures from year to year. The Reserves Policy suggests a prudent level of general reserve be set at 2% of the IJB net revenue budget, this would equate to around £5m. Whilst this level of free general reserve would allow the IJB a degree of flexibility and assurance this must be proportionate and take cognisance of the level of savings required to be delivered. Given the unprecedented economic climate in which the IJB are facing this should be kept under review and the proposed 2% should be viewed as an optimum level of reserves to be built up over time, recognising the tensions between prudent financial planning and budgetary constraints. Therefore there is no recommendation as part of the budget to plan for a surplus to be credited to reserves.

## **4. CONTRIBUTION TO STRATEGIC PRIORITIES**

4.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery. The proposed Quality and Finance Plan for 2017-18 and 2018-19 has been developed in line with delivering the strategic objectives.

## **5. GOVERNANCE IMPLICATIONS**

### **5.1 Financial Impact**

- 5.1.1 The Board is required to set a balanced budget, the proposed Quality and Finance Plan for 2017-18 and 2018-19 has been developed with a view to identifying savings. There is a shortfall in the savings identified with a remaining budget gap of £2.8m in 2017-18 and a further £5.6m in 2018-19. There are significant financial risks as a result of the unidentified savings and also around the delivery of the Quality and Finance Plan in light of the scale and pace of change required.

### **5.2 Staff Governance**

The appropriate HR processes will required to be followed where staff are impacted by any service changes proposed in the Quality and Finance Plan.

### **5.3 Clinical Governance**

None

## **6. EQUALITY & DIVERSITY IMPLICATIONS**

Equality Impact Assessments will be carried out where required.

## **7. RISK ASSESSMENT**

None, financial risks are noted in the report.

## **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT**

- 8.1 Where required as part of the development and delivery of the proposed Quality and Finance Plan local stakeholder and community engagement will carried out as appropriate in line with the re-design of service provision.

## **9. CONCLUSIONS**

- 9.1 The report outlines the budget gap for Integrated Services for 2017-18 and 2018-19, and the savings requirement to be delivered in the Quality and Finance Plan. The 2016-17 financial position, with savings not being delivered in full and other cost and demand pressures resulting in a projected overspend position is placing additional pressure on the budget position for 2017-18 and additional savings require to be identified as a result of this.
- 9.2 There is more clarity around the funding available from the partners, with the Council budget allocation already agreed and the Health Board budget due for approval at the end of March. The level of cost and demand pressures is significant and these are a major contributing factor to the ongoing funding gap. The financial position for 2017-18 is unlikely to materially change however there are more uncertainties around the position for 2018-19.

- 9.3 The Integration Joint Board should view the contributions from partners as one Integrated Budget with flexibility to distribute as required to ensure priorities in the Strategic Plan are met. The 2016-17 financial year resulted in both partners having the same level of resources delegated back to them to fund services. This was the first year of integration, it is unlikely that this will be the approach in future years. The Health and Council positions are noted separately in the report for transparency to allow the IJB to assess the respective funding gap being passed to the IJB from each of the partners and to highlight the financial risk to each of the remaining budget gap.
- 9.4 The proposed Quality and Finance Plan for 2017-18 and 2018-19 identifies savings totalling £11.6m over the two years, however there remains a shortfall in identified savings to fully address the budget gap. There is a requirement to identify further savings which will be brought back to the IJB in May 2017. There is a significant financial risk in that not all savings have been identified and the lessons learned from a shortfall in delivering savings in 2016-17. The risk of delivery will be mitigated by the approval of an investment plan to ensure the appropriate level of project management support and investment in community services is in place.
- 9.5 The future outlook for the Integrated budget is one of a continuing funding gap, mainly due to any uplift in funding being outweighed by increased costs due to demand and inflationary cost increases. This was foreseen, however the expected savings poses the IJB with a particular challenge in terms of delivering the transformational change required to services. The monitoring and development of the Quality and Finance Plan will be an iterative ongoing process to ensure financial balance can be achieved for the partnership.

## **APPENDICES:**

Appendix 1 – Cost and Demand Pressures

Appendix 2 – Quality and Finance Plan 2017-18 to 2018-19



## COST AND DEMAND PRESSURES

## APPENDIX 1

No	Cost/Demand Pressure	Description	2017-18	2018-19
			£000	£000
1	Growth in Demand for Services for Older People	The number of older people is increasing and older people are living longer with significant health and support needs and significant expectations of the support they are entitled to receive. Demand pressure estimates 3% growth in homecare and care home placements.	600	600
2	Growth in Demand for Replacement Care for Younger Adults	There has been continuing increase in demand for care and support services for profoundly disabled younger adults (ie under 65) whose parents have historically provided care but are no longer able to as they enter old age.	300	300
3	Living Wage	Full year impact of payment of Living Wage to all social care workers from 1 October 2016 and additional cost of increasing Living Wage rate from £8.25 to £8.45 from 1 May 2017. Assume in 2018-19 there will be a further stepped increase to the rate to reflect the national commitment to reach a national living wage of £9.00 by 2020.	2,391	720
4	Extension of continuing care for Looked After Children.	Demand pressure for services for young people of continuing care for Looked After Children arising from the Children and Young People (Scotland) Act whereby the period of responsibility for care is extended. Full year cost pressure for 2017-18 is £615k, reduced pressure as £115k already provided in 2016-17 budget.	500	735
5	Prescribing	Demand growth at 2%, assume this will be met from savings in prescribing of at least this value, savings have been included in the Quality and Financial Plan.	386	386
6	New Medicines Funding	This was a cost pressure during 2016-17 which was accommodated by Scottish Government non-recurring funding, £500k of the cost relates to GG&C and £200k for LIH.	700	0
7	Commissioned Services/Care Packages	New and existing health care packages.	400	200
8	Apprenticeship Levy	New charge of 0.5% of payroll costs, cost pressure includes cost for both health and social care budget.	426	0
9	NDR Revaluation	High level estimate of outcome of NDR revaluation, full implications are not yet clear.	250	0
10	Remote and Rural Project	Ongoing recurring commitments post project funding from SGHD	197	0
11	£107m funding commitment - Veterans and Carer's Act	Provision for the Veterans and Carer's Bill pre-implementation, which have been included as a cost pressure on the basis of the share of additional £7m funding allocation.	130	0
12	Carer's Act	Carers Act will commence on 1 April 2018, high level estimate of cost. There are concerns re the Scottish Government fully funding the commitment and implications of the Act.	0	400
13	Sleepovers - Children's Services	Additional cost to bring sleepover rates in school hostels into line with National Living Wage.	116	0
14	Criminal Justice Services	New model of providing service on cessation of the Criminal Justice Partnership will result in additional costs. This may reduce in the future as funding is re-aligned incrementally across Scotland	60	0
15	Provision of new service in Kintyre	Establish a new adult care service at Lorn Campbell Court in Kintyre. Cost pressure allows for a lead in time for developing the service in 2017-18.	370	400
16	Mental Health Services	Unfunded discharges from Argyll & Bute Hospital	105	0
17	GG&C SLA	Additions to the GG&C SLA including pharmacy, H&L Community Mental Health Team, Laboratory Services and Homecare Pharmacy.	194	0
18	A&B Hospital Junior Doctors Rota	Increased payments to junior doctors for out of hours work	65	0
19	LIH Laboratory Services	Growth in supplies costs, activity related	30	0
20	ADP Funding Shortfall	To address current year shortfall in total budget allocation.	26	0
21	Consultant Outreach Clinics in Oban	Increased orthopaedic clinics	5	0
22	Interpretation Costs (syrian refugees)	Currently funded non recurringly by Home Office	30	0
23	Orthoptics SLA	Approved increase to SLA	11	0
24	Telehealth pod maintenance	Currently funded from TEC budget, project funding only covers initial equipment purchase costs and doesn't cover ongoing annual maintenance costs.	21	0
25	Cowal FME in hours contract	Increased cost arising from tendering exercise	43	0
26	Consultants discretionary points	Based on 2016-17 cost growth	16	0
27	NSD Service Developments	Funding for these services is top-sliced from Health Board allocations during the financial year. The cost pressure allows for new developments in 2017-18. Estimate based on previous years costs.	50	0
28	Lorn and Isles Hospital	General Surgery additional EPA payments	21	0
29	Children's Services	Physiotherapist increase	26	0
30	Cluster Quality Leads	New requirement	41	0
31	NHS Lothian - TAVI procedures	Growth in cardiac surgery procedures charged on a cost per case basis.	110	0
32	GG&C Growth - Laboratory services	Based on trend analysis	60	0
33	GG&C Growth - Hepatitis C	Based on trend analysis	40	0
34	Urology service development	Development of service at RAH to replace service at LIH.	204	0
35	New Health Pressures	Provision for new Health Cost and Demand Pressures in 2018-19, historic pattern of emerging pressures for health services which have not always been fully funded.	0	1,000
<b>Total Cost and Demand Pressures</b>			<b>7,924</b>	<b>4,741</b>







# **Argyll and Bute Health and Social Care Partnership**

## **Quality and Finance Plan 2017-18 to 2018-19**

March 2017

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## Introduction to the Plan

The Argyll and Bute Health and Social Care Partnership (HSCP) came into being in April 2016. The Health Board and Local Authority have delegated the responsibility for planning and budgeting for service provision for health and social care services to the Integration Joint Board. The Integration Joint Board are responsible for directing a total resource of £256m. Our Strategic Plan 2016—2019 outlines our ambitions and our local priorities for the next three years which will ensure that we deliver our vision that:-

“People in Argyll and Bute will live longer, healthier, happier independent lives”.

The Argyll and Bute Health and Social Care Partnership has identified six areas of focus in delivering our vision:



In December 2016, the Scottish Government published the Health and Social Care Delivery Plan which highlights the urgent need to address the rising demand being faced across health and social care services and the changing needs of an ageing population. Critical to this is shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes, when that is the best thing to do. This provides a clear

impetus to the wider goal of the majority of the health budget being spent in the community by 2021.

Our Quality and Finance Plan 2016-19 is key to supporting the delivery of the strategic plan and setting out our plans to deliver a shift in the balance of care. The ability to plan based on the totality of resources across the health and care system to meet the needs of local people is one of the hallmarks of integrated care. Financial planning is key to supporting this process and identifying the transformation which is required to provide safe and sustainable services to the local community over the medium term.

### **Case for Change**

Argyll and Bute Health and Social Care Partnership is facing significant challenges as a result of our ageing population, challenges of recruitment and a reduced workforce, the cost of implementing new legislation and policies and financial pressures. If nothing else changes spend would need to increase by 11% by 2020. While not a new set of challenges for Argyll and Bute, the scale and pace of change which is required over the next two years is unprecedented, with a reduction in costs of £20 million required over the next two years.

The recent Report on Social Work in Scotland (Social Work in Scotland, Accounts Commission Sept 2016) recognised that current approaches to delivering health and social care are not sustainable in the long term. The report highlighted the significant level of challenges faced by Health and Social Care Partnerships because of the combination of financial pressures caused by a real-terms reduction in funding, increased demographic pressures and the cost of implementing new legislation and policies. Audit Scotland concluded that if Health and Social care Partnerships continued to provide services in the same way, spending would need to increase by 16-21% by 2020.

Increased demand for services linked to constraints in public sector funding and changing demographics are the most dominant challenges. It is estimated that between 2010 and 2035 the population of Argyll and Bute will decrease by 7% overall, the number of working age adults will decrease by 14%, whilst the number of people aged 75+ will increase by 74%. This leads to reduced Scottish Government funding allocations for both the Health Board and Local Authority, reduced workforce capacity and increased demand for services.

Within this local and national context it is essential that the Partnership develops and maintains a Quality and Finance plan to enable it to direct resources at the services which will deliver the greatest impact, support a shift in the balance of care and will set the context for annual budgets.

Some difficult decisions and choices need to be made which will understandably cause concern if people don't understand or accept the case for change.

## **National Priorities**

The Scottish Government have outlined expectations from the integration of services which include:

- Commitment to shift the balance of care, so that by 2021-22 more than half of the NHS front line spending will be in Community Health Services
- Invest in prevention and early intervention, particularly in early years, with the expectation that work will continue to deliver 500 more health visitors by 2018
- Produce plans to minimise waste, reduce variation and duplication
- Reduce medical and nursing agency and locum expenditure as part of a national drive to reduce spend by at least 25% in-year
- Reduce unplanned admissions, occupied bed days for unscheduled care and delayed discharges therefore releasing resources from acute hospital services
- Shift the balance of spend from institutional to community services

Health and Social Care Partnerships are required to measure performance against nine National Health and Wellbeing Outcomes and for Argyll and Bute there are 23 sub indicators which sit below these outcomes to demonstrate the performance of the Partnership. In addition to these the Scottish Government will track:

1. Unplanned admissions
2. Occupied bed days for unscheduled care
3. A&E performance
4. Delayed discharges
5. End of life care; and
6. The balance of spend across institutional and community services

There is a focus on integrated services to deliver real change to the way services are being delivered, with a realism that the care system is broken and delivering services in the same way is not a viable option.

## **Our Approach**

In considering these challenges the Partnership must redesign care, services and ways of working to ensure we deliver safe, high quality services which are sustainable and affordable. It is clear from the scale of the financial challenges faced that the current models of care are not sustainable. This will be a major challenge as doing more of the same will not deliver the scale of change required.

You said “We want to stay at home for as long as possible.” To support people to live in their homes for as long as possible, we need to provide more community based services and aim to do this by investing an additional £1.1 million in these services. This alongside the continuation of investment of specific funding allocations to drive forward integration work including the Integrated Care Fund, Technology Enabled Care and Delayed Discharge will lead to a total investment in transformational change of £3.5m.

This means we can reduce the number of beds in our hospitals but we will not compromise safety of patients and there will always be sufficient beds for those who do need a stay in hospital. Fewer people will need to be cared for in a nursing or care home as we provide a higher level of care to support people within their own homes.

Ensuring local access to care in the face of workforce challenges means urgently reviewing our use of technology to support people to access care and reduce the need for travel.

While service redesign and change is high profile, a focus on eliminating the waste and inefficiency in our systems is another way in which we can ensure the most effective use of both our workforce and our budget. Within the Partnership we are building our capacity and capability to use the tools of lean and quality improvement, while recognising that it is wholesale adoption of these approaches which will have maximum impact.

There are minimum requirements for the services delegated to Integration Joint Boards, which are broadly adult social care services, adult community health services and a proportion of adult acute services. In Argyll and Bute all health and social care services have been included in the delegations to the Integrated Joint Board, including children's services and all acute hospital services. This leaves the Argyll and Bute Integration Joint Board with full responsibility and resources for the whole of the care pathway. This puts us in a unique position to influence and take decisions based on a whole system approach and this is something that can be capitalised on when developing and implementing the Quality and Finance Plan, particularly when shifting the balance of care from hospitals or institutional settings to the community.

## **Pace of Change**

We need to do more. The Scottish Government Health and Social Care Delivery Plan (December 2016) says we need to change services more quickly. The focus on preventing ill health, early intervention, reducing health inequalities and supported self—management mirror our local priorities but we know we need to do a lot more than we are now.

Across the country and beyond the challenges to bring in new models of care that are sustainable from both clinical and financials view points are significant. Here in Argyll and Bute we also face some additional pressures due to the remoteness and rurality of some of our communities plus we have a higher proportion of older people. Many of our communities are therefore fragile. As an important partner in maintaining the social and economic vibrancy, concerns around health service quality or service changes can and do generate considerable attention from communities, local and national politicians as well as staff.

While there appears to be a general understanding and acceptance that the models of care have to change there are many views on what and where these changes should be. The biggest challenge we face is needing to speed up the pace of change while at the same time taking staff, communities and partners with us.

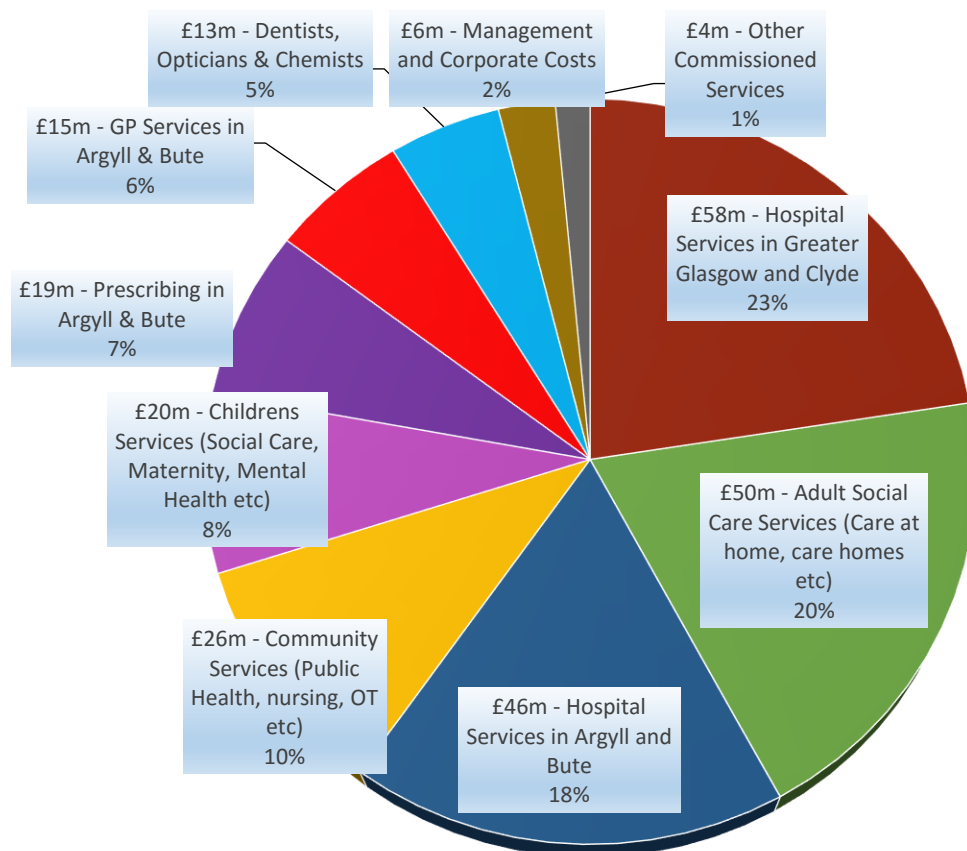
This plan sets out our commitment to continue to transform care to deliver the best possible outcomes for the people of Argyll & Bute. Our transformational journey includes moving towards more people being cared for at home. These aspects will be delivered through a combination of prevention and anticipatory care, better use of technology and developing and embedding new models of care. It will also very much be a collaborative approach working with our statutory partners, voluntary and third sectors as well as our staff and local communities. Clearly wider work delivered through public health, primary care, children’s services are ongoing and will shape improved outcomes in the longer term.

There are risks around the pace and scale of change being insufficient or delivery of change being compromised which may result in:

- No or little reduction in health inequalities, especially for those in poverty who experience the poorest health
- Continued focus on more acute care which will not reduce the numbers of people acquiring long term conditions
- A missed opportunity to improve the quality of life of those with long term conditions.

### Integrated Budget – Key Facts

How do we spend our money just now?



This is summarised below:

Hospital Services	40%	£103m
Adult Social Care Services	20%	£50m
Community Services	10%	£26m
Prescribing	7%	£19m
GPs, Dentists, Opticians and Chemists	11%	£28m
Everything else	12%	£30m

In Argyll and Bute a relatively small number of service users account for much of the activity and resource consumption in the health and social care system, with 50% of the resource spent on hospital and prescribing costs to provide services for 2% of the population. Across Scotland less than 4% of all service users account for 50% of total expenditure in health services, so this is consistent with the national picture. A better understanding of this group of service users and how they interact with health and social care services will help the Partnership better manage and commission services in the future and ensure an improved care experience and outcome for these people.

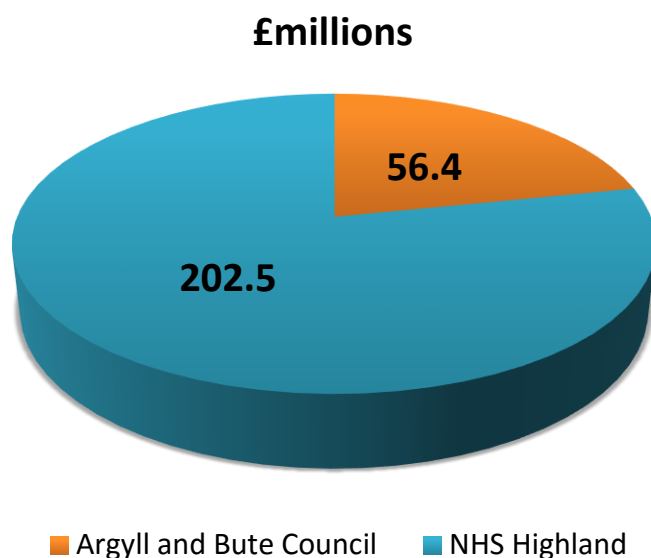
There is a clear direction from the Scottish Government that the integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes. By 2018 the national aim is to reduce unscheduled bed days in hospital care by up to 10 percent (i.e. by as many as 400,000 bed days) by reducing delayed discharges, avoidable admissions and inappropriate long stays in hospital. Actions taken by Integration Joint Boards to deliver on these targets will assist to reduce the growth in the use of hospital resources, support balance across NHS Board budgets and give clear impetus to the wider goal of the majority of the health budget being spent in the community by 2021.



## Understanding the Financial Challenge

### Funding

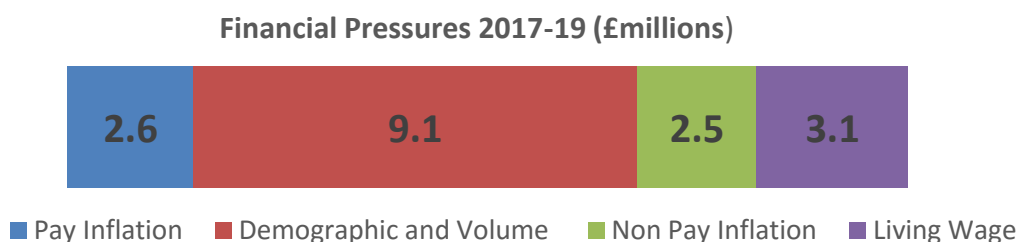
The Health and Social Care Partnership is funded through delegations from the Council and Health Board, the estimated funding for 2017-18 is illustrated below:



Partner contributions to the Health and Social Care Partnership are contingent on the respective financial planning and budget setting processes of the Council and Health Board and the financial settlements that they receive from the Scottish Government. There is uncertainty around funding available from 2018-19 onwards as both partners will set one year budgets for 2017-18 and the impact of the Scottish Government budget allocation and local spending decisions is not known. However funding assumptions can be made around the ongoing reductions to public sector funding and priorities.

### Cost and Demand Pressures

A detailed analysis of the cost and demand pressures has been undertaken for the Partnership and assuming nothing else changes an additional £17m would be required to meet current and anticipated costs and demand over the next two years. These are illustrated below:



- The assumptions for pay inflation costs reflect the current inflationary assumptions of both partner bodies and the cost of the apprenticeship levy
- Demographic and volume pressures reflect increases across all service areas including amongst other areas healthcare packages, new medicines funding, growth in prescribing demand, growth in adult care services, younger adult supported living services and continuing care for children
- Non pay inflation includes anticipated increases to third party payments, including the expected uplift to NHS GG&C for acute services and cost increases for prescribing
- The Living Wage pressures include the full year implications of moving to the Living Wage from October 2016 and the increased rate for 2017-18, with an assumption the rate will increase year on year to reflect the national commitment to reach a national living wage of £9.00 per hour by 2020.

There are significant cost and demand pressures across health and social care services and these are expected to outstrip any funding uplifts and have a significant contribution to the overall budget gap for the Partnership.

### The Budget Gap

The Integration Joint Board has a responsibility to set a balanced budget and to delegate resources back to the Council and Health Board for the delivery of services. The funding and cost estimates are prepared for each partner separately but these are consolidated and viewed as one integrated budget with one bottom line position for the delivery of health and social care services.

Taking into account the estimated funding and the pressures in relation to costs, demand and inflationary increases the estimated budget gap for the Partnership for the two years to 2018-19 is outlined below:

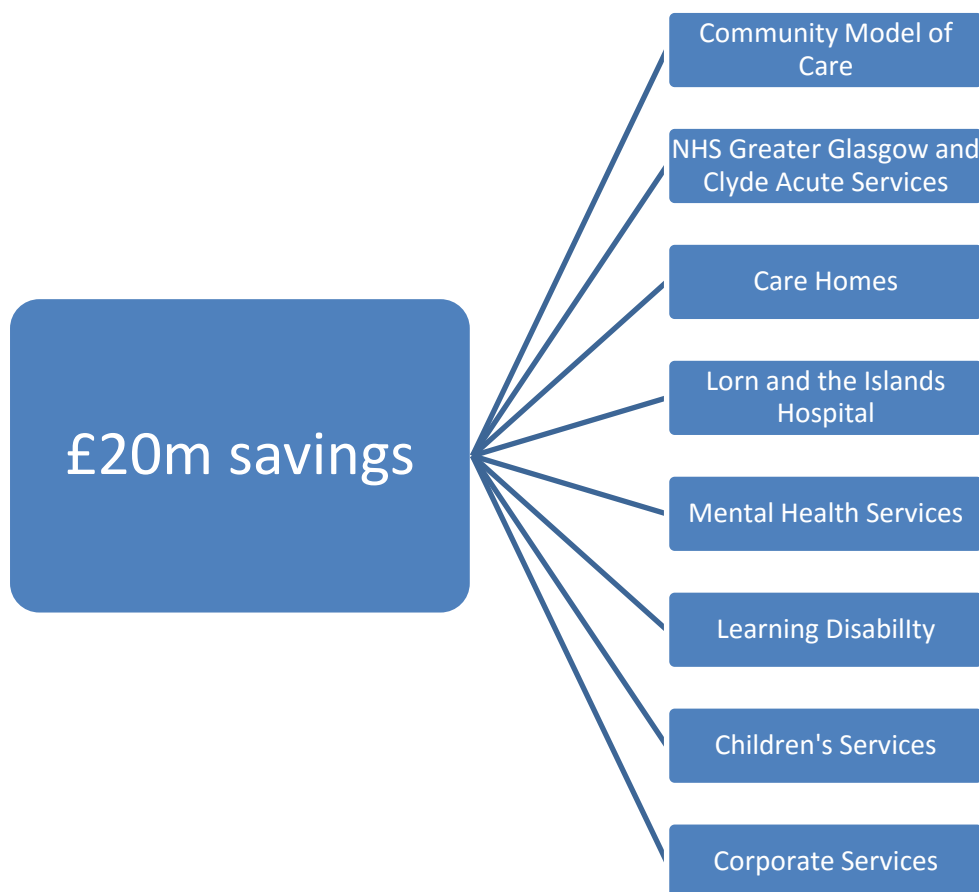
	2017-18 £m	2018-19 £m
Baseline Budget	256.1	258.9
Cost and Demand Pressures	7.9	4.7
Inflation	2.0	2.6
Total Expenditure	266.1	266.2
Total Funding	(258.9)	(257.3)
<b>Budget Gap</b>	<b>7.2</b>	<b>9.0</b>
Impact of 2016-17 Position	3.8	0.0
<b>In-Year Budget Gap</b>	<b>11.0</b>	<b>9.0</b>
<b>Cumulative Budget Gap</b>	<b>11.0</b>	<b>20.0</b>

The overall budget gap for the delivery of Health and Social Care services is £11m for 2017-18 and a further £9m in 2018-19, a total of £20m over the two years. The Quality and Finance Plan requires to outline service changes which will achieve these savings together with delivering on strategic objectives and outcomes.

### **Proposed Quality and Finance Plan 2017-18 to 2018-19**

The Quality and Finance Plan has been in development since October 2016 when the process started with Locality Planning Groups identifying priority areas for service change to deliver on the strategic objectives and the required savings to deliver a balanced integrated budget for the two years 2017-18 and 2018-19.

The areas of focus identified as part of this process are illustrated below:



The Quality and Finance Plan is included as Annex A, this provides the detail around plans to change services in line with the areas of focus identified.

The key principles that have been identified through the process are:

- Requirement to plan over a longer period and produce a two year plan in line with the remainder of the Strategic Plan

- Build on lessons learned from the current year where there are a number of service changes that haven't progressed as planned
- Staff costs account for a significant proportion of the budget, we need to reduce our budget but also need to retain the staff skills and experience we have and implement service changes through workforce flexibility to deliver services in a different way
- View the budget gap as one bottom line position and develop plans around that, no assumption that same level of resource will be allocated back to partners for Health and Social Care services
- Acknowledge that an investment plan is required to build capacity in Community Teams to shift the balance of care and that project management support is required to drive forward the change agenda

The Quality and Finance Plan 2017-18 to 2018-19 builds on the service changes aimed at shifting the balance of care that commenced in 2016-17.

There are savings totalling £3.1m from 2016-17 which have not been delivered on a recurring basis and these will remain on the plan. In addition efficiency savings totalling £2m have been identified that can be removed from service budgets without any impact on front line service delivery.

The savings identified on the plan total £11.6m, with £8.2m planned to be delivered in 2017-18 and a further £3.4m in 2018-19.

The Quality and Finance Plan does not fully address the estimated budget gap with a shortfall in identified savings of £2.8m in 2017-18 and a further £5.6m in 2018-19, there will be a requirement for further service changes to be identified to bridge the remaining budget gap. There is a significant financial risk to the Health and Social Care Partnership and the Council and Health Board partners of not fully identifying savings. There is a risk that any further service changes may impact on the delivery and safety of services and the ability of the Integration Joint Board to meet strategic objectives and national expectations around service delivery.

## **Risks**

There are major risks associated with the scale and pace of change required to deliver the service changes and recurring savings from the Quality and Finance Plan. There are a number of specific identified risks:

- Project management skills and capacity are not sufficient to deliver in the required timescales
- Evidence base and communications and engagement is insufficient to convince communities of the case for change in required timescale
- Demands on leadership and management capacity to lead transformational change while maintaining current services

- Evidence base and communications and engagement is insufficient to convince staff of case for change in required timescale
- Scale of efficiency requirements means some plans may not be in line with the Health and Social Care Partnership's strategic objectives

## **Investment Plan**

The Argyll and Bute Health and Social Care Partnership has an ambitious strategic plan. In order to facilitate this additional funding has been provided by the Scottish Government which can be used to help transform services and to support integration. This additional funding is now recurring baseline funding for the Partnership. It is important to note that whilst the allocation of this funding is extremely useful in directing resource specifically to delivering the strategic plan, the totality of the HSCP budget is available to transform health and social care services.

The total investment resource available is £3.5m, which consists of £1.8m Integrated Care Funding, £0.6m Delayed Discharge Funding, £0.5m Technology Enabled Care and £0.6m set aside for community investment, from the additional £250m of Scottish Government funding allocated in 2017-18. £1.1m of this funding has been set aside specifically to deliver on the service changes outlined in the Quality and Finance Plan. The investment plan is included as Annex B. The ongoing allocations from the Integrated Care Fund and Delayed Discharge funding are currently being reviewed and will be included when allocations for 2017-18 and 2018-19 have been finalised.

The investment plan includes resource requirements for additional programme management support to deliver the service changes. One of the lessons learned from the current year is that there is limited capacity within service teams to deliver on the scale of service change required together with continuing to have a focus on operational service delivery. This investment will ensure that there is dedicated support to ensure the delivery of service changes and ultimately recurring budget savings.

## **Next Steps**

This Quality and Finance Plan is a step in developing the Health and Social Care Partnership's strategy to meet the challenges of health and social care integration. The plan has been aligned to the objectives of the Strategic Plan and the performance outcomes and objectives. There will be a requirement to further develop the plan to add further savings to address the remaining budget gap. This work has already started and all services and the Integration Joint Board will be involved in developing plans to ensure we have a financial plan which is sustainable over the longer term.

Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
<b>CHILDREN'S SERVICES:</b>							
CF01	Redesign of Internal and External Residential Care Service	<p>Minimise the use of external placements, increase the capacity of our residential units by adding satellite flats and developing a core and cluster model. Develop social landlord scheme to support 16+ young people moving from foster care or residential care. Further review and where possible bring back all 16+ year olds to local area, to do this we need:</p> <ul style="list-style-type: none"> <li>to work with our education partners to support complex young people</li> <li>to work closely with SCRA, who make decisions on placements, to evidence that our internal homes can provide better meet the needs of young people in Argyll than external placements.</li> <li>to increase capacity through satellite flats by working with housing providers in Oban, Dunoon and Helensburgh</li> <li>Work with foster carers to help them understand continuing care, work with adult services to develop a transitions protocol and understanding of where responsibility lies.</li> </ul> <p>This means:</p> <p>We need to develop a pilot model in Helensburgh for core and cluster to test the model, work to increase employment opportunities for young people to increase their links to local community.</p>	<p>Children and young people from Argyll and Bute live in Argyll allowing greater access to services as they grow older. We believe we are best equipped to supported our most vulnerable however we need to increase our capacity and redesign the services to meet growing needs place on us by Children and Young People Act. Continuing care has 75% of individual young people costed to stay in their current placements as it is their legal right. If redesign successful then there will be opportunities to minimise the cost of continuing care for 16, 17 and 18 year olds. The current costs for continuing care in 2016-17 is £550k and is estimated to be £615k in 2017-18. Using the redesign this could be reduced by £300k in 2016-17 and a further £100k in 2018-19.</p>	<p>Social Work working with higher need young people impacts on Police, Education and SCRA.</p> <p>Volatile Budget based on need and influenced by decisions made by outside bodies, potential to over spend.</p> <p>Lack of capacity to undertake redesign of service.</p> <p>Funding is required to set up the pilot, without the pilot and a new model of care we will be unable to fulfil our statutory duty for continuing care under the CYP Act.</p>	<p>Potential risk impact unable to fulfill our statutory duty to deliver continuing care for 16-25 year olds if redesign increases the number of placements risks can be reduced significantly.</p>	300	400
CF02	Redesign staffing structure across Children and Families service to cope with duty under CYP Act and government initiatives within NHS.	<p>Scoping of children and Families staffing requirements as case load increases due to the requirements of the Children and Young People (Scotland) Act the service will be looking after children for longer. For the next 8 years there will be a steady increase only levelling out in 2026. Incrementally the service will require 5 additional social workers. Health visiting pathway requires additional Health Visitors, additional services for children in distress are required. Requirement to scope and cost a new staffing structure through consultation with staff and those who use the service, we will develop a programme board and look at front line staff and management structure to further develop integrated teams. Reviewing workloads and supporting third tier sector to undertake social care tasks.</p>	<p>Service should be better equipped to deal with service demands and legislation.</p> <p>Services potentially will be delivered by the third sector on behalf of the health and social care partnership in line with 3 year HSCP strategic plan</p> <p>Managing transformational change while meeting the current demands places risks on service delivery</p> <p>Capacity to undertake redesign of service</p> <p>Reputational risk if third sector do not deliver appropriate service.</p> <p>Reduction in public sector workforce</p> <p>Increased use of third sector partners</p>	<p>Redesigned service as well as third sector providing services traditionally provided by health and social care partnership.</p> <p>Managing transformational change while meeting the current demands places risks on service delivery</p> <p>Capacity to undertake redesign of service</p> <p>Reputational risk if third sector do not deliver appropriate service.</p> <p>Reduction in public sector workforce</p> <p>Increased use of third sector partners</p>	<p>Reduction is suitably qualified staff will impact on ability to deliver health visiting, NHS, Social Work Services however this risk could be mitigated by undertaking review of all childrens services where staff, young people and families will help to develop a new model of service delivery.</p>	100	200
CF03	School Hostels - Explore the opportunities to maximise hostel income.	<p>May be opportunities to actively market accommodation over holiday periods and use annexe accommodation to attract locums at a reduced cost. Although we have an income budget that we currently do not achieve we would hope to over recover income.</p>	<p>Opportunity to use HSCP assets to generate income in line with 3 year strategic plan</p>	<p>Lack of Use</p>	<p>No risk to statutory service.</p>	0	10

Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
<b>LORN AND THE ISLANDS HOSPITAL:</b>							
AC01	Lorn and the Islands Hospital Future Planning to improve the local services and engage specialist services appropriately to deliver best possible care.	LIH group established with representation from public, community, third and independent sector working jointly to design services that will minimise or avoid all delayed discharges, offer excellent quality local care complemented by specialist care out of area as required. Prevention of admissions to be achieved by shifting the overall balance of care and staff to ensure anticipatory care planning in place. Working with the LIH group to explore clinical options and offer continued, consistent appropriate hospital care. Data collection and scrutiny to inform the service design. Recruitment and retention strategies to support the service.	Improved data collection and scrutiny will meet performance criteria for safety, quality and sustainability when considered alongside the shift in the balance of care and commitment to quality outcomes for patients. Positive outcomes relate to H&SC Delivery Plan and HSCP Strategic Plan. Improved clinical care should expedite discharges. Balance of care in the community will reduce acute admissions.	LIH planning group will produce range of options for wider consultation, with commitment to 24/7 emergency care. LIH Group will examine surgical and medical provisions, the shift in balance, and in full knowledge of GG&C plans as well as links with local hospitals.	None anticipated.	347	647
AC02	Further improvement and investment in the scope of OLI Community Wards to offer quality services and support on discharge and timely assessment and readmission.	Community staff further upskilled through training and understanding of scope of services. Resource to ensure that 'virtual wards' feel and give a service which is perceived as real and more effective than location based services.	This supports Clinical Strategy, HSCP Strategic Plan, H&SCP Delivery Plans. Major shift in community based care inclusive of all sectors working jointly to deliver improved care and experience and to minimise delayed discharge.	Shifting the balance to care will require engagement, training and dialogue with community staff to develop ways in which a 24/7 community ward can be delivered to benefit patients. Alongside the LIH group will consider an enhanced consultant role eg for assessments.	Shifting care into the community has positive outcomes for patients and users of services, as well as SG Integration Performance measures eg unplanned admissions, unscheduled care, delayed discharges and A & E performance.	included above	included above
<b>CARE HOMES:</b>							
AC03	Putting environment, independent living and service user choice at the heart of care support by reviewing the current buildings and care service employed by Ardernaigh and Eader Glynn to deliver an improved environment, better choice and control.	Identify all options with partners to better provide support when care at home is no longer possible. Seek engagement to review all options with full regard for choices and control of people who use these services.	Priority is the choice and quality of care provision to those using services, and to fully utilise aspects of shifting balance of care to a homely setting in a safe and caring, sustainable environment.	Engagement will assist in stakeholder understanding of options of care available and of the choices of service users. Long term plan which consults appropriately at all stages. Potential for lack of interest from external providers. Lengthy timescale.	Future potential changes to registration status and scope of work (eg outreach). Investment would be in improved environment.	0	53
AC04	Identified demand for greater choice of support care on Tiree, currently and for future planning .	Island demand to be quantified, and provision reviewed in line with current and emerging demands.	Based on older people's views, advance the shift in balance of care to support independence and empowerment. Partner working with Curam to achieve best outcomes.	Engagement and understanding with stakeholders and close involvement.	Future potential changes to registration status and scope of work. Improved environment, potential greater support in the persons home.	0	46
<b>LEARNING DISABILITY:</b>							
AC05	Redesign of Learning Disability services including day services and support at home for adults across Argyll and Bute, the priority needs to be given to service user need and demand in each local area.	Utilise learning from Helensburgh redesign, and engage with stakeholders. Full account of service user views and the current and emerging needs, encouraging independence and shifting the balance of care.	Redesign the service to maximise the independence of service users. This should deliver a better service and improve the value for money. Shifting the balance of care in line with Strategic Plan and H&SC Delivery Plan, into community settings which develop independence and choice for service user.	Families, carers and local support groups may resist the planned changes without a full understanding of the redesign. There may be a detrimental impact on existing staff in their current roles. Redesign must include engagement and understanding of families, carers, support groups and stakeholders. Staff to be consulted and engaged as the work progresses and all stakeholders kept fully informed. Redesign seeks to improve user outcomes whilst addressing overspends from a service no longer fit for purpose.	Potential changes to the type of registration with the Care Inspectorate. Positive impact on supporting independent living and improved environment.	175	325
<b>COMMUNITY MODEL OF CARE:</b>							
AC06	Repatriate top 15 high cost young adult care placements from outwith Argyll and Bute. This includes service users who are in residential care and some who are receiving specialist supported living services outwith the area.	Identify then review top 15 adults outwith the area currently and undertake review with a view to bringing their care package back to Argyll and Bute. Need to link with housing providers and social care providers to identify capacity and cost to bring adults back to shared tenancy arrangements.	Returning service users to their own communities, closer to their roots and families. Delivering best value and support the local economy by bringing HSCP spend back to Argyll.	Families might be reluctant to move service users away from where they have been living. The partnership may not be able to access the range of services required to look after these people in Argyll or may be unable to source appropriate housing.	No anticipated impact.	73	194
AC07	Supported living is categorised into four categories. Critical (P1) and substantial (P2) needs will be met and others will be signposted to self-help and community resources.	Review existing supported living care packages to ensure that cases meet the priority of need framework. Promote use of SDS. Introduce Area Resource Groups to scrutinise adult care supported living and delayed discharge packages.	Ensuring that care packages are tailored to meet the needs and maximise the independence of service users as well as deliver value for money and deliver services in local communities. Introducing new Locality Monitoring Groups to ensure equality in the delivery of supported living for categories P1 & P2.	Families, carers and local support groups may resist the planned changes. Where the decision to make changes to packages is extended to carers and families, experience suggests that change is unlikely to be agreed. Risk in terms of deliverability of savings, savings are understated as there is a current year overspend to be addressed before savings can be released.	No anticipated impact.	0	460
AC08	Review the delivery of services for older people to consider alternative ways of delivering services for older people.	Ensure all new packages adhere to Value for Money principles. Consider alternative ways to deliver support/meet the assessed outcomes of service users.	To maintain people at home for as long as possible, to spread the limited resources available to the HSCP across as many service users as possible. Deliver value for money.	Non support of families. A shift in practice to ensure we deliver consistency in outcomes for individuals and families. Consistent approach adopted across all locations within Argyll and Bute.	No anticipated impact.	200	200

Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
AC09	Redesign the provision of sleepovers provided by the HSCP.	Shift to new model of care using telecare/overnight response teams. Work with care providers to redesign unavoidable sleeper provision and look for opportunities to share provision across multiple service users.	Encouraging service users to be independent whilst maximising the opportunity to keep people living in the community for as long as possible. Deliver best value. Change to a new model of care provision that is safe, but person centred and improved independent living.	Families, carers and local support groups may resist the planned changes. Where the decision to make changes packages is extended to carers and families, experience suggests that change is unlikely to be agreed. We have a current overspend and that needs to be addressed as we move ahead.	No anticipated impact.	200	200
AC11	Investment in 'Neighbourhood Team' approach to delivery of care at home for the community across Mid Argyll, Kintyre and Islay. Putting service users at the heart of service design.	More responsive and person centred approach to delivery, better meeting needs. A best practice model, which is truly person centred, maintains independence and recognises dignity alongside independence, and improved outcomes.	Shift from time and task/silo working to team based approach to care provision. In line with clinical strategy, Health and Social Care Delivery Plan and HSP Strategic plan. Developed working with third and independent sectors to deliver care. Devised on best practice models of person centred care.	IT support required for community based models. Significant staff HR implications and organisational change. Unlikely to deliver any early savings however prioritises resources to support primary care and deliver services more efficiently and effectively initially, to then gain economies of scale from integrated teams.	Supports shift in balance of care to a genuinely person centred service which values the users and puts them at the heart of design. Supports independence, dignity, and assists reduction unplanned admissions. Built on local knowledge to improve outcomes for adult protection and carer support.		
AC12	Investment in 'Neighbourhood Team' approach to delivery of care at home for the community across Oban Lorn and the Islands. Putting service users at the heart of service design.	More responsive and person centred approach to delivery, better meeting needs. A best practice model, which is truly person centred, maintains independence and recognises dignity alongside independence, and improved outcomes.	Shift from time and task/silo working to team based approach to care provision. In line with clinical strategy, Health and Social Care Delivery Plan and HSP Strategic plan. Developed working with third and independent sectors to deliver care. Devised on best practice models of person centred care which maintains independence and dignity.	IT support required for community based models. Significant staff HR implications and organisational change. Unlikely to deliver any early savings however prioritises resources to support primary care and deliver services more efficiently and effectively initially, to then gain economies of scale from integrated teams.	Positive shift in balance of care and supporting people to remain at home and reducing unplanned admissions to hospital. Improved leverage of local knowledge to improve adult protection and carer support.		
AC14	Modernise community hospital care in Campbeltown establishing a cross agency 'Planning for the Future' group, to actively review range of bed space uses and options. Aim to achieve community based, and community focussed hospital model linking seamlessly with enhanced community services.	Review group to identify and engage with stakeholders on best use of bed spaces to maintain a quality and responsive service 24/7 which supports patients appropriately and timeously. Improving community focus and hospital criteria aims to reduce or negate delayed discharges, improve prevention and anticipatory care planning. Potential for greater joined up working with other hospitals, and effective use of data assumed.	Enabling people to live independently in their own homes, and avoid delayed discharges is key to improving community based care. Alongside better working with third and independent sectors to ensure person centred approach and quality outcomes, aligns with HSCP Strategy and H&SC Delivery Plan.	Improvements to IT support underpin improved community care. Requires engagement with all stakeholders to achieve shared aims and understanding.	Nil anticipated	232	232
AC15	Improvements to community focussed care in Mid Argyll, with focus on improving the model of delivery and service in MACHICC. Improved responsive community services able to respond 24/7 supporting patients in their own homes. Shifting the balance of care and ensuring effective and efficient use of hospital services.	Improvements and expansion of community based services in Mid Argyll to achieve reduced or nil delayed discharges, greater prevention and anticipatory care planning to enable people to live in their own homes, or return to their own homes as quickly as possible.	Person centred, community focussed and maximising our resources to respond to what people tell us matters to them. Shifting balance of care aligns with HSCP Strategic Plan and H&SC Delivery Plan.	Improvements to IT support underpin improved community care. Requires engagement with all stakeholders to achieve shared aims and understanding.	Nil anticipated	170	170
AC16	Continue with the review and redesign in patient ward in Cowal Community Hospital currently reviewing the acute observation beds, short term assessment beds, delayed discharges, prevention of admissions and A&E breaches. The review will include considering enhanced community care to prevent admissions.	Continue the current review and consider how we deliver community services in Cowal to provide 24/7 response to support patients at home.	Ability to maintain patients at home including some who would have been admitted to hospital, in line with strategic direction and developed working with third and independent sectors.	The delivery of IT support for community teams is a consideration. Recruitment issues for rural areas recognised as an issue.		537	537
AC17	Continue with the review and redesign GP in-patient ward in Victoria Hospital currently reviewing the acute observation beds, short term assessment beds, delayed discharges, prevention of admissions and A&E breaches. The review will include considering enhanced community care to prevent admissions.	Redesign of community services in Bute to provide 24/7 response to support patients at home. Community and staff engagement.	Ability to maintain patients at home including some who would have been admitted to hospital, in line with strategic direction and developed working with third and independent sectors.	IT support for community teams. Recruitment. Stakeholder understanding.		250	250
AC18	Improve and expand community based care on Islay through investment in preventative measures to address delayed discharge and reduce admissions. Shifting the balance will include making better use of Islay Hospital and Gortanvogie Care home to meet community care demands.	Review use and need of community services on Islay to better support people to live at home with quality services. Enhancing community based care including using technology where appropriate, and consider use of alternative booking systems. Support from and engagement with both communities and staff to help shift balance.	Positive measures enable people to live as independently as possible, in their own homes or a homely setting and to provide care without unnecessary travel or hospitalisation. Meets Scottish Government performance measures.	Requires recruitment, engagement with stakeholders including local community and improved IT for staff.	Success of community care and support may in future require change of registration status.	330	330



Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
AC19	Review of AHP Out-patient service delivery	Consider increasing protocol driven review of follow-up and domiciliary visits. Use of technology like VC and Flo. Review whether AHPs could offer review instead of trips to GG&C to see consultants. Extension of roles like Orthopaedic triage and 'First Contact' input into GPs.	Support repatriation activity and reduce travel and inconvenience for patients. Reduce GP/consultant appointment 'right clinician, right time, right place'. This review may release savings but may be more appropriate to use released resources for investment in new initiatives detailed eg increased support to GPs.	Ensuring the right clinical skills of clinicians to offer extended roles and ensuring patient compliance or outcomes are not impacted.			
AC20	Seek to ensure care at home services offer flexibility and choice and are person centred and fit for purpose. Current in-house services are restricted and review would enable options to be explored with external providers to improve West Argyll service.	Neighbourhood teams with external providers give flexibility and should be considered within options following period of market testing. Would require input from procurement and commissioning staff to expand and improve the current care at home service.	Care at Home services are not fully able to meet demand particularly in rural areas. Better options require to be identified involving whole range of providers to review, test and implement change. Positive impact on outcomes offering person focussed service across in particular Kintyre area, with a developing and enhanced local service.	Clients to be engaged and consulted and helped to understand where a change of provider may occur, whilst benefiting from an improved service. Some risk of staff leaving prior to any transfer and thus staff need be kept informed and consulted. Whilst some savings can be achieved, the current service is failing its clients and not sustainable.	Reduced numbers of in house registered services.	0	160
AC25	In older people day resource centres improve and address issues of high levels of management structure to integrate and consolidate services within realistic opening hours based on client demand.	Review the management at HSCP operated day services. Consider a reduction in opening hours of adult day services. Evidence indicates shorter opening hours would be appropriate and acceptable in day services. Moreover, there is a high management resource which is capable of rationalisation. Engagement and consultation with service users and with staff to align needs and demands.	Service becomes more efficient, and is an effective use of resource. Service hours will reflect the needs and desired outcomes whilst meeting demand, Evidence supports this, and will be fully explored with service users and staff.	Organisational change which may take time to achieve and may not deliver savings in given timescale. Careful consideration to balance risk of reduced hours with potential home care need, review should highlight this.	Nil	50	208
<b>MENTAL HEALTH SERVICES:</b>							
AC21	Improve community based support and services for dementia to achieve shift in balance of care and respond to need and demand in person centred service.	Implement full review and scoped options for community models which meet user demand, support carers and person centred outcomes. Appraise neighbourhood model and scope options which shift balance of care.	Dementia Strategy is key to achieving aims which support the shift in balance of care, and offer person centred services as close to home as possible.	Models of care, once reviewed require stakeholder engagement and consultation, and understanding of option(s). Potential variance in future levels of specialist care as yet unresearched.	Potential impacts for support from detention and mental health officers.	250	250
AC22	Deliver improved mental health consultant support and create dedicated consultants to each locality Community Mental Health Team, and a dedicated consultant for inpatients. Better sharing of on call services, additional locality clinics and support for crisis response and places of safety.	CMHT services and patients would benefit from the redesign to support an improved model. Locality consultation and with CMHT's to support change, and achieve better outcomes.	This will achieve consistent care management which in turn can reduce hospital stays, assessment and review would be improved and locality services benefit from dedicated support. Joint and partnership working is an integral part of improving patient outcomes and these changes would achieve this.	No major risks, work to ensure recognised care pathways and effective communication is implemented and maintained throughout.	Nil anticipated		
AC23	Steps to ensure and maintain patient and community safety will be taken by redesigning and maintaining a secure locked environment for those with the most fragile mental health requiring extra care. This is based on the needs of service users, and experience from current Intensive Patient Care Unit.	Actions required pertain to legislation relevant to service delivery, which will be strictly followed. Work with staff to make changes to overall establishment and working practices and to agree robust admission criteria. Some work with GG&C should needs arise for additional services.	No change to secure and safe locked environment for those needing this service.	Discussions with GG&C where a rare need arises which is chargeable, eg with forensic care.	Aligns with specialist services (eg acute surgical) provided by central specialist provision.	100	200
AC24	Further enhancement to community based care to ensure those with mental health issues have the same opportunities and choices. To include consideration of a step up / step down model for Lochgiphead and area service users.	Adopt community focussed approach, and use technology when possible, to review use of Ross Crescent to make this appropriate for a modernised mental health service. Ensuring patient choice and views are at the centre of service provision, with independence encouraged and supported.	Future needs should reflect less dependence on high care packages, and greater focus on community based support. Access to 'step up' when needed is maintained.	Prediction of mental health needs can be difficult, but use of reablement and community resources effectively should overcome any peaks within demand.	None anticipated.	45	45
<b>CORPORATE SERVICES:</b>							

Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
CORP1	Front line health and social care staff working together in same locations, and move corporate and support staff.	Co-locate staff into unused space in our hospitals, close the corporate support HQ building in Lochgiphead, move to other sites in Lochgiphead including council offices. Savings expected to be achieved from a range of departmental budgets including: finance, planning, IT, HR, pharmacy management, medical management, lead nurse and estates.	Front line services should benefit from a more joined up approach and a single point of contact from support services. There would ultimately be reduced workforce but this is offset by more efficient practices (see Corp 2 & 5) reducing duplication and improving communication	Not all support services are directly within the HSCP's control. There is a risk that partners (Council and NHS Highland) will not support any changes to the current arrangements as these are outside the scope of the integration scheme.	Nil anticipated	335	335
CORP2	Integrate health and social work administration, implement digital technology and centralise appointment systems.	Follow on from co-location CORP 1, a targeted piece of work would commence in 2017-18 to extend the review of social work administration and medical record keeping. The implementation of electronic solutions to improve efficiency and a move to electronic medical records would be required.	Moving to central booking and electronic records would reduce the need for as much local management. Reduced workforce for admin support, but should be accommodated from within a more efficient process, systems and new structure.	There will be a requirement for professional leadership and project management resource for fixed period. This will incur a cost.	Nil	120	325
CORP3	Management /Professional Leadership Review	Review the overall management structure.	Current structure has been in place for a period of time. A review could result in a reduction in management capacity and capability.	May not be significant savings, reduced management capacity could reduce ability to implement strategic development, to manage change in the culture, operational integration, workforce planning and delivery, staff partnership and public and political engagement and communication and realise financial and performance targets.	Any reduction to the management structure could lead to reduced capacity and capability to fulfil statutory duties.	tbc	tbc
CORP4	Rationalisation of Estates/Property-linked to CORP's 1 and 2.	Review of current property portfolio and opportunities to rationalise this. Review the current leases in place and find alternative accommodation to reduce costs.	Cultural change impact on staff and service users. May be a period of disruption if staff are displaced.	Any proposed changes to accommodation would require to follow a business case approach to ensure the benefits of any changes are transparent. Requires discrete expertise and project management resource. That may be a cost.	Nil	75	75
CORP5	Implement Lync/Skype for Business	Implement Skype for Business (Microsoft Lync) communications platform, this will reduce telephone and travel costs and improve communication and collaboration. Business case is due to be finalised. It is required to maximise benefits in Corp 1 and Corp 2.	Will make operations more efficient with less time spent travelling, and with IT communication services being more efficient across both health and social care. Savings both in cost and in productivity clearly evidenced in other organisations. This will benefit services across the partnership	The infrastructure is not in place, and business case benefits may be difficult to quantify as efficiencies will be across the whole of the HSCP. Risk that financial benefits may not be achieved in the short term, with initial investment and a cultural shift required to fully realise potential.	Nil	0	0
CORP6	Catering and Cleaning and other Ancillary Services	Reduction in buildings occupied and opportunities to work with our partner organisations, take opportunities to reduce costs for catering and domestic services. Significant opportunities to share services and reduce costs.	This could result in significant changes to workforce rostering, operational delivery and quality of service and strategic partnership across public sector supplying a number of organisations catering requirements at locality level.	This will require a formal project process, centralising responsibility, with professional leadership over a fixed period.	Nil	505	505
CORP7	Vehicle Fleet Services	Explore opportunities for the centralisation of shared fleet service (as in part of NHS Grampian), look to share vehicles with partners, and a review of the provision of services.	More efficient fleet service, better aligned to service requirements.	Different governance arrangements with partners and loss of locality direct responsibility. May not be any significant savings.	Nil		
CORP8	The agreement with NHS Greater Glasgow & Clyde (NHSGG&C) provides hospital services outside Argyll and Bute.	Invest in community services and IT to reduce delayed discharges and patients length of stay in NHS GG&C hospitals, and commission NHSGG&C to reduce return appointments and follow up rates. Activity targets to be agreed based on national target for Scotland to free up 400,000 occupied bed days.	Front line services will benefit by only providing acute services in hospital and enhancing services in communities by facilitating rapid assessment and support and discharge to community/home with support. Any reduction in the agreement with GG& C would build capacity for community and care sector to expand to meet workload, and reduce beds in local hospitals.	Timescale for deliverability starts 1 April 2017 when GG&C will recharge us for extra activity. There may be other demand and cost pressures from acute services. We recognise a potential difficulty by NHSGG&C to change to meet our commissioning intentions.	Nil	TBC	TBC
CORP9	Capital projects - Dunoon GP practices new build, Bute Health and care campus, Care Home redesign, and new model of care relocation of Salen Surgery to Craignure & elements of CORP 4	Formal capital design projects at large and small scale, latter to be costed by March 2017 for inclusion in capital programmes for next 2 years. Large scale projects require formal processes and resource.	Front line services will benefit both as operational single point of contact and co-location advantages. New developments with suitable accommodation with greater energy, utilisation efficiency rating etc and other cost reductions.	We require to centralise the capital planning function with financial support and clear project management processes. Timescale for deliverability depends on the availability and accessibility of capital from the Council, NHS and Housing associations.	None at present as longer term projects	0	0

Ref	Description	Proposed Actions Required	Positive Impact on Quality and Outcomes and Fit with Strategic Priorities	Risks and Other Impact	Impact on Statutory Services	2017-18 Budget Reduction £000	2018-19 Budget Reduction £000
CORP10	Alcohol and Drugs Partnership	The ADP will look to review and reduce costs being incurred in delivering alcohol brief interventions, supporting the voluntary sector and the ABAT statutory service sector. The reduction in 17-18 equates to 8% of the total budget for ADP.	More efficient use of resources.	Risk that ADP cannot reduce costs in line with reduced subsidy.		100	150
<b>TOTAL</b>						<b>4,494</b>	<b>6,507</b>

<b>PREVIOUSLY APPROVED 2016-17 Q&amp;F PLAN:</b>			
<b>Previous Ref</b>	<b>Description</b>	<b>2017-18 £000</b>	<b>2018-19 £000</b>
<b>STILL TO BE DELIVERED:</b>			
1	Prescribing	100	100
5	Redesign of the Out of Hours Service for Cowal	300	300
13	Closure West House	100	100
14	Closure AROS	150	150
15	Kintyre Medical Group	25	25
27	Kintyre Patient Transport	25	25
45	Ardlui	10	10
51	Supporting Young People Leaving Care	17	17
52	Consultation Support Forum	5	5
59	Bowman Court Progressive Care Centre	80	80
61	Internal Mental Health Support Team	60	60
62	Assessment and Care Management	12	12
63	Assessment and Care Management	30	30
		<b>914</b>	<b>914</b>
<b>FULL YEAR IMPACT:</b>			
55	Struan Lodge (paused)*	0	175
56	Thomson Court (paused)*	0	10
58	Tigh a Rhuda	22	22
		<b>22</b>	<b>207</b>
<b>ADDITIONAL DELIVERABLE SAVINGS:</b>			
1	Prescribing	700	1,400
3	Further Savings from closure of Argyll and Bute Hospital	282	282
4	Kintyre Patient Transport	25	75
5	Redesign of the Out of Hours Service for Cowal	29	29
10	NHS GG&C contract / services	100	100
		<b>1,136</b>	<b>1,886</b>

\* Decision taken at the IJB meeting on 2 November 2016 to pause implementation of these service redesigns to allow for additional period for consultation and engagement. No formal decision taken to reverse decision, therefore for financial planning purposes assume that full year saving will be realised in 2018-19. This position will be updated following outcome of communications and engagement process.

<b>NEW EFFICIENCY SAVINGS:</b>			
<b>Ref</b>	<b>Description</b>	<b>2017-18 £000</b>	<b>2018-19 £000</b>
1	Commissioned Services	500	500
2	General Medical Services - Enhanced Services	64	64
3	Budget Reserves	350	200
4	Equipment Depreciation	30	30
5	Increased Patient Services Income	50	50
6	Community Dental Services	20	20
7	Review of Podiatry Services Budgets	20	20
8	Helensburgh & Lomond Locality - recurring underspends	20	20
9	Medical Physics Department - supplies budget underspends	45	45
10	Energy Costs for Health Buildings (excluding A&B Hospital & AROS)	50	50
11	Oban, Lorn & Isles Locality - patients' travel	40	40
12	Review of Radiography Services Budgets	50	50
13	Mental Health Bridging Funding	0	400
14	HEI Budget - requirement will reduce in line with beds	0	50
15	Mid Argyll Social Work Office	10	10
16	Admin - Travel Reduction	3	3
17	Planning	51	51
18	Review MAKI Management Structure	130	250
19	Children and Families Service Efficiencies	40	40
22	Adult Services Fees and Charges	50	50
24	Adult Services Charging Order - Long Term Debt Adjustment	25	25
25	Social Work Utility Costs	33	33
26	Mull Medical Group - reduction in use of GP locums	50	50
		<b>1,631</b>	<b>2,051</b>

Theme	Investment Details	2017-18 £000	2018-19 £000
Implement New Community Based Models	Argyll and Bute Area Teams - Mobile devices	471	632
	Argyll and Bute West Sector - Develop capacity Neighbourhood/Community Team models		
	Helensburgh and Lomond Anticipatory/Emergency Nurses		
	Reablement update for providers		
	Cowal and Bute - Nurse Practitioner, admission prevention		
	Investment in Early Intervention		
Co-location of Teams	Co-location of staff in Cowal and Bute	260	-
	Co-location of staff in Kintyre		
	Co-location of staff in Islay		
Communications and Engagement	Communications	106	45
	Public Involvement Manager		
	Planning Support		
Project Management	Adult Service Redesigns	300	322
	Catering and Cleaning Services		
	Medical Records and centralised booking		
	Administration Services		
	Children's Services Redesigns		
	HR Support - organisational change		
		<b>1,137</b>	<b>999</b>



## **Argyll & Bute Health & Social Care Partnership**

**Integration Joint Board**

**Agenda item : 5.2iv**

**Date of Meeting : 29 March 2017**

**Title of Report : Proposed Quality and Finance Plan 2017-2019 Initial  
Community and Staff Engagement Update – March 2017**

**Prepared by : Caroline Champion, Patient Focus Public Involvement  
Manager**

**Presented by : Stephen Whiston, Head of Strategic Planning &  
Performance**

### **The Integration Joint Board is asked to :**

- Note the content of this report outlining the outcome of the initial community and staff engagement and feedback received
- Note the plans for future events going forward

## **1. EXECUTIVE SUMMARY**

This paper provides the IJB with an update on the mechanism, progress and initial feedback from communities and staff on the HSCP Quality and Finance Plan 2017-2019 service redesign proposal.

The IJB wished to ensure that within the resources available to it and with its partners support, its staff and communities are informed of what was being developed and proposed by Locality Planning Groups. Further this information to also include the levels of savings required from the financial budget which was forecast to be provided by NHS Highland and Argyll and Bute Council as at February 2017. The IJB also wanted to ensure the community and staff groups were provided with the opportunity to provide feedback and suggestions.

It was therefore agreed that as part of what will be an ongoing series of communication and engagement events a specific piece of work should be conducted in February/March to provide the IJB with assurance that communities were aware of the scale of the change and if possible provide some initial feedback on the proposals.

It was also recognised that it was important the exercise planned should not be a one off but a continuous one which was aligned with the work being done by the

developing locality planning group's communications and engagement groups as well as the health care forums, the TSI and others.

A number of mechanisms were suggested for this initial work including an initial on-line survey. However, following discussion at Strategic Management Team and the core HSCP Communications and Engagement Group comprising members of the public, TSI representatives, HSCP managers and communications officers identified that a leaflet and conversation style café events were a better way to collect people views on the changes and redesigns. Therefore the following was put in place:

- Briefing information in the form of a leaflet to be prepared and circulated across Argyll and Bute to community councils, stakeholders the public and staff.
- An initial series of conversation cafes be conducted in March to provide the public with the opportunity to hear more about the changes required and learn and feedback on initial areas identified.
- The TSI would undertake some similar complementary conversation café events.
- Managers cascaded and briefed all their staff on the Quality and Finance plan proposals at team meetings etc and a number of specific drops in briefing events also attended by senior managers were set up.
- Feedback was collected at the conversation cafés and by a feedback form available on line or hard copy with a freepost address and social media.
- The HSCP generic email address was provided for anyone wishing to share their views, comments or put forward alternative ideas.
- Promotion of the events and work was done through standard cascade methods, media releases and adverts, flyers, etc.

The purpose of all this work was to ensure the approach to communications and engagement activities is in line with Statutory Guidance CEL 4 (2010)<sup>1</sup> and specifically the "Informing" stage.

The attached report provides the initial feedback up date as at the 16th March 2017 for members review. The deadline for all responses is 31<sup>st</sup> March therefore the report will be updated to include all feedback received within the engagement period. At the end of this period, the full report will be available online.

#### **4. CONTRIBUTION TO STRATEGIC PRIORITIES**

This report provides a briefing on how the HSCP is progressing engagement and communications with its communities as part of its Fit for the Future Quality and Finance Plan 2017-19.



## **5. GOVERNANCE IMPLICATIONS**

5.1 Financial Impact – N/A

5.2 Staff Governance – supports and augments staff involvement and engagement.

5.3 Clinical Governance – N/A

## **6. EQUALITY & DIVERSITY IMPLICATIONS**

These issues are considered within due process as part of CEL 4 2010 process.

## **7. RISK ASSESSMENT**

Risk assessment is included on the IJB risk register and supports mitigation actions.

## **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT**

This report aligns with the strategy and approach the IJB has approved regarding communications and engagement with its communities.



# Argyll and Bute Health and Social Care Partnership (HSCP)

## Quality and Finance Plan 2017-19 First Round of Engagement Events



### INTERIM COMMUNITY & STAFF FEEDBACK REPORT

V0.2

17<sup>th</sup> March 2017

Quality and Finance Plan Website:  
<http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Pages/QualityandFinancialPlan.aspx>

# 1 Introduction

## 1.1 What is our vision and objective?

The Argyll and Bute Health and Social Care Partnership (HSCP) came into being in April 2016. Our Strategic Plan 2016—2019 sets out our local priorities for the next three years in response to the national policies of the Scottish Government. It also takes account of what the public have said is important to them, that you want your local services to :

- Reduce the need for emergency or urgent care, or a crisis response (anticipatory care)
- Prevent ill health—increase confidence and improve skills to support us to live life to the full and
- Maximize independence
- Maintain health and wellbeing – provide the support to look after ourselves and stay well

People have said “**We want to live a long, healthy, happy and independent life**” supported by health and social care services when we need them. This is important to us and what we are aiming to achieve with the help of our citizens and staff.

## 1.2 Services need to change

Our challenges are no different to anywhere else in Scotland or indeed nationally. We have seen through newspapers, television and on social media that the NHS and Social Care system is under increasing pressure. Services are becoming overwhelmed by the increasing number of people who need our support and are struggling to deliver the high quality care that we want to provide.

We are having problems recruiting key medical and care staff. This means we are paying for locums and agency staff which costs us a significant amount of money. A number of care homes have closed as they have been unable to meet appropriate care standards, or are unable to recruit care staff and the cost of providing services has proved too much.

We are required to get value for money and use our resources more efficiently and effectively, and we must be honest about that. In the next 2 years we need to save £20million (7.8%) on our annual budget of £257 million. This is due to cost and inflation pressures and the level of funding given to us by NHS Highland and Argyll and Bute Council.

The Argyll and Bute HSCP recognises that if we change our services to what people want we can better meet these demands.

## 1.3 What changes have been identified and proposed

The following areas for change have been identified by Locality Planning Groups (LPGs) building on work already in place.

- **Children and Families Services**—reduce the number of children placed out of area
- **Services in the Community**—review how we provide some services which will enable us to invest £2 million new money in more community care teams (nursing, care services), improving health and anticipating care needs
- **Hospital and Care Home Services** – prevent people staying in hospital longer than they need to and use our resources to support more community based services (Balance of Care)
- **Corporate or Support Services** – reduce the number of buildings we operate from, co-locate with the Council in Lochgilphead, centralise appointment booking, and integrate social work and health administration.

## 2.0 How the public and staff think and have been involved

The Integration Joint Board (IJB) wished to ensure that within the resources available to it and with its partners support, staff and communities are informed of what is being developed and proposed. Further they are provided with the opportunity to provide initial feedback and suggestions.

It was agreed that as part of what will be an ongoing series of communication and engagement events, a specific piece of work should be conducted in March to provide the IJB with assurance that communities are aware of the scale of the change and provide some initial feedback on the proposals.

It was also recognised that it is important the exercise planned should not be a one off but a continuous process which was aligned with the work being done by the developing locality communications and engagement groups of the HSCP, health care forums, the TSI and others.

A number of mechanisms were suggested for this initial work including an initial online survey. However, following discussion at Strategic Management Team (SMT) and following advice at a one off meeting of Locality Planning Group (LPG) community representatives, TSI representatives and HSCP managers, it was agreed to develop and produce an information leaflet then run a series of conversation style café events to begin collecting peoples views on the changes and redesigns.

The communication and engagement outline plan :

- Develop and produce an information leaflet for circulation across Argyll and Bute (community councils, local Councillors, communities, staff and partner organisations)
- An initial series of conversation cafés be carried out during early – mid March to provide our citizens and staff an opportunity to hear more about the changes required, learn and feedback on initial areas identified
- Third sector Interface (TSI) would carry out similar complementary conversation café or similar style events

- Managers cascade and brief staff on the Quality and Finance Plan proposals at team meetings and specific drops in briefing events attended by senior managers
- Feedback collected at the conversation cafés and by feedback form available online or hard copy by 31<sup>st</sup> March 2017
- HSCP generic email address used for anyone wishing to share their views, comments or put forward alternative ideas

The purpose of all this work was to ensure the approach to communications and engagement activities is in line with Statutory Guidance CEL 4 (2010)<sup>1</sup> and specifically the “Informing” stage (Appendix 7 Summary Flowchart).

Appendix 1 details the briefing leaflet which was developed. A total of 5,000 leaflets were printed of which approximately 4,000 leaflets were distributed to Locality Planning Groups (LPGs) for distribution to key locations across their areas and through other local networks. The remainder were made available for people attending the engagement events. A copy of the information leaflet was also posted on the HSCP website and Facebook.

### 3 Feedback “We Want Your Views!”

The table below summarises the responses received from the various mechanisms employed as at the 17<sup>th</sup> March 2017. The deadline for submitting the “We Want Your Views!” Feedback Form for this part of the engagement process is the 31<sup>st</sup> March 2017.

Mechanism	Locations	Date	Number of Attendees
Conversations Cafes- HSCP	Corran Halls, Oban	1 <sup>st</sup> March	31
	Village Hall, Craignure, Isle of Mull	2 <sup>nd</sup> March	15
	Community Centre, Lochgilphead	3 <sup>rd</sup> March	12
	Community Centre, Campbeltown	8 <sup>th</sup> March	6
	Columba Centre, Isle of Islay	9 <sup>th</sup> March	?
	Cowal Community Hospital, Dunoon	13 <sup>th</sup> March	35
	Green Tree, Rothesay, Isle of Bute	15 <sup>th</sup> March	31
	Victoria Halls, Helensburgh	16 <sup>th</sup> March	28
Conversations Cafes- TSI	Garelochhead	14 <sup>th</sup> March	3
Community Council meetings	Tarbert CC	9 <sup>th</sup> March	6

<sup>1</sup> CEL 4 (2010) Informing, Engaging and Consulting People in Developing Health and Community Care Services, Scottish Government, February 2010

Other meetings	Mid Argyll Health & Care Forum (HCF)	7 <sup>th</sup> March	6
	Islay / Jura Health & Care Forum (HCF) Islay High School	11 <sup>th</sup> March	20

Most of the engagement activities were based around the Conversation Café method where people were invited to come along for a ‘chat and a cuppa’ and share their views about what is being proposed.

At the engagement events, people were encouraged to record their views, comments, ideas / suggestions on tablecloths or flip chart paper. The feedback received against each of the questions is detailed in Appendix 4.

The evaluation of the formal feedback forms received has provided qualitative feedback only. A total of 39 responses have been received by 17<sup>th</sup> March, a breakdown of how the feedback has been received is as follows:

Feedback Method	Number Received
Feedback Form	15
Survey Monkey	22
Email	0
Letter	1
Other	1

#### 4 Evaluation

This process elicited a reasonable richness of qualitative data some of which was in response to the questions posed.

A total of 39 responses have been received, either by post, online using Survey Monkey, emailing to the generic email address or by letter. This represents a reasonable response but given the anecdotal level of anxiety expressed by the public and for example the attendance at public meetings in Oban and Dunoon, is disappointing.

The table below lists the key themes / general points that emerged from the feedback received. These are not in any order of priority.

Key Themes / General Points	
1	Promotion of good health & well being; encouragement to stay fit & well
2	Support to maintain independence at home for as long as possible – home help, house alterations
3	Community services – more investment required to ensure appropriate community infrastructure in place to support people depending on individual needs; early intervention & prevention
4	Local services – better & faster access to primary care (GP) services; A&E service; more services provided locally; more drop-in / self referral services
5	Promote social care – especially for island communities
6	More carers with adequate support
7	Support to tackle loneliness & isolation
8	Staff – appropriately trained & supported; proper contracts; GPs living in rural communities; more GPs, dentists & nurses / care staff, allied health professionals (physio, OT, etc)
9	Communication – what services are currently available & how to access these services; local newspaper?
10	More emphasis on reablement
11	Transport – especially in rural locations where there is no public transport; better co-ordinated transport
12	No cuts to services
13	More telecare / telemedicine – needs to be developed whilst recognising limitations
14	Improve services for people with mental ill health; better services locally
15	Day care services - important
16	More community engagement; listen to local communities
17	NHS Greater Glasgow & Clyde – better communication between Glasgow / Inverclyde / Paisley & HSCP; localities need to understand the Service Level Agreement; more services provided locally; reduce the need for patients to travel large distances for very short appointments; better discharge planning needed including communication between professionals; better appointment times
18	Reduce prescribing

Discussions at the community engagement activities have echoed these key themes.

The Feedback prior to implementing any proposed change in how services will be delivered is crucial to ensure the local population is given the opportunity to share their views and have their ‘voice’ heard, this is in line with Statutory Guidance

The engagement period carried out has been done with the support and guidance of the HSCP core Communications and Engagement Group, Locality Planning Groups, TSI and the HSCP communications and engagement team.



All feedback received has been very important and of great value. Many thanks to all those who returned their completed “We Want Your Views!” feedback forms attended our engagement events or responded using other methods.

## 5 Next Steps

Statutory Guidance CEL 4 (2010) has five distinct sages :

1. **Planning**
2. **Informing**
3. **Engaging** – Development of Models with Key Stakeholders
4. **Consulting** –
  - a. A proportionate approach may include a form of consultation for proposals not considered major service change
  - b. If considered Major Service Change – minimum three month formal consultation required

### 5. Feedback and Decision Making

The process the HSCP has been progressing since April 2016 in developing its transformational change proposals, framed by its three year Strategic Plan (2016 / 17- 2018 / 19) which has resulted in its Quality and Finance Plan both at HSCP wide and Locality level as below :

- HSCP wide - continuing the process of **informing** communities and its staff and stakeholders of the direction of its Strategic plan and the scale and speed of transformation required as detailed in its Quality and Finance Plan
- Locality Level - specific redesign projects in localities working with its LPGs and then specific project groups to **engage** to develop alternative models- e.g. Planning the Future of Lorn and Islands Hospital
  - This has led to some projects progressing to the engaging stage e.g. Struan Lodge, Thomson Court

This feedback report focuses on HSCP wide engagement and is the first of an ongoing series of reports taken forward over the next three months. Whilst it will always stray into the detail of local issues as can be seen in the feedback received and this is appropriate it will not replace the locality led communications and engagement work.

This report will be presented to the Integration Joint Board (IJB) on 29<sup>th</sup> March 2017, to assure the Board that Argyll and Bute residents are aware of the changes in services being planned and developed and will have an opportunity to be involved and engaged with as proportionate over the next two years.

A copy of this report will become a public document. It should be noted that this is a ‘snap shot’ of what people have been telling us up to 17<sup>th</sup> March 2017, the deadline for all responses is 31<sup>st</sup> March therefore the report will be updated to include all feedback received within the engagement period. At the end of this period, the full report will be available online.

Caroline Champion  
Public Involvement Manager  
Argyll & Bute Health & Social Care Partnership

(on behalf of Stephen Whiston, Head of Strategic Planning & Performance)

17<sup>th</sup> March 2017



Argyll and Bute  
Health and Social Care Partnership (HSCP)



## FIT FOR THE FUTURE

### QUALITY & FINANCE PLAN 2017/18 & 2018/19

#### ARGYLL & BUTE HSCP—OUR FIRST YEAR



The Argyll and Bute Health and Social Care Partnership (HSCP) came into being in April 2016. Our Strategic Plan 2016–2019 sets out our local priorities for the next three years in response to the national policies of the Scottish Government. It also takes account of what **you have said is important to you**.

**You told us** that you want your local services to :

- reduce the need for emergency or urgent care, or a crisis response (anticipatory care)
- prevent ill health—increase confidence and improve skills to support us to live life to the full and maximize independence
- maintain health and wellbeing – provide the support to look after ourselves and stay well

#### What have we achieved?

In the last year, we have done a lot. We have successfully established a local **kidney dialysis unit in Campbeltown** with the support of the community there. **Mental health inpatient services** will soon be moving into the Mid Argyll Hospital providing a higher standard of care in a more caring environment for our patients. We have **community day responder services** which support people in their homes and allow unpaid carers to have a break from their caring role. We have **invested money and recruited more staff to maintain our 24 / 7 casualty (A&E) departments** in our local hospitals.

#### We need to do more

The Scottish Government Health and Social Care Delivery Plan (December 2016) <http://www.gov.scot/Publications/2016/12/4275/downloads> says we need to change services more quickly. The focus on preventing ill health, early intervention and supported self–management mirror our local priorities but we know we need to do a lot more than we are now.

#### Pressures on providing services

We are having problems recruiting key medical and care staff. This means we are paying for locums and agency staff which costs us a significant amount of money. A number of care homes have closed as they have been unable to meet appropriate care standards, are unable to recruit care staff and the cost of providing services has proved too much.

#### Our unprecedented challenge

We are required to get value for money and use our resources more efficiently and effectively, and we must be honest about that. **In the next 2 years we need to save £22million (8.5%) on our annual budget of £257 million**. This is due to cost and inflation pressures and the level of funding given to us by NHS Highland and Argyll and Bute Council. It is challenging but with your assistance we can do it.

This is where we need your help to identify what services are important to you and tell us where you think we can make savings.

**What is the Timeframe?** At its meeting on 29th March, the Integration Joint Board (IJB) will be presented with the budget plan which will outline how we aim to achieve £22 million savings. We want to hear your views and ideas on this over the next few weeks. This does not mean your involvement will end. We will continue to speak to you so you are involved in how services are delivered in the coming months.

## ARGYLL & BUTE HSCP—WHAT'S NEXT?



### What is happening?

Our Strategic Plan outlines our priorities for health and social care services across Argyll and Bute Oban  
<http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/SP%202016-2019%20%20Final.pdf>

Our priorities are in response to national policies as set out by the Scottish Government but also based on what you have said is important to you. When we consulted with you in the past, **you said** “We want to live a long, healthy, happy and independent life supported by health and social care services when we need them.” **You said** “We want to stay at home for as long as possible.” **We want** to support you to achieve this.

**What does this mean for you?** This means that we can no longer provide services as we do now. If we carry on as we are, we will not be able to support the growing number of people who will need our support in the future.

Our staff pride themselves on ensuring our service users receive high quality care and in a way that treats them as individuals. We know you value your local services and how important it is to ensure you have **the right service, in the right place, at the right time.**

**Our challenges** are no different to anywhere else in Scotland or indeed nationally. You will have seen in the newspapers, on TV and on Social Media that the NHS and Social Care system is under increasing pressure. Services are becoming overwhelmed by the increasing number of people who need our support and are struggling to deliver the high quality care that we want to provide.

**How has this happened and what are we doing about it?** Have a look at the short video Audit Scotland—How We Can Transform Health and Care Services, it explains what we are facing and what we must do to get us back on track <https://www.youtube.com/watch?v=2nqp9bZzK28>

### Financial Challenge—£22 Million Savings

Our citizens and staff have said they understand the need for change, they know we need to make significant savings. In the next 2 years we need to save £22 million. **Why?** The cost of delivering services as we do now, the cost of inflation and the level of funding given to us by NHS Highland and Argyll and Bute Council to deliver health and social care services.



### We Want Your Views!

Our vision is to build on the excellent services currently provided across Argyll and Bute. We want to ensure that your local services will support you to live a long, healthy, happy and independent life. However, we need to change how services are delivered in the future and make significant savings.

**We want to hear your views on how we can meet our financial challenge.** Do you have any ideas? Come along to one of our events, see back page or look out for adverts in your area.



**Your feedback is important.** We will be using what you say to consider how we can redesign and improve services so they are fit for the future but with the money available to us.

Duart Castle, Isle of Mull

## WHAT ARE WE PLANNING TO DO?

We need to ensure we have **the right services in the right place at the right time**. We are committed to keeping your local hospital at the heart of your community and will ensure we retain the high quality level of care and safety which they provide, when people need it. But we also know we can no longer provide services as we do now.

**You said** “We want to stay at home for as long as possible.” To support people to live in their homes for as long as possible, we need to provide more community based services and aim to do this by investing an additional £2 million in these services.

This means we can reduce the number of beds in our hospitals but we will not compromise safety of patients and there will always be sufficient beds for those who do need a stay in hospital. Fewer people will need to be cared for in a nursing or care home.

What we are proposing will be a new way of organising and delivering care. This will have an impact on everyone in Argyll and Bute, both our citizens and our staff. We understand how anxious you are about the proposed changes and we want to work with you during this difficult time.

## WHAT AREAS ARE WE LOOKING AT?

- **Children and Families Services**—reduce the number of children placed out of area
- **Services in the Community**—review how we provide some services which will enable us to invest £2 million new money in more community care teams (nursing, care services), improving health and anticipating care needs
- **Hospital and Care Home Services** – prevent people staying in hospital longer than they need to and use our resources to support more community based services (Balance of Care)
- **Corporate or Support Services** – reduce the number of buildings we operate from, co-locate with the Council in Lochgilphead, centralise appointment booking, and integrate social work and health administration

## COMMUNICATION & ENGAGEMENT WITH YOU

**Your local Communications and Engagement Group** is responsible for the engagement plan for changes proposed for your local area. These groups are made up of public, third sector, union, NHS and Council Staff. The Scottish Health Council provide guidance and support. Our plans for the next few months are to :

**Inform you** - we need to share information about the services, their costs, the needs our communities have now and in the future, our resources, and other background information

**Engage with you** - we need the time to discuss all this information with you. We will be holding a number of events across Argyll and Bute during March for both our citizens and staff. See back page for details of the events already planned. These are the first in a series of events to keep you updated on what is happening locally and keep you involved.

**Reporting on what you say** - we need to gather what people say and report that back to the Integration Joint Board (IJB)

If there are other ideas about how to develop services according to good practice, but within the budget of the Health and Social Care Partnership, we want to hear about them

### INVOLVING YOU

**Email** You can email us at [nhs.abhscp@nhs.net](mailto:nhs.abhscp@nhs.net)

#### **Feedback forms**

will be available at your local event or you can phone for one. You can also download the form from our website [www.tinyurl.com/jqgp8j6](http://www.tinyurl.com/jqgp8j6)

#### **Information & Engagement events**

Feedback forms will be available at the events.

#### **Ask us to your meetings**

We can come to you - phone us! Telephone **01546 605680**



Westpoint Beach  
Kintyre



Rest & Be Thankful, Argyll

If you have any questions, would like to receive this leaflet in an alternative format or a different language, please contact

Jackie Harvey

Admin Support to  
Public Involvement  
Manager



01546 605680

or



jackie.harvey@  
nhs.net

For more information  
visit our webpage

[www.tinyurl.com/  
jagp8j6](http://www.tinyurl.com/jagp8j6)

## CONVERSATION CAFÉS

We are holding a number of drop in events (conversation cafés) for local communities and staff to come and join us in discussion. Here you can share your views, tell us if you have any ideas on where we can save money and ask questions.

Events for March have been arranged as follows :

LOCATION	DATE	TIME
Conference Room, Corran Halls, Oban	1st March	2pm—5pm, 6pm—8pm
Village Hall, Craignure, Isle of Mull	2nd March	12noon—3pm
Community Centre, Lochgilphead	3rd March	2pm—5pm, 6pm—8pm
Community Centre, Campbeltown	8th March	2pm—5pm, 6pm—8pm
Columba Centre, Bowmore, Isle of Islay	9th March	2pm—5pm
Conservatory, Cowal Community Hospital, Dunoon	13th March	2pm—5pm, 6pm—8pm
Green Tree Café, Rothesay, Isle of Bute	15th March	12noon—3pm
Pillar Room, Victoria Halls, Helensburgh	16th March	2pm—5pm, 6pm—8pm



**Come and join us for a  
chat and a cuppa**



**Remember, you can ask us to come to your group or meeting!**

Further events will be organised for April and May, look out for details in the local paper or social media

*“ WE WILL LISTEN TO YOU, LEARN FROM YOUR EXPERIENCES  
AND USE THIS INSIGHT TO GUIDE WHAT WE DO ”*



Kyles of Bute



Argyll and Bute Health and Social  
Care Partnership (HSCP)



## QUALITY AND FINANCE PLAN 2017-2019



### WE WANT YOUR VIEWS!



#### Why?

You said "We want to live a long, healthy, happy and independent life supported by health and social care services when you need them"

You said "We want to stay at home for as long as possible"

We want to support you to achieve this

You said "We want public involvement in service redesign"

We want to do that and have put in place a series of events and ways to gather your views

We can no longer provide services as we do now. We need to provide more community based services which are responsive and flexible to meet demand. We need to make sure the services provided in Argyll and Bute are safe, sustainable and affordable so they meet the needs of our population now and in the future.

Your feedback is important. We will use what you say to help us redesign and improve your local services so they are fit for the future.

#### How can you do this?

Complete this feedback form and return it to the FREEPOST address on page 2



complete the form online <https://www.surveymonkey.co.uk/r/9RP53NP>




email us your comments/ suggestions / views to [nhs.abhscp@nhs.net](mailto:nhs.abhscp@nhs.net)

Your feedback will be confidential. By that we mean :

- ✓ we will not name you in the document
- ✓ if you share your views but you do **not** want these to be part of the public record of the feedback we receive, we will respect that and your views will not be included.

Please tick this box if you **do not** want your views included in the feedback report

**Q1** Thinking about yourself, what would enable you to live a long, healthy, happy and independent life?

Please turn over 

**Q2 What support might you need to achieve this?**

What could services look like in 3 years?

**Q3 We want to provide a range of community services to support people to stay at home for as long as possible. What services would you like to see developed?**

**Q4 How do we increase confidence in community services to ensure they meet your needs?**

What do you need to have in place to be confident in community services?

**Q5 Do you have any ideas, concerns or questions about how we redesign services to move away from hospital to community based services?**  
(Please continue on a separate sheet if necessary)

**We welcome your more detailed comments, ideas, concerns or questions. Please attach them to this sheet**

Please return this feedback form **no later than 31<sup>st</sup> March 2017** to :

**Caroline Champion, Public Involvement Manager  
FREEPOST RRYT-TKEE-RHBZ  
NHS Highland (Argyll and Bute HSCP)  
Blarbuie Road, LOCHGILPHEAD, Argyll, PA31 8LD**

If you need help completing this form or to receive a copy in a different language / format (e.g. large print) contact Caroline ☎ 01546 605680 or [caroline.champion1@nhs.net](mailto:caroline.champion1@nhs.net)

*Thank you*



## Quality and Finance Plan 2017-19 First Round of Engagement Events

### FEEDBACK

*The following provides detailed **unedited written** feedback received from all forms received by post, online survey monkey and email. Each has been given a unique reference as part of the overall analysis of responses.*

#### **Q1 Thinking about yourself, what would enable you to live a long, healthy, happy and independent life?**

- BETTER LIFESTYLE, BETTER QUALITY OF ADVICE ON HEALTH MATTERS ESPECIALLY IN LATER YEARS, KNOWING THERE IS EXPERT MEDICAL ADVICE AVAILABLE LOCALLY. [qfp001/01mar17]
- More routine cardiac gym sessions. Waiting list for phase 4 in leisure centre. One size does not fit all. Lower level activities. [qfp002/01mar17]
- More from isolated rural area to Oban [qfp003/01mar17]
- BETTER QUALITY OF HEALTH & CARE ALONG WITH PROPERLY MAINTAINED HOME [qfp004/01mar17]
- THE ASSURANCE THAT YOUR BASIC SERVICES ARE GUARANTEED AND YOU DO NOT HAVE THE STRESS OF NOT KNOWING WHO IS DEALING WITH YOUR HEALTH ISSUE. [qfp005/02mar17]
- To be honest I will never be independent now. That said happiness could be brought by having basic services eg GP, dentist CPN assured [qfp006/02mar17]
- THE SERVICES & STAFF THAT WE HAVE ON MULL. ARE VERY GOOD & STANDARDS SHOULD BE MAINTAINED AND NOT CUT [qfp007/02mar17]
- Continuity in General Practice – avoiding major changes without more consultation. Maintaining the present number of beds in Craignure Hospital available for G.P.s to use. Physiotherapy, O.T. Chiropody, Optician, Dental Service, Audiology, Dementia clinic [qfp008/14mar17]
- Good hospital service & day care support outwith my home so I don't feel isolated & stuck at home. Transport links. [qfp009/15mar17]
- Develop extra care housing – better use of staff providing support & easier & quicker access to support. [qfp010/15mar17]
- Local services for care especially elderly. Local Care Home on Bute. People should not have to go off the island for care. People in hospital for too long – costs more than treating people locally [qfp011/15mar17]
- Easy to access resources, GP service very good. A+E service very good Letters could be better. Glasgow Hospital [qfp012/15mar17]
- To have contact with people & not be lonely [qfp013/15mar17]
- KEEP SOCIAL CONTACTS ACCESS TO EXERCISE & ACTIVITIES KEEP BUSY [qfp014/15mar17]
- By ensuring care in the community will support and enable care to continue be provided at home. [qfp015/16mar17]

- better health services. more care in the community home care staff better trained and less money spent on travel expenses [qfp003/02mar17sm]
- A new immune system. Meanwhile, enhanced services at Craignure Hospital so I don't have to be carted off to Oban every time I'm unwell. [qfp004/02mar17sm]
- support for complementary health instead of ineffective drugs - Keeping myself out of a wheelchair cost me a fortune because there are no effective drugs and all useful therapy is private and costs money [qfp005/02mar17sm]
- Having doctors and Dentist's here on the island [qfp006/02mar17sm]
- Better mental health care for my son, so less stress for me. [qfp007/02mar17sm]
- Good medical care [qfp008/02mar17sm]
- Enough money to continue to eat well, exercise daily and keep social contacts past retirement. [qfp009/02mar17sm]
- More decision making in the delivery of my care – I choose when where and what [qfp010/02mar17sm]
- Complimentary services being more widely available. [qfp011/02mar17sm]
- To have permanent doctors. [qfp012/02mar17sm]
- Being able to live at home as part of my own community with help if I needed it [qfp013/02mar17sm]
- Companionship, a purpose, interests, my own transport and a home that is appropriate to my health and level of fitness and basically enough money to be able to pay for any support that I need [qfp014/03mar17sm]
- Good community services . [qfp015/03mar17sm]
- Good support system, easy access to health services [qfp016/03mar17sm]
- Gp's who are encouraged to come and to stay with proper decent contracts [qfp017/03mar17sm]
- Support & encouragement to help me to stay healthy [qfp018/04mar17sm]
- (being well!) Locally situated GP and surgery. Adequate community care and nursing support [qfp019/04mar17sm]
- Access to health care within my local community. Transport in rural areas with no public transport. Community events/clubs/ fitness facilities [qfp020/04mar17sm]
- Support when and if required, quicker turn around when support is needed. More emphasis on reablement and short term support. Clear information on how to get support if required and confidence that this can be delivered if necessary. [qfp021/04mar17sm]
- good all round health care you can rely on the way things are going we won't have much health care or support on the Isle of Mull [qfp022/04mar17sm]

## **Q2 What support might you need to achieve this?**

- MORE COMMUNITY BASED ADVICE + ASSISTANCE, CO-ORDINATED SERVICES + SUPPORT AT A LOCAL LEVEL TO ADDRESS LOCAL NEEDS [qfp001/01mar17]
- More access to exercise classes. No waiting list for the classes [qfp002/01mar17]
- Persuade my disabled husband that this is a good idea! [qfp003/01mar17]
- MORE COMMUNITY BASED WITH BETTER HOME CARE AND ADVICE & MORE MONEY SPENT ON COMMUNITY SERVICES [qfp004/01mar17]

- PROPER CONTRACTS AND PACKAGES TO ATTRACT HEALTH PROFESSIONALS [qfp005/02mar17]
- The continued help of my carer husband and better Island GP and dentist services [qfp006/02mar17]
- MAINTAIN THE STATOS QOE OR IMPROVE NO CUTS [qfp007/02mar17]
- More Community Nurses Full time organiser of Home Care – not part time More Home help staff who are better paid [qfp008/14mar17]
- I would hope that there would be a hub on the island to enable people to access services as required. [qfp009/15mar17]
- Promote social care on the Island to meet growing demands & ensure consistency of care. [qfp010/15mar17]
- More telecare. Consult with GP's by Conference Call? Prescribe swimming and exercise not just medication [qfp011/15mar17]
- Supplies still go missing Administration [qfp012/15mar17]
- ADL egt has been fab : quick access to egt for all when it is needed. [qfp013/15mar17]
- FAST ACCESS TO GP SERVICES SERVICES THAT VISIT YOU AT HOME INSTEAD OF BEING SENT TO A&E FILL THE 6HR GAP IN DAY RESPONDER SERVICES. CURRENT COMM. SERVICES OPERATE 9-5 THIS DOESN'T MEET THE NEEDS OF COMMUTERS. [qfp014/15mar17]
- That infrastructure and investment in planning produces fewer in-patient beds needed. There is a lack of in-patient provision at this point so improve provision in the community. [qfp015/16mar17]
- Support for carers would be a start. The "Fit for the Future" leaflet states, "We have community day responder services which support people in their homes and allow unpaid carers to have a break from their caring role." Not on Mull you don't. I have been caring (unpaid) 24/7 for years, and have never heard of this. Currently I have two medical appointments to go to in Oban, and no way of being able to attend. So not only can I not "get a break from my caring role," I cannot even attend to my own health care needs. [qfp002/02mar17sm]
- bring back more funding to shelterhousing who could provide more support to enable people to remain at home [qfp003/02mar17sm]
- Enhance Craignure Hospital and keep/enhance services in Oban Hospital. Ideally, offer even more services to avoid patients having to travel to Glasgow so often. [qfp004/02mar17sm]
- Muscle therapy and herbalism on the NHS - would save a lot of money. [qfp005/02mar17sm]
- health boards to recruit permanent Doctors [qfp006/02mar17sm]
- A change in attitude from Mental Health staff - I would want them to intervene more often. [qfp007/02mar17sm]
- GPs, dentists and practice nurses [qfp008/02mar17sm]
- Adequate pension. The government in Westminster changed the pension rules so now I won't get my state pension, which I have paid towards all my working life, until I am 68. Put pressure on UK gov to revert to original dates for women's pensions. [qfp009/02mar17sm]
- More drop in/ self referral services, less generalised care e.g. unnecessary cervical screening letters etc. [qfp010/02mar17sm]
- Different services for improving mobility and pain management [qfp011/02mar17sm]
- Grim by all accounts. [qfp012/02mar17sm]

- Carers and budgets to pay them [qfp013/02mar17sm]
- help with house alterations, repairs and maintenance, gardening, house cleaning and help with anything heavy [qfp014/03mar17sm]
- Lots of nurses and carers in the community [qfp015/03mar17sm]
- A good old fashioned "home help", someone who ensures personal hygiene and social needs are met. For someone with medical problems an experienced trained carer from social services could support me whilst community nurses are also available [qfp016/03mar17sm]
- They are looking so dismal now I cannot project 3 years hence with anything. We on the islands are tired of being treated as though we don't matter. [qfp017/03mar17sm]
- Education, information, access to groups, access to gym/strengthening equipment for all ages [qfp018/04mar17sm]
- GP and surgery in Salen, Mull. Increased access to services [qfp019/04mar17sm]
- Local doctors and health care providers e.g. dentist, nurses, carers, [qfp020/04mar17sm]
- Services need to be available quickly cutting down on the long term impact of having to wait. Preemptive solutions need to be considered rather than waiting until things become urgent. [qfp021/04mar17sm]
- Permanent doctors, dentists, hospital care and a place for end of life care [qfp022/04mar17sm]

**Q3 We want to provide a range of community services to support people to stay at home for as long as possible. What services would you like to see developed?**

- CARE AND REPAIR TECHNOLOGY ENABLED CARE / TELEHEALTH PERSONALISED CARE SERVICES [qfp001/01mar17]
- Designated named person for care in the community. Pharmacy care member of team. Vulnerability register for crises prevention [qfp002/01mar17]
- Financially and practically it will not be possible to provide adequate services in very rural areas & therefore likely to have more call on emergency / hospital care. [qfp003/01mar17]
- MORE ACCESS TO DOCTORS, PHYSIOTHERAPISTS <sup>ETC</sup> PLUS MORE MONEY SPENT ON IMPROVING AND ADAPTING HOMES MAKING IT EASIER TO REMAIN THERE LONGER [qfp004/01mar17]
- BASIC SUPPORT FOR HOME CARERS AS OFTEN ELDERLY PEOPLE HAVE TO CARE FOR AILING ELDERLY RELATIVES TO THE DETRIMENT OF THEIR OWN HEALTH [qfp005/01mar17]
- Occupational Therapy people will increasingly need equipment. [qfp006/02mar17]
- MORE CARE IN HOME AND COMUNITY [qfp007/02mar17]
- Community nursing services McMillan nurses Marie Curie nursing services Meals on Wheels Optician Chiropodist Physiotherapist Home Carers \* [qfp008/14mar17]
- People perhaps don't need care or access to services every day but they need to know services are available for their needs. A social / care hub & transport & appropriate care in home with well trained staff who are aware of needs & appropriate behaviour. [qfp009/15mar17]

- Develop different models of respite care – home, community resources & care beds. [qfp010/15mar17]
- Not just carers but visitors for elderly at home alone. Interloch or similar to take folk shopping. [qfp011/15mar17]
- More telecare or gadgets. I have a falls pendent which is great. Transport is key to keep in contact. [qfp013/15mar17]
- Home care services improved and increased, again pro-active care in the community is the best prevention of acute problems. [qfp015/16mar17]
- giving funding back to shelter housing who can provide care cheaper than social work also people can return home from hospital early [qfp003/02mar17sm]
- Better skills for carers so the ambulance isn't called out just because someone needs lifting of the floor (assuming they're unharmed) [qfp004/02mar17sm]
- Far better community care; properly paid carers services; no postcode lottery for community care; Food for health; Growing food projects; Activity projects; [qfp005/02mar17sm]
- 21st Century health care not the pre war health care we are being given now [qfp006/92mar17sm]
- Better local transport for thiose withoput a car. [qfp007/02mar17sm]
- Home care [qfp008/02mar17sm]
- Exercise classes beyond the gym, in village settings, I presently pay to do yoga, Pilates and Bowen therapy to maintain good health, this won't be so easy on a pension. [qfp009/02mar17sm]
- Home help, community day care facilities, carer support [qfp011/02mar17sm]
- More carers [qfp012/02mar17sm]
- The Lismore Community Transport model used in other areas. [qfp013/02mar17sm]
- For me it would be making it simple stress free and not a rip off to find trustworthy, reliable, convenient for me support services quickly and easily as and when I need them. This wouldn't have to be necessarily people you provide directly but could be strict vetting of providers and making information available to the public so we can easily find and pay for reliable services ourselves without the stress and worry caused by cowboy builders, unreliable people and crooks [qfp014/03mar17sm]
- Reduction of social isolation [qfp015/03mar17sm]
- Trained experienced carers are a must who works along side NHS staff to ensure I would be fully supported with an integrated service [qfp016/03mar17sm]
- Social care, mental health care well everything really as everything is being taken away. [qfp017/03mar17sm]
- Exercise support workers - people to go house to house daily. A community space for a gym. Support workers in gym/pool (such as LOHO in Oban). [qfp018/04mar17sm]
- Specialist nurses in various disciplines [qfp019/04mar17sm]
- District nurse visits and input. Care for the whole family. Support for the carers team who already to a great job. Listen to your workers and clients. Named person for people to access when required. [qfp020/04mar17sm]
- Day care services, make it easier for home visits from services ie chiropody, dental services etc. [qfp021/04mar17sm]
- Care givers to give respite to carers [qfp022/04mar17sm]

#### Q4 How do we increase confidence in community services to ensure they meet your needs?

- WELL INFORMED AND ACCESSIBLE SUPPORT SERVICES CONSISTENCY OF SERVICES, QUALITY OF SERVICES PROVIDED POINT OF CONTACT CLEARLY ?? [qfp001/01mar17]
- More publicity of the services we provide. More feedback avenues to hear good and bad experiences. [qfp002/01mar17]
- To know who to contact in time of need. [qfp003/01mar17]
- DEVELOP COMMUNITY BASED CARE SERVICES + SUPPORT SERVICES LIKE ARGYLL + BUTE CARE & REPAIR – MORE COMMUNICATION BETWEEN RELEVANT SERVICES I.E. OT'S + TELECARE OPERATIVES [qfp004/01mar17]
- HAVE A REGULAR SET OF GP'S AND DENTISTS AND MENTAL HEALTH AVAILABLE ON ISLAND [qfp005/02mar17]
- A Gp A dentist [qfp006/02mar17]
- IMPROVE COMUNICATION. MORE CONSULTATION AT TIMES WHEN PEOPLE CAN ATTEND IE EVENINGS [qfp007/02mar17]
- Better funding. A system which is readily available with clear communication and access. Plenty of beds available in Craignure Hospital – Do not put surgery or dental unit there. [qfp008/14mar17]
- If volunteers were to be used in any way I would want to know that they have been fully trained are covered by appropriate indemnity insurance & there is consistency. People with dementia need familiarity & stimulus & not to feel isolated. [qfp009/15mar17]
- Volunteer driver scheme to support with apts on / off the Island. [qfp010/15mar17]
- Better information about services – events, drop in, posters, local radio. [qfp011/15mar17]
- More services in the community to prevent lonieness & isolation. [qfp013/15mar17]
- First, information about what is available – let people know what services are local. Continue to inform key groups and make sure they are informed at all stages. [qfp015/16mar17]
- better management [qfp003/02mar17sm]
- Word of mouth is the best thing. If people have good experiences, they'll tell others; likewise bad experiences get around pretty fast on an island! [qfp004/02mar17sm]
- not having some services available in one parish and not in the others. Having sufficient district nurses. [qfp005/02mar17sm]
- Make sure the doctor lives in the community. [qfp007/02mar17sm]
- Decent permanent gps who know you and your family [qfp008/02mar17sm]
- Don't really know what is available at the moment or what the plans are to change. [qfp009/02mar17sm]
- More community engagement narrowing the age divide in communities. [qfp011/02mar17sm]
- Permanent doctors [qfp012/02mar17sm]
- Care at home if needed, transport , efficient local medical service if required - not necessarily hospital – based [qfp013/02mar17sm]
- Staff [qfp015/03mar17sm]

- Staff need to be given more time to meet the needs of me socially rather than totally physical needs. Continuity of services, regular friendly face, preferably over 30 as they have more life experience. [qfp016/03mar17sm]
- Stop all the posturing and statistics. Get a proper grip on a very real dire situation. [qfp017/03mar17sm]
- Clear information - all in one place - on what is out there for us to access. Who we need to contact in which situation. [qfp018/04mar17sm]
- Communication (tell us what is happening and why). tell us ow to access services easily [qfp019/04mar17sm]
- Clear records/ reporting between agencies so everyone working together as a team. Support workers so that they feel valued then they will have greater confidence and improved work ethic. [qfp020/04mar17sm]
- More public awareness especially at ground level. Allow people using services more insight into every aspect of services. Service user and prospective service user feed back and discussion. [qfp021/04mar17sm]
- Assurity from the N H S that they will not be cutting down on any of the few facillitys we already have [qfp022/04mar17sm]

**Q5 Do you have any ideas, concerns or questions about how we redesign services to move away from hospital to community based services?**

- DEVELOP BETTER COMMUNITY BASED SERVICES AND SUPPORT SUCH AS CARER ORGANISAITONS, CARE AND REPAIR SERVICES, LOCAL HEALTH HUBS (INFORMAITON, ADVICE, ACCESS TO SERVICES,) EXERCISE, BASIC HEALTH CHECKS). VARIOUS PATHWYAS + ACCESS TO ASSISTENCE + SUPPORT [qfp001/01mar17]
- Hospital and community need to be more joined up – not in silos. Something in between hospital at home that is not GP. Drop-In Centre - ?Poor Discharge advice ?frailty assessments [qfp002/01mar17]
- Will it be possible to recruit sufficient nos of well trained home care staff.? [qfp003/01mar17]
- PUT MORE MONEY INTO SERVICES WHICH HELP PEOPLE REMAIN LONGER IN THEIR HOMES VIA ADAPTATIONS & CARERS, AS PEOPLE TEND TO BE HEALTHIER + HAPPIER THE LONGER THEY STAY IN A HOME ENVIRONMENT [qfp004/01mar17]
- PRECRIPTION SERVICES ON ISLAND ARE DIFFICULT A DELIVERY SERVICE FOR THOSE ISOLATED AND NOT NEAR A PHARMACY INSTEAD OF MAKING IT MORE AWKWARD TO GET MEDS. [qfp005/02mar17]
- Better times for in home carers to work with clients not just travel to them. (referring to the feedback form – deadline date circled several times”??? For a plan out on 29.3.17 TOO LITTLE TOO LATE” [qfp006/02mar17]
- DO AWAY WITH SHORT TERM CONTRACTS ENCOURAGE & SELL MOULL SO AS TO ATTRACT LONG TERM. NO ONE WILL UPROOT & MOVE IF NO JOB SECURITY [qfp007/02mar17]
- Funds for community midwife services Absolutely essential to keep places available in Bowman Court for our aging population & increase in Dementia [qfp008/14mar17]
- Professional support must be provided in the community appropriate to needs of both the recipient & their carers. [qfp009/15mar17]

- Travel Concessions – charge £1 for every journey. Talk to local churches – they provide Befriending services yet the HSCPO is paying the third sector for this. Church is a great resource for volunteers. [qfp010/15mar17]
- More local provision eg dialysis x-rays for fractures some chemotherapy more local consultant clinics Residential care home also needed. [qfp011/15mar17]
- Universal transport can't be allowed Tax needs to go up to afford the future commitments. [qfp012/15mar17]
- CAMPUS BRINGING ALL SERVICES TOGETHER. ADDRESS THE INEQUITY IN RESOURCES BETWEEN BUTE & COWAL. [qfp014/15mar17]
- Adequate staff and adequate training. Infrastructure in place as soon as possible. Right staff at right time. [qfp015/16mar17]
- My family and many of my friends, would have liked to have attended the meeting today on Mull (2nd March). However as very little notice was give (I only read it in the local RoundandAboutMull yesterday) this has unfortunately not been possible. [qfp001/02mar17sm]
- look into reducing miledge paid tort workers working in remote areas. increasing hours in sheler housing. [qfp003/02mar17sm]
- Community-based services are all very well and a commendable idea but those with serious long-term conditions (like me) need to know the Craignure and Oban hospitals are there and fully-equipped when we need them. The DBU at Oban is excellent - without it, I might have to travel to Glasgow and I'm not sure I'd do that ... one less patient to worry about, I suppose! [qfp004/02mar17sm]
- INvest more in community based services ! [qfp005/02mar17sm]
- investment on the services we have paid for. [qfp006/02mar17sm]
- Make more use of the splendid GP surgery in Bunessan. And local dental Services. [qfp007/02mar17sm]
- Do away with after hours nhs 24 . Bring back our gps on call. There is nothing more calming than having a dr visit when you are ill [qfp008/02mar17sm]
- see above. Concerns over discussions about downgrading local hospital. [qfp009/02mar17sm]
- Continuity of care is essential and needs to be considered as a propriety as done standardisation of care. [qfp011/02mar17sm]
- More funding is required [qfp012/02mar17sm]
- Talk to communities - see what they need and request [qfp013/02mar17sm]
- People need to start planning for their old age more. putting things in place whilst they are young and fit enough to sort things out. We are saving and planning on moving to a lovely still but more suitable house for our latter years that could also be adapted to wheelchair living, supports and aids etc. the biggest thing for us is to be able to easily access any help or support that we need. We are currently managing the old age/final stages of elderly parents and this gives a powerful insight into what can happen. They are powerless, dependant on others to not only do things for them but to sort out paperwork make decisions, everything is too stressful for them Its horrible to watch. The bad thing is sorting things out are even difficult and stressful for us so the elderly stand no chance. Processes need to be simplified. The old need to be THE key part of the decision making process. Things should not be don't TO them but be done for them with their consent. Help at home should be provided in a way that suits them not for the convenience of the service provider and having the same person come to help them is essential!!!! Strangers equal stress and upset. [qfp014/03mar17sm]



- You need to recognise that you cannot do that without investment in providing robust community teams who have the resources and skills to deliver care . [qfp015/03mar17sm]
- What is the point. We are not being listened to. Everything is in an appalling state of affairs. Giving views and responding are all well and good but it is proper results and actions that are urgently needed. [qfp017/03mar17sm]
- As always in a relatively small community - developing a full range of services and sustaining them long-term is challenging. I can see many things starting, then losing momentum due to a dip in interest or a lack of qualified people to continue running them (particularly if these people are volunteers). [qfp018/04mar17sm]
- On Island of Mull with widespread dwellings requiring long travel times on single track roads (worse in summer due to influx of tourists). Significant investment needed to increase staffing numbers with staff living/based in or near widespread communities. Develop "bank" staff who would be available at short notice to deal with sudden increases in demands. There is a danger of losing hospital beds increasing waiting times/access. Keep service local. Plan for patients without transport to access the GP for consultation, repeat prescription collection. This would include the elderly or frail or mothers with young children, and working mothers. Very important to keep in touch with the community, ask for feedback AND respond in a positive way. 'Conversation Cafes' do to achieve anything from the point of view of patients so a better way of identifying our thoughts should be sought. Experience of previous similar consultations has left us very cynical about the current survey. no problem if you are listening, local knowledge is more powerful than ideas from office bound staff [qfp019/04mar17sm]
- Agencies need to work more together. E.g. district nurses could visit when carers are there giving advice, answering questions etc Each client should have a named person who coordinates their care. The council needs to work together a cross the department's e.g. rds need to be gritted for carers to get there safely. More beds need to be available for respite care on Mull to prevent having to leave island. More beds in Mull to treat patients rather than emergency evacuation to Oban. [qfp020/04mar17sm]
- Emphasis on integration of services, more collaboration between all agencies involved along with service users. A&B need to look at some way to work with care agencies to try to encourage employment especially at ground level. There is a very limited pool from which to draw the work force. This needs to be addressed as staffing issues from the bottom up will impact upon the ability to deliver care services. [qfp021/04mar17sm]
- A place for people to convalesce after being in hospital. It is too far for people to travel to visit patients after all visitors play their part in speedy recoverys too. Plus they can bring to the patient change of clothes and supply toiletries [qfp022/04mar17sm]

### EVENT TABLECLOTHS / FLIP CHARTS

Corran Halls, Oban, 1<sup>st</sup> March 2017 (2pm – 5pm, 6pm – 8pm)

- Improve communication between Oban and GG+C hospitals
- Text message/email appt reminders
- Stop or tick box/system service
- RTT needs to mean something. Feeling that figures are being fudged
- Good information and advice re services available in all mediums
- Community care is knowing what is needed in the community. Drop in Forum.
- GP/nurse information sessions around LTC
- Repeat prescriptions direct from pharmacy
- Make pharmacy part of the community team
- Annual Medication Reviews with pharmacists
- Need to respond to thank yous
- Increased joined up working efficiency
- Neighbourhood – community and capacity
- Single point of contact
- O.T self assessment with support
- Repairs etc to H.A properties, especially minor providers
- Appropriate housing – progress re care
- Flat share for learning disabilities/communal living
- Care workers based in core sites e.g.
- More responsive care at home to prevent admissions – outreach from the hospital (catheter care)
- Telecare – social care outreach team
- Would an overnight hospice enable people to stay at home longer?
- Internalise care at home
- Podiatry – toe nail cutting
- Housing for key workers

- Housing options instead of care homes
- What does care at home mean? Some don't know – explain more clearly
- Transport – in town too – Dial a ride service. Link with tourism (McCaigs Tower)
- Make sure pathway from community team passes onto voluntary sector/community groups
- Zoning of homecare
- Reduce trips to Glasgow
- Community team – help to get into car, no further visits - ?healthy options - ? referral onto TSI/3<sup>rd</sup> sector
- Can Annie go to Senior's forum (Maggie Dougal)
- Improve community transport to link remote areas to Oban so elderly can attend events
- Telehealth/Telecare – preventative
- Increase volunteers
- Missing local equipment store (Don't need an O.T!) Wait for equipment not good. “Where is the care in the service?”
- Home assessments – large houses and gardens – service to recommend ‘genuine safe businesses’
- Need more staff reablement
- Community/voluntary sector services keep changing. Staff cannot keep up to date with services offered – Link ECCT meetings & TSI / carers centres
- Using ECCT as care and home providers – expensive form of care or care at home skill (&pay)
- 3<sup>rd</sup> sector work – yearly contracts – link with TSI and community teams (ALISS)
- Links with health and wellbeing network not good
- Realistic expectations
- Centralising catering/kitchen
- More info on the finances e.g. what amount will be saved per decision and what will be the impact?
- Look into battery packs for ventilators in ambulance transport
- Preventative approach for sensory disability (Autism) Invest to

save (Proactive desensitisation)

- Look at services in Holland where elderly people let out their rooms to young people for free who in turn support the older person
- Fostering elderly adults and adults with learning disabilities
- More localised specialist/shared housing/ shared carers
- Bring back 'Bob a Job', Duke of Edinburgh , Saltire award, time banking
- (lighting fires, putting bins out, walking dogs, washing windows, shopping, companionship etc)
- Wiltshire model – Radio 4
- Capitalise on Oban as a University town – skill up carers. Create a 'Centre of Excellence of Care' 3<sup>rd</sup> sector must be involved moving to outcomes
- Schools visiting residential care facilities – good idea – needs to be more
- Bus links from Fort William to encourage people to come and work.
- Stop reinventing the wheel
- Register of vulnerable people in their homes
- Crisis prevention – more anticipatory care
- Patient confidentiality
- More use of telemedicine in the communities
- Single point of contact for community services
- Links with first responders and community teams
- Improving transport links to other hospitals
- Improving times of transport
- Care in the community needs to tie in with hospital care – joined up – talking to each other – not compartmentalised
- Implement named person
- Oban hospital needs to decide what specialism it is going to do
- Better timed appts in Glasgow
- Stop sending letters – use technology – offer options
- Think 2025!
- Care services at home – if care providers given an area each – e.g.

one has 10 clients another 6 - do you think they will be willing to accept less money coming in?

- Leap of faith is needed
- Hospital and community integration of staff (working between)
- Trust in community services needs to increase
- What is the cost of an elderly person wanting to stay in their own home?
- “Make the community first – not the hospital”
- Advanced practice roles
- Rotational consultants
- Reduce consultant visits to Glasgow
- More simple procedures in Oban
- Reduce follow up (post-op) in Glasgow unless necessary
- Pre-ops
- VC links with Glasgow
- We need improved IT systems to stop duplication
- Depts. not joined up
- Improved links with other sectors and independent services in the community
- No provision for visually impaired
- Laptop/PC/Tablets to support disabilities
- Poor exercise available for cardiac patients who have finished hospital class – 6/12 month waiting list for phase 4 cardiac rehab at Atlantis Leisure
- Improve community resilience through support, training and knowledge
- Provision of services ( Too many different professionals inputting to individuals)
- Access to GOs out with 9-5
- Need integrated teams – with a professional team lead
- Continuity of care from Professionals within the service
- Better signposting
- Integration and sharing of current facilities, once in residential settings – seen as activity care needs being met by staff
- Hand held devices for community staff

- Coordinate transport
- Better referral systems
- Change the lack of weekend services/ support required 24/7 for community groups to meet lifestyles
- Individuals need to take responsibility for self
- Recognise limitations and develop alternatives to cope
- Change attitudes to self care
- Go paper free
- Knowledge of where and how to access community based support
- Tackle concerns within communities
- Reduce prescribing budget by: Do not over prescribe/less waste, only have what is needed esp. treatments for eczema, diabetes (syringes, blood test strips etc), have triggers to check if repeat prescriptions are actually needed, only get if medically required, let patients know the cost of drugs, generic more acceptance if not branded as cheaper, need to have confidence it will work.
- Education and culture change alternative to drugs as an alternative treatment
- Have an agreed exit strategy/planned weaning off discussed and agreed at first visit if appropriate
- Fewer drugs requested
- Public toilet and PSV bus required from town centre to McCaigs tower – lots of people live here but unable to walk to use bus pass
- Housing – Progressive care core & cluster – future adaptations should be built in row
- Centralising booking systems is not efficient
- More support required for young carers
- More emphasis on early intervention and prevention
- Cultural expectation, better communication
- Need to promote community assets and balance this with success measures of reducing dependency
- Going well - Quality hospital and dental services Macmillan services – ‘Anchor points)
- Should care packages for both adult and child be capped?
- More publicity around understanding S.D.S. Not enough support

for S.D.S – Only 1.0 WTE for adult and child across HSCP

- Keep dementia patients at home – better for person
- Alteration in clients medication e.g. dementia) needs to be joined up with home care
- Assessment and implementation of care packages more than 6 more than 6 monthly.

**Village Hall, Craignure, Isle of Mull, 2<sup>nd</sup> March 2017 (12noon – 3pm)**

### **HOSPITAL**

- Logistics of moving Salen Surgery
- Why do we go to A & E for 4+hours after being flown, ambulated to Oban? Should the bed not be ready on arrival?
- Attractive long term packages to encourage GPs, nurses  
Radiographers etc
- Prescriptions should be available in hospital for residents in Craignure, Lochson, Lochbuie and Crogan. We won't want to have to go to Oban or Tobermory (as a result of not being allowed to leave prescriptions at the local village store)
- Do not reduce beds in hospital - need:
  - Clinical need
  - Step down care ? hospital
- In between acute and community what provision for respite beds

### **COMMUNITY**

- Increased notice of meetings
- Open surgery times
- Dental access – South Mull
- Recruitment of GPs
- NHS24 – Don't understand geography & water
- Cost of equipment for home care
- The cost to child's education taking a full day off to visit dentist rather than 15 mins to visit the van
- Stress on household carers keeping elderly at home – leading to the carer's health failing
- Want consultation on future of Salen surgery

- Don't want to take anything away from Craignure and may need more parking
- Proper career structure for carers, links to schools, combining health care roles
- Young people cannot afford to live here as cannot afford housing costs
- New roles, expand these:
- Care at home – staff supported by professionals
- Salary care – living wage
- Target Recruitment in local areas – make more interesting:
- Career Pathway, Smaller teams being more community minded
- Dental Access
- GPs (1 year contract!)
- Hospital beds – limited community services
- Progressive care centre being reconfigured
- People in hospital need hospital care only
- System is broken if not providing the care needed
- Support to carers
- LPG – communication & updating locals
- Future events planned around LPGs
- Timing of events/time in the day/ cover island
- Sell it!
- Reduce the number of managers
- 24 hour care lacking on Mull
- Equipment costs for anyone staying at home
- Salen surgery - ? move to Craignure – reduce access for Salen community – accessing prescriptions – How will the service operate?
- **Conversation cafe was too focused on 'money' service provision – not actually patients**
- Carers – rewarding job, hard work, late hours, split shifts, minimum contract: How do we make more attractive to promote
- Change perception of it as a career structure/limited career pathways
- Tourism impact – lose workforce, better pay



- Carers spending so much time travelling end to end/more time spent travelling than caring
- Need to recruit local carers
- Winter road conditions before gritters been out
- How do we map out journeys/zones/teams sometimes crossover/joined up info
- Holiday cover –temp housing to support cover
- What is lease dentistry?
- Marjorie Taylor advised not policy to advertise short term contracts
- Could the flats in Bowman court be divided into 2:
- Is everyone in Bowman Court proving care?
- Double capacity/ more respite/ step down
- Complex tenancies
- Housing care required

**Community Centre, Lochgilphead, 3<sup>rd</sup> March 2017 (2pm – 5pm, 6pm – 8pm)**

- Drs to signpost pats to group
- Drs to do home visits, to anticipate issues
- Preventative healthcare
- Early intervention and prevention – invest to disinvest
- Podiatry care/access for all
- Medication reviews – reduce costs in pharmacy
- Support groups for people with chronic conditions
- Keep reablement programme
- More trained staff in the community
- More local activities for the elderly. Increase inclusion in the community
- Telemedicine – Reduce travel
- Community transport to allow people to visit other areas to socialise – avoiding isolation and mental health issues
- Care must be led by needs assessment
- No 1 fear by people receiving homecare is they may end up in a care home

- Home carers trained in mental health e.g. Mental health first aid
- Appreciate good one on one interaction with homecare staff
- Extended time of community teams
- Overnight response
- Public holiday cover
- Antibiotics at home for frail elderly
- Extended hours CMHT
- Crisis response team

**Community Centre, Campbeltown, 8<sup>th</sup> March 2017 (2pm – 5pm, 6pm – 8pm)**

#### **HOSPITAL CARE :**

- Community care can only provide so much support before intervention could be required in a hospital setting.
- There is waste in the system e.g. people calling ambulances or getting repeat prescriptions. Could we do more public education so people value NHS more and take personal responsibility for their health.
- By cutting more beds this increases the likelihood of having to transport/place patients out of the area.

#### **COMMUNITY CARE**

- Care in the community (as a carer) needs to be publicised more as a lifelong career
- A lot of people locally do not know who/what the community team is.
- Older people living on their own are lonely – more activities to prevent this
- More opportunities for older people to live in supported accommodation – progressive mode.
- More and continued funding in third sector groups and charities to enable support in community to flourish.
- Concerns about pay disparity
- Need to promote community services
- Community support needs to include dealing with social isolation

- Worried about rural services e.g. GPs. No nurse in Muasdale practice last week, older people can't get to Elderbernes from Muasdale
- Third sector interface are not supporting voluntary organisations. They are developing own projects. A review is needed of the above.

**Columba Centre, Bowmore, Isle of Islay, 9<sup>th</sup> March 2017 (2pm – 5pm)**

**Services the community would like to see developed:**

- Transport to shops, surgeries, medical appointments including dental, physio, optical. Direct access to healthcare support i.e. empowered to call out health staff.

What do we need to have in place to be confident in community services?

- Easy communication, easy communication with any appropriate provider and early response ( 1 or 2 days max!)

**Flipchart feedback:**

- A list of drugs we will not prescribe as an organisation e.g. deep heat, quinine, surgical spirit, cotton wool. Support GP's to prescribe strict formulary.
- As we move towards community based form of care, away from a centralised hospital based service, wont things cost more? Due to the requirement to move resources around the islands, travel time and costs for staff? And if so how can we save money when we will need more?
- Reduction to repetitive roles, making the HSCP one team, with one leadership rather than having members of 2 or more teams covering the same areas of work.
- Hospital is not fit for purpose - 50 years old. Develop new progressive model plan.

- Multi skilling the workforce to fill gaps e.g physio assistant on islay can cut toe nails. Also something about the community nurses doing a wider range of tasks.
- Reduce transport - stop escorts - one rule for all.
- Self booking for plane to enable discount card
- Eliminate the use for travel agent - expotel
- Reduce hospital beds and staff
- Most economical approach to travel
- Get rid of free prescriptions
- Raise income tax
- Islands are different to the mainland - more resilient but shouldn't take that for granted because other areas have more services at hand. People are very dispersed over the island.
- LPG group should have teeth - no nebutory nonsense
- Formal strategy regarding buildings so "fit for purpose". Not ad hoc changes - especially dentistry
- Everybody needs to keep active e.g. walking
- Privatisise lesser elements
- Social ENT to invest in NHS locally
- Progressive care centre
- Would like to access hospital appointments remotely e.g. skype or VC however the bandwith on the island is not good.
- Too much money spent on leaflets - why glossy?
- Take a hard look at ordering supplies at the hospital.
- Access to hospital can be a great problem for folks with no private

cars and cost of taxi is expensive.

- Surgery opening hours can be too limited - refer to Christmas 2016 and New Year. Problems regarding transport if private car not available.
- Transport escorts can be reduced if different appointments can be times, dated, to allow single visit to local hospital AND Glasgow appointments.

**Conservatory, Cowal Community Hospital, Dunoon, 13<sup>th</sup> March 2017  
(2pm – 5pm, 6pm – 8pm)**

- Let people know about consultation in plenty of time
- Tip for Conversation Cafés : wear clear legible labels, so that people know who they talk to
- Presentation with info and then conversations around tables
- Q5 Community Hubs, Healthy Living Centres, Wellbeing Centres
- It's difficult to make suggestions about finance, if you don't know much about it. How can you improve that
- Why has transport not mentioned?
- Rapid response service for MH service. Short term + immediate response not only effective but prevents costly and traumatic admission – more flexible MH services can be more cost effective
- Self help – best value – needs supported + invested in
- More time + effort required to support link clubs in our communities – communities best served by own resources – soft approach (MH)
- Inclusion is vital in ensuring that local comm's can be at heart of solutions
- Can support carers group access NHS / ABC technology for video conf meetings (include parents, carers access to this technology)
- Teletherapy
- Patient experience : perception that patients at Inverclyde Hospital (from A&B), feeling of not being “wanted”, patients feel

they are treated differently (second class citizens)

- Appoint times : too early, no concept of the need for people to travel for appts
- IJB – why can't people attend & ask questions? – Why did we lose CHP structure? It worked
- Ability to stay at home for as long as possible : not just for old people – meals on wheels good
- Communications (common theme) – needs to improve, people not clear about what is available & how to access. Idea – local newsletter (BL) similar to GG&C (regular newspaper)
- Need to do more to be open & transparent with our communities – more engagement with local people
- Hospice – what is happening to this? What is happening with funds raised by local people?
- Lip reading service / training for local people – helps with tackling loneliness & isolation, building confidence – what opportunities are there to set up a base & apply for funding
- Patient experience – need for an evaluation post hospitalisation thru' a variety of methods e.g. paper based, online, face to face – chaplaincy service or advocacy service?
- Audiology – need to review service provided by GG&C – would like service provided locally – why 2 month waiting list? – cost of patients travelling to Inverclyde – reinvest to provide local service. Someone with hearing loss, not enough information about what is available to help / support people & no link to social services / benefits (only finding out thru' attending other groups – people don't know where to look for help & support – need to do more to build peoples confidence
- Care in the Community – need good communication between all professionals & partners (HSCP & GG&C) – Inverclyde doesn't have access to local records therefore service not patient centred. Story of duplicated appointment for the same thing, need central access to records
- Need better discharge planning (GG&C)– information for OT assessments not forthcoming – causes delays in making “safe”

decisions for patients on discharge – real issue for people who don't have capacity to make decisions (power of attorney). Need better understanding of how discharge planning works (or should work). Confusion about what the SLA includes – “post code lottery” – a lot of time is wasted chasing / discussing issues. Current issue re: having sufficient bed capacity to facilitate discharge from Inverclyde. People need to be home to be assessed properly but we need staff locally to do that. More info readily available for “nhs” staff, less for “social work” staff. Feeling that people are discharged too quickly resulting in re-admissions – perception that patients need to leave quickly to “free up beds” – insufficient care when discharged – critical that patients have the right care package to allow early discharge & prevent potential re-admissions. People need to know who the “discharge team” are & how services come together to support people – revisit leaflet – people get cross, they think OT & physio don't talk to each other.

- What is “step up, step down?”
- People need to be treated as individuals, care based on individual need
- Case for assessment beds to help with assessments locally
- Right way forward but different options to achieve this – be bold, give it a go
- Continue to use modern technology to reduce mileage (travel) – therefore savings to be made
- Message from Inverclyde that patients not welcomed
- Pacemaker services not good enough as need to travel to Inverclyde – local clinic required
- Package of cares required in the community in order that my support is tailored to my needs – preventing being looked after in residential care – cost effective
- People should have choices
- Need to use caring connections coaches more
- Carers need support
- Need to take the time to really listen

- Need to understand what is available to support / help people – which door to open, how to open it
- Understanding “real” problems – issue may manifest itself as something else
- Mental health – no out of ours service / crisis response – retrieval service – cover responsibilities – supervision of people : medication, ongoing support post hospitalisation
- Relationship between GPs & third sector
- Y.P. negative experience of using M.H. service – Videolink to consultant psychiatrist – bad experiences – need to improve access and practices around these types of appointments / interventions
- Issue regarding appointment times for Inverclyde / Glasgow. Too early. Better or improved communication with Glasgow / Inver
- Poor admin support from Glas / Inver
- Lack of good publicity regarding what consultants / clinics are held in Dunoon – better communication
- Ambulance service redesign – signposting required to alternatives
- Volunteer driver scheme to be co-ordinated + cost savings / shared
- Issue re the locality of our MH. Hospital in Lochgilphead – Lochgilphead to isolated – only used for short term detention
- Better explanations / communication as to reason behind non provision of services (radiography)
- How do we improve attendance at events? - get transport in place – public event – go to already existing groups – go to natural community areas if brave enough ie pub, gets you in touch with people who want to go to events
- Need to get clubs / events taking place in our community – remapping required
- Are we better off being realigned to a different health Board
- Improve transport infrastructure between Dunoon + Inverclyde – can we ensure that buses / transport are available at ferry point
- ABHCSP – too beauracatic heavy – more coal face staff
- Develop campus model – co-located



- Strong message if SW staff relocate to hospital – message to public that nothing going to happen to our hospital
- Better way coordinate transport / sharing with patients to mainland services / hospital appointments
- GP surgeries ineffective in Dunoon – appointment system isn't working
- Are we getting value for money from our S.L.As.

**Green Tree, Rothesay, Isle of Bute, 15<sup>th</sup> March 2017 (12noon - 3pm)**

- I.T needs to be ahead of the game, not patching the errors
- Cardiac rehab needed on the island
- Palliative care needed on the island
- Individual people with 24 hour care – change to 4-6 people, one carer. Inclusion - isolation
- Feeling that fewer services on Bute
- Very sheltered housing on Bute could help stop people going into care
- Too many working groups/meetings etc
- Draw too much on small groups or volunteers to support committees
- Need better communication
- Education for (carers – unpaid)
- Adapting the family hope for dementia O/T D/N all working well
- Will this affect service development – kidney dialysis, Training for doctors and nurses
- Prescription – could it not be voluntary?
- Winter allowance – could we not pay it back?
- Respite – outside our home
- Advocacy service access
- Carers need to be supported
- Sheltered housing underused on Bute
- Information on services re community services
- Transport is a huge issue
- Dementia is a huge issue

- We need to expand services
- Mental health huge issue
- Free ferry tickets
- Free transport not sustainable
- **Good news stories** – what is working here?
- Virtual wards (community placements)
- Role of the local newspapers (Buteman)
- Extra care housing needs developed
- Stream line process – more self referral for things like hearing aids, do we have to go to GP for an appt? Why can't a nurse or someone else see me first
- GP service good
- Hospital service very valued
- Air service very good
- DN service excellent
- SW service assessment activity
- Glasgow services have worked ok.
- Alternative therapies – identifying local resources
- Help to anticipate health issues before they happen
- Community funded therapies
- Tapping into resources
- Facilitating conversations between generations

**Victoria Halls, Helensburgh, 16<sup>th</sup> March 2017 (2pm – 5pm, 6pm – 8pm)**

- How do we involve people who do not attend events, have the confidence to have their voice heard? C&E Group
- Toolkit – communities toolkit? designing communities (community planning Partnership) - training in Helensburgh on 31<sup>st</sup> March (inc NHS, Planning)???
- Community advertiser free to all households / URTV
- For info sharing: Helensburgh Community Opinion facebook page
- More support for carers is required
- Care at home was very general
- Consistency of care packages through patching

- Is there a role for Golden Jubilee hospital in Glasgow?
- Volunteers are untapped resource – what are we doing re volunteers?
- The Inverness connection does not always work
- People need to accept change – change needs to happen
- Workforce plan
- Communication – waiting lists, travel, missed appointments
- ‘Halo’ ambulance service
- Acute care / social care
- Greater Glasgow & Clyde VOL / RAH / IRH
- Primary, Acute, Community and Social care
- Integrated Teams: Primary care – Social care – Volunteer help groups – shedding
- Physiotherapy, occupational etc – Community
- Look both ways
- Finance
- Infrastructural Planning
- Service level agreement 100 million to GG&C
- People do not know how to access some services e.g. self referral to physiotherapy. Some going private because they are unaware of other options.
- Need image sort of role to ‘signpost’ people to services: problem with housing, problem with x,y,z, role of TSI
- Hub for Helensburgh/Lomond area: one stop shop
- Website option?
- Dementia centre has become a hub with cafe.
- Everyone doing a really good job but working in sites: need to have everybody together on neutral ground.
- Missed appointments: are there statistics about numbers of patients missing appointments and reasons for this (pressure on system)
- Factor in travel commitment for patients attending appointments
- Consider a health centre where everyone is together e.g. GPs, nursing etc similar to Drumchapel – shared patient pathways
- Are we heading for private care – similar to other countries e.g.

benefits those who can afford it

- Look at repeat customers
- GP contracts – loopholes that allow them to work in ‘their’ way, not in a responsive way i.e. working in partnership.
- Locality not involved in how the contract with GG&C is decided, what services are purchased, needs to be more patient/person centred – ‘hands tied’
- ‘Step up, step down’ care locally
- Central management?
- Telemedicine – needs to be developed further whilst considering limitations.
- Always more we could do
- Holding onto services “by the skin of our teeth”
- How can we make cuts when talking about investing in community care
- Example of link worker in Dunoon & starting same programme on Bute.
- Social prescribing – not everyone will require medical support
- Dislocation between social care & secondary care – discharge of patients from hospital, ensuring appropriate packages of care in place.
- Potent, powerful cuts
- Idea that everyone works ‘together’
- I administration would make a lot of sense
- Redevelop district nursing service – not happy doing relatively “simple” tasks
- Point about visits at home limited (15mins) – metropolitan vs. rural
- GP surgeries are stretched
- Social services are stressed
- GPs in rural areas should be taken out of their practice to refresh their skills for say 2 weeks
- Appropriate vetting of staff – check qualifications
- Excellent practice in one area compared with others. Standard? – home visits

- Argyll & Bute pays for a lot of the safety aspects of Faslane
- More money should be spent on out of hours service at Vale of Leven – MIV current issue
- H/L – everyone is located in different places, would be better to be collocated with single point of contact.
- Need good infrastructure in place, including planning to ensure we can make changes necessary.
- Need to communicate a lot better & listen to people
- Community is where care should be – primary care is where it should happen (prevention not cure)
- Need to pay GG&C less
- Medical contracts should have clause – should work in rural areas as part of their training, also in deprived areas
- Clinical risk about to happen – patient stories (VOL)
- Concern about maternity services at VOL moving to Glasgow – not just about £ , about safety
- Future of VOL
- Care standards does away with 15 min visits, up to 1 hr will be the norm – need more staff to ensure standards met
- Fear of change perception – need to be able give justification for change
- OT service assessments
- How fast can we get people out of hospital?
- Staffing is an issue – need staff in the right place with the right skills – role for foreign staff – accommodation required – cost of locums is excessive
- Need to prioritise where £ going to be spent
- How can we keep people at home? – help/support/equipment/good service/better nutrition
- Role of paramedic practitioner – new co-host of staff currently undergoing training
- Contract between Red Cross & Service provider to facilitate discharge patients from hospital – goes beyond “dropping” patient at home, checks if anything needed e.g. milk in fridge, etc
- If people don’t engage or respond – they need to support the

changes

- Use community councils to engage about changes – test of change in Helensburgh
- Seminars: - engagement – use local professionals to Q&A for the public + awareness and explain need for change
- Where is the locality emergency plan?
- How does the major incident plan work?
- Include chamber of commerce as a partner – making Helensburgh dementia friendly
- How can we build healthy communities – look after each other – getting ground level engagement
- Communications – get a column in local newspaper, improve interface between communities & service providers
- Why are there no volunteers at GP practices?
- GP practice issue that if you are talking in confidence there is no privacy, everyone hears
- Idea of a community mental health hub (enable one of the partners)
- Quiet Scotland
- If we crack having better access to support services, that are safe, will help tackle pressures on health care
- No directory for people who are struggling financially – helps to tackle loneliness and isolation
- Are leisure centres & other activities discounted for people who cannot afford full prices?
- A&B HSCP uses facebook now – could be used as an information hub – challenge is how to keep this up to date
- NHS inform is a good website, but generic, not picking up locally based information
- Provision of electric cars
- Local services (patching)
- Use of Jubilee hospital (vacant floor)
- Use of volunteers (are we looking at this area in more detail)
- Use of carers service
- Technology at home and for workers

- Lack of GPs and nursing professionals (training required-upstream)
- Incentive schemes for rural recruitment
- Acute care in specialist resources
- Broader care services in the community
- Training and Apprenticeships for Y.P.

## OTHER FEEDBACK

Mid Argyll Health & Care Forum (HCF) – Extraordinary Meeting, 7<sup>th</sup> March 2017

### We intend to:

- Develop flats to be attached to our children's houses to support young people to live independently with the right amount of support
- Where it is safe to do so, ensure all children are placed in Argyll & Bute
- Change our support to ex-care leavers to ensure they can be better supported in Argyll
- In conjunction with Education develop specialist education resources so that children are not placed out with authority
- Recruit supported lodgings, these are people who can support young people in their transition from children's houses to the community
- Continue to recruit foster carers
- 

### Public comments:

- Stability for staff/vulnerable people – consistency
- Transparency
- Equitable services Provision – Third sector
- How to achieve equitable – M R & Rural
- Equity of outcome
- Should be/is me focus
- (services are being planned regionally) – expect places
- C&E talking and listen
- Need to do better
- Calculator tool
- Remain focused
- Focus on £257m
- Structures during change (integration) Council & NHS



- Continuity of case workers – appropriate person
- GAPS, Skill mix
- LPG – AP Redesign
- Reablement
- HWB
- Falls reductions
- Q&F = start plan implementation – 6 areas of focus
- Blue badge
- Beurocracy
- Invest to disinvest
- A&B has less private sector = less competition = lost
- Income maximisation
- Language – questions are too big
- Stories, not questionnaires
- Funding – govt
- Regional services
- Travelling distances
- Costs of care
- Understand shift
- Need educated comms
- Loneliness – who is responsible?
- Bed – community
- Stage production – Barabelle as a new way of comms

**Care in the community:**

- Differential costs between villages and those in rural housing i.e Lochgair v Ellary
- One person in either might need same care but costs may be different
- Public education – use 7 pharmacies
- Local pharmacies still not using CMS
- Have input from social housing, Fyne Homes, ACHA to support assisted living
- Register of unpaid carers?
- Future learning after CPD courses
- Patient transport esp. Regards routine & rural

## Tarbert Community Council, 9<sup>th</sup> March 2017

- Access to Community Care – perception that independent sector couldn't recruit
- Attracting young people onto local caring roles
- People having to leave the area to access long terms care
- Questions about Mental Health: “when will there be a new MH hospital”
- Reference to Dialysis in Campbeltown and the fact that local people had to fund raise
- Concerns re loss of maternity scanning
- Who provides first aid training
- Locality Action Plan details requested

### LETTERS / EMAILS RECEIVED

*(names and addresses have not been included to protect the identify of individuals unless as a representative of a partner organisation)*

#### Helensburgh Community Council



25/02/17

#### **Argyll & Bute Health and Social Care Partnership (HSCP) Quality and Finance Plan 2017/18 & 2018/19**

Members of the Helensburgh Community Council have just been informed at this very late stage that the HSCP, in the form of the Integration Joint Board (IJB), proposes to cut £22m from its existing budget. The cut would be split over a two-year period with £16.3m in 2017/18, followed by £5.7m in the following year.

Are we to assume that this situation has been imposed by the Scottish Government at an executive level? According to the limited documentation on the subject the IJB will be presented with the budget plan which will outline how the cut is to be achieved on the 29<sup>th</sup> March. The cut is to be imposed on,

- Children's and Family Services
- Services in the Community
- Hospitals and Care Home Services
- Corporate or Support Services

There was no indication of this cut at the most recent meeting of the Policy and Resources Committee of Argyll & Bute Council of 16 February 2017 when the latest budget monitoring for the IJB was discussed within a full discussion on financial matters. There appears to be a disconnect between the HSCP and Argyll & Bute Council, and, in turn, this implies it has been imposed at extremely short notice and without discussion at the upper reaches of the local authority. In view of the gravity of the situation, this distinct lack of communication with health and social care staff and local communities within Argyll & Bute is most disturbing.

An extract from the Committee report is relevant.

“The Chief Financial Officer of the IJB will also keep the Council up to date on the financial position.” “Any potential deviation from the planned outturn should be reported to Argyll and Bute Integration Joint Board, the Council and NHS Highland at the earliest opportunity.”

In addition, at the same Committee meeting, the Argyll & Bute Council approved a 2017-18 allocation to the Health and Social Care Partnership of £54.223m.

There is an underlying contradiction in a situation where cuts are being imposed, yet high overhead costs are incurred due to failures in the healthcare system support. The HSCP acknowledges that;

- there are problems recruiting key medical and care staff
- a reduction in care homes due to failure to meet appropriate care standards
- inability to recruit care staff

These shortcomings have exacerbated the high costs of medical provision in the employment of locums and agency staff. They indicate a failure of medical process over time in levels of recruitment and training outwith the responsibility of the HSCP.

Without detailed knowledge of the totality of budgets, the relevant financial background and options where cuts may fall, it is difficult to see how local communities can meaningfully assist any process of budget cuts. This would imply that any consultative process is paying lip service to the principles of consultation. The invitation to attend 'Conversation Cafes' throughout Argyll & Bute would tend to bear this feeling out.

However a number of questions can be logically raised.

- This is a precise cut of £22m. On what basis was it decided upon?
- Is the cut confined to Argyll & Bute?
- Is there any detail on the options available for potential cuts?
- Are all aspects of HSCP up for consideration including management structures?
- What are the likely impacts on health and social care within Argyll & Bute?
- What is the impact on the Argyll & Bute budget?
- Who is in charge of the cost-cutting process?

There will undoubtedly be more questions raised on an issue of such importance. The Helensburgh Community Council will make every effort to ensure that there will be community representation at the Victoria Halls on the 16 March from 2-5 pm and 6-8 pm..

Norman Muir  
Convener  
Helensburgh Community Council

Received at event  
13 Mar '17

Fit For the Future- Quality and Finance Plan

Contributions from ACUMEN

david@acumennetwork.org

#### Mental Health

- More research needed into what other services have done around the world and what has worked.
- Consult with service users and carers this can go a long way to ensuring that services and aspects of services are targeted in accord with what public actually use and value.
- Hold local listening events to identify what service users and carers want and what the issues are.  
Doing this jointly with service user and carer groups will encourage good attendance and interaction resulting in good data on what matters to people.
- There are savings to be made by copying good practice from other areas good examples include:
  - 1) On one of the (I think Orkney) islands, there was funding available for one additional health care professional. It was left to the local community to decide which profession best suited their needs. The locals had meetings and interviewed various professionals, as part of an options appraisal before voting on their choice based on the best fit with their demographic, ie. young families/childcare v older adults.
  - 2) At Mid Park Hospital in Dumfries, people with frequent admissions were consulted about expected interventions for the year ahead. They were guaranteed the agreed projected admissions. In each case the projected number of admissions and lengths of stay were shorter and less frequent than in past years. This was viewed as being due to giving patients some control in their care planning and resulted in considerable savings.
  - 3) Ensuring the viability of support groups can impact on hospital admissions. These groups function as an informal early warning system and can support someone in distress to obtain early intervention in a crisis which can circumvent the need for an admission that a delay would have caused. There is very real need for advice and early intervention in mental health as part of an integrated system.
  - 4) Mental Health link workers attached to GP Practices can provide additional support often as an alternative to hospital admission and fully utilise local support from community organisations.
  - 5) Information and signposting is very useful in reducing dependency, eg. "Triangle of Care", "15 Steps" and similar initiatives which inform and empower service users and carers.

- Collecting data from the local area to find out exactly what they need from the service, save money wasting into pointless endeavours which will remain unused, instead spending on vital services that target needs.
- Research local groups/charities that may be able to do research on your behalf.
- Incorporating online resources for widespread information on events or gathering views/opinions from locals.
- Research travel and how this affects service users, what can be done to limit the effects: telecare, telehealth, social prescribing?
- Put in place long term goals/aims within the service and continue to assess the progress made. Publish updates while inviting further contributions and public involvement.

David Wright






ACUMEN



*Informing, Engaging and Consulting People in  
Developing Health and Community Care Services  
(CEL4 (2010))*



## Flowchart

<p><b>Planning</b></p> 	<p><b>Identifying need for change</b></p> <ul style="list-style-type: none"> <li>Initial contact with the Scottish Health Council for preliminary discussion on approach</li> <li>Develop a background paper detailing the rationale for change</li> <li>Identify stakeholders and establish a project group to oversee process</li> <li>Equality Impact Assessment (EQIA)/ Health Inequality Impact Assessment (HIIA) of <a href="#">process</a></li> <li>Develop an Involvement and Communication Plan including evaluation of activity</li> <li>Consider work with Local Authorities and other NHS Boards who may be affected by change</li> <li>Consider initial discussion with Scottish Government if appropriate</li> </ul>
<p><b>Informing</b></p> 	<p><b>Inform potentially affected people of the planned timetable for engagement, reasons for change and share any other background information</b></p> <ul style="list-style-type: none"> <li>Carry out communication and engagement activities that can be used to inform the engagement work and development of options and benefits that are expected to flow from proposed change</li> <li>Consider evaluation of engagement</li> </ul>
<p><b>Engaging</b></p> 	<p><b>Development of model(s) with key stakeholders and Option Appraisal process</b></p> <ul style="list-style-type: none"> <li>Develop options with key stakeholders including patients and carers (this can be assisted by Scottish Health Council guidance on <a href="#">Involving Patients, Carers and the Public in Option Appraisal</a>)</li> <li>An option development process should be used to seek consensus, even when there are limited number of options in line with requirements of paragraph 29 of <a href="#">CEL 4 (2010) guidance</a></li> <li>Agree criteria and weightings, option appraisal and scoring process, sensitivity analysis</li> <li>Agree preferred option(s) for consultation and feedback to those involved</li> <li>EQIA / HIIA assessment on preferred <b>option(s)</b></li> <li>Complete Scottish Health Council major service change template for proposal</li> <li>Seek Scottish Health Council view</li> <li>Seek Scottish Government view</li> </ul> <p><b>If considered Major Service Change:</b></p> <p><b>NHS Boards should not move to consultation until confirmation received from the Scottish Health Council that public involvement has been in accordance with guidance</b></p> <ul style="list-style-type: none"> <li>Follow guidance for independent scrutiny <a href="#">if relevant</a></li> </ul>
<p><b>Consulting</b></p> 	<p><b>A proportionate approach may include a form of consultation for proposals not considered to be major. Seek support and advice from Scottish Health Council on methods and process.</b></p> <p><b>If considered Major Service Change</b></p> <ul style="list-style-type: none"> <li>Plan for minimum 3 month consultation period, timescales for analysis of results and reporting to relevant Board meetings</li> <li>A consultation paper needs to be produced which incorporates requirements of paragraph 33 of <a href="#">CEL 4 (2010) guidance</a></li> <li>Agree how information will be shared for the Scottish Health Council to quality assure the process</li> </ul>
<p><b>Feedback and decision making</b></p> 	<p><b>Provide feedback to stakeholders and interested parties on outcome</b></p> <ul style="list-style-type: none"> <li>Explain results of the consultation process, final proposals and next steps</li> <li>Evidence how views were taken into account in developing final proposals</li> <li>Provide reasons for not accepting any widely expressed views</li> <li>Outline plans for implementation and further opportunities for engagement</li> <li>Evaluation of engagement, and consider undertaking an <a href="#">after action review</a> organised by the Scottish Health Council</li> <li>For major service change, seek ministerial approval (you will need quality assurance report from Scottish Health Council)</li> <li>After Action Review organised by the Scottish Health Council</li> </ul>

Throughout the process contact should be maintained with the Scottish Health Council for advice on good practice and proportionate approach. For more information please visit: [www.scottishhealthcouncil.org/servicechange.aspx](http://www.scottishhealthcouncil.org/servicechange.aspx)







# Argyll & Bute Health & Social Care Partnership

**Integration Joint Board**

**Agenda item: 5.3**

**Date of Meeting: 29 March 2017**

**Title of Report: Auchinlee Care Home Update**

**Presented by: Lorraine Paterson, Head of Service West**

## **The Integration Joint Board is asked to :**

1. Note the update on expected closure of the Auchinlee Care home.
2. Consider the outcome of the work to extend the operation of the home for a further 12 months maximum until alternative services are in place.
3. Consider the implications regarding service risk, user impact and financial implications and the potential mitigations and thresholds.
4. Note the estimated cost pressure of £291k to support CrossReach with operating costs and consider the approach to identifying funding to support this.
5. Note the continued intention to develop a future model of care for Elderly dementia care for the West of Argyll.
6. Agree the partnership arrangements to implement the transition process.
7. Agree the funding mechanism to progress the transition process.

## **1. EXECUTIVE SUMMARY**

1.1 The IJB decided in January to not support the proposal to maintain Auchinlee care home for a further 3 months, until the end of March 2017. This decision was informed by:

- No realistic plan to provide an alternative service beyond this point should CrossReach serve notice.
- The workforce and subsequent user safety risks remained unchanged with no improvement in recruitment etc.
- The financial implications for the HSCP were considered to be of an order which would impact on other core services and the HSCP ability to deliver a balanced budget in 2017-18.

1.2 This decision resulted in significant local and national political pressure to identify a meaningful and realistic alternative and at the request of the Leader of Argyll and Bute Council and MSP Mr Mike Russell a meeting

involving all parties was arranged. The members of the meeting included the political leadership of the Council and the Chief Executive of the Council, the Convenor and senior members of CrossReach, representatives of Save Auchinlee campaign, local Councillors, Scottish Government Representatives and Senior Managers of the HSCP and the Chair of the IJB on the 16<sup>th</sup> February.

- 1.3 Agreement was reached at the meeting that the current care model was not safe or sustainable in the short term. It was also agreed in principle that none of the existing residents subject to their individual needs and client choice should have their placements outside Kintyre.
- 1.4 It was also agreed a transitional period was required to develop a local alternative for the existing residents and it was agreed that this should be complete and in place by the 31<sup>st</sup> March 2018. This would also be used to support the development of the future care model for the West of Argyll
- 1.5 A number of specific actions were agreed to attempt to achieve this outcome, the findings of which were to be taken to the respective Board meetings of CrossReach and the HSCP at the end of March.
  - Open book assessment by the HSCP and CrossReach of:
    - The staffing requirements and future carer employment opportunities through and after the transition period in Kintyre
    - Robust modelling of the financial costs to achieve the aim of minimising the scale of the financial risk to both organisations
    - A clear understanding of how a partnership agreement could be reached and the tolerance for each over the potential risk, mitigations and thresholds
  - Joint meeting with representatives of the Save Auchinlee Group, local councillors and the HSCP and CrossReach (8 March 2017) to clarify the proposal and work towards agreeing the way forward within the principle agreed.

2. The outcome of these discussions has identified the following proposal:

### 2.1 **Service Transitional Model**

It was agreed that the local team could progress to have discussions with residents, their families and carers and undertake a full up to date assessment of need with each of the residents. Where residents and their families would like to relocate to an alternative care home, this would be progressed and facilitated.

The local team will continue to work with Cairn Housing, the Care Inspectorate, and Scottish Care to develop a Progressive Care model within Lorn Campbell Court.

It was acknowledged that this will take a period of approximately 6 months to complete.

Only residents whose care needs can be met within this environment would be considered for relocation and this would be done with careful transition processes utilising staff known to the residents where possible.

On completion of the up to date assessment, any resident whose care needs can only be provided in a residential care home environment would be prioritised for any vacancies arising in Kintyre Care Home when available.

Two priorities were agreed which are firstly that residents are not moved out of area, unless it is their wish to do so, and secondly that we do all we can to protect the jobs and staff in the area, acknowledging that there are difficulties in recruiting care staff in Kintyre.

## **2.2 Financial Assessment**

It has been highlighted previously that CrossReach have been incurring significant losses in the last 3 years in operating Auchinlee and the CrossReach Council have assessed that these losses can no longer be sustained. Previous proposals that have been considered by the Integration Joint Board have all contained a request for additional financial support to enable the service to continue.

The proposal now being put to the IJB is around supporting CrossReach to wind down the service by the end of March 2018. An open book approach to the financial information around running costs and assumptions has been adopted between HSCP officers and Crossreach, this has been very successful in facilitating an understanding of the financial position, the costs and risks associated with continuing the service.

There were principles around what a partnership model might look like, and these have been carried into the financial assumptions, including:

- Estimation that a maximum 15 month period would be required to allow the service to close with an end date no later than 31 March 2018.
- Assumption that financial support from the IJB would be from the period January 2017 to March 2018, given the previous request for support during the January to March 2017 period.
- An assumption that the HSCP will continue to invest the current level of resource in Auchinlee over this 15 month period and not reduce resources as client numbers reduce.
- CrossReach contribution to costs over the same period would be £133k, which is £100k from a charitable source and £33k towards unavoidable maintenance, with an additional 50/50 contribution to the financial losses from January to March 2017.

- Open book approach to costs and assumptions would be adopted to allow costs and estimates to be challenged and agreement to be reached.
- Assistance with staff in kind from the HSCP, where available, to mitigate the impact of the recruitment difficulties.

Following on from this and further discussions with CrossReach agreement has been reached that financially CrossReach will plan to contribute a total of £194k across the 15 month period, this consists of £100k charitable contribution, £33k contribution to maintenance and an estimated additional £61k in recognition of the previous commitment to share financial losses from January to March 2017.

The estimated financial costs to operate Auchinlee for the 15 month period together with the expected income from January 2017 to March 2018 are summarised in the table below:

	£000's
Staffing Costs	739
Premises Costs	142
Transport Costs	11
Supplies and Services Costs	60
Central Support Costs	78
<b>Total Estimated Expenditure</b>	<b>1,030</b>
<b>Income:</b>	
Estimated Client Income	(166)
Previously Agreed Crossreach Contribution	(133)
Additional Crossreach Contribution Jan to March 2017	(61)
<b>Net Cost to be Funded by HSCP</b>	<b>670</b>
Existing Cost to HSCP	(379)
<b>Additional Estimated HSCP funding requirement</b>	<b>291</b>

Agreement has been reached that financial losses from January to March 2017 would be shared 50/50 between CrossReach and the HSCP and the contributions for that period would be finalised in April 2017.

There are a number of financial assumptions and estimations around the costs over the 15 month period. In the main, cost reductions across the period are forecast in line with the projected number of clients which is assumed to reduce over the period. Any deviations from these estimates will either increase or decrease the costs and there is a significant risk of the costs not being in line with the estimates. The IJB need to be aware of the risks in relation to costs, given the assumption that any deficit over and above the CrossReach fixed contribution will require to be funded by the HSCP. The open book approach has allowed HSCP officers to work with CrossReach to come to agreement over these assumptions in terms of being a sound and reasonable basis and officers are satisfied that the costs represent a true and fair view of the expected position.

Financial losses for Auchinlee are expected to decrease through the transition period, with estimated quarterly losses for the financial year 2017-18 being Q1 £82k, Q2 £88k, Q3 £23k and Q4 £36k. One important assumption in the financial model is that the client numbers will reduce to a level by September 2017 that will allow the staffing structure to be reviewed and reduced, if this does not happen costs will be significantly impacted.

There are significant risks around the financial assumptions and a number of variables which could impact on these costs, the specific risks that the IJB need to note are:

- The kitchen at Auchinlee may need replaced as this has been subject to an inspection, this would cost an estimated £70k. A mitigation for this risk would be exploring using HSCP facilities to provide meals if this risk materialises.
- The level of income from residents could reduce due to changes in financial circumstances or due to a greater reduction in the number of residents.
- There is a risk that the number of residents does not reduce in line with expectations and therefore costs cannot be reduced, for example if the reduction in client numbers by September is not achieved the deficit will increase by £10k per month for the remaining period.
- There is provision in the budget for agency staff and reliance on agency staff has been reducing, however in the event that any staff withdraw from the service there remains a significant risk of an increase in staff costs from an increased reliance on agency staff. This risk could be mitigated by the HSCP exploring ways to support CrossReach with staff resources.
- The financial costs do not take into account that some clients may move to other homes, which will essentially double the amount of funding required for the client if the funding provided to Crossreach is fixed and doesn't follow the client. The risk of this would be an additional cost of £27k per annum for each client.

There are significant financial risks and with the proposed CrossReach financial contribution being fixed, apart from the 50/50 deficit sharing January to March 2017, the majority of the financial risk would rest with the IJB. If the IJB approve a partnership agreement a process would be put into place to ensure that the open book approach continues with CrossReach partners and that the financial position is closely monitored on a regular basis. This will allow the Board to be informed at an early stage where the actual costs are off track from the estimated position. A tolerance in terms of cost variation is suggested to be 10% and any deviation from this position will be reported back to the IJB together with reasons for any deviation. This will allow the IJB to take an informed decision as to whether the transitional support arrangements should continue if costs increase to an unacceptable level.

The additional financial cost to the HSCP across the 15 month period is estimated to be £291k, this represents the additional cost requirement in addition to the current commitment of £379k for the current client base. There has been an assumption that this contribution of £379k (£308k annual contribution) will remain in place, ordinarily if client numbers reduced this resource would be released for other services/demand within the HSCP. This results in an effective additional funding requirement/cost to the HSCP, however this also maintains a level of funding which can be transferred to fund the alternative care model on the closure of Auchinlee. The IJB are currently developing the Quality and Finance Plan for 2017-18 and 2018-19 and we are not at the stage of having savings that meet our expected target savings of £20m across the 2 years. The IJB are not permitted to approve a budget which would result in a deficit position, therefore any decision to support the additional cost pressure would require consideration of how this is to be funded.

This could be funded in one of two ways:

- Approach Argyll and Bute Council for additional one-off non-recurring funding of £291k to facilitate the longer transition period for closure
- Add the £291k to the Quality and Finance Plan for 2017-18, which will in turn require further savings to be identified from other service areas

### **2.3 Stakeholder support:**

There is unanimous agreement from all stakeholders that the principle that we are working to is that any current residents of Auchinlee should remain in Kintyre, where their needs and relatives wish that to happen. A further principle is that future service provision should remain in Kintyre, to ensure security of employment for this staff group. It was also agreed and accepted that Auchinlee itself will close at some point during the next 12 months; work is commencing now to ensure future local provision. A transition period of up to one year to the 31 March 2018 was also agreed.

At the meeting on 8 March there was agreement to take back to respective Boards a recommendation that Auchinlee continues to be funded, for up to 1 year whilst local arrangements are put in place.

### **2.4 Assessment and Recommendation:**

The commitment of all organisations and stakeholders to the principle to retain local provision of dementia care.

### **2.5 Proposed HSCP and CrossReach Partnership Agreement:**

- That CrossReach continue to provide their care home service if needed until the 31 March 2018.
- That the CrossReach contribution to financial losses will be fixed at £133k for the period from 1 April 2017 to 31 March 2018 plus a 50% share of financial losses from January to March 2017, in total

estimated to be a total contribution of £194k. The remaining deficit will be funded by the HSCP.

- An open book approach will continue to be adopted to information sharing around financial costs and pressures and the financial position will be reported on a regular basis to both Boards.
- CrossReach and the HSCP will work together to mitigate any emerging financial pressures and risks, for example with the HSCP providing replacement staff resources to avoid additional agency staff costs.
- CrossReach will inform the HSCP if triggers/thresholds are met in terms of the continuation of safe care in Auchinlee, for example if there are recruitment issues and an over-reliance on agency staff.

2.6 The Strategic Management Team (SMT) has participated fully together with operational management and stakeholders and representatives of the Save the Auchinlee Group and local elected members in developing this proposal. It believes this proposal:

- Prevents the transfer of clients outwith Kintyre
- Maintains a local, safe service up to 31 March 2018
- Gives additional time to plan and implement a replacement service in Kintyre
- Provides an approach of risk sharing between partners.

2.7 The HSCP are confident that if this proposal is approved CrossReach will not serve formal 13 week notice of closure. However, if agreement is not reached CrossReach will serve notice and the HSCP will have to put in place alternative care arrangements for residents both in Kintyre and outside Kintyre in other units.

### **3. OVERALL ASSESSMENT**

3.1 The HSCP implications of the proposals are:

- Service risk and impact on residents:

If the IJB cannot support the partnership agreement between the HSCP and Crossreach, the majority of residents would require to be relocated to other care homes out with Kintyre. The detrimental effect this would have on residents is widely publicised.

- Financial risk to HSCP:

The majority of the financial risk will sit with the HSCP, with CrossReach sharing financial losses January to March 2017 and contributing a fixed amount thereafter. This position would be closely monitored for deviations from the forecasts and any actions that can be taken operationally to deliver the service without incurring additional costs would be explored.

- CrossReach commitment:

CrossReach and the HSCP have made every effort to find an improved solution to this situation, resulting in CrossReach increasing their financial commitment, and a commitment to continue to be the service provider up to 31 March 2018. The HSCP have agreed to provide staff “in kind” where this is possible, and to consider transfer of employment from CrossReach to the HSCP to prevent staff losses.

- Transition Service Model:

The extra care model under development for Lorne Campbell Court is based on tried and tested progressive care developments evidenced to meet the needs of older people both within Argyll and Bute and elsewhere across the country.

An extra care model provides accessible housing and, for this proposed development, on-site 24/7 care at home workers who will provide care and support tailored to meet the needs of any resident of Auchinlee whose needs could be met by this type of service.

At this stage it is anticipated that the service will have three staff daytime and two overnight to meet the needs of 6 or 7 residents.

The extra care development will be managed through the HCSP internal homecare service, and from the outset will have the same capacity we now have within Kintyre’s Community team to pull on other community resources such as the responder service, Community nursing, healthcare assistants. This means the development will have the potential to increase care at home support if an individual requires this.

This service will require to be developed regardless of the decision to provide additional support for Auchinlee, therefore financial provision for the service costs have been included as a cost pressure in the integrated budget for 2017-18 and 2018-19.

#### **4. CONTRIBUTION TO STRATEGIC PRIORITIES**

- 4.1 Argyll and Bute HSCP strategic plan provides a clear road map on the expectations for health and care provision for the communities of Argyll and Bute. The strategic plan also acknowledges that safety and sustainability are key challenges and drivers for the transformational change in Health and Social care that is required.



***Extract from HSCP Strategic Plan:***

- provide seamless, joined up, high quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so;
  - At the heart of this approach to strategic planning will be the provision of services and support across the sectors in a way that meets the needs of particular individuals, communities and localities.
- 4.2 The Strategic direction for care of older people, including those with dementia is within community models of care across a transition pathway. Assessment of investment priorities need to be within this context with person centred care and safety for patient and residents paramount.
- 4.3 The revised proposal which supports the implementation of a progressive care model in Lorn Campbell Court and use of the Kintyre Community Care home and the planned enhancement of community services aligns with the strategic direction of the HSCP.

## **5. GOVERNANCE IMPLICATIONS**

### **5.1 Financial Impact**

There is an estimated additional cost pressure of £291k for the 15 month period. The IJB do not have uncommitted budget available to fund this additional cost and if approved the IJB will require to take a decision on the approach to funding this. This would either be to approach Argyll and Bute Council to request additional funding or to add this amount to the Quality and Financial Plan for 2017-18 and inevitably increase the requirement to deliver savings from other service areas.

The financial model also assumes that the current level of committed resource for the current client base at Auchinlee would remain for the duration of the agreement. This represents an effective additional cost in terms of the lost opportunity to release funding as clients leave to fund either replacement care for those clients or to fund other services.

The additional cost is based on a number of assumptions around operating costs, with assumptions around client numbers and staffing requirements. Deviations from these planning assumptions could have a significant financial impact. The position would require to be closely monitored to ensure the IJB are informed of the financial consequences on an ongoing basis during the transitional support period. Any deviation of 10% or more from the estimated position would be brought to the IJB at the earliest opportunity to allow further decision making where necessary.

## **5.2 Staff Governance**

If a decision is reached to enter into this partnership agreement with CrossReach until the 31 March 2018, CrossReach staff and HSCP staff will work together to find staffing solutions as we continue an existing care home service and develop a new progressive care model.

There is also consideration that HSCP senior staff would offer management support to Auchinlee. Therefore staff may be required to undertake a change in their duties for the duration of the service transition.

Further consideration will be given to determine the feasibility of CrossReach staff being transferred to the new model under TUPE to reduce the risk of staff resignations during transition and continued availability of care staff in the area.

## **5.3 Clinical and Care Governance**

Potential care governance issues as Care Inspectorate ratings for Auchinlee have recently been low. However, CrossReach have undertaken a significant amount of work with staff to improve standards and the most recent feedback from the Care Inspectorate is that they are satisfied with the progress made. A review by the Care Inspectorate in October resulted in an increase from 2 to 3 for all criteria.

Risk mitigation measures would need to be in place during transition to ensure ratings do not drop below this standard.

## **6. EQUALITY & DIVERSITY IMPLICATIONS**

- 6.1 Significant equality implications if the current situation leads to closure and loss of this service. The loss of 55% of the local dementia specialist care home places will disadvantage the local community and lead to a high number of out of area placements with significant distance and travelling time. The impact on the individual clients as a result of reduced or potentially complete loss of contact with friends and family would be significant and have further negative health implications.
- 6.2 There may also be a wider social and economic impact adding further to the depopulation and economic viability of area/region.
- 6.3 If a decision was made to re-house the residents an EQIA would require to be undertaken to support mitigation of impact of resident, cares and families.

## **7. RISK ASSESSMENT**

- 7.1 A number of critical risks have been identified and an operational/implementation project and risk register developed. This will

be updated regularly by the Project Group/Locality Management tasked to progress the option agreed.

## **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT**

- 8.1 The issue remains highly sensitive, meetings and agreed statements have been issued by all stakeholders to the residents and staff. A commitment was made to hold further staff meetings on the 31 March 2017 to brief staff and relatives on the decision of the IJB and CrossReach Boards and a media briefing will also be issued.

## **9. CONCLUSION**

- 9.1 The SMT acknowledge and appreciate the intent of CrossReach to co-operate and seek to find a mutually satisfactory solution to secure the immediate future of the service particularly for the current residents.
- 9.2 The SMT has had as its main aim to do everything it can to retain local provision for Auchinlee residents, taking into account safety and sustainability of the service, for not only the health and well-being of Auchinlee existing residents, but also any future elderly dementia residents.
- 9.3 The transitional arrangement developed with CrossReach mitigates some of the risk exposure the HSCP would face regarding safety, sustainability, finance, clinical/care and staff governance. The greatest risk remains the financial exposure, and the operating staff governance process.
- 9.4 The additional financial cost of £291k is not currently included within the delegated budget for social care services. This cost could be funded in one of two ways, firstly to approach Argyll and Bute Council for additional one-off resource and secondly if this is not agreed to add the additional cost pressure to the IJB Quality and Finance Plan for 2017-18, which will in turn require additional savings to be identified. Pending a decision by the IJB on whether to agree the additional support to maintain the service the cost pressure is not currently included in the integrated budget plans for 2017-18, these would require to be updated to include this cost pressure if approved.
- 9.5 The care governance and staff governance risk is being further assessed and an appropriate operational steering group is established and an action plan with risk register is in development.

## **10. RECOMMENDATIONS**

- 10.1 The SMT believe there is now a sustainable and viable way forward for provision of a local alternative for the current residents of Auchinlee which

has public, stakeholder, political support and commitment to progress. The SMT therefore recommends :

- The IJB proceeds with the partnership arrangement agreed to implement the transition process.
- The financial consequences require further discussion with Argyll and Bute Council as part of the IJB's ongoing discussion regarding the delegated budget and cost and demand pressures within Social Care, against a context of the Council's stated commitment towards a transitional model in Kintyre. If the Council do not approve the additional financial support add the cost pressure of £291k to the IJB Quality and Finance Plan for 2017-18.



# Argyll & Bute Health & Social Care Partnership

**Integrated Joint Board**

**Agenda item : 5.4**

**Date of Meeting: 29 March 2017**

**Title of Report: Performance Report National Health & Well Being Outcome Indicators**

**Presented by: Stephen Whiston, Head of Strategic Planning & Performance**

## **The Integration Joint Board is asked to:**

- Note the HSCP performance against National Health and Well Being Outcomes 5, 6, 7 and 8 for Quarter 3
- Note the actions identified to address deficiencies in performance as detailed in the exception reports
- Note the new performance indicators prescribed for the HSCP across 6 domains for performance monitoring in 2017/18

## **1 Background**

The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. These suites of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, 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.

## **2 HSCP Performance against the NHWB outcomes for Financial Quarter 3 16/17**

Figure 1 below provides a summary of the performance on the pyramid reporting system, noting the 101 scorecard success measures and of these 70 are currently reported as being on track for FQ3.

Integrated Joint Board [IJB] Scorecard		Success Measures	101
		On track	70
Outcome 1 - People are able to improve their health	FQ3 16/17	No of indicators	14 <b>A</b>
		On track	7 ➡
Outcome 2 - People are able to live in the community	FQ3 16/17	No of indicators	18 <b>A</b>
		On track	13 ➡
Outcome 3 - People have positive service-user experiences	FQ3 16/17	No of indicators	11 <b>A</b>
		On track	10 ➡
Outcome 4 - Services are centered on quality of life	FQ3 16/17	No of indicators	15 <b>A</b>
		On track	10 ➡
Outcome 5 - Services reduce health inequalities	FQ3 16/17	No of indicators	5 <b>C</b>
		On track	5 ⬆
Outcome 6 - Unpaid carers are supported	FQ3 16/17	No of indicators	1 <b>C</b>
		On track	1 ➡
Outcome 7 - Service users are safe from harm	FQ3 16/17	No of indicators	12 <b>A</b>
		On track	9 ➡
Outcome 8 - Health and social care workers are supported	FQ3 16/17	No of indicators	4 <b>R</b>
		On track	0 ➡
Outcome 9 - Resources are used effectively in the provision of health and social care services, with	FQ3 16/17	No of indicators	12 <b>A</b>
		On track	9 ➡
Customer Services	FQ3 16/17	No of indicators	9
		On track	6

The IJB has requested that it has visibility of all indicators which are off track and a summary schematic on page 5 of the exceptions report details this.

### 3 Detailed Performance Report Outcome Indicators 5, 6, 7 and 8

**Outcome 5** - Health and social care services contribute to reducing health inequalities.

There are 5 indicators being measured against this outcome, all are reported as on track.

**Outcome 6** - People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.

There is one indicator being measured against this outcome, this is reported as on track.

**Outcome 7** – Service users are safe from harm

There are 12 indicators being measured against this outcome, 9 are on track, 3 are off track and red flagged as follows:

- Falls rate per 1,000 population aged 65+-
- % of Children on Child Protection Register with a completed CP Plan
- % of Child protection investigations with IRTD (Initial Referral Tripartite Discussion) within 24 hours

**Outcome 8** – Health and Social care workers are supported

There are 4 indicators being measured against this outcome, all 4 are off track and red flagged.

The report attached provides the detail of the indicators and the exception report for those indicators red flagged which are listed below:

- Social Work staff attendance
- % of NHS Sickness and absence attendance
- % of HSCP staff completed Performance review
- % of HSCP staff completed Knowledge skills framework review

The exception report attached provides the detail of the performance against each of the indicators and the action in hand to rectify performance.

## **4 Integration Authorities Performance Indicators 2017/18**

The Ministerial Strategic Group for Health and Community Care (MSG) has agreed that for 2017/18 it will direct Integration Authorities to monitor progress across the following domains:

- Reduce unplanned (Emergency) admissions – by increasing anticipatory care activity in the community and in primary care
- 10% reduction in occupied bed days for unscheduled care (emergency);
- A&E performance;- meet the 4 hour target and reduce unnecessary attendance
- Delayed discharges – reduce the amount of time (occupied bed days) patients are delayed in hospital
- End of life care – increase the provision of patient end of life care in the community
- The balance of spend across institutional and community services by 2021 have the majority of the health budget being spent in the community

The Health and Social Care Delivery Plan (<http://www.gov.scot/Resource/0051/00511950.pdf>) sets a clear objective of reducing the use of hospital based unscheduled care by around 10% over the next financial year including making further progress on delayed discharge. This objective moves the focus from being purely about discharge to being about the whole pathway of care and the use of anticipatory planning and action to prevent admission in the first place.

Each HSCP has therefore been asked set out its local objectives and targets for each of the indicators for 2017/18 by the 24<sup>th</sup> of February. The HSCP has only received a breakdown of information against these domains in early February and has flagged that this requires further validation, analysis and consideration. This includes presenting this activity information at locality level within Argyll and Bute reflecting activity in NHS Greater Glasgow and Clyde hospitals as well as Argyll and Bute hospitals, to ensure it is meaningful for clinicians and locality planning groups.

The MSG is expecting to that it will receive a quarterly overview on progress across the whole Health and Social Care system and the HSCP are expected to produce objectives and activity targets on that basis.

## **5 Governance Implications**

### **5.1 Contribution to IJB Objectives**

The PPMF is in line with the IJB objectives as detailed in its strategic plan.

### **5.2 Financial**

There are a number of NHWBO indicators which support the quality and financial performance of the HSCP including productivity, value for money and efficiency.

### **5.3 Staff Governance**

A number of indicators under outcome 8 are pertinent for staff governance purposes

### **5.4 Planning for Fairness:**

The NHWBO indicators help provide an indication on progress in addressing health inequalities.

## **5.5 Risk**

Ensuring timely and accurate performance information is essential to mitigate any risk to the IJB governance, performance management and accountability.

## **5.6 Clinical and Care Governance**

A number of the NHWBO indicators support the assurance of health and care governance and should be considered alongside that report

## **5.7 Public Engagement and Communication**

A number of the NHWBO indicators support user and patient experience/assessment of the HSCP services and planning processes.





# Argyll & Bute Health and Social Care Partnership

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Performance Exception Report for Integrated Joint Board  
Outcomes 5, 6, 7 & 8 - March 2017

**Performance & Improvement Team**

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

## Exception Reporting & Briefing Frequency

The Integrated Joint Board will receive this performance and exception report on a 6 weekly basis, this will be taken from a live snapshot of the current overall HSCP performance; focussing on those measures showing as below target performance. The layout of the report is designed to give IJB members a quick easy-read overview of exception across the IJB Scorecard, the format of the report uses the key aspects of the Pyramid Performance Management System in order to ensure continuity and consistency. Trend indicators are included within the report to ensure that performance variance and movement is reflected against the most recent reporting episodes.

This exception report format will be used to communicate performance across the HSCP and key stakeholders including its host bodies. The table below notes the groups and briefing frequency:

Group	Briefing Frequency
Local Authority –PR Committee	Quarterly
NHS Board	Quarterly
Community Planning Partnership *	Quarterly
Area- Community Planning Partnerships*	Quarterly

All indicators under Outcome 5 & 6 are reported to be **on track** for Q3 16/17, and have therefore only been included within the exceptions report for visibility and scrutiny by IJB.

*Outcome 5 - Health and social care services contribute to reducing health inequalities.*

*Outcome 6 - People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.*

Outcome / Performance Indicator		Target	Actual	Trend	Period	Responsible Manager
5	Rate of emergency admissions per 100,000 population for adults	12,492	12,225	→	FQ3	Lorraine Paterson
5	Rate of premature mortality per 100,000 population	441	392	→	FQ3	Lorraine Paterson
5	AC21 <=3 weeks wait between Substance Misuse referral & 1st treatment	90%	92.6%	→	FQ3	Allen Stevenson
5	No of treatment time guarantee completed waits >12 wks	0	0	↑	FQ3	Lorraine Paterson
5	No of treatment time guarantee ongoing waits >12 wks	0	0	→	FQ3	Lorraine Paterson
Outcome / Performance Indicator		Target	Actual	Trend	Period	Responsible Manager
6	% of carers who feel supported to continue in their caring role	41	41	→	FQ3	Lorraine Paterson

The following indicators under Outcome 7 & 8 are reported as off track for Q3 16/17 and are included with associated exceptions report for visibility and scrutiny by IJB.

*Outcome 7 – Service users are safe from harm*

*Outcome 8 – Health and Social care workers are supported*

Outcome / Performance Indicator		Target	Actual	Trend	Period	Responsible Manager
7	Falls rate per 1,000 population aged 65+	21	22	→	FQ3	Lorraine Paterson
7	CP16 - % of children on CPR with a completed CP plan	100%	84%	↓	FQ3	Louise Long
7	CP17 - % of CP investigations with IRTD (Initial Referral Tripartite Discussions - a multi-agency meeting) within 24 hours	95%	86%	↓	FQ3	Louise Long
Outcome / Performance Indicator		Target	Actual	Trend	Period	Responsible Manager
8	Social Work staff attendance	3.8 days	4.1 days	→	FQ3	Allen Stevenson
8	% of NHS sickness absence	4%	4.79%	→	FQ3	Lorraine Paterson
8	HSCP (SW) % of PRDs completed	90%	59%	→	FQ3	Louise Long
8	% of NHS staff with a completed & recorded KSF/PDP review	20%	12.55%	↓	FQ3	Lorraine Paterson

### FQ3 16/17 Other NHWBO indicators currently off track presented for IJB reference

Outcome/Performance Indicator	Target	Actual	RAG	Trend	In charge
<b>Outcome 1</b>					
AC1 - % of Older People receiving Care in the Community	80%	75 %	●	↓	Allen Stevenson
AC15 - No waiting more than 12 weeks for homecare service - assessment authorised	6	23	●	↓	Allen Stevenson
No of alcohol brief interventions in line with SIGN 74 guidelines	765	651	●	↑	Lorraine Paterson
No of ongoing waits >4 wks for the 8 key diagnostic tests	0	49	●	↓	Lorraine Paterson
NHS-H7 - Proportion of new-born children breastfed - STANDARD	33.30%	30.0 %	●	⇒	Louise Long
% >18 type 1 Diabetics with an insulin pump	12%	6 %	●	↓	Lorraine Paterson
<b>Outcome 2</b>					
AC5 - Total No of Delayed Discharge Clients from A&B	12	14	●	↑	Allen Stevenson
CPC01.4.4 - % Waiting time from a patient's referral to treatment from CAMHS	90%	71 %	●	⇒	Louise Long
% of patients who wait no longer than 18 wks for Psychological therapies	90	63	●	↓	Lorraine Paterson
Falls rate per 1,000 population aged 65+	21	22	●	⇒	Lorraine Paterson
<b>Outcome 3</b>					
No of patients with early diagnosis & management of dementia	809	809	●	↓	Lorraine Paterson
<b>Outcome 4</b>					
No of outpatient ongoing waits >12 wks	0	91	●	↓	Lorraine Paterson
% of patients on the admissions waiting lists with social unavailability	15.70%	22.2 %	●	↑	Lorraine Paterson
<b>Outcome 9</b>					
CJ65 - Average hrs per wk taken to complete CPO Unpaid Work/CS Orders	7.5 Hrs	4.9 Hours	●	↓	Louise Long
% of SMR1 returns received	95%	88.3 %	●	⇒	Allen Stevenson
<b>Customer Services</b>					
% of NHS simple complaints - achievement against 20 days	80%	60 %	●	↑	Liz Higgins
AC - Resolve your queries the first time you contact us	90%	88%	●	↓	Allen Stevenson

Outcome 7 – Service users are safe from harm

Outcome 7 - Service users are safe from harm FQ3 16/17	No of indicators	12	<b>A</b>
	On track	9	➔

Summary of all outcomes

% of adults supported at home who agree they felt safe	Actual	84.0 %	<b>G</b>
	Target	84.0 %	➔
	Benchmark	84.0 %	
Emergency Admissions bed day rate	Actual	105,984	<b>G</b>
	Target	124,517	➔
	Benchmark	124,517	
Rate of emergency admissions per 100,000 population for adults	Actual	12,250	<b>G</b>
	Target	12,492	➔
	Benchmark	12,492	
Readmission to hospital within 28 days per 1,000 admissions	Actual	71	<b>G</b>
	Target	95	➔
	Benchmark	95	
Falls rate per 1,000 population aged 65+	Actual	22	<b>R</b>
	Target	21	➔
	Benchmark	21	
% of SW care services graded 'good' '4' or better in Care Inspectorate inspections	Actual	86 %	<b>G</b>
	Target	83 %	➔
	Benchmark		
% of health & care resource spend on hospital stays, patient admitted in an emergency	Actual	22.0 %	<b>G</b>
	Target	23.0 %	➔
	Benchmark	23.0 %	
AC17 - % of AC users reporting they feel safe at assessment	Actual	80 %	<b>G</b>
	Target	70 %	➔
	Benchmark		
CP7 - % of Children on CPR with a current Risk Assessment	Actual	100 %	<b>G</b>
	Target	100 %	➔
	Benchmark	100 %	
CP15 - % of Children on CPR with no Change of Social Worker	Actual	85 %	<b>G</b>
	Target	80 %	⬆
	Benchmark	80 %	
CP16 - % of Children on CPR with a completed CP plan	Actual	84 %	<b>R</b>
	Target	100 %	⬇
	Benchmark	100 %	
CP17 - % of CP investigations with IRTD within 24 hours	Actual	86 %	<b>R</b>
	Target	95 %	⬇
	Benchmark	95 %	

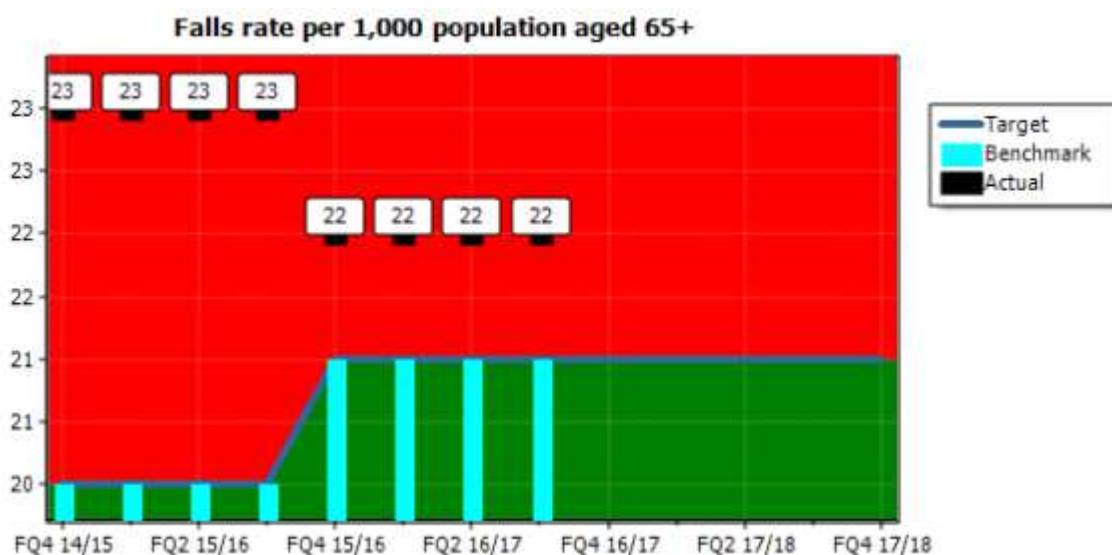
There are 12 indicators being measured against this outcome, 9 are on track, 3 are off track and red flagged.

- Falls rate per 1,000 population aged 65+-
- % of Children on Child Protection Register with a completed CP Plan
- % of Child protection investigations with IRTD (Initial Referral Tripartite Discussion) within 24 hours

## Management Exception Reporting

<b>Performance Indicator: Outcome 7</b> Falls rate per 1,000 population for adults aged 65+	<b>Responsible Manager:</b> Lorraine Paterson
Target: 21      Actual: 22	Date of Report: FQ3 16/17

### Description of Exception



QUARTERLY CONVERSION – Shows annual values

The focus of this indicator is the rate per 1,000 population of falls that occur in the population (aged 65 plus) who were admitted as an emergency to hospital.

Data source: ISD published updated FY15/16 data Feb 2017. 22.3 rate per 1000 (65+) based on 475 Falls episodes against 65+ population of 21324. (NRS 2015 mid-year estimates)

Linked to IJB Outcome 2, 4, 7 and 9.

### Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

Work has taken place supported by the ICF across all localities to meet the requirements of the national minimum standard for prevention and management of falls in the community. The national framework for prevention and management of falls in the community has 4 stages -

**Stage 1** is around active ageing and self-management and there are a number of resources available for the public on the NHS Highland Public site –

<http://www.nhshighland.scot.nhs.uk/YourHealth/Falls/Pages/Welcome.aspx>

In the past year leisure services have trained staff to deliver exercise programmes to prevent falls and we will be working to work across services to promote exercise to reduce falls and frailty.

**Stage 2** is identifying people at risk with a Level 1 conversation (which all staff in health and social services are recommended to do with older people) and directing to Level 2 screening to identify modifiable risk factors. This screening is taking place across localities but we are struggling to collect data on the number of Level2 screens completed due to electronic systems.

**Stage 3** involves responding to an individual who has fallen and requires immediate assistance. We are currently involved in a Quality Improvement Project with Healthcare Improvement Scotland and the Scottish Ambulance service to develop responding services to keep people at home and avoid unnecessary conveyance to hospital. Equipment has been provided to local community teams and training has taken place.

**Stage 4** is coordinated management, specialist assessment and pathways are in place to ensure people receive evidence based interventions and are provided with a plan and intervention to reduce their risk of falls.

**Actions Identified to Address Current /Future Barriers**

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Community teams will be required to keep local action plans current and to work with the falls prevention coordinator to implement measures across the 4 stages of the national framework. These plans will be monitored through the quality pathways group.

**Additional Support Requirements Identified**

Training needs have been identified and requirements are being explored. In particular the Level1 conversation and basic awareness training needs developed for all health and social care staff in contact with older people.

**Improvement Forecast Date:**

**Review Date:**

October 2017

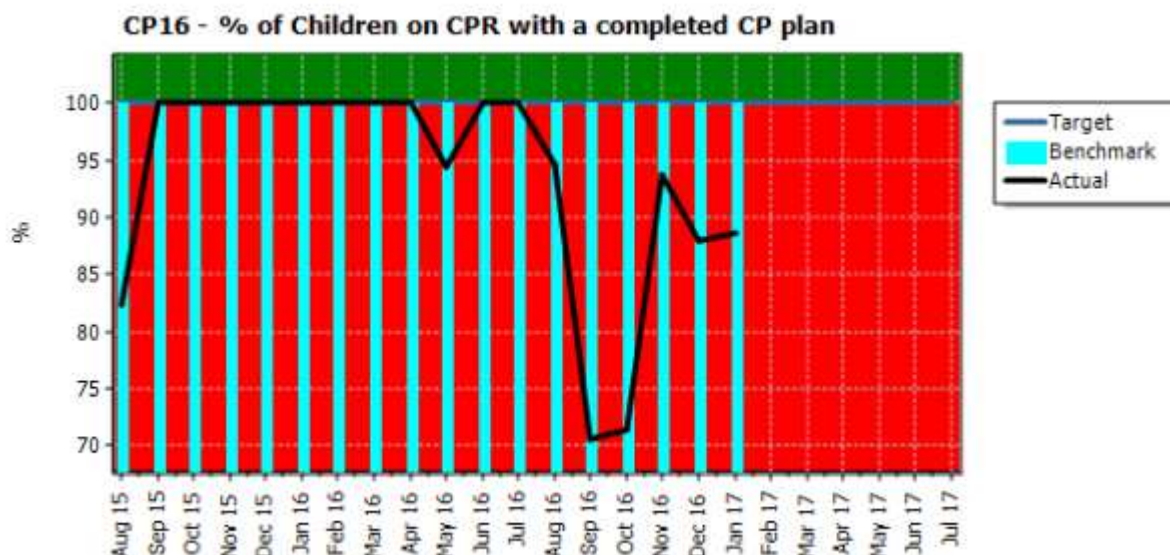
November 2017



## Management Exception Reporting

<b>Performance Indicator: Outcome 7</b> CP16 - % of children on Child Protection Register with a completed CP plan	<b>Responsible Manager:</b> Louise Long
<b>Target:</b> 100% <b>Actual:</b> 84%	<b>Date of Report:</b> FQ3 16/17

### Description of Exception



The percentage of children on the Child Protection Register (CPR) with a completed Child Protection Plan (CP). Monthly data on the performance indicator and quarterly data for the IJB Scorecard.

Data source: CareFirst      Linked to IJB Outcome 7.

### Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

All children on the child protection register have a child protection plan agreed at conference.

There have on occasions been delays in convening child protection core groups or approving these plans within the five working days due to staff absence/holidays.

Performance data is being made available to managers on a weekly basis and revised guidance has been issued to minimise the occurrence of delays in approving the plans.

### Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

### Additional Support Requirements Identified

<b>Improvement Forecast Date:</b>	<b>Review Date:</b>
	Monthly

## Management Exception Reporting

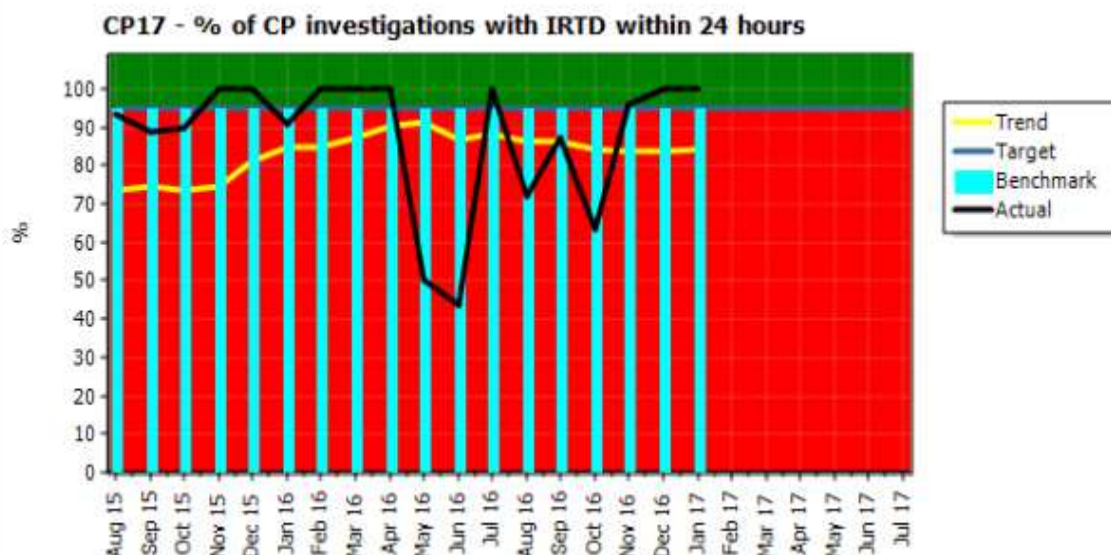
**Performance Indicator: Outcome 7**  
 CP17 - % of CP investigations with IRTD within 24 hours

**Responsible Manager:**  
 Louise Long

Target: 95%    Actual: 86%

Date of Report: FQ3 16/17

### Description of Exception



The percentage of Child Protection (CP) investigations where there is an inter-agency planning meeting (Initial Referral Tripartite Discussion - IRTD) within 24 hours. Monthly data on the performance indicator and quarterly data for the IJB Scorecard.

Data source – CareFirst/IRTDForm

Linked to IJB Outcome 7 and the ICSP 2014 - 2017, Outcome 1.1

### Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

This performance indicator continues to be affected by issues around out of hour's access to the IRTD process.

All out of hours CP investigations are considered jointly between Social Work and Police to agree and implement plans to investigate concerns and safeguard children. The CPC has now approved arrangements for out of hours IRTD processes and agreed a revised and improved IRTD protocol, which has been rolled out.

### Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Action was taken by the standby social worker in partnership with the police immediately to investigate concerns and an IRTD convened on the first working day, thereafter.

### Additional Support Requirements Identified

**Improvement Forecast Date:**

**Review Date:**

Quarterly

Outcome 8 – Health and Social care workers are supported

Outcome 8 - Health and social care workers are supported		No of indicators	4	<b>R</b>
FQ3 16/17		On track	0	➔

Summary of all outcomes
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Under dev - % of staff who say they would recommend their workplace as a good place to work	Actual		
	Target		
	Benchmark		

Update!  
Target!

	<b>FQ3 16/17</b>	Target	Average days lost	
<b>Social Work staff attendance</b>		3.8 Days	4.1 Days	<b>R</b> ↓

% of NHS sickness absence	Actual	4.79 %	<b>R</b>
	Target	4.00 %	➔
	Benchmark		

FQ3 16/17	Corporate target % PRDs -	90 %	Number of employees	No. PDRs complete	% PDRs complete	<b>R</b> ↓
Health & Social Care Partnership % of PRDs completed			514	301	59 %	

% of NHS staff with a completed & recorded KSF/PDP review	Actual	12.55 %	<b>R</b>
	Target	20.00 %	↑
	Benchmark		

There are 4 indicators being measured against this outcome, all 4 are off track and red flagged.

- Social Work staff attendance
- % of NHS Sickness and absence attendance
- % of HSCP staff completed Performance review
- % of NHS staff completed Knowledge skills framework review

The rise in sickness absence rates in the NHS and decrease in return to work interviews being completed for social work staff are both giving cause for concern. Whilst operational managers are actively involved with HR support in regularly reviewing their sickness absence, the Strategic Management Team are also investigating in more detail the reasons for absence and more creative ideas for improving the underlying causes.

## Management Exception Reporting

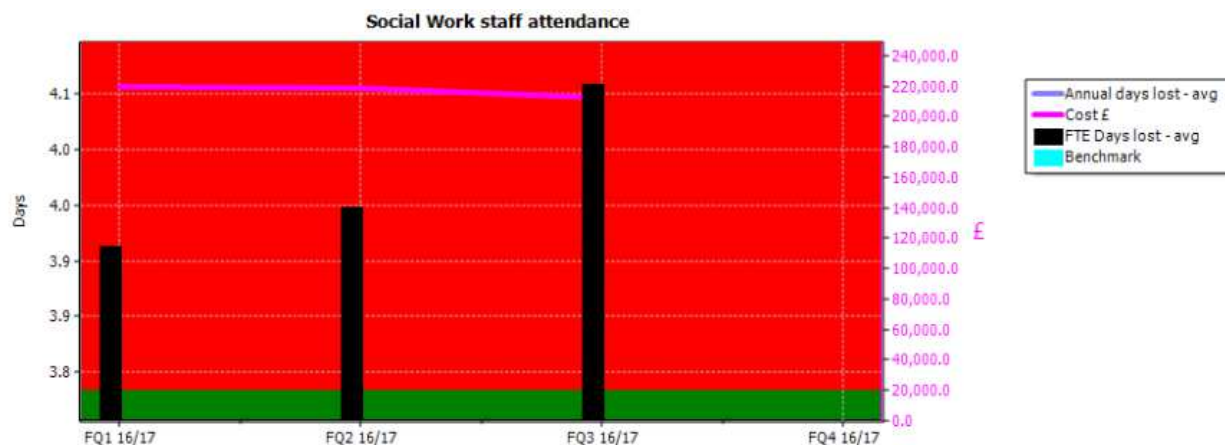
**Performance Indicator: Outcome 8**  
Social Work staff attendance

**Responsible Manager:**  
Allen Stevenson

**Target:** 3.8 days    **Actual:** 4.1 days

**Date of Report:** FQ3 16/17

### Description of Exception



Sub-elements		Value	Color	Trend
Type	Name			
🔧	Adult Care East Attendance [from April 2016] (Adult Care East Attendance [from April 2016])	4.68 Days (FQ3 16/17)	🔴	⬇️
🔧	Adult Care West Attendance [from April 2016] (Adult Care West Attendance [from April 2016])	4.43 Days (FQ3 16/17)	🔴	⬆️
🔧	Children & Families Attendance [from April 2016] (Children & Families Attendance [from April 2016])	3.06 Days (FQ3 16/17)	🟢	⬇️

The Heads of Service continues to monitor attendance closely and reinforces through Managers, at OMTs, to follow the Councils policy and procedures in maximising attendance.

Therefore high rates of return to work interview forms, in co-production with staff, have been completed in the East. The HSCP values the contribution of its staff in the delivery and maintenance of quality services to the community.

Whilst recognising that employees may be prevented from attending work through ill health, the HSCP has a duty to maintain service delivery and minimise disruption.

### Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

Adult Services are targeting work over the next 3 months at team leader level to ensure all relevant policies and procedures are being followed.

OMT East and West will continue to monitor progress and ensure management action is taken to improve compliance with HR policies and procedures.

The HSCP is therefore committed to managing attendance and sickness absence and believes that it is the responsibility of the HSCPs managers, trade union representatives and employees to work together to promote the management of sickness absence and ill health.

### Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Absence line procedures are in place for all staff to follow from first day of absence to minimise disruption in maintaining service delivery.

Maximising attendance for short and long term absence leaflets are available and close contact with line managers to help staff return to work as soon as possible.

The process for long-term absences is summarised as follows -

**Employee submits sick note indicating they will be absent beyond the 4 week trigger**

Stage 1 - 4 to 8 weeks - Initial attendance review meeting (informal)

Stage 2 - 4 to 12 weeks - 1st formal attendance review meeting

Stage 3 - 13 to 24 weeks - 2nd formal attendance review meeting

Stage 4 - 24 to 36 weeks - final formal attendance review meeting

Case review

Return to work - long term absence

The HSCP requires up-to-date medical information to plan ahead and decide upon a course of action that is in the best interests of all concerned. Wherever possible the HSCP will, on the advice of OH (Occupational Health), try to facilitate the employee's return to work.

The HSCP will consult with the employee throughout, taking their views and ideas into consideration.

**Additional Support Requirements Identified**

The HSCP is identifying further training and procedural process support from the councils HR department for additional support for team leaders, if required, to ensure return to work interviews are completed as per the procedures.

**Improvement Forecast Date:**

**Review Date:**

April 2017

Quarterly

## Management Exception Reporting

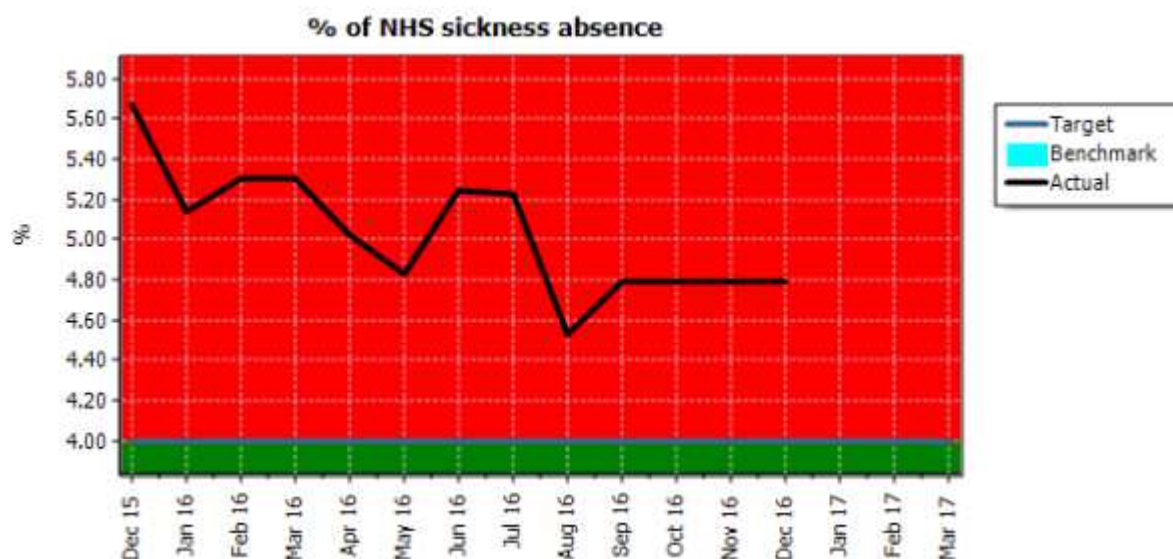
**Performance Indicator: Outcome 8**  
% of NHS sickness absence

**Responsible Manager:**  
Lorraine Paterson

Target: 4%    Actual: 4.79%

Date of Report: FQ3 16/17

### Description of Exception



The percentage of NHS staff sickness absence. Monthly data on the performance indicator and quarterly data for the IJB Scorecard.

Data source – NHS Balanced scorecard  
Linked to IJB Outcome 8.

### Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

In both the NHS and Council the HR support teams are providing input to the management of long term absence through Occupational Health Case Conferences, support to managers where health is affecting capability and there is the need to consider redeployment. All efforts are concentrated on getting staff back to work as quickly as possible and using phased return, changes in duties and other support mechanisms.

### Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Longer term there is a need to focus on the organisational culture of the HSCP, making it a happy and healthy workplace and ensuring high levels of staff engagement as these are all shown to contribute to the health of the workforce. Plans are being developed for a values and behaviour framework which could be used to support recruitment, training, team meetings, PDPs etc... and the evidence suggests that organisations with a framework that has been co-produced with staff have much higher levels of staff engagement. The roll out of iMatter, the new employee engagement survey and team improvement tool will also help to address these underlying causes.

### Additional Support Requirements Identified

There is a need to stabilise and move forward with strategic HR support for the HSCP workforce, something that is currently being considered by the Strategic Management Team.

Having a well resourced and strategically aligned HR lead will help a joint approach to tackling issues such as sickness culture and staff engagement.

**Improvement Forecast Date:**

**Review Date:**

March 2017

Quarterly

## Management Exception Reporting

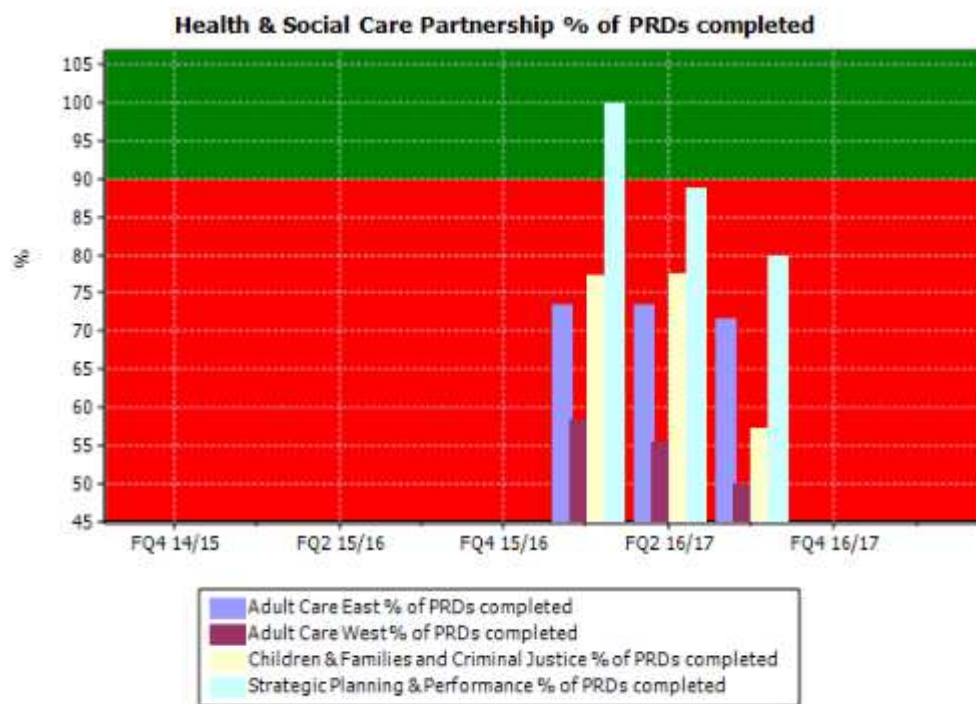
**Performance Indicator: Outcome 8**  
HSCP (SW) % of PRDs completed

**Responsible Manager:**  
Louise Long

Target: 90%      Actual: 59%

Date of Report: FQ3 16/17

### Description of Exception



FQ3 16/17	Corporate target % PRDs - 90 %	Number of employees	No. PDRs complete	% PDRs complete	<b>R</b> ↓
Health & Social Care Partnership % of PRDs completed		514	301	59 %	

#### Breakdown of numbers by service, total, completed and percentage

Service	Number of employees	No. PDRs complete	% PDRs complete	Status
Health & Social Care Partnership % of PRDs completed	514	301	59 %	<b>R</b> ↓
Adult Care East % of PRDs completed	131	94	72 %	<b>R</b> ↓
Adult Care West % of PRDs completed	200	100	50 %	<b>R</b> ↓
Children & Families and Criminal Justice % of PRDs completed	173	99	57 %	<b>R</b> ↓
Strategic Planning & Performance % of PRDs completed	10	8	80 %	<b>R</b> ↓

The percentage of council PRDs completed for the HSCP.

Data Source – Resourcelink (HR2 data)

Linked to IJB Outcome 8

### Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

The performance review is a formal meeting that happens on an annual basis and sets the context for the year ahead, traditionally financial quarter 4, has been the period for the PRDs to be completed with line managers.



The aim of the review is to help clarify key targets and development needs for all staff. Effective performance review and development is a key element in achieving this. It ensures that:

- All staff are clear about their contribution to the overall ambitions of the Health and Social Care Partnership's Strategic Plan.
- All staff targets are aligned to the values and priorities of the organisation.
- All staff learning and development needs are linked to their individual targets.

### **Actions Identified to Address Current /Future Barriers**

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

An annual review meeting will include:

- A review of the key documents relevant to the post i.e. job description, person specification and occupational standards/ competencies.
- An assessment of performance against last year's targets.
- Identification of the coming year's targets; tasks and behaviours.
- Identification of learning and development needs in order to achieve the targets.

Line managers are being directed to set up the six monthly review meetings for staff, at the time of the annual review to ensure the continuing support for addressing targets and development needs of staff.

### **Additional Support Requirements Identified**

We now have an e-learning course available to help with the PRD process.

**Improvement Forecast Date:**

**Review Date:**

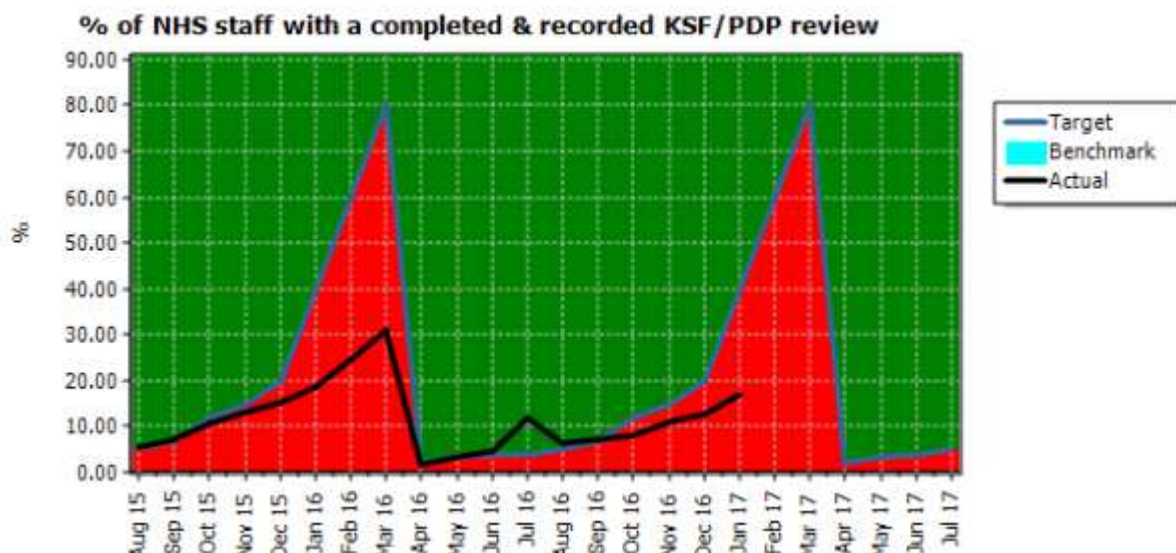
March 2017

March 2017

## Management Exception Reporting

<b>Performance Indicator: Outcome 8</b> % of NHS staff with a completed & recorded KSF/PDP review	<b>Responsible Manager:</b> Lorraine Paterson
Target: 20% Actual: 12.55%	Date of Report: FQ3 16/17

### Description of Exception



The percentage of NHS staff with a completed and recorded KSF/PDP review. Monthly data on the performance indicator and quarterly data for the IJB Scorecard.

Data source – NHS Balanced scorecard  
 Linked to IJB Outcome 8

### Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

- NHS Staff within the organisation are aware and having it reinforced of the need to complete PDPs/ksf review on an annual basis and the benefits for staff to have a review and encourage development.
- Managers and team leads use the eksf system to monitor performance and development of staff.
- Data for this is discussed on a monthly basis with senior managers who cascade to team leads to complete the reviews in a timely manner.
- The SMT requires to ensure there is a greater focus on completion and adherence to the e-KSF process

### Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

Managers & team leads are to ensure PDPs/KSF reviews are distributed throughout the year & will ensure when reviews are completed that the electronic system is up to date. Also, NHS bank staff reviews must be included to ensure the target for NHS Highland is achieved.

### Additional Support Requirements Identified

<b>Improvement Forecast Date:</b>	<b>Review Date:</b>
	March 2017



## Argyll & Bute Health & Social Care Partnership

### Integration Joint Board

Agenda item : 5.5

**Date of Meeting:** 29 March 2017

**Title of Report:** Obesity/Healthy weight

**Presented by:** Elaine Garman

**The Integration Joint Board is asked to :**

Note the work that is being undertaken in partnership to promote healthy weight in Argyll & Bute.

### 1. EXECUTIVE SUMMARY

1. Obesity is the biggest preventable burden on our economy second only to smoking, however the potential future costs of reduced workforce productivity due to excess weight in addition to treatment costs could see obesity rise to the top.
2. Obesity is caused by the accumulative effect of a positive energy imbalance, with energy from food exceeding that used in daily physical activity. Excess energy is then stored in the body as fat, this accumulation leads to the short and long term physical and mental health consequences of overweight.
3. Obesity is an increasingly common societal problem because for many people modern living involves eating and providing excessive amounts of cheap, high-energy foods and spending a lot of time sitting down, at desks, on sofas or in cars.
4. In 2015, two thirds (65%) of adults in Scotland were overweight, including 29% who were obese, figures which have changed little since 2008.
5. The percentage in the 'obese' category of P1 children in Argyll and Bute has been consistently higher than in Scotland as a whole, each year from 2008/09 to 2015/16.

It is essential that we collaborate in creating healthy communities, develop and implement evidenced based initiatives strategically and locally and link to national campaigns to support the overall aim of reducing obesity. In order to achieve this we need to:

- Develop and implement targeted initiatives which will contribute to the population in Argyll & Bute maintaining a healthy weight
- Increase the number of people who consume a healthy diet that is consistent with the UK Dietary Reference Values.
- Increase the number of people who are physically active in line with the latest recommendations for physical activity.

- Make the greatest gains in those population groups who have the highest burden of obesity and poorest health outcomes.
- Create environments which promote and encourage healthy eating and physical activity.
- Develop and implement a care pathway for overweight and obese individuals.
- Collaborate with a wide range of partners to co-produce a local action plan that will achieve the above aims.

## 2. INTRODUCTION

The Scottish Government recognises that investment is required to tackle the growing concern of adult and childhood obesity. Both adult and child healthy weight have separate implementation frameworks with associated targets, and thus have progressed as distinct projects under the overall umbrella of the healthy weight strategy. However the knowledge that the family environment has a significant influence on obesity risk and the recommendations for interventions to focus on maternal health and whole family involvement, suggests that a more collaborative approach between the two threads is necessary. (See also appendix A and B for more details.)

## 3. DETAIL OF REPORT

Adult healthy weight (AHW) service development became the remit of the Argyll and Bute dietetic team in 2012, outlined in the 4 tier structure shown in Figure 1

The Tier 2 intervention for Argyll & Bute follows the NICE guidelines aimed at this level of intervention: ‘Managing overweight and obesity in adults – lifestyle weight management services’ (NICE PH53 2014). They recommend that Tier 2 programmes should be “part of a comprehensive approach to preventing and treating obesity...that aim to change someone's behaviour to reduce their energy intake and encourage them to be physically active (NICE PH53 2014, p.61).

To meet these guidelines in Argyll & Bute, the Tier 2, accredited programme of choice is ‘Counterweight’, and consists of 1 session every fortnight, for 12 weeks, in either individual or group settings (Counterweight 2004). The focus of the programme is life-long lifestyle change and the prevention of future weight gain. Programme participants are reviewed and supported after the 12 week programme at 3 month time points for a year. Achievable goals for weight loss are agreed for different stages, using a variety of behaviour-change methods.

To ensure a cost effective sustainable model, staff from the third sector, the integrated HSCP and community volunteers, are trained to deliver Counterweight. They receive regular professional development sessions and governance is provided by a Dietician to ensure quality of service is maintained. In Lorn, the use of practitioners out with the health setting led to the NHS AHW pathway integrating with “Healthy Communities”, a joint initiative with Lorn and Oban Healthy Options and the North Argyll Carers Centre supported through the ICF fund.

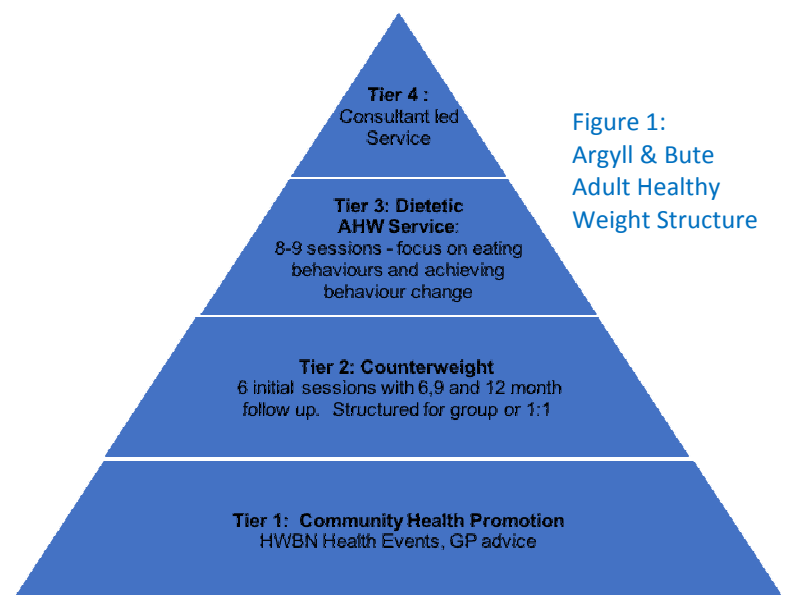


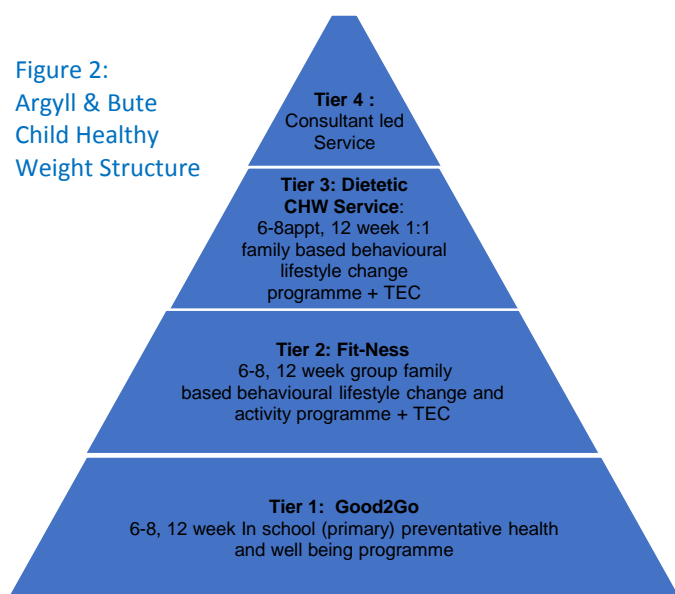
Figure 1:  
Argyll & Bute  
Adult Healthy  
Weight Structure

A specialist Dietetic-led weight management intervention (Tier 3) has been in place since January 2013. This comprises an assessment appointment, and if the patient opts in, this is followed by 8 appointments over 6 months with a planned discharge to Tier 2 services in the community.

More recently, July 2016, the child healthy weight (CHW) fund was also allocated to dietetics. Prior to this, funds were allocated in response to localised bids which led to inequitable sporadic interventions.

Following the employment of a fixed term CHW dietitian, the Argyll and Bute Healthy Weight team was established. The team uses guidance from the Scottish Public Health Network Obesity Specialist Group report, commissioned by Scottish Government to collate national outcomes of existing CHW interventions and provide recommendations for the future direction for CHW interventions to include preventative, family intervention and treatment strands. As a result, we devised a tiered structure, similar to that of adult services.

Figure 2:  
Argyll & Bute  
Child Healthy  
Weight Structure



- The percentage in the ‘obese’ category of P1 children in Argyll and Bute has been consistently higher than in Scotland as a whole, each year from 2008/09 to 2015/16
  - The proportion of P1 children in at risk of obesity is higher in more deprived areas.
  - Although the proportion varies with each cohort of P1 children (2011/12 to 2014/15), the proportion of children at risk of obesity in HSCP locality areas has been highest in Bute, Cowal, Kintyre and Islay and Jura (including Colonsay).
- <http://www.isdscotland.org/Health-Topics/Child-Health/Child-Weight-and-Growth/>

We have to date developed a primary school based preventative resource, Good2Go, which delivers to Curriculum for Excellence Health and Well being indicators. In partnership with education we have promoted and delivered training to teachers in 76% of primary schools within Argyll and Bute, ensuring our key preventative messages are consistently delivered equitably throughout the HSCP. Initial evaluation of the training is overwhelmingly favourable. It is our plan to support implementation within the classroom setting to ensure the programme is embedded in the curriculum. In addition we are now focused on development of family intervention and specialist treatment programmes. We have initial plans to develop a Tech component, using Florence (national technology enabled care platform). Evidence suggests increased review frequency significantly improves outcomes in child healthy weight. Florence will increase frequency of interaction without impacting capacity, school/work attendance and travel costs.

Physical activity is an important component in achieving and maintaining healthy weight: Appendix A and B show details of current levels of physical activity for both adults and children. In 2014, a scoping exercise was completed resulting in the Argyll and Bute Physical Activity Position Statement with 7 recommendations for action. <http://healthyargyllandbute.co.uk/wp-content/uploads/2014/12/Argyll-Bute-Physical-Activity-Position-Statement-Summary-Oct-2014.pdf>

During 2015/16 Sport Scotland supported Argyll and Bute Council leisure service to update its Sport and Leisure Framework. This strategic framework is targeting all levels of activity (from getting people to change sedentary behaviour through to high level sport) and across the life course (from cradle to grave) in a variety of settings (school, community and work).

<https://www.argyll-bute.gov.uk/sport-and-leisure-framework-2015-2019>. Much focus is on inclusion and promoting local opportunities.

Health Behaviour Change training is available for all health and social care staff and third sector partners. This is currently offered as a blended learning course, making use of NES Scotland’s updated suite of e-learning modules complemented by two days face to face contact. We now recommend that participants complete one generic module before the course and the “Raising the Issue of Physical Activity” and/or “Raising the Issue of Child Healthy Weight” before the second contact day. We have also promoted the BMJ Motivational Interviewing module amongst GPs, which addresses healthy weight. Increasing knowledge of HSC staff of the importance of physical activity to prevent ill health and to attain and maintain health, remains a priority.

Maintaining a healthy weight can reduce risk of many illnesses, including cancer. Being physically active can improve outcomes during treatment. MOVE MORE is a physical activity programme promoted by Macmillan Cancer Services. A consultation to introduce this programme in Argyll & Bute was completed in 2016. It gauged how we can promote and deliver a physical activity programme for people with a diagnosis of cancer in remote and rural areas. The implications of this report and the way forward are currently being discussed with Macmillan, Public Health and the emerging Leisure Trust. Macmillan offers a course called *Understanding Physical Activity and Cancer*. This accredited training can be accessed by joining a monthly Webex training session ([www.learnzone.org.uk/vbawebinar](http://www.learnzone.org.uk/vbawebinar)) or completing their e-learning module ([www.learnzone.org.uk/vbatraining](http://www.learnzone.org.uk/vbatraining)).

Health and Leisure staff and volunteers throughout the region have benefited from ICF funded training programmes which has seen qualifications attained to deliver a number of low impact programmes. This includes walking, Tai chi, GP Referral for Exercise (targeted to people with long term conditions (LTCs) or being overweight), Otago and PSI strength and balance training - targeting people at risk of a fall, but also very suitable for people with LTCs who are inactive to gain confidence and benefit from a tailor made, monitored programme, with progression to mainstream activity. A Living Well Activity Coordinator post is being piloted in Helensburgh, who takes referrals from primary care and supports individuals to make long lasting health behaviour changes.

#### 4. CONTRIBUTION TO STRATEGIC PRIORITIES

1	Healthier Living	x
2	Independent Living	x
3	Positive Experiences & Outcomes	x
4	Maintained or Improved Quality of Life	x
5	Reduced Health Inequalities	x
6	Carers are Supported	
7	People are Safe	
8	Engaged Workforce	
9	Effective Resource Use	x

## **5. GOVERNANCE IMPLICATIONS**

### **5.1 Financial Impact**

All funding for developing and implementing an action plan to tackle obesity in Argyll & Bute come through specific ring-fenced funds from Scottish Government. An asset based approach seeks to ensure best value through partnership working. Implementation of other key elements within the strategy will depend on the availability of financial resource. In 2016, around £60,000 was channeled through the Health and Wellbeing Networks for community based projects that have a direct impact on healthy weight. Furthermore, the ICF has distributed funding via locality planning groups for third sector services contributing directly and indirectly on healthy weight initiatives, with a particular focus on those who are inactive, make unhealthy food choices or have limited access to opportunities to improve their lifestyle. Some of those initiatives have the potential for delivering more community based services with our partners i.e. Branching Out, Living Well Activity Coordinators, Lorn Healthy Options, Carers' Centre Network, MAC Pool, MOVE MORE Scoping and many more. By working in partnership with other organisations, through our network of committed volunteers and by exploiting Tech resources we can meet shared outcomes and maximise the resources available in the very challenging financial environment facing the HSCP.

### **5.2 Staff Governance**

All staff have to work collaboratively towards shared outcomes of prevention and early intervention. This may take the form of signposting, supporting colleagues and peer educators and promote prevention and self management.

### **5.3 Clinical Governance**

The patient care pathway will be based on the best available evidence and will require a change in interventions with patients, communities and referral procedures. The use of motivational interviewing skills and screening questions about diet and levels of activity during consultations will highlight the importance of attaining or maintaining a healthy weight and could be an opener for brief advice or a brief intervention as part of any consultation.

Royal College of Paediatrics & Community Health report *State of Child Health 2017* recommendation for Scotland, indicated the need to tackle childhood obesity effectively. NHS Scotland and professional bodies should ensure that all health care professionals can make every contact count by having that difficult conversation with their patients (whatever their age) who are overweight.

We also feel that this should reach further than health and have encouraged teachers to complete the NHS Education Scotland resource "raising the issue of child healthy weight" to ensure they are also equipped with the relevant skills.

## **6. EQUALITY & DIVERSITY IMPLICATIONS**

Working with the third sector, volunteers and use of technology is enabling us to deliver local interventions to build healthy inclusive communities.

## **7. RISK ASSESSMENT**

Robust monitoring and evaluation systems are in place to ensure that delivery of programmes is of high standard. Service Level Agreements and contracts are in place and regularly monitored.

## **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT**

Healthy Communities shape the care and support that they receive by focussing on community based initiatives to deliver the identified needs of the individual to promote their health and

wellbeing. This aligns with Scottish Government's overarching statement within its document "National Health and Wellbeing Outcomes"

## **9. CONCLUSIONS**

Obesity affects people at all ages and stages of their life, however it is clear that it is self-perpetuating as children with overweight parents are much more likely to become overweight than children in homes with parents of normal weight, suggesting a collaborative lifecycle approach to weight management is essential: not just strategically but also organisationally.

We need to stop thinking about child and adult healthy weight interventions in isolation and instead favour a collaborative Lifecycle Healthy Weight Service. Rooting Tier 1 and 2 programmes in the community, equipping and enabling families to self-regulate, will go some way to delivering to the wider health and integration agenda and will ensure reduced costs and a sustainable service.

Developing Healthy Communities will empower individuals and communities to take more responsibility for their own health and wellbeing which is essential in progressing and sustaining lifestyle changes required to prevent and treat overweight within our population.

To deliver the aim, a universal whole community approach will be needed to support self-management and reablement. A unique blend of community-based support service through community organisations (community councils, LOHO, leisure trusts, Third Sector organisations etc.) and from (health) professionals (Dietetics, Physiotherapy, Public Health), Education, Council and Housing etc., and private organisations leads to the outcome vision of Healthy Communities.

### **References:**

Scottish Health Survey 2015

Scottish Government/COSLA, 2010, Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight

Scottish Government/COSLA, 2011, Preventing Overweight and Obesity in Scotland: An Action Plan

Scottish Public Health Network Obesity Specialist Report 2015

RCPCH State of Child Health 2017 Recommendations for Scotland.



Adults in Scotland

## OBESITY

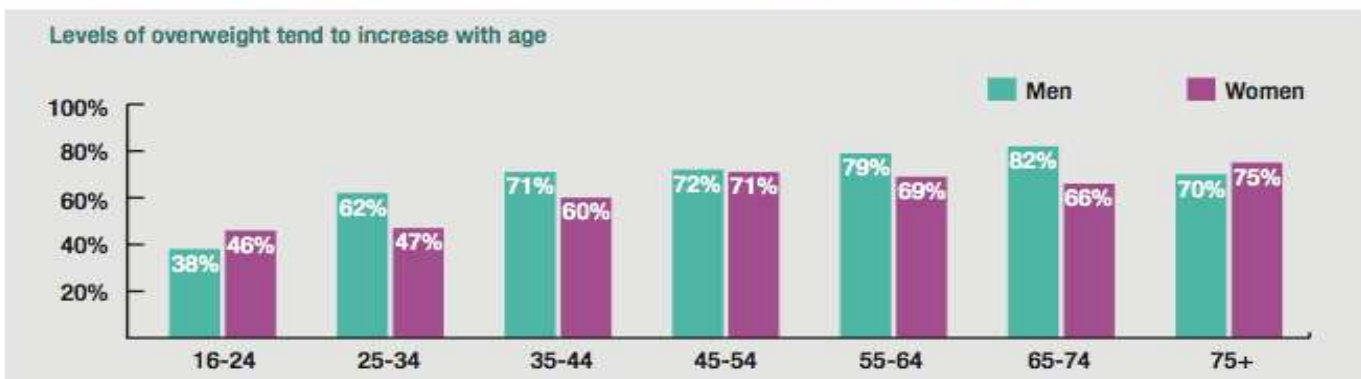
- In 2015, two-thirds of adults (65%) were overweight, including 29% who were obese, figures which have changed little since 2008.



**Two thirds**  
(65%) of adults were overweight, including



**29%**  
who were obese



- Waist circumferences were higher on average in 2014/2015 than in 2003 for both men (98.2 cm in 2014/2015 and 95.3cm in 2003) and women (89.5 cm in 2014/2015, 86.3 cm in 2003).
- The proportion of men with a raised waist circumference (greater than 102cm) increased from 28% in 2003 to 37% in 2014/2015. The proportion of women with a raised waist circumference (greater than 88cm) increased from 39% to 52% over the same period.
- Around two-thirds of all women (66%) and three in five men (59%) had an increased risk of disease based on their BMI and waist circumference.

## PHYSICAL ACTIVITY

- Just under two-thirds (63%) of adults in 2015 met the guideline for Moderate or Vigorous Physical Activity (MVPA), a similar level to those seen since 2012 (62-64%).
- Just over a quarter (26%) of adults met both the MVPA and muscle strengthening guidelines, with men being significantly more likely to do so than women (29% compared with 24%).
- The proportion of adults meeting both guidelines decreased with age, from 42% of those aged 16-24 to 7% of those aged 75 and over.

Men were more likely than women to meet the Moderate or Vigorous Physical Activity guidelines



Average time spent sedentary (adults) excluding time at work

Weekdays



5.2 hours

Weekend days

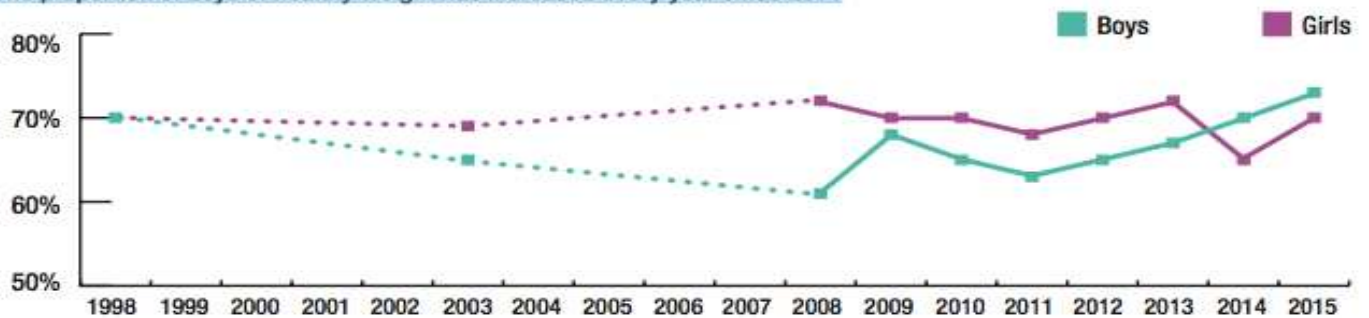


5.9 hours

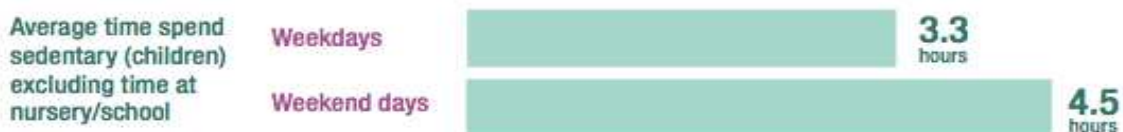
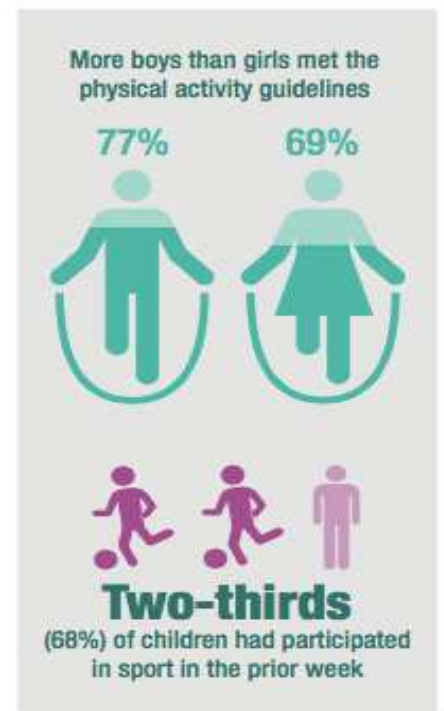
Children in Scotland

- **The proportion of boys of healthy weight (73% in 2015) has increased year on year since 2011 (63%) and is comparable to the level seen in 1998 (70%).**
- The proportion of girls who were a healthy weight in 2015 was 70%, a level which has remained relatively steady since 1998.
- In 2015, 15% of boys and 14% of girls were at risk of obesity, figures which were identical to those in 1998.
- Compared with children with parents who are not overweight, children with an obese parent were significantly more likely to be at risk of overweight, including obesity (40% compared with 22%), or at risk of obesity (23% compared with 11%).

The proportion of boys of healthy weight has increased every year since 2011



- **In 2015, just under three-quarters (73%) of children met the guideline on physical activity (including school-based activity), a similar proportion to that seen in 2008 (71%).**
- The proportion of children meeting the guideline in 2012-2015 was significantly higher if their mother was active at the recommended level than if their mother was not. There was no significant difference according to whether their father met the recommendations or not.
- Around two-thirds (68%) of children had participated in sport in the prior week, a similar level to that seen in 2014 (67%) but lower than in 2008 (71%).
- Sports participation levels were comparable for boys (69%) and girls (66%)





# Argyll & Bute Health & Social Care Partnership

## Integration Joint Board

Agenda item : 5.6

**Date of Meeting:** 29 March 2017

**Title of Report:** Clinical & Care Governance and Infection Prevention & Control

**Prepared by:** Liz Higgins, Lead Nurse

**The Integration Joint Board is asked to :**

Note content of report, the risks identified and the risk management plans

## 1. EXECUTIVE SUMMARY

Report detailing:

1. Significant Adverse Events
2. Significant Case Review
3. Oban Laboratory Update
4. Infection Control

## 2. INTRODUCTION

Clinical and care governance is the system by which Health Boards and Local Authorities are accountable for ensuring the safety and quality of health and social care services, and for creating appropriate conditions within which the highest standards of service can be promoted and sustained.

Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation – built upon partnership and collaboration within teams and between health and social care professionals and managers.

It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening

This report outlines current Clinical & Care Governance issues that require to be noted by the IJB and outlines action taken to address performance.

### 3. DETAIL OF REPORT

#### 3.1 Significant Adverse Events

A significant adverse event is the term to describe an event that fulfils at least one of the following:-

- An event which caused or had the potential to cause serious harm to an individual or group of individuals. (patients / service users or staff)
- An unusual or unexpected clinical or non clinical event with or without an adverse outcome that has the potential for significant learning.
- An event that may cause reputational damage to the organisation/undermines public confidence in the organisation to deliver safe services

The following events are all considered as potential significant adverse events and assessed against the criteria outlined above.

1. All DATIX adverse events risk rated as Major or Extreme on Datix incident form 2
2. Events of concern brought to the attention of the operational unit management team including but not exclusively:- SPSP Global Trigger Tool Adverse Incidents, Deaths identified at mortality reviews with adverse features (Type 2 and Type 3)
3. Any suicide (All suicides of persons who have had contact with mental health services within 12 months prior to death are reported to Health Improvement Scotland and are subject to review)
4. Serious Complaints
5. Unexplained deaths, including maternal death, work related deaths
6. Significant near misses
7. Major incidents
8. Externally reported adverse events (e.g. HSE)

#### **What is a Significant Adverse Event Review (SAER)?**

A Significant Adverse Event Review (SAER) is the term used for a review of a significant incident. The purpose of a SAER is to learn from the incident and to identify whether there are any aspects which could have been done better, actions which might have prevented the incident or minimised the impact of the incident as well as to identify good practice and lessons which could be shared more widely.

A SAER is **not** about apportioning blame. Systems are in place to minimise the risk of incidents occurring, these include e.g. guidelines and policies, training, appropriate environments and equipment. A Significant Adverse Event Review looks at all the contributing factors resulting in an incident and determines whether the systems in place are adequate to minimise the risk of an incident recurring or whether systems need to be changed or further actions or systems put in place. The aim is to ensure high quality, safe and effective processes and systems for patients / service users and staff.

#### **Who decides whether a Significant Adverse Event Review will take place?**

Each significant adverse event is assessed by the HSCP SAER Scrutiny Group to determine the appropriate level of review. The SAER Scrutiny Group comprises: the three Heads of Service (one of whom is the Chief Social Work Officer); Lead Nurse and Associate Medical Director.

## **How is a Significant Adverse Event Review conducted?**

There are a number of phases to the Significant Adverse Event Review process which are summarised below:

Formation of a SAER panel and identifying a person to lead the SAER: the panel usually comprises senior managers/clinicians/ staff with knowledge of the incident type. The panel will not have been involved in the incident. One member of the panel will lead/chair the review. The panel will identify a person to investigate the incident, the information required and delegate any other tasks.

Investigation/Information gathering: when all available evidence will be collected. This may include: information from case notes or other records or data sources e.g. clinic lists or maintenance schedules, local and national policies or guidelines, training programmes and attendance records or photographs. During this process staff involved will either be interviewed or asked to provide a statement about their recollection of events.

Organising and summarising the information gathered: usually the best way to organise and summarise the information is by creating a timeline of events. The source of all information included in the timeline should be indicated e.g. letter, case record, statement.

Review of the findings of the investigation: a pre-SAER meeting of the SAER panel will review the information from the investigation to ensure that all the information required for the SAER meeting has been obtained, this makes best use of everyone's time at the SAER meeting.

The Significant Adverse Event Review meeting – when all staff involved in the incident will be asked to attend a meeting to review the incident and the findings of the investigation and to conduct a root cause analysis which identifies all contributing factors, so that appropriate actions are identified to minimise the risk of the incident happening again.

### Report writing

Following the SAER meeting a report is drafted in consultation with the SAER Panel, and agreed with the participants and patients / service users as appropriate. The final report including the actions is ratified by the HSCP SAER Scrutiny Group.

### Implementation of Actions

Actions are assigned on Datix and once completed are reviewed and approved by the HSCP SAER Scrutiny Group.

### Sharing the Learning

A number of mechanisms are used to ensure that learning from SAERs is shared with patients/ service users and shared widely both in the HSCP and across NHS Highland.

## **Who attends a Significant Adverse Event Review?**

To support shared learning all staff involved in the incident must attend. The Review Panel: members will reflect the type of incident that is being reviewed. Sometimes an expert(s) will be invited; in some cases this person(s) might be external to the organisation.

## **Active SAERs**

There are currently 13 SAERs at various stages of review. A summary is provided below:

**Table 1: Active SAERs**

Type of Event	Number	Number: Investigation in progress	Number: Draft SAER Report being prepared	Number: SAER Report Awaiting Ratification
Complaint: Care and treatment	3		2	1
Care and treatment	3	1	2	
Unexpected Death	2	1	1	
Suicide of person who had contact with mental health services within 12 months before their death	2		1	1
Suicide of young person	2	2		
Concerns raised by MWC re care and treatment of young person	1	1		
	<b>13</b>	<b>5</b>	<b>6</b>	<b>2</b>

**Adverse Events – level of review to be determined**

There are currently 9 adverse events where an initial investigation / information gathering is in progress. Once available the information will be used to aid decision making by the HSCP SAER Scrutiny Group about the appropriate level of review.

These events are summarised below:

**Table 2: Level of Review to be Determined**

Type of Event	Number
Unexpected death / possible suicide	1
Adult Suicide 1	1
Unexpected death 1	1
Difficulties / delays with transfer arrangements	2
Discharge arrangements 1	1
Care and treatment	3
	<b>9</b>

**3.2 Significant Case Review**

Significant case reviews are carried out where a child has died or has been significantly harmed or where they have been at risk of harm. Significant case reviews (SCRs) aim to identify if anything could have been done to prevent harm, and what could be done to stop a similar event happening in the future.

As one of its key functions, Child Protection Committees (CPC) and Adult Protection Committees (APC) are responsible for undertaking reviews of significant cases. There are two levels of case review an Initial Case Review and Significant Case Review.

The refreshed National Guidance for Child Protection Committees Conducting a Significant Case Review, 2015 is intended to assist practitioners and managers to identify significant cases, collate information to inform the decision making process, understand the review process and fulfil their responsibilities in relation to initial and significant case reviews.

The purpose of conducting an SCR is not to apportion blame it is to identify learning and the CPC and APC are responsible for both identifying and disseminating the learning to ensure any identified improvements in processes or practice are implemented and their impact measured.

Argyll and Bute CPC and APC jointly completed a Significant Case Review in November 2015 and there is currently one initial case review being undertaken on behalf of the CPC and the Criminal Justice service are undertaking an initial case review.

### 3.3 Oban Laboratory Update

#### Background

Laboratory services are governed nationally by a number of bodies namely – MHRA (Medicines & Healthcare Products regulatory agency), Scottish Blood transfusion service (SBTS), UK Accreditation Service (UKAS).

UK Accreditation Service (UKAS) inspected LIH laboratory on 16<sup>th</sup> – 22<sup>nd</sup> August 2016 for ISO 15189 transition and CPA (Clinical Pathology Accreditation) which is a large list of quality assurance and competence standards. It is best practice to achieve CPA/ISO accreditation although not all laboratories have this, however full compliance of ISO standards is expected by 2017. As a result of the inspection UKAS made 133 recommendations and CPA was suspended.

The Oban laboratory was also inspected by the Health & Safety Executive (HSE) jointly with Raigmore Hospital on the 8<sup>th</sup> and 9<sup>th</sup> November 2016 and separately following a RIDDOR reportable incident within Microbiology.

As a follow on from the earlier inspections, MHRA carried out a formal inspection of the Oban laboratory service on the 23<sup>rd</sup> & 24<sup>th</sup> February and the CPA visited on the 22<sup>nd</sup> and 23<sup>rd</sup> February 2017 to review the progress on the findings from the August visit and to assess whether CPA status could be reinstated

**MHRA** report has now been received and contains 3 Major recommendations;

1. Ensure a robust incident management system within Haematology (not Datix) for transfusion related incidents.
2. Ensure Blood compliance report completed appropriately and strong clinical governance arrangements to be in place, including Clinical Director role.
3. Audits had not been completed within transfusion for 3 years; they only started in August 2016.

The MHRA will monitor the progression of the resulting action plan to address these concerns.

**CPA accreditation:** Following the visit in February, the inspectors acknowledged all the hard work and improvements that had taken place since August 2016 but that, within the timescale given, there remains some gaps which require action. In particular, the Clinical Director role arrangements have still to be confirmed as this is crucial to CPA accreditation. A meeting to discuss and agree way forward will take place on 20<sup>th</sup> March. Additionally the Quality management system currently in use in Oban, was assessed as not being adequately robust. Agreement was reached that Lorn & Islands lab will adopt NHS Highlands quality management system.

In discussion with the inspector, the team at Lorn & Islands Hospital agreed to voluntarily withdrawn from CPA accreditation at this point, to resubmit an application and to aim to achieve UKAS ISO 15189 accreditation by the end of the year

**The HSE:** Within the microbiology section of the Oban laboratory a RIDDOR reportable incident occurred, involving one member of staff contracting 'shigellia'. This has been fully investigated and corrective measures taken. As a result of the incident the Health & Safety Executive visited and made a number recommendations for improvement

Bob Summers Health & Safety Manager for NHS Highland and his team are leading on this work and supporting the local staff in the improvement work. A response to HSE was submitted on 28th February and an action plan will be generated to monitor progress against the findings.

### 3.4 Infection Control

Eader Glinn Care Home in Oban was closed to admissions following an outbreak of viral gastroenteritis in mid-January which affected staff and residents. Reopening was delayed largely due to the high attack rate among staff members. The outbreak was managed with the assistance of the Health Protection Team in Inverness who have responsibility for managing infection outbreaks in community settings.

Influenza A continues to circulate in the community, with a number of outbreaks in Care Home settings in North Highland – not in A&B HSCP so far.

#### SABs up to end Feb 17

	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
<b>MRSA</b>	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>MSSA</b>	0	0	1	0	0	1	1	0	1	0	2	1	1
<b>Total Sabs</b>	0	0	1	0	0	1	1	0	1	0	2	1	1

#### CDI up to end Feb 17

NB – the 4 cases in January were fully investigated and were unrelated in time or place.

	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
<b>Ages 15-64</b>	0	0	0	0	0	0	0	0	0	1	0	1	0
<b>Ages 65 plus</b>	0	0	0	0	1	0	2	2	1	2	0	3	0
<b>Ages 15 plus</b>	0	0	0	0	1	0	2	2	1	3	0	4	0

## 4 CONTRIBUTION TO STRATEGIC PRIORITIES

Robust governance arrangements are key in the delivery of strategic priorities

## 5 GOVERNANCE IMPLICATIONS

### 5.1 Financial Impact

Potential for financial impact

### 5.2 Staff Governance

Nil highlighted in the report

### 5.3 Clinical Governance

Some issues identified



## **6 EQUALITY & DIVERSITY IMPLICATIONS**

There are no equality and diversity implications

## **7 RISK ASSESSMENT**

Risks articulated within the report.

## **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT**

The membership of the Clinical and Care Governance Committee and the Health and Safety Group includes public representation

## **9. CONCLUSIONS**

The report provides updates and information about some key areas of work in relation to clinical and care governance.



## Appendix 1: OLI Laboratory Meeting Governance Action Plan

Laboratory improvement plan is available as a detailed separate document (Action 2)

Action Number	Action - Governance	Who	When	Red Amber Green Status R= Incomplete A= Started and end date agreed & on track G= complete
1	Establish SLWG	Alex Javed, A&B Planning rep (TBA), A&B Finance rep (TBA) Geoff Day, Caroline Henderson or Annie Macleod, Mark Ashton, Quality Manager (NHS), Clinical Leads Inverness tba	SLWG established. Regular meetings held and planned for 2017. Monthly meetings established across NHS Highland and inclusive of NHS Greater Glasgow & Clyde Consultants	Green
2	Action plan developed for all lab non conformances and monitoring of 133 outstanding actions (85 actions are CPA related)	Geoff Day (interim lab manager). Monitoring in place through weekly meetings.	All non conformances submitting to UKAS for re Inspection end of Feb 2017.	Green
3	Future of OLI lab governance & define structure for Lab user manual	Caroline Henderson & Alex Javed	New organisational structure agreed, with clear Clinical Governance arrangements. The only post not filled is Lab Director. Memorandum of understanding agreed with NHS Greater Glasgow & Clyde for clinical Consultant input to the Lab from Glasgow. Clear Roles & Responsibilities agreed.	Green
4	Appointment of Clinical Director	Alex Javed	Meeting took place with NHS Greater Glasgow & Clyde on the 22 <sup>nd</sup> February 2017. Glasgow informed us that they	Amber

			<p>could not provide a Clinical Director. On previous discussions with Glasgow, they felt that this was possible.</p> <p>This is an essential role and you cannot get CPA Accreditation without the CD Role. Meeting taking place on 20<sup>th</sup> March 2017 to discuss and agree way forward.</p>	
<b>5</b>	Line Management of Geoff Day By Alex Javed to comply with governance arrangements	Alex Javed	Completed. Lab Quality BMS has also got accountability now to NHS Highlands quality manager for Labs.	Green
<b>6</b>	Define clinical input for microbiology and biochemistry	Mark Ashton	Completed. Memorandum of understanding complete around Consultant role in and out of hours	Green
<b>7</b>	Haematology and transfusion service consultant input	Caroline Henderson, HSCP planning team and GGC planning team	Completed. Two new Haematologists appointed. Lab responsibilities outlined in memorandum of understanding	Green
<b>8</b>	Update organisational chart when clinical structure confirmed.	Geoff Day	13 <sup>th</sup> December 2016 – Clinical Director role outstanding (see action 4)	Green
<b>9</b>	Service Planning between NHSH, A&B & Glasgow – detailing schedules in SLA with GGC	Stephen Whiston	Meeting took place on 22 <sup>nd</sup> February. At sign off stage.	Green
<b>10</b>	E Health – Appraisal of IT to support quality management from NHSH and GGC – initial discussions held through SLWG and further detail to be agreed	Mark Ashton/Stephen Whiston	End March 2017. IT Telepath system for Oban Lab is linked with Glasgow, not NHS Highland currently.	Amber
<b>11</b>	SLA – current total £1.2m (diagnostics and LIMMS alone) – Alex to provide matrix of what SLA value should be on a population basis. Geoff to provide overview of all current activity and LIMS.	Alex Javed & Geoff Day	2 <sup>nd</sup> December 2016	Green

<b>12</b>	Confirmation of consultant support for different laboratory disciplines	Mark Ashton	Completed and agreed with Greater Glasgow & Clyde. Clinical Director role outstanding.	Green
<b>13</b>	Independent investigation of MHRA submission (blood compliance report) to comply with MHRA	Caroline Henderson (& external reviewer)	External review carried out and report sent to MHRA. <ul style="list-style-type: none"> <li>• Report highlighted good clinical practice.</li> <li>• Poor leadership and management from the Lab manager.</li> <li>• Criticism of lack of Clinical Director role. Highlighted that this should have been addressed when Argyll &amp; Clyde Health Board ceased.</li> </ul>	Green
<b>14</b>	MHRA Inspection 23 <sup>rd</sup> & 24 <sup>th</sup> February 2017.	Alex Javed & Caroline Henderson	MHRA inspection carried out over 2 days. Report received. Action plan to address the gaps to be submitted within 4 weeks. Another MHRA visit will take place later in the year to follow up on action plan to ensure it is completed.	Amber
<b>15</b>	CPA inspection 22 <sup>nd</sup> & 23 <sup>rd</sup> Feb 2017	Alex Javed & Geoff Day	Following review of CPA inspection, the inspector acknowledged the huge amount of work that has been carried out, but within the timescales there was still some gaps within the Quality management system. We also have not appointed a Clinical Director role, which is crucial to CPA accreditation. Following visit, we agreed to voluntarily resign from CPA accreditation and resubmit another application for UKAS ISO 15189. This was discussed with inspector at the time, and	Amber

			she felt we would get a pre-inspection in October 2017 and formal inspection January 2018.	
<b>16.</b>	HSE joint visit with Raigmore Hospital 8 <sup>th</sup> & 9 <sup>th</sup> Nov 2016.	Geoff Day & Bob Summers	Formal response submitted from NHS Highland to HSE.	Amber
<b>17.</b>	HSE inspection for Riddor reportable incident	Alex Javed & Geoff Day	Formal response submitted. Following to be addressed: <ul style="list-style-type: none"> <li>• Ensure adherence to lone working policy.</li> <li>• Ensure Wet Working Occupational Health policy implemented. This is being reviewed across NHS Highland.</li> <li>• Onerous on call to be reviewed</li> </ul>	Amber



## Argyll & Bute Health & Social Care Partnership

### Integration Joint Board

Agenda item : 5.7

Date of Meeting : 29 March 2017

Title of Report : Staff Governance Report – February 2017

Prepared by : Moira Newiss, Head of HR (HSCP) & Jane Fowler, Head of Improvement & HR (A&B Council)

Presented by : Stephen Whiston, Head of Strategic Planning & Performance

#### The Integration Joint Board is asked to :

Note the content of this quarterly report on the staff governance performance in the HSCP.

## 1. EXECUTIVE SUMMARY

This paper sets out performance data and current key issues for staff governance in the Health & Social Care Partnership. As the IJB is aware the HSCP does not employ staff, this remains the statutory responsibility of Argyll and Bute Council and NHS Highland respectively.

The elements detailed in this paper provide the IJB with information on the staff governance issues which the HSCP and its respective employer bodies are addressing to:

- Support staff in their work and development.
- Assess workforce performance and identify issues
- Establish staff partnership and trade union relationship and operation
- Ensure compliance with terms and condition and employing policies
- Adopt best practice from both employers
- Identify service change implications for the workforce and compliance with the above.

## 2. INTRODUCTION

This report provides an overview of the staff governance issues identified above as raised and discussed at the Senior Management Team and Joint Partnership Forum.

This report will be presented to the IJB on a quarterly basis. This report includes updates on:

- Employee Survey (Council) & iMatter (NHS)
- Organisation Change and Service Redesign issues
- Employee redundancy and redeployment position
- Roll out of eEES, the electronic employment support system (NHS)
- Workforce Planning
- Terms & Conditions
- Workforce performance including attendance management, turnover, vacancies, suspension, disciplinary and grievance statistics.

The majority of the data in this report relates to Quarter 3 (September to December 2016) unless stated differently.

### **3. DETAIL OF REPORT**

#### **3.1 Employee Survey & iMatter**

Argyll & Bute Council employee survey response rate was 24% across the council. We have received initial feedback from the organisation who was engaged to conduct the survey and this will be reviewed in detail by our culture steering group at their meeting on 21<sup>st</sup> February.

iMatter, the new NHS staff experience survey, is due to be rolled out to Argyll & Bute HSCP from May 2017. A presentation has been given to the Strategic Management Team and Partnership Forum and it has been agreed that it will cover all staff in the HSCP (both health and council employees).

iMatter is a continuous improvement tool designed with staff in NHS Scotland to help individuals, teams and Boards understand and improve staff experience. This is a term used to describe the extent to which employees feel motivated, supported and cared for at work. It is reflected in levels of engagement, motivation and productivity. Understanding staff experience at work is the first step to putting in place measures that will help to maintain and improve it. It will benefit employees, and the patients, their families and other service users that they support.

The iMatter tool is a short survey completed annually by individuals confidentially which results in a Team Report which is then discussed to develop a team Action Plan. It is the action plan element that is the key to identify and managing change and improvements in the workplace.

#### **3.2 Statutory & Mandatory Training**

Argyll and Bute NHS Health and Safety Team provides face to face training in relation to Fire Safety, Moving and Handling and Prevention of Violence and Aggression. In addition staff undertake on-line training as per the requirements of the NOSH Training Prospectus. Argyll and Bute Council provides training in these topic areas for Council employed staff.



At the meeting of the HSCP H&S Group on 21 February 2017 the following items were discussed:

- An options paper for the future provision of V&A training, specifically examining the viability of the part-time trainer model
- That all localities should continue to ensure that they have a system of recording training needs and training attendance in place for all staff and report back the situation at the next meeting (Locality Managers), noting that the group are awaiting progress with the Oracle Learning Management System reports and the HQA Team Boards which will roll out across the HSCP.
- An update on progress with the integration of moving and handling training.
- Scrutiny of training compliance including Moving and Handling and how improved use of the Oracle Learning Management System is helping to improve compliance.

**Table 1 Example of HQA Team Board**

Refresher Period (Days)	1095	730	1095	1095			365
Delivery Method	learnPro	learnPro	learnPro	learnPro	learnPro	learnPro	Meeting
Staff Name	Highland : Fire Safety	Moving and Handling - Not-People Handling (Module A)	Violence and Aggression - Theory (Non-clinical)	Equality and Human Rights	HAI Induction Programme (Non-clinical)	Safe Information Handling - Foundation	Personal Development Review
Mr A	30/07/2015	23/10/2015	10/06/2014	27/10/2015	09/06/2016	26/09/2012	15/09/2016
Mrs B	11/05/2016	11/05/2016	23/11/2016	23/07/2016	08/06/2016	24/12/2012	07/12/2015
Miss C	21/06/2016	16/06/2016	12/04/2012	16/06/2016	09/06/2016	16/06/2016	23/12/2015

Members of the Health & Safety Team are the providers of training and it is the responsibility of managers to ensure that their staff attend the training provided and maintain training records, for both NHS and Council.

The IJB had previously asked about the risk relating to non compliance with training. The law imposes a responsibility on the employer to ensure safety at work for all their employees and as employers the Council and Health Board are vicariously liable for the actions of their employees. Much of the law regarding safety in the work place can be found in the **Health & Safety At Work Act 1974**. Employers have to take reasonable steps to ensure the health, safety and welfare of their employees at work. Failure to do so could result in a criminal prosecution in the Sheriffs Court or a High Court. Failure to ensure safe working practises could also lead to an employee suing for personal injury or in some cases the employer being prosecuted for corporate manslaughter. As well as this legal responsibility, the employer also has

an implied responsibility to take reasonable steps as far as they are able to ensure the health and safety of their employees is not put at risk. So an employer might be found liable for his actions or failure to act even if these are not written in law. Training that is categorised as statutory or mandatory is therefore based on the assessment of risk in relation to not providing /receiving training.

Progress with the roll out of the Oracle Learning Management System now means we have the first data available for NHS employees in Argyll & Bute. Managers will be able to use this to accurately measure compliance with statutory and mandatory training requirements.

The Council are rolling out a programme of mandatory equalities training and staff who have not yet completed this training should be encouraged to do so. This training is available both face to face and through e learning. The electronic recording of all training requirements and training completed is currently under development and will provide accurate records and inform future training programmes. The HR and OD team are currently working on proposals to provide first aid training and personal safety training in house.

The Council continues to deliver SSSC registration training through its SVQ centre to Adult Services and Children and Families Social Care employees. There is also a programme of Social Work Degree student learning underway. This is reported through the Social Work Training Board and supports both the mandatory requirements for social work registration and Growing Our Own – the Council's initiative to support workforce planning.

### **3.3 Workforce Planning**

Workforce development sessions have been delivered for each of the Locality Planning Groups. Support is being provided from the national iHub improvement team (<http://ihub.scot/>) who have provided additional consultancy support. This work will help the LPGs to complete their redesign proposals to deliver the strategic plan for the HSCP. The work will focus initially on the Oban, Lorn & Isles Locality with a plan to roll out to others in the following couple of months.

### **3.4 NHS and Council Terms & Conditions**

#### **3.4.1 NHS Terms and Conditions Issues New Policies**

##### **3.4.1.1 NHS National Band 1 Review**

The Scottish Government asked NHS Boards to consider the roles and responsibilities of staff on Agenda for Change pay band 1, with a view to assisting with advancing the low pay agenda in NHS Scotland.

We are required to identify all band 1 posts, including bank only, and expand the job descriptions to meet similar roles at Band 2. This is an exciting opportunity for the IJB to invest in staff, both in terms of reward and training, as well providing them with more fulfilling work opportunities. It also provides the opportunity to review the way in which the services provided by these groups of staff are carried out. Most staff at Band 1 are domestics, and other affected groups include catering, portering, laundry and administrative staff.

The band 1 review work is progressing well locally with all new band 2 job descriptions now either approved or still with the Agenda for Change team for evaluation. Most staff meetings are complete and the majority of staff are expected to accept a band 2 post. All staff accepting the move to band 2 will have their pay back dated to 1<sup>st</sup> October and if additional training is needed, this will be completed by October 2017. There is an option for staff to remain on band 1 if they do not feel able to take on the additional duties or complete the training. There will be no more bank shifts offered at band 1.

It is recognised that the organisation may need to retain some band 1 posts as some existing band 1 employees may want to remain in their current post. Retaining these posts would be on an exceptional basis and as staff leave the band 1 post would be upgraded to Band 2.

Progress to date is that all staff in Mid-Argyll have moved to band 2 and received their back pay. All staff in Campbeltown have accepted band 2 post and back pay is being processed. Staff in Oban we are still waiting an outcome. In Cowal, Bute and Helensburgh a couple of staff have declined the move to band 2 but all others have confirmed. Staff in Islay are still awaiting an offer as are a couple of other staff groups as their job descriptions have not been reviewed yet by the Agenda for Change Team and this includes catering and portering staff.

#### **3.4.2 Council Terms and Conditions issues**

Savings as agreed by the IJB identify a number of Council posts at risk of redundancy. The Council's redundancy policy seeks to achieve voluntary severance or redeployment as the preferred option when a redundancy situation arises. There is accompanying guidance that advises managers clearly how to go about communications with employees and Trades Unions. Statutory redundancy consultation on the posts at risk began in October 2016 with the Joint Trades Unions supported by the Council's HR Team. It was then halted to allow for the IJB to carry out further consultation in relation to the savigns.

Any Council employees who may be at risk of redundancy as a result of any other proposed changes to services agreed by the IJB must be treated in accordance with the Council's policy. Any proposed changes that affect employees must be advised to them in advance of any information going into the public domain as per the Council's procedures.

### **3.5 Integrated HR Issues**

#### **3.5.1 Integrated HR Processes**

Work has been ongoing to try to develop integrated HR processes to support managers recruiting and managing a joint workforce. So far a proposal for Recruiting to Integrated Management Posts has been agreed in principle subject to national guidance. Work is ongoing to consider ways to join up processes for Workforce Monitoring and Organisational Change whilst adhering to both NHS Highland and A&B Council HR Policies. Proposals for consultation, organisational change and workforce monitoring will go to the next Partnership Forum and Strategic Management Team Meetings for approval. Consideration of how best to join up other

HR areas such as workforce planning, staff engagement, culture and leadership are being explored.

### 3.5.2 Integration Below Tier 3

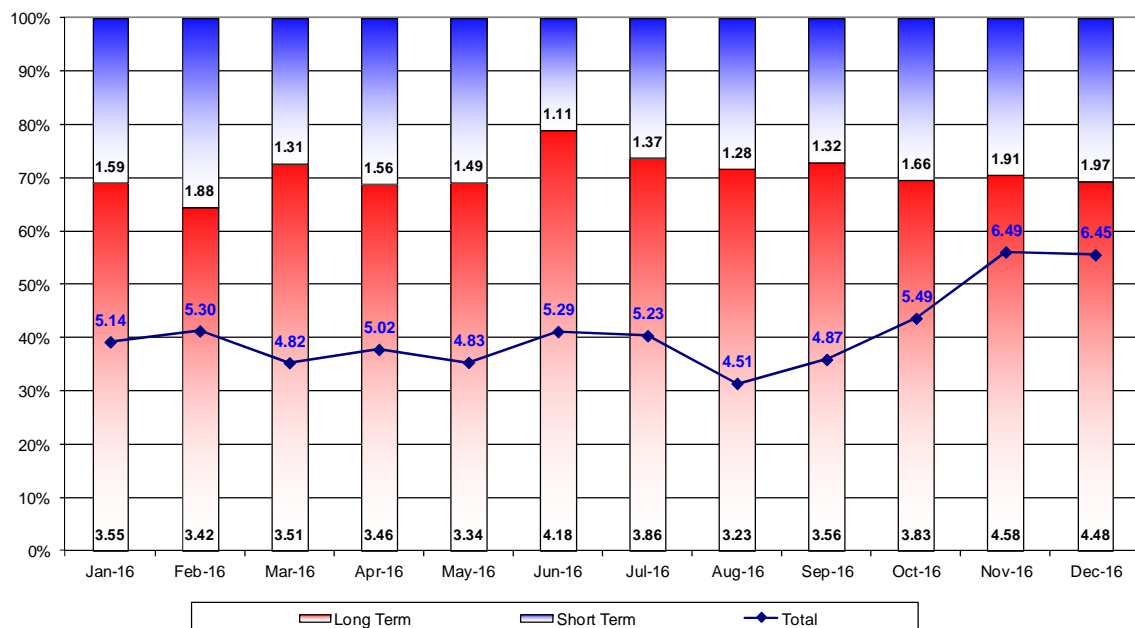
This issue has been discussed at length at the Partnership Forum and latterly a specific service redesign for the Performance & Information Team was tabled and debated. Further discussion at the Integrated Process Short Life Working Group resulted in agreement that in the first instances redesign of posts should concentrate on enhanced/extended roles and joint responsibilities with posts still hosted by either NHS or Council.

## 3.6 Workforce

### 3.6.1 Attendance Management (NHS)

The NHS Staff Sickness Report is in the process of being updated to represent the three operating management units, this work is not complete so the data presented is not 100% accurate. The latest data available from payroll is for the quarter September to December 2016. The roll out of the Scottish Standard Time System, which has begun in Oban, Lorn & Isles Locality, will improve reporting to near real time, this will hopefully be complete by March 2017 and be rolled out across all areas. All Operating Management Units remain above the national target of 4%. There has been a significant rise in sickness absence across all areas and actions are being taken by the HR Team to support operational managers, including supporting occupational health reviews, raising the issue at operational management team meetings and locality meetings and the offer of policy awareness sessions for department heads

Argyll & Bute - Sickness Trend & Breakdown  
Total figure shown on line, LTS/STS breakdown as columns



December 2016	STS	LTS	Total
Adult West	1.48%	4.31%	5.78%▼
Adult East	2.74%	4.69%	7.43%▲
C&F	1.17%	6.82%	7.99%▲
Corporate (incl Dental)	3.04%	4.11%	7.15%▲
<b>A&amp;B Total</b>	<b>1.97%</b>	<b>4.48%</b>	<b>6.45%▲</b>

STS = Short Term Sickness, LTS = Long Term Sickness

### 3.6.2 Attendance Management (Council)

The Council has a system in place that records accurate and live absence information by use of a Sickness Absence telephone line that ensures all absence is recorded by the HR team into the HR and payroll database.

This information is available to managers through MyView at their desktops. Automated emails are also generated to inform managers of the start or end date of absence in their teams.

The Council measures sickness absence as working days lost as per the required SPI for local government. The data available for this report is for Quarter 3 ending in December 2016. In Q3 the total number of working days lost per FTE employee was **4.07** against a target of **3.78**.

**Table 5**

Service	Target WDL per FTE Employee 16/17	WDL per FTE Employee in Q3 16/17	WDL per FTE Employee in Q3 15/16	WDL per FTE employee in Q3 14/15	% Change from Q3 15/16
Adult Care	4.10	4.52	3.86	4.49	0.17
<b>Children &amp; Families</b>	<b>3.15</b>	<b>3.07</b>	<b>3.35</b>	<b>3.52</b>	<b>-0.08</b>
<b>TOTAL HEALTH &amp; SOCIAL CARE PARTNERSHIP</b>	<b>3.78</b>	<b>4.07</b>	<b>3.69</b>	<b>4.13</b>	<b>0.10</b>

Children & Families has traditionally been an area of high absence but it has shown a very steady downwards trend against a backdrop of significant change with the creation of the Health and Social Care Partnership.

Adult Care has not met their target this quarter and their performance has deteriorated in comparison against the same quarter in the last two performance years.

## Health and Social Care Partnership – Council employees Absence Trend

The Council agreed a target for Return to Work Interviews of 100%, as research indicates that return to work interviews are an important and effective tool in managing attendance. The Council average for % of Return to Work Interviews completed was 76% for this quarter this year a reduction in comparison to the same quarter last year where the average was 86%. The most notable change is the 17% reduction in Return to Work Interviews carried out by Health and Social Care Partnership. This has been highlighted to management in this service.

**Table 6 % return to work interviews completed September - December 2016**

Department	% Completed FQ3 2016/17	Average Time to Complete (calendar days)	% Return to Work Interviews Completed FQ3 2015/16
Health & Social Care Partnership	67%	8.6	84%

A paper has been prepared for the Strategic Management Team to consider how best to support managers with promoting attendance. The proposals take a public health, organisational development and HR joint approach to try to tackle some of the underlying causes, including culture and staff engagement. The roll out of iMatter and the associated staff engagement/improvement approach as well as the values and behaviour framework development will both help with this.

### 3.6.3 Recruitment

**(NHS)** Employment Services reported 24 vacancies being advertised (January 2016). There are 159 vacancies currently being processed by department (recruitment process started but not yet complete). A new monitoring process is now in place allowing detailed scrutiny of the time taken to recruit and any delays in the process.

**(Council)** Recruitment Services reported 5 vacancies advertised internally and 7 externally (December 2016).

### 3.6.4 Redeployment

**(NHS)** There are 33 staff on the primary re-deployment register (no change) and 27 on the secondary re-deployment register (no change) (January 2016).

**(Council)** There are 1 staff currently on the redeployment register (December 2016).

### 3.6.5 Fixed Term contracts

**(NHS)** There are 32 staff currently on fixed term contracts (a reduction of 5) (December 2016).

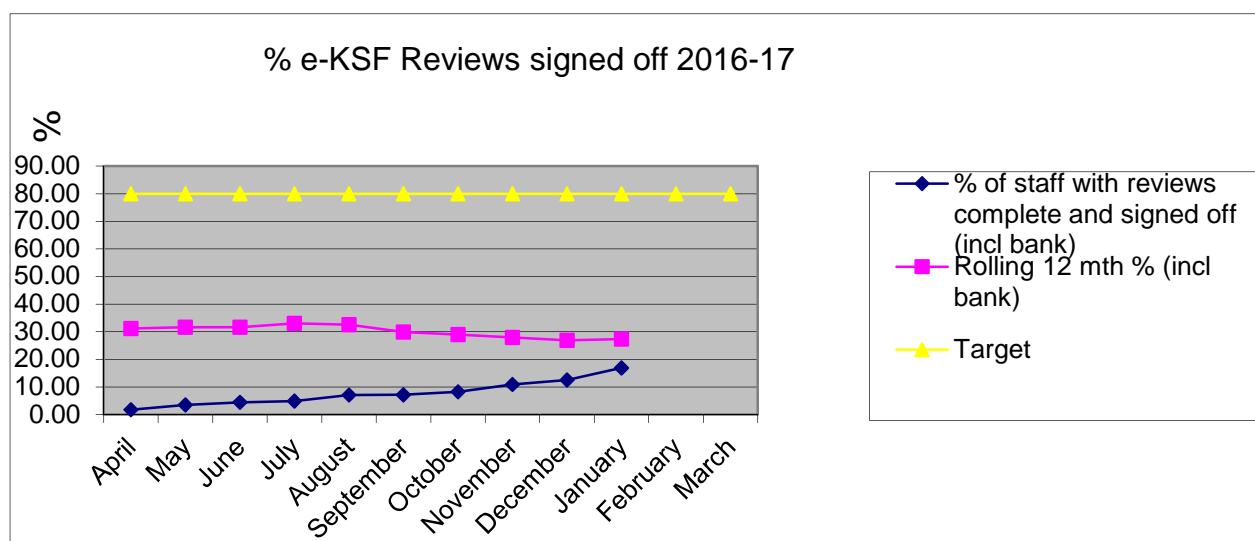
**(Council)** There are 118 staff on temporary or fixed term contracts (a reduction of 2) (December 2016). This is a high number as fixed term contracts are issued instead of employing a contractor to undertake care work in some area.

**Table 2 Fixed Term Contracts Council Staff**

Adult Care West	<b>46</b>
Adult Care East	<b>36</b>
Children and Families	<b>33</b>
Strategic Planning & Perf	<b>2</b>
<b>TOTAL</b>	<b>118</b>

### 3.6.6 Personal Development Plans & KSF (Knowledge & Skills Framework)

**(NHS)** Percentage of staff reviews completed and recorded on e-KSF from 1 April 2016 to 31-12-16 was 16.11% (across A&B HSCP for NHS staff covered by Agenda for Change). For a rolling 12 month period the figures were **27.43%** a slight increase.



(The Council has a target of 90% Performance Review and Development (PRDs) completion. This reflects the importance of holding regular meetings with employees to review targets set and identifying training and development needs for the following year. The % of Performance Review and Development (PRDs) completed at the end of Quarter 3 (*December*) was **59%**. The final target date for completion is the end of March, so it is anticipated that this will improve and meet the target by then. Managers must be made aware of the importance of carrying these out.

### 3.7 Organisational Change & Redesign

As the HSCP Quality & Finance Plan is developed to meet the budget requirements for 2017/18 and 2018/19 there will be a number of significant redesigns impacting on the workforce. Proposals going to the Partnership Forum and Strategic Management

Team include the set up of a new Staff Liaison Group to enable formal consultation with HR and Staff Partners. This will be the first stage of a new joint organisational change process that will support the redesign work using both NHS and Council policies.

#### **4. CONTRIBUTION TO STRATEGIC PRIORITIES**

The staff governance paper sets out the issues relating to staff that support or have an effect on the delivery of the HSCP strategic priorities.

#### **5. GOVERNANCE IMPLICATIONS**

5.1 Financial Impact – N/A

5.2 Staff Governance – this is the staff governance report.

5.3 Clinical Governance – N/A

#### **6. EQUALITY & DIVERSITY IMPLICATIONS**

These issues are picked up within the NHS and Council HR departments as appropriate when policies and strategies are developed.

#### **7. RISK ASSESSMENT**

Risk assessment will be addressed at individual project level. There are HR issues flagged up in the A&B HSCP Strategic Risk Register.

#### **8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT – N/A**

#### **9. CONCLUSIONS**

There are various challenges from a staff governance perspective including high sickness absence rates, the challenges of joining up health and safety and human resources processes for use in an integrated environment as well as the challenges of ensuring good communication and consultation on the redesign processes. The HR and Health & Safety Teams work to support Service Managers in addressing these concerns by providing expertise, advice and facilitation.





## Argyll & Bute Health & Social Care Partnership

### Integration Joint Board

Agenda item: 5.8

**Date of Meeting:** 29 March 2017  
**Title of Report:** Chief Officer Report  
**Presented by:** Christina West, Chief Officer

**The Integration Joint Board is asked to :**

Note the following report from the Chief Officer.

#### **New Locality Manager for Cowal and Bute**

Alison McKerracher took up her post as the new Locality Manager for the Cowal and Bute area on the 20 March. Alison brings with her a wealth of experience having previously worked for NHS Lothian and has a very good understanding of service development/improvement work.

#### **Head of Children & Families**

Louise Long, Head of Children and Families and Chief Social Work Officer for the HSCP will be leaving the organisation in May to take up the post of Chief Officer/Corporate Director of Health and Social Care in Inverclyde. I would like to congratulate Louise and wish her every success in this new and challenging role.

Alex Taylor, Locality Manager, Children's Services, Oban, Lorn & Isles will be taking over as the interim Head of Children & Families until the recruitment process for the Head of Service post is complete. Alex has substantial experience in Children and Families and will be able to support the service moving forward.

#### **HSCP Facebook Page Launched**

The HSCP Facebook page ([www.facebook.com/abhscp](http://www.facebook.com/abhscp)) launched at the end of February and is already proving very successful as another communications channel to engage with our local communities, staff and other stakeholders.

#### **No Smoking Day in Argyll and Bute**

No Smoking Day was held across the country on the 8<sup>th</sup> March. Public Health in Argyll and Bute worked this year with ASH Scotland to highlight that it's not always obvious just how much smokers could save if they quit.

Someone who smokes a pack a day would spend more than £3,000 a year which if they quit could be used instead for a family holiday, a new kitchen or bathroom, or even a second-hand car!

We know from surveys that more than two thirds of smokers want to quit. So No Smoking Day was about telling people 'you can do it!' and there is lots of free, expert support and advice available from the NHS and other organisations.

If people want to quit they can call Smokeline on 0800 84 84 84 for free expert advice and help. Lines are open from 8am to 10pm seven days a week.

### **Look Good Feel Better**

The national cancer support charity, Look Good Feel Better (LGFB), is now running free skincare and make-up workshops, at the Macmillan Day Unit, in Lorn & Islands Hospital in Oban. These style of LGFB workshops are held throughout the UK and are led by volunteer Beauty Professionals who take cancer patients through specially designed skincare and make-up sessions, which include instructions on how to look after changes to the skin and to help them define their best features with make-up. The aim is to improve the wellbeing and confidence of people undergoing treatment for any type of cancer.

The service is tailored to each individual patient and they are also given a special gift bag full of luxury beauty products which are supplied by the charity. Look Good Feel Better is the only global cancer support charity created to help women combat the visible side effects of their treatment. This confidence-boosting service is available in 26 countries and collectively the charity has supported more than 1.7m people to date.

### **Technology Enabled Care in Argyll and Bute**

The Technology Enabled Care (TEC) team in Argyll and Bute has recently launched its TEC Integrated Hub. The hub covers home/mobile health monitoring and Telecare services and will be the first point of contact to access all TEC services within the HSCP. The TEC team will triage and manage referrals, organise installations, training, monitoring and reviews for clients and patients using the services. They will also take part in engagement activities, organise training and support the implementation of TEC.

The team is led by a Programme Manager and consists of a TEC coordinator, 2 TEC development nurses, 2 project support officers, a Living it Up engagement officer and 6 Telecare outreach workers.

The team provides a home and mobile health monitoring service through the use of home pods for more intensive home monitoring. The home pod service is actually being relaunched and TEC nurses will be able to remotely support patients while they are being monitored. The nurses will also be able to assess, review and monitor the patient in conjunction with local clinical staff when required and they are also working closely with the Integrated Equipment Store who install equipment and provide first line support.

The TEC team also provide a text monitoring service called Florence which is used for long term condition management, falls strength and balance, hypertension, medication prompts, supporting reablement, and mental health. Work is also ongoing to develop further new Flo services and the team is looking to build on the current 6 GP practices who are working with them.