Integration Joint Board **Agenda item : 5.7i**

Date of Meeting: 25 September 2019

Title of Report: Engagement Framework Update

Presented by: Alison McGrory, Acting Associate Director Public Health

The Integration Joint Board is asked to:

- Note progress made in community engagement over the past 12 months and completion of the Engagement Quality Standards
- Approve the associated action plan for 2019-20
- Agree appropriate annual reporting and governance of engagement to be within the HSCP Annual Performance Report

1. EXECUTIVE SUMMARY

Argyll and Bute HSCP adopted an improved approach to community engagement during 2018-19. This has culminated in the following documents being developed:

- Engagement Framework (ratified by the IJB in May 2019)
- Engagement Action Plan 2019-20
- Engagement Quality Standards September 2019

This paper provides an update to the IJB on progress with engagement quality standards; seeks agreement that the action plan is adequate to meet the HSCP's obligations; and proposes governance of engagement is via the HSCP's Annual Performance Report in subsequent years.

2. INTRODUCTION

The Integrated Joint Board (IJB) approved the HSCP's strategic approach to engagement in May 2018. Since then a range of actions were progressed to achieve a consistent, comprehensive and effective approach to engagement across Argyll and Bute. These actions are outlined in the updated Engagement Framework which was ratified by the IJB in May 2019. This Framework sets out the importance of effective engagement with the public, people who use health and care services, carers, partners and staff, and provides detail on how effective engagement will be achieved. It can be viewed here: https://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/ABHSCP/AandB%20HSCP%20ENGAGEMENT%20FRAMEWORK%20April%202019.pdf

3. DETAIL OF REPORT

3.1 Engagement Action Plan

An action plan for engagement has been compiled during the second quarter of 2019-20 in order to map the range of engagement activity taking place across the HSCP. This includes activity for corporate services, adult services, children and families, primary care, and public health. Service managers have been supported in delivering their engagement activity by input and training from the Public Health Department.

The engagement action plan has embedded plans for how each activity will be delivered. These cannot be opened in a PDF file and are available on request. This action plan is evolving and will be added to throughout the year. The HSCP Senior Leadership Team provides oversight and direction for the activity in this action plan, for example, it was discussed at a business meeting in July 2019.

3.2 Engagement Quality Standards

The Engagement Framework set out clear standards for how the HSCP will conduct engagement activity. The Quality Standards have been updated to show comprehensive progress over the past 12 months.

Further oversight of engagement activity and professional expertise has been provided by the Strategic Engagement Advisory Group. This comprises officers and partners including Kirsteen Murray from the Third Sector Interface, Alison McCrossan from the Scottish Health Council and Heather Grier in an IJB and community representative capacity. Their input has been invaluable and collectively this expertise is helping to inform engagement activity throughout the Community Planning Partnership.

4. RELEVANT DATA AND INDICATORS

No relevant information to report.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The activity in this paper supports delivery of the following strategic objective for the HSCP set out originally in the 2016 – 2019 Strategic Plan and reinforced in the latest iteration:

> *We will underpin our arrangements by putting in place a clear, communication and engagement arrangements involving our staff, users, the public and stakeholders.*

6. GOVERNANCE IMPLICATIONS

Governance of the engagement and communications action plans is proposed to take place by annual tabling of prospective action plans to the IJB and retrospective reporting of activity via the HSCP Annual Performance Report.

6.1 Financial Impact

There are no financial impacts inherent in the activity in this paper.

6.2 Staff Governance

Health and social care staff will be supported to participate in engagement processes outlined in the Engagement Framework by the Public Health Department. Effective engagement is a core competency of Public Health as set out in the Public Health Skills and Knowledge Framework.

6.3 Clinical Governance

There are no clinical governance issues in this paper.

7. EQUALITY & DIVERSITY IMPLICATIONS

The strategic approach to engagement has been written from the perspective of inclusion, fairness and equity. The Frameworks recognises the importance of using a range of techniques and approaches in order to ensure everyone has the opportunity to access information and take part in engagement activities. There is specific reference to “hard to reach groups”.

8. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

There are no GDPR issues within the actions of this paper.

9. RISK ASSESSMENT

There are no risks from implementing the actions in this paper. Community engagement is identified as a risk in the HSCP risk register and the action plan seeks to mitigate these organisational risks.

10. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The purpose of the engagement action plan is to achieve improved public, service user, staff and partner involvement.

11. CONCLUSIONS

Significant progress has been made with improved approached to engagement. The HSCP recognises the importance of effective community engagement and has developed and implemented improved approaches to achieve this objective. This paper outlines an action plan for engagement and proposes implementation is reported via the HSCP Annual Performance Report.

12. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

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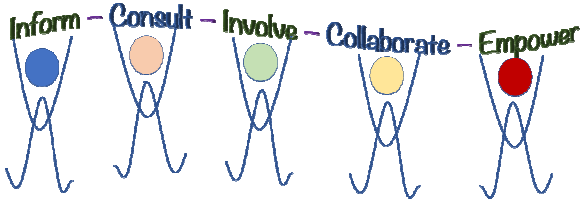
Argyll & Bute Health & Social Care Partnership



Argyll & Bute Health & Social Care Partnership
Annual Engagement Plan - 2019/2020
(September 2019)

Version 6 13th September 2019

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CHILDREN & FAMILIES

1.	3. Engagement Specification.CARO.J

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Business Case and options regarding Child Assessment and Reviewing Officer's Service (CA.R.O.)	Service Users	X	Consultation and full business case have been completed. Recommendations to be considered in the larger management and service restructuring process.		Yes	X	No	
	Carers	X		**Timeframe**	April 2019			
	Partners	X		**Strategic Lead**	Alex Taylor			
	HSCP Staff	X		**Operational Lead**	Mandy Sheridan			
	IJB/SPG/LPG			**Activity completed**	Yes	X	No	

2.	2. Engagement Specification DISABIL

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed

Inform and **Consult** staff and others on the review of services for children and young people with disabilities.	Service Users	X	Face-to-face meetings with parents / guardians and social work staff - to share their views, experiences, and any concerns or ideas for changes to the service. Survey sent out to others.			Yes	X	No	
	Carers/Parents	X			**Timeframe**	Feb-Aug 2019			
	Partners	X			**Strategic Lead**	Alex Taylor			
	HSCP Staff	X			**Operational Lead**	Bethany Fanshawe			
	IJB/SPG/LPG	X			**Activity completed**	Yes		No	X

3. 1. Engagement Specification.MAT.do

Purpose	**Audience**	(x)	**Engagement Method**	**Engagement Specification completed**				
Inform and **consult** service users and **involve** staff in the redesign aspects of maternity services.	Service Users	x	Staff engagement days; service user questionnaire; Best Start Newsletter; Facebook and Twitter updates; Care Opinion and Staff reflections following cross boundary working. Engagement with media to highlight Best Start.		Yes	X	No	
	Carers			**Timeframe**	Throughout 2019			
	Partners			**Strategic Lead**	Alex Taylor			
	HSCP Staff	x		**Operational Lead**	Catriona Dreghorn/ Jaki Lambert			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

4. 3. Engagement Specification Hostels.

Purpose	**Audience**	(x)	**Engagement Method**	**Engagement Specification completed**				
Inform and **Consult** on School Hostels services in Dunoon and Oban to determine if services are fit for purpose and represent value for money.	Service Users	X	Issue a Hostel News Letter every term and develop a Hostel Facebook Page. Hold community events and celebrations. Annual questionnaire to parents; collate the feedback and respond as appropriate. Regular face to face meetings with School Staff.		Yes	X	No	
	Carers/Parents	X		**Timeframe**	Throughout 2019			
	Partners	X		**Strategic Lead**	Alex Taylor			
	HSCP Staff	X		**Operational Lead**	Mark Lines/Pamela Hoey			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

5.	5. ENGAGEMENT SPECIFICATION PILC

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Consult on the establishment of a core and cluster accommodation model in Helensburgh	Service Users	X	One to one discussions with young people and meeting discussions with HSCP staff and key partners.		Yes	X	No	
	Carers			**Timeframe**	2019			
	Partners	X		**Strategic Lead**	Alex Taylor			
	HSCP Staff	X		**Operational Lead**	TBC			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

6.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Redesign of mental health services for children and young people. To improve value for money and responsiveness to service user needs.	Service Users	X	Summary based on Engagement Specification TBC		Yes		No	X
	Carers			**Timeframe**	2019			
	Partners	X		**Strategic Lead**	Alex Taylor			
	HSCP Staff	X		**Operational Lead**	Brian Reid			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

ADULT SERVICES

1.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Informing and **consulting** on the redesign of MACHICC, Lochgilphead community Hospitals	Service Users		Summary based on Engagement Specification TBC		Yes		No	X
	Carers			**Timeframe**	2019-20			
	Partners			**Strategic Lead**	Liz Higgins			
	HSCP Staff			**Operational Lead**	Donald Watt			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

2.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Informing and **consulting** on the redesign of Campbeltown Community Hospital	Service Users	X	Summary based on Engagement Specification TBC		Yes		No	X
	Carers	X		**Timeframe**	2019-20			
	Partners			**Strategic Lead**	Liz Higgins			
	HSCP Staff	X		**Operational Lead**	Donald Watt			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

3.	DSLWG Engagement Specification.docx

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Informing and **consulting** on the review and redesign of services for people with dementia.	Service Users	X	Review the structure and function of dementia services, with the aim of eventually developing recommendations for future service provision.		Yes		No	X
	Carers	X		**Timeframe**				
	Partners	X		**Strategic Lead**	Donald Watt			
	HSCP Staff	X		**Operational Lead**	Lora White			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

4.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Informing and **consulting** on the review and redesign of LD services.	Service Users		Summary based on Engagement Specification TBC		Yes		No	X
	Carers			**Timeframe**	2019-20			
	Partners			**Strategic Lead**	Jim Littlejohn			
	HSCP Staff			**Operational Lead**				
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

5.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Informing and **consulting** on the review of Lorn Local Resource Centre Lynnside.	Service Users	x	Summary based on Engagement Specification TBC		Yes		No	X
	Carers	x		**Timeframe**	2019-20			
	Partners	x		**Strategic Lead**	Donald Watt			
	HSCP Staff	x		**Operational Lead**	Lora White			
	IJB/SPG/LPG	x		**Activity completed**	Yes		No	X

6.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Informing and **consulting** on Staff co-location in Mid Argyll and OLI.	Service Users		Summary based on Engagement Specification TBC		Yes		No	X
	Carers			**Timeframe**	2019-20			
	Partners			**Strategic Lead**	Donald Watt			
	HSCP Staff	x		**Operational Lead**	Nikki Gillespie			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

7.	Insert Engagement

	Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Informing and **consulting** on the model for care homes and housing	Service Users	x	Summary based on Engagement Specification TBC		Yes		No	X
	Carers	x		**Timeframe**	2019-20			
	Partners	x		**Strategic Lead**	Linda Currie			
	HSCP Staff	x		**Operational Lead**				
	IJB/SPG/LPG	x		**Activity completed**	Yes		No	X

8.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Informing and **consulting** on the community model of care	Service Users	x	Summary based on Engagement Specification TBC		Yes		No	X
	Carers	x		**Timeframe**	2019-20			
	Partners	x		**Strategic Lead**	Linda Currie			
	HSCP Staff	x		**Operational Lead**				
	IJB/SPG/LPG	x		**Activity completed**	Yes		No	X

PRIMARY CARE SERVICES

1.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Informing and **consulting** on the national Primary Care Modernisation programme and local delivery	Service Users	X	Inform stakeholders about the implications of the programme and the service developments taking place. A range of workstreams in this programme are progressing their own engagement activity.		Yes		No	X
	Carers	X		**Timeframe**	2019 ongoing			
	Partners	X		**Strategic Lead**	Rebecca Helliwell			
	HSCP Staff			**Operational Lead**	New officer TBC			
	IJB/SPG/LPG	X		**Activity completed**	Yes		No	X

2.	 Engagement Specification KMG mei

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Informing and **consulting** on provision of primary care services in Kintyre.	Service Users	X	Continuation from previous year's work. ▪ Inform through newsletters, press releases, social media.		Yes	X	No	
	Carers	X		**Timeframe**	2019-20			
	Partners			**Strategic Lead**	Donald Watt			
	HSCP Staff			**Operational Lead**	Alison Hunter			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

3.	 Re__Link_working_-_engagement_specific

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Consult on service user and service provider	Service Users		Surveys have gone out to GPs and third sector.		Yes	X	No	
	Carers			**Timeframe**	Jan-June 2019			

experience, design of potential Link Worker model(s)	Partners	X		**Strategic Lead**	Alison McGrory			
	HSCP Staff	X		**Operational Lead**	Caroline MacArthur			
	IJB/SPG/LPG			**Activity completed**	Yes		No	

CORPORATE SERVICES

1. Conversation Cafés.docx

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Inform staff and partners on the function of Conversation Cafés. **Involve** LPGs and staff in setting up Cafés.	Service Users		Develop and deliver training on the function of the Cafés and how they should be planned and run. Distribute documents outlining this process.		Yes	X	No	
	Carers			**Timeframe**	March-Aug 2019			
	Partners	X		**Strategic Lead**	Alison McGrory			
	HSCP Staff	X		**Operational Lead**	Jay Wilkinson			
	IJB/SPG/LPG	X		**Activity completed**	Yes		No	X

2. LPG Reestablishment.doc

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Inform and **consult** on the changes to the LPGs. **Collaborate** with communities, partners, and staff to develop the LPGs.	Service Users	X	Engagement activity to recruit new members: - TSI for third sector reps - Carers centres for carers reps - ADP for alcohol/drug reps - Local authority for community councils		Yes	X	No	
	Carers	X		**Timeframe**	Oct 2018-July 2019			
	Partners	X		**Strategic Lead**	Kristin Gillies			
	HSCP Staff	X		**Operational Lead**	Laureen McElroy			
	IJB/SPG/LPG	X		**Activity completed**	Yes		No	X

3. Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Inform people on the changes to the Carers Act	Service Users		Summary based on Engagement Specification TBC		Yes		No	X
	Carers	X		**Timeframe**	2018-2019			
	Partners			**Strategic Lead**	Linda Currie			
	HSCP Staff	X		**Operational Lead**	New officer			

	IJB/SPG/LPG			**Activity completed**	Yes		No	X

4.	Insert Engagement Specification

Purpose	**Audience**	(x)	**Engagement Method**	**Engagement Specification completed**			
Inform people on the HSCP Workforce Plan	Service Users		▪ Workforce planning (WFP) conversations in localities ▪ Short Life Working Group set up to shape HSCP Workforce plan and develop Action plan and governance process Draft Workforce plan in November		Yes		No	X
	Carers			**Timeframe**	2019-2020			
	Partners			**Strategic Lead**	Jane Fowler			
	HSCP Staff	X		**Operational Lead**	Fiona Sharples			
	IJB/SPG/LPG	X		**Activity completed**	Yes		No	X

5.	Insert Engagement Specification

Purpose	**Audience**	(x)	**Engagement Method**	**Engagement Specification completed**			
Inform and **consult** Culture Fit for the Future	Service Users		Summary based on Engagement Specification TBC		Yes		No	X
	Carers			**Timeframe**	2019-2020			
	Partners			**Strategic Lead**	Jane Fowler			
	HSCP Staff	X		**Operational Lead**	Charlie Gibson			
	IJB/SPG/LPG	X		**Activity completed**	Yes		No	X

6.	Engagement Spec Finance Sept 2019

Purpose	**Audience**	(x)	**Engagement Method**	**Engagement Specification completed**				
Inform people on the HSCP financial position	Service Users	X	Key messages from meetings Staff briefing Press releases		Yes	X	No	X
	Carers	X		**Timeframe**	2019-2020			
	Partners	X		**Strategic Lead**	Judy Orr			
	HSCP Staff	X		**Operational Lead**	Judy Orr			
	IJB/SPG/LPG	X		**Activity completed**	Yes		No	X

7.	Engagement Spec Commissioning Plan

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Inform, **consult** and **involve** stakeholders on the development of the Commissioning Plan	Service Users	X	Work with SPG and LPGs and other partners to establish baseline for commissioning intentions. Review exising contracts with a view to equality of provision with partners. Form a reference group and work with Strategic Engagement Advisory Group.		Yes	X	No	X
	Carers	X		**Timeframe**	2019-2020			
	Partners	X		**Strategic Lead**	Stephen Whiston			
	HSCP Staff	X		**Operational Lead**	Laureen McIlroy			
	IJB/SPG/LPG	X		**Activity completed**	Yes		No	X

8.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Consult, **inform** and in iMatter staff survey	Service Users		▪ Annual iMatter participation based on national programme timelines. ▪ NHS Board Operational lead leads process in NHS Highland ▪ Local A&B communications planned at each stage to support ▪ Leadership at all levels to promote and encourage participation in iMatter and the action planning improvement cycle		Yes		No	X
	Carers			**Timeframe**	2019-2020			
	Partners	X		**Strategic Lead**	Jane Fowler			
	HSCP Staff	X		**Operational Lead**	Fiona Sharples			
	IJB/SPG/LPG	X		**Activity completed**	Yes		No	X

9.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Empowering the Health and Wellbeing Working group and **Collaborating** on the development and implementation of recommendations for Staff Health and Wellbeing in the HSCP	Service Users		▪ Working group Terms of Reference reviewed ▪ Paper with recommendations to SLT to seek approval following some engagement with staff ▪ Develop action for implementation once recommendations approved Communication updates		Yes		No	X
	Carers			**Timeframe**	2019-2020			
	Partners			**Strategic Lead**	Jane Fowler			
	HSCP Staff	X		**Operational Lead**	Fiona Sharples			
	IJB/SPG/LPG	X		**Activity completed**	Yes		No	X

10.	Insert Engagement Specification

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed			
Informing and **consulting** on catering provision	Service Users	x	Summary based on Engagement Specification TBC		Yes		No	X
	Carers	x		**Timeframe**	2019-20			
	Partners	x		**Strategic Lead**	To be confirmed			
	HSCP Staff	x		**Operational Lead**				
	IJB/SPG/LPG	x		**Activity completed**	Yes		No	X

PUBLIC HEALTH

1. Engagement Specification SM strat

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Inform, **consult**, and **involve** stakeholders in the writing of the Self-Management Strategy	Service Users	X	Focus groups developing priorities with service users who have LTCs. Survey out to staff. Discussion with partners. Involvement of stakeholders and partners in working group. Consultation papers sent out to staff, partners, and public.		Yes	X	No	
	Carers	X		**Timeframe**	Jan-July 2019			
	Partners	X		**Strategic Lead**	Alison McGrory			
	HSCP Staff	X		**Operational Lead**	Maggie Clark			
	IJB/SPG/LPG	X		**Activity completed**	Yes	X	No	

2. HWN review.docx

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Consult on the effectiveness of the current Health and Wellbeing Network structures and functions.	Service Users	X	Group discussions with Health & Wellbeing Network members and coordinators. Survey online, to include feedback on consultation process.		Yes	X	No	
	Carers	X		**Timeframe**	June-Aug 2019			
	Partners	X		**Strategic Lead**	Alison McGrory			
	HSCP Staff			**Operational Lead**	Angela Coll			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

3. Cool2Talk.docx

Purpose	Audience	(x)	Engagement Method	Engagement Specification completed				
Inform and **consult** users on the new iteration of the	Service Users	X	Pending decision of service's future.		Yes	X	No	
	Carers			**Timeframe**	August-Dec 2019			
	Partners			**Strategic Lead**	Sam Campbell			

Cool2Talk service	HSCP Staff			**Operational Lead**	Sam Campbell			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

4. ADP Engagement Specification (2).docx

Purpose	**Audience**	(x)	**Engagement Method**	**Engagement Specification completed**			
Collaborate with representatives of recovery organisations and family support movement to develop ADP activity in Argyll & Bute	Service Users	X	Stakeholder representatives included in Alcohol & Drug Partnership.		Yes	X	No	
	Carers	X		**Timeframe**	Ongoing			
	Partners	X		**Strategic Lead**	Craig McNally			
	HSCP Staff	X		**Operational Lead**	Craig McNally			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

5. EQIA Briefings.docx

Purpose	**Audience**	(x)	**Engagement Method**	**Engagement Specification completed**			
Inform managers and staff on the guidance and legislation around EQIAs.	Service Users		There will be two one hour webex sessions to run through the new paperwork. The guidance document has comprehensive information on the process and pathways.		Yes	X	No	
	Carers			**Timeframe**	July 2019			
	Partners			**Strategic Lead**	Alison Hardman			
	HSCP Staff	X		**Operational Lead**	Alison Hardman			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

6. Insert Engagement Specification

Purpose	**Audience**	(x)	**Engagement Method**	**Engagement Specification completed**			
Consult and **involve** staff, partners, people, cares and people who	Service Users	X	Stakeholder representatives included in Alcohol & Drug Partnership.		Yes		No	
	Carers	X		**Timeframe**	Ongoing			
	Partners	X		**Strategic Lead**	Alison McGrory			

use services on the development of the ADP strategy	HSCP Staff	X		**Operational Lead**	Craig McNally			
	IJB/SPG/LPG			**Activity completed**	Yes		No	X

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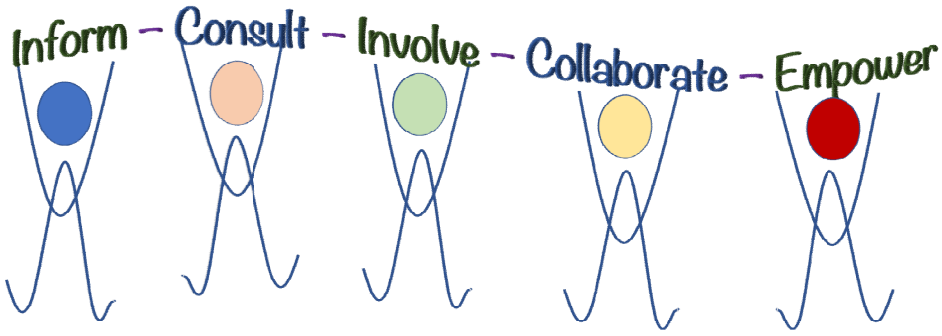
Argyll & Bute Health & Social Care Partnership

Engagement Quality Standards Framework

SEPTEMBER 2019



INTRODUCTION

The Integrated Joint Board approved the *HSCP Engagement Framework* in May 2018. This document articulated the Health & Social Care Partnership's approach to engagement, providing a foundation for all future engagement approaches relating to major service change or transformation.

The Engagement Framework draws on the International Association for Public Participation's *IAP2 Spectrum for Public Participation*[2] and the Scottish Health Council's *Participation Toolkit*[3], both of which outline incremental levels of engagement. It also ensures compliance with the Scottish Government's *CEL4* statutory guidance outlining organizational requirements for engagement.

QUALITY ASSURANCE

This Engagement Quality Standards Framework supports the 2018 *HSCP Engagement Framework,* providing a means of benchmarking and evidencing engagement activity and achievement against well-documented good practice.

Quality Assurance is focused on planning, documenting and agreeing a set of standards from the outset in order to provide greater transparency to processes and activity. Quality is assured and evaluated against these standards. It reflects a strong commitment to demonstrable approaches to engagement with service users, carers, partners and staff (stakeholders) and aims to achieve excellence in all aspects of engagement, embedding a culture of continuous improvement and meeting a range of regulatory and legislative requirements.

Quality assurance focuses on four key standards and a number of quality dimensions (Fig 1.).

Fig 1. Engagement Standards

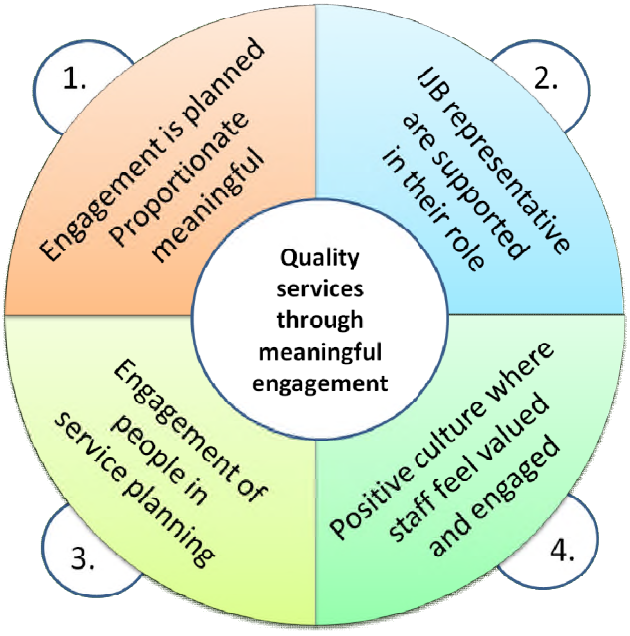


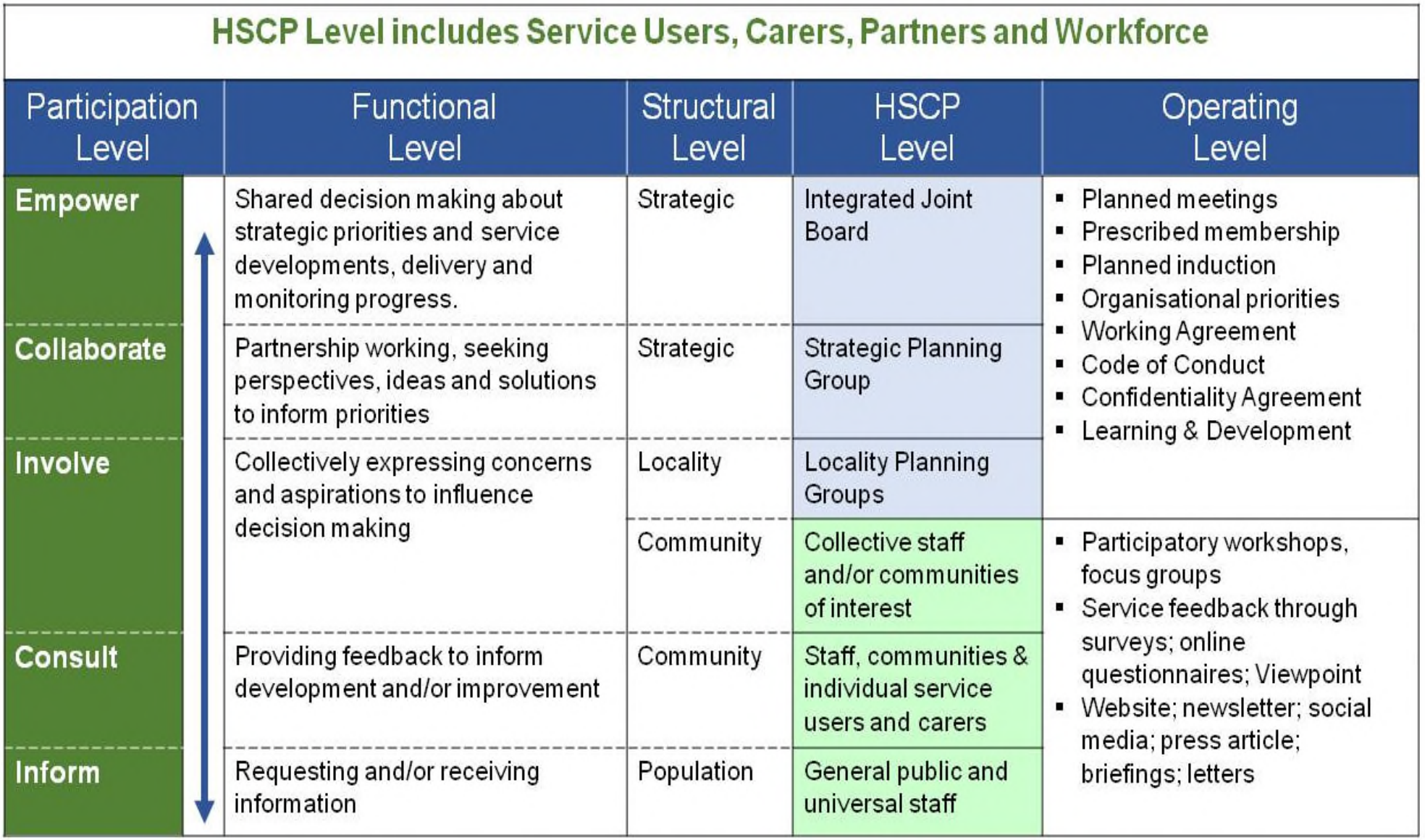
Fig 2 (below) sets out an engagement matrix which describes the levels of organisational engagement that can be expected by stakeholders. The matrix is designed to be explicit about the:

a) different degrees of engagement;
b) the nature of engagement;
c) theoretical basis, essentially distinguishing between normative and/or pragmatic; and
d) objectives for which engagement is used.

The purpose is to ensure stakeholders clearly understand:

- **who** is being engaged;
- **what** method is utilised;
- **why** they are being engaged; and
- **how** their contribution informs decisions.

Fig 2. Engagement Matrix

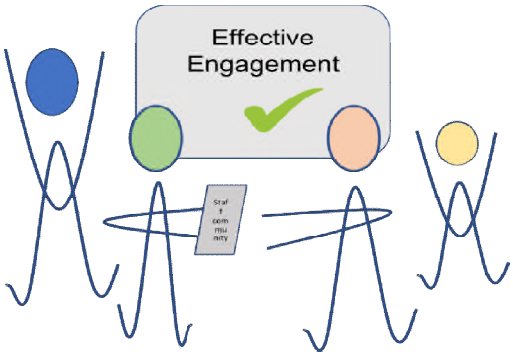


STANDARD 1.

Stakeholder engagement is planned, proportionate, meaningful and effective

Outcomes

- The HSCP is recognised as an organisation that is committed to engaging citizens, partners and staff (stakeholders) in strategic planning and decision-making.
- IJB strategies, plans and policies are informed by the views of stakeholders through effective engagement
- Engagement plans are explicitly recorded.



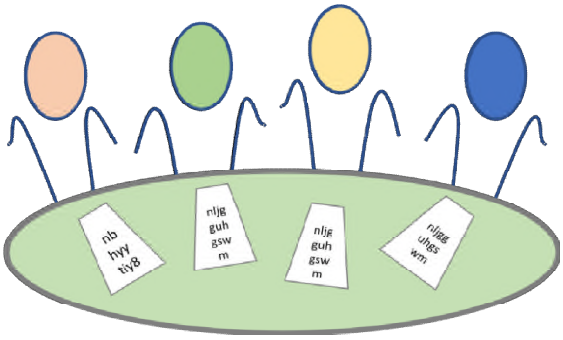
Quality dimension		Evidence
a.	**Board members and senior managers are able to articulate the organisation's approach to stakeholder engagement.**	Engagement Framework discussed and endorsed by IJB in May 2019. Report delivered on stakeholder engagement structures in December 2018. Progress report and action planning presented to IJB in September 2019.
b.	**Clear organisational governance structures are in place to meet the statutory duties in relation to participation/engagement.**	The Strategic Engagement Advisory Group provides a semi-autonomous "check and balance" to organisational engagement and informs best practice. Engagement is regularly discussed at SLT.
c.	**The IJB has robust mechanisms in place that provide assurance that a culture of engagement is encouraged throughout the organisation.**	Engagement Specifications have been rolled out over summer 2019 with training made available to project/service managers. Conversation Cafes have been set up in all localities. Processes for routine service feedback are under review.
d.	**The IJB is able to access and benefit from independent strategic engagement expert advice and support.**	The Strategic Engagement Advisory Group has been set up, meeting bimonthly. Links with the Scottish Health Council have been developed.
e.	**All organisational engagement is planned, recorded and reported.**	Engagement Plans developed for 2018-2019 and 2019-2020. Engagement Specifications rolled out over summer 2019, with training delivered on their use.

STANDARD 2.

Service user, carer and third sector representatives on strategic planning groups are supported to effectively undertake their role

Outcomes

- Service user, carer and third sector representatives are clear about and feel confident in undertaking the responsibilities of their role.
- Service user, carer and third sector representatives are able to evidence their contribution to the work of the IJB, Strategic Planning Group and locality planning groups.



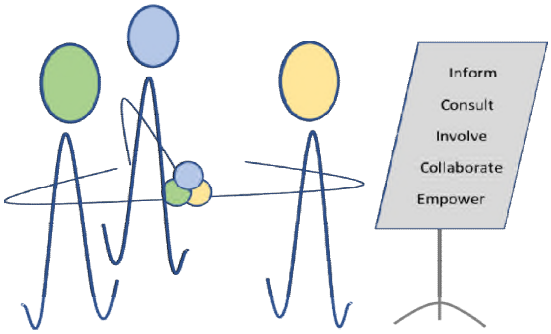
Quality dimension		Evidence
a.	**Processes for the recruitment and induction of service user, carer and third sector representatives are clear, proportionate and fair.**	Recruitment of representatives to the new Locality Planning Groups has been recorded in detail and reported to the Strategic Planning Group in June 2019. Matrices developed for this purpose have been adapted to other groups, e.g. the Alcohol and Drug Partnership.
b.	**Mechanisms are in place to enable service user, carer and third sector representatives to have their development needs met through shared learning, exchanging ideas and generating actions.**	Leaflets have been developed and distributed to outline engagement processes, available resources, and key contacts. Health and wellbeing development days allow service users, carers, and health and social care workers to build their knowledge base. Further training needs are being assessed.
c.	**Mechanisms are in place to enable service user, carer and third sector representatives to be involved in service planning and development.**	New Locality Planning Groups convened, with representatives from service users, carers, and the third sector. Community Conversation Cafes will be held quarterly in all localities (4 held to date). Routine service feedback is under review. Leaflets on engagement and feedback have been publicly distributed during summer 2019.
d.	**Service user and carer representatives will have their expenses reimbursed including the costs of any 'substitutionery' care that might be required.**	A budget of £2,000 exists for this purpose. There was no spend on this budget in quarter 1 suggesting representatives could be better informed of this facility.

STANDARD 3.

There is supported and effective engagement of service users and carers in service planning and improvement.

Outcomes

- Engaging service users and carers in the planning and delivery of their care contributes to responding to needs, as well as improving outcomes and service experience.
- Positive experience of engagement improves public confidence in health and social care services.
- Health and social care staff feel confident about engaging service users and carers, and this forms part of the day-to-day planning, delivery and monitoring of services.



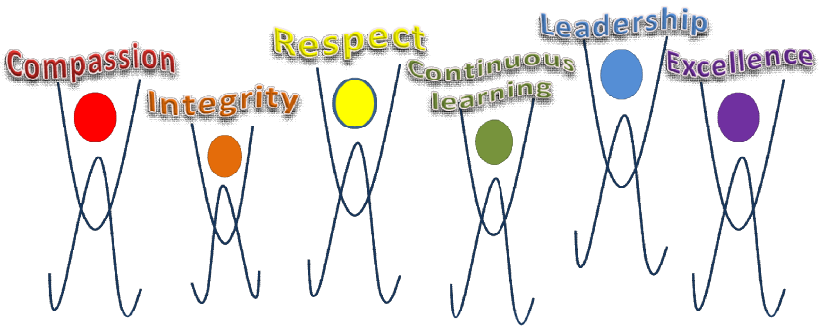
Quality dimension		Evidence
a.	**Supportive policies, protocols, tools and learning opportunities are available to assist staff in undertaking effective engagement.**	Training delivered in all localities was attended by 11 staff members. A unified engagement email inbox was set up in June 2019. Further training needs are being assessed.
b.	**Systems are in place to routinely obtain and record service user feedback about their experience of services.**	Routine service feedback is being reviewed. Leaflets have been developed and distributed outlining routes for engagement and feedback. A draft feedback database is in development.
c.	**The people who are affected by proposed service change are identified and supported to be appropriately engaged in the process.**	The Engagement Specification encourages identification of affected and vulnerable groups in engagement planning.
d.	**Feedback is provided to service users and carers about how their contribution was taken into account and influenced outcomes, or why requested changes could not be made.**	This is an important step in the planning of engagement activity within the Engagement Specification tool. Engagement activity owners are responsible for this individually.
e.	**Staff, service users and carers have the opportunity to learn from their own and others' experiences of engagement.**	This was a topic at the training for managers in July 2019. The Scottish Health Council support the HSCP with "After Action Reviews" and Vision workshops.

STANDARD 4.

The organisation creates a positive workplace culture that enables staff to feel valued and engaged.

Outcomes

- Health and social care staff are committed to the organisation's vision and values
- Health and social care staff are motivated to contribute to the success of the organisation.
- Health and social care staff feel their voice is heard in the organisation's decision making processes.



Quality dimension		Evidence
a.	**Staff communications channels are in place to efficiently and effectively receive and transmit information.**	An HSCP Communications Framework was adopted by the IJB in March 2019. This includes actions for staff communications.
b.	**Staff are able to articulate the organisational values and practice and reflect them in everyday behaviours.**	CIRCLE posters have been distributed to staff throughout the Partnership. Staff have been consulted in the development of, and have access to, the 2019-2021 Strategic Plan.
c.	**Mechanisms are in place to enable staff to be involved, contribute their experience, expertise and ideas. Structures and pathways to support staff are well-understood.**	iMatter survey conducted annually and team leads develop action plans in conjunction with their team.
d.	**Staff are well-led, given feedback on their contribution and developed to meet the needs of future roles.**	Staff management and one to ones/development planning/appraisals delivered via online TURAS system.

Integration Joint Board

Date of Meeting: **25 September 2019** **Agenda item : 5.7ii**

Title of Report: **Annual Communications Plan**

Presented by: **David Ritchie, Communications Manager**

The Integration Joint Board is asked to:

- Note the progress made in communications over the past 12 months
- Approve the Annual Communications Plan
- Agree appropriate annual reporting of communications to be within the HCSP Annual Performance Report

1. EXECUTIVE SUMMARY

Argyll and Bute HSCP has adopted an improved approach to communications during 2018-19 and this has culminated in the following documents being developed:

- Communications Framework
- Annual Communications Plan

This paper provides an update to the IJB in relation to the Annual Communications Plan and proposes that communications is an element within the HSCP's Annual Performance Report.

2. INTRODUCTION

The HSCP's Communication Framework, which was ratified by the IJB in March 2019, outlined how the HSCP communicates timely, relevant and accurate information. This included maintaining a strong and consistent identity for the HSCP, articulating the organisation's policies, decisions and procedures where appropriate; engaging and motivating the workforce and building trust with the public, staff, service users and partners.

The Framework focussed on communication principles, communications channels, the audiences, key messages and roles and responsibilities. It also provided an example of a template that would be form the basis of the emerging Annual Communication Plan.

3. DETAIL OF REPORT

The Annual Communications Plan is a high level document outlining key elements of the communications activity carried out across Argyll and Bute. This activity is detailed under the following objectives:

- Communicating Health & Social Care Partnership Business
- Staff Experience
- Delivering Quality Services
- Performance and Improvement
- Involving the Public, Service Users and Carers
- Engaging Health and Social Care Staff
- Working with Partners
- NHS Highland Corporate Messages
- Argyll and Bute Council Corporate Messages

Within the Annual Communications Plan there are a wide range of communications activities which are carried out across the HSCP. Many of these activities are owned and implemented by the Communications Team while others are owned by senior managers and teams across the HSCP.

There are also a number of key operational documents owned by the Communications Team which link in with communications activity on a daily basis. These documents include a media interactions log which outlines the key media activity, both proactive and reactive, implemented by the Team and also a Communications Roadmap which outlines how the HSCP will be linking in to national and local campaigns over the coming year.

3. RELEVANT DATA AND INDICATORS

No relevant information to report.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

Effective communication is fundamental to all strategic and service planning.

5. GOVERNANCE IMPLICATIONS

Governance of the communications action plan is proposed to take place by annual tabling of prospective action plans to the IJB and retrospective reporting of activity via the HSCP Annual Performance Report.

6.1 Financial Impact

There are no financial implications identified in the report

5.2 Staff Governance

The Annual Communications Plan will form part of staff governance activity.

5.3 Clinical Governance

There are no clinical governance issues in this paper.

6. EQUALITY & DIVERSITY IMPLICATIONS

Equality and diversity will be evaluated in terms of the reach of communications activity.

7. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

There are no GDPR issues within the actions of this paper.

8. RISK ASSESSMENT

There are no risks from implementing the actions in this paper.

9. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The Annual Communications Plan enables the IJB to be clear with stakeholders about the expected standards for internal and external communications.

10. CONCLUSIONS

The HSCP recognises the importance of effective communications and this Annual Communications Plan outlines the key communications activity carried out across Argyll and Bute to achieve this objective.

11. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Argyll and Bute Health and Social Care Partnership
Annual Communications Plan 2019/20

ARGYLL AND BUTE HSCP ANNUAL COMMUNICATIONS PLAN 2019/20				
KEY OBJECTIVE: Communicating Health & Social Care Partnership Business				
WHAT	**WHY**	**HOW**	**WHEN**	**WHO**
Chief Officer Report for IJB	The Chief Officer highlights a range of positive topics to the IJB	• Written reports produced • Digitally available on website	Every IJB meeting	Chief Officer
IJB Papers	It is a statutory requirement for the IJB to meet on a regular basis	• Written reports produced • Digitally available on website	Every IJB meeting	Senior Leadership Team
Annual Performance Report	It is a statutory requirement to produce an annual performance report setting out an assessment of performance in planning and carrying out the integrated functions for which the HSCP is responsible	• Written reports produced • Digitally available on website	Annually	Head of Strategic Planning & Performance
Chief Social Work Officer Annual Report	There is a requirement to produce an annual report providing an overview of social work activity undertaken during the previous year	• Written reports produced • Digitally available on website	Annually	Chief Social Work Officer

Updated: 17/09/19

Press releases	Ensure effective communications with staff and the public to positively outline the aims and visions of the organisation	• Release issued to media • Published on website • Published on social media platforms and digital networks	Ongoing	HSCP comms
Develop rolling feature roadmap	Ensure effective communications with staff and the public to positively outline the aims and visions of the organisation	• Features published in local media • Published on website • Published on social media platforms and digital networks	Ongoing	HSCP comms

KEY OBJECTIVE: Staff Experience				
WHAT	WHY	HOW	WHEN	WHO
Values and Practices Framework (CIRCLE)	Can help create a shared sense of identity and help define the behaviours that staff demonstrate towards each other and service users	• Focus groups with staff • presentation to IJB	Presented to IJB in March 2019	Head of HR & OD
iMatter survey	To understand and improve staff experience to benefit staff, patients, service users and their families	Continuous improvement tool with an annual iMatter survey	Annually	Senior managers and team leaders
Promoting staff health and wellbeing	Health and wellbeing is a vital element in supporting and developing employees	Actions to be agreed as part of an annual plan	Ongoing	Head of HR & OD

KEY OBJECTIVE: Delivering Quality Services				
WHAT	WHY	HOW	WHEN	WHO
Clinical Governance Committee minutes	Provides assurance that robust clinical governance controls and management systems are in place	• Publicly available as part of IJB meeting papers • Digitally available on website	Every IJB meeting	Lead Nurse
IJB Audit Committee Minutes	Provides assurance that robust audit controls and systems are in place	• Publicly available as part of IJB meeting papers • Digitally available on website	Every IJB meeting	Audit Committee Chair

KEY OBJECTIVE: Performance & Improvement				
WHAT	WHY	HOW	WHEN	WHO
Quarterly Performance Reports	Outlines the HSCP's performance against the national health and wellbeing outcomes	• Written performance reports • Digitally available on website	Published quarterly at IJB meetings	Head of Strategic Planning & Performance

KEY OBJECTIVE: Involving the Public, Service Users and Carers				
WHAT	WHY	HOW	WHEN	WHO
Data Activity Infographic	To raise awareness of a range of key health and social care activity data	• Cascaded to staff • Intranet • Internet • Social media platforms • digital networks	Monthly	HSCP comms
Disseminating public information at a local level	To keep people up to date with local health and social care issues and national health and	• Information screens • Local media	Ongoing	Public Engagement Lead

	wellbeing messages.	• Locality Planning Groups • Social media platforms • digital networks		
HSCP webpages and digital platforms	Ensure effective digital communications with staff and the public Increase website, social media, intranet/internet traffic, content engagement and brand awareness	• Social media platforms • digital networks • search engines • Internet	Ongoing	HSCP comms
Conversation cafes	Open up discussions in the community about health and social care	• Social media platforms • Local media • Marketed via local networks including digital	Ongoing	Locality managers/public engagement lead

KEY OBJECTIVE: Engaging Health & Social Care Staff				
WHAT	WHY	HOW	WHEN	WHO
Chief Officer Team Briefing	Ensure regular communication from the Chief Officer to staff	• Email cascade via senior managers • Posted on intranet • Distributed to IJB members	Monthly	Chief Officer
A&B Partnership Forum	Ensure effective communications with staff	Cascaded via members	Bimonthly	Forum members
NHS Highland intranet (staff announcements section)	Ensure effective communications with staff	Intranet	Ongoing	HSCP comms
Argyll and Bute Council newsflash	Ensure effective communications with staff	Internal announcements	Ongoing	Argyll and Bute Council comms

Argyll and Bute Council intranet	Ensure effective communications with staff	Intranet	Ongoing	Argyll and Bute council comms
NHS Highland internal announcements (all user email)	Ensure effective communications with staff	All user email	Ongoing	NHS Highland corporate comms
NHS Highland Chief Executive Weekly Bulletin	Ensure effective communications with staff	All user email	Weekly	NHS Highland corporate comms
Staff engagement sessions ('A Culture Fit for the Future')	Key outcome of the Sturrock Report	• Local promotion of sessions • Intranet	Aug – Oct 2019	NHS Highland Board/Senior Leadership Team
NHS Highland Team Brief	Ensure effective communications with staff	• All user email • Intranet	Monthly	NHS Highland corporate comms

KEY OBJECTIVE: Working with Partners				
WHAT	WHY	HOW	WHEN	WHO
▪ Community Planning Partnership	Ensure the sharing of good practice across the CPP and deliver outcomes within the single outcome agreement	• Regular meetings • Digital cross promotion	Monthly	Chief Officer/designated senior manager

KEY OBJECTIVE: NHS Highland Corporate Messages				
WHAT	WHY	HOW	WHEN	WHO
NHS Highland Director of Public Health Annual Report	It is a statutory requirement to produce an Annual Report	• Written reports produced • Digitally available on website	Annually	Director of Public Health
Press releases	Ensure effective communications with staff and the public to positively outline	• Release issued to media • Published on website • Published on social	Ongoing	Corporate comms

	the aims and visions of the organisation	media platforms and digital networks		
NHS Highland website	Ensure effective communications with staff and the public	Relevant information provided on website	Ongoing	Corporate comms
Media Weekly Summary	Inform senior managers and IJB members of the weekly media interactions	Distributed by email to dedicated distribution list	Weekly	Corporate comms
KEY OBJECTIVE: Argyll and Bute Council Corporate Messages				
Press releases	Ensure effective communications with staff and the public to positively outline the aims and visions of the organisation	• Release issued to media • Published on website • Published on social media platforms and digital networks	Ongoing	Argyll and Bute Council comms
Argyll and Bute Council website	Ensure effective communications with staff and the public	Relevant information provided on website	Ongoing	Argyll and Bute Council comms

Integration Joint Board

Date of Meeting : 25 September 2019 **Agenda item : 5.8**

Title of Report : Argyll & Bute Health & Social Care Partnership Primary Care Improvement Plan Year 2 September 2019

Report by : Rebecca Helliwell, Associate Medical Director

Presented by : Dr Angus McTaggart, Principal Lead GP & IJB GP Rep

The Integration Joint Board is asked to :

- **Note the Year 2 Primary Care Improvement Plan (PCIP) and note its submission to the Scottish Government.**

1. EXECUTIVE SUMMARY

The Primary Care Improvement Plan has been drafted and agreed by the leads for each work stream of the Primary Care Improvement Plan. The plan has been reviewed by the Project Board and its content agreed and supported. The draft is at the IJB for noting and has been submitted to the Scottish government. The original plan was submitted for approval by the IJB in June 2018 and the Year 2 plan is focussed on continued delivery of the Primary Care Improvement Plan.

Overall progress is being made in all work streams with recruitment to posts and some of the services being delivered in localities with strong working relationships being built between HSCP and GP Practice teams.

2. INTRODUCTION

The purpose of this report is to update on the Year 2 Primary Care Improvement Plan (PCIP).

3. DETAIL OF REPORT

The 2018 General Medical Services (GMS) Contract was approved by the profession in January 2018.

THE PRIMARY CARE IMPROVEMENT PLAN

The PCIP Year 2, attached, sets out how Argyll and Bute HSCP continues to implement the new GMS Contract by 31 March 2021. This is Year 2 plan that meets both the national and pan Argyll requirements as set out in the MoU.

The aim of the plan is to set out a clear direction of travel and act as a core framework for the HSCP and NHS Board to reform primary care services. The plan describes the discussions and actions to date that have been approved through the previously agreed governance and programme arrangements. It is noted that further discussion with General Practice, service providers and the public is required as implementation arrangements evolve and mature, this will fall within the Primary Care and Strategic Planning functions of the IJB.

Each requirement within the MoU is being addressed through the implementation action plans along with associated workforce and funding plans. The implementation and recruitment plans have been developed on the phased funding that is available from 2018/19 and 2019/20.

The attached PCIP will provide an update on implementation plans for each workstream.

4. RELEVANT DATA AND INDICATORS

Each service will have a specific set of data to be collected as services roll out, some of which is directed at a national level. The data collected will aim to monitor quality and outcome of services and impact on GP practice and HSCP teams.

5. CONTRIBUTION TO STRATEGIC PRIORITIES

The PCIP is the document to allow the IJB to meet its commissioning requirements under the MOU.

6. GOVERNANCE IMPLICATIONS

Argyll & Bute Integration Joint Board has responsibility for the PCIP and has established a programme and structure to support its development and implementation taking account of stakeholder requirements regarding development, approval and implementation of it.

7. Corporate Governance

7.1 Financial

There are direct financial implications implementing the plan with funding identified as specified to be implemented to deliver the PCIP.

7.2 Staff Governance

There are staff governance implications which will require to be addressed as services develop.

7.3 Planning for Fairness

An EQIA is not directly required for the PCIP but will be required for the implementation plans of the various work streams.

7.4 Clinical and Care Governance

The Clinical and Care Governance Committee will need to consider service proposals and details in the implementation plan to ensure no compromising of safety, performance and standards.

8. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Normal GDPR principles will apply to all services.

9. RISK ASSESSMENT

9.1 There is a risk that PCIP requirements could affect the IJB with regard to the operational services that it directs and has operational and financial management responsibility and accountability for. This could once the detail of the plan is known affect its ability to meet performance standards or outcomes as set by regulatory bodies.

10.PUBLIC & USER INVOLVEMENT & ENGAGEMENT

10.1 HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users.

10.2 In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to):

- Patients, their families and carers
- Local communities
- SAS and NHS 24
- Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees)
- Primary care providers
- Primary care staff who are not healthcare professionals
- Third sector bodies carrying out activities related to the provision of primary care

and will be undertaken according to the Engagement Framework as required.

11. CONCLUSIONS

The Primary Care Improvement Project Board presents the Primary Care Improvement Plan Year 2 for information.

12. DIRECTIONS

Directions required to Council, NHS Board or both.	**Directions to:**	tick
	No Directions required	x
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

REPORT AUTHOR AND CONTACT

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PRIMARY CARE IMPROVEMENT PLAN Argyll and Bute HSCP Year 2 2019-2020

ARGYLL AND BUTE HSCP – PRIMARY CARE IMPROVEMENT PLAN (PCIP)

1. INTRODUCTION

The Argyll and Bute Primary Care Improvement Plan Year 2, 2019 – 2020 remains focused on ensuring a viable, developing but sustainable General Medical Services (GMS) within the rural and island geography of the area.

The PCIP Year 2 Plan provides an update on the initial Primary Care Improvement Plan which was submitted to the Scottish Government following agreement with the Local Medical Committee and approval at the Integration Joint Board in August 2018. Click here to view original plan. .

2. LOCAL CONTEXT

2.1 Primary Care Profile

There are currently 33 GP practices in Argyll and Bute with a registered population of 88,520 as at 1 April 2019.

29 practices provide Primary Medical Services under a General Medical Services Contract. There are 4 salaried GP Practices;

- Tobermory Medical Practice, Isle of Mull
- Salen Surgery, Isle of Mull
- Bunessan Surgery, Isle of Mull (with a branch surgery on the Isle of Iona),
- Kintyre Medical Group, Muasdale (with a branch surgery in Southend),

NHS Highland has recently awarded a General Medical Services Contract for a single GP Practice covering the islands of Mull and Iona, moving away from having the 3 salaried GP Practices on Mull. In addition to providing Primary Medical Services for the new "Mull and Iona Medical Group" the GPs will also provide Out of Hours and Community Hospital cover for the islands.

The HSCP is also currently advertising a General Medical Services Contract for Kintyre Medical Group which, if successful, will result in independent GP Contractors providing Primary Medical Services in all 31 GP Practices.

2.2 Argyll and Bute HSCP Strategic Plan 2019/20 – 2021/22

"People in Argyll and Bute will live longer, healthier independent lives"
https://bit.ly/2NVGR4w

Argyll and Bute Integration Joint Board (IJB) has established a "Transforming Together" programme with 8 workstreams to build on achievements to date and continue progress towards service transformation to meet the vision, priorities and objectives of the IJB.

Primary Care is one of the key workstreams identified in the Strategic Plan.

The challenges for Argyll and Bute HSCP include:

- We cannot sustain all GP practice provided “Out of Hours” (OOHs) services in their current form particularly in our isolated and remote island communities.

- The ageing workforce and increasing vacancies in our GP practices, when considered alongside the need to provide GP OOHs, means it is more difficult to recruit GPs

- Developing new service models and recruiting other clinical staff to allow the transfer of work from GP practices to HSCP staff

- Using technology to offer support and provide a service to staff and patients

2.3 Argyll and Bute HSCP Engagement Framework

> “Argyll and Bute Health and Social Care Partnership (HSCP) is committed to working with the people of Argyll and Bute to ensure services are responsive and appropriate to the needs of our communities.”
>
> *Argyll and Bute HSCP Engagement Framework March 2019* : https://bit.ly/2SgPp4q

The engagement framework sets out how the HSCP will engage with people to deliver health and social care services. This will ensure effective engagement arrangements are in place when services are being developed and any service changes are being planned across the four locality planning group areas:

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

2.4 Governance

At the beginning of 2019 the HSCP established a Primary Care Modernisation Programme Board, directly accountable to the HSCP Integration Joint Board, co-chaired by the Chief Officer and Associate Medical Director.

The remit of the PC Modernisation Programme Board includes the following:

- Oversee the development and delivery of the implementation plan of the 2018 General Medical Services Contract in Scotland within Argyll and Bute HSCP.

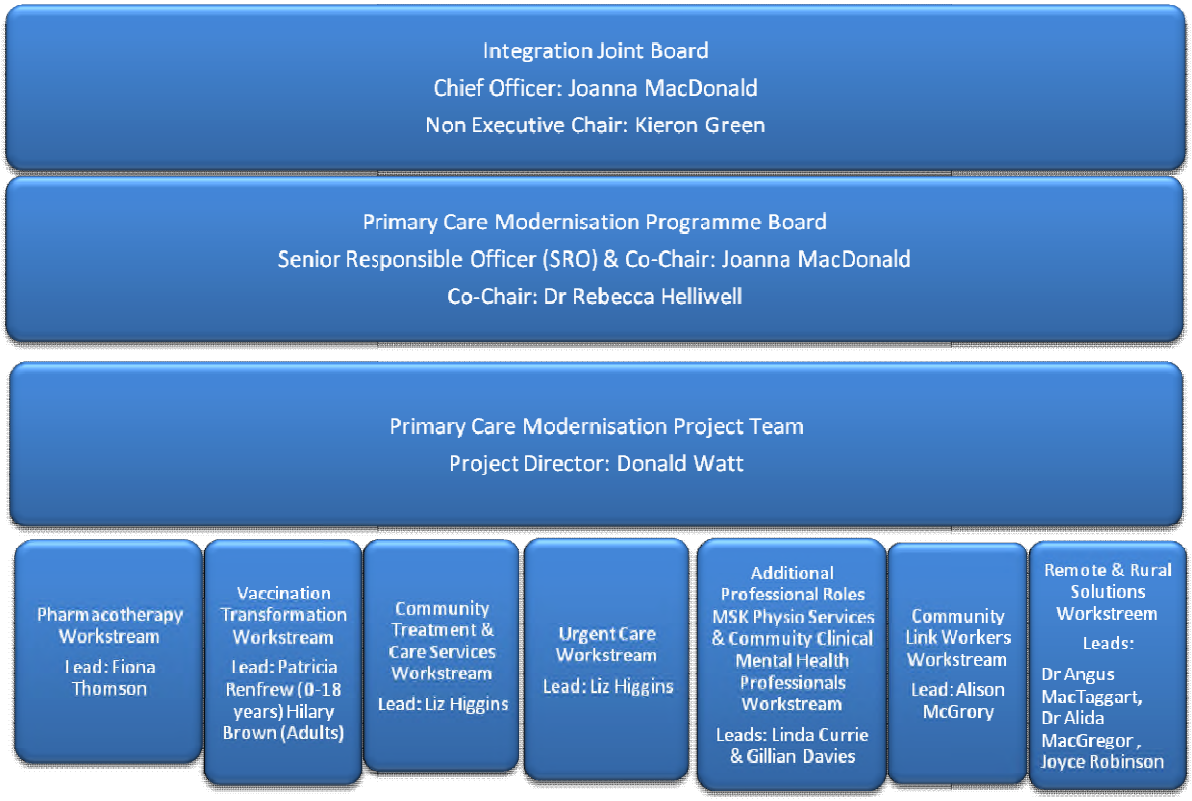
- Provide assurance and scrutiny on the work undertaken by the Project Team and submit recommendations to the Integration Joint Board in line with the Memorandum of Understanding.

- Ensure that decisions relating to the implementation of the 2018 General Medical Services Contract in Scotland are developed in

collaboration with GP Sub Committee and with the agreement of the Local Medical Committee (LMC).

- Provide support and guidance to the Project Team.
- Ensure that the project is delivered in accordance with agreed milestones.
- Understand and monitor risks outlined in the project risk register and ensure appropriate mitigating actions are taken forward by the Project Team.

The structured framework to oversee the delivery of the Primary Care Modernisation Programme is set out below.



Representatives of NHS Highland GP Sub Committee are included in the membership of both the Primary Care Modernisation Progamme Board and the Primary Care Modernisation Project Team and have been included in the drafting of the year 2 PCIP at all stages.

The Programme Board has approved the appointment of a Transforming Primary Care Programme Manager to lead the development and delivery of primary care service redesign in line with the 2018 GMS Contract in Scotland across Argyll and Bute. There have been delays with this post, which have now been resolved and it is expected that recruitment will commence shortly. NHS Highland GP Sub Committee Representatives are included in the membership of both the Primary Care Modernisation Project Team and Programme Board.

2.5 Remote and Rural

Argyll and Bute Health and Social Care Partnership serves a population of 88,520 patients across an area of 6,909km2.

29 of these 33 practices meet the Scottish Government criteria for enhanced funding (e.g. Golden Hello payments) based on rurality.

It has become clear during the scoping work which has been undertaken for each of the Primary Care Improvement Plan (PCIP) workstreams that the implementation of the services proposed in the Memorandum of Understanding (MOU) will pose a significant challenge in many parts of Argyll and Bute. This is due to a variety of factors out with the control of the HSCP, including:

- Geographically remote practices (including small Islands) with small patient populations
- Limited availability of a suitably qualified workforce
- Logistical challenges in providing services which are required infrequently using professionals based in larger population centres e.g. First Contact Physiotherapist travelling from Oban to Colonsay (5hr return trip with a compulsory overnight stay) for a small number of patients
- Potential for diminution in accessibility and quality of service e.g. Vaccine Nurses visiting remote practices on an infrequent basis impacting on vaccine uptake
- Services specified in the Memorandum of Understanding not being relevant or appropriate for small, remote practices.

A unanimous decision was taken at the Primary Care Transformation Project Board meeting in June 2019 to adopt an alternative approach to the provision of some services defined in the MOU, taking account of the following provisions set out in the 2018 GMS Contract:

“In necessarily small remote GP practices, extra resources will continue to be made available to ensure long-term sustainability. Remote GP practices will, as they do now, continue to provide a broader range of services more appropriate to remote settings”
(Page 22, The 2018 GMS Contract in Scotland)

“In rare circumstances it may be appropriate for GP practices, such as small remote and rural practices, to agree to continue delivering these services through locally agreed contract options”
(Page 17, The 2018 GMS Contract in Scotland)

“Patients should be able to conveniently and confidently access community treatment and care services. In some circumstances it may be appropriate for certain GP practices, such as small remote and rural GP practices, to locally agree to deliver these services. If GP practices locally agree to deliver community treatment and care services, then support will be provided in the form of either expenses for the required practice employed staff capacity, or the deployment of NHS Board employed staff”.
(Page 33, The 2018 GMS Contract in Scotland)

The review of services provided to these practices will be progressed under 2 related processes, as outlined below:

General Nursing Provision
It is proposed that an Option Appraisal process, led by a senior member of the Nursing management team, is undertaken to review the provision of those services detailed in the MOU which could be provided by staff with either healthcare assistant, nurse or advanced nurse training. The services to be included in the Option Appraisal are:

- Vaccination Transformation Programme
- Urgent Care Services
- Community Care and Treatment Services.

It is felt that there is an opportunity to utilise staff already employed within practices to provide these services in blended roles, with a number of means by which this could be achieved. This process may be relevant to the majority of practices in Argyll and Bute and a clear business case will require to be developed prior to implementation, including robust justification for any deviation from the standard model of service delivery outlined in the 2018 GMS Contract.

The Option Appraisal process will follow the standard 5 phase approach and report back to the Primary Care Transformation Project Board before the end of 2019.

Small Remote and Rural Practices
A Short Life Working Group (SLWG), composed of the Primary Care Manager and 2 Clinical Leads, has been set up to identify, and engage with, the smallest and most remote practice within Argyll and Bute. The first meeting of this group has identified an initial 12 practices which, by virtue of geography or list size, are unlikely to benefit from the majority of services outlined in the MOU, in particular those involving input from the wider multi-disciplinary team.

Over the next 3 months the SLWG will engage with each of these practices to gather opinion and seek consensus on how the additional funding allocated to Primary Care through the 2018 GMS Contract can benefit the GPs, staff and patients living in the most isolated parts of Argyll and Bute. The SLWG will report to the Primary Care Transformation Project Board in September 2019.

3. DELIVERY OF MOU COMMITMENTS

The initial key priorities for development of service delivery plans within Argyll include:

- Community Treatment and Care Services; involving a generic primary care nursing role to address several of the six priorities would be more cost effective.

- The primary care nursing role to include phlebotomy, dressings, vaccinations, DMARDS etc. It was noted that the primary care nursing role may vary in each locality.

- Pharmacotherapy; with 1 technician and 1 Pharmacist in each locality was also a priority.

- Community Clinical Mental Health Professionals in some localities.

- Community Link Workers development at locality level utilising variety of delivery methods/options from employed through 3rd sector.

- Enhancing the IT and digital service infrastructure to support the transformation and transfer of work from GPs to the HSCP e.g. repeat prescriptions, online appointments, mobile working etc.

- First Contact Physiotherapy in position in Oban and Campbeltown and the Helensburgh and Bute roles are in recruitment

The following sections outline the initial developments and progress in year 1 and a forward look at the expected progress in year 2.

3.1 VACCINATION TRANSFORMATION PROGRAMME (0-18)

Key Lead: Patricia Renfrew, Consultant Nurse Children's and Families
Clinical Lead: Dr Jeremy Phillips, Clinical Lead Mid Argyll

1. INITIAL DEVELOPMENTS AND PROGRESS IN YEAR ONE 2018/19

Helensburgh & Lomond

- Helensburgh centralised immunisation clinics are established and working well
- Immunisations rates remain at 95% uptake
- Immunisation team in place, two staff members remain on FTCs, one x 0.8 wte until March 2019 and one 0.6 wte until March 2020

Oban, Lorn and Mull

- Oban: plans to develop immunisation team for Oban and Lorn area have not progressed, as no agreement at this time on delivery model.

Mull

- Centralised immunisation clinics delivered from the Community Hospital, Craignure, Isle of Mull, commenced in June 2018.

- Equality Impact Assessment and Standard Operating Procedure developed.

Dunoon

- Delivery model through ITR situated in Community Hospital is being piloted and recently extended to include a further Dunoon practice with discussions underway for a third practice to be included

2. EXPECTED PROGRESS IN YEAR TWO 2019/20

- Delivery of 2-5 year old flu in Helensburgh potentially through Helensburgh immunisation team. Still to be finalised at time of writing
- Consolidation of centralised service in Dunoon
- Model for delivery in Oban to be developed, possibly in collaboration with

other workstreams, this will be informed by options appraisal

Options Appraisals
An overarching options appraisal is to be undertaken with potential for collaborative work involving other Primary Care modernisation workstreams

Continuity of Care
Aim is to have identified tests of change for different aspects of immunisation programmes. Current national MOU is there should be no cessation of service delivery by GP practices until there is a safe, sustainable and effective delivery model established.

3. WORKFORCE

This will be dependent on the models of delivery agreed upon and the operational divisions.

- **Local Workforce Planning**
  The Agenda for Change process has a significant impact on the recruitment process.

- **Workforce Capability**
  Currently immunisation skills and knowledge sits predominantly within GP practice, Delivery of education and training is acknowledged as being key in developing a safe and effective service.

  It has been identified that staff would require an intense induction, including 2 day face to face training based on NES Promoting Effective Immunisation Programme. Co-operation from GP practices will be required and sought to assist with the practical aspects and signing off of competencies.

- **How potential gaps related to workforce planning will be addressed**
  Gap analysis to be completed as part of option appraisal process, informed by tests of change, and areas of concern highlighted to the Project Team for further discussion.

4. PUBLIC AND PATIENT ENGAGEMENT

Communication strategy to be developed for the VTP in conjunction with the divisions. This would be in line with PCI communication strategy.

Current thoughts Social media, partnership forum, patient focus groups.
Public and patient engagement planned as part of the tests of change, to inform further developments.

5. INFRASTRUCTURE

- **Digital**
  IT infrastructure is key to the VTP, this has been recognised at National level and work is ongoing at national level to establish both interim and long term solutions. Ideally staff delivering immunisations should have access to GP systems (Vision/EEMIS) to directly enter immunisations into the patient's record. This would be the most efficient method and reduce other layers of

work being developed and adding steps to the process that would likely increase the risk of mis-communication, poor record keeping that could result in issues with vaccine errors for individuals.

6. EVALUATION

Where model of delivery has moved from GP practice, the immunisation uptake rates are being monitored.

Parent satisfaction survey carried out.

3.2 VACCINATION TRANSFORMATION PROGRAMME (ADULT)

Key Lead: Hilary Brown, Associate Lead Nurse
Clinical Lead: Dr Jeremy Phillips, Clinical Lead Mid Argyll

1. INITIAL DEVELOPMENTS AND PROGRESS IN YEAR ONE 2018/19

There was initial scoping work completed mapping adult vaccine delivery and Driver Diagram completed. Discussions on what tests of change would be most useful and achievable were held.

2. EXPECTED PROGRESS IN YEAR TWO 2019/20

Small tests of change are proposed for routine >65 flus and newly eligible pneumococcal vaccines in one practice in Helensburgh and in Cowal. The Cowal test of change is building on the development of the Care and Treatment service there while the other test of change is on its own but working closely with the practice using the practice premises and infrastructure. Both are at early stages of development and useful learning should be achieved to inform future scale up of the programme. The tests of change are for this year only at this stage.

As preparatory work progresses and people's thinking matures it has become clear there are significant overlaps of nursing roles and functions between the workstreams of Vaccine Transformation, Care and Treatment Services and Urgent Care. In recognition of this it has been agreed by the Project Board to combine the workstreams going forward. This will improve the leadership capacity across one workstream instead of three and improve the potential for recruitment to more interesting posts.

There is a plan with timescales to scope out treatment room models in line with Cowal, scope out models of delivery to suit rural/island areas, combine the three budgets, develop an implementation plan up to 2021 and develop treatment room services in localities based on their identified priorities by Late 2019.

- **Options Appraisals**
  Models to suit a range of geographical locations will be developed in association with local practices, primary health care teams and the public. One size may not fit all but there will be core principles applied to assure consistency of standards and services.

- **Continuity of Care**
  Working closely with practices and local communities is paramount and the intention is to provide services at least as good as the existing services and to ensure good communication and collaboration between new and existing services.

3. WORKFORCE

Workforce is an issue locally and nationally. Recruitment is difficult and the existing workforce is ageing with a lot of experience forecast to be lost through retirals in the next few years.

This is part of the reason to combine the nursing workstreams creating more attractive posts and ones that are across the skill range producing career development opportunities along with entry level and support posts.

Scoping of workforce learning needs will be conducted but there should be a range of capabilities available and mentoring and succession planning will be accommodated.

Consideration of part time and bank posts will help support the transformation initially with some full time posts for leadership and continuity of the transformation. There may be split posts where staff work for the practice and for the NHS depending on personal circumstances and preferences.

4. PUBLIC AND PATIENT ENGAGEMENT

Communication with patient groups and the public is in the Driver Diagram and is part of the transformation project plan. Communication via social media and more traditional media outlets will be utilised.

5. INFRASTRUCTURE

- **Premises**
  The tests of change are being accommodated in the respective practice premises and there is recognition of the potential for accommodation for primary care services may be an issue. It is a standing agenda item for the Transformation Board meetings.

- **Digital**
  IT costs for hardware and soft ware are included in the plans.

6. EVALUATION

Evaluation measures are being considered and will be agreed with the practices and the Transformation Board by the end of 2019.

3.3 PHARMACOTHERAPY SERVICES

Key Lead: Fiona Thomson, Lead Pharmacist
Clinical Lead: Dr Gordon Wallace, Clinical Lead Bute

1. INITIAL DEVELOPMENTS AND PROGRESS IN YEAR ONE 2018/19

The pharmacotherapy service has been introduced gradually with the funding available and where staff have recruited to undertake the roles. During 2018/19 2.6wte pharmacists were recruited with 1.6wte starting after 31st March 2019. Existing staff also increased hours from December 18 providing an additional 0.6wte for the service.

The NHS Highland Pharmacotherapy Working Group (PSWG) agreed a service specification detailing the core and additional services and how they will be delivered by pharmacy staff working as part of a primary care MDT. The PSWG also agreed that pharmacy staff resource will be allocated equitably to every practice where it is reasonably practical, effective and safe to do so. Policies and standard operating procedures have been developed for pharmacy team members to ensure governance of the service.

The implementation of the service has been supported by a written agreement with individual practices to provide flexibility dependent upon local priorities as well as capacity and experience of the local pharmacy team. Pre service checklists have been undertaken to identify the workload within the practice and the priorities for the service. Initial work plans are being agreed practices and will be reviewed in six months or sooner where staffing levels change.

Remote IT access to clinical systems is being set up where required. Equipment, software and licenses have been purchased to support remote access. Input into the rural practices may be delivered remotely with onsite visits from the pharmacy team if appropriate.

Currently the pharmacy teams are hosted by practices and as the staff numbers increase alternative premises will be required.

2. PROGRESS IN YEAR TWO 2019/20

Further recruitment in year two is planned of a team leader and a technician.
Training of staff is ongoing and work plans are being finalised with practices.

- **Options Appraisals**
  Once the activities to be undertaken by the pharmacy team has been agreed a timetable is developed showing when the pharmacy team is available. Standard operating procedures and policies are agreed with the practice outlining the roles of the pharmacy team in the MDT. These also make clear how patients will be referred to other members of the MDT. In year one staff levels have not been sufficient to provide cover for leave. Notice will be given to practices of planned leave until staff levels increase to allow cover.

3. WORKFORCE

- **Local Workforce Planning**
  Estimates for work force required for the pharmacotherapy were developed using the outcomes from the Inverclyde new ways of working and work in other Boards. The funding allocated to the work steam did not cover this estimate of staff and plans were adapted to work within the funding. The skill mix required for the service also requires to be refined (70% pharmacist, 30% pharmacy technicians from Inverclyde work) and the role of pharmacy technicians in primary care is being expanded.

- **Workforce Capability**
  Training of staff is ongoing and all pharmacists will progress to be independent prescribers.

- **How potential gaps related to workforce planning will be addressed**
  To date recruitment to pharmacist posts have been successful. At the end of this year the skill mix of the teams will be reviewed taking into account the work being undertaken by other Boards on the introduction of pharmacotherapy assistants, development posts for pharmacists and pharmacy technicians in primary care. These training developments will assist with the workforce pressures going forward. In 2018 two student pharmacists undertook their placement in Lochgilphead and experienced the varied role of the pharmacy teaming the area who work across mental health, community hospital and primary care. This year places will also be offered in Oban and may lead to pharmacists wishing to work in A&B HSCP in the future.

4. PUBLIC AND PATIENT ENGAGEMENT

Communication strategy will be developed for the pharmacotherapy service in line with PCI communication strategy.

3. INFRASTRUCTURE

- **Premises**
  Remote access is essential to deliver this service in remote and rural areas as outlined within this report. To enable remote access at least two workstations within a confidential space are required for each of the four localities within the HSCP. Currently working to identify and set up infrastructure for the pharmacy teams.

- **Digital**
  eHealth have agreed to provide enable remote\agile working with Shared Practice Access to GP systems & Docman for pharmacy teams to islands and any other practices within the HSCP.

  Remote access will assist the service to:-
  - cover during periods of leave\absence
  - improving workflow (with access to GP systems)
  - prescription authorisation
  - access to STU (Scottish Therapeutics Utility) to identify prescribing issues, serial script opportunities

- o ability to identify savings, review patient medication and adjust prescribing accordingly
- o increase use of VC services for medication reviews

Funding of £36,536 was agreed to provide all hardware, software and licence costs to establish a new platform for this purpose. To date £27,000 of the funding has been utilised.

4. EVALUATION

The activities undertaken by the teams are tracked in a spreadsheet and shared with the PSWG. This will assist with the identification of gap in service provision and the evaluation of the service. Review of work plans after six months will also provide information for the evaluation of service implementation.

3.4 COMMUNITY TREATMENT & CARE SERVICES

Key Lead: Liz Higgins, Argyll & Bute Lead Nurse
Clinical Lead: Dr Alida MacGregor, Clinical Lead Cowal

1. INITIAL DEVELOPMENTS AND PROGRESS IN YEAR ONE 2018/19

Community Care and Treatment Service establishes in Cowal covering 4 GP practices although majority of activity currently from one.

Currently the Treatment Room delivers the following services –
Phlebotomy, ECG Spirometry Dressings, Suture and clip removal, Ear irrigation' STI screening, Smears, Cardiac monitors, Travel advice and vaccines. Bloods and other investigations from secondary care clinics. Childhood immunisations for 2 practices at present.

Protocols created for – Spirometry, BP monitoring, Urine testing, Venepuncture, Ear irrigation, ECG.

Other existing appropriate NHS Highland/GG&C protocols currently being adapted for use in Primary Care Clinic.

Methods of referral currently being trialled include email from practice and form created to be completed at practice and given to patient to book.
Band 3 job description specific to Primary Care Clinic created and banded by AFC board. Band 5 job description in development.

2. EXPECTED PROGRESS IN YEAR TWO 2019/20

Currently exploring feasibility of replicating Cowal Treatment room model which combines Vaccination Transformation Programme, Community Care and Treatment services and Urgent Care as a bundle with all service delivered via the TR. This model fully meets the aspirations of the contract and delivers best value for money.

Plan

- Approval of recruitment of permanent Band 3 for Cowal Treatment room - June 2019
- Scope Treatment room model and priorities across localities as described- July 2019
- Scope island/rural model to best meet needs of smaller rural practices –July 2019
- Combine three budgets and cost the delivery of model- July 2019
- Develop implementation plan to cover until 2021-July 2019.
- Some treatment room services, as prioritised by localities, in place in Lochgilphead, Bute, Helensburgh, Oban and Campbeltown by Oct 2019

3. WORKFORCE

- **Local Workforce Planning**

There will be a requirement to go out to recruit new staff to be employed solely within the treatment room model however given rurality and practice populations there will also be a requirement to build on existing staffing structures with the HSCP

- **Workforce Capability**
  Competencies for staff delivering the service are being developed.

- **How potential gaps related to workforce planning will be addressed**
  Approaching the delivery of several workstreams as a bundle is key to utilising the full capacity of our workforce.

  The potential to work with existing practice staff is being explored as are all available staffing models utilising HSCP staff working differently

4. PUBLIC AND PATIENT ENGAGEMENT

An engagement strategy will be developed as part of the role out of the service

5. INFRASTRUCTURE

- **Premises**
  Will form part of the scoping exercise

- **Digital**
  Working closely with IT and GP colleagues on access to patient records across the GP Practices and the Treatment Room services. Access to patient records is a key requirement of talking this programme forward.

6. EVALUATION

Early work on patient experience of the changes in Cowal ongoing and will build on that as a bundle-will look to measures around access, experience, vaccination uptake initially.

3.5 URGENT CARE SERVICES (advanced practitioners, nurse or paramedic)

Key Lead: Liz Higgins, Argyll & Bute Lead Nurse
Clinical Lead: Dr Brian McLachlan, Clinical Lead Helensburgh & Lomond

1. INITIAL DEVELOPMENTS AND PROGRESS IN YEAR ONE 2018/19

Minimal progress in year 1. Test of change in Cowal with some Urgent Care services being delivered in conjunction with the Community Care and Treatment Service. A number of on-the-day appointments diverted from GP Practice. No progress on home visits

2. EXPECTED PROGRESS IN YEAR TWO 2019/20

Currently exploring feasibility of replicating Cowal Treatment room model which combines Vaccination Transformation Programme, Community Care and Treatment services and Urgent Care as a bundle with all service delivered via the TR. This model fully meets the aspirations of the contract and delivers best value for money.

Plan for 19/20

- Scope TR model across localities as described- June 2019
- Scope island/rural model to best meet needs of smaller rural practices – June/July 2019
- Combine three budgets and cost delivery of model- June/July 2019
- Develop implementation plan to cover until 2021-July 2019.

Further development for Urgent Care in Cowal to include home visits and increased on- the -day appointments.

Development of governance structure for ANPs.

3. WORKFORCE

Local Workforce Planning
There will be a requirement to go out to recruit new staff to be employed solely within the treatment room model however given rurality and practice populations there will also be a requirement to build on existing staffing structures with the HSCP.

- **Workforce Capability**
  Supported development of existing staff toward Advanced Practitioner level is required along with recruitment of existing ANPs**.** Limited funding and university places has an impact on how quickly this can be achieved but this work has started with a number of HSCP staff working towards achieving advanced practice status.

How potential gaps related to workforce planning will be addressed
Approaching the delivery of several workstreams as a bundle is key to utilising the full capacity of our workforce.

The potential to work with existing practice staff is being explored as are all available staffing models utilising HSCP staff working differently

4. PUBLIC AND PATIENT ENGAGEMENT

An engagement strategy will be developed as part of the role out of the service

5. INFRASTRUCTURE

Premises
Will form part of the scoping exercise

Digital Working closely with IT and GP colleagues on access to patient records across the GP Practices and the Treatment Room services. Access to patient records is a key requirement of talking this programme forward.

6. EVALUATION

Early work on patient experience of the changes in Cowal ongoing and will build on that as a bundle-will look to measures around access, experience, Vaccination uptake initially.

3.6 MUSCULOSKELETAL FOCUSED PHYSIOTHERAPY SERVICES

Key Lead: Linda Currie, Lead AHP
Clinical Lead: Dr Angus MacTaggart, Clinical Lead Islay & Jura

1. INITIAL DEVELOPMENTS AND PROGRESS IN YEAR ONE 2018/19

From April 2018 – December 2018 progress involved creating a JD and recruitment to the First Contact Physiotherapy Lead post. Marsaili Ross started in post 1 January 2019 and since then has been working on the following with current members of the Physiotherapy leadership team and the Lead AHP;

1) Scope and find solutions to logistical needs in terms of location of clinics/room availability – ideally FCP services would be co-located within GP Practices but this may not always be possible.
2) Scope and lead on implementation of IT requirements for each area for example Vision 360 may need to be made available for clinics held out with GP practices.
3) Facilitate GP shadowing and competency development for existing APP staff in each area by supporting existing orthopaedic triage work.
4) Engage and communicate with Physiotherapy service to support through change and in implementation.
5) Develop a communication strategy to ensure staff at all levels including SMT and transformation boards are aware of plans/progress/threats.
6) Development of communication strategy to engage public support for changes – yet to roll out.
7) Develop governance and evaluation structure for FCP and MSK services in line with National guidelines.
8) Link with NHS Highland/other HSCPs to ensure compliance with National implementation guidelines.
9) Draft Memorandum of Understanding.
10) Scope existing resource capacity and develop workforce plan for each area. Develop action plans for recruitment and future workforce planning with local team leads.

2. EXPECTED PROGRESS IN YEAR TWO 2019/20

The above activity continues into year 2.

The progress following agreement of the MOU will involve recruitment to;

- 1 WTE in Oban-starts in July 2019 and will be the first practising FCP role in Argyll & Bute so will be closely supported by local team and FCP Lead with induction and establishing standard work.
- Full implementation on Bute (have been piloting for some time)
- Pilot work in Cowal and Mid Argyll, Kintyre and Islay
- Recruitment of 1 WTE in Helensburgh.
- As we recruit to First Contact Physiotherapists and implement in each locality a structured action plan will ensure that local and FCP support is clear and that induction and governance is fully supported in each

area.
- Involvement in the options appraisal process for smaller remote and rural practices.

This means we will have progressed implementation across all four localities within Argyll & Bute.

- **Continuity of Care**
  The A&B FCP model vision is;

'The vision for First Contact Physiotherapy (FCP) services in Argyll and Bute is to offer patients timely access to a specialist MSK service. There will be local differences in how this service will operate due to variance in staffing, expertise, facilities and practice geography.

The aim is that a sustainable and equitable FCP service will be delivered across Argyll and Bute, which will in future look to blend FCP and MSK Physiotherapy services to create the most effective pathway for patients and to ensure the right level of triage and intervention across a tiered range of First Contact, mainstream Physiotherapy and local exercise providers.'

Our MOU states that cover for annual leave and small practice/island cover will be evaluated and progressed once larger practices have been established and if service continuity can be ensured.

3. WORKFORCE

Local Workforce Planning

- The FCP working group are looking to use existing Advanced Practitioners to provide local leadership and governance to new post holders and practices.
- A number of AP's have completed their non-medical prescribing course this year.
- We are working on a Band 6 development post JD to see if we can recruit less experienced Physiotherapists and 'grow our own' FCP's
- We are looking at the whole Physiotherapy workforce and third and leisure sector to support the whole MSK pathway to fulfil our vision
- Carrying out training for admin and reception staff
- Using social media to recruit to new post and as we implement ensure posts are full time when possible and offer opportunity to develop into the role if not all the competencies are in place.

Workforce Capability

- Our current cohort of Band 7 Advanced Practitioners are highly skilled, already provide Orthopaedic triage work and work closely with GP's and Consultants and work closely to the Orthopaedic pathways of NHS GG&C (our clinical pathway). There is an APP in each locality to support our highly skilled FCP lead (previous post was an AP in Argyll & Bute). These members of the team alongside our Physiotherapy Team leads are crucial in successful local implementation and we are working closely with them in implementation.
- We have many Band 6 Physiotherapists with excellent MSK skills who will be given the option to develop into FCP's.

- We will look to increase our Band 5 skill mix to ensure we have a sustainable workforce
- We are exploring Modern Apprentices and aiming to increase the number of Physiotherapy Students joining our teams.

How potential gaps related to workforce planning will be addressed
We currently have a number of gaps in our mainstream Physiotherapy service, particularly in Mid Argyll and Kintyre. Innovative solutions are being considered and social media has been used but the difficulty in recruiting to this area can be problematic. Our vision of providing a whole team approach to First Contact and mainstream Physiotherapy services is designed to ensure we use the full skill mix and the wider team to ensure service continuity and service at the right level for patient in primary care.

4. PUBLIC AND PATIENT ENGAGEMENT

The Primary Care Modernisation Project group will oversee all wider public engagement .

The practices offering FCP services will provide leaflets and posters and we will produce a local press release before services start in local areas.

5. INFRASTRUCTURE

Premises
In scoping most of our GP practices have offered us space to deliver FCP services within practice. There is a shortage of space in the Cowal area.

Digital
During initial implementation, existing GP IT will be utilised to deliver this service within GP practices. As the service becomes established it may be that part of this service can be provided from Physiotherapy departments providing IT infrastructure and sound clinical governance is achievable. This requires further scoping.

6. EVALUATION

A local data-set will be collected at each location including details such as number of referrals, source of referrals, referral routes onwards, diagnosis, actions (imaging, prescribing, injections) and collated for each FCP site and as a whole A&B service. There is work ongoing at a national level to agree and establish a national data-set for collection, which will replace this local data-set once complete.

Patient reported experience measures such as the CARE measure will be used to assess patients' perceptions of their experience whilst receiving FCP care.

Practice and clinician feedback will also be gathered to assess this service and facilitate improvements.

3.7 COMMUNITY CLINICAL MENTAL HEALTH PROFESSIONALS

Key Lead: Gillian Davies, Consultant Nurse Mental Health A&B Hospital
Clinical Lead: Dr Angus MacTaggart, Clinical Lead Islay & Jura

1. INITIAL DEVELOPMENTS AND PROGRESS IN YEAR ONE 2018/19

- Development of Primary Care Mental Health Nursing, Specialist Occupational Therapist and Primary Care Mental Health Team Leader Job Descriptions.
- Test of Change using 'Near Me' to support increased access and availability of psychological therapies to a remote and rural location (Island Setting)
- Formation of a Primary Care Working Group to further develop and implement the Community Clinical Mental Health Professional plan in Argyll and Bute HSCP.
- Future vision of Community Clinical Mental Health for primary care developed for presentation to PCIP Programme Board.
- Community Mental Health Service Review concluded.

2. EXPECTED PROGRESS IN YEAR TWO 2019/20

- Approval of the Community Clinical Mental Health Primary Care plan by PCIP Programme Board
- Recruitment, phased over 2019/20 and 2020/21, to 1.0 wte Primary Care Team Lead post, 0.5 wte Administrator and x 2.0 wte Primary Care Mental Health Nurses and 2.0 wte Specialist Occupational Therapists.
- Phased implementation of service in two Argyll and Bute HSCP localities in the second half of 19/20
- Additional implementation of 'Near Me' and Digital Technology to increase access and availability of psychological therapies in Argyll and Bute HSCP
- Participate in the Options Appraisal process being proposed for smaller remote and rural practices within HSCP

3. WORKFORCE

- **Local Workforce Planning**

Support recruitment to vacant posts.
Make efficient use of current primary care mental health post holders to support wider service delivery and enact the PCIP plan for mental health.
Undertake workforce planning/reviews twice yearly.
Support succession planning for service.

- **Workforce Capability**

To be measured and monitored through the use of the Wiseman Workload Tool in respect of activity/demand at least twice per year.

- **How potential gaps related to workforce planning will be addressed**

For discussion at safe staffing and workforce review meetings. Team lead will be required to ensure safe staffing and report and concerns through the appropriate management and professional structures.

4. PUBLIC AND PATIENT ENGAGEMENT

Service User and Carer representation on working group.

Plans for wider engagement with Service Users and Carer in collaboration with the Scottish Health Council around mental health care in Argyll and Bute HSCP.

5. INFRASTRUCTURE

- **Premises**
  To support engagement and continuity of care it would be of benefit for mental health practitioners to be located and or based within general practice.

- **Digital**
  Licences will be required for SCI/Vision/CoreNet and Near Me.

6. EVALUATION

Establish a baseline of current practice which includes spend on anti-depressant therapy, number of referrals to CMHS for primary care, waiting times for access to psychological therapies (RTT) compliance, crisis admissions/attendance at A and E, uptake of technology enabled care for psychological therapy (NHS24/cCBT/Near Me/Digital Health).

Clinical evaluation of service to include treatment related specific outcomes within the Clinical Outcome Routine Evaluations (CORE).

3.8 COMMUNITY LINK WORKER SERVICES

Key Lead: Alison McGrory, Interim Associate Director of Public Health (A&B)
Clinical Lead: Dr Malcolm Lazarus, Clinical Lead Kintyre

1. INITIAL DEVELOPMENTS AND PROGRESS IN YEAR ONE 2018/19

- A scoping exercise took place during 2018-19 to investigate an appropriate model for link working in Argyll and Bute. This involved the following:
  - Investment of £10,000 in a local social enterprise to investigate link working delivery
  - Online questionnaire with third sector partners to investigate the referral pathways from link working to community based services (56 responses)
  - Online questionnaire with primary care staff to investigate different models for link working (11 responses)
  - Discussions at Argyll and Bute Primary Care Implementation Board (PCIB)
- An options appraisal including the following models for link working delivery:
  - Directly employed NHS staff employed by NHS Highland
  - Staff employed by GP practices or existing GP practice staff delivering link working
  - Staff employed by the third sector on third sector terms and conditions
  - A mixed model of the above

  The PCIB favours commissioning link working to the third sector.

2. EXPECTED PROGRESS IN YEAR TWO 2019/20

- Establish the level of investment for link working in year 2 as this will determine the ongoing actions. A nominal figure of £100,000 has been stated within the budget plan.
- A third sector contract of this value will require a formal procurement process through the national commissioning portal. This will take 3 – 6 months.
- A third sector contract will be in place by end March 2020 and paid quarterly in advance.

3. WORKFORCE

- **Local Workforce Planning**

The workforce plan for delivering link working in Argyll and Bute includes small numbers of staff. This is yet to be confirmed but if the directly employed staff model is followed there will be between 4 and 6 workers located throughout local communities. Link worker appointments do not require specialist professional qualifications so no major barriers to recruitment are envisaged.

An alternative model favoured involves commissioning the delivery of link working to the third sector. There is a vibrant third sector in Argyll and Bute, some of which is already involved in delivering a form of link working.

- **Workforce Capability**

As above, link workers will be recruited within Argyll and Bute and likely filled by local people. Training and support will be provided to enable staff to deliver link working in a consistent and appropriate manner.

4. PUBLIC AND PATIENT ENGAGEMENT

A comprehensive engagement plan has been implemented during February to May 2019 using the Health and Social Care Partnership's Engagement Specification planning tool. This involved engagement with primary care colleagues and third sector partners.

5. INFRASTRUCTURE

- **Premises**
  None required
- **Digital**
  None required

6. EVALUATION

No evaluation has been conducted to date as year one has involved scoping for appropriate models for the future delivery of link working in Argyll and Bute. During subsequent delivery an evaluation plan will be developed and will include the following:

- Quantitative data – numbers of people referred to link workers, number of people attending appointments, number of appointments per person, base line score and progress following treatment, for example using WEMWBS tool.
- Qualitative data – feedback from people attending link working appointments, case studies, investigation with GP practice staff, scoping referral experiences with third sector partners etc

4. ADDITIONAL TRANSFORMATION ACTIVITY

4.1 GP Cluster Groups and CQL Leadership Development

The 6 GP Cluster groups within Argyll and Bute continue to meet regularly and have reported on a wide range of quality improvement work including:

- Physical activity projects and primary prevention with the emphasis on physical activity for patients.
- Palliative care:
  - Gold standards monthly review – active cancers and palliative patients
  - Heart Failure Palliative Care
  - Use of Supportive & Palliative Care Indicators Tool (**SPICT)**
  - eKIS/respect
  - DNACPR
- AF review of anticoagulation and screening
- BNP protocol

Quarterly meetings of Cluster Quality Leads have been set up to facilitate leadership development and shared learning.

4.2 Practice Administrative Staff Collaborative (PASC)

During 2018/19 Argyll and Bute HSCP took part in the Healthcare Improvement Scotland "Practice Administrative Staff Collaborative" (PASC). 4 of the 6 GP Cluster groups engaged in both Care Navigation and Workflow Optimisation.

- To improve care navigation and direct patients to the most appropriate source of help or advice and be able to demonstrate that their patients receive the right care at the right time
- To improve processes and develop protocols for seamless documentation management and be able to demonstrate reduced GP involvement in correspondence management
- To promote collaboration and communication across practice teams and with other care providers
- To build capacity and capability in QI methodology and develop leadership, facilitation and influencing skills
- To develop and test protocols and related resources to support testing of interventions and measure improvement in care navigation and document management

Feedback from Cluster Leads involved in the PASC collaborative reported on the huge success in improving the working of the cluster and providing a common focus from which practices and patients could benefit. Practice staff attended training and shared learning, empowering administrative staff to take a more active role in care navigation.

A Community Cluster Care Navigation Event was held in one Cluster area attended by over 80 people; GPs, Practice Administrative Staff, Nurses, Healthcare

Assistants, Dentists, Pharmacists, Opticians and third sector organisations to facilitate better care navigation.

Clusters benefited from the use of the PASC Quality Improvement tools, e.g. process maps and readiness for change tools.

A reduction in the time spent by GPs on paperwork was reported in some clusters groups.

5. KEY ENABLERS

5.1 PREMISES

- **Sustainability Loan Scheme**
  3 of 4 GP practices who own their own premises, have made successful applications for the GP Sustainability Loan Scheme
  - Lorn Medical Centre
  - Millig Practice Helensburgh
  - The Medical Centre, Helensburgh

- **Transfer of GP leases to Health Boards**
  7 GP Practices in leased premises:
  - Port Appin, Branch Surgery, Public Hall, Isle of Lismore
  - Carradale, Branch Surgery, Skipness Village Hall, Skipness
  - Easdale Medical Practice, The Surgery, Clachan Seil, Isle of Seil
  - Dr Glen Hall & Partners, Argyll Street, Dunoon
  - Dr Louise Taylor-Kavanagh & Partner, Argyll Street, Dunoon
  - Church Street Surgery, Dunoon
  - Arrochar Surgery, Kirkfield Road, Arrochar

  To date there has been no discussion regarding the transfer of leases to the Health Board.

- National Survey of GP premises with Head of Estates.

- Accommodation required for implementation of key priority workstreams across Argyll and Bute.

5.2 INFORMATION TECHNOLOGY AND DIGITAL TRANSFORMATION

The HSCP has been making significant progress in putting in place the infrastructure to support the application of Digital technology in support of General Practice with the aims streamlining administrative processes as well as freeing up General Practitioner time and releasing resource and enhancing productivity.

Further options to be finalised within this work include:

- Increasing On-line access for patients to book appointments.
- Increasing On-line access to order repeat prescriptions.
- Increase the maturity of the Electronic Patient Record (EPR) and support for community staff.

- Extending the deployment of digital solutions in the community so that all operational areas are accessing and recording clinical activity in all healthcare setting.
- Investigate to extend the use 'Vision Anywhere' to support mobile working by allowing clinicians to access a patient record and update clinical notes out with the practice, at the point of care; and to provide shared GP access, shared appointments, and reporting facilities for GP staff and others within the HSCP i.e. MSK staff
- video conferencing equipment as an educational tool and opportunity for remote clinical consultation by the MDY and supporting cluster working
- Extend the use of Care Portal to GP's to enable improved information sharing between clinical professionals within social care and other health boards i.e. NHSGGC, GJNH

5.3 ARGYLL AND BUTE HSCP INTERGRATED WORKFORCE PLANNING

The first HSCP Workforce Plan for 2018/19 was developed focusing primarily on Adult Services and approved at the August IJB. This Plan includes actions to improve the process of workforce planning as well as actions to bridge the gap. The governance group for this work has still to be confirmed. The next HSCP Workforce Plan will include information about all services including Primary Care and will align with the HSCPs refreshed 3 year Strategic plan for 2019 to 2022 as well as the Scottish Government's guidance (draft at present).

There is likely to be a requirement on both NHS Boards and IJBs (through HSCPs) to develop three year Workforce Plans, publishing the first of these by 31 March 2020, covering the period up to 31 March 2023. Workforce planning conversations are being held with managers to inform the workforce plan as part of a programme of joint working between HSCP and Council Organisational Development teams.

There are ongoing developments at national level which will inform the development of our next plan. The National Health and Social Care Integrated Workforce Plan was expected earlier in the year, but there is still no confirmed date for publication. The aim is to bring our refreshed HSCP Workforce Plan 2019-2022 to Argyll and Bute IJB for approval in early October 2019.

6. FUNDING PROFILE

The table below provides a high level summary of available funding and proposed commitments.

PCIF : Summary of funding, actual expenditure and commitments

Available funding					
	2018/19	2019/20	2020/21	2021/22	
Nationally	£45.75m	£55m	£110m	£155m	
	£	£	£	£	
Argyll & Bute's share	848,000	1,019,000	**2,039,000**	**2,873,000**	**6,779,000**
18/19 funds returned to SG for carry forward	212,000	212,000			
18/19 underspend carried through IJB	207,684	207,684			
	428,316	**1,438,684**			

	Actual	Budgets			
	2018/19	2019/20	2020/21	2021/22	
Workstream budgets	£	£	£	£	
Vaccination transfer programme - Children	70,094	150,949	313,511	405,262	
Vaccination transfer programme - Adults	0	33,988	19,704	20,217	
Pharmacotherapy services	207,480	464,951	884,994	909,893	
Community treatment and care services	26,214	123,730	338,053	347,125	
Urgent Care (advanced practitioners)	0	0	0	0	
Additional professional roles					
- First Contact Practitioner Musculoskeletal Service	70,086	157,650	363,879	443,637	
- Community Clinical Mental Health Professionals	0	78,230	264,094	371,652	
Community link workers	10,000	51,873	198,335	204,075	
IT investment	24,494	30,560	0	0	
Cluster Quality Lead payments	4,907	20,520	20,520	20,520	
Programme management	15,042	39,663	53,555	0	
	428,317	**1,152,114**	**2,456,645**	**2,722,380**	**6,759,457**
(Over)/Under Commitment		286,570	(417,645)	150,620	19,543

The financial plan remains subject to change as individual workstream plans develop in year and with agreement by the Programme Board and GP Sub Committee.

Local Implementation Tracker Guidance

The following tracker should be used by Integration Authorities in collaboration with Health Boards and to monitor progress of primary care reform across their localities, and in line with service transfer as set Memorandum of Understanding.

The **MoU Progress tab** should be used through local discussions between Integration Authorities and GI agree on progress against the six MoU priority services as well as enablers required to deliver these. Th completed using a RAG system, and comments boxes have been provided to supply further information

If you are funding staff through different funding streams, for example, mental health workers through please include this information in the relevant section so we are aware that you are taking steps to recr

The **Workforce and Funding Profiles tab** replaces the Template C returns that were provided to Scottisł 2018/19. These tables should allow Integration Authorities to consider financial and workforce planning primary care improvement, and reassure GP sub-committee of progress. These tables will also support Authorities in requesting the second tranche of the Primary Care Improvement Fund allocation in Octob

If you are funding staff through different funding streams, for example, recruiting mental health worker record these in Tables 1 and 2. However, they should be included in Tables 3 and 4 to inform workforce

We would also ask that this local implementation tracker be updated and shared with Scottish Governm 2019 for the period July 2018 to March 2019 and by 30th October 2019 for the period April to Septembe

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Primary Care Improvement Plans: Implementation Tracker DRAFT NOVEMBER 2018

Health Board Area: NHS HIGHLAND
Health & Social Care Partnership: ARGYLL AND BUTE HSCP
Number of practices: 33

Completed by:
HSCP/Board Joyce Robinson, Primary Care Manager
GP Sub Committee Dr Erik Jespersen Argyll and Bute Repres
NHS Highland GP Sub Committee
Date: 06/08/2019

Implementation period
From: 1 July 2019
To : 31 March 2020

	fully in place / on target	partially in place / some concerns	not in place / not on target
Overview (HSCP)			
MOU – Triumvirate enabled - GP Sub Engaged with Board / HSCPs	G	A	
Comment / supporting information			
PCIP Agreed with GP Subcommittee	G	A	G
Comment / supporting information (date of latest agreement)	Original Plan agreed with GP Sub Committee. Year 2 Plan: agreed with GP Sub Committee		
Transparency of PCIF commitments, spend and associated funding	G	A	G
Comment / supporting information	All budget decisions are approved through the Project Team and Programme Board governance structure		

Enablers / contract commitments			
BOARD			
Premises			
GP Owned Premises: Sustainability loans supported	G	A	G
comment / supporting information	Applications	**3**	
	Loans approved	**3**	
	narrative:	3 of 4 GP owned premises applied for loan in Year 1	
GP Leased Premises: Register and process in place	R	A	R
comment / supporting information	Applications	No.	
	Leases transferred	No.	
	narrative:	Discussion with 7 practices re leased premises not yet taken place	
Stability agreement adhered to	G	A	G
comment / supporting information	Current funding arrangements remain in place		
GP Subcommittee input funded	G	A	G
comment / supporting information	Agreement in place		
Data Sharing Agreement in Place	R	A	G
comment / supporting information	Awaiting national Template Information Sharing Agreement document - expected at end of summer 2019. Resistance from some GP Practices to share data at this early stage.		

HSCP			
Programme and project management support in place	R	A	G
comment / supporting info	Project Board agreement for Transforming Primary Care Prgoramme Manager to be recruited. Workstream Leads appointed with support from Clinical Leads		
Support to practices for MDT development and leadership	R	A	R
comment / supporting info			
GPs established as leaders of extended MDT	R	A	G
comment / supporting info			
Workforce Plan reflects PCIPs	G	A	G
comment / supporting info			
Accommodation identified for new MDT	R	A	R
comment / supporting info			
GP Clusters supported in Quality Improvement role	G	A	G
comment / supporting info	Established Cluster Groups with Cluster Quality Leads in place. Regular meeting to support Quality Improvement and share learning. HIS PASC engagement promoted QI tools.		
EHealth and system support for new MDT working	R	A	G
comment / supporting info			

MOU PRIORITIES			
Pharmacotherapy			
PCIP pharmacotherapy plans meet contract commitment	R	A	G
Pharmacotherapy implementation on track vs PCIP commitment	G	A	G
Practices with PSP service in place	21		
WTE/1,000 patients	1:12700		
Pharmacist Independent Prescribers (as % of total)	%		
	Level 1	Level 2	Level 3
Level of Service	10	14	No. practices
comment / narrative	The time allocation for the small practices low (1 hour per week in some) and they have chosen medication or review of systems instead of level 1		
Community Treatment and Care Services			
PCIP CTS plans meet contract commitment	R	A	G
Development of CTS on schedule vs PCIP	R	A	G
Practices with access to phlebotomy service	4		
Practices with access to CTS service	4		
Range of services in CTS	Phlebotomy, ECG Spirometry Dressings, Suture and clip		
comment / narrative			
Vaccine transformation Program			
PCIP VTP plans meet contract commitment	R	A	G
VTP on schedule vs PCIP	R	A	G
Pre-school: model agreed	R	A	G
practices covered by service	No. practices		
School age: model agreed	R	A	G
practices covered by service	No. practices		
out of schedule: model agreed	R	A	G
practices covered by service	No. practices		
Adult imms: model agreed		A	R
practices covered by service	0		
Adult Flu : model agreed	R	A	G
practices covered by service	1		
Pregnancy: model agreed	G	A	G
practices covered by service	33		
Travel: model agreed		A	R
practices covered by service	0		
comment / narrative			
Urgent Care Services			
Development of Urgent Care Services on schedule vs PCIP		A	R
practices supported with Urgent Care Service	0		
comment / narrative	Plans to deliver the requirements of the contract have up until now been developed in separate work streams which is proving time consuming, expensive and at times contentious. In Cowal which is the early test of change site for CT&CS and Urgent Care, the mode of delivery is based on a central treatment room based within the hospital and serving 4 GP practices. Some Childhood vaccinations are already being delivered from the TR along with the range of treatment room interventions and some on-the-day appointments. Given the complexities involved in implementing different models in each locality whilst adhering to the aspirations of the contract, it is proposed that, building on the learning from Cowal, we combine the CT&CS, Urgent Care and VTP work streams and deliver them by replicating the Cowal model across all localities. This allows us to apply equitable standards of delivery whilst making best use of workforce and available funding.		
Additional Services (complete where relevant)			
APS – Physiotherapy / MSK			
Development of APP roles on track vs PCIP	G	A	G
Practices accessing APP	2		

WTE/1,000 patients	1:13000		
comment / narrative			
Mental health workers			
On track vs PCIP	R	A	G
Practices accessing MH workers / support	28		
WTE/1,000 patients	1:16250		
comment / narrative	Helensburgh and Lomond primary mental health care delivered by SLA with NHS GG&C. No cross reference to Action 15 within PCIP.		
APS – Community Links Workers			
On track vs PCIP	R	A	G
Practices accessing Link workers	0		
WTE/1,000 patients	1:29500		
comment / narrative	Service still being developed		
Other locally agreed services (insert details)			
Service			
On track vs PCIP	R	A	G
practices accessing service	No. practices		
comment / narrative			

Overall assessment of progress against PCIP	R	A	G
Specific Risks The rural and island geography of Argyll and Bute			
Barriers to Progress Capacity and recruitment of a "Transforming Primary Care Programme Manager"			
Issues FAO National Oversight Group			

Funding and Workforce profile

Table 1: Spending profile 2018 - 2022 (£s)
Please include how much you spent in-year from both PCIF and any unutilised funding held in reserve

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend	70094	0	205956	1524	21940	4274	0	0	69453	633	10000	0
2019-20 planned spend	200000		360000		100000		130000		300000		10000	
2020-21 planned spend	300000		600000		250000		250000		518000		50000	
2021-22 planned spend	414000		800000		400000		400000		738000		100000	
Total planned spend	984094	0	1965956	1524	771940	4274	780000	0	1625453	633	170000	0

Table 2: Source of funding 2018 - 2022 (£s)

Financial Year	Total Planned Expenditure (from Table 1)	Of which, funded from:		
		Unutilised PCIF held in IA reserves	Current year PCIF budget	Unutilised tranche 2 funding held by SG
2018-19	383874		428316	
2019-20	1100000	207,684	1019000	212000
2020-21	1968000		2039000	
2021-22	2852000		2873000	
Total	6303874	207684	6359316	212000

Table 1 - Other 18/19 costs = 44,443. Other 2019/20 planned spend = 131,000 + 207,684. Other 2020/21 planned spend = 71,000. O

Table 3: Workforce profile 2018 - 2022 (headcount)

	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
Financial Year	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL headcount staff in post as at 31 March 2018	3	1	0	0	0	0	0	0	0	0	0	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	3	1	4	0	0	0	0	0	0	4	1	0
PLANNED INCREASE in staff headcount (1 April 2019 - 31 March 2020) [b]	3	0	13	2	0	3	0	0	4	4	4	4
PLANNED INCREASE in staff headcount (1 April 2020 - 31 March 2021) [b]	5	5	4	4	0	2	0	0	0	5	1	5
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	0	0	2	0	0	3	0	0	2	0	0	0
TOTAL headcount staff in post by 31 March 2022	14	7	23	6	0	8	0	0	6	13	6	9

[a] please specify workforce types in the comment field below
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 4: Workforce profile 2018 - 2022 (WTE)

	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and Care Services			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
Financial Year	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers	MSK Physios	Other [a]	
TOTAL WTE staff in post as at 31 March 2018	3	1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	3	0	1.5	0.0	0.0	0.0	0.0	0.0	0.0	4.0	1.0	0.0
PLANNED INCREASE in staff WTE (1 April 2019 - 31 March 2020) [b]	3.0	0.0	9.0	2.0	0.0	2.5	0.0	0.0	4.0	2.5	3.0	3.0
PLANNED INCREASE in staff WTE (1 April 2020 - 31 March 2021) [b]	3.0	3.4	2.0	2.8	0.0	2.5	0.0	0.0	0.0	3.0	0.5	4.0
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	0.0	0.0	2.0	0.0	0.0	3.0	0.0	0.0	2.0	0.0	0.0	0.0
TOTAL WTE staff in post by 31 March 2022	11.2	4.6	14.5	4.8	0.0	8.0	0.0	0.0	6.0	9.5	4.5	7.0

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Integration Joint Board **Agenda item: 6**

Date of Meeting: **25 September 2019**

Title of Report **Living Well Strategy Launch September 2019**

Presented by: **Alison McGrory, Acting Associate Director Public Health**
Linda Currie, Lead AHP

The Integration Joint Board is asked to:

- Endorse and provide strategic leadership for the implementation of Argyll and Bute's Living Well Strategy

1. EXECUTIVE SUMMARY

The Living Well Strategy has been developed to support people to live better and more active lives in order to achieve better health and wellbeing outcomes in our population. It sets out leadership and direction to prevent long term health conditions, and for people already diagnosed, support enablement, and promote self management.

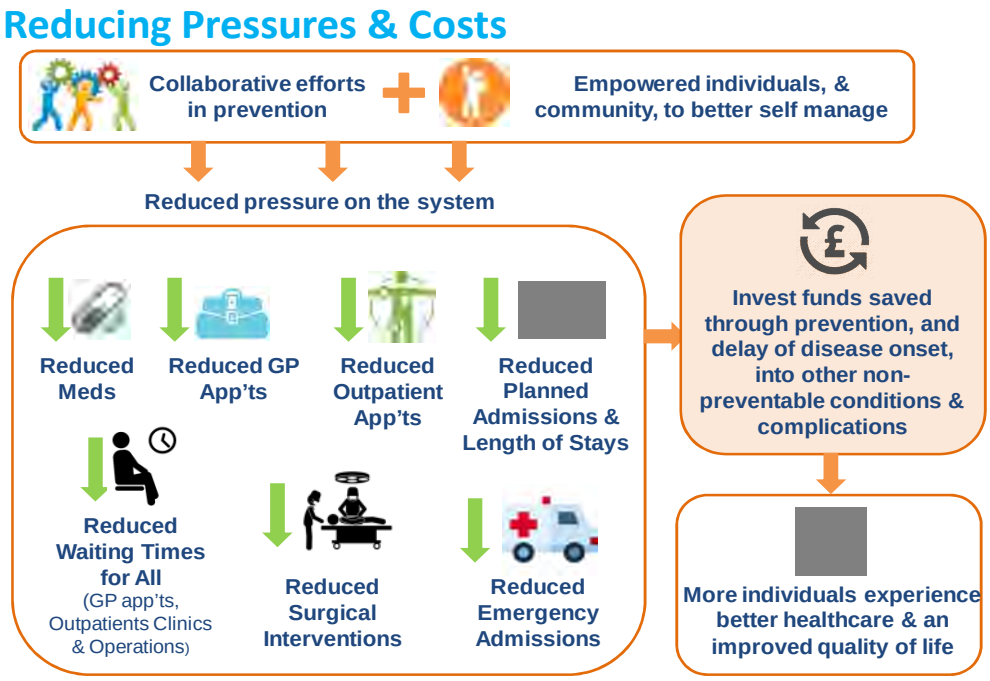
Aim:	Highlight the importance of self management and ensure structures and resources are in place to enable people to self manage their health more effectively.
Leadership:	The Public Health Department has developed the Living Well Strategy in a multi-disciplinary way with a range of HSCP staff, third sector partners and community members.
Engagement:	Wide ranging engagement has taken place since August 2018 involving more than 450 people.

Through this engagement four clear strategic outcomes emerged:

- People - People living in Argyll and Bute will have the tools and support they need to enable them to Live Well
- Community - A wide range of local services exist to support people to Live Well
- Our workforce - Staff are able and motivated to support people to Live Well
- Leadership - Effective leadership directs delivery of the Living Well Strategy

A strategic approach to the self management of long term health conditions has the potential to benefit the HSCP and our population in the following ways:

- More efficient and effective patient pathways
- Reduced demands on health and social care services
- Improved health and wellbeing outcomes for Argyll and Bute's people



2. INTRODUCTION

Argyll and Bute has a population of 86,810 with a quarter of the population over 65 and with a further 27% within the 45-64 age group. People are living longer but they are living longer with Long Term Conditions (LTCs). It is also known that an increasing number of people in the middle age group are developing or at increased risk of developing LTCs. Our population is projected to ***increase by 32% for those 85+ 2029 with a decreasing overall population by 4% by 2029.*** This is a worrying trend and represents a challenge to our current models of care.

(National Records for Scotland 2016-based population projections)

Trends show increasing prevalence of LTCs, for example, type 2 diabetes and hypertension, both of which are risk factors for other LTCs such as CHD and stroke. In Argyll and Bute:

- 45% of adults have a LTC
- 32% of adults have a *limiting* LTC
- 17% of children have a LTC
- 10% of children have a *limiting* LTC

(Scottish Health Survey 2017)

The principles of self management are at the heart of person centred care and have a clear strategic, policy and moral grounding in health and social care delivery in Scotland. The national strategy for Scotland Gaun Yersel illustrates this:
"I am the leading partner in management of my health" and**,**
"I am a whole person and this is for my whole life"

(Alliance 2009)

Current health and social care delivery in Scotland works to a traditional medical model with services designed around the needs of the service rather than the needs of the person and a focus on treating symptoms rather than their cause. The drive towards Realistic Medicine captures the

essence of sustainability and the pressing need to change the way healthcare is delivered in developed countries. This approach focuses on achieving better value and outcomes through identifying and eliminating harm and waste, minimising unwarranted variation in clinical practice with the consequent potential for underuse or overuse of resources.

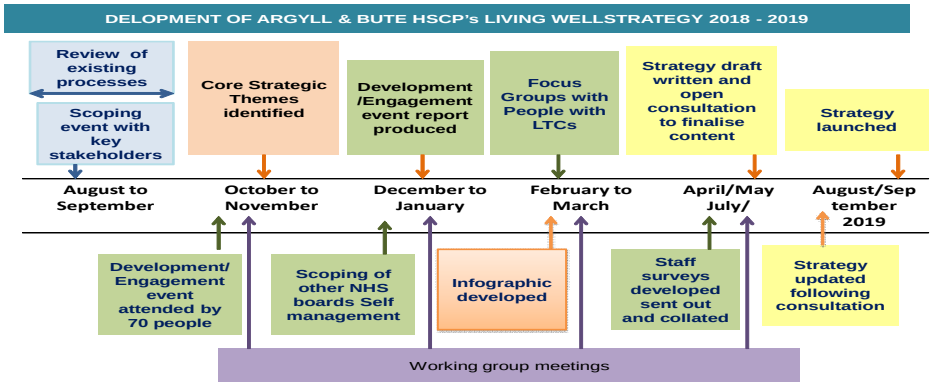
Realistic medicine puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to you so that the care of your condition fits your needs and situation. Realistic medicine recognises that a one size fits all approach to health and social care is not the most effective path for the patient or the NHS.

(Scottish Government 2017)

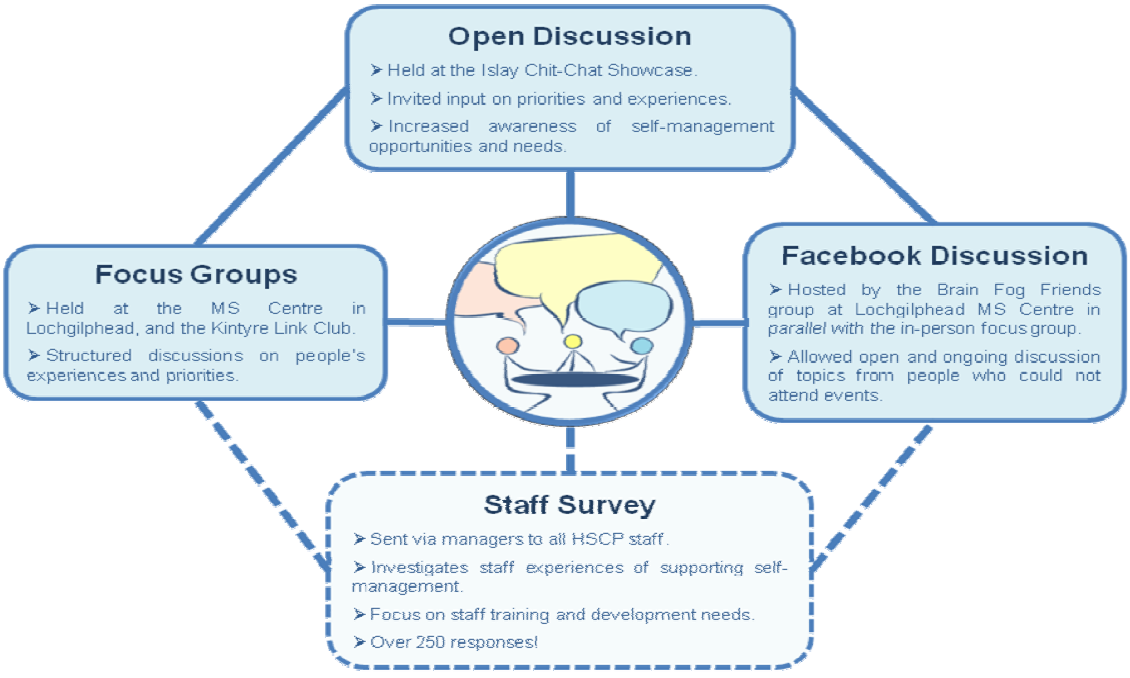
3. DETAIL OF REPORT

3.1 Engagement and Participation

The development of the Living Well Strategy has been overseen by the Public Health Department with considerable involvement from other professional groups, partners, people who use our services and the wider community. Work commenced in August 2018 and over 450 people were involved. The following timeline outlines key steps in the engagement process:



More detail is provided in the following diagram:



3.2 Recommendations

The following outcomes emerged from the data gathered from the engagement activity:

PEOPLE

- People with LTCs will be more informed about managing their health
- Self management courses and toolkits are accessible to people
- People will understand what support is available and how to access it
- People in our communities will be more physically active
- The skills and expertise of people living with their conditions is recognised, supported and developed (peer support)

COMMUNITIES

- Our community assets (services and resources) are recognised and promoted
- Links with the third sector and HSCP will be stronger
- There will be an improved understanding of community led self management activity and its availability in our communities
- Joint working opportunities will be increased for community groups/organisations to support them to build on existing activity/resources
- There will be an increase in activities available in communities

LEADERSHIP

- Living Well in Argyll & Bute has a clear and recognisable brand and identity
- Good practice for living well is recognised and promoted
- A strategic group exists to lead and direct activity
- There are effective connections between Living Well activity
- The Living Well Strategy has a 5 year Action plan

WORKFORCE

- Our staff will feel supported to self manage their own health and wellbeing
- There will be increased understanding of what support and activity is available in our communities and how people can be signposted to it
- The workforce will feel more confident in referring/signposting people to community led activities/support
- Our staff will be better equipped to support people to self manage

These outcomes will be delivered in the 5-year Action plan.

3.3 Next Steps

ACTION	TIMESCALE
Launch Living Well Strategy	25 September 2019
Local roadshows, social media campaign, press releases and reflective workshops with staff	Autumn- winter 2019
Agree 1st iteration of 5-year action plan	Autumn 2019
Formally convene Self-management/Living Well Steering Group	Autumn 2019
Implement actions in plan	2019 - 2024

4. RELEVANT DATA AND INDICATORS

- 45% of adults have a LTC, for example approximately 4,800 have diabetes (88% type 2), 9% of all health spending in Scotland is on diabetes and its complications
- 32% of adults have a *limiting* LTC
- 17% of children have a LTC
- 10% of children have a *limiting* LTC

(Refs Scottish Health Survey 2017 and Scottish Government Diabetes Prevention and Support Framework 2018)

5. CONTRIBUTION TO STRATEGIC PRIORITIES

There is alignment with the priorities in the HSCP's Strategic Plan 2019 – 2022:

- Support people to live fulfilling lives at homes, for as long as possible.
- Promote health & wellbeing across all our communities and age groups.
- Support unpaid carers, to reduce the impact of their caring role on their own health and wellbeing.
- Reduce the number of avoidable emergency hospital admissions and minimise the time that people are delayed in hospital.
- Support staff to continuously improve the information, support and care that they deliver.
- Institute a continuous quality improvement management process across the functions delegated to the Partnership.
- Efficiently and effectively manage all resources to deliver Best Value.

6. GOVERNANCE IMPLICATIONS

6.1 Financial Impact

The approach outlined in this paper has the potential to save the HSCP money from more effective investment of resources. There are few upfront costs in launching this strategy and they are being accommodated within the Public Health Department's financial plans for 2019-20. Other costs are anticipated, for example releasing staff for training.

6.2 Staff Governance

The approaches outlined in this paper will rely on staff applying different processes to how they deliver health and social care services. Appropriate organisational governance will be required to agree and embed these changes. Local implementation will be via service planning, staff objectives and PDP.

6.3 Clinical Governance

There are no issues regarding safety and quality with consequent health and care governance implications within this approach.

7. EQUALITY & DIVERSITY IMPLICATIONS

Public health supports the shift to prevention and to tackling inequalities in society with a wide-range of preventative approaches. Improving equality and diversity is at the heart to public health practice and this has underpinned the approach used to develop the strategy. The strategy promotes principles of person centred working. Disability is one of the nine protected characteristics of the Equality Act. The Living Well Strategy has the potential to reduce health inequalities as people experiencing deprivation and other inequalities are more susceptible to disease and ill-health.

8. GENERAL DATA PROTECTION PRINCIPLES COMPLIANCE

Not applicable.

9. RISK ASSESSMENT

None required.

10. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

See section 3.1.

11. CONCLUSIONS

The prevention of health and social care problems is imperative on moral and financial grounds, yet there are challenges for front line staff to balance prevention with service delivery. Ageing population demographics, increasing incidence of LTCs and reducing public sector resources are compelling drivers for the Living Well Strategy. This Strategy provides a new approach to transforming how health and social care is delivered that has the potential to improve outcomes for people while at the same time making the services delivered by the HSCP more effective and efficient.

12. DIRECTIONS

	Directions to:	tick
Directions required to Council, NHS Board or both.	No Directions required	
	Argyll & Bute Council	
	NHS Highland Health Board	
	Argyll & Bute Council and NHS Highland Health Board	

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A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Living Well Strategy SUMMARY

Living well IN ARGYLL & BUTE

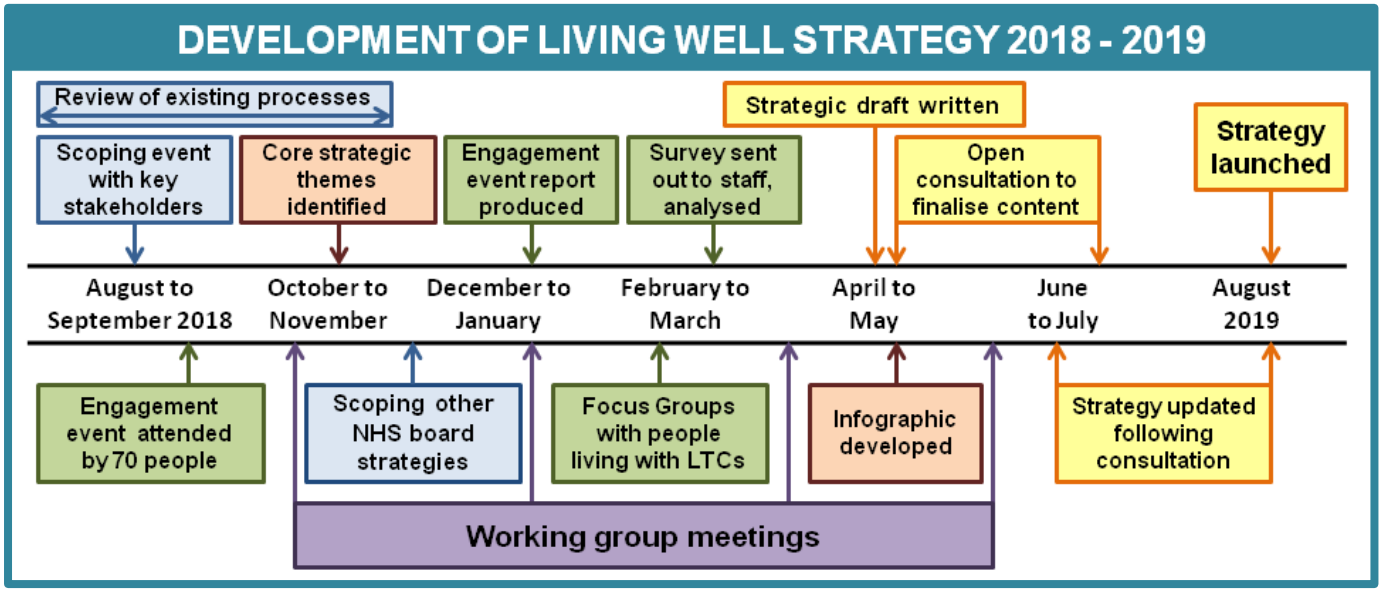
Supporting Enablement, Prevention, and Self-Management in Argyll & Bute 2019-2024

WHAT *is the Living Well in Argyll & Bute Strategy ?*

Our intention is to highlight the importance of self management, and to ensure that we have the structures in place to support people to Live Well effectively with the right information, and support when they need it.

The Living Well Strategy sets out the key outcomes that Argyll & Bute HSCP with our partners will to strive to achieve through the actions contained in the Living Well Implementation Plan. We hope, through this strategy, to **Empower** people, **Enable** the workforce, and **Improve Access** to support.

HOW *did we get here?*



WHY *are we doing this?*

Argyll and Bute has a higher proportion of older people that Scotland as a whole, with 11.6% aged 75+ compared to 8.5% in Scotland as a whole. Over the next 10 years, the population is projected to decrease overall by 4% to 83,120 people. However, the population of those 85+ is projected to increase by 32% in 2029.

This decrease in the overall population with the increase in numbers of the eldest in society represents a challenge to Argyll & Bute. Trends show increasing prevalence of diseases, particularly Type II Diabetes and hypertension, both of which are risk factors for other conditions like heart disease or stroke.

WHAT *did we learn?*

There are many different ways that people self manage. Most of this is supported within the community, some by services. The diagram on the next page highlights some of the different services that have a role to play in supporting people to self manage.

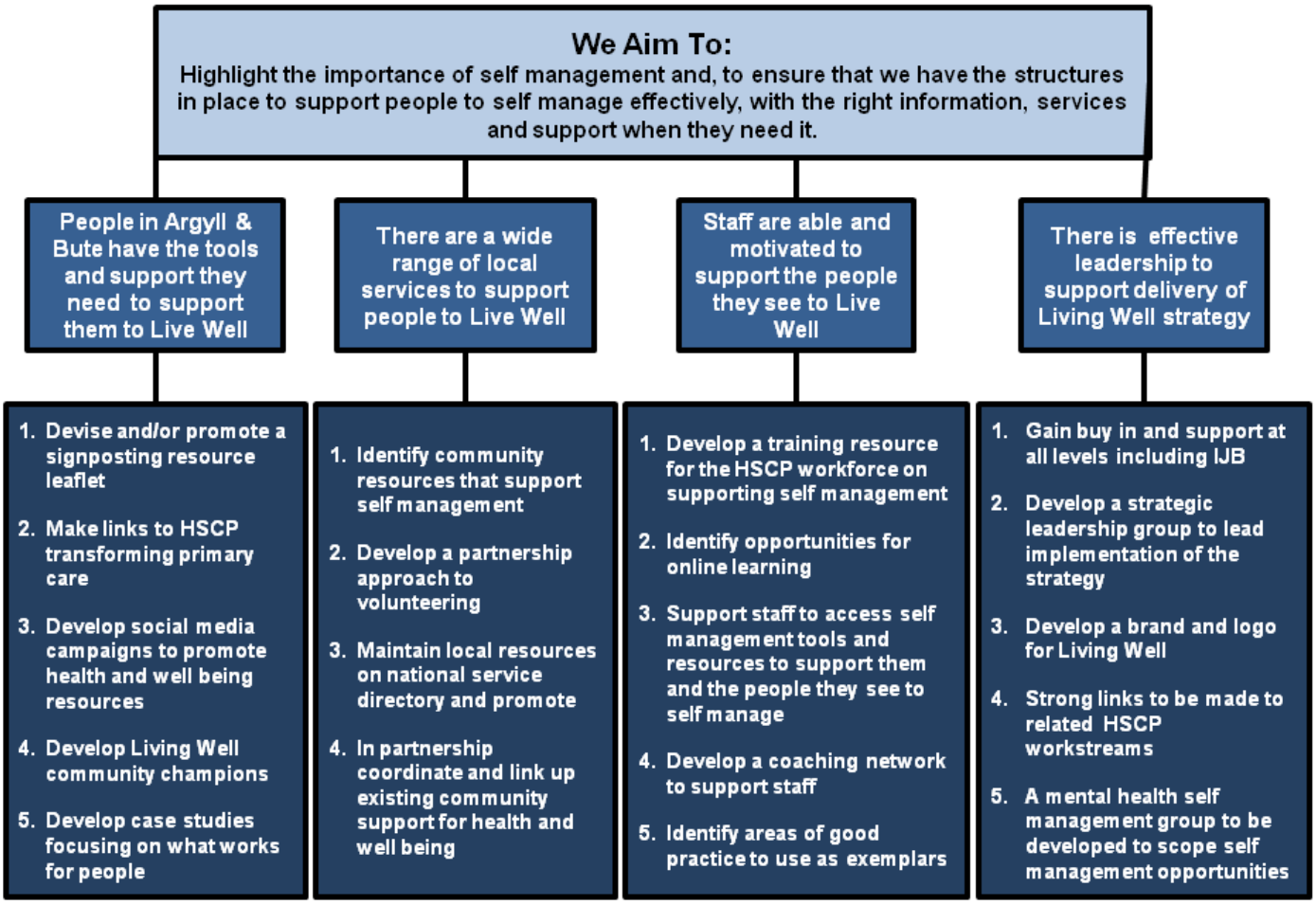
We found excellent examples of third sector community-based person-centred services / approaches already in place in Argyll & Bute, and highlighted these in case studies in the strategy. Other useful tools include personal plans such as WRAP (Wellness Recovery Action Plan), Anticipatory Care Plans and the self-management toolkit.

The strategy is built around our vision where all level of services, community, third sector and statutory services work together to enable people to take control and support them to live well. Based on our engagement activity, 4 outcomes were identified:

Outcome 1 – People ***People in Argyll & Bute have the tools and support they need to support them to live well.***	
1.1	People living with Long Term Conditions will be more informed about how to manage their condition
1.2	Self management courses and toolkits are accessible to people
1.3	People in Argyll and Bute will understand what support is available and know how to access it
1.4	People in our communities will be more physically active
1.5	The skills and expertise of people living with their conditions is recognised and supported
Outcome 2 – Communities ***There are a wide range of local services to support people to live well***	
2.1	Our community Assets (services) are recognised and promoted
2.2	Links with the third sector and HSCP will be stronger
2.3	There will be an improved understanding of community led self management activity and its availability in our communities
2.4	Joint working opportunities will be increased for community groups/organisations to support them to build on existing activity/resources
2.5	There will be an increase in activities available in communities
Outcome 3 – Our workforce ***Staff are able and motivated to support the people they see to Live Well.***	
3.1	Our staff will feel supported to self manage their health and wellbeing
3.2	There will be increased understanding of what support and activity is available in our communities and how people can be signposted to it
3.3	The workforce will feel more confident in referring/signposting people to community led activities/support
3.4	Our staff will feel better equipped to support people to self-manage
Outcome 4 – Leadership ***Effective leadership to support delivery of Living Well Strategy***	
4.1	Living Well in Argyll & Bute has a clear and recognisable brand and identity
4.2	Good practice for living well is recognised and promoted
4.3	A strategic group exists to lead and direct living well activity in Argyll & Bute
4.4	There are effective connections between living well activity in Argyll & Bute
4.5	The Living Well Strategy has an implementation plan

HOW *will we do this?*

We have developed a 5 year action plan that will be implemented over the next 5 years. The summary actions are highlighted in the diagram below:



The full strategy contains information about self-management, demographics, and our engagement process, as well as more detail on our outcomes.

You will also find a few case studies on some person-centred activity currently happening in Argyll & Bute.

You will find the Living Well Strategy and the more detailed Living Well Action Plan at

www.healthyargyllandbute.co.uk

A&B HSCP Transforming Together

Argyll & Bute Health & Social Care Partnership

Living Well Strategy

Living well IN ARGYLL & BUTE

Supporting Enablement, Prevention, and Self-Management in Argyll & Bute 2019-2024

CONTENTS PAGE

NAVIGATING THE DOCUMENT

FOREWORD

People living with long-term conditions live with them 24 hours a day, the input from professionals is a very tiny portion of that time. Coping, surviving and thriving are skills that some people need more support with than others. I see it as a key part of our role as health and social care practitioners that we enable and support self-management.

Hand in hand with self management we need to work towards providing care that is personalised and minimally disruptive. Living with a long-term condition is challenging. As Dr Victor Montori says, in his excellent book championing a patient revolution for careful and kind care "Why We Revolt", "treatments for diabetes, high blood pressure, depression, and other chronic conditions are lifelong, they must be woven into life, interlacing threads with the warps of family, friends, labor, recreation and community. This weaving, like the art of the skilled workers of the Andes, must be planned yet flexible, and must realise the themes that run through the length of the tapestry." Using her "Realistic Medicine" vision, the Chief Medical Officer for Scotland describes how important it is that as health and social care practitioners we "should always consider what matters to the person in front of us and try to better understand how their disease and our treatment fits into the broader context of their lives." An important tenet of personalised plans is self management enabling people to live more independently, confidently and with greater quality in the things that matter to them.

This plan is broad, exciting and fresh. It brings together the work of many individuals and teams and I shall be encouraging everyone I work with to read it! Please do the same! I hope the effect this document has is that many more people have access and encouragement to the support they need to live healthier, happier, more fulfilling lives in Argyll and Bute.

Dr Rebecca Helliwell

GP, Lochgilphead;
Associate Medical Director, Argyll & Bute HSCP;
Clinical Lead, NHSH Realistic Medicine.

INTRODUCTION

What are we doing?

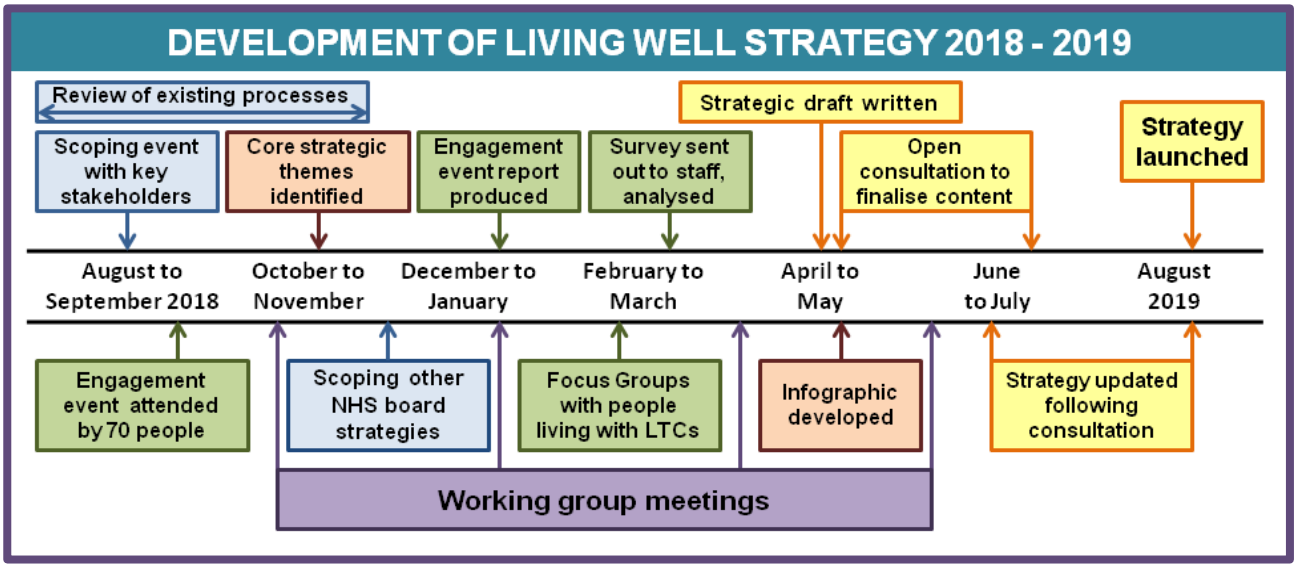
> **"Long term conditions are health conditions that last a year or longer, impact on a person's life, and may require ongoing care and support"**
> *Scottish Government definition*

The Living Well Strategy highlights the importance of self management, sets out our intentions to support people to live healthy and well lives in Argyll and Bute.

This Strategy has been developed by Argyll and Bute Health and Social Care Partnership (HSCP) and our partners. We intend, through this strategy, to **Empower** people, **Enable** the workforce, and **Improve Access** to support.

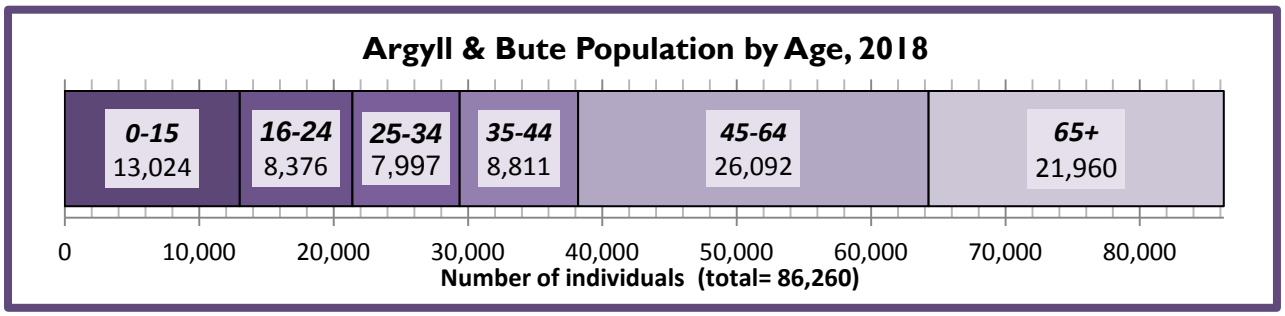
How did we get here?

It was important that this strategy be developed alongside the people affected by it. We consulted with people across Argyll & Bute to determine our actions and outcomes. Our full engagement reports are available at healthyargyllandbute.co.uk



Why are we doing this?

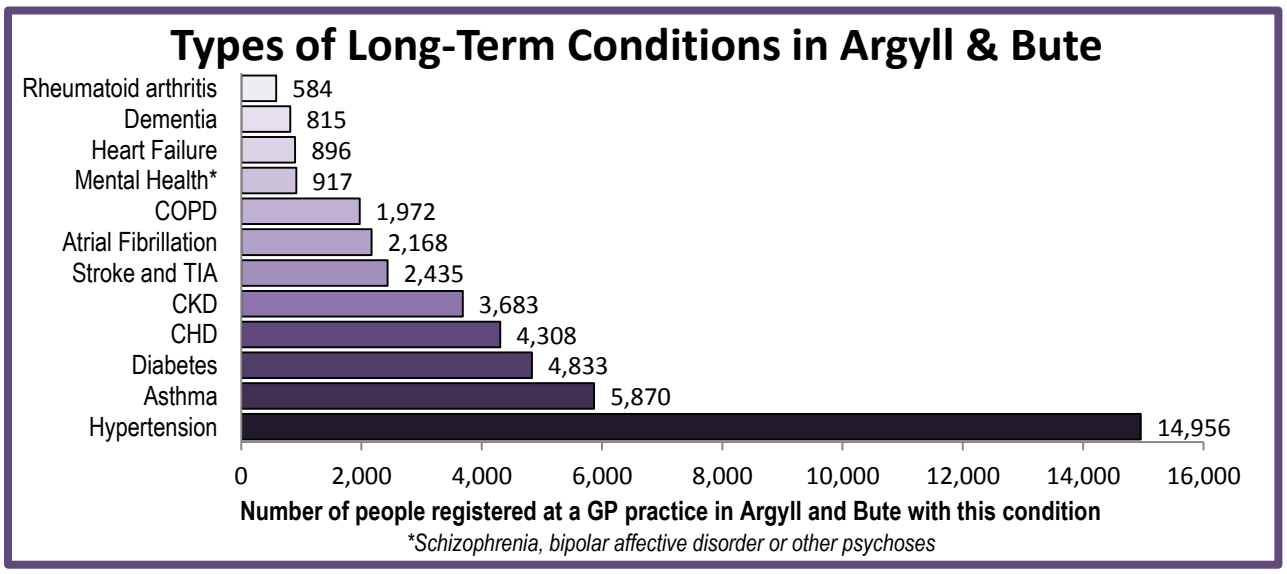
Argyll and Bute has a population of 86,810 with a quarter of the population over 65 and a further 27% within the 45-64 age group.



Source: *National Records of Scotland - Mid-Year Population Estimates*

Data shows that not only are people living longer; they are living longer with long term conditions. It is also reported that an increasing number of people in the middle age group are developing, or at high risk of developing, a long term condition.

Trends show an increasing prevalence of diseases, particularly Type II Diabetes and hypertension, both of which are risk factors for other conditions like heart disease or stroke.

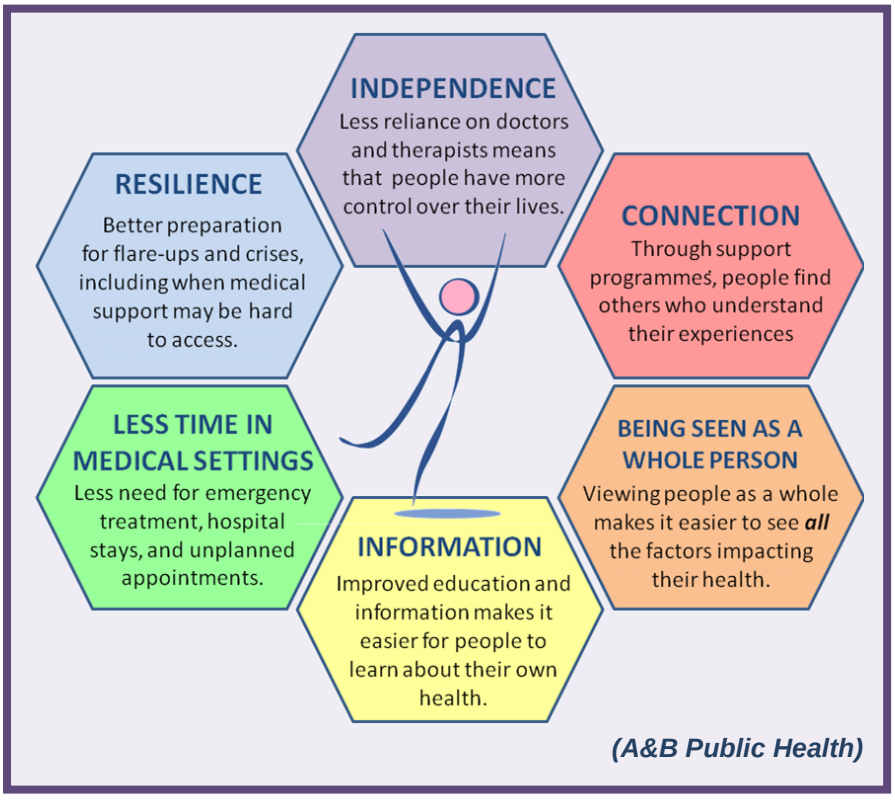


Source: *ISD Scotland Quality and Outcomes data*

People who have risk factors (eg. hypertension, smoking, addiction, pre-diabetes, inactivity, obesity) are at risk of developing one or more long term conditions.

More information on these diseases and the risk factors for them, including smoking, is available in Appendix 1.

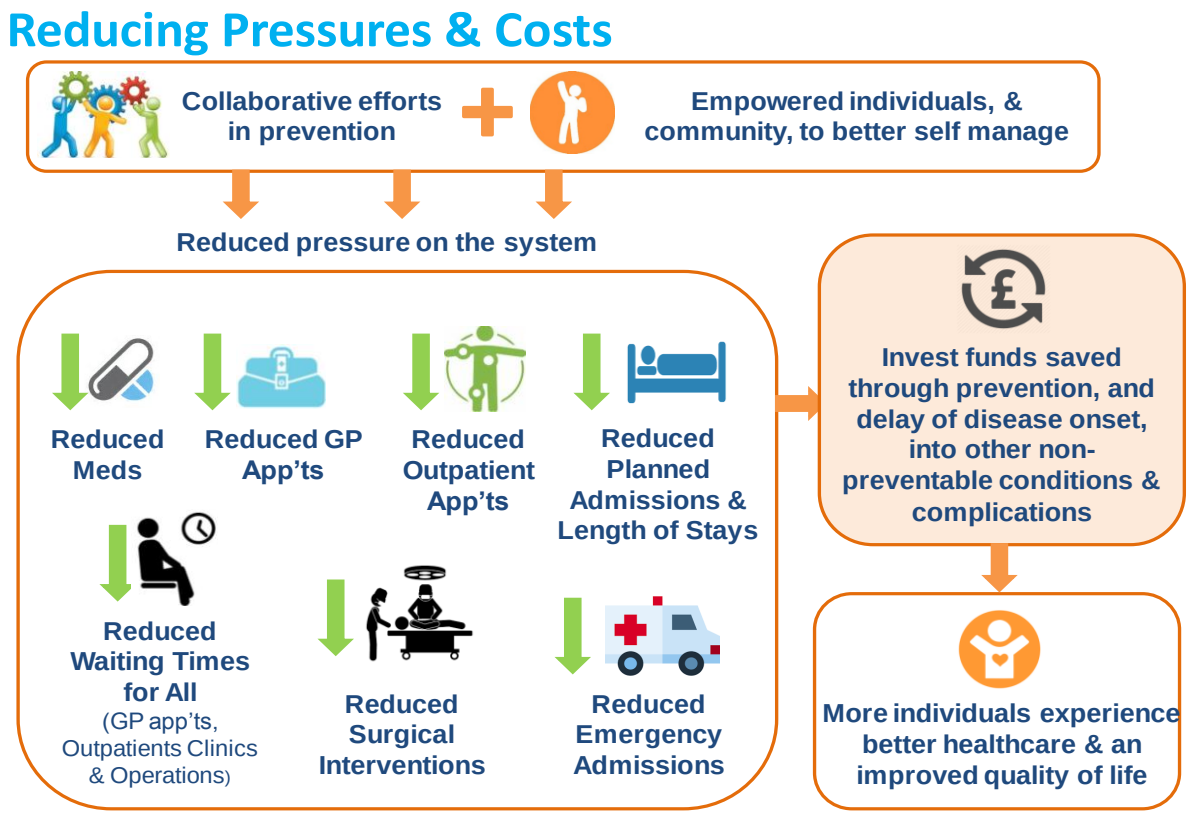
There are many benefits for people who have the tools and support to enable them to live well. Increased self esteem, enabled to take control, feeling connected, less isolated, reduced anxiety, improvement in mood, feeling empowered to challenge and question health professionals, recognised as experts in their condition, able to provide peer support, are just some examples of benefits.



NHS services generally treat people when they are ill. This medical model of healthcare is old fashioned and needs to change if we are going to fully support people to live well. More and more services can be delivered in communities. An increase in peer support models and third sector support is required. A change in culture is needed to build trust between NHS and third sector partners, allowing more people to be signposted to these community services.

Self management does not have to be complicated; there are many quick wins, for example, giving people the right information at the right time, treating people as individuals, recognising the impact of their condition on their day to day life, and ensuring they can access support all allow people to take control.
Local opportunities to support increasing physical activity and weight management carried out as part of a behaviour change model can also be effective.

Supporting people to manage their conditions and live well has the potential to impact on demand for HSCP services. People who are managing their health better are less likely to use these services.



Self-management fits well into the HSCP's strategic objectives, as laid out in our Strategic Plan 2019-2021.

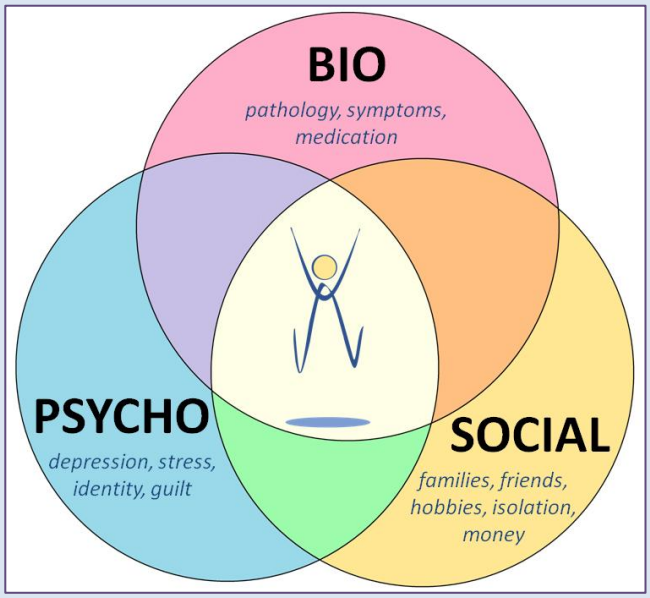
WHAT IS SELF-MANAGEMENT?

In Scotland, the term **self-management** is used in relation to people who already have a long term conditions In Argyll and Bute we are using the term in a wider context - encompassing not just people with long term conditions but also those who may be at risk of developing long term conditions.

Gaun Yersel *defines self-management as:*

"...the successful outcome of the person and the appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more Long Term Condition."

The Health and Social Care Alliance (often referred to as the Alliance)) developed the Self Management Strategy for Scotland - "***Gaun Yersel***" - on behalf of the Scottish Government in 2008. The strategy remains very relevant. *Gaun Yersel* states that "self-management is not a replacement for services. Rather, it's about developing the tools to support people alongside services. By managing conditions effectively, people can take control and live fuller, more independent lives". It's important to remember that people are not always accessing services, most of the time they are living in the community and therefore they have become experts in how their condition affects them. It's important to remember that many of the most effective services that support people are community based, probably third sector and often peer led.

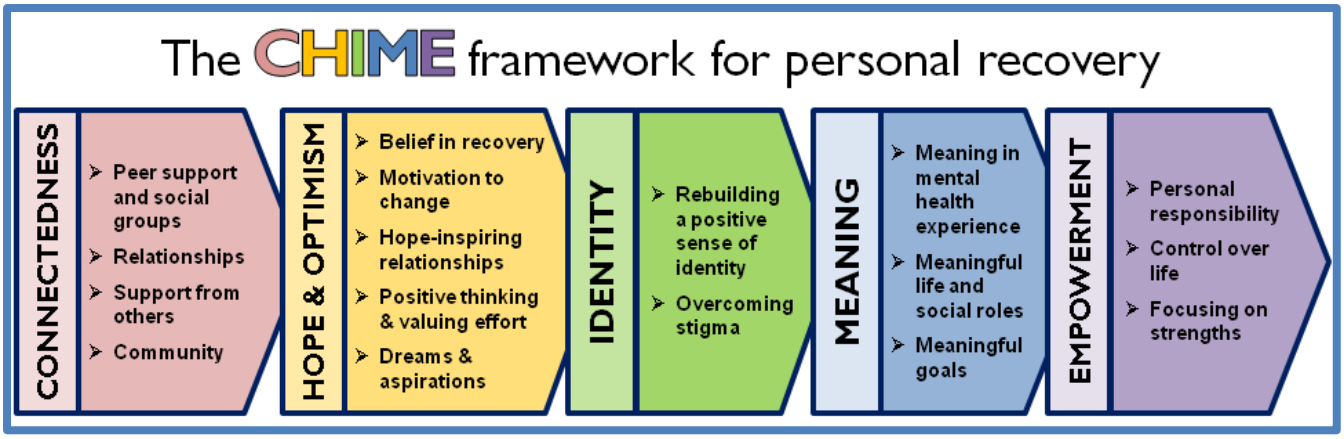


Adapted by Argyll & Bute HSCP from the Health Foundation resource centre

Health and well-being are a combination of biological factors (physical symptoms), psychological factors (such as stress and depression) and social factors (like isolation, money, and work). These factors impact on each other.

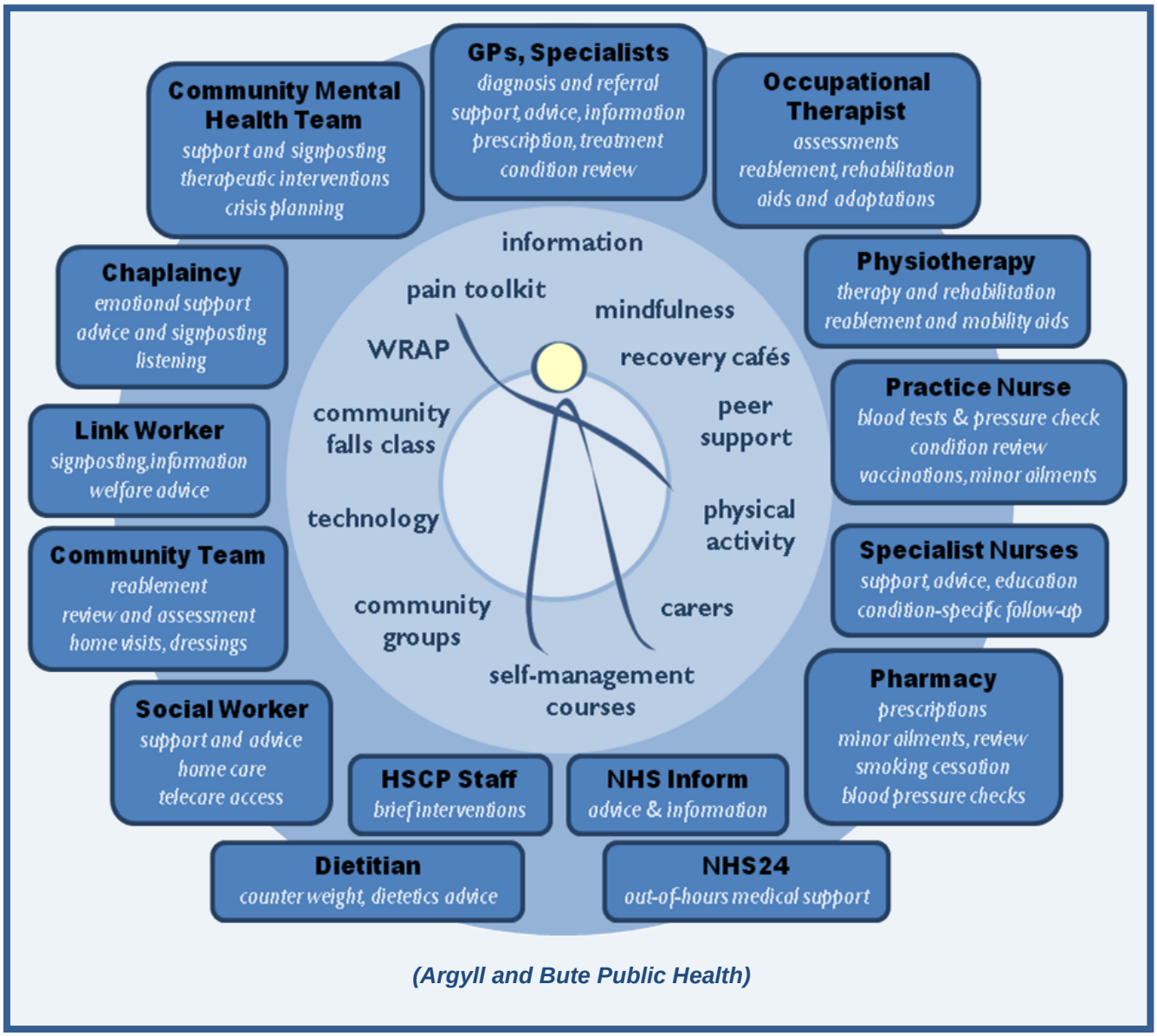
Enabling people to better manage their health does not always include health and social care services; other appropriate services may be financial, housing, socialisation or support.

Recovery is defined by the Scottish Recovery Network as: "being able to live a good life, as defined by the person, with or without symptoms. Recovery can be very personal and mean different things to different people". The CHIME framework is a recovery based framework that groups the common themes that support recovery (www.therecoveryplace.co.uk/chime-framework/)



Adapted from Scottish Recovery Network

There are a wide range of services and support available in Argyll & Bute that can help people to live well. NHS services are complimented, by community based third sector services many of them peer led/supported. Several examples are summarised below.



(Argyll and Bute Public Health)

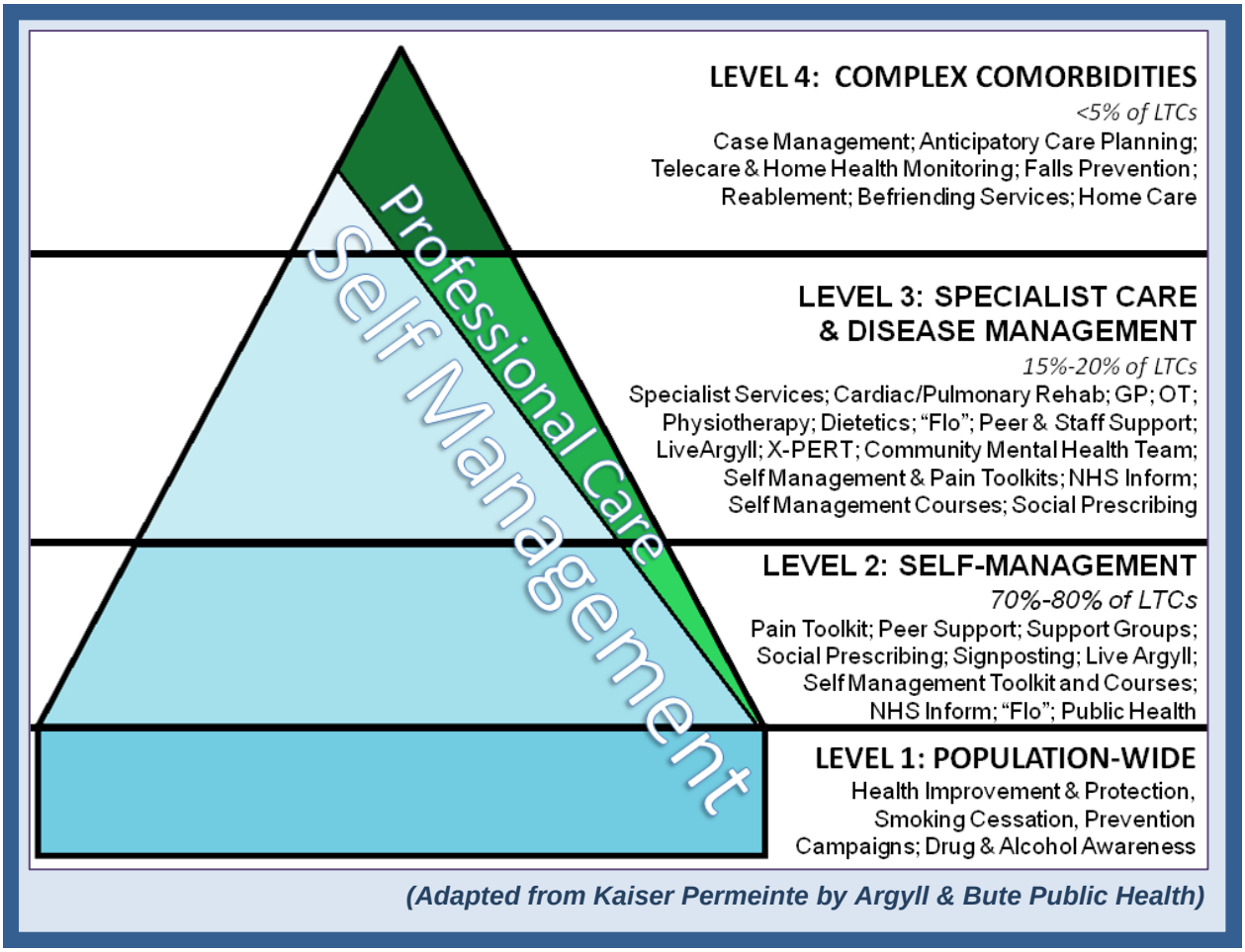
Levels of Self Management

There is no one size fits all with self management. It should be designed around the person (**Person-Centred**) and not around the service. Self management is everyone's responsibility and should be a collaborative approach.

Self management support/interventions/tools should not be seen as something only HSCP professionals are involved in, but rather something we can all do more of in our communities (as noted in our example case studies later in this document).

There are different levels where self-management is required, and the approaches used will vary based on the severity of the condition and level of need. Self management can't be viewed on just one level but crosses all four levels of need from prevention to people requiring more complex care (visualised below)

Providing support and information at the right time and in an appropriate way is important. The table on the next page explains how self management input can be provided at different stages.



(Adapted from Kaiser Permeinte by Argyll & Bute Public Health)

Key stages where people need support (adapted Alliance Diagram)		
Key Stage	**Issues**	**Impact of Self-Management**
Prediagnosis	High risk of developing a long term condition May not wish to change behaviour	Reduced risk of developing a Long Term Condition More able to make healthy choices
Diagnosis	Life and ability to manage may already have been seriously impacted by symptoms People feel challenged about their place in the world and the reality of the situation	Can help people come to terms with diagnosis Key to helping people reconnect with themselves and others Helps people make better decisions about their treatment options
Living for today	People need information and skills to maintain optimum well being Serious risk of social exclusion Risk of depression and anxiety	Supports people to navigate an often difficult journey Challenges social exclusion by helping people build bridges back into society and social roles
Progression	Cycle of illness and wellbeing arises from fluctuations in condition Increasing severity of symptoms Struggle to get additional support during flare ups Possible loss of capacity Increased risk of depression, anxiety	Helps to avoid (or reduce) flare-ups/crisis by enabling people to recognise early warning signs and react effectively Tackles psychological impact of flare ups/crisis or progression Supports changing needs
Transitions	Moving between services sometimes to different levels/ types of support/change in lead professional Dealing with multiple needs/conditions and therefore a range of services Often a stressful time and this can have serious impact, including on persons condition	Supports people to manage transition processes Maintains focus on the person's needs ensuring services are organised around these Provides people with control at a time when this can be undermined Helps to avoid (or reduce) flare ups/crisis
End of Life	Difficult time, complex challenges Death may be premature Person may have to cope with symptoms of condition alongside end-of-life challenges	Supports people to maintain control Addresses broader needs e.g. emotional, financial family and lifestyle Enables people to use advanced/anticipatory care plans to plan the end stages

What helps people to self-manage?

There are many factors that help people self-manage. Some examples are listed below.

The more access people have to these examples, the better enabled they will be to live well in Argyll and Bute.

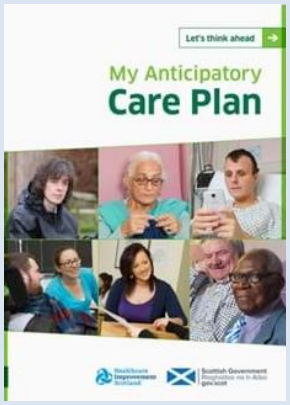
Not all of these are examples of services but some are how as an HSCP we should communicate and support people who are accessing our services. Taking a person centred holistic approach, and ensuring we signpost people to community support will positively impact on their ability to self manage.

Planning for the future

Planning ahead can help people to be more in control, help to manage their condition, and support health and wellbeing changes.

Anticipatory care plans

People with some long term conditions may already have an Anticipatory Care Plan (ACP) in place, but they could be more widely used. These plans should be developed in partnership with the person, their family/carers and their health professionals. They should be person-centred, reflecting the person's wishes on how they currently manage and how they plan to manage in the future. A good ACP records the person's preferred actions and interventions if their physical or mental health deteriorates. It should also cover legal and practical issues that may arise as conditions become more complex.



ihub.scot/media/1982/my-acp.pdf

Effective ACPs shared with relevant professionals, can help reduce hospital admissions.

Legal Planning

There are other practical steps everyone should take whether diagnosed with a long term condition or not, such as: making a will and setting up power of attorney. Many people leave this until it is too late. Age Scotland and Citizens Advice both have information on how to go about doing these.

- Power of attorney
- Will
- Welfare guardianship
- Care and support
- Money matters

Setting up a power of attorney early while there is still capacity can save a lot of heartache, expense and in many cases prevent lengthy unnecessary hospital admission. Power of attorney allows a legally appointed person to make financial, health and care decisions when the person receiving care is deemed incapable.

Dying Well

Good Life, Good Death, Good Grief is an initiative of the Scottish Partnership for Palliative Care. Its vision is "for Scotland to be a place where people are well informed about the practical, legal, medical, emotional and spiritual issues associated with death, dying and bereavement."

www.goodlifedeathgrief.org.uk has a range of resources available to support people to plan for the future. It also offers practical support for families, carers, communities, and guidance for health professionals.

Palliative care is important in the later stages; this can range from practical symptoms, support, practical help and advice to preparing for death. Talking about death and dying is difficult for many people and may be put off to avoid upset - but in fact, early planning for death reduces later stress on the person and their families, by enabling people to plan their death and final stages with their wishes taken into account.

Further palliative care information and support can be found at www.nhsinform.scot/care-support-and-rights/palliative-care

This strategy identifies four top-level outcomes based on our engagement activity. These outcomes are:

Outcome 1 – People *People living in Argyll and Bute have the tools and support they need to support them to live well.*	
1.1	People living with Long Term Conditions will be more informed about how to manage their condition
1.2	Self management courses and toolkits are accessible to people
1.3	People in Argyll and Bute will understand what support is available and know how to access it
1.4	People in our communities will be more physically active
1.5	The skills and expertise of people living with their conditions is recognised and supported
Outcome 2 – Communities *There are a wide range of local services to support people to live well*	
2.1	Our community assets (services) are recognised and promoted
2.2	Links with the third sector and HSCP will be strengthened
2.3	There will be an improved understanding of community led self management and peer support activity, and its availability in our communities
2.4	Joint working opportunities will be increased for community groups/organisations to support them to build on existing activity/resources
2.5	There will be an increase in activities available in communities
Outcome 3 – Our workforce *Staff are able and motivated to support the people they see to live well.*	
3.1	Our staff will feel supported to self manage their own health and wellbeing
3.2	There will be increased understanding of what support and activity is available in our communities and how people can be signposted to it
3.3	The workforce will feel more confident in referring/signposting people to community led activities/support
3.4	Our staff will feel better equipped to support people to self manage
Outcome 4 – Leadership *There will be effective leadership to support delivery of the Living Well Strategy*	
4.1	Living Well in Argyll and Bute has a clear and recognisable brand and identity
4.2	Good practice for Living Well is recognised and promoted
4.2	A strategic group exists to lead and direct Living Well activity in Argyll and Bute
4.3	There are effective connections between Living Well activity in Argyll and Bute
4.4	The Living Well Strategy has a 5 year action plan with achievable and measurable outcomes

Outcome I – People

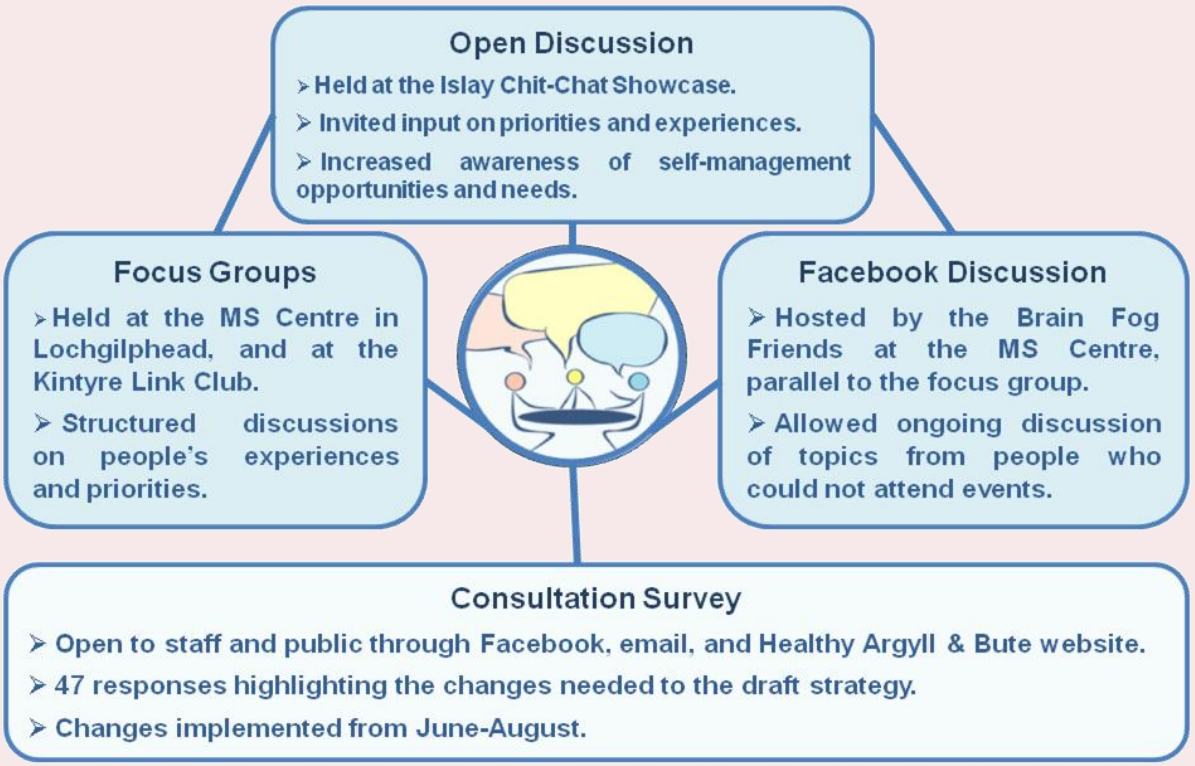
People living in Argyll and Bute have the tools and support they need to support them to live well

What do we know?

- People need access to the right support at key stages.
- Self management support should be in partnership with people
- People are experts. They know more about how their condition impacts on them
- Healthy lifestyles can reduce disease development
- People are living longer with long term conditions; increasing older population
- Significant increase in obesity, diabetes and hypertension, all of which are risk factors for other diseases
- People who have accessed self management support feel more in control of their condition
- People with mental health conditions are at higher risk of developing health conditions and vice versa.

What did we do?

This strategy was developed with input from people with direct experience of self management– staff, carers, and most of all, people with long-term conditions. As such, we went out over several months to consult with these people on their priorities, needs, and experiences.



Summary of the engagement activity informing the strategy (A&B Public Health)

What did people tell us?

Community support
People credited being part of a community or support group with improving their health. Sharing experiences and peer support is a key need. People who had attended self management courses valued them and felt more able to self manage and to access services appropriately. Access to services and to community support can be difficult from rural communities

Professional input and understanding
It was difficult to know who to turn to or how to access professional help. There is a perceived lack of continuity both within and between services. People felt that NHS staff don't routinely signpost to community services. There was a lack of recognition of the expertise of the person with a condition. It was important to be heard, believed, and respected by professionals. There was a perception that GPs were gatekeepers to all services, and uncertainty on where they go for the right support, eg pharmacies. They want their stories and experiences to be heard.

"I thought I was protecting myself from the world, but I was stopping myself from living my life."

Exercise and activity
Exercise may be difficult or intimidating for some people, but was seen as very important. People also said that having available, accessible activities helped them to self-manage.

Catherine Kennedy Think its very important to get a chat and a laugh is the best medicine..

"Be Kind To Yourself"
An important theme was the benefit of holistic approaches. Rest, relaxation, pacing, and comfort are key to self-management, as is self-forgiveness. Mindfulness, meditation, and gentle activities like Tai Chi were highlighted as helpful.

Information and signposting
Access to information and available services locally & nationally alleviates anxiety and helps people to feel more independent. People often struggled to find information about their conditions. Knowing what was trusted, good-quality information was difficult. Most information is online, which may not be easy for everyone to access. People felt there was a gap in signposting to services, support and information.

Only 1 person was aware of NHS Inform.

Those that did find support did so through:

- **Online searches**
- **Word of Mouth**
- **Community Postings**
- **Support Groups**
- **Advocacy Networks**

What do we need to do?

The following key actions have been identified.

Increase promotion of physical activity and community activities by using a range of methods, social media, press releases, and working with our third sector partners and community groups to support us to do this.
Explore ways to improve access to community support
Develop a bank of case studies/personal stories and share widely using different methods of communication
Support staff with skills to empower and enable people
Identify ways to improve signposting for people to make it easier for them to find the right type of support or information
Increase access to self management courses and tools
Explore how we raise awareness of our self management experts

Outcome 2 – Communities

There are a wide range of local services to support people to live well

What do we know?

- There are lots of community led activities in place across Argyll & Bute.
- People can live in a community and not be aware of them or signposted to them. Those that do value them
- Staff don't know about them or how they can support people
- It's difficult to keep a register of all community services up to date
- Self management courses and pain workshop are held but uptake is low
- Several groups/organisations are accessing the same bank of volunteers; there is a risk of saturation.

Examples of person-centred community-led approaches

- Strachur Hub
- Lorn and Oban Health Options (LOHO)
- Self management courses
- Self management toolkit and personal plan
- Diabetes self management education
- Branching Out
- MS centre Mid Argyll

Short case studies are available to read later in this strategy

What did we do?

As part of our planning and scoping work we invited some of community partners to come along and tell us what was happening in their communities on self management. We also asked them to identify any gaps.

What did our communities tell us?

These are some of the points identified in our scoping work. The report is available on wwwhealthyargyllandbute.org.uk

- Our community partners were able to highlight a number of examples of self management activity across Argyll and Bute.
- They identified a need to promote these activities with our HSCP staff as they felt there was a lack of knowledge of what these services can offer.
- There is varied support available but it is inequitable and can be patchy meaning not accessible to everyone.
- There was an element of volunteer fatigue and something would need to be done to address this.
- The benefits of these services to people accessing them needed to be more widely promoted

What do we need to do?

The following key actions have been identified.

Devise a resource of community and third sector services to include pharmacy, GP and HSCP services to be promoted and marketed across Argyll and Bute. Thus allowing clarity on what is available and how to access it
Link up with and work alongside LIVE Argyll, Versus Arthritis, LOHO, MS centre etc to build on and coordinate what is already in place to allow us to increase reach/awareness and accessibility
Identify support available in our communities and find ways to ensure people are able to access the right support when they need it
Work with the voluntary sector/community groups to explore how volunteers in relevant groups could further support self management and increase physical activity
Promote the use of NHS Inform and other national websites widely in our communities
Develop stronger relationships and understanding between HSCP workforce and our third sector partners
Increase promotion and recognition of the work of our community organisations and in particular peer led activity
Support community capacity building

Outcome 3 – Our Workforce

Staff are able and motivated to support the people they see to Live Well

What do we know?

- Our HSCP services are working to capacity
- Our workforce is dedicated but continues to work to a traditional medical model
- How services are delivered needs to change
- Staff need support to enable people to self manage

What did we do?

We engaged with staff through an online survey cascaded through management structures across the HSCP, 263 staff responded

What did staff tell us?

The survey provided us with very important information about the general knowledge and understanding our HSCP workforce has about self management. From the data provided this was lower than we would like and provides a good starting point for improvements in our action plan. Some examples include-

Signposting to community led education courses - from our responses (68.64%) were not aware of community led education courses to support self management, and only 21% of those staff regularly referred people to them. 17% of all respondees did not know what the content of these courses were.

Signposting to local resources – such as community support centres or carers' centres was mixed, with the majority of regular signposting being clinical.

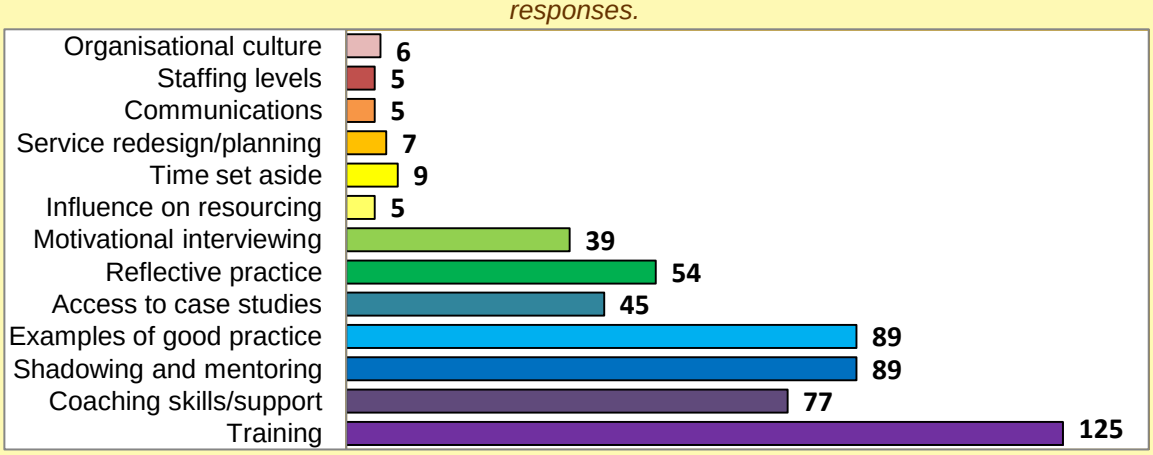
Information resources – 50% of staff in the survey still give out verbal information, only 29% signposted to websites.

It was also felt that the HSCP's culture may not be receptive to self-management in some cases, due to a very medicalised model of care and to increasing workloads for staff making it hard to develop new approaches. However, it is worth noting that increased self-management, if implemented successfully, would reduce this workload and the limits on capacity and time which were highlighted throughout the survey.

Another emerging theme was the need for **improved communication and information availability**, both in terms of informing staff of what they can recommend, and providing service users with prepared documents on self-management resources. Specific suggestions included a database or directory of available services; email bulletins and reminders of self-management courses; and leaflets available to hand out.

Staff development needs- we asked staff to identify what development needs were required to support them

*We asked: "**What development do you think would help you/your staff/your colleagues to improve their delivery of person-centred care?**" These were the responses.*



What do we need to do?

The following key actions have been identified.

Develop and utilise case studies to promote what works well for our citizens to support staff to refer to community services, identify ways to promote and make available widely to our staff
Increased promotion of self management activity to staff
Develop training and development opportunities to support staff to deliver person centred care
Explore development of a new model of HBC/MI training and ongoing support to include coaching support for staff
Increase awareness and availability of resources such as the self management toolkit, WRAP/anticipatory care plans, goal setting and pain toolkit
Identify our self management champions and promote them
Explore development of a resource/directory of trusted community services and make it easily accessible to our staff

Outcome 4 – Leadership

There will be effective leadership to support delivery of Living Well Strategy

What do we know?

Realising the benefits of improved health and wellbeing and taking a more holistic approach in Argyll and Bute will take a significant culture change and this will only be achieved through clear leadership and direction.

The HSCP Strategic Plan sets out clear intentions to transform how health and social care services are currently delivered and the Living Well Strategy provides an opportunity to do this.

What did we do?

We scoped out relevant aligned work streams in Argyll and Bute and discovered they have similar themes and aims. We interviewed service leads and professional leads.

What did people tell us?

In order to support a culture change that enables a more person centred approach, more robust governance and leadership is required. There are several aligned pieces of work currently in place within Argyll and Bute, more could be done to link them up and make better use of resources. Some examples are highlighted below.

Aligned Work in Argyll & Bute

AILP

The **A**ctive and **I**ndependent **L**iving Strategy 2017-20: 'Enabling AHPs to Enable the People of Scotland', promotes enablement, empowering staff and patients to think differently and achieve their full potential. **AILP** is underpinned by an acknowledgement of the importance of prevention and early intervention to people's lives.

Reablement

Reablement helps people learn or re-learn the skills necessary for daily living, which have been lost through deterioration in health and/or increased support needs. A focus on regaining physical ability is central, as is active reassessment. It may also comprise of interventions like exercise programmes and provision of equipment to improve function or regain daily living skills.

Social prescribing/Link Workers

Social prescribing links medical care to (typically) non-clinical, locally delivered support services**.** It enables professionals to refer to a range of activities and services. It empowers citizens and communities, supports independence, reduces reliance on primary health care and ultimately delivers better outcomes for citizens. **Link workers** enhance social prescribing by not just signposting but supports people to enable them to attend social prescribing activities and/ or support within their community.

Aligned Work in Argyll & Bute

Type 2 Diabetes Prevention and Management

Argyll and Bute HSCP have been awarded a sum of money to implement the Scottish Government's "A Healthier Future: type 2 Diabetes prevention, early detection and intervention: framework" 2018. To date a needs assessment has been carried out across the HSCP involving the public, service users and staff and an initial implementation plan for 2019/20 funding has been created

Mental Health

Mental Health services have recently undergone review, with examination of both the NHS Highland Mental Health Needs Assessment and Community Mental Health Services. The Partnership has adopted and supported a recovery approach to mental health care, forming working relationships with the Scottish Recovery Network over the last 8 years. The essential components of CHIME (Connectedness, Hope and Optimism, Identity, Meaning, Empowerment) are integral to the care and treatment within mental health services in Argyll and Bute HSCP.

Transforming Primary Care

This is work currently underway to support the new GP contract. Key to this work is access to a multi disciplinary team through the GP practice including Physiotherapist and CPN. The additional input from Physiotherapy will support further development to the MSK service allowing better and quicker access to services for people suffering with musculoskeletal pain. The additional CPN resource will improve local access to mental health services. Link worker roles will also be developed. All of these roles will be funded through the transforming Primary Care Fund as part of the new GP contract

Realistic Medicine approach

Realistic medicine refers to putting the person receiving health and social care at the centre of decisions about their care and creates a personalised approach. It encourages health and care workers to find out what matters most to patients so that the care of their condition fits their needs and situation. Realistic medicine recognises that a 'one size fits all' approach to health and social care is not the most effective approach for the patient or the NHS.

A&B Self-Management Partnership

The self management partnership is an recently developed partnership. It was formed with partners who were working together to deliver Self Management courses and pain workshops across Argyll and Bute. The partnership is expanding to support further development of community led self management approaches in Argyll and Bute

Falls/Frailty

Falls account for 87% of emergency admissions for unintentional injury in people aged 65 years and over. Falls and frailty are closely linked. Frailty is a clinically recognised state of increased vulnerability in older adults. It is associated with a decline in an individual's physical and psychological reserves. Frailty is related to falls in that an older person living with frailty has an increased risk of falling; conversely, a fall may be a sign of underlying frailty.

Chaplaincy

Chaplains provide support to staff, patients and relatives/carers and in this respect have a wider remit than all other NHS employees. In an average week they talk to managers, a wide range of staff, patients, carers and as well as seeing people in the hospital buildings will see people in their own homes. By listening to people in a non-medical way, chaplains can support people work through their anxieties and concerns.

What do we need to do?

The following key actions have been identified.

Raise the profile of self management and its impact at senior leadership and Integrated Joint Board (IJB) levels
The self management partnership needs to have a clear purpose and plan in place and be promoted and visible
Further develop the self management partnership to support its development as an ongoing resource to support self management delivery and coordination the community
Formalise a governance structure for the self management partnership to report to, to ensure implementation of the Living Well Strategy.
Develop a Living Well brand and Identity
Identify and forms links between current related workstreams/projects
Develop a communication plan to highlight and promote Living Well activity
Develop an implementation plan for the Living Well Strategy
Develop/formalise a strategic group to drive forward the Living Well implementation plan

LIVING WELL ACTION PLAN

Summary

This is a summary of the Living Well action plan and links to our 4 previously identified outcomes. These actions are based on our findings from our engagement activity with people, community and our workforce. This action plan will be supported by partnership working across Argyll & Bute and will link to other relevant work currently being carried out. The more detailed action plan can be found at www.healthyargyllandbute

Aims		Actions	
OUTCOME 1 - PEOPLE	1.1	Devise a small leaflet to be shared widely in communities, signposting to health and wellbeing support	Short-Term (0-1 year)
	1.2	Make links with the HSCP transforming primary care work stream to ensure that Living Well is linked to any new developments around the new GP contract.	
	1.3	Share our engagement reports with leads for link working and developing access to MSK practitioners in GP practice	
	1.4	Develop social media campaigns to promote • Self management courses • NHS Inform • National service directory • Health and well being campaigns	
	1.5	Work with community organisations to develop a bank of case studies • Self management course participants • Physical and social activities	
	1.6	Engage with local & national organisations and the public to explore ways to recognise expertise	2 - 4 years
	1.7	Work with local organisations to explore the development of Living Well Champions	
	1.8	Explore the potential development of a Living Well incentive scheme	
OUTCOME 2 - COMMUNITY	2.1	Develop or build on an existing resource of community services, HSCP services, GP & pharmacy that highlights what they are and what support is offered	0-1yr
	2.2	Work with local groups to build community capacity through the self management grant and health and well being networks	0-2yr
	2.3	Link up with and work alongside other organisations to build on and coordinate what is already in place	2 - 4 years
	2.4	Scope out what is available in communities and identify gaps, opportunities and Identify local resources to support self management	
	2.5	Maintain development of local resources on the National service directory accessed through NHS inform and promote widely	
	2.6	Work with community groups/voluntary sector to explore potential links with their volunteers and self management and physical activity	5+ Yrs

OUTCOME 3 - WORKFORCE	3.1	A training Public health prospectus will be developed that will promote training opportunities with the HSCP for our workforce this will include health behaviour change and health inequalities.	Short-Term (0-1 year)
	3.2	Identify online materials and courses that can be built into PDPs	
	3.3	Identify areas of good practice and promote as exemplars	
	3.4	Build in examples of good practice from our communities and promote at staff training and awareness events	
	3.5	In partnership with the Alliance develop a round of staff reflective practice development sessions across A&B using real case studies and user stories.	
	3.6	Ensure the HSCP workforce plan has actions embedded that help staff to support the people they work with to Live Well	
	3.7	Identify activities/opportunities that promote engagement between HSCP and third sector organisations at very local levels (such as local showcase events within the local hospitals)	2 – 4 Years
	3.8	Develop a network of local coaches to help staff to continue to develop and practice their skills.	
	3.9	Foster and develop a network of Self-Management Champions/coaches within our workforce	
OUTCOME 4 - LEADERSHIP	4.1	Gain buy-in and support from the IJB and senior leadership teams.	Short-Term (0-1 Year)
	4.2	Launch the Living Well strategy across Argyll and Bute through a series of locality based road shows	
	4.3	Ensure Living Well strategy is actively promoted at every opportunity (inc. LPGs, HWNs, team leads meetings, professional leads meetings). Develop infographic updates on implementation, to be shared on a bimonthly basis with support from our communication department	
	4.4	A Strategic Group will be in place to oversee the implementation of the action plan and ensure it is linked to other related work	
	4.5	The Argyll and Bute Self management partnership will be asked to support elements of the implementation plan	
	4.6	Progress updates on the implementation plan will be reported to the A&B HSCP Professional Leads group on a regular basis	
	4.7	Brand identity for Living Well will be developed and embedded into all relevant work	
	4.8	The Living Well strategic leadership group to identify how to be more involved in the realistic medicine approach	
	4.9	Scoping and review of current self management approaches and potential developments to be carried out to support people with mental health conditions.	
	4.10	The public health role of all professional groups for example AHPs to be considered and embedded into all associated work	

PERSON CENTRED CASE STUDIES

The next section is made up of some example case studies of person centred approaches to self management.

Most of these are co-productive examples led by the third sector and developed from the needs of communities.

Funding for many of them is a challenge and due to the fragility of funding can be at risk.

But the evidence of improved self management from these approaches is strong.

The case studies contained in the next section are summarised below:

- **Strachur Hub:**
  A partnership approach between the GP surgery and volunteers to support people to be more independent, less isolated, and self manage their conditions.
- **Lorn and Oban Healthy Options (LOHO):**
  A charitable organisation that works closely with HSCP services but also delivers a range of healthy options services.
- **Self Management Programme:**
  A partnership approach with third sector organisations coordinated by Versus Arthritis, delivering self management courses and pain workshops across Argyll and Bute
- **Self Management and Pain Toolkit:**
  Personal plans that support people to manage their condition delivered as part of self management courses.
- **Diabetes Education Programmes:**
  2 programmes - X-PERT and ABBBIE - are structured education programmes, run by specialist HSCP staff across Argyll and Bute
- **Branching Out:**
  A 12 week programme outdoor woodland based activity for people referred by mental health teams. Run by Argyll communities trust (ACT). It offers activity, peer support and personal development.
- **MS Centre Mid Argyll:**
  Supports people with long term conditions in Mid Argyll and offers outreach to Kintyre and Islay. It offers a range of therapies, activities, and support.
- **Wellness Recovery Action Plans (WRAP):**
  Peer-led self management plans that support people with their mental health recovery and plan for setbacks.

Strachur Hub

Strachur Hub was developed in 2016 by a local practice nurse and proactive local volunteers. **The objectives were to:**

- Ensure that older people had the opportunity to live independent lives in their own home for as long as possible
- Provide some respite to carers and family members
- Reduce social isolation and improve quality of life
- Improve mobility and prevent falls.

In the past 3 years the hub has worked with local providers such as Cowal Befrienders, Interloch transport, the Strachur medical practice, a local hotel and local tea room, and the village hall to provide a health and well being service to the community.

The service is provided collaboratively by a range of professionals from GP practice, public, third sector and local volunteers.

THE COMPETITION HOTS UP BETWEEN THE BLUES AND THE REDS - BOCCIA

Key measured outcomes (By Dr F McKirdy)

- 80% reported increased confidence
- 87.5% improvement in their overall health
- 91% reduction in falls
- 96% increased socialisation and exercise most enjoyable aspects
- 100% of respondents recorded improved quality of life

What do we do?

- Support older frail people at risk of falls
- Work with people who are lonely and isolated
- Provide exercise for people with weight or mobility issues
- Support people in need of transport
- Offer mindfulness to people with mental health needs
- Offer education/ support to people with diabetes to manage their condition
- Offer reablement on discharge from hospital
- Preventative exercise for younger age groups
- Support for people with dementia
- Respite for carers

What does it cost?

- £12,827 per year
- £251 per week for 51 weeks
- 5 hours a week
- Average attendance 52 per week
- Average hourly rate is £0.96p per person per hour

Lorn and Oban Healthy Options (LOHO)

LOHO is the link between health services in Oban and Lorn (Physiotherapy, Dietetics, and Lorn Medical Centre) and the community. It provides a specialist individually tailored service predominantly activity based to support and educate people to make positive changes to improve their health.

Healthy Options Steps to a Healthier Future

Changing Behaviour
Clients work with qualified professional staff.

Changing Minds
By engaging in activities, a better future is envisaged resulting in attitude change

Changing Lives
- Health and wellbeing is created.
- Less need for support.
- Wider vision on what is possible for themselves.

"I feel better able and better equipped to manage my life choices"

8,381 total health intervention sessions projected to be delivered in 2019
(LOHO Strategic review Feb 2019)

"If a problem has a solution don't talk about the problem"

95% of new consultations referred from GPs or AHPs

Healthy Options Services

- 1 to 1 consultation
- Personalised programmes
- Social prescriptions
- Link working
- Education programmes
- Self management courses
- Social/physical activity programmes
- Link work
- Tai Chi
- Walks
- Tailored 6 to 8 week reablement programme
- Outreach
- Support healthy villages developments and Oban healthy town
- Client progression within Healthy Options and other community organisations in a "Healthy Living Community"

"By developing skills to keep people healthy we empower our clients to better manage current conditions and significantly reduce the risk of new health problems in the future"

"I've felt my strength and mobility improve after just one session which really helps me to deal better with living with MS"

Mini case study

One of our mainstream clients with long standing mental health problems that medical services were struggling to treat was happy for us to share their story.

Healthy Options Intervention: A graded and supported exercise programme was tailored to the client's needs and abilities: the client was offered the opportunity to participate in a health & wellbeing education programme and in group exercise and gym sessions.

Health Outcome: The client experienced a marked improvement in their mental health. A 39Kg weight loss, reversing weight related liver damage. 19 GP consultations in 2016 went down to 5 in 2018. A supervised reduction in medicines was achieved resulting in a saving of £2700 in drug costs.

Self-Management Programme A&B

Versus Arthritis coordinates and supports delivery of the self management programme Living Well. The programme is delivered in partnership with North Argyll Carers, MS centre, and Lorn & Oban Healthy Options and is open to anyone with a long term condition. The programme for delivery includes:

- Self-management sessions (5 weeks modular programme)
- Pain Toolkit sessions
- Tai Chi sessions-taster sessions and courses
- Health walking groups
- Peer support including group activity
- Building community capacity for integrated self-management support.

- ✓ 47% reported increase in quality of life
- ✓ 17% increase in confidence in expressing how their condition affects them
- ✓ 15% increase in confidence on dealing with everyday life

April 2018 to March 2019 Activity

- 13 self management courses
- 9 Pain Toolkit sessions
- 23 Tai Chi classes (5/6 weeks)

Participants

- 361 with 1 or more of the above interventions
- 303 walkers participating in 3 walking groups

Volunteers

- 20 volunteers
- 9 new volunteers just completed training course and due to be inducted.

This partnership approach to course delivery has now been formalised into a working Self Management Partnership which also includes membership from A&B HSCP and the Third Sector Interface. The partnership has been successful in being allocated funding from the Health and Social Care Alliance to support the development of a more sustainable community led model for the self management programme.

What do you value most about attending the sessions?

"The understanding of our conditions within the group. The help and support I've received, and I have had a lot of support!
And the friendship."

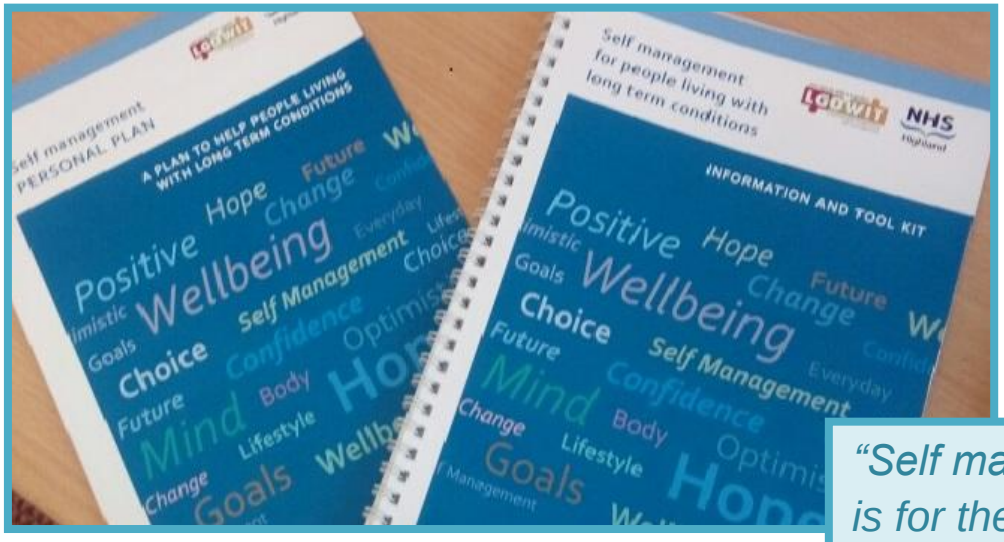
Tai Chi in Gigha

Self-Management Toolkit / Self-Management Personal Plan and Pain Toolkit

The Self Management toolkit and personal plan are person centred approaches supporting people to manage their condition, by understanding their symptoms and how they impact on their daily lives, manage their medication, set personal goals and give tips that will help them to get back into the driving seat.

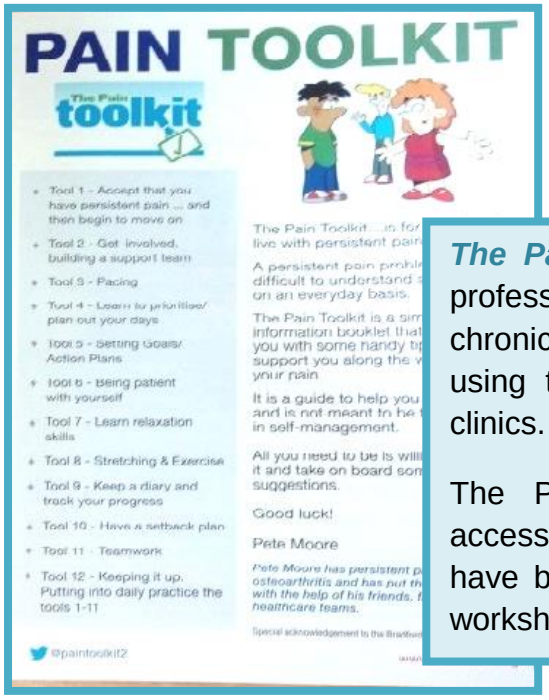
NHS Highland has worked closely with LGOWIT (Let's Get On With It Together) A self management partnership in Highland to develop the Self Management Toolkit and the Personal Plan.

These resources have been designed in partnership with third sector organisations and people living with long term conditions. They are now available to people attending Argyll and Bute self management courses. Further development of these resources will be to identify different ways that the plan and toolkit can be utilised widely across other related services including HSCP services.



"Self management is for the life I live, not the conditions I live with"

www.lgowit.org.uk



The Pain Toolkit has been introduced to health professionals as a tool to support people with chronic pain. Physiotherapists across A&B are using this tool to support people attending their clinics.

The Pain toolkit is also available to people accessing self management courses and there have been some stand alone community led pain workshops held using the pain toolkit as a resource.

Diabetes Education, X-PERT & ABBBIE

X-PERT: The X-PERT Diabetes structured education programme is offered across Argyll and Bute to adults with, or at risk of, type 2 diabetes. X-PERT diabetes is a group programme which is delivered in six 2.5hour sessions over the course of six weeks. The programme promotes self-management and aims to empower people with diabetes, ensuring they are receiving up to date knowledge and education in a relaxed and friendly manner, to enable them to discuss their ongoing treatment with their healthcare professional.

Each week of the programme different topics are discussed and participants are given the opportunity to think about making changes or setting goals.

> "The whole programme was very useful and has improved my knowledge"
>
> "Very good course, I think every diabetic should go on this course"
>
> *Quotes from A&B X-PERT participants*

ABBBIE: ABBBIE (Argyll & Bute Basal Bolus Insulin Education) is an interactive course available throughout Argyll and Bute for adults with type 1 and 2 diabetes taking multiple daily injections of insulin.

ABBBIE is a four day programme and people attend once a week for four weeks. During the sessions participants learn how to match their insulin to their food and their lifestyle. The aim is for people to be able to work their diabetes into their chosen lifestyle, rather than working their life around their diabetes.

The sessions have a curriculum to follow but they are relaxed and there is always lots of discussion, with the opportunity for people to learn from each other.

> "I found the course to be a massive help in understanding the condition I have had for 20+ years. [The educators] have been very helpful and patient during the course, repeating things when necessary and allowing me to feel more confident in controlling my blood glucose levels."
>
> "This was a great opportunity to discuss issues which can't be dealt with at 'practice reviews' or 'annual reviews'. Just having the time raises lots of issues – very helpful!"
>
> "A true self-improvement course, quite inspirational, freshens my approach"
>
> "Being in a group was helpful, listening to other people discussing how they treat and cope with diabetes"
>
> "I now feel more up to date and have developed a genuine interest in understanding how to manage my blood glucose levels better"
>
> *Quotes from A&B ABBBIE participants*

Branching Out

Branching Out is a scheme first developed by *Forestry Scotland* in 2007 and in 2015 *Argyll & the Isles Coast & Countryside Trust* (ACT) launched a project to bring Branching Out to Argyll.

It aims to improve the quality of life of adults with moderate to severe mental health problems. Participants are referred by NHS community mental health teams. Branching Out supports people through a 12 week programme of outdoor, woodland based activities. These activities support members to overcome local issues such as isolation, lack of access to appropriate services and stigma. Taking part and making contact with other members of the group gives participants strategies to maintain positive mental health.

"When everyone started there'd be no eye contact. Now it's a vibrant group with lots of chat & a network of peer support"

"I've been an occupational therapist for 21 yrs. Branching Out has given us the best set of outcomes of any group work we have ever run"

Many participants in the programme need continued support and a follow on scheme ***Moving On*** picks up after the 12 week programme. It gives a different approach giving people the chance to volunteer for different activities shaped by the participants themselves. Projects such as producing books of poetry and recipes are examples of the therapeutic benefits of the programme.

Branching Out: 2 years on

- 16 programmes completed across Argyll & Bute
- 5 teams able to deliver programmes
- 226 people referred
- 120 have completed a John Muir award
- 12 Moving on pilots trialled

Branching Out in Argyll costs on average £43/person per 5-hr session. It achieves all of the outcomes outdoors in a group setting that an OT would hope to achieve in a clinical, 1-to-1 setting.

14% of the average cost of running a session has been spent on participant travel. Lack of access to activities contributes to social isolation; enabling travel is key to combating it.

"We are talking about ordinary people doing ordinary things like making themselves a seat and a table to sit and eat from... people working together and getting on. People like me who seldom sees anyone, cannot even approach being angry in that situation."

BEES

Walking slowly
through the trees
I somehow hit a hive
of bees
Upset they were
And they attacked
I ran behind Carlyn and threw her back
Stung she was
And set for a fight
I took to my heels and I took flight!

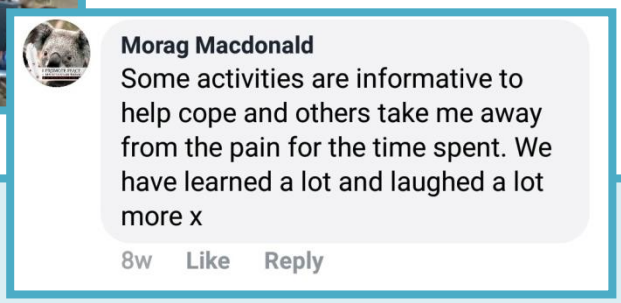
-Gus

MS Centre, Mid Argyll

The Multiple Sclerosis(MS) Centre, Mid Argyll supports people living with various long term conditions across Mid Argyll, Kintyre, Islay and Jura to effectively self manage their own conditions enabling them to live happier, more fulfilling lives. The service offered is highly personalised, with support often given to the whole family, not just the person with the condition(s).

Over the years the work and reach of the organisations has grown and developed to include an outreach service for people previously hard to reach.

Recipients of the service have described the crucial difference the work of the MS Centre, Mid Argyll have made, not only for their self management but their overall wellbeing and it has become a fundamental part of their life.



Support is offered in a variety of ways with access:

- to a range of therapies
- to a range of exercise classes all adapted for people with poor mobility, balance or for those who have not exercised for a while.
- to self management workshops and Pain Toolkits
- to Peer support
- to education on own condition, educating family and friends through our Try on A Long Term Condition workshops.
- to one to one supportive listening and preparation for appointments
- to scribes for benefit forms, and companion as assessments.
- to community activities and groups
- to Group and individual outings.
- to up skilling for centre Members to enable and empower them to become volunteers, run classes -
- to Home visits
- to networking and signposting to other organisations
- to online support through private facebook groups
- to connecting people in their own homes to group members participating in our self management workshops.

Wellness Recovery Action Plans (WRAP)

Wellness Recovery Action Planning (WRAP) grew out of the personal experience of people living with long-term mental health conditions. It helps them take control over their own mental health recovery and wellness. It recognises that they are the expert in their own experience and there are no limits to recovery.

Resources that encourage self-compassion and boost optimism

- ***Wellness Tools***: what you do already to keep yourself well. Activities that you enjoy, that help you through the day.
- ***Daily Maintenance Plan***: the daily routines you need to keep yourself feeling well and in control of your life.

Source: Scottish recovery network

WRAP can be used every day to help people deal with challenges to their mental health.

WRAP Workshops are not classes, but small groups where everyone has an equal voice. Over 9-12 hours of workshop sessions the focus is on wellness and recovery not illness. Facilitators are people who have their own recovery story and journey who are trained to share their experiences of wellness not illness. WRAP workshops have been held regularly in Cowal and Bute. They are likely to be replaced with a new peer led model of support called peer2peer. This model is based on the same principles of supporting people to build inner resilience.

The philosophy of WRAP recognises that everyone is unique, and their path to improved wellbeing will also be unique.

Through this peer-led self-management process people can also be signposted to skills like changing habits & behaviour; assertiveness; mindfulness; self-talk & affirmations; goal-setting; problem solving; breathing & relaxation exercises; grounding (for anxiety); focusing; journaling.

WRAP supports people with their mental health recovery and to gain resilience.

Recognising that life brings you knocks, and preparing to deal with them:

- **Triggers and Action Plan:** the things or events that make you feel low or stressed and how you can plan to deal with the effects of these triggers.
- **Early Warning Signs and Plan**: the signs that tell you that you are starting to struggle or becoming unwell, and plan to control these early warning signs.
- **Things Are Starting To Break Down Plan:** in spite of your best efforts you begin to feel worse and worse and you need to plan to stop things getting even worse.
- **Crisis Plan and Post Crisis Plan**: for during and after very difficult periods, to help you get back in control.

Fundamental to this is belief that people can and do change, learn and grow, including gaining insight into what keeps them well, being curious about their responses to life and trying new ways to keep well and deal with setbacks.

SIGNPOSTING

Useful Links & Organisations

These are just some links that may be useful for people looking for more information relating to health, support, advice. They are also useful for our workforce and partners to help them to sign post people.

We have only identified a very small number of resources here. NHS Inform, Argyll & Bute Advice Network, and Argyll & Bute Council also have links that will direct people to a wide range of services available to them.

Advice & Information

NHS Inform - Health information and links to trusted information sources
www.nhsinform.scot/

NHS 24 – Out of hours advice and support for urgent health concerns.

NHS Highland –Find NHS services in Argyll & Bute.
www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute

Argyll & Bute Council – Access to Social care, housing, welfare and other Council services in Argyll & Bute.
www.argyll-bute.gov.uk/

Argyll & Bute Advice Network – Access to some local services
www.argyllandbuteadvice.net/

ALLIANCE Scotland –A national voice for self management and other resources
www.alliance-scotland.org.uk/

Healthy Argyll & Bute – Website for Health & Wellbeing .
www.healthyargyllandbute.co.uk/

Pain Association – Support in managing chronic pain.
www.painassociation.com

Marie Curie – Cancer and terminal illness support.
www.mariecurie.org.uk/

LAAS – Advocacy service for patients and carers in Lomond and Argyll.
www.laas.org.uk/

SAMH – Scottish Association for Mental Health, can connect you to mental health services and support.
www.samh.org.uk/

Scottish Recovery Network – An initiative to promote recovery from mental illness and trauma.
www.scottishrecovery.net/

Community pharmacy – Your local pharmacy can offer support, advice and treatment for minor ailments and minor illness

Appendix I

Data on Long-Term Conditions in Argyll & Bute

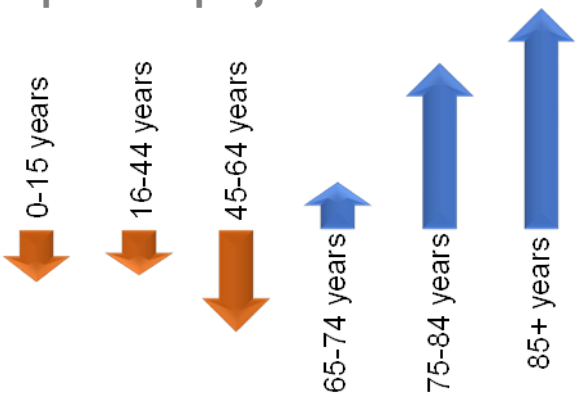
2019 Population size

86, 863 people

Age	Number	%A&B	%Scotland
0-15	13,086	15%	17%
16-44	25,111	29%	37%
45-64	25,834	30%	27%
65-74	12,349	14%	11%
75-84	7,388	9%	6%
85+	2.595	3%	2%

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

Population projections 2019-2029



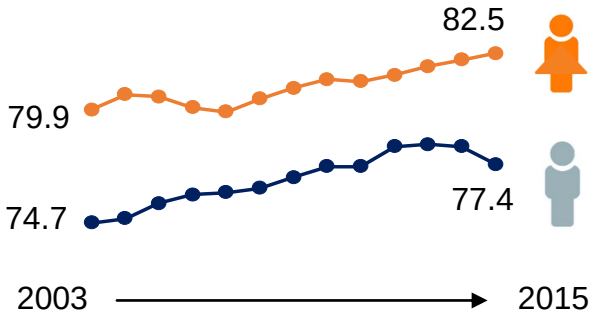
Over 10 years, the population is projected to **decrease overall by 4%** to 83,120 people. The population is projected to **increase by 32% for those 85+** to a total of 3,437 people in 2029, with an increase to 2,715 people by 2021.

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

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

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

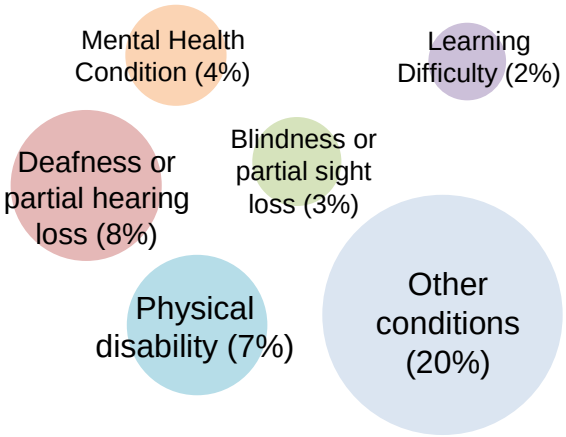
Life expectancy



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

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

Health Conditions



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

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

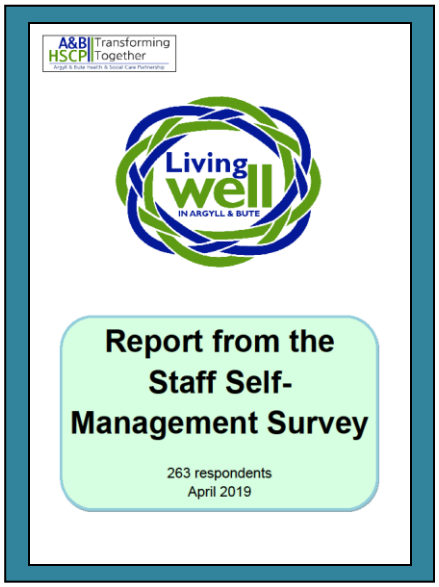
Appendix 2

Associated Documents

All of the below documents can be found at
www.healthyargyllandbute.co.uk

Scoping and Planning Event
A report on the scoping and planning event held with key partners in August 2018

Living Well Engagement Report
This report summarises our 3 community and public enagagement sessions we held while developing this strategy. The reports from the individual sessions in Lochgilphead, Kintyre and Islay are available on our website as above



Staff Survey Report
This report summarises the responses from our staff engagement survey

Consultation Report
This report summarises the responses to our survey on the consultation of the draft strategy.

GLOSSARY OF TERMS

Key words & phrases

AHP	Allied Health Professions, a term which covers all healthcare workers who are not doctors, pharmacists, or nurses. For example: physiotherapists, clinical scientists, or dietitians.
ACP	Anticipatory Care Plan. A plan arranged between a person, their carers/family and their health professionals, to ensure their needs and wishes are taken into account in future care.
Comorbidity	When multiple conditions or illnesses exist in the same patient – common with long-term conditions.
HSCP	The Health and Social Care Partnership, an organisation combining NHS and Council resources in Argyll & Bute to provide health and social care services in the area.
HWN	Health and Wellbeing Network. A network which brings together health and social care staff, volunteers, and service users to help improve and support healthy living. There are 8 local HWNs in Argyll & Bute.
LPG	Locality Planning Group. There are four LPGs in Argyll & Bute, and their function is to bring together key players in health and social care to make decisions on a local level about services.
Long Term Condition	Also “LTC”. Any health condition or illness that lasts longer than 4-6 months, particularly if it has an impact on lifestyle or capacity.
MI	Motivational Interviewing. A technique to effectively help people to change their behaviour.
MSK	Musculoskeletal. MSK practitioners include physiotherapists, rheumatologists, and occupational therapists.
Person-Centred	An approach to services that is built around the individual and recognises the need for people to have a voice in their own care.
Power of Attorney	A written authorisation for someone else to act on your behalf in legal matters if you become incapable.
Polypharmacy	A situation where someone is taking multiple different medications at the same time.
Third Sector	Voluntary services and not-for-profit organisations.
WRAP	Wellness Recovery Action Plan. A plan for managing conditions, designed by the person themselves and with a focus on their strengths and capacity.

Living Well Short Life Working Group

Maggie Clark
Alison McGrory
Jay Wilkinson
Rebecca Helliwell
Karen McCurry
Caron Jenkins
Sharon MacPherson
Fiona Sharples
Seonaid Morrison
Jessica Fletcher
Jacqualin Barron
Caroline McArthur
Gillian Davies
Linda Currie
Gill Bruce
Charlotte Wilson

Consultation

Brain Fog Friends (MS Centre Lochgilphead)
Chit-Chat Islay
Kintyre Link Club
Isobel MacIntosh
Daniel Heydecker

Partners & Sources

NHS Highland
Argyll & Bute Council
Argyll HWNs
Versus Arthritis
MS Centre Argyll
ALLIANCE Scotland
Kaiser Permiente
Health Foundation
LOHO
Argyll & Bute Self-Management Partnership
Strachur Hub
Branching Out
Scottish Recovery Network
Argyll and Bute HSCP Public Health Department

Find our complete action plan and a summary of the strategy at:
www.healthyargyllandbute.co.uk

To keep up with health and wellbeing work in Argyll and Bute:

On Facebook
Search ***HEALTHY ARGYLL AND BUTE***

Visit our website at
www.healthyargyllandbute.co.uk

You can contact us at:

High-UHB.ABHealthImprovement@nhs.net

Health Improvement
Campbeltown Hospital, Campbeltown
PA26 6LE

Integration Joint Board **Agenda item: 7**

Date of Meeting: **25 September 2019**

Title of Report: **Chief Officer Report**

Presented by: **Joanna Macdonald, Chief Officer**

The Integration Joint Board is asked to:

- Note the following report from the Deputy Chief Officer

New Free Mindful Service 'Take Time to Relax Technique' Launched

The HSCP has officially launched an innovative digital self-help service called 'Take Time to Relax'. This service has been developed by the Technology Enabled Care (TEC) Team to help people learn mindful breathing exercises to help experience the benefits that relaxation techniques can have on improving mental wellbeing. It is a simple technique, easy to learn and can be practiced almost anywhere.

The TEC Team have produced accompanying audio guidance and soothing music to go along with the service and have also partnered with the Florence text messaging self-management system to provide service users with a daily text message at an agreed time to remind them to practice the technique.

Beating the Blues CBT Course Rolled Out Further

Beating the Blues (BTBs) is an online cognitive behavioural therapy course for the treatment of low to moderate anxiety and depression which can be accessed by people living in Argyll and Bute. It helps people make sense of their feelings and uses interactive tools to help people change their thinking pattern, and learn how to overcome negative thoughts about themselves.

The course can be accessed following a referral from a GP and has been designed to be completed in the comfort of people's own homes and patients are in control of when and where they want to complete the online CBT therapy.

There is no need to visit busy clinics or sit waiting for an out-patient appointment and patients can quickly access the programme through a whole range of electronic devices including through their desktop/laptop, Smartphone and Tablet.

HSCP Working with Heartstart to Deliver Basic Life Support Training

The HSCP is working in close partnership with Heartstart to deliver Basic Life Support Training (BLS) direct to members of the public. The programme is a British Heart Foundation initiative delivered free by Heartstart fully trained staff.

A series of drop-in training sessions on cardio-pulmonary resuscitation (CPR) and automated external defibrillator (AED) awareness have been arranged and the first of these was held on the 11 September in Campbeltown.

The aim of these training courses is to ensure that more people will survive an out-of-hospital emergency and cardiac arrest through increasing the confidence and skills of bystanders to deliver CPR and use an AED if someone collapses with a cardiac arrest.

Latest Conversation Cafe Held on Islay

The HSCP has been holding a series of Community Conversation Cafes across Argyll and Bute as one of the ways of engaging with local communities and opening up discussions about health and social care.

The topics to be discussed at each of these events are decided locally through the Locality Planning Groups and at the most recent Conversation Cafe on Islay on the 25 September the discussions focussed on Reablement and the various ways of accessing the service.

Oral Health Improvement Team Launches New Facebook Page

The HSCP's Oral Health Improvement Team has recently launched their dedicated Facebook page to highlight their work across Argyll and Bute and help them target key sectors from the local community.

Some of the initiatives that they are promoting on Facebook at the moment include *Caring for Smiles* (care homes residents), *Smiles for Life* (homeless), *Open Wide* (adults with additional care needs) and Nursery, Primary and Secondary School education programmes.

Lorn Medical Centre Awarded GMS Contract for Mull and Iona

Following an extensive evaluation process Lorn Medical Centre has been successfully awarded the General Medical Services Contract for the Mull and Iona Medical Group.

This contract includes Primary Medical Services, Out of Hours GP Services and GP services within Mull & Iona Community Hospital