To: **Renfrewshire Integration Joint Board**

On: **20 November 2020**

Report by: **Chief Officer**

Heading: **Recovery and Renewal Planning Update**

Direction Required to Health Board, Council or Both	**Direction to:**	
	1. No Direction Required	**X**
	2. NHS Greater Glasgow & Clyde	
	3. Renfrewshire Council	
	4. NHS Greater Glasgow & Clyde and Renfrewshire Council	

1. Summary

1.1. This report provides an update to the IJB on the HSCP's Recovery and Renewal Programme being implemented alongside the ongoing response to the COVID-19, and related impacts of the pandemic on the IJB's financial planning processes.

1.2. An update is provided on Strand 1 activity within the Recovery and Renewal programme, which is focused on the development of a community-led approach to improving health and wellbeing, continues to progress. An application process for funding to support projects which deliver on the health and wellbeing priorities agreed by the Strategic Planning Group has been launched. An evaluation panel is in place and assessment of proposals submitted will take place in December 2020.

1.3. Increased levels of infection locally have necessitated the prioritisation of the HSCP's continued response to the pandemic, alongside recovery activity where possible. An update to the IJB on the HSCP's operational response to COVID-19 and ongoing recovery activity, is provided in a separate paper to the IJB. In this context, while the HSCP continues to progress existing change activity (including Care at Home which is included as an update in this paper) and contractual commitments, available resources within services and Change and Improvement are currently very stretched and this is impacting our ability to deliver the Strand 2 programme as envisaged earlier in the summer. Consequently, the development of additional renewal activity will only be able to be taken forward on a prioritised basis and the HSCP will continue to flex its approach to medium-term transformation in line with operational priorities and available resources.

1.4. This report also provides an update of the impact of COVID-19 on the IJB's agreed Medium-Term Financial Plan approach, which set out a two-tiered process for delivering savings in FY 2020/21 prior to a strategic approach to

transformation contributing to financial sustainability from FY 2021/22 onwards. COVID-19 has significantly impacted upon the HSCP's ability to implement savings agreed by the IJB in January 2021 and has delayed opportunities to commence wider transformational activity, an impact which will continue over the winter period and into the next financial year. The HSCP therefore proposes the extension of the two-tiered approach into FY 2021/22 to include the identification of targeted savings opportunities and to recognise the continued need to prioritise COVID-19 response and recovery prior to entering a renewal phase.

2. Recommendations

It is recommended that the IJB:

- Note the progress made in implementing the Strand 1 community-led approach to improving health and wellbeing in Renfrewshire with partners in the Strategic Planning Group;
- Note the complex context influencing the HSCP's scoping and progression of Strand 2 renewal activity and the need to maintain flexibility in approach to transformation to enable the ongoing delivery of the HSCP's operational priorities;
- Note the contents of the Journey Associates final report delivered as part of the engagement phase of the Older People's review;
- Note the progress made in taking forward change activity with Care at Home; and
- Agree to the extension of the Medium-Term Financial Plan's two-tiered approach into FY 2021/22 and the process set out for developing savings options for the next financial year.

3. Background

3.1. The current level of restrictions in place across Renfrewshire, and Scotland more generally, are described in further detail in the operational update paper also provided to this IJB. These restrictions, and the second wave of increased infection levels which they are designed to combat, further underlines that progress through the COVID-19 pandemic is not linear and that health and care services will not move smoothly through response, recovery and renewal activity.

3.2. The pandemic has required the HSCP to continuously re-evaluate and reprofile the delivery of in-year savings and both the nature and phasing of change activity. As the second wave of infections has grown, the HSCP will continue to focus on its response to COVID-19 alongside recovery activity where this remains possible.

3.3. Plans for medium term transformation through the 'renewal' programme will continue to be scoped however the degree to which these can be progressed will be determined by a range of factors including (i) the ongoing response to

COVID-19; (ii) ongoing service delivery priorities including flu vaccinations and winter service provision; (iii) the recommendations of the national review of adult social care; and (iv) the availability of resources within operational services and Change and Improvement to deliver complex change requirements.

4. Recovery and Renewal programme update

Strand 1: Community-led approach to improving health and wellbeing

4.1. Following the last update to the IJB on Strand 1 activity in August 2020, the Strategic Planning Group has continued to progress work focused on determining health and wellbeing priorities which will form the basis of work over the next 12 months, and the supporting processes which will enable this activity. An agreed Terms of Reference is now in place to guide this work.

4.2. Subgroups, led by SPG members and including participating organisations beyond the Strategic Group, were formed to identify up to three areas of focus within each of the agreed health and wellbeing priority areas. The areas agreed are:

Priority	**Areas of focus**
Loneliness and social isolation	• Developing Neighbourhood approaches to tackling loneliness: supporting local solutions with local people • Supporting people transitioning at different life stages and experiencing increased risk of loneliness and isolation • Reaching and engaging with people fearing future loneliness, loss of purpose and fragile connectedness because of societal change
Lower-level mental health and wellbeing	• Awareness of and access to information and services • Communication barriers • Availability of counselling support
Housing as a health issue	• Preventing homelessness: Supporting people to remain in their home who have become homeless or who are susceptible to homelessness or who may need support from time to time to sustain their tenancy and maintain their health • Supporting older people and vulnerable groups to live independently and without the need for expensive specialist care • COVID-19 and specific support services who are affected by the pandemic
Inequalities	• Support to access health information and services • Specific action targeted at BAME communities given COVID-19 impact • Tackling digital inequality and barriers to support inclusion COVID-19 times
Early years and vulnerable families	• Easy to ignore families – face to face contact and food and essentials • Informal play and learning face to face for young children • Digital access and knowledge for families

Healthy and active living	• Inactivity: Reduced inactivity amongst those residents who are at risk as a result of COVID-19 by providing more accessible community projects • Community resilience: Increased knowledge, awareness and training about healthy eating, healthy and active lifestyles through the provision of local volunteering opportunities, training, support and resources which build community resilience • Free local sustainable activities: Improved access to free, fun, and sustainable activities / challenges which engage and motivate people to live healthy and active lives

4.3. The HSCP has identified a pot of funding which will be allocated to support delivery of community-led projects which aim to deliver upon the above priorities. In total, £250k non-recurring funding is available through this process. A further £70k has been allocated for the acceleration of the 'Hear for You' helpline delivered by RAMH, and additional Action 15 funding was also identified to support priority areas within Adult Mental Health Support. Action 15 funding is subject to strict criteria and proposals are currently under consideration by the Mental Health and Wellbeing Steering Group.

4.4. A competitive application process for project proposals was launched on 23 October 2020. Proposals must be submitted by 25 November 2020 and will subsequently be assessed by an evaluation panel consisting of senior representation from the IJB, Renfrewshire Council and NHS GGC. Comprehensive guidance was issued to support the development of funding proposals, setting out the following criteria which applications must meet to be successful: (i) collaborative and inclusive; (ii) community-led; (iii) co-produced; (iv) evidence-based; (v) sustainable; (vi) scalable; and (vii) innovative and future-proofed.

4.5. As this is the first year in which such a process has been adopted, and awards are relatively small and non-recurring, applications are limited to SPG member organisations or groups involved in the priority subgroups only. This will enable a clear focus on the priorities identified by the SPG, to evaluate their impact, and to build on successes whilst ensuring the process remains manageable. Developing and broadening partnerships locally remains a key objective of SPG members. A further update on progress will be brought the IJB in January 2020.

Strand 2: Internally focused renewal activity

4.6. The HSCP continues to progress existing change activity alongside the ongoing response to and recovery from COVID-19. This includes progression of (i) the recommendations of the Addictions Review including implementation of a Recovery Hub; (ii) the Learning Disabilities review recommendations; (iii) continued development of the Older People's Services Review Programme; and (iv) implementation of the ECLIPSE case management system within Adults and Criminal Justice services following go-live of the system within Children's Services within Renfrewshire Council. Work also continues across the NHS GGC board area to transform Mental Health services in line with the NHS GGC Adult Mental Health Strategy 2018-2023.

4.7. This change activity is being delivered concurrently alongside the HSCP's response to COVID-19, which includes the ongoing provision of the Renfrewshire COVID Assessment Centre, provision of PPE and enhanced support for Care Homes. In addition, significant work continues to be undertaken to deliver this year's increased flu vaccination programme and to prepare health and care services for winter. There is consequently substantial existing demand on constrained resources within both operational services and in Change and Improvement support, which limits the HSCP's ability to progress renewal activity in the short-term.

4.8. Uncertainty also remains over the overall financial impact of COVID-19 on the HSCP, and the extent of additional funding which will be received from the Scottish Government to address these additional costs. The national review of adult social care may also identify recommendations which have a significant structural or operational impact on the IJB and HSCP. A National Care Service will be considered as a potential option for the future of adult social care.

4.9. The HSCP will therefore continue to maintain flexibility in the ongoing approach to recovery and renewal activity and in associated timescales, reflecting the fluid and changeable COVID-19 situation and ongoing and emerging operational priorities.

5. Strand 2 Older People's Services Review

Journey Associates Report

5.1. An update was provided to the IJB in October 2020, describing the work undertaken to progress the Older People's Services Review, building on progress made prior to the COVID-19 pandemic. This included the process of engagement undertaken by Journey Associates, work on which has been now been completed and a final report provided to the HSCP (work on which had been delayed due to the COVID-19 response). The final report is provided as an appendix to this paper.

Update on Care at Home

5.2. This paper also provides a further update on work which has continued to modernise Care at Home services following a pause during the crisis response to COVID-19.

5.3. Care at Home services have undertaken a series of development sessions to identify and implement improvements to support the service in managing challenges around increasing demand, recruitment, and retention, whilst also addressing requirements and recommendations from the Care Inspectorate report of October 2019, with an update of this provided to the Audit, Risk and Scrutiny Committee on 13th November 2020.

5.4. This work will create a vision for care at home services, a set of operating principles and a delivery model to underpin a strengthened operational structure. It will also be underpinned by an engagement and communications strategy for the service, incorporating involvement of both staff and trade unions, whilst providing awareness of the work underway.

5.5. In August 2020, a four-phase design roadmap was agreed by the development group, with these phases expected to take around 18 months to be fully realised. The phases included are:

- Phase 1: exploring current challenges, needs, aims and objectives for a future service model
- Phase 2: focus on the current capabilities and issues whilst identifying opportunities for improvement and associated benefits
- Phase 3: design and sign-off of the future service model, including the supporting implementation activity
- Phase 4: the service model is fully implemented and is monitored and tracked against the agreed objectives and benefits to be delivered

5.6. It is anticipated that phase 1 will take between 4 to 6 months, however, it should be noted that within these timelines, fast-track opportunities may be identified which will be able to deliver improvements and benefit at a quicker pace.

5.7. Within Phase 1, a Vision and Structure workstream has been created, through which stakeholders will develop a vision for the service, and develop a revised service model and supporting structure which allows the service and our Care at Home teams to proactively work towards delivering the agreed vision. This workstream has made early progress and has sought to deliver on several fast track improvement opportunities.

5.8. For example, the workstream has introduced a new fast-tracked recruitment process for Home Care workers. Further to this, and in order to support the management and ongoing improvement work across Care at Home services, three senior management roles have also been developed and are currently being recruited to, with the objective of strengthening the management structure across the service.

5.9. The implementation of a scheduling and monitoring system, Totalmobile, continues with this nearing implementation stage and expected to commence over the coming months. Totalmobile is an electronic system which will provide functionality to support enhanced delivery of care at home services. Accessed by frontline staff through an application on their work mobile device, Totalmobile aims to empower the workforce with the ability to access information needed to deliver services efficiently. Providing a centralised way to determine the most efficient and effective use of resources, the system will provide staff with their scheduled care visits electronically and also gather a range of data to inform the management and operations of the service. The system aims to reduce risks associated to paper-based processes currently adopted by the service, whist ensuring care services are provided in the most effective way.

5.10. Implementation of Totalmobile is a significant project, both in terms of scale and in terms of the transformational nature of change required, with it being a key enabler to future phases of Care at Home design work. Work is ongoing

to ensure dedicated operational and management resources are in place to support and ensure project success.

5.11. There are a number of change initiatives planned in both current and future phases of the design roadmap. These plans are subject to COVID pandemic progression and any subsequent impact this may have on Care at Home services, and the associated level of resource available to deliver change initiatives.

6. Financial planning for FY 2021/22 and alignment with Recovery and Renewal activity

6.1. The IJB agreed its Medium-Term Financial Plan (MTFP) in November 2019. This plan set out the IJB's two-tiered model for delivering financial sustainability by addressing short-term financial pressures, through 'Tier 1' savings in FY 2020/21, whilst embedding a strategic approach to transformation, 'Tier 2' from FY 2021/22 onwards.

6.2. A detailed update on the IJB's financial for 2021/22 is provided in a separate paper to this board. The COVID-19 pandemic has impacted upon this process significantly. Implementation of a number of FY 20/21 savings proposals agreed by the IJB in January 2020 was paused at the outset of the pandemic, and £1.178m of unachieved savings is incorporated within the HSCP's overall assessment of the projected financial impact of COVID. More widely, the scoping of the transformational activity also paused in March 2020. Consequently, service transformation is not expected to deliver savings within FY 2021/22.

6.3. The HSCP is therefore requesting an extension to the two-tiered approach into the next financial year, and Heads of Service are now developing options to deliver:

- Targeted or opportunistic financial savings within FY 2021/22.
- Options for service and organisational transformation which will be delivered in the medium-term and which will form the scope of Strand 2 'renewal' activity (alongside existing change activity) when resources and circumstances allow for this to be progressed.

6.4. The above options will need to be assumption-based due to the significant degree of uncertainty which exists within health and social care at this time. These include, but are not limited to:

- The unknown timescales of the pandemic, and the number of additional future waves of infection to emerge.
- The full impact of COVID-19 on our local communities including on employment, inequalities and mental health and wellbeing.
- The associated financial impact of COVID-19, and the degree of additional funding which will be provided by the Scottish Government to cover costs incurred. However, as noted in paragraph 4.2 of the Financial Outlook the Scottish Government provided in principle confirmation in March 2020 that all reasonable additional associated

with the crisis will be fully funded. The IJB also sought more specific follow up confirmation on this commitment in July 2020.

- The overall fiscal framework within which services and the public sector will need to work in the next financial year. The UK Government has confirmed that on 25th November 2020 a one-year spending announcement will be made and not as previously planned a 3-year spending review. Decisions relating to Tax and Borrowing will be considered in March 2021 along with consideration of the economic forecast. As a consequence, the Scottish Government budget will be pushed back into 2021/22, most likely early February 2021. A subsequent date for the Scottish Government's budget for FY 2021/22 is yet to be announced.

- The recommendations to emerge from the national review of Adult Social Care, and the structural and financial implications of this.

6.5. Based on the above context, it is prudent that financial planning progresses on the basis of a range of funding scenarios from our partner organisations, as outlined in paragraph 9.10 of the Financial Outlook for 2021/22, ranging from a reduction of 1% to an increase of 2%. Consequently, savings options which do not align with the guiding principles for transformation previously agreed by the IJB will require consideration. Therefore, prior to the next IJB meeting on 29 January 2021, the HSCP proposes that this activity is underpinned by further engagement with the IJB through Development Sessions in December and January and is supported by additional engagement between IJB members and Heads of Service to discuss emerging savings proposals in further detail.

6.6. Should it not be possible to identify and agree necessary savings with the IJB which deliver a balanced budget in FY 2021/22 the Chief Officer, working with the Chief Finance Officer and the Senior Management Team, will require to effect the necessary management action to implement a financial recovery plan with immediate effect to manage the budget shortfall. These programme actions would include:

- The Chief Officer requiring all discretionary spend decisions by him/her in partnership with the relevant Head of Service;

- Suspension, where necessary, of ongoing development initiatives;

- Holding, on a temporary basis, any 'non frontline' service vacancies. In doing so, only appointing to those posts which the Chief Officer considers to be a service priority. These decisions would be taken on an individual and fully risk assessed basis; and

- Review of all non-recurring monies and other budgets to determine where these can be used in-year to fund the budget shortfall.

6.7. Notwithstanding the above, the HSCP continues to work with partners within NHS GGC and Renfrewshire Council to understand the developing budget position for FY 2020/21, and to determine a balanced budget for FY 2021/22.

This will align with the ongoing consideration of targeted savings options as outlined above.

6.8. The options for transformational change identified by the Senior Management Team will be considered alongside existing change activity to determine the scope and phasing of renewal activity undertaken by the HSCP, and a process of prioritisation will be undertaken to ensure that the agreed scope will (i) deliver on the HSCP's guiding principles; (ii) the expected benefits of implementation (cost-benefit); and (iii) capacity and capability of the HSCP to deliver the required changes when taking into account wider demands on resources.

Implications of the Report

1. **Financial –** Financial implications are discussed above in this report. Further details are also provided in the Financial Outlook 2021/22 paper.
2. **HR & Organisational Development** – There are no immediate HR & OD implications from this report. However, as recovery and renewal planning progresses HR & OD implications will be identified and managers will liaise closely with staff-side and HR colleagues as appropriate.
3. **Community Planning** – Recovery and renewal planning, and in particular activity under Strand 1 of the programme, will involve consideration of the role of communities and community planning partners in future service delivery. Community planning governance and processes will be followed throughout.
4. **Legal –** Supports the implementation of the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014. Legal guidance will be sought at appropriate junctures throughout the delivery of recovery and renewal activity.
5. **Property/Assets –** No immediate implications however ongoing COVID guidelines around physical distancing, proposals for future service delivery models and the increased adoption of technology will impact upon the nature of property and assets used to deliver services.
6. **Information Technology –** Future proposals will require consideration of how technology can be most effectively adopted and utilised to support new ways of working.
7. **Equality and Human Rights** – There are no Equality and Human Rights impacts from this report. However, future proposals will be assessed in relation to their impact on equalities and human rights.
8. **Health & Safety –** None from this report.
9. **Procurement** – Procurement activity will remain within the operational arrangements of the parent bodies.
10. **Risk –** Risks and issues arising during the COVID response are tracked and managed on an ongoing basis.
11. **Privacy Impact** – None from this report.

List of Background Papers – Journey Associates, Renfrewshire HSCP Older People's Services Review Engagement Final Report

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Renfrewshire Older People's Services Review

Project Report — August 2020

Renfrewshire Health & Social Care Partnership

Journey Associates

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Addendum

This report relates to the Older People's Services Review Phase 2 (the Project). It presents the aims, process, and outputs for community-based services in Renfrewshire that form part of the RHSCP Older People's Services Review.

The Project involved stakeholder engagement and co-creation activities with over 200 participants between September 2019 and February 2020. All engagement work was, therefore, completed in advance of the Covid-19 crisis. The outputs presented reflect participants' contributions before the pandemic took hold. However, Covid-19 has provided an additional lens through which to view the outputs and suggestions. Some key themes have been amplified, such as addressing loneliness and social isolation. Others need to be reconsidered within a significantly changed context, such as the use of digital technology and enabling remote connections, and the experience of the pandemic has highlighted important learning to build on and take forward in shaping future community-based services, such as opportunities for volunteering.

Themes amplified in response to Covid-19:

- The prevention of **loneliness and social isolation** was a recurring theme across the Project and is mentioned in the Action Areas. Significant life changes, such as losing contact with friends and family and bereavement, are recognised triggers that can affect mental health and lead to loneliness and isolation, which may now be more prevalent in the wake of the pandemic. As a result, community-based services will have a vital role in supporting social connections post-Covid-19.

- RHSCP has experienced a new wave of **volunteering** through the setting up of Neighbourhood Hubs, a collaboration between RHSCP, Renfrewshire Council, and third sector partners to assist citizens with shopping and to support wellbeing through, for example, befriending phone calls. The success of volunteering programmes provides a strong basis for extending opportunities, including micro-volunteering, post-Covid-19.

Addendum

Themes to review in response to Covid-19:

- A clear message from participants related to **connecting with a human**, whether face-to-face or speaking to someone on the telephone. Covid-19 has encouraged many people to use technology more regularly and in new ways, such as for shopping online and keeping connected with friends and family. A change in attitude towards technology, and direct experience of keeping connected remotely, requires deeper exploration to identify new opportunities for digital solutions to complement those delivered in person.

- The need for a **centralised hub** providing access to the range of community-based services available was consistently mentioned by Project participants. The Neighbourhood Hubs were set up to provide a limited range of priority services in direct response to Covid-19. The success of the hubs will provide valuable learning to inform the potential for centralised services in the future. They have also highlighted the opportunity to explore provision of services that are not building-based as well as the new use of existing buildings.

Opportunities to build on new knowledge and learning

- The **Neighbourhood Hubs** have provided important insights and learning on centralising access to services. Engaging the local community through volunteering has resulted in new ways of working for staff. Many of the hub users have had no prior contact with RHSCP and so a wider community base has been reached, including those who would previously have been considered 'hard to reach'. The success of the service prompts questions: What might the opportunity be for Neighbourhood Hubs (or a form of them) in the delivery of community-based services? Where could they be based? What services might they provide? What role might technology play in the provision of future services? How to keep volunteers engaged?

The core messages in each of the Action Areas that will help inform future community-based services for older people remain valid and relevant despite Covid-19. Indeed, as mentioned above, some themes now seem even more important, and acting on others has been brought forward. This will provide valuable lessons to inform the next phase of the Review.

Executive Summary

The Older People's Services Review Phase 2 (the Project) was an ambitious programme of engagement to involve older people in the shaping of community-based services in Renfrewshire. The Project explored opportunities for enhancing future services in line with the wider strategic ambition of RHSCP's emerging Transformation Programme as reported in March 2020. This has community connectedness at its foundation and is underpinned by four guiding principles: shared responsibility and ownership with our communities; taking a person-led approach to public health and wellbeing; providing realistic care; and delivering the right services at the right time and in the right place.

Building on the outputs of Phase 1, the aim of the Project was to identify themes, insights and opportunities to improve, remodel and transform community-based services that meet the needs of older people. This was achieved through a tailored programme of person-centred engagement using a Design Thinking approach.

The Project culminated in the Define stage, providing clarity on the topics (Action Areas) that participants considered important for shaping community-based services to meet the needs of older citizens. This process is consistent with the Scottish Government's approach to service design, helping to ensure that the right topics are identified before moving towards generating ideas for future services.

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During a five-month period of activity, the project delivered 10 interviews, 12 workshops, a public event and a feedback session. It engaged with over 200 people with wide-ranging knowledge and experience of the delivery of community-based services for older people. These included those with lived experience, such as older people and carers, staff in health and social care roles, third sector representatives and wider community members.

Executive Summary

The Project delivered the following outputs:

Nine Action Areas: clearly defined topics that are user-focused and co-created with key stakeholders reflecting their needs and preferred outcomes. They are:

1.1 Caring for Carers
1.2 Accessing HSCP Services
1.3 HSCP Processes
2.1 Supporting a Culture of Volunteering
2.2 Re-imagining GP Surgeries and Services
3.1 Enhancing Community Connections
3.2 Making Information Accessible
4.1 Caring for Our Community
4.2 Engaging Community Businesses and Connectors.

Four Cross-cutting Themes: Partnership Working; Place; Information and Communication; and Enablers (e.g. transport and technology).

These are important considerations and should be addressed in the design solutions responding to each Action Area. These Cross-cutting Themes align with the Enablers identified in the Transformation Programme.

Six Personas derived from user research, representing a wide range of service users with different and multiple needs to ensure future services are relevant and desirable.

Service Project Principles to aid decision-making in the design of older people's services and ensure consistency of approach in line with the needs and desired outcomes of service users.

Project Packs providing collated information on each Action Area and the personas generated in the Co-design Workshops to support idea generation in the next phase of the Project, drawing on the rich and diverse ideas proposed by participants.

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Values and a Manifesto for Partnership Working co-created by members of the Reference Group and Steering Group to underpin true partnership working in the design and delivery of new and enhanced community-based services.

The 12 Output Statements presented below summarise the key messages from the outputs above and the wider insights gained through the Project. They are presented as considerations to support idea generation in the next phase of the project. These include:

The Co-design Process:

- **Build on the Knowledge Shared:** *The extensive knowledge and experience shared between stakeholders in the creation of the Action Areas should inform future engagement and the development of person-led, community-based solutions.*
- **Continue to Engage the Wider Community:** *Maintain regular contact with participants, updating them on progress and involving them in the subsequent phases of developing services.*
- **Finalise the Service Project Principles:** *Review and finalise the Principles to guide decision-making during idea generation in the Development phase.*

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Amplified Themes:

- **Mitigate Against Social Isolation and Loneliness:** *Ensure community-based services are designed to enable access and connection, to reduce the chances of loneliness and social isolation.*
- **Prioritising Dementia-friendly Communities:** *Given the projected increase in the numbers of people living with dementia, it is imperative that community-based services are dementia-friendly, helping make them accessible to everyone.*
- **Community Hub - Connect Existing Services:** *Build on existing community assets and explore how available services can be centralised and accessed more easily, in parallel with developing new services.*

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- **Keep the Human Connection:** *Explore how future services can be designed to be personal, human-centred and accessed in different ways. Ensure no one is excluded.*

Preparing for the Next Phase:

- **Review the Reference Group:** *A Reference Group with the appropriate composition of members should remain operational beyond Phase 2 and have an active role in shaping the design and delivery of new/enhanced services.*
- **Reference the Personas:** *Embed personas within the idea generation activities in the Development phase to guide decision-making. They may be expanded to include other characteristics.*
- **Review Title and Identity:** *Agree a name and identity for the Project to raise its profile and generate interest.*

During the Project activities, it was apparent that further research was required to fully engage day-care centres and those citizens who have had no contact with services in the community. Both groups could have an important role in the future of community-based services and should be included in future activities. In addition, further exploration is required on the provision of appropriate and flexible transport options that enable citizens to remain connected and that support individual choice and independence.

The Report concludes with a series of activities to prepare for the Development Phase, where potential solutions to the Action Areas are explored. These suggestions are provided to support RHSCP in applying and building on the outputs of Phase 2, as appropriate. Among other things it could involve auditing and prioritising the Action Areas for those that align

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with RHSCP strategic objectives and finalising the Project Service Principles. It could also include assembling Working Groups through careful selection of a cross-section of stakeholders. They will be responsible for driving the development phase for specific themes using the Project Packs created for each Action Area.

The engagement activities were concentrated in the Johnstone area to provide a local context and focus for activity and to build momentum with the local community.

Johnstone was selected as the population is broadly representative of the region and it is anticipated that the Action Areas and insights will broadly parallel the communities elsewhere. This means solutions generated in the Development Phase can be tested with and adapted to suit the needs of older citizens in other parts of Renfrewshire.

1. Project Overview

1.1 Project Overview / Introduction

The Older People Services Review Phase 2 (the Project) explored the opportunities for enhancing community-based services for older people in Renfrewshire, ensuring they are fit for purpose, relevant to changing needs and demands and support people to live well independently, in line with the Strategic Plan 2019-22 for Renfrewshire Health and Social Care Partnership (RHSCP).

In line with the emerging Transformation Programme to remodel and redesign RHSCP services, the Project connected with community-based services as a mechanism to support health and wellbeing by engaging and connecting citizens. In particular, the Project aligns with the outward-facing strategic objectives, with a focus on prevention and early intervention. It also focuses on working with the community, and nurturing shared responsibility and ownership for health and wellbeing. It connects with aspects of the Scottish Government's *A Fairer Scotland for Older People: framework for action (2019)* to celebrate older people and their role in the community, and to challenge inequalities, ensuring

citizens have access to the services they need to be "happy, healthy and secure in old age"[1]. The Project initiated meaningful engagement with the wider community, including citizens, and delivery and support agencies. Consistent with the internally-focused objectives of the Transformation Programme relating to organisational change, it is anticipated new ways of working will result that will require a cultural change to enable partnership working, and that the outputs will inform future strategic commissioning.

1.2 Project Overview / Aim & Objectives

The Project sought to identify themes, insights and opportunities to improve, remodel and transform community-based services for older people in Renfrewshire, through a person-led, inclusive and tailored programme of engagement.

Phase 2 builds on the findings of Phase 1, which involved multi-stakeholder engagement with 40 participants over five workshops and identified six themes important for older people's community-based services: Place, Health and Wellbeing; Early Intervention and Prevention; Partnership Working, Information and Communication; Range of Services and Supports; People and Community; and Enablers. The Project tested and extended these initial findings to find areas of opportunity so RHSCP and partners could focus collaborative efforts to meet the needs of citizens from a community-based perspective. A partnership approach involved the direct participation of service users, carers, and the wider community, as well as third-sector and other organisations representing the diverse ecosystem of support and delivery of older people's community-based services.

The Older People's Services Review aims to maximise collective resources. By embedding a collaborative approach from the outset, the Project actively sought opportunities to increase community capacity. This approach is consistent with the priorities from the Christie Commission on the future delivery of public services (2011): "Effective services must be designed with and for people and communities – not delivered 'top down' for administrative convenience."

The outputs include a series of clearly defined Action Areas – topics that represent opportunities for RHSCP and partners to enhance older people's services delivered with and for the community. The Action Areas have been co-created through a process of continual engagement of key stakeholders, reflecting service-user needs and preferred outcomes, and drawing on the depth of knowledge and expertise of staff and participants across the sector. The Action Areas present a robust platform for RHSCP and partners to explore and co-create appropriate, person-led solutions to community-based services.

1.3 Project Overview / Drivers for Change

Driving factors that underpinned the review of community-based older people's services align with RHSCP strategic objectives and , in particular, two of the guiding principles of the Transformation Review. These are presented below.

Shared Responsibility and Ownership with our Communities:

- Help older people remain independent and minimise over-reliance on services
- Understand how best to support changes in people's behaviour to encourage active lifestyles and help people maintain physical and social mobility, reducing the risk of loneliness and social isolation
- Put in place activities to minimise the risk of loneliness and social isolation that can be detrimental to physical and mental wellbeing

Person-led Approach to Public Health and Wellbeing:

- Build on existing strengths and adopt a people-centred approach to services
- Ensure that older people have choice in the services available to them and control to spend their budget as they choose

Early Intervention and Prevention:

- Address the anticipated increase in the need for dementia-specific services
- Mitigate against loneliness and social isolation by supporting community connections
- Intervene early to improve outcomes, reduce frailty and vulnerability and help avoid unnecessary harm
- Sustain and grow the successful falls prevention initiatives in Renfrewshire, consistent with the Scottish Government's *National falls and fracture prevention strategy 2019-2024*.

1.3 Project Overview / Drivers for Change (cont.)

New Models of Delivery:

- Given the financial pressures and increasing demand for services, it is necessary to be smart with resources. This will mean doing things differently, finding new ways of providing services to help older people live well in the community.

These drivers connect with the Scottish Government's support for positive engagement with older people in the design of services, to challenge assumptions, collaborate in new ways, and "recognise and value the wisdom, knowledge and experience of older generations." (*A Fairer Scotland for Older People: A Framework for Action, 2019*).

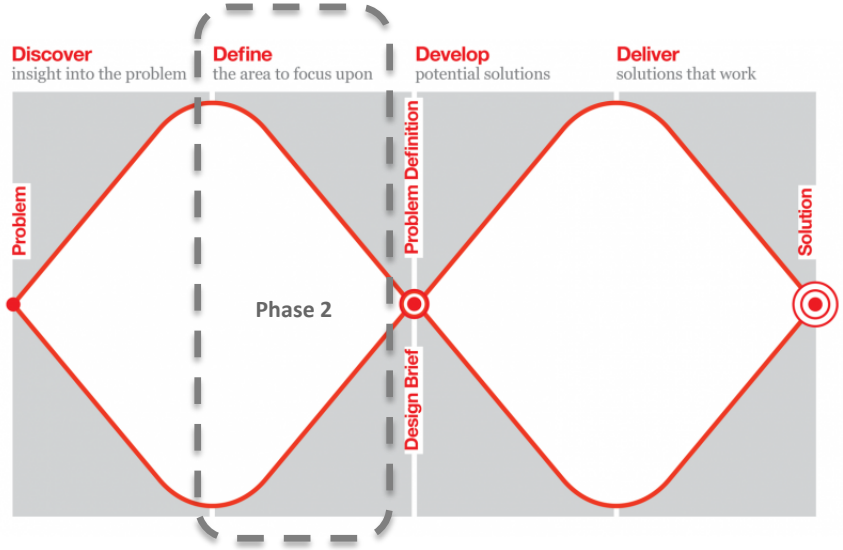
2. Design Thinking Approach

2. Design Thinking Approach / Overview

A Design Thinking approach, using the Double Diamond model (shown opposite), was taken to support inclusive participation and to enable participants to define together potential opportunities for action to enhance community-based older people's services. This holistic approach involved the direct engagement of diverse stakeholders: older adults, carers, RHSCP staff, third-sector organisations, and other community members.

Three principles guided the Design Thinking process: being **people-centred**, having a structured **process** for co-creation, and **preliminary testing** through continual cycles of sharing, testing and refining outputs during the process.

The Project focused on the Define stage and progressed and extended the findings from Phase 1 (Discover stage). This deeper exploration of the initial findings combined with the testing of outputs at each stage of engagement in Phase 2 ensured that the resulting Action Areas (see 9.3 below) provided robust and clearly articulated areas for action to enhance older people's services in the future. This approach aligns with the Scottish Government's design approach which advocates knowing the problem before exploring solutions – ensuring you are designing the right thing.

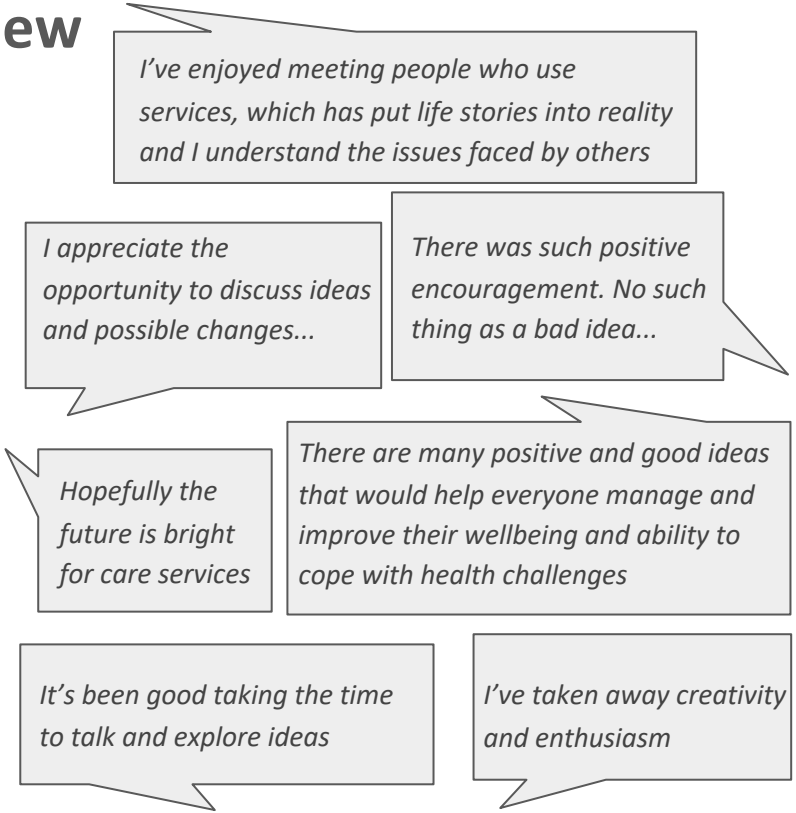


Source: UK Design Council

2. Design Thinking Approach / Overview

The benefits of a Design Thinking approach include that it is:

- **User-focused**
  Nurtures empathy and understanding of user needs and perspectives and challenges assumptions
- **Participatory**
  Facilitates multi-stakeholder engagement, ensuring wide and varied perspectives and experiences of services are embraced
- **Inclusive**
  Provides the support necessary to ensure that anyone can participate and that everyone has an equal voice
- **Co-creative**
  Values the contributions of people who use services as well as those with professional knowledge and experience
- **Motivating and empowering**
  Ensures that participants feel consulted and have an active role in shaping the future of their services.



Examples of feedback from participants

3. Project Activities

3.1 Project Activities / Overview

The project consisted of six key strands of activity relating to:

1. Familiarisation and desk research
2. Steering Group (governance)
3. Reference Group (partnership network)
4. User Research (interviews and co-design workshops)
5. Staff Engagement
6. Feedback Session

Across the Project, the findings from Phase 1 were tested and verified with key stakeholder groups. This allowed consensus to be reached on which themes to prioritise for deeper exploration of the issues, challenges and opportunities faced by community-based older people's services.

Phase 2 involved a broader range of voices including service users; older adults and carers with lived experience; the wider community; and service-delivery organisations, including the third sector and charities. This holistic engagement of stakeholders enriched the co-creation process and helped ensure the 'right' focus of attention to enhance community-based services, with many pertinent challenges explored and opportunities identified. As a result, RHSCP and its partners – through the Reference Group and citizen engagement – are well placed to explore potential solutions that are informed directly by key stakeholders and have user outcomes at their heart.

For each engagement, activities were carefully planned and bespoke materials were created to be action-oriented. They were also intended to nurture empathy for service users; ensure each individual had the maximum opportunity to contribute; enable a shared understanding of challenges and opportunities for future services; facilitate informed discussion; and record key messages for synthesis and analysis. Through skilled facilitation, a safe space was created to allow each participant to share their views, perspectives and ideas, ensuring effective knowledge sharing.

As shown in the Activity Map below, over a five-month period of engagement, the Project delivered 10 interviews, 12 workshops (150 participants), one public event (25 people were consulted) and one feedback session (30 participants).

3.2 Project Activities / Phase 2 Activity Map

A more detailed Activity Map including Journey Associates activities can be found in Appendix 1.

4. Familiarisation and Desk Research

4. Familiarisation and Desk Research

The following summarises a selection of case studies that have informed our approach and can provide inspiration for further co-creative explorations of the future of older people's services.

The **Wigan Deal** exemplified asset-based working in public services, building on the strengths of individuals and communities to improve outcomes. The six-year initiative supported new cultural behaviours within Wigan Council and closer integrated working between health, care and third-sector professionals.

Emerging principles for creating robust **Dementia Friendly Communities** include adopting a social model of disability, rather than a medical model; taking an assets-based approach that identifies and mobilises individual and community 'assets'; being multi-generational; and providing appropriate training to staff and volunteers that goes beyond awareness-raising.

By embracing kindness, individuals and organisations can play an important role in tackling loneliness and social isolation, as shown in North Ayrshire and reported in **The Practice of Kindness.**

The Design Council's **'Transforming Ageing'** Project ran a three-year learning programme connecting communities in south-west England with a range of third-sector and health organisations. Working in a co-productive way the partners and communities used human-centred design tools and developed six project briefs for social entrepreneurs to respond to.

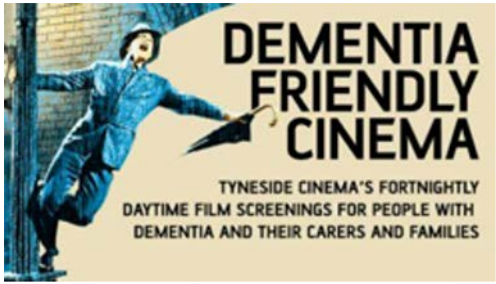
My Care, My Way is an integrated health and care service operating in 44 GP practices in West London. It provides health and care support tailored to the patient's needs. It empowers individuals to work in partnership with their GP with a focus on prevention, self-care and person-centred case management.

The **City and Hackney Innovation Fund** supports community-based innovative ideas. Projects focus on health and wellbeing services and information, resulting in improved health, increased self-management and more effective use of services.

4. Familiarisation and Desk Research

The following examples were presented in detail to the Co-design teams to stimulate thinking around innovative support services for older people.

- **Dementia Friendly Cinema** helps people living with dementia continue to feel a part of their community by selecting appealing films and adjusting the environment to suit their needs (being sensitive to sound and lighting and encouraging sing-alongs)
- **Homeshare UK** brings together people with spare rooms and people who are willing to lend a hand around the house in return for affordable, sociable accommodation
- **Southwark Circle** was a membership service providing on-demand support for the over 50s. A simple technology platform enabled a small local team to respond to practical requests
- **Amazon Echo** (or other platforms) uses artificial intelligence to learn user behaviors and preferences and suggests relevant activities to support their physical and mental health.



HS UK
HomeshareUK

Southwark Circle

5. Governance / Steering Group

5. Governance / Steering Group

A Steering Group was assembled to provide governance for the project, ensuring that outputs and recommendations aligned with the Scottish Government's national priorities (e.g. A Fairer Scotland for Older People: A Framework for Action, 2019; and A Connected Scotland: our strategy for tackling social isolation and loneliness and building stronger social connections, 2018) as well as regional priorities (e.g. Moving Forward Together, NHSGGC; RHSCP Strategic Plan 2019-22).

The Steering Group met bi-monthly led by Chief Officer David Leese, and was made up of 13 senior members from RHSCP, Renfrewshire Council, NHSGGC and Engage Renfrewshire, which represented third-sector organisations to mitigate any potential conflict of interest that might have arisen from involving commissioned organisations. The Steering Group was responsible for monitoring performance in relation to targets and risk. Consistent with the original intention, it is recommended that the Steering Group continues to operate beyond Phase 2, and into the subsequent phases of solution generation and new service delivery.

Members of the Steering Group also joined the Reference Group workshops, outlined below.

6. Partnership Model / Reference Group

6. Partnership Model / Reference Group

A new partnership model was sought by RHSCP with key organisations in the sector to support the co-creation of novel, sustainable ways of addressing the needs of older citizens through community-based services. For this purpose, a Reference Group was formed which extended the membership and role of the pre-existing SLWG from Phase 1 of the Project. It comprises 30 members representing the range of stakeholders concerned with shaping and delivering community-based services to older people, including several older people who access services themselves or who care for service users.

Taking an assets-based approach, the Reference Group drew on the knowledge and experience of those with specialist expertise across the multi-stakeholder ecosystem in Renfrewshire. Focused engagement with this broad range of stakeholders enhanced the understanding of user needs and enabled meaningful insights to emerge. The Reference Group acted as both advisor and 'critical friend' to the Project Team, contributing to the development of the Service Themes and workshop content and providing access to service users, carers and staff.

A total of 54 members of the Reference Group and Steering Group participated in three workshops tailored to explore partnership working and to help shape the core content explored in the Co-design Team workshops.

Reference Group Workshop Participants

Workshop	RHSCP / Council Staff	3rd Sector	Older Person / Carer	Total*
1	14	6	3	23
2	11	4	-	15
3	9	6	1	16

* Where a participant was both a carer and an older person, they were categorised as both although only counted once in the Total column

6. Partnership Model / Reference Group

The first two workshops explored models for partnership working and generated an agreed set of six values and a manifesto, through an iterative process of drafting, testing with the group and refining. The values and shared purpose in the manifesto made explicit the foundations for 'true' partnership working between RHSCP, local agencies and third-sector and community groups, and are presented below. During the second workshop the Service Themes proposed for use in the Co-design Team workshops were critiqued and enhanced. The final Reference Group workshop reviewed the outputs from the Co-design activities and further evolved the Action Areas presented in Section 9.

The Reference Group played a vital role in the co-design process, offering deep insight and knowledge. A Reference Group with the appropriate composition of members should remain operational beyond Phase 2 and have an active role in shaping the design and delivery of new/enhanced services.

Reference Group Workshop Agendas

WS1 / Shared Purpose	WS2 / Developing Ideas	WS3 / Future Action
• Context and Phase 1 overview • Exploring Partnership Values • Exploring Partnership Manifesto	• Refine Values and Manifesto • Agree Terms of Reference (ToR) • Explore models of Partnership Working • Review Service Themes	• Finalise Values, Manifesto, ToR • Service Theme and Persona Refinement • Build on Co-Design • Service Ideas for future Action

Reference Group Member Organisations

Alzheimer Scotland Action on Dementia
Renfrewshire Carers Centre
ENGAGE Renfrewshire
FLAIR Federation of Local Housing Associations
Food Train supporting older people
RAMH
Roar
Scottish Care

6. Partnership Model / Reference Group

The Manifesto and Values presented below were co-created by the Reference Group and Steering Group. They were generated through an iterative process of collective idea generation, drafting, testing, critique and refinement led by a sub-group of members.

Manifesto

We are committed to improving services for people over 65 years old so that they can live life as they choose and be connected to their communities.

- We will enable people to experience and deliver better health and social care services to work together.
- We will get this right by always listening and ensuring a rich diversity of voices is heard.
- We will continue to treat each other with respect and not assume we know what is needed or is best.
- We will build on each other's strengths, celebrate what is already working well, and agree on sustainable solutions.

6. Partnership Model / Reference Group

Values

Together we believe in…

Equality - We embrace equal collaboration, respect each other and value the diversity of perspectives. We promote independence, support self-determination and challenge inequality.

Openness - We are open so we build and maintain trusting relationships and create safe spaces to invite sincere and honest conversations. We use open communication channels to share knowledge.

Listening - We appreciate each other's unique experience and strengths. We listen! We are curious and will challenge biases and assumptions. We empower each other by learning from mistakes and sharing our knowledge and experiences.

Compassion - We are considerate of the needs of others, empathise with their situation and will support each other with a kind and caring spirit to achieve the greater good for all.

Creativity - We champion our collaborative way of working and actively seek creative approaches to ensure sustainable services. We will imagine the best possible futures and set clear goals that achieve outcomes that improve lives.

Courage - We enthusiastically and positively embrace innovative ideas and methods and are brave in our actions. We will push the boundaries to tackle complex social challenges to deliver the right services that offer the best value.

6. Partnership Model / Reference Group

The Reference Group agreed that a model for good partnership working required: Trust; Openness; Commitment; Collaborative Action (mutual support and community involvement); Collective Vision; and Inclusive, Adaptable and Courageous practices. Members suggested that to progress the partnership, it is necessary to have:

- An agreed vision
- A clear and concise plan
- Listening organisations
- A community drawing on external knowledge, professional leadership and people to drive the agenda
- The right tools and information

The values and manifesto go some way towards articulating the principles and vision. However, clear leadership and a detailed plan of engagement are required for the group to coalesce. Members identified that lack of drive, partner involvement and resources as well as bureaucracy and conflicts of culture could stand in the way of true partnership working.

It is suggested that the discussion is revisited to agree a model that provides a robust foundation for meaningful partnership working that can be sustained during the design and delivery of new services.

7. User Research

7.1. User Research / Overview

The User Research strand involved a range of activities that supported a deeper understanding of what older people need from the services they use, what outcomes they want from them, and what other services they would like to have access to. These included:

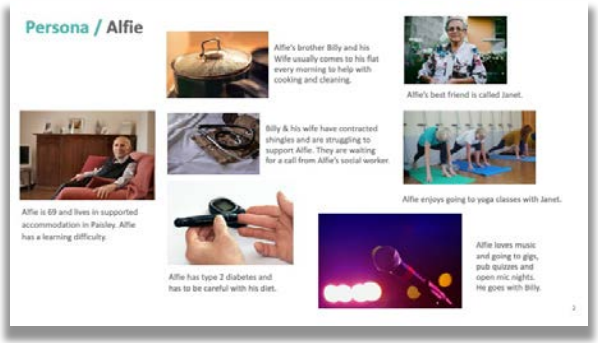
- **In-person interviews** with 10 individuals to gain deeper insights into individual needs and experiences
- **Three co-design Workshops** that involved a mix of stakeholders, and tested and progressed ideas across consecutive workshops
- **A Public Event** that captured wider perspectives on services from citizens in the Renfrewshire region who were not directly involved in other aspects of user research
- **Feedback Session** to present the findings of the project for accuracy and to gain constructive feedback before finalising them

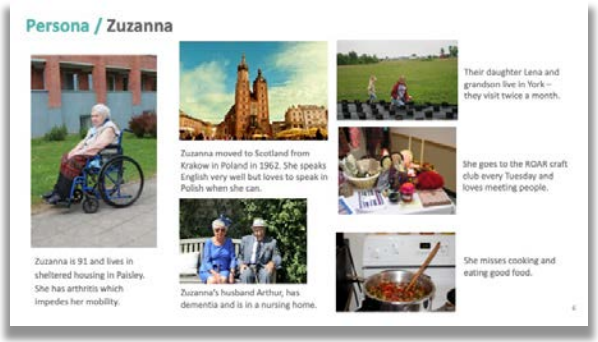
Each activity is described in more detail below.

7.2. User Research / Interviews

In-person interviews and observation of service users, carers and staff provided a deep and insightful understanding of needs and opportunities for different services. The service-user and carer interactions also provided rich data to build user personas (fictional characters based on real life that help us to connect emotionally to service users). These were used within the workshops to explore existing and future community-based services, and were enhanced through the participatory process.

Participants included one person with a learning disability (interviewed with their social worker), one person recovering from a stroke (interviewed with carer), and four people who attend day-care centres.





7.3. User Research / Co-design Workshops

Three bespoke and sequential Co-design Workshops were devised to support inclusion, gain a range of perspectives and draw on a broad range of experiences from stakeholders who had accessed or delivered services.

In total, 86 participants attended with 16 (19%) participating in all three workshops and 10 (12%) present at two of the three, providing a level of continuity across the workshops. An overview of types of participants is shown in the table opposite.

Attendance was voluntary with no incentives other than refreshments and lunch. All six workshops were well-attended and a general increase in numbers was noted as word of mouth generated interest and attracted new participants to Workshops 2 and 3.

Co-design Workshop Participants

Workshop	RHSCP Staff	Older People	Carer	3rd Sector	Other Service Users*	Total**
1	9	6	5	4	2	23
2	8	13	5	6	2	30
3	11	15	9	4	2	33

* Five participants had a physical disability and one had a learning disability

** Where a participant was both a carer and an older person, they were categorised as both although only counted once in the Total column

7.3. User Research / Co-design Workshops (cont.)

Workshops were hosted at Johnstone Town Hall with each one run twice to increase the opportunity for community participation. An overview of the agenda for each of the workshops is shown opposite.

Each workshop was user-focused and participatory and included service users, older people, carers, other citizens, third-sector and Reference Group representatives, and RHSCP staff. Participants worked in groups (each with a range of stakeholders) to ensure a broad range of views was heard on each topic.

The first workshop introduced the proposed Service Themes and a series of personas to explore outcome-focused services. The Service Themes presented were developed in response to participants' feedback, and the personas were further developed, with two new ones created to encompass ethnic and religious diversity.

Co-design Workshop Agendas

WS1 / Shared Purpose	WS2 / Developing Ideas	WS3 / Project Actions
• Getting to know each other • Becoming familiar with the project themes • Meeting our personas	• Presenting refined project themes • Using the personas to develop ideas connected to project themes	• Visioning future service ideas • Developing project plans to inform project actions

7.3. User Research / Co-design Workshops (cont.)

The revised Service Themes and personas were shared in Workshop 2. Innovative service ideas identified in the desk research were used to stimulate ideas on how existing services for older people could be enhanced, and what new services might be considered.

The ideas from Workshop 2 were categorized into sub-themes for review and further development in Workshop 3. Groups prioritised ideas which were developed further as newspaper headlines showing visions of future success, accompanied by high-level project delivery plans. Outputs across the workshops were analysed and synthesized into the Action Areas presented below in Section 9.

7.4. User Research / Public Event

To reach a wider audience, the project team manned a stall at the SOOPIR public event in Paisley Lagoon in November 2019.

At the event, 25 people, 24 of them aged over 65, shared their thoughts on what living well means to them and what they do to keep well. Using coloured pins they indicated on a map where they thought was the most caring place in Renfrewshire.

Independence, exercising, socialising, getting out and about, being active, attending clubs and keeping healthy were considered important for living well, as shown in the wordcloud opposite. Participants identified a range of physical and group-based activities that helped them to keep well. All activities involved socialising and 10 of the 13 took place out of the home, emphasising the importance of providing a range of activities in the community and ensuring easy access to them. This is concurrent with the themes from the Co-design Workshops which had a specific focus on the Johnstone area.

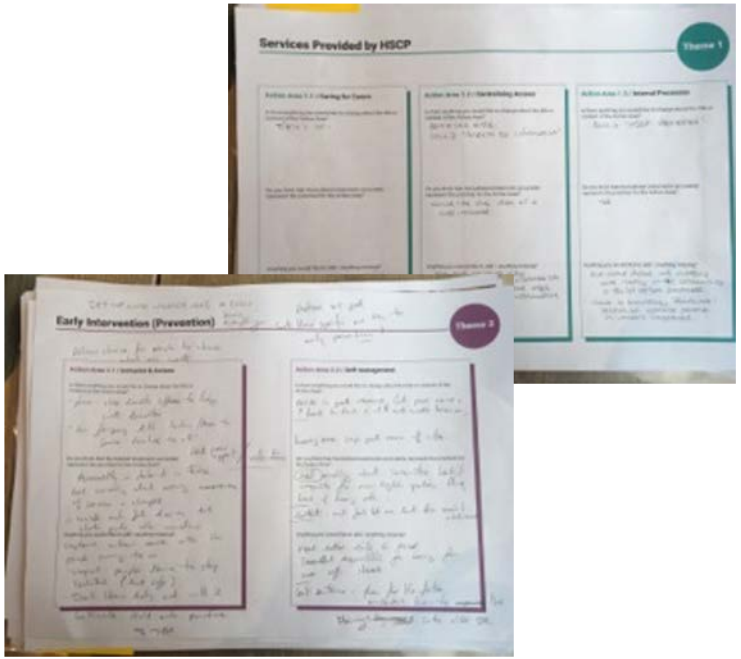
Interestingly, Johnstone had the greatest number of responses as the most caring place in Renfrewshire.

What does living well mean to you?

7.5. User Research / Feedback Session

The Feedback Session held on 5th February 2020 was open to participants across all activity strands of the Project, with 30 attending, including service users, carers, third-sector and RHSCP staff, and representatives from the Reference Group and Steering Group. A summary of the activities and outputs of the Phase 2 Older People's Services Review was presented. The main focus of this session was to present the Project findings, share the process and experience, test and validate the outputs for accuracy, and gather feedback on the nine proposed Action Areas distilled from the project activities.

As with previous engagement activities, multi-stakeholder collaboration was encouraged. Participants worked in four groups, each reviewing the Action Areas associated with one of the four Service Themes. Pre-printed templates with key questions were provided as prompts to ensure constructive feedback, with a view to refining and validating the Action Areas. The reviewed Action Areas form the key outputs of this report and inform the outputs statements for the Project.



Examples of completed feedback templates

8. Staff Engagement

8. Staff Engagement / Overview

Consistent with the RHSCP's emerging Transformation Programme, the service lead identified that capacity-building was necessary for staff to embrace new ways of working. It was also necessary to support service change with a particular focus on ensuring a consistent and efficient approach to the assessment and delivery of Self Directed Support (SDS). The detail of this engagement is contained in a separate report and summarised below.

Staff across multiple health and social care functions and from various locations across Renfrewshire enthusiastically took part in a series of three tailored, participatory workshops designed to collaboratively explore challenges and potential solutions to the assessment process. A total of 39 staff attended across the three workshops, representing a range of health and social care roles, as indicated in the table opposite. Five members of staff attended all three workshops and 10 members attended two of the three workshops, allowing for consistency in the progression of ideas of consecutive workshops alongside fresh perspectives.

Staff Workshop Participants

Workshop	Health	Social Care	Total
1	2	13	15
2	2	9	11
3	2	11	13

Social Care roles included:

- Reablement
- Occupational Therapy
- Social Work
- Adult Social Care
- Day Centre
- Service Coordination
- Direct Payment Development
- Change & Improvement

Health roles included:

- Rehabilitation & Enablement
- Physiotherapy
- Nursing

8. Staff Engagement / Overview

Consistent with Co-design and Reference Group workshops, each workshop built on the cumulative knowledge and outputs of the previous activities.

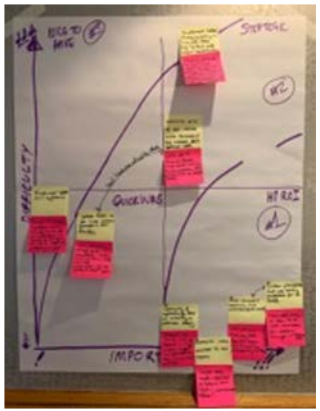
The diagram opposite provides an overview of the main focus and activities for each workshop. Workshop 1 started with participants relating in detail the current assessment process to uncover the associated challenges and opportunities for improvement. Staff worked in three groups and each developed a service-user journey map of the SDS process using the personas mentioned previously. These were supplemented with a series of complex scenarios for each service user, describing their particular circumstances to highlight deficiencies in the current system. Outputs were written up and shared with participants to conduct further research, in advance of Workshop 2, by sharing their user journeys with colleagues to gather feedback and generate a wider range of perspectives to inform the challenge.

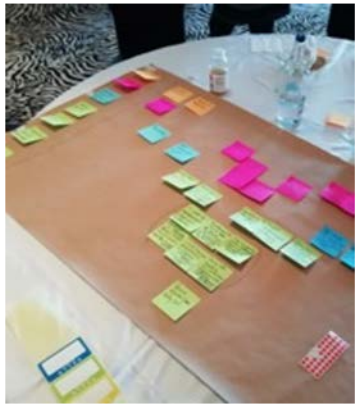
Staff Workshop Agendas

8. Staff Engagement / Overview (cont.)

Workshop 2 built on the findings of Workshop 1 combined with the staff research to create Challenge Areas that each group used to develop ideas to enhance the assessment journey. The final workshop involved a review and prioritisation of the ideas from Workshop 2 and the creation of outline actions plans to support implementation.

The Staff Engagement workshops generated three Challenge Areas and 20 potential actions to enhance the assessment process that should be reviewed and prioritised. The detailed outputs and recommendations from these activities are presented in a separate report.





9. Outputs

9.1. Outputs / Overview

This section provides an overview of the main outputs distilled from the project activities. These include:

- Johnstone as a demonstrator site
- Nine Action Areas aligned with the four Service Themes
- Four Cross-cutting Themes that are relevant for every project or opportunity and should be addressed in each of the potential solutions taken forward
- Six Service Project Principles to ensure that user outcomes are embedded in potential solutions, and to guide decision-making
- Six Personas that demonstrate a range of service-user characteristics, outcomes and needs
- Project Packs collating the relevant information to help inform idea generation in the Development Phase

Each output is provided in more detail below.

Map of Renfrewshire Area (from Google Maps)

9.2. Outputs / Johnstone as Demonstrator Site

Johnstone was proposed as a demonstrator site for the User Research aspects of the Project and was approved by The Steering Group in October 2019. Having a single location to concentrate activity was important for building momentum and, by making meaningful local connections, for gaining traction for co-creating future services, and putting new ideas into action.

Johnstone was considered a suitable pilot area as it exhibited average scoring on several socio-demographic data points for Scotland nationally and Renfrewshire regionally. It represents around 10% of the population of Renfrewshire and encompasses both urban and rural communities. It is also looking to become a Dementia Friendly town and has a proactive community which could help expedite future plans for change.

Map of Renfrewshire Area (from Google Maps)

9.3. Outputs / Action Areas

The Action Areas are a development of the four Service Themes evolved from Phase 1, with a deeper dive into each theme to identify specific areas for improvement. The four Service Themes were identified during the first Steering Group meeting when the eight themes identified during Phase 1 were reviewed in detail to align with the strategic priorities of RHSCP.

This led to the categorization of four Service Themes and four cross-cutting themes. The Service Themes are:

- Theme 1: Services Provided by RHSCP
- Theme 2: Health and Wellbeing
- Theme 3: Early Intervention (Prevention)
- Theme 4: Living in Our Community

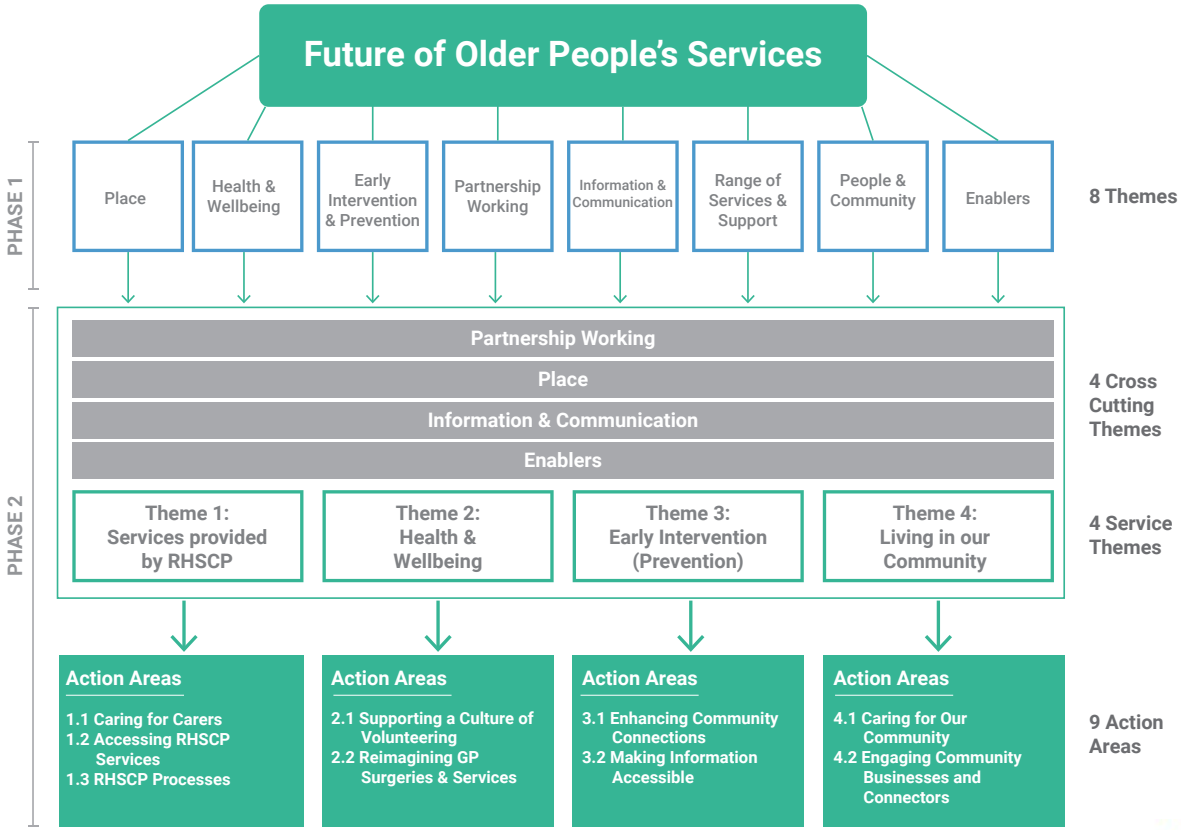
The cross-cutting themes were identified as relevant to the design and delivery of any service. They are:

- Place
- Partnership Working
- Information and Communication
- Enablers (such as transport and technology).

The Service Themes were tested and further developed in Steering Group and Reference Group workshops, providing the core content for detailed exploration in the Co-design Team workshops.

A visual mapping of the evolution of the Service Themes and how they connect to the Action Areas is presented below.

9.3. Outputs / Action Areas



9.3. Outputs / Action Areas

Nine Action Areas have been generated through a robust process of inclusive and collaborative engagement and have been shared, tested, reviewed and refined throughout Phase 2 of the Project. As a result, the Action Areas draw from rich, user-focused, multi-stakeholder knowledge, expertise and experience. They give clear focus for exploring potential solutions to the issues, challenges and opportunities related to community-based services for older people.

The Action Areas and associated Service Themes are:

Theme 1: Services Provided by RHSCP

Action Area 1.1 Caring for Carers
Action Area 1.2 Accessing RHSCP Services
Action Area 1.3 RHSCP Processes

Theme 2: Health and Wellbeing

Action Area 2.1 Supporting a Culture of Volunteering
Action Area 2.2 Reimagining GP Surgeries and Services

Theme 3: Early Intervention (Prevention)

Action Area 3.1 Enhancing Community Connections
Action Area 3.2 Making Information Accessible

Theme 4: Living in Our Community

Action Area 4.1 Caring for Our Community
Action Area 4.2 Engaging Community Businesses and Connectors

An overview of the Service Themes and detailed descriptions of the associated Action Areas is provided.

Theme 1

Services Provided by RHSCP



Overview

Renfrewshire RHSCP provides a range of services for older people which are valued by the communities who use them. However, there is a need to enhance the spectrum of services provided to ensure that the needs of older adults are met and that better outcomes are achieved – these are the things that older people value, that give them pleasure and meaning and enhance their quality of life. Many older people want to remain independent and services should help citizens retain independence while accessing the support they need and without stimulating an over-reliance on services. Each individual will value experiences and services in different ways, therefore, to deliver services that are outcomes-focused requires responsive and more flexible services.

To deliver services that meet citizen's needs, the workforce needs supported to enhance capability, think creatively and build confidence in new ways of working.

Services Provided by RHSCP



Action Area 1.1 / Caring for Carers

Carers play a vital role looking after and supporting older citizens. The caring role can vary considerably from providing occasional help though to deep involvement in all aspects of a loved one's life.

While caring for someone can be rewarding, it can also be challenging. The Carers (Scotland) Act 2016 was introduced to support carers in their role and ensure their health and wellbeing does not suffer as a result of this. However, participants suggested that more person-centred support for carers is needed and that carer support plans should be promoted and regularly reviewed. Young carers may face particular challenges that can affect their education and impact on social connections. Local authorities have a duty to offer support and to involve carers in the design of carer services.

Participants noted that many carers can feel isolated in their role, finding it very difficult to access information and find out about services and support that is available. Some carers will not seek help or may be dissuaded from asking for help as they will be met with resistance from the person they care for. It was suggested that existing carer support groups and activities should be more visible and that support be available in more locations.

Participants noted that the SDS process is challenging. This is particularly true for carers of people living with dementia. The SDS assessment should be triggered at the point of diagnosis and the process itself streamlined.

It is important that an individual's needs are acknowledged and their outcomes met to allow carers to have a good quality of life in their role, to plan ahead and prepare for the future. This could include accessing respite for carers and emotional support services.

Potential areas to explore include:

- Supporting the health and wellbeing of carers to help them fulfil their caring role while ensuring their outcomes are met
- Developing the assessment process and administration of SDS to ensure that it is accessible for carers
- Approaches (including the use of technology) that can help minimise the pressure on individuals or families who are caring for people with dementia

SDS is great once you get it. It's just a difficult and lengthy process to get through.

Services Provided by RHSCP



Action Area 1.2 / Accessing RHSCP Services

Feedback received suggested that having a hub as a designated and widely recognised 'go to' place where information on services and activities in the local community are readily accessible could help centralise access and enhance the wider active engagement of older people. This could be a physical hub complemented by centralised online information. It was suggested that, rather than having one regional hub for Renfrewshire, each town or community should have a local hub.

Participants commented that the hub could connect older people to what is going on in the wider community as well as to RHSCP services. This could include clubs, groups, and third sector activities. The hub could provide training for local businesses and organisations on adapting services to be more appropriate for older people including being dementia friendly and embracing kindness to tackle loneliness and social isolation. Existing community venues including day centres and libraries could be explored as potential hubs. Third sector organisations could provide the information and content that is accessed through the hubs.

Participants also thought that having a single point of contact in the hub who could assist with identifying services to suit individual needs and assessing eligibility; and that supporting citizens through the SDS process would make services more accessible.

Some people noted that they would be willing to pay for or contribute to the cost of services such as Care and Repair and taxi services.

Potential areas to explore include:

- Making information easily accessible by older people and the wider community in a way that reduces stigma
- Create a network of local hubs that share information across the region
- Exploring ways that people can pay for or contribute to the cost of services

People have told us that it is very difficult to find and access relevant information, "you don't know what you don't know".

You have to know how to navigate the system [ASeRT]- it's hard.

Services Provided by RHSCP



Action Area 1.3 / RHSCP Processes

Feedback from a selection of staff who attended the staff engagement workshops noted their ambition to work in more integrated ways. This would support improved communication and joined-up support between the services delivering health and social care. Feedback suggested that a care coordinator could be identified who has most regular contact with the service user and whom all other professionals should update on any changes. They could then liaise with families.

A more coordinated approach to delivering services could be enabled through IT systems that are accessible to all professionals and co-location of staff across the HSCP. Service Users with more complex needs would benefit from multi-disciplinary teams with a clear understanding of the roles and responsibilities of each team member. Although, it was noted that increasingly complex needs can present particular challenges for coordinating teams.

People noted that they liked the flexibility and choice that SDS can provide but do not feel clearly informed about it. It was suggested by both citizens and staff that having a designated person in place to help coordinate strands of activity and signpost to services would be beneficial.

Participants also suggested that a clearer focus on individuals' outcomes could allow for the provision of social time within service delivery. For example, at the moment, meals are delivered with no or little conversation, missing the opportunity to check in with the older person and to engage them in conversation. Having time to spend with a person while they are eating can ensure they are receiving the nourishment they need and the social contact can help reduce loneliness, in line with Scottish Government strategy. This may be an opportunity to work more closely with third sector and community partners.

Feedback received also suggested that improving the commissioning and procurement processes could help improve equality in service provision across the region.

Potential areas to explore include:

- Continuing to develop a more integrated and coordinated approach to care which is outcomes-based
- Further developing SDS to clarify the offer and simplify the process
- Partnership working to help shift the focus of service delivery to better meet the outcomes of older people
- Delivering equality of access across the region

[Staff] just don't have time…[it seems] the targets are more important than people.

People have told us that, "the service feels disjointed wherever you are in the system"

Theme 2

Health & Wellbeing

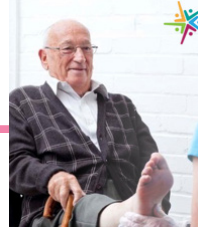



Overview

Many older people want to remain independent for as long as they can while others need to be encouraged and supported to have an active role in their health and wellbeing. To support independence, older people should have the freedom to choose how they spend their time and which activities they take part in. To encourage citizens to be active and engaged, services must connect to the individual's personal outcomes – these are the things that are important to them in their life.

We need to find new ways of connecting with older people ensuring that they know how best to look after their own health and wellbeing. Information about what impacts our health and wellbeing should be easy to understand and services and activities that can support individuals to make positive choices should be easily accessible.

To enable older people to support themselves and retain their independence, we should take a strengths-based approach, drawing on the existing wealth of knowledge, skills and potential that our citizens and communities have access to.




Action Area 2.1 / Supporting a Culture of Volunteering

Volunteering may have a vital role to play in supporting individual health and wellbeing. It also helps to build social connections that benefit both the volunteer and the recipient and can reduce the potential for loneliness and isolation that can be detrimental to our health and sense of wellbeing.

Volunteering can be very rewarding and a great way to get people active in their communities, whether giving something back to the community, meeting new people or learning a new skill. To ensure no-one is exploited and the principles of mutuality and reciprocity are upheld, a 'volunteer ready' programme could help prepare people to volunteer. The programme could help build self-esteem and skills for people to volunteer effectively and that they can add to their CV. Volunteering could be incentivised and Renfrewshire volunteering prizes might encourage momentum and build a movement. Additional information on how to volunteer, training and ongoing support also needs to be in place.

Participants suggested that activities underpinned by shared interests are most rewarding. There are many types of volunteering programmes online and offline from those that offer assistance in taking people to appointments (e.g. Emergency Mum); buddying services to learn something new (e.g. digital buddy groups in libraries), to those that help with shopping (e.g. at Braehead Shopping Centre). Soft options for volunteering (e.g. keeping an eye out for a neighbour) and micro-volunteering (small tasks that do not require significant time or commitment) also need to be easily accessible. It was suggested that the HSCP could be more proactive in signposting and linking volunteering opportunities to SDS. This would help ensure more of a two-way flow of information between programmes and potential beneficiaries and support grass-roots activity.

Mapping the variety of volunteering programmes could help identify opportunities for new ways to engage citizens, exchange life skills and build relationships (e.g. bringing generations together based on shared interests where older people teach young people how to play traditional card games, whilst young people teach older people how to do online shopping). This could build on the existing knowledge and expertise of organisations in Renfrewshire. It was suggested that existing halls and other community venues could be used to reach older adults and connect people to services and help others recognise vulnerabilities in their own communities.

Initiatives that connect the generations through shared interests earlier in life can help to break down social divides and reduce stigma.

RHSCP could connect citizens to volunteer programmes for services that are outside of its remit.

Potential areas to explore include:

- Encouraging and supporting connections between peers and across generations who have similar interests
- Helping older adults and carers to understand the variety of volunteer programmes that exist
- Putting in place the right structures to encourage volunteering and ensure citizens are 'volunteer ready' and are supported in their roles
- The role of RHSCP in signposting and linking existing RHSCP services with volunteer programmes

It gave me great pleasure to start a lunch club at the community hub - people get dressed up and enjoy going out together

Getting volunteers is difficult - often there aren't enough people and when you do get some, they often let you down




Action Area 2.2 / Reimagining GP Surgeries and Services

GP surgeries serve our local communities and can be a valuable route to connecting older people to other services and opportunities in the community. For many people, GP-based services can feel less daunting and more accessible than council-based services.

Community Link Workers based at GP surgeries provide access to community support and opportunities for citizens to self-manage their health and wellbeing.

As a hub serving all generations in the local community, participants suggested that GP surgeries could play a wider role in supporting the health and wellbeing of older adults through signposting to local services and groups. One suggestion was creating a 6-monthly 'what's on' brochure, targeted at vulnerable groups, funded by local businesses and disseminated through GP surgeries.

To support preventative action, it was also noted that increasing knowledge and awareness in the community to look after your own health and wellbeing could assist in keeping people healthier for longer.

A 'Social MOT' was suggested as a way of checking in with older adults and signposting to information, resources and activities that can help ensure good mental health and address the potential for loneliness or social isolation. This could be carried out by community connectors in a local GP surgery or alternative suitable locations.

Older people who attended the workshops said they would value having a deeper relationship with their GPs. Suggestions included having a single GP as the point of contact from the age of 65, helping to build the relationship, allowing for consistency, and reducing the need to have to repeat their history with different GPs. Workshop participants also suggested that longer appointments for older people could help them feel less rushed.

Some participants acknowledged that any proposals considering such changes would need to reflect the GP contract and Primary Care Improvement Plan which are currently being implemented and which set out the role of extended HSCP and NHS Board employed health professions in and around general practice. These changes include new ways of working and signposting and support to patients.

Potential areas to explore include:

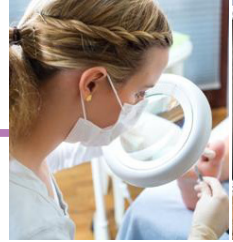
- Options around Community Health provision that would enable older people to have a more active role in their health and wellbeing
- The role of GP surgeries in connecting older adults to appropriate information and support
- The role of a 'Social MOT' as a means of supporting early intervention and prevention for health and wellbeing

My GP service feels smaller and more manageable - the Council feels huge

Once diagnosed you're forgotten about. It would be good to have [more regular] 3 to 6 month reviews.

Theme 3

Early Intervention (Prevention)



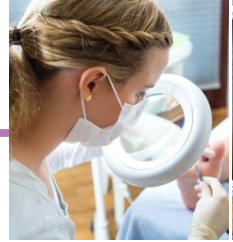

Overview

The demographics of society are changing. Increasing numbers of people are living longer, often with multiple or complex health conditions requiring specialised support which demands more from our public services while public finances are increasingly constrained. Keeping well and having a good quality of life through older age can benefit from early intervention and preventative action. Supporting older people to maintain their independence, including choosing what to eat, keeping in touch with friends and family, and living in one's own home, are important in meeting personal outcomes and maintaining a good quality of life.

Loneliness and social isolation can be deeply detrimental to an individual's health and wellbeing. Supporting older people to remain connected and reducing the chances of social exclusion are vital. This is particularly important at times of transition, when life changes such as having a health scare, becoming a carer, or losing a partner can affect our health and wellbeing. Reaching those who do not engage with services, and before they are at risk, is a challenge.

Theme 3

Early Intervention (Prevention)




Action Area 3.1 / Enhancing Community Connections

Connecting Citizens

Participants noted their view that citizens want existing activities such as arts and cultural activities (cinema and concerts), and Renfrewshire Leisure classes to be more accessible, including having better transport options. They suggested that services could be made more accessible through peer support, grassroots activities (such as setting up a lunch club for friends and neighbours) and volunteering opportunities as well as a having a community link worker hub. It was also suggested that it is important for services to be welcoming to encourage people to engage.

For some services, accessibility could be enhanced by making small changes, for example, having someone in a 'meet and greet' role, cinema showings with lights on and sing-alongs for those living with dementia, talking books to convey information, and using sign language and translation services. Other suggestions included engaging pubs, clubs (e.g. golf, bowling), leisure centres and other local amenities advised and supported by a compliance outreach programme.

Potential areas to explore include:

- Ensuring existing services and activities are accessible for everyone
- Supporting people to volunteer on a small scale in their own community
- Supporting older people to feel comfortable and confident to join a group for the first time

Loneliness & Social Isolation

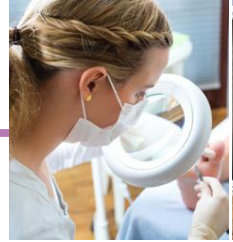
To minimise loneliness and social isolation, feedback noted we need to find ways to reach seldom heard groups to ensure everyone has equitable access to services and in advance of crisis. Although, we must also respect people's desire to stay isolated (and safe).

People who are particularly vulnerable include those who have undergone a life transition such as retirement, losing a partner, becoming a carer, having a medical condition including mental health issues, and being housebound.

Potential areas to explore include:

- Engage those who are difficult to reach
- Engage those who have experienced a major change in life or crisis

It gave me great pleasure to start a lunch club at the community hub - people get dressed up and enjoy going out together




Action Area 3.2 / Making Information Accessible

Reaching Citizens

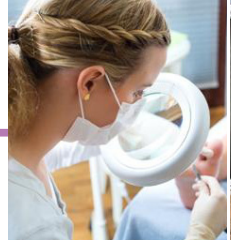
It was recognised that there is a broad range of existing services that citizens value but that can be difficult to find. ALISS (A Local Information System for Scotland) and WIRE (Well in Renfrewshire) are good information resources but they are not well known and can be difficult to access and need to be updated regularly. One professional took 16 clicks to access ALISS from the RHSCP website.

Feedback provided noted that information about services should be available in different formats. Suggestions included:

- Printed information that is easy to read and can be found in everyday settings – local newspapers, 'keep' leaflets like the waste collection diary, and be combined with information mailed to those over 65, e.g. notifications for pension and heating allowance and when signing up for services
- Online: information that is only available online can exclude citizens who do not have access. Resources like ALISS and WIRE could be made available in other formats including in posters and leaflets, and in local community venues such as libraries, housing associations, GP surgeries, leisure centres and hospitals. Phone numbers and direct email addresses should be easy to find
- Human connection: Stakeholders suggested that there should be a balance between online and in-person contact. Human interaction is very important as not everyone has access to or can use technology. While future generations will be more familiar and comfortable with online resources and apps, technology could be an isolating factor and exacerbate social isolation. Having a person at the end of the phone rather than a recorded message is preferable and more helpful for older people
- Multiple channels: information on services could be made available in different ways such as local radio, community groups, volunteer groups, housing associations and other community activities
- Supporting inclusion: information should be made accessible for those who are non-English speakers, blind, hard of hearing, lack literacy skills, dyslexic, etc.

Potential areas to explore include:

- Helping connect older adults to existing services
- Making information about existing services accessible for everyone
- Improving links to ALISS and other online resources




Action Area 3.2 / Making Information Accessible

Planning Ahead

Participants suggested that story-telling and sharing the journey of ageing with younger people could help build understanding and empathy between the generations. It could also allow people to plan for older age and help ensure they have choice and control over the services they consider important for their quality of life. We can future-proof for our needs by knowing what questions to ask, and what information or services are available and where to access them. It was suggested that we should plan for the future earlier in life, e.g. when at school and in mid-life.

Those who participated in the engagement sessions noted that many people value their independence and want to retain this. Providing prompts, such as activity planners can encourage individual action; and toolkits on how to start a group or activity locally can help guide and give confidence to initiate activity. Keeping physically active through groups and classes could also help reduce the risk of frailty and has the additional benefit of helping participants be socially connected reducing the chance of loneliness and social isolation.

Engaging with services and other community initiatives can be preventative and enable early intervention in identifying those at risk, whether related to frailty, the need for post-bereavement support or foot health. For older vulnerable adults, it was suggested that a more joined up approach is needed to connect with and introduce them to services earlier e.g. toenail cutting is one of the first signs of things failing, therefore people who request a toenail cutting service should be targeted for other prevention services.

Many older people noted that they do not want to feel like a burden on their families or friends. Creating a care plan (such as an Anticipatory Care Plan) for the future puts the individual in control and can help avoid a crisis situation. Another suggestion was nurturing a shared or societal responsibility for caring for oneself.

Potential areas to explore include:

- Approaches to supporting a shift in mindsets to motivate people to manage their own health and wellbeing before reaching older age
- Providing useful support to help older people identify and look after their own needs throughout their lives
- Options for helping citizens of all ages understand the process of ageing and plan for the future and understand how to live thriving into older age
- Extending prevention and early intervention services to avoid crisis

You need to know what to search for to begin understanding how you need to be supported

I don't know what I'm entitled to

Things used to be really good and it raised expectations. People now need to recognise they have a responsibility to solve issues first before accessing services

Theme 4

Living In Our Community




Overview

The way that services are designed and delivered is changing. The needs of each individual are different and so the services or activities that they use will also be different.

We need to ensure that older people have access to local services that meet their needs and their desires. To do this we need to involve diverse voices in our community to help shape the services offered. Involving older people in the planning and deliver process, we can enable them to live independently by ensuring we create robust communities and safe, desirable neighbourhoods e.g. providing housing, access to transport, public services such as libraries, leisure and social activities.

Many citizens think we have lost a sense of caring in our communities. We need to encourage a culture of neighbourliness across the generations and all sectors of the community including local businesses, where embracing approaches to embed kindness and compassion can help counter loneliness and social isolation.

Theme 4

Living In Our Community




Action Area 4.1 / Caring for our Community

Intergenerational Connections

Participants recognised that activities that happen across the generations can be energising and motivating. They are particularly enjoyable where the connections are made through shared interests e.g. community choirs and reading groups with the focus on connection, inclusion and community rather than age. Feedback suggested that opportunities to share knowledge, skills and experience could help build stronger, more compassionate communities where older generations mentor younger people for example in cooking or life skills (such as communication and relational skills), and that younger people could support older adults to develop technology and digital skills. Opportunities for sharing knowledge or experiences and exchanging skills could be online and offline and be supported through Community Link Workers.

Potential areas to explore include:

- Supporting connections across the generations to build compassion and share knowledge that enhances each person's quality of life

We often talk about 'Getting it right for every child'. But we should be 'Getting it right for every adult' too!

Prioritising Dementia-friendly Communities

Dementia brings particular challenges for the person living with the condition and for those who support them. Those living with dementia need a broad range of support to live well in the community, and their needs can change over time. Support can include help remembering to eat and to take medication and they may need to be escorted shopping and to attend appointments and be encouraged to socialise.

Participants suggested that educating all sectors of the community (including young people, business owners and older adults) about how best to reduce the risk of dementia such as keeping active, eating well, keeping your brain active and socialising (alzdiscovery.org) could help keep people well for longer. Communication between services is key and Community Link Workers could have a valuable role here, for example, providing drop-in sessions at libraries. Bringing awareness to the symptoms and challenges faced by those living with dementia could help nurture empathy and understanding and encourage more kindness in the community. By addressing the needs of people with dementia, all citizens can benefit.

Potential areas to explore include:

- Options for helping communities to be dementia aware and considerate in the products and services they provide
- Ways to encourage more kindness to support vulnerable members of the community
- Options where technology could support those living with dementia and their carers.

Theme 4

Living In Our Community




Action Area 4.2 / Engaging Community Businesses and Connectors

Local businesses and tradespeople are key members of our community providing services and activities to a wide range of citizens. Participants proposed that local employees and organisations could be trained to provide relevant information and also help reach people who have not sought assistance nor used services in the past. In this way they could provide a new link to support and information that is available for older people helping to connect citizens in the community.

In developing this idea, stakeholders thought that linking with organisations like 'Trusted Traders' who vet and approve trades people, could identify opportunities for training on services available to older people and to signpost them to relevant assistance e.g. VAT-free goods for over 65 year olds, Care and Repair services, or that grants might be available to make adaptations to their home.

Community leaders and connectors could link older citizens to services and help with planning for the future. These could include solicitors, funeral directors, religious leaders, local clubs such as the Bowling Club or Polish Club, libraries, and local shop assistants. Local cafes and bars could run incentives for older people to socialise e.g. with a lunch discount or designating a space to encourage people to sit together and talk.

It was suggested that trust underpins the success of this type of activity. It was also noted that information should be made available and be disseminated through a range of information channels.

Potential areas to explore include:

- Options to engage with local businesses to create a more dementia-friendly, compassionate town
- Helping those delivering services to be aware of the needs of older people, e.g. bus drivers give enough time to enter and exit the bus, that music is not too loud, that flooring is not slippery, etc
- Options to engage with local businesses to help them be more aware of needs of older people in the community and the support available to them
- Opportunities to engage employers to encourage and motivate staff to look after their own health and wellbeing

I paid for the adaptations to my home from my own pocket. It was only after that I was told I could get a grant. Why didn't I know before?

One Saturday afternoon in Wetherspoons I saw 5 older men each sitting by themselves. It made me feel sad and I thought, wouldn't it be good if there was a way to connect them?

9.4. Findings / Cross-cutting Themes

The Cross-cutting Themes are recognized as important for the delivery of all future services. As such, each transversal theme should be considered and addressed during the design and delivery of future services.

The Cross-cutting themes are:

- Place
- Information and Communication
- Partnership Working, and
- Enablers (such as transport* and technology)

With regard to Partnership Working, a direct response to this topic has been initiated through the formation of the Reference Group, with their values and manifesto. Their continued involvement will be vital in the future delivery of services.

The Cross-cutting Themes closely map onto the Enablers identified in the emerging Transformation Programme – Internal and External Property, Communications, Organisational Development, and Digital and Data.

Descriptions of the Cross-cutting Themes are presented below.

* Transport was not explored in detail in Phase 2 as the team were informed that an independent review was being undertaken of transport in the region.

9.4. Outputs / Cross-cutting Themes

Cross-cutting Themes

Place

Where is the best place for each service or activity to be accessed? This could be a physical location such as a community venue or online or a combination of both.

What is the best place to ensure that each service provides the best outcomes for citizens?

When thinking about where services are accessed from, are existing locations fit-for-purpose? If not, could they be made to be so?

Where else can services be delivered?

What venues can we partner with?

People have told us:

- We need to create 'safe spaces' for everyone where people feel comfortable whether they are by themselves or in company
- Some of the new community buildings are prohibitively expensive for groups to use.

Ideas that have been suggested:

- We would like to see the extended use of existing buildings, e.g. care homes that could be more accessible and open up to other members of the community such as school groups.

Information and Communication

How do we ensure that communications about services reach the people who need them or would benefit from them?

What are the key messages we need to share?

What are the best channels to do this?

How do we reach those who are difficult to reach?

People have told us:

- It is difficult to find information about services
- Newsletters are a good way to connect, quarterly would be ideal
- ALISS and Well in Renfrewshire exist, but you need to know that they are there, and many people do not
- Sheltered housing often provides activities but information about them is not widely known. You only find out about activities through people who live there
- Getting information from the Carers Centre is like accessing the secret service!
- It is important to have a person at the end of a phone - not a recorded message.

Ideas that have been suggested:

- There is a need for strong public health messages around wellbeing and mental health to help with the culture change needed
- RHSCP could have a presence in libraries and other community buildings to build awareness of activities and resources like ALISS and Well in Renfrewshire
- Create a leaflet on community services and activities to keep and refer back to, like the local waste collection diary
- Introduce the range of services for older people with a 65th birthday card to every citizen
- Free introductory classes could attract people to activities and services.

9.4. Outputs / Cross-cutting Themes (cont.)

Cross-cutting Themes

Partnership Working

Working in collaboration with local organisations and individuals underpins the future development and delivery of older people's services.

The Reference Group connected to the Project represents a broad range of expertise, knowledge and experience in shaping and delivering such services.

To enhance existing services and develop new services that meet the needs of users we need to consider:

Who are the key partners to involve?

What support is needed for this?

What needs to change to support collaborative working and to enable 'true' partnership working with RHSCP to thrive?

Enablers

What is needed to enable services to be delivered effectively to meet citizens' needs? What are the transport considerations? What role might technology play? What other enablers do we need to consider?

People have told us on Transport:

- Transport is vital to allow people to access activities and remain active in their communities
- There is a particular need for transport services that suit citizen's needs rather than operate to a fixed timetable. Some participants had to leave the workshop early as their transport had arrived
- Similarly, MyBus is a limited service in terms of the distance it can travel and times of operation, it does not operate in the evenings which can restrict an individual's choice of activities
- Older people can feel anxious about and unsafe using public transport, e.g. not all bus drivers show patience and understanding that older citizens require the access step and need more time entering and exiting a bus than other passengers
- A lack of transport provision to attend community-based services can lead to exclusion.

Ideas that have been suggested on Transport:

- Bus drivers should be trained to be sensitive to the needs of older people - especially on the time needed to enter, settle onto and exit the bus safely and to activate the step to assist citizens
- Provide more accessible transport, at a time that suits citizens' needs and supports their choices, in cluding transport operating in the evenings, which is important for people to connect with their interests. Some people would be willing to contribute to the cost
- Extend the time on pedestrian crossings to allow people to cross the road in comfort
- Taxi+ services where drivers send passengers reminders in advance and offer additional assistance in and out of the vehicle
- Coordinating travel with other local citizens.

People have told us on Technology:

- Technology could be used to enable people to self-manage their health, e.g. for medical updates and results via text or online
- Cost can be a barrier to accessing technology, can it be made more accessible?
- Technology solutions that support people to live well in their own homes for longer by supporting their interests and hobbies and can give the user and family peace of mind e.g. voice activated tech and medication reminders, falls alarm and cameras
- Technology should not replace human contact but rather complement it.

Ideas that have been suggested on Technology:

- Provide older people with reconditioned iPads for free to encourage the use of technology

Ideas that have been suggested on Other Enablers:

- Could we develop a toolkit of best practice to motivate staff to use technology as an enabler e.g. remote technology solutions for people living in rural locations.

9.5. Outputs / Proposed Service Project Principles

Six Service Project Principles are proposed to guide idea generation and subsequent phases of the design process.

The Service Project Principles are drawn from the input from the User Research and the experience and expertise of the Reference Group. Adhering to the Service Project Principles as services are designed, enhanced and delivered, will keep co-design teams focused and help with decision making, ensuring proposed solutions for each of the Action Areas meet the needs of service users and align with the values of partnership working.

The Service Project Principles proposed are presented below.

In designing and delivering our services for older people:

We will… Put people at the centre
Creating services that recognise and respect people's needs by taking the time to understand their physical, emotional and technical needs and involving them in the design process

We will… Be respectful
Designing services and interactions that make people feel respected. We will treat each person as an individual and reduce stigma, e.g. addressing older people's desire for "being treated like people and not antiques"

We will… Be caring and kind
Designing and delivering services with compassion that in turn fosters empathy with service users. We do this by adopting a culture of kindness to help counter loneliness and isolation

9.5. Outputs / Proposed Service Project Principles

We will… Promote independence
Improving the health and wellbeing of citizens by designing services that are outcome-focused allowing people to have choice and control and to live as independently as possible while accessing the support they need

We will… Encourage connection
Involving the diverse voices within our communities to shape, test and enhance our services. Through deeper and regular engagement with our communities we will nurture a culture of connection to build safe and desirable services

We will… Ensure user safety
With the safety of users at the heart of the design of our services, whether online or by creating safe spaces where people feel comfortable to be by themselves or in company.

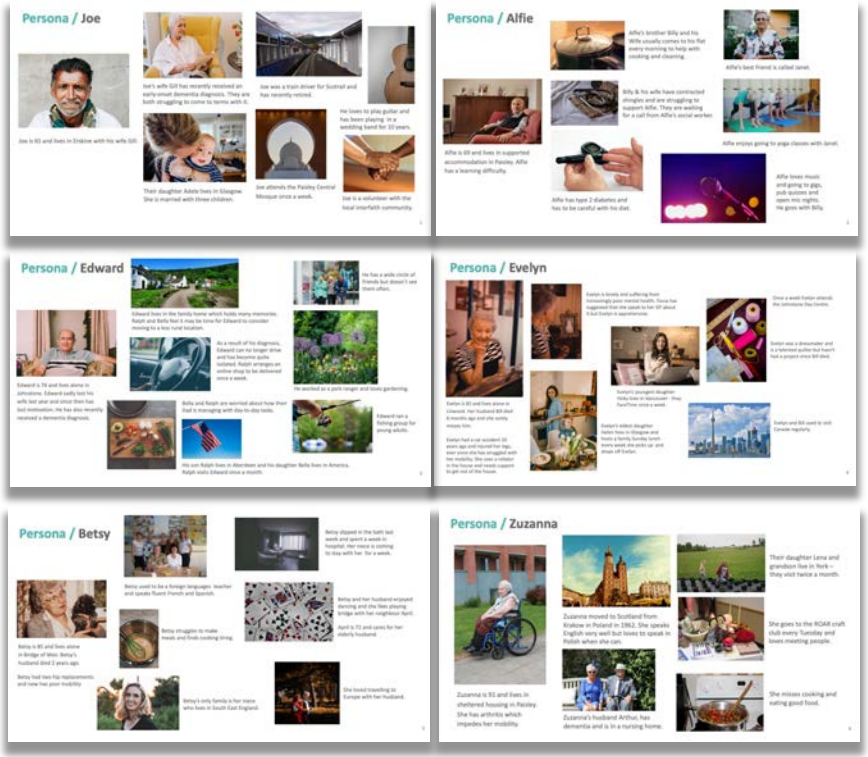
Agreeing and applying Service Project Principles is consistent with service design approaches taken by the Scottish Government's seven principles for service design and the UK Government's Design Principles for Digital Service.

9.6. Outputs / Personas

Six personas representing a broad spectrum of service users were created from the user research and desk research. They represent a diversity of user needs and circumstances related to ethnicity and religious beliefs as well as mobility and cognitive impairments.

The personas performed a vital role in the development of the Action Areas and helped participants imagine future services from varied and realistic user perspectives.

The personas are provided in the Action Areas Project Packs.



10. Output Statements

10. Output Statements

Across the Project, a number of valuable insights emerged. They are combined with the key information in the Findings above and presented as 10 Outputs Statements to guide the next phase of development for community-based services for older people. They are described in more detail below.

The Co-design Process
1 Build on the Knowledge Shared
2 Continue to Engage the Wider Community
3 Finalise the Service Project Principles

Amplified Themes
4 Mitigate Against Social Isolation and Loneliness
5 Prioritising Dementia-friendly Communities
6 Community Hub - Connect Existing Services
7 Keep the Human Connection

Suggested Actions for the Next Phase
8 Review the Reference Group
9 Reference the Personas
10 Review Title and Identity

Participants are keen to be kept informed on how the Project progresses and to be involved in future development phases. Regular communications, such as blogs on progress and future opportunities to continue being involved will help maintain momentum and strengthen the connection between RHSCP, citizens and staff.

10. Output Statements

The Co-design Process

1. Build on the Knowledge Shared: The engagement identified clear themes for exploring provision of future services through the nine Action Areas. The deeper consideration of themes in the Project brought new topics forward from Phase 1. This included embracing volunteering, connecting with local businesses and other organisations, and understanding the life journey to build empathy and nurture compassion in the community, particularly across generations. ***The extensive knowledge and experience shared between stakeholders in the creation of the Action Areas should inform future engagement and the development of person-led, community-based solutions.***

2. Continue to Engage the Wider Community: Much goodwill has been generated between citizens and RHSCP through the engagement. Co-design Team participants greatly valued it and were enthusiastic about the opportunity to be involved. They are keen to continue to do so. The involvement of older people in shaping services aligns with Scottish Government recommendations (A Fairer Scotland for Older People: A framework for Action, Scottish Government, 2019) that consultation and involvement of service-users in the development of services is necessary to ensure they meet users' needs. Potential service ideas should be piloted and tested in the local area with a view to extending their application across Renfrewshire. ***Maintain regular contact with participants, updating them on progress and involving them in the subsequent phases of developing services.***

3. Finalise the Service Project Principles: Support sound decision-making in the design of service solutions. To ensure the proposed principles are accurate, reflect user needs and desired outcomes and that no strategic priorities are missing, they should be tested and refined. This will be done by the Steering Group and Reference Group. ***Review and finalise the Principles to guide decision-making during idea generation in the Development phase.***

10. Output Statements

Amplified Themes

4. Mitigate Against Loneliness and Social Isolation: Keeping citizens connected, engaged and active was a recurrent theme across the Project. It was explicitly mentioned in seven of the nine Action Areas and suggested by way of enhancing community connections in the other two. Taking action to mitigate against exclusion, respond to life transitions which can trigger a change in circumstances, and promote community connections, is consistent with the objectives of the Transformation Programme and the Scottish Government's strategy to tackle loneliness and social isolation. It will align with the Carers' Strategy (in development). ***Ensure community-based services are designed to enable access and connection, to reduce the chances of loneliness and social isolation.***

5. Prioritising Dementia-friendly Communities: As the number of people living with dementia is projected to rise by 47% by 2035, with a projected 64% increase in of people over 75 by 2039, there is a pressing need to ensure community-based services are accessible to those living with dementia and their carers. Providing information to reduce the risk of dementia as well as nurturing understanding and kindness in the community could benefit all citizens. This is closely related to the development of a Local Dementia Strategy and Carers Strategy. ***Given the projected increase in the numbers of people living with dementia, it is imperative that community-based services are dementia-friendly, helping make them accessible to everyone.***

6. Community Hub - Connect Existing Services: There are many existing services that meet the needs of older people. However, it can be difficult to find information about them and, in some cases, they can be difficult to access. Consistent with the Cross-cutting Themes, there is a need to make sure services are available to everyone by ensuring information channels are appropriate, venues and online spaces are

10. Output Statements

accessible, and transport is available. A local community hub was suggested as a possible solution. ***Build on existing community assets and explore how available services can be centralised and accessed more easily, in parallel with developing new services.***

7. Keep the Human Connection: Human contact, in person or on the telephone, was often the preferred way of connecting for older people. It is important to recognise that while many older people are technology savvy, others have no interest in using it. It is necessary to ensure different modes of contact are available to reduce the potential for exclusion. ***Explore how future services can be designed to be personal, human-centred and accessed in different ways. Ensure no one is excluded.***

Suggested Actions for the Next Phase

8. Review the Reference Group: The group played a vital role in the co-design process, offering a depth of knowledge, expertise and experience. To be most effective, it should reflect the challenge being addressed. The composition of members, their skills and the benefits they bring to the next phase of the project should be reviewed to ensure the right mix of representatives. The ideal model for partnership working should be reviewed and agreed. ***A Reference Group with the appropriate composition of members should remain operational beyond Phase 2 and have an active role in shaping the design and delivery of new/enhanced services.***

9. Reference the Personas: Personas help build empathy and understanding and should be used in the subsequent phases of the design process. Current personas represent a range of user needs and circumstances related to ethnicity and religious beliefs as well as mobility and cognitive impairments. ***Embed personas within the idea generation activities in the Development phase to guide decision-making. They may be expanded to include other characteristics.***

10. Output Statements

10. Review Title and Identity: An engaging and relevant name should be created for the programme to help raise awareness, build interest and maintain momentum for change. ***Agree a name and identity for the Project to raise its profile and generate interest.***

Three gaps were identified in the Project that require further research and should be addressed in more detail in the next phase:

Day-Care Centres: The direct engagement of Day-Care Centres is required to fully understand the breadth of services they provide to the community and explore what role they may play in the delivery of services in the future.

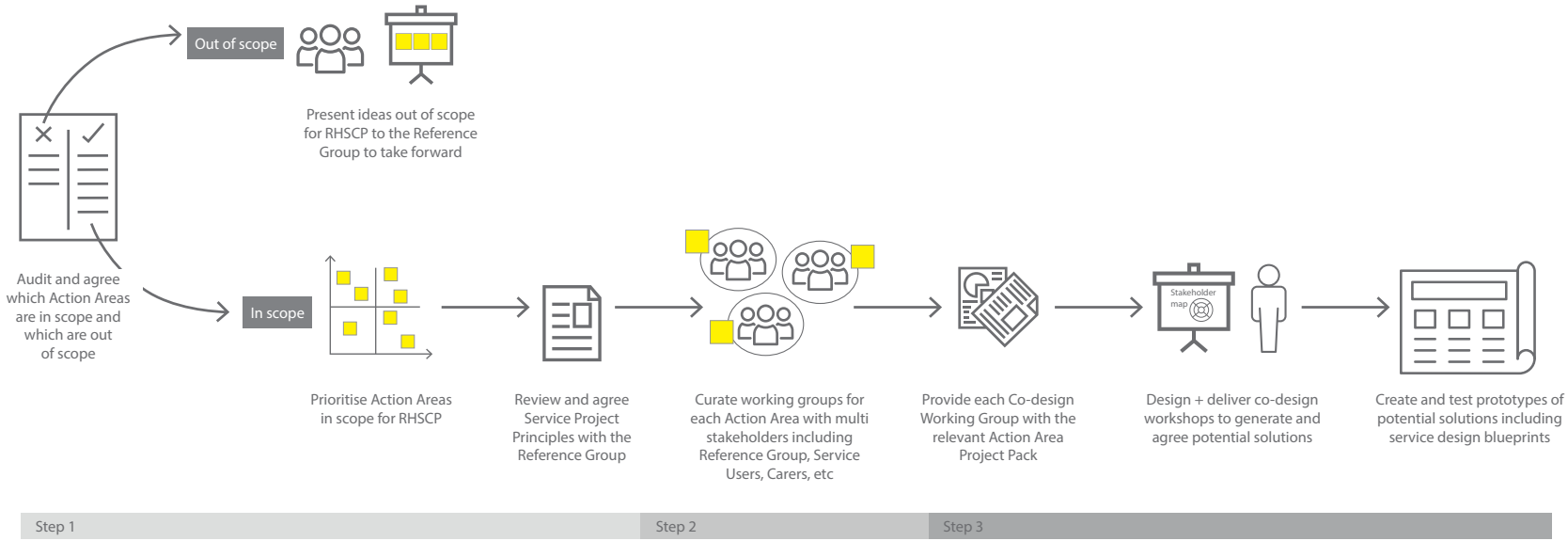
Reaching the Hard to Reach: Opportunities should be sought to directly engage with those who do not currently use services, in advance of need or crisis. This aligns with several of the Action Areas. It requires further research and the design of engagement activities with a specific focus on this group.

Transport Provision: Access to transport is vital for many older people to remain connected and to access community-based activities and services and is highlighted as a Cross-cutting Theme. Specific issues require deeper exploration to support individual choice and independence including: availability of transport options in rural areas; more accessible and friendly public transport – in particular for bus drivers to be sensitive to the needs of older people to feel safe on entering and exiting the bus; and flexibility to suit the needs of the individual. This includes in the range of transport options available and in the timings of scheduled transport to fit with activities. These considerations align with transport needs identified in other reviews including for learning disability day and respite services.

11. Preparation for the Next Phase

11. Preparation for the Next Phase

The suggested next steps, outlined in the illustration below, support moving into the next phase of the Project – Development, which focuses on idea generation. Further detail on each step is provided in the following page.



11. Preparation for the Next Phase

Step 1

Audit the Action Areas to determine which actions are in the scope of RHSCP and which are not. In the latter case, it is anticipated that Actions Areas (or aspects of them) be shared with the Reference Group members to identify possible project owners to take suggestions forward.

Prioritisation of Action Areas for those Action Areas, and associated ideas, within RHSCP scope. This will help ensure that challenges taken forward align with the Strategic Plan 2019-22, The Transformation Programme, and other strategic priorities.

Review Service Project Principles to support sound decision-making in the design of service solutions. To ensure that the proposed principles are accurate and that no strategic priorities are missing, they should be tested and refined. This will be conducted by the Steering Group and Reference Group.

Step 2

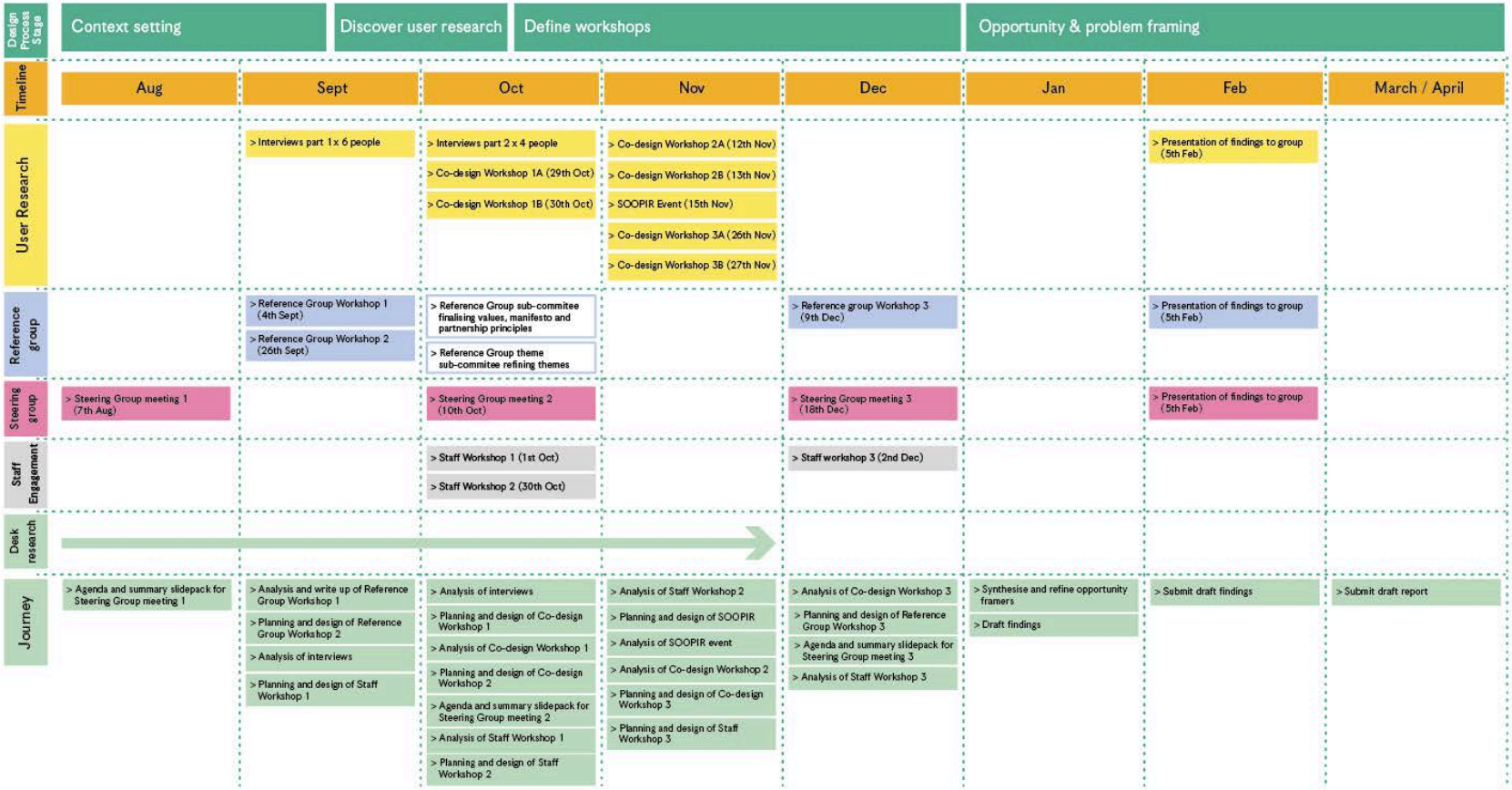
Working groups will be deeply involved in the idea generation phase to explore the Action Area and develop potential solutions. Working Groups are set up to include relevant members of the Reference Group, staff, those with lived experience of community-based services, previous participants and other community representatives where relevant.

Step 3

Project Packs have been assembled to support the idea generation phase and to build on the wealth of knowledge, ideas and expertise generated through the project. Project Packs comprise of: Service Theme overviews; associated Action Area descriptions; and initial service ideas as outlined in the final Co-design Team and Reference Group workshops. They are captured in Idea Framers and Renfrewshire Courier headlines. Supporting information is also included: Service Project Principles, Cross-cutting Themes and Personas.

Appendix

Appendix / Phase 2 Project Activity Map - Extended



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