West Lothian Integrated Joint Board

Stakeholder Engagement prior to developing Commissioning Plans 2020-2023

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Executive Summary	This paper outlines our engagement approach, activity and feedback from stakeholders within West Lothian in shaping our commission plans for: • Older People • Learning Disabilities • Physical Disabilities • Mental Health Engagement underpins our commitment to work with all health, social, voluntary sector & 3rd sector partner organisations; we employed a joined-up process to optimise service-user experience, health and well-being, with a focus on self-help, staying well, maintaining independence and prolonging the need for longer-term care.
Legislative and National Standards to Public Engagement	Community engagement and empowerment is relevant to all parts of the public sector and is an area of increasing importance, particularly given developing legislation and policies. The Community Empowerment Act 2015 requires community planning partners to secure the participation of community bodies in community planning, in particular those that represent the interests of people who experience inequalities of outcome from socio economic disadvantages and hard to reach groups. Reference to • The Social Care (Self-directed Support) (Scotland) Act became law in Jan 2013. It aims to create a fairer, person-centred social care and support system, with an increased focus on user participation. • National Standards for public engagement Voice Scotland

West Lothian Health & Social Care Partnership
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NHS Lothian

West Lothian Council

West Lothian Commissioning Plans

Stakeholder Engagement Paper

Version Control

Version	Date	Description of change and person responsibility for making change
V1	16 November 19	Draft Paper – Jeanette Whiting
V2	19 December 19	Revised

Contents

1. Introduction - Engagement and Communication Strategy

'Engagement is important to the way we work; engagement with people delivering and receiving services, results in safer and better outcomes'

West Lothian Health and Social Care Partnership is committed to transparency and meaningful engagement in all of areas of our service improvement and development of person-centred care. To improve care for people, families, carers, health and social services need to work together in new ways. This means the public, carers, GPs, hospitals, local health and social care partnerships, voluntary and wider community services need to agree joint plans to improve local care groups experience and outcomes. This includes helping people and families to plan ahead, maintain their independence by 'staying well' using preventive measures and enabling support at the earliest opportunity to prevent/reduce health deterioration, and by supporting using resources as appropriately and effectively as possible.

Engagement and communication with partners, stakeholders and public inwhole system planning, design and delivery of our community work is essential, if we are to get this right. For example, this includes providing good quality accessible information, and understanding the way to access, co-produce and engage with each care group in meeting their needs.

Working in Partnership

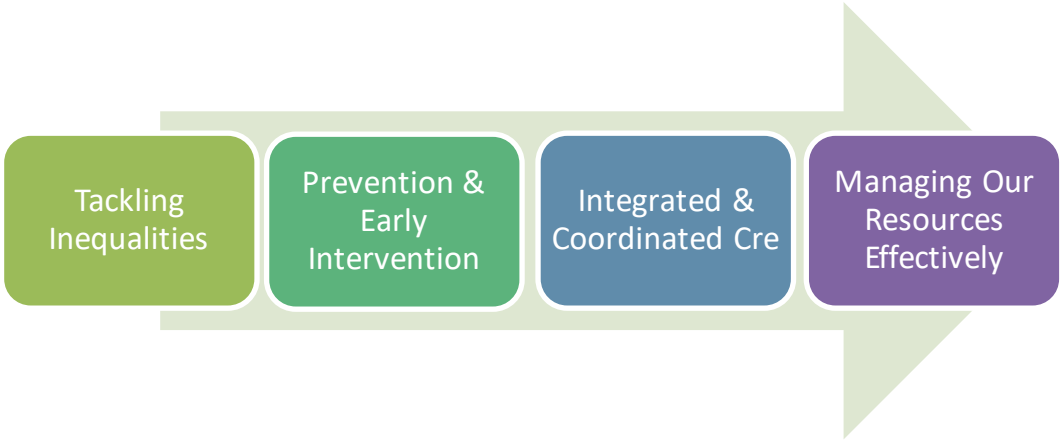
A key principle in developing robust commissioning plans is to continue working in partnership with all organisations, voluntary and independent sector, where existing relationships already in place at a local level. We shall also reach out to the wider community and organisations that could support, influence and shape the development of our commissioning plan. Our engagement activity will focus on informing, sharing, listening and responding.

Strategic Plan

West Lothian's Strategic plan has been developed in conjunction with the IJB Strategic planning group with member ship from key stakeholders including Service Users, Families, Carers, West Lothian Council, NHS Lothian, public sector partners ,third and independent sectors and health and social care professionals, staff partnership.

The Strategy aligns to the Our health, Our Care, Our Future, West Lothian Council's Corporate Plan 2018-2023 and NHS Lothian Strategic Plan 2014-2024.

West Lothian's strategic priorities extracted from the strategic plan 2019-2023 below



2. Engagement Process

2.1 Overview, Engagement approach for commissioning plans

This paper describes the engagement activity undertaken by West Lothian Health and Social Care Partnership, in collaboration with key stakeholders; public, service providers, service users, carers, families, independent, voluntary, 3rd sector and housing in relation to the following care groups

- Older People
- Mental Health
- Learning Disabilities
- Physical Disabilities

It was agreed that our commissioning leads would reach out to both internal and external stakeholders (see figure 1) in identifying areas of 'what is currently working' and 'what areas of improvement / development and or gaps in shaping our next 3 yrs Commissioning planning cycle 2020- 2023. The views and opinions gained during the engagement period will be used to help inform future option appraisals and commissioning activity during the next planning cycle.

It was proposed that each of the Commissioning Boards for the above care groups communicate and engage with both internal and external

stakeholders, to capture views and determine the priorities going forward.

2.2 Aims of the engagement

- To underpin the development of a strategy and commissioning plan for communicating the compelling vision around need for change
- To raise awareness and understanding of why it is important that the Health and social care Partnership has a plan to deliver sustainable and viable services for the next 3 yrs 2020-2023
- To ensure that appropriate mechanisms are in place so that the public, key stakeholders and partners feel engaged and informed throughout the process
- To contribute to shaping public, and health and social care staff, expectations of NHS and Social services in West Lothian
- To maintain credibility by being open, honest and transparent throughout the engagement process
- To monitor and gauge public and stakeholder perception and respond appropriately.
- To maintain trust between NHS, Social, Independent, Voluntary, 3rd sector and the public that actions are being taken to ensure high quality whole system connection service provision
- To demonstrate that the Partnerships are planning for the future

2.3 Engagement Activity

West Lothian Health and Social Care Partnership initiated a wide range of engagement activities during August, September and early October 19, designed to generate a wealth of feedback from key audience groups. The focus was to tailor the engagement activity within each care group to the needs of stakeholders.

This involved attending existing network groups, forums but also setting up separate meetings to with specific care group providers, carer and advocacy groups. The work was enhanced further by reaching out to the voluntary and 3rd sector organisations and individual meetings with their stakeholder groups both in and out of hours. A full log of engagement events can be found in section 2.3.1

The stakeholders that we engaged with in developing our commissioning plans can be seen in diagram figure 1 below

Stakeholder Engagement

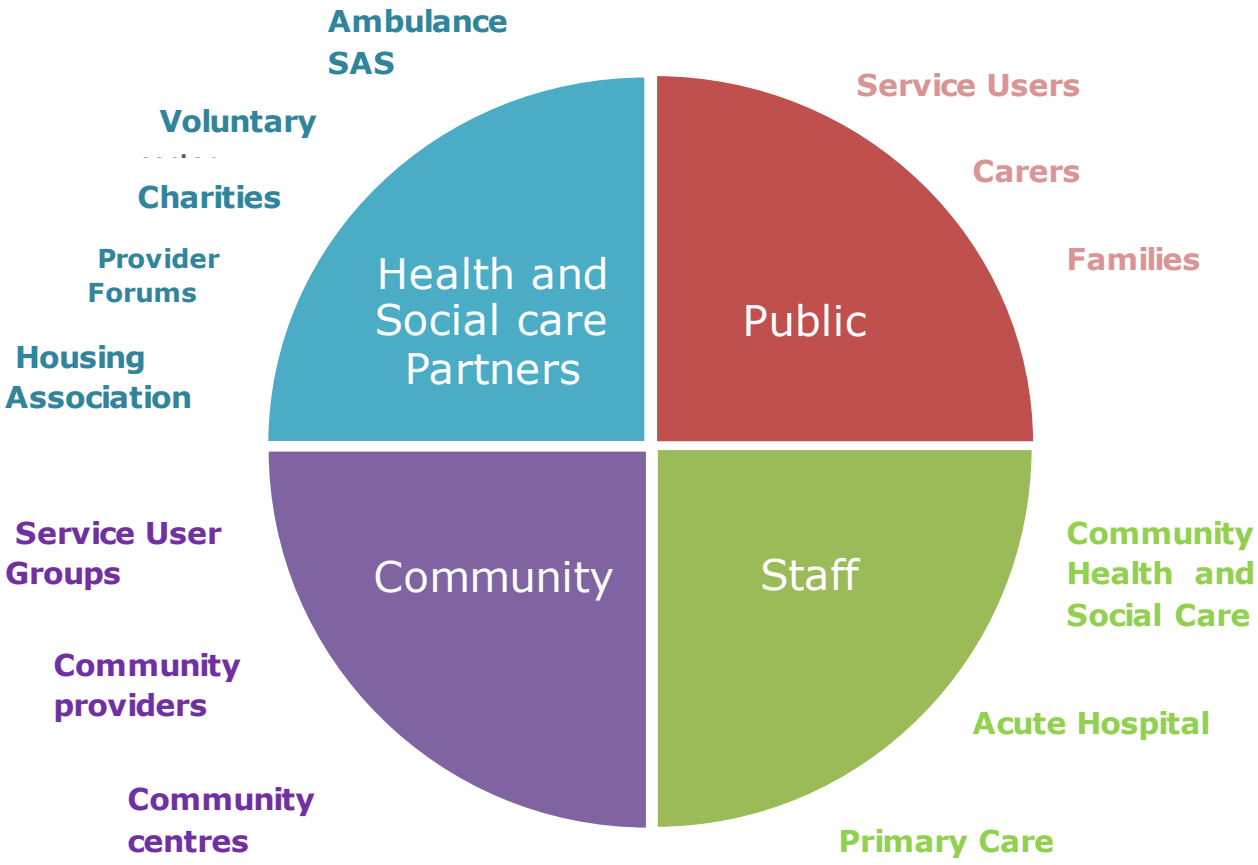


Figure 1

2.3.2 Public Engagement Events

The commissioning planning team held two public events

8 Oct 19 2-4 pm Howden Park, Livingston

10 Oct 19 6-8pm Bathgate Academy, Bathgate

These engagement events were disseminated widely through existing forums, networks but also advertised on social media ' West Lothian Council' Facebook and Twitter page. The team also ensured the event was

shared with a request to display in all the Community Centres in West Lothian.

The Howden Park event was well represented by 3rd sector mental health providers, carers, parents and general members of the public with an audience of 38 people. However the event at Bathgate was not well attended and was not help by being dark and inclement weather and attracted in the region of 10 people, parents/families and providers largely interested in contributing to learning disability and mental health commissioning plans.

Both public events were 'drop in' in their nature, with 4 facilitated tables representing the care groups and a wall area to post comments on. Attendees were encouraged to have group and or individual discussions – but also to move to other tables where they wished to contribute to the conversation or add comments.

2.2 Key Themes Emerging from the Engagement

Over 645 carers/advocates, service users, service providers, members of the public have received direct face to face contact and responded to the engagement activity. There was a significant number of people who were elderly, vulnerable, limited mobility or were living with mental health and or long-term conditions. Respondents were drawn widely across the whole of West Lothian.

Several key themes emerged from the engagement work which are outlined, below. Full details of all the responses received can be found in appendices 1-3.

Older People and People Living with Dementia emerging themes

- Dementia care and support
- Support for Carers
- Community capacity building and living well
- Integrated Frailty and Community Teams & Access to information
- Care pathways and service development
- Bed based care and support
- Palliative & End of life care
- Technology Enabled care
- Housing
- Ensuring Choice through Self-Directed support

Mental Health emerging themes

- Community Mental Health Team implementation
- Accommodation and housing options with links to rehabiliation & care at home
- Third sector /partnership working/ peer support models
- Access and waiting times for treatment
- Improving physical health
- Access to information when needed
- Further development of a transition model
- Crisis support for people in mental distress

Learning Disability emerging themes

- Transition - a Whole life approach
- Develop suitable housing options
- Meaningful and sustainable day opportunities
- Supporting carers and families
- Ensuring Choice through Self Directed Support (SDS)
- Complex needs relating to those displaying stressed and distressing behaviour
- Peer support and social activities
- Health screening
- Access to information
- Inclusive services for Autistic People
- Employment

Physical Disability emerging themes

- Supporting people back into the community
- Meaningful and sustainable day opportunities
- Supporting Families and Carers
- Ensuring Choice through Self Directed Support (SDS)
- Peer Support and Social Activities
- Access to information
- Supporting those with Sensory impairment
- Develop suitable housing options
- Development of BSL in policy
- Technology enabled care

These emerging themes have been identified as areas for improvement & development will be expanded upon as part of the care group commissioning plans 2019-2023.

Appendix 1 Commissioning Plans Engagement Feedback Log Care Group: Older People

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Third sector Service Provider Forum	12	Access, Inequalities	Local inclusive groups Age Scotland Benefits guides Access to' Help' to benefits i.e. winter fuel, TV licences, council tax, one off payment boiler breakdown etc	• Transport required to access local groups
Older People Provider third sector – Hill group	7	Prevention and early intervention		• Need to improve communication between all health , social and voluntary and 3rd sector • Increase demand on services for dementia patients • 3rd sector would like to be more involved and funded to increase preventative and early intervention work i.e. proactive wash floor to prevent fall, tackling loneliness before a person becomes isolated • Increase social prescribing i.e. Art link, Art in Hospital , linked to GP practices • Early intervention for example grow existing malnutrition education and supported intervention after leaving hospital • Early intervention – gap in ability to provide Carer respite to enable people to stay in their homes for longer • Develop intergenerational work (circle of support) to keep people in their own homes. • Exercise classes are needing to adapt to give access to people with an increasing number of mobility aids, people coming to groups that are older and with more needs • Transport issues of not being able to attend groups and strain on existing resources to provide minibus to support this group • Missing housebound older people group that the 3rd sector is unaware of or the older people don't know of the groups. Better connected Health, social and 3rd sector providers will lead to better identification of people in need. • Lack of information about 3rd sector organisations and associated groups and support can lead to inequalities in access to provision

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				• Need to map services across health, social and voluntary/3rd sector to manage person centred resources across organisational boundaries
GP Practice 2 Oct 19		Older People and Dementia	• Patients referred to the memory clinic presently receive a very good detailed and reasonably timely CPNE assessment	• Too big a delay to the consultant appointment (also very good when it happens) • We need to ensure that our secondary care colleagues are following the Shared Care Agreement re prescriptions
Sheltered Housing 4 Oct 19	30 flats	(Access) Inequalities	Social Company active in mind, enjoy actives	• Need bus service, outside toilet and paths need clearing in winter • Post office
Retirement home 4 Oct 19	31	Prevention / early intervention	Dial a bus Mobility service Livingston Opal groups Other groups Keep Bingo	• Local café to meet people • Pathway clear and smooth for mobility • Exercise classes fit for older people
Unknown – Care Home	1	(Access) Inequalities	Company meeting people and activities in Opal	
Silver Sunday Event 6 Oct Whitburn	150 Older People Attended	Care in own homes	Company meeting people and activities in Opal	• Inadequate care for neighbours currently with care commission. In-house teams provided better care than independent providers. • Questioned- what level of training and qualifications do the independent providers receive as medication had been left – *advised public that all care providers were registered with Care Inspectorate*
Silver Sunday		Integrated Care	Once a GP is aware of health conditions the care is good	• No changes suggested

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Event 6 Oct Whitburn				
Silver Sunday Event 6 Oct		Prevention and early intervention		• Not happy waiting time to see a dermatologist at SJH 12 months • GP Stoneyburn closed really impacted on Older people and young mothers with prams, challenges with buses to Fauldhouse • More social inclusion activities • Withdrawal of access to High school swimming pools 26 Oct 19 i.e. Deans- huge impact on older people group for social and exercise
Silver Sunday Event 6 Oct Whitburn		Prevention /early intervention		• Stoneyburn GP closure, bus infrequent to Fauldhouse,-steep hill from bus to practice difficult for older people • Wish to top withdrawal of swimming to public within schools
Silver Sunday Event 6 Oct Whitburn		Prevention/early intervention		• Pavements need improvement, not getting treated the way they should. Waited long time to get a chemist open in Pumpherston
Silver Sunday Event 6 Oct Whitburn		Prevention/early intervention		• Remove drug addicts in Pumpherston, concern about damage to properties • More awareness of clubs – maybe list in local papers • Key safe can have a friend/support to hold number as friend moved away?
50+ West 7 Oct 19		Prevention/early intervention		• Good few clubs, a few closed recently (disappointing) • Bins removed from bus stops (Deans road) rubbish everywhere
Silver Sunday Event 6 Oct Whitburn		Prevention/early intervention		• Currently waiting 52 weeks for Physiotherapy appointments within GP practice.
Silver Sunday Event 6 Oct Whitburn	Unknown	Access Inequalities		• Train passes cuts – feedback that service users worried as they use the train frequently.

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Ambulance Staff/ Crews	50	Integrated and joined up care		• Easier access to up to date DNACPR and ACP. • Access to patient's medical history/assessment (hx) as some patients are unable to tell us their hx /what is normal for them. At 3am there is no way of finding that out! • Emergency palliative care teams made available to treat patients at home. • Emergency care for elderly people whose carers need taken into hospital, at the moment we have to take both into hospital. • Ways for crews to refer straight to a ward when appropriate rather than take vulnerable elderly people to A/E. Also set areas in A/E for elderly people as it can be a distressing experience for them.
HSCP Community staff	25	Integrated joined up care	• Our District Nursing teams are attached to GP practices which promotes person-centred care through effective communication and well established relationships with GP's and wider Primary Health Care team • Community equipment store provides an efficient and timely supply of a large variety of equipment to facilitate hospital discharges and to enable patients to stay at home longer • Good collaborative working with the Community Palliative Care team based at St Johns Hospital to provide safe effective care	• Provision of packages of care delivered by an in-house service
HSCP Community	15	Integrated and	• Integrated discharge hub at St Johns Hospital	• Prevention and early intervention posts required, e.g. Occupational therapists based in Primary care/ GP practices - patients can get the

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Occupational and Physio therapy therapists		coordinated care	• Having Reablement located in the Integrated discharge hub makes communication easier • Having a 72 hr response to Reablement request is excellent for ESD • Quicker response by REACT and day of discharge visits • Day today communication within ward teams and within occupational therapy service • Ability to be flexible with staffing to meet fluctuating demands. • Availability of COWL on site • Good access to all agencies based in St Johns via Integrated Discharge Hub • SORT collaborates with CRABIS (room for improvement) for onward referral and have assisted with reducing amount of referrals to their service • SORT enables patient centred	care and advice they need in a timely manner from the most appropriate professional in their own local area, without waiting to be referred on. (reduce attendances at GP/A&E/admissions to hospital, increased confidence (patients and carers) and ability to cope at home) • Increase capacity and scope of role of Occupational therapist in Emergency department (OT's can immediately assess and treat people directly in the Emergency Department and determine whether a discharge directly home is feasible) • Immediate responsive care and assessment available in the community that can be tailored quickly to patients' needs. • Occupational Therapist in/linked to REACH team/linked in with early frailty pathway to improve quality of early intervention if patient is admitted to hospital. • Responsive Duty OT based at Strathbrock as tend to end up playing phone ping pong • Responsive equipment stores delivery who can also assist with relocation of furniture • Lack of information from social care partnerships especially from Edinburgh re organisational change • Develop relationship between health and social work occupational therapy services to work together on common goals • Manage public expectations through education, information • Develop REACT and Reablement services to work more closely

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
			care to occur in the home environment • SORT developed due to feedback from stroke patients • Stroke ward aiming to develop a self-management group for discharged patient (pilot study to be run - April?). Again this was highlighted as a need from feedback from stroke patients and is in line with stroke strategy plan. Aiming to also involve CHSS + potentially CRABIS, if able.	together • Support for carers – Not just training required ongoing support should be considered. • Technology – Far more possible than medication prompts – e.g. Edinburgh smart house. • End of life care • Changing environment and growing public expectations are areas that can be improved. Often left to the OT to make patient + family members aware of criteria for items such as equipment (costings / stair lift / showering items) and packages of care. Would be beneficial if there could be leaflets / TV adverts that informed the general public of these changes. If family members are educated / aware of the criteria / process this would assist with more appropriate referrals to OT being made and manage family expectations. Educating other health professionals on these changes will also ensure all patients are receiving the same, correct information. • Prevention + Early Intervention - ? Telecare / home safety service could have more of an input in d/c planning and reducing package of care needs • Integrated + Coordinated Care – at times Reablement Assessor Assessment can be risk adverse / duplicate work/ Assessment (Ax) already completed by ward therapist – more joined working / trust could reduce this. Need for Reablement assessor can at times interrupt patient flow.

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Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Community Staff	20		• REACT Hospital at Home and Rehab at Home supporting early discharges from SJH • REACT supporting complex discharges • REACT as a team works really well • REACT development in new areas such as care homes, respiratory service • Emergence of community led projects • Consideration of implementing home first	• Need a more systematic approach for identifying suitable patients as early as possible in their journey. REACH nurses are a good source of referrals, but they are limited to MAU only We need equivalent roles on the downstream wards and rehab wards, and this is needed 7/7 • Interface with integrated discharge hub can be greatly improved. • The role of the discharge coordinators is unclear. • Handover from wards can be improved. • Need clear and realistic expectation setting for patients and families from wards. • The team is increasingly stretched to compensate for infrastructure lacking elsewhere – eg. Primary care, care provision, case management, St Michaels Hospital – all without adequate increase in resource. • Need to ensure these services are sustainable • Need to promote professional growth within all members of the team. • Considerable lack of prevention and early intervention focused services, engrained culture of reactive response without any consideration of a proactive approach. • Very limited poorly coordinated and resourced rehabilitation services which are essential in ensuring better wellbeing in the ageing population. • Links between statutory and community based services required

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
				development. • Very poor integration between health and social care, overly bureaucratic processes and lack of strategic vision to ensure the best outcomes for patients. • Implementation of home first requires integration, leadership and clarity of what this term actually means.
Acute Staff SJH			Identification of Frailty in Medical Admissions Unit (MAU) by the REACH team A consultant geriatrician based on each Gen Med Ward to help with management of frail elderly patients Integrated working as demonstrated by the Discharge Hub, REACH assessment and frailty pathways	• Currently limited to MAU Mon-Fri. We need a Frailty service 7 days a week, 12 hours per day, to keep up with current and future volume and complexity of medical admissions, which are predominantly frail elderly. • This service should be extended to other wards, including Gen Med wards, surgical and oncology patients. • A Stroke Outreach Nurse to improve the stroke pathway and meet national standards of stroke care. • Regular MDT meetings currently only available on wards 21 and 25. Need this across all wards, including boarded patients. • Robust and consistent AHPs for each ward, to ensure continuity for MDT working. Social work presence would be helpful. • More consultant geriatricians, to be on par with other areas of Lothian and Scotland (per head of population) • More responsive domiciliary care providers that can provide POC on a needs basis. More stringent review of twice daily POC to release capacity. • Reduction in delayed discharges. Proactive role for the Integrated Discharge Hub coordinating the Daily Dynamic Discharge huddles on

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
				the wards. • An agreed Guardianship pathway, with consideration of alternative care arrangements for patient awaiting Guardianship rather than hospital care. • More co-ordinated approach to case management for individuals with LT conditions in community to manage exacerbation in their condition at an earlier stage. Patient client education programmes re specific disease self management • Explore further the use of technology to support specific LTC as the older population becomes more IT efficient.
			Close working with Old Age Psychiatry	• Timely input from Old Age Psychiatry team to assess and manage acute admissions with delirium, dementia and other psychiatry issues on the medical wards, in order to facilitate a plan for safe discharge. • Reduction of dementia patients admitted to hospital because of behavioural issues. More support for carers and families to enable individuals to remain at home. Increase dementia support facilities in the community.
			Community Hospitals in West Lothian	• Clarity of use and model of care for these facilities. • One geographically accessible dedicated HBCCC unit for West Lothian with the appropriate number of beds and staffing levels at the right skill mix in line with other HBCCC facilities in Lothian and nationally. • Regular palliative care input providing good end of life care for those who are unable be at home, but should not be in an acute hospital setting.

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Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Public Event 8 Oct	37	Community based review/ Carer Support	• West Lothian Social work team are excellent, very responsive. • Social workers and community care workers do an excellent job. District nurses excellent	• **Recruitment of new care staff, we are not encouraging young adults at school to go for a career in caring.** ➢ We need to raise the profile for the job, currently new employees have to pay for their own disclosure and some young adults will not have the money to do this whilst still at school. ➢ Encourage the carer's job as an entry path to the start of a lifetime career with opportunities. ➢ Make the job more attractive, promote the service more. ➢ Need more done from educational point within schools as not promoted within schools, as like other careers. ➢ Colleges have students in the carer education path working towards HNC (theory), needs to be more linked up to SVQ2 (practical training), therefore more aligned with what the qualifications required for the role. ➢ Currently cannot put young adults at 17 into a caring role, therefore many leave school and take up other positions whilst waiting to turn 18 to apply for the caring role and end up not applying as they have another job in different sector. Missed opportunities. • **Consistency of staff for clients** ➢ It is very difficult to have consistency for clients due to staff sickness/ holidays and turnover. The care provider tries very hard to have consistency but this proves to be very difficult. • **Care provider service** ➢ Care plans are set out very difficult, so very hard to support client adhoc, for example client needing additional help at time of visit. The task was completed that the carer was there for and there was time left over, the client wants you to change batteries – if caught doing this time will be cut from the agreed POC, for instance 30 minutes would be cut to 20 minutes as they see this time sufficient as the carer had time to do an additional task. Need more flexibility

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Public Event 8 Oct Continued				with contract to give best care to client. ➢ Council implementing too many changes, that it is very difficult for the service provider to retain staff, example of this all staff have phones now to log in and log of at every visit – very controlling and making the job very stressful for the staff as they are under too much pressure for very little pay. ➢ Introducing the phones also has an additional cost to the service provider, they have to currently pay £8000 a month for the phones, contracts and sims and co-ordinators to run the system scheduling for log on and log off. • **Family/ friend carers** ➢ Important to have support for younger carers. ➢ Need more respite beds in West Lothian, currently not enough respite beds – you have to book 18 months in advance…sometimes this is not feasible. ➢ Reduced day centres or day centres now too expensive to allow carers to have more time. ➢ Within East Lothian, care provider used to offer training for identified family members who help look after their parent/spouse etc. This training could be handling and moving or similar. This helped reduce the amount of care required from care provider as families were enabled to support their loved one. • **Dementia training** Need more training for carers to work with clients that have dementia, especially those that live with someone that has dementia

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Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Third Sector Charity OP Stakeholders forum	6		<u>One to one</u> • Befriending to build confidence getting out again, meet new people, be more active • Telephone Befriending providing conversation – particularly if housebound and not seeing many people • Older people have talent – showcasing older people in the community • Local groups – allowing people to get out, come together and have some fun <u>Groups</u> • Age Scotland – access to help • Volunteer Activity like OPAL • MP's do house calls • Company- meeting people at groups • Dial a bus service • Mobility service, Livingston • Post Office services • OPAL group • Other support groups available • Bingo • OPAL group - Social, company, active mind	• Shopping service to take people to shops to pick their own foods • Accessible/Affordable transport for older people • Day care facilities – costs are too high and were a place to socialise people. Get out for many older people • Lunch clubs – many older people mention it would be nice to get out and have coffee and food • Transport • Need more communication about events, services, activities – TV and local radio campaigns • Leaflets for those who can't get out • Advice shop visits to support form filling • Taxi cards/dial a bus re-instated • Difficulty accessing by telephone • Pavement clearing in bad weather – consistent throughout WL • Local café to meet people over tea

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Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Public Event 10 Oct	1 (representing friends from Opal)			• Consider how we can access housebound older people that aren't aware of services and social provision - Can this be shared through the WLC Bulletin to each household – i.e. section on news from 3rd sector/voluntary – only have access only a care plan is initiated - Also consider connections circular within WL - Use of GP practices, chemists to share 'what is going on in community - Only OP who have accessed 3rd sector organisations are known and invited to future events thus missing a huge number of OP that are isolated at home without access to the community. • Need for more sustainable transport to get people to groups i.e. Opal provider transport for people who know about their groups if more people were aware then the transport would be over capacity. More funding for additional minibuses to access groups by Older People. There was reference that OP would be willing to pay a small amount to support transport costs i.e. 50p per trip • Need to increase the number of volunteers able to drive Op to groups • Wish to see housing developed involving OP in the design and preferable to have individual private housing units with wrap around model of support as the needs present to allow flexibility in increasing and decreasing support. • Consider including a telephone number for future public events for more information
Third Sector Charity stakeholders	10			• Increase the number of advice shops and additional support with completing forms- took 5 days to complete form for someone with MS • People are unaware of services that exist • 10 mins care visits insufficient to meet needs of older people, time to chat to be built into care plans

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
				• Reference to training for dementia for care at home providers as they are taking what dementia client says at Face value • Older people need a service to take them to the shops, described lack of connected communities and access to public transport at a reasonable cost to older people • Dissatisfaction with the closure of day services and the un affordability of attending these services • Positive discussion about the need for more intergenerational working and initiatives • Joint working i.e. police and WLC on keeping communities safe from dangerous sex offenders • Develop trigger support mechanisms that ensure services are linked to other services as need arises i.e. not taking inhaler noted by care at home link to District nurse and to 3rd sector where appropriate to holistically support someone • Develop an understanding of what other services cover i.e. shopping, housework, befriending etc • Knowledge and awareness of power of attorney at an earlier stage.
Third Sector stakeholders and volunteers	17	• Access and joined up care		• Directly affected by contribution policy – care and cost for visits to be found by older people – 2 hr visits being withdraw will lead to further isolation and more pressure on carers • Need customer point of contact into health and social care system • Need to build network of voluntary organisations and networks ‘ going to neighbours to help’ • Increase the number of volunteers within West Lothian – coordinated volunteer recruitment campaign by 3rd sector – approach large businesses i.e. Sky to support, radio grapevine local radio • Education in primary schools to develop ‘intergenerational’ initiatives to develop community connectivity, networking, capacity and resilience i.e. write a letter to an old person • Introduce an adopt or sponsor a ‘granny or granddad’ scheme

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
				• Introduce TV afternoons in community centres • Concern about people being a prisoner in own home following operation and having to navigate steps to their house • Need a service to change beds and small jobs around the home i.e. bed moves – miss the old care repair contractor • Need for first responder training, how quickly would community respond if an ambulance wasn't called • Interest in developing an holistic ' Out to Home' package from hospital to include (Assessment, food, check heating is working, check power is on, contact NOK, keypad etc)
HSCP Social care team	19			• Significant gap in ability to provide personal care for palliative patients. Previous Palliative team within domiciliary team provided short term support for EOL this dedicated team for short term care in now not in place which means that all service user groups are using the same resource which has impacted on the ability to provide flexible short term personal care • Concern that Marie Curie can only offer 7 day EOL support but there are challenges to extend this when required putting further pressure on the system • Breaks from care (often referred to as Respite) Need to define respite in terms of need and risks. Currently 5 beds available within WL – current challenges with restriction on types of service users suitable resulting in our of area placements. Whilst these beds where appropriate a few years ago there is a need to review these beds in terms of access and demand needs of service users and models of care - also explore whether sheltered housing and care homes can be used differently. Noted that the system has lost Westport (Bield) for short term respite • Suggestion that co-location would significantly help the team in setting up care in the community – Care Mgt team in Bathgate, reablement and community OT in Strathbrock with DNs being central, unaware of changes (staff aligned to what area) unknown community capacity-

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
				significant time spend telephoning emailing leading to delays, 'lack of real time conversations' but too often not being in a position to put care in place. • Challenges with existing processes- Care Mgt team often given 2 days notice to provide care package – need more whole system robust response • Opportunity to develop holistic integrated palliative care assessment • inc (DS1500) Health/Social/ Marie Curie and other 3rd sector
Housing Association Forum providers	12			• Acknowledged near for understanding the needs for main stream and specialist housing for the future older people • Recognise emerging needs for bespoke support from 24 hours to wrap around support for individual needs whilst maintaining independence as much as possible • Seeing a young group 55+ requiring affordable accommodation with complex longer term needs • Initial work with dementia and adapting environment has been tested by West Lothian in Rosemount gardens • Faced with challenges of recruiting and retaining staff to deliver care within 20mins if and when required. • Need to develop the infrastructure, model, evidence and demand before considering how to respond to housing/care need • Need to consider flexible models in the future that take into account of differing physical and mental deterioration within joint tenants • Acknowledge that majority of older people are entering into affordable housing at an older age which is presenting more complex long term conditions and adaptations to manage • Need to consider how technology can support housing developments in the future
Third Sector Hard to Reach	5			• Access to services – linked to self service at GP, language barriers to access, cultural training needed to mainstream services • Benefits system – process is distressful, demeaning

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Groups				• Participation – real opportunity to have voice heard and shape services • Social Isolation – challenges to engage, need to be culturally motivated and language barriers. Need to support carers at an earlier point
West Lothian Senior People Forum	15-20			• Strong feelings about the increased costs to carers to provide day care with the rationalisation of day places in West Lothian. Cited examples such as home gardens charge for the service and people can't afford this. The rationalisation was linked to the usage of the existing facilities. • Discussion about older people being proud and their mindset not being aware of the benefits and services available to them. Need to raise awareness through GP practices for Carers and relatives as this is a well known access point. • Need to consider how to access older people, suggestion of a mobile app and locator tool although helpful – there is a need to access this group through more traditional methods i.e. written- one size doesn't fit all. • Notes that GPs in Craigshill used to provide a circular to about 9,000 people but the vast majority don't • Need to education and generational work i.e. Artwork in the library – collaboration between offbeat and art generations • Another area of good practice of intergenerational work is the 'forest groups' making charcoal inter generational coming together • General conversation about the need for early intervention, not being afraid of condition and focus on the individual need for positive recovery. Older people to integrate and build and expand support around geographical zones and communities
Dementia Early Onset Service Users and Carers < 65yrs	10			• Referred to old age psychiatry despite being younger than 65 yrs – - Had brain scanned but had to fight to have sight of the doctors report, which signalled that the person shouldn't be driving – financial challenges with working employment resource allowance without diagnosis - One person waited 6 months and another 9 months for a link

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
workshop Dementia Early Onset Service Users and Carers < 65yrs workshop				worker and about 3 months for Alzheimers Scotland, links to Community psychiatric nurses, Carers of west Lothian and food train - **Once they received a link worker the service both NHS and Alzheimers was great** - Received a service user/carer pack of Dementia information about local services – this resource is not targeted to the under 65yrs who have family members working – **They would have preferred a link worker visit within 1 week of diagnosis –** family in turmoil processing the diagnosis and the information in main not helpful at that time - Had to seek a review of medication the appointment was not automatic? Needed to go back to GP as person appeared to get worse with medication - One Carer stated that she had received a copy of letter sent to her GP re diagnosis - One Carer had to stop working and move home within 6-8 weeks of diagnosis due to rapid deterioration and felt access to a link worker immediately would have been helpful. - The Carers all felt that access to established peer support networks at each stage of illness would be invaluable – often linked to others much further in diagnosis which doesn't reflect their day to day challenges ie one person diagnosed continued to actively play golf and feels this has slowed the process down and is still driving - Information packs are pitched at someone with advanced dementia- need to be more specific to the needs of an individual (person centred) - The service users interviewed were really keen to take part in research/trials. One service user was recently involved in a trial at Ninewells hospital this has withdrawn. It was suggested that Scotland should be engaging in research on dementia with other countries ie research for dementia consortium?

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Dementia Early Onset Service Users and Carers < 65yrs workshop				- Discussion about the benefits to own or have links to a dementia dog - Many views about the need to maintain as much independence as possible ie walk to local shop and preventing loss of confidence - Challenges with accessing dementia day ops to enable spouse to continue working – recent SDS changes had resulted in one of carers waiting over a year to be awarded 4 hours break but still awaited access carer budget (Processes in Social worker too slow, lost paperwork and multiple assessments over telephone and 1-1) - Significant waiting time for community OT to assess need for a wet room to shower person with Dementia - Went to 6 week group – a lot pitched at older people. <u>Key areas for improvement</u> - Responsive link worker – start within week of diagnosis - Dementia service to be more joined up, right information/pack at the right time linking NHS and 3rd sector - Improve the time delays between assessments - If an information pack is shared there should be one for under 65yrs and one for over 65yrs - Social teams to have more knowledge of assessment times and Carer entitlements and be clear and transparent when undertaking an assessment. - Need to find a balance between future planning and managing needs of the service user/Carer at the point in their journey post diagnosis. - Flu jab to be offered for Carers that are not in the vulnerable group - More communication, not send a letter with a diagnosis prefer face to face conversation - Education for the professional workforce on the needs of under

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
				65yrs with dementia diagnosis – keep focus on social aspects as the majority are generally very mobile.
Dementia Service Users and Carers >65yrs workshop	12		Service User • Attending group 5 Sisters café/ enjoyed chat with **students/ inter-generational involvement important to feel connected** • Peer support • Being out and about and going to things • Advice shop good at supporting filling in for benefits • Good support in times of illness when wife was admitted • Prefers dementia café to normal café • Enjoy the Alzheimers scotland afternoon tea and chat	<u>Service User feedback</u> • Experience fear and anger (don't want to!). If can't answer question then leave situation as this makes me angry - Often stand there 'like a lemon' • Family and Friends don't understand dementia – 'how do you put up with them' hurts Carer • Worry about spouse as they are doing too much • Like to say that 'they are Ok to spouse (but not ok!) • Driving simulator – had to use automatic and not manual at test – challenging if unfamiliar with automatic car 'Worse thing took driving license away' – driving assessment not explained properly, Japanese care and traffic horrendous - didn't know what I had done wrong! License removed in a very unsupportive manner • Felt it was good to provide feedback without Carer/Spouse • Unhappy with doctor for sending letter to DVLA which activated an driving assessment – upset and anger – used to get out – Holidays main thing to look forward to as lost so much – don't hide dementia but results in many responses from others • Information sometimes ok other times too much, depends on the doctor when information is given • The post diagnostic support link was a total stranger • Challenges with different doctors and there support with completing the

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Dementia Service Users and Carers >65yrs workshop (continued)			Carer Feedback -Peer support -Lots of information – but could be simpler -Caring Café Linlithgow monthly Boness Dementia – Falkirk are excellent	forms for benefits • Difficult to join a pre-formed group – try and bring new people together at the same time groups need to share experiences of people at each stage of their illness Carer Feedback Experience 1 - Post diagnostic worker did ask how he was,' when asked what the support worker thought- she stated that the spouse lived with him', focus on life story book and not the person Felt isolated when PDS finished – 'feel very alone' Referred to Carers of WL – not heard Barriers No contact from Carers of WL – not joined up Can't drive Don't do face book /internet Meetings too early in the morning If person with dementia deteriorate call GP – 7/8 weeks wait for social care assessment. Experience 2 4 yrs since diagnosis 6 week peer support group (Alzheimer Scotland / OT) – valued – information, lawyer, social team etc Need to offer peer support immediately PDS should have a link worker visit within 1 week of diagnosis instead of information as it is too much to process just after diagnosis Would like an option to delay PDS until needed as person cared for remained well – visits a waste of time at that stage – need help now 4 yrs on No consistency – link worker off sick for 4-6 months in the middle of PDS

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
Dementia Service Users and Carers >65yrs workshop (continued)				support with no replacement <u>Experience 3</u> Spouse became unsteady (unbalanced) – assessment for handrails – Council put in the cheapest steel rails (when wet slit, when hot burns , and cold freeze – Sister within another council area was offered rubber rails for a contribution – happy to consider contributing to the cost if given a choice – no choice offered? Care line used to be free – now has to be paid for – choice- but risk if this isn't taken up <u>Experience 4</u> Memory Clinic 4 hr assessment – daughter CPN and asked allot of questions Scan decided not to scan - diagnosed Alzheimers on that day. – Would have been helpful to see a scan as it would help family process the diagnosis – why do some people have scans and offers not? Medication gave 'Mum very bad headache and her condition didn't noticeable improve with medication <u>Experience 5</u> Diagnosed 1.5yrs ago Initial GP didn't listen – never looked up at patient Changed GP referred to hospital – stopped test half way through 2 month wait from GP to memory assessment clinic Then wait of further 5 months for a scan Diagnosis of Alzheimers disease via letter Return to GP to adjust tablets – didn't notice any difference – now declining Feeling frustrated as no support now available post 1 yr Concern expressed about the withdrawal of day care opportunities – using attendance allowance and family topping up – council invoiced for more

Engagement Feedback form	Event Representing number (s)	Themed Priority	What works well	Suggested areas of improvement
				than the person placing directly into day opportunities. Essential for family as daughter works. No support in evening and weekends for respite to allow family to be out for the evening – respite for evening deemed a priority for family - need a sitter -Informed by Carers of west Lothian that there are 5 respite beds in West Lothian -Links to financial assessment – cost more for a package of care from the council – cheaper to pay privately – not offered SDS option -Spent days trying to speak to social care team – not responsive **-Blue Badge** – received form can't be signed by GP to support person with dementia – took to psychiatrist never seen this form before. Council rejected application because a section referred to 'see above' Psychiatrist then crossed out section and didn't initial change and again rejected – very frustrating Wanted to appeal decision but criteria doesn't fit people with dementia – some people getting if adding mobility – need consistency. <u>Carer Priorities</u> Different caring relationships – need respite at right time, someone you can trust When you ask for respite you need an assessment quickly to prevent the carer role breaking down – can't relax and can't go out. Social support as Carers feel shut away from people Need help at later stage of illness – not at early stage - roles have reversed with person suffering from dementia calling daughter mum Need links to befriending

Appendix 2 Commissioning Plans Engagement Feedback Log Care Group: Mental Health

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
Engagement Event Howden Park 8 October	Total number at event 37 8 people participated in Mental Health Discussion Including Third Sector providers	Access to Information Accommodation & Housing Review Peer Support and Natural networks Transitions Across All Ages Develop Community Mental Health Teams	Willingness to engage by HSCP	• Provider Framework driven by activity i.e. hours and not outcomes • Identification of people with mental health required support for employment not traditionally access to Job Centre • Greater flexibility in the commissioning response by exploring different models of commissioning • Individual and collective development with/ through a commissioning focus • Use case studies to illustrate the potential of an individual and collaborative approach • Supported Accommodation post discharge unknown demand • Variety of opportunities and supports • Peer support through sharing interests and purposeful activity • Greater emphasis on individual potential and capacity • Prevention such as support for teen mental health in schools- funding withdrawn service mainly delivered by volunteers (feedback this to children and families) • No Mental Health provider forum or service user forum need to identify gaps • Focus on young people in transition • What is the need /demand across mental health tiers • Crisis care a lack of support or links to voluntary sector

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
		Crisis care/support Prevention/early intervention		• Need for more social prescribing • New models of commissioning whole system Health/ Social Care and 3rd sector • Impact of eligibility criteria and contributions – against aims of prevention and early intervention • Circa 25% loss of referrals – where are these referrals? • Reduced referrals to voluntary sector • Links to other community focus e.g. fitness, angling, woodwork etc. • Current commissioning models are failing • Natural connections and opportunities • Greater opportunities for joint working – case studies create examples and stimulate ideas • Strength based approach – linked to strengths of other organisations • Organisations being clear about what they offer • Map of existing services but how do we share practice and purpose? • How to set up forums to identify capacity and resources in other organisations • Interesting model in Dundee around housing fair community model • Robertson Trust – investment fund tests of change • Community opportunities are getting less and less • Offer a platform for ongoing discussions to enable sharing of information • Illustrations of what people have done and how they are sharing examples • People going through PIP process can be stressful • Not enough options for holistic opportunities – many fewer opportunities now
Public Engagement event 10 October	Total number at event 7 3 people participated	Accommodation and Housing Review		• Long term plan for Barony developing estate across the piece • WL Housing Partnership new builds due to completed in 2021. Opportunity for core and cluster with common areas and amenity provision

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
	in the mental health discussion including Third Sector Providers and HSCP staff	Access to Information Prevention /Early Intervention C & YP Mental Health Prevention/ Early intervention	Almondale Hub Health in Mind over 55 project Wellbeing Hubs a positive development	• Barony keen to replace 3 accommodation services to core and cluster • Consider structural issues to support this e.g. Broadband in housing developments as part of the infrastructure • Mental health/social delays in Acute Hospital not just MH acute • Develop Contact Point for adults with mental health issues based in community • Peer support prevents people from reaching critical and substantial and accessing service • Falkirk Framework unifying commissioning cycles • Children and Young People's Team only available resource. • WL Youth Action Project counselling service is the only service. • Referrals rejected by CAMHS suggest C and YP team first (pass this on to C and Families) • Gaps for older people as age limitations for Hubs
Adult Social Work			LAMH as a provider. They are outcome focussed, adopt a pragmatic approach to support LAMH has good management	• Increase in number of referrals for self-neglect/ hoarding. No pathway to manage the complexities of these cases. The practise is usually to be managed under ASP given the risks however it is becoming more evident that this approach does not offer any benefit

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			leadership. There has been some good example of multi-agency working within the team. SW staff has found addictions model/ service beneficial for clients and offer good communication with staff.	and service users find it too restrictive. • Supported accommodation – consensus that current contracts are not suitable to support the needs of the current client group. • There is a gap in service for clients who have complex needs and would not manage in current supported accommodation provisions but do not require specialist care placements. Some of these clients have long hospital stays as a result. • SW tends to offer more crisis intervention work (especially via duty system). Agreement by staff that early intervention work would be beneficial to client group, especially Personality disorders
ACAST nurse led service provide unscheduled same day MH assessments			70% of the mental health referrals within the ED are returned to the GP. ACAST offer a least restrictive option of care at home as an alternative to hospital providing intensive home treatment 7 days a week. Recent increase in establishment of the multi-disciplinary team In reach into Ward 17 to support early discharge	• Current waiting times for all other community follow up i.e. CPN / OT/ psychiatry /drug and alcohol services • Consultant input/ sessions • Inappropriate referrals from GP and ED due to lack of other mental health services
HSCP staff business support		Access to Information	Multi-Disciplinary Teams working together to deliver services. i.e. Community Wellbeing Hubs	• Better resourced Admin support for teams such as CPN & CPNE's • Development or use of existing Mobile Apps for CCBT and similar therapies such as mindfulness • Accessible up to date data base
HSCP community mental health staff		Supported accommodation	OPD 5 Nurse led clinic has been established to help manage the demand for psychiatry outpatient activity helped reduce waiting list	• Supported accommodation/housing • Reviewing all supported accommodation placement currently provided and funded in West Lothian include a review of out of area placements.

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
		Early Intervention/ Prevention	Community Wellbeing Hubs The Brock Garden, Woodwork and Craft Centre. It provides training and experience in woodwork horticulture and arts and crafts.	• Redesigning community services to form two (East & West) Multi-disciplinary Community Mental Health Teams (CMHTs). This will enable the delivery of a more person centred and holistic model of care treatment and support for each patient/client who needs these services due to the complex nature of their Mental Health Condition • Physical health for people with long term use of neuroleptic medications focused review of the physical health care needs of this client group.
HSCP Staff MHO service		Supported accommodation	Advocacy Services – good relationships with advocacy services although some issues related to available advocacy resources being able to meet demand. MH Act Administration – good quality service and good lines of communication from MH Act Administrator at St John's. Provision of Duty MHO Service – Day-time on call rota to address requests for MHO assessments continues to provide flexible and responsive service.	• Lack of integration between various service areas, Adult MH, OP MH, LD, CAMHS – suggestions made around 'ageless service • Lack of appropriate supported accommodation provision in West Lothian to meet the needs of a core group of patients/service users resulting in bed-blocking, costly out of area placements and pressure on existing resources • Significant issues for recruitment and retention of MHOs in West Lothian, inefficiencies in model of work and challenges to meet statutory requirements on an ongoing basis. Review of service model would be beneficial. • Lack of incentive and career pathway for social workers to encourage MHO training and retention of MHO workforce. Review would be beneficial. • Recruitment and retention of Consultant Psychiatrists/Approved Medical Practitioners leading to reliance on locum cover which can leads to inconsistent and poor quality care. • Lack of provision of a Duty Consultant/AMP rota leads to use of Emergency Detention Certificates during day-time hours which impacts on detained patient's rights and leads to multiple assessments, inefficiencies and duplication of work.
HSCP staff			Occupational Therapy staff are	• Current group service is limited however with recent investment this

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
OT community/ outpatient			flexible and keen to look for new ways to deliver service in this area. There is an enthusiasm for development of a variety of group interventions. Recent additional funding to provide Occupational Therapy in Wellbeing Hubs and also in new CMHTs will enhance opportunities for multidisciplinary approach for patients referred to these services Occupational therapy approach closely linked with the ethos of recovery	will provide opportunities to enhance the interventions available for patients referred in the future through CMHT providing an occupational focussed service. • Increase opportunities for supporting people to access and retain employment and be active part of society/ build the skills required to engage in meaningful occupations, education and employment
HSCP staff OT inpatient			Addition of OT post in ACAST Physiotherapy input at Pentland Court has been of great benefit in promoting movement and physical exercise.	• Frequent admissions of a number of patients. Could address this by co-ordination of the delivery of interventions and inclusion of relapse prevention plans
HSCP staff OT Older Adult		Early Intervention and Prevention	Addition of Occupational Therapy post to WELPAT and OPCMHT has enhanced the opportunity for timely multidisciplinary working for this client group Close professional links with OT colleagues working within elderly service, having regular meetings as a team to improve service delivery and continuity of care within elderly.	• It would be appropriate to have some sort of group for the elderly with the aim of keeping well? So the people going to the group does not necessary have to have a diagnosis, it would be a group to discuss a bit about mental health promotion and to self-manage…along the lines of early prevention • Early intervention at post diagnostic stage for Occupational Therapy to facilitate early teaching of strategies for cognitive decline • Having a designated physiotherapist input for ward 3, with specific time allocated to spend on the ward, (which is already implemented

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			Group programme delivered on ward 3	on ward 17, ward 1 and Pentland Court) could increase the opportunity for more timely and in-depth interventions for the elderly inpatient service.
HSCP Staff MH rehabilitation Pentland Court			Multi Disciplinary and Interagency working	• Some patients are admitted to Hospital from their own tenancy where they live alone, have no or limited family contacts, accept minimal support or decline it altogether from service providers. When admitted from home it is secured but in many cases not checked. If admission lasts a lengthy period conditions within the house can deteriorate to the extent whereby it becomes temporarily uninhabitable. This can delay discharge for up to several weeks and have a financial cost especially if a deep clean is required. The suggestion is that on admission to Hospital a home visit should be carried out at the earliest opportunity to assess conditions. It is recommended that a comprehensive Home Assessment checklist is used to ensure that all aspects of home living is checked including; Tenancy details, Utilities, safety factors/ hazards both internal and external, condition of building and contents and bathroom facilities. Issues highlighted can then be dealt with promptly ensuring that on discharge the patient has a habitable and fully functional dwelling to return to.
HSCP Staff Inpatient ward			Management of inpatient beds within west Lothian. Patient flow is at a level of average 50 admissions and discharged PCM. This is reflected in our strategy to manage local patients locally. We have input from various AHP including now psychology for first time in order for our acute patients to receive 1 to 1 psychology whilst in the ward to aid a significant recovery	

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			and longstanding recovery.	
Mental Health Advocacy Project Community Representatives Group	7		The OPD5 drop in works well. Keyworkers at Strathbrock usually works well. Pentland Court works well I like support from my keyworker, they encourage me and provide emotional issues.	• A&E needs to be improved and a CPN should be available at all times (24 hours a day) • W17 staff need to be more involved in patient care – hard to see keyworker. • Getting help when you have a severe in illness e.g. not dressed for the weather, chest infection • Consultant appointments are not working, I haven't seen one for over a year. • I waited a year and a half so I use the drop in at OPD5 • Consistent keyworker would help I have had 6 in the last couple of years. • Need more Pentland court type service • I didn't get into hospital when I needed • Better supported housing – some people have to leave West Lothian - leaving friends, supports and family – very difficult for people on top of illness. • There are people who were in Bangour Village Hospital who are in Pentland Court how can that be? • I went through a PIP assessment with a keyworker I didn't know and it didn't work out – I did the form on my own with the Advice Shop and lost my PIP. I was so anxious and disturbed I didn't answer properly, didn't tell them about my symptoms – I hear voices. I lost my PIP and now having to go through an appeal process – very stressful , I started drinking and now getting help from WLDAS – they are very good but that could have all been prevented. • Difficult to get GP appointments – sometimes have to wait weeks • NHS Lothian should get the money to West Lothian! • ACAST didn't work for me, I felt interrogated, I was up to high doh. • Don't know who to phone out of hours, would be helpful to know better what options are so providing helpful information could be improved.

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
Bathgate House Service User Groups between 7 October and 17 October 2019	42		• Enjoy coming to Bathgate house drop ins, feel it is a chance to meet people, see different views and feel that they are in a safe environment • Enjoy the walking group, the men's group, the music group • Generally find the staff very pleasant • Works well (Step Out) • Having the opportunity to open up at Step Out is great for making that first step • Good having a place to be listened to • Support to get out of the house and have someone listen to you and not feel alone • Having groups to attend long term • Being able to trust and feel safe in a group • Confidentiality • Lack of judgement • Using different alternative therapies to find out what works for you • Feeling of progression	• Would like more services for people to get on outings and to have more choices • Would like more social events at Christmas e.g. used to go to the bowling club for a meal and a disco • Would like more recognition that mental illness is not like a physical illness as mentally ill people do not always look ill • Enjoy local walks • Would like more convenient bus routes or provision of taxis to make current services accessible • Would like more groups such as a group for card and board games, computer groups, local interest groups, quizzes and sports groups • Would like to get input from the college • Would like outings with staff such as the cinema, theatre, transport museum, safari, butterfly farm, bird sanctuary, Museum of Childhood • Would like more groups to be based in Bathgate • Would like easier access to services • Would like more outings, used to go to the theatre, cinema, out for meals • Previously outings were 2 or 3 times a year with choices but these have been cut • Would like night groups: Burns night, bingo, quizzes, movie nights etc • Seeing different psychiatrists results in repeating yourself • People are being over medicated when they could be making improvements through talking therapy • GPs just want to write prescription straight away • Treatment could be more person centred • Nowhere near enough groups, Step Out is one of the only ones and it is voluntary • Not all are suitable for Step Out e.g. people with anger management issues

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			• Sharing experiences • Easier for attendees when the facilitator is a volunteer • Feel more like a normal person after attending the group • Would be lost without the group • Talking to others is the best therapy • Works both ways – you get out what you put in • General good points • Finding the right psychiatrist • Consistency - seeing a familiar face as opposed to a changing constantly Good points (about Step Out) • Very efficient group • Would not get out of the house otherwise • Gets things done • Everyone supports one another • Don't all suffer from the same issues but feel like they have all been in the same boat • This is more of a support group than others In other groups you have to	• Not enough CPNs • Time between appointments with psychiatrists • Receptionists asking for details for appointments – this puts people off of phoning for appointments and causes mental health to get worse without seeking help • Mental health service users are easily mistreated as they are less likely to stand up for themselves e.g. one service user said she cancelled a psychiatry appointment due to having surgery and was told she would be sent out another appointment but never was • Different psychiatrist every time is like starting again every time • Some psychiatrists don't live in the real world • Feel there is no support out there • Groups and organisations are not advertised • Having to travel from Polbeth to Carmondean for the only group available • Step Out is vital but difficult to get to, attendees rely on one another for lifts etc • No continuity with psychiatrists/locums – do same things over and over again and feel like they don't read their notes • Some psychiatrists are good, some terrible, one asked an attendee "Why are you here?" "What is wrong with you?" • Would be good to have a group for advocacy in St Johns Problems/limitations • Rely heavily on a group run by a volunteer Nothing to fall back on if Marilyn gets ill Marilyn tries to coach them not to be too dependent They are happy knowing it will be back on and for Marilyn to take time off Some expect too much • Not for everyone

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			watch what you are saying' Other groups can be cliché-ish Other groups more about activities and getting out than peer support • Great at identifying problems • Learn things to take to everyday life • Volunteer gets a lot of enjoyment and reward out of it Good points (about groups in general) • Big spaces Good to do exercise activities Get to do activities that are more fun/have a laugh Can use the space for different forms of therapy and activity	
HSCP staff West Lothian Psychological Approach Team (WeLPAT)			Strong collaborative team work. Effective communication. Building relationships with care home staff.	Access to out of hour/crisis response service for care homes Clarification of REACT service remit – in supporting care homes with the physical health checks required prior to mental health assessment taking place. Designated psychiatric liaison team

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
				Formal post diagnostic support for residents in care homes.
HSCP staff Psychological Therapies Service			The service has developed from a Psychology Service to a Multi Disciplinary Psychological Therapies Service with a broad skill mix. Having a single PTS makes managing issues which relate to (A12) psychological therapies more straightforward – i.e. management of waiting lists, development of services, training, workforce planning, and governance. Positive working relationships within and between teams. Formal & informal channels of communication. Development of a group programme with over 30% of patients being offered a group intervention	• It is positive that in the near future West Lothian will have Psychology posts at all tiers of service – Wellbeing Hubs, Psychological Therapies (PTS), CMHT & In-patient (IPCU & Ward 17). • Ensuring patients gets triaged to most appropriate service most directly. It is not always clear from referrals received which service at which tier might be best to meet needs –perhaps particularly useful to consider with the development of the above. • Need for clear & accessible referral criteria for all services & guidance regarding information needed by Triage team– Provide details on Ref Help. • Use of PHQ9 & GAD 7 (free to use) by GPs as a measure of severity (rather than current use of HADS which requires licence) • Joint assessments by different professionals for patients where it is unclear which service may be most appropriate – This would have a cost in terms of staff capacity but may reduce need for repeat assessments & contribute to above aim of services being more able to do a generic assessment
GP representation Strategic Planning Group		Early Intervention and Prevention	The mental health hubs are very welcome but it is a bit too soon to judge whether they are working well. The linkworkers about to come on stream are also welcome	• The CPN's to do 'first contact' appointments at some point in the next few months will be even more welcome. • Waiting times from referral to actual treatment remain far too long in clinical psychology. • Waiting times for initial psychiatry appointments are also too long • Review dates for psychiatry long or not seen within timeframe expected and this generates GP appointments. • Gaps in support for adolescents.
HSCP Staff			Engaging with patients, carers to	• Social infrastructure resources are declining for patients with needs

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
Older People's Community MH Team			access resources in the local community through joint working, carrying out detailed assessments that are person centred and effect positive change, identifying follow up support pathways through effective team working and signposting relevant services, team constantly updating their knowledge to deliver better care Working within a Multi disciplinary team to delivery high levels of care, assessment and follow up within the hospital and community Early intervention or anticipatory information that follows people to try and maintain their independence to reduce and prevent services pushing people to require higher levels of intensive supports that they do not require leading to dependence.	impacting on suitable alternative options surrounding care in the community for over 65. Impact of cost of day services. • Feedback highlighted concerns surrounding the amount of ageism and attached stigma when patients become 65 years of age they are suddenly transferred or not suitable for the service provision leaving over 65 services to pick up patients. • Health inequalities are a major issue for this age group as mental health and deprived areas have been evidenced to contribute to shorter life spans and less follow up support in the patient's local community. Staff and health professionals have good intentions to address this in short-term but on their own cannot promote positive change large scale as this needs legislation to effect real changes that provide follow up care in the local community for all. • Once assessed and supports identified with follow up in place using robust care pathways and supports, due to shortfalls in services within social and third sector from funding, staff shortages and a non consistent support follow up in the community patients are not receiving the care they need leading to patients being misdirected back to CPNE services as only viable options when resources are stretched. • Currently a lack of Old Age Consultant cover within the service has a dramatic impact at times on service provision and delivery for patient and CPNE staff which can impact on patient not being assessed in a collaborative team based approach
Scottish Ambulance Service		Crisis Services/Support		• There are no mental health pathways in West Lothian at the moment that we can use; it's A/E or nothing. • Triage tool available for risk assessment. • On call mental health assessment team that we can liaise with while at patient's home. At the moment we have no support and that leaves us no choice but to take patients to hospital as we are not qualified to make assessments or decisions regarding care of mental health patients. When patients refuse to travel this takes up

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
				a lot of the SAS and Police's time as we can't leave them at home when they are a potential threat to themselves or others but we also can't take them to hospital against their will. • On call drug and alcohol teams that can deal with patients who are detoxing, or somewhere to refer these patients to in times of crisis. • Separate area in A/E for mental health patients, it is often inappropriate to take them into a busy A/E department. This can distress the patient further and also distress other patients if the patient is volatile or distraught. They often have to sit for hours waiting on a psych assessment, another area where they could wait would be less distressing and take the pressure off the A/E department as they do not have the time or resources to constantly monitor/comfort these patients . • Easier access to Social Work.

Appendix 3 Commissioning Plans Engagement Feedback Log **Care Group: Adults with a Disability**

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
Autism Strategy Sub Group – Active Citizenship	3	Inclusive services for Autistic people	General comments: - Within the Lothians there is not a strong enough focus on ensuring the themes identified for those living with ASD are consistent. - One of the biggest concerns highlighted is the mapping of services for those living with ASD. One of the points raised at the strategy group was that if you are living with Autism in Wets Lothian, there is no 'one stop shop' for information on service. I explained the new HSCP would be soft launched by the end of July and Shiona Jenkins (BSO) was currently acting as the lead on this. See PASDA resource for Edinburgh and the Lothians. - Both Cath and Christine asked if it was possible for a dedicated member of staff from the council to be in control of the information or a third party could be contracted to do it. I explained in a smaller local authority we would potentially look at 'access to information' as a priority on a wider scale, not simply focusing on Autism. We may look at LD, disability or all services under this work stream. - Midlothian's Two Trumpets strategy for Autism has received a lot of praise. - Discussion on Autism Awareness week (April 2020) was focused on how to reach a new audience and ensure that services in West Lothian are highlighted and participation increases as a result. - A question was raised about how much money is provided for Autism services, West Lothian was not able to provide information during recent FOI request. - Project Search and Supported Employment was mentioned where I provided more information of how these models are delivered in WL. Questions were raised around the waiting list for Project Search in which I explained the model has a service user/staff ratio that must be met and agreed between the Council, West Lothian College and the host employer. - Cath and Christine asked what the purpose of Autism Champions within the council was and is this something that is a focus. I explained this point would be best raised at the strategy group as it will cover all four priorities. - Transport was raised as a concern. I explained the commissioning process in which transport and providers being able to access service users to meet their needs was key. - Individual cases were raised where SDS was not a focus of service user annual reviews. I explained the	

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			care inspectorate monitor this through inspection. This however will be a focus on two of our priorities; SDS development and Access to Information.	
Employability Review	4	Employment	The supported Employment service is working at capacity and supporting a good number of individuals into employment in West Lothian. The presence of the supported employment service is well known within West Lothian and works closely with other services. Project Search continues to attach a full cohort every year and continues to deliver a high percentage of individuals with a learning disability accessing the open labour market.	The uncertainty around European Social Funded posts within the supported employment programme. Some referrals coming into the supported employment programme are not able to be taken on due to a lack of understanding of the need to desire 16 hours paid employment. The access to information around the support employment service could improve.
Artlink – Autism Strategy Development and Commissioning Intentions	3	Inclusive services for Autistic people	General Feedback: *Note, the priorities were not covered off one by one, this was an open conversation about what works and doesn't in service.* - Some of the most important things to Autistic people and their families can be very straight forward. Examples given were the right support made available at the right time, teachers/social workers/other professionals have a basic understanding of the conditions those they support live with. - One strong example came out of the two trumpets strategy (one trumpet at home, one at school) demonstrated that if those supporting Autistic people are allowed to 'bend the rules' or be flexible with the support they give, better, holistic and many times more cost effective solutions can be found. - Local Authorities must take a radical look at how commissioning works. Paying providers by an hourly rate to deliver hourly support does not support individuals in the best way. - Older people with Autism can be harder to engage with, many live without a diagnosis and many are not aware of the services available to them. Mapping out services would be beneficial for this service users group; however this is needed across the board.	

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			- There are people out there that are Autistic and do not have a Learning disability or other additional support need. Service can be confusing for these individuals. - There is no teacher training in Autism, this is unacceptable. - Transitions pathways to adult services are concerning as it is very difficult to navigate. - Families and carers of Autistic people need people to talk to whether this is a drop in service or networks with other families and carers.	
Community Learning Disability Team – OT specific	Email feedback	Access to information; Suitable housing options	Specialist OT in Community Learning Disability Team (CDLT) Links with Housing OT and CLDT OT Ability Centre Outreach groups Pulmonary rehab Stroke group Cares of West Lothian	Clear pathway to involve community OT when client returning/moving into independent living Specialist OT is part time and has a waiting list, shared resources to support increase community OT links Better promotion of existing services i.e. staff not aware of the Autistic Spectrum Disorder Team SMART centre – hub or link with West Lothian Communication between services could be better regarding any changes/available resources More awareness of technology e.g. Alexa system Available directly of resources Addressing social isolation
National Autistic Society meeting regarding services for Autistic people in	3	Inclusive services for Autistic people	General Feedback: - The Scottish Strategy for Autism Outcomes and Priorities 2018-2021 will soon be up for review. It is unclear what investment the Scottish Government will place into producing a new priority plan, if they do at all. This may shape the way in which Autism services may look. - NAS priorities currently are looking into social isolation, mental health and the lifecycle of autism diagnosis as a focus. - Services to address the risk of social exclusion are key, you can put all the services in world in place	

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
West Lothian			however if people cannot leave their own house, they will never access the help and support. - One area that was shared was potential solutions to those suffering public "meltdowns" and demonstrated challenging behaviour. Better services must be in place to support these incidents that could be avoided with better care planning. The "Crash pads" example demonstrated in Durham was given. - The discussion around provision within exiting mental health hubs was discussed however this proved problematic as to take an autistic individual to a mental health hub when they are having a bad day doesn't support the need for culture and public perception change that is needed. - NAS would like to see more One Stop Shops. Edinburgh service is no good for those in West Lothian. - Hubs, information, crisis points etc. can work but must have an Autism focus with trained professionals. - There will allows be a need for Autism specific social care providers however better training and understanding across the social care sector is needed. There is no one service that will support everyone with Autism. - When discussing transitions, it was clear to see from NASplus experience that in West Lothian schools the support Autistic individuals receive does not mirror the support that West Lothian College offers. - The difference in children and adult services autistic individuals is vastly different. This must be addressed and supported by better transitions support from aged 14 at least. - Broxburn Academy's Autism hub/base was proving to be successful, this is a local decision made by the school. NASplus supported the development of this. - Schools and organisations must work closer together to support Autistic individuals to transitions into adult service/ education/ training or employment. - Skills Development Scotland workers in schools provide an excellent type of support to those that don't have additional support needs, however there is no effective service mirrored for those that do. - An effective supported employment service can benefit those who wish to work however West Lothian's service has a waiting list. - The local authority must have a closer working relationship with providers and organisations if it wishes to commissioning effective services that will produce better outcomes for those engaging. - West Lothian must commission more community based services and work with organisations and providers to attract funding to do the same. Partnership working would benefit service users greatly.	

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
West Lothian Council Housing Team	2	Suitable Housing Options; Access to information; Transitions	Adequate collaboration on core & cluster accommodation as part of the new build council housing programme. Engagement on housing for people with complex care needs has been positive.	Improve knowledge and understanding of the housing needs of people with learning disability so that accommodation can be planned for. Every effort should be made to ensure that properties that are allocated and occupied quickly to ensure best use of housing stock. Identifying concealed households with learning disability that are at risk so that their accommodation needs can be planned for rather than presenting as an emergency. Potential for greater collaborative working between services and agencies that support people with learning disability to ensure that they receive to sustain their tenancies and live safely within their community. Greater collaboration between Social Policy, Health, Housing and Planning to identify opportunities for housing development for people with Learning Disability. This would ensure that adaptations to homes can be built in at the design stage of a property to avoid the need for retrofit.
Community Learning Disability Team	Email feedback	all	Excellent Positive Behavioural Support plans in place for some patients with significant challenging behaviour. Some care providers providing excellent standard of care for these individuals. This has improved the quality of life of the individual, prevented hospital admissions and re housing in expensive placements. Employment support including project search Multiagency working in emergency	We have completed a demand analysis and concluded the increase in resource required across all CLDT disciplines to meet future demand and PBS in particular – this resource increase to be met ASAP. Particular requirement on nursing and psychology There is only one part time psychologist who is qualified to write PBS plans. No funding in place to help care providers implement these plans. Some care providers are not implementing these plans despite significant health involvement and support. Adequately funded positive behavioural support service for those with significant levels of challenging behaviour is required, probably using a small number of handpicked organisations to work with health team on implementing these plans. Community support is required for those who do not meet criteria for

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			situations. MHO team, social work team, and health team work well together to solve complex problems related to the care of individuals with LD in an emergency. High quality day services such as Pathways and the Community Inclusion team and the commissioning of effective care providers who provide individuals with the opportunity to meet their goals, increase their confidence and contribute to society. Highly competent social workers and team managers are motivated to support individuals to access this support. Health component of LD specialist services: dietetics, OT, Physio, Psychology, Psychiatry, SALT and nursing. Specialist services should be maintained at current levels and in the case of nursing they should be increased.	critical and substantial care as they are developing mood disorders including suicide thoughts. They are increasingly socially isolated and not participating in community life. This support would include employment support, benefits advice, housing advice, volunteering opportunities, gig buddies etc and would ideally be based in health or other community centres. Perhaps this could be in a different location each day of the week. This would encourage informal peer support. Somewhere with a cafe! Sometimes individuals require emergency placements eg when a parent/carer dies or they have to be removed from the family home due to adult protection concerns or challenging behaviour. A variety of resources must be in place to accommodate these individuals. If this does not happen they could end up in inappropriate placements, often costing large amounts of money, to support them. This support and development of individuals with LD is vital but often is not provided timely. People will wait for several months to be allocated a social worker, their assessments can be lengthy. Once these assessments are completed the individual is placed on the unmet needs list. There are several stages to go through after that before the support is provided and there is a significant delay at each stage. Communication between all the agencies involved can be difficult .It can often be 18 months between referral and commencement of support. During this time individuals often have a significant deterioration in their mental state, carers can become burned out and, as a result the individual requires higher levels of health and social care than they would have done if their support had commenced in a timely manner Reduction in the bureaucracy of this process would release council workers time and result in timely and more effective support. Additional nursing staffing or a redefining of nursing role as a long waiting list of 1 year plus is not in my opinion sustainable long term.

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
				A generic assistant post. Maybe future service development might include a generic Assistant post instead of a purely Physiotherapy assistant post. However that would be dependent of course on budgetary changes from the current system Additional core and cluster accommodation would be good. This would be along the lines of the Ark project in Blackness Road, Linlithgow. Additional ground floor accommodation is going to be necessary as out LD population ages.
Social Work practice team – physical disabilities	Email feedback	all	Respite – Forrest Walk. Service users and carers are able to book planned respite in their local area. The respite bed can also be utilised in an emergency (if available) to alleviate carer stress, facilitate carer hospital admissions or any unforeseen circumstances. Day Care – Forrest Walk. This provides smaller scale support for those who cannot cope with group/busy environments. Day Care – Ability Centre. This provides opportunities for PD service users to interact with their peers, develop relationships, access their local community, reduce social isolation and it often provides carers with a break from their caring role. Income Maximisation – As part of	Ensure the unit is used to its maximum capacity. Utilise the respite bed for emergency situations to potentially reduce hospital admissions. Make sure service users/professionals are aware of this and it is utilised fully. Utilise the free days to support carers who are experiencing stress and minimise the risk of home situations breaking down. Promote services users independence and encourage them to develop additional opportunities to meet out with the Ability Centre. In line with WLC's anti-poverty strategy ensure and signpost service users to the Advice Shop and request home visits where appropriate. In line with the **Carers** (**Scotland**) **Act 2016** ensure that health and wellbeing of carers is supported by actively encouraging the uptake of ACSP. Develop a better working relationship with CWL and signpost accordingly. Develop these links further with joint team meetings at regular intervals.

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			the contributions policy services users as getting income maximisation assessments. Carers West Lothian – Adult Carer Support Plan (ACSP). CRABIS – Multi- disciplinary team. There is evidence of good joined up working which ensures a holistic assessment for service users.	
Community Learning Disability Team – Clinical phycology	Email feedback	Complex needs relating to challenging behaviour	There has been some progress made in the past 18 months regarding how multi-agency and third sector services work together to support those who present with significant behaviours that challenge. Some people have comprehensive specialist plans in place and there are some providers who provide excellent support for who require highly specialist support in this area. There has been some Lothian wide work done on developing a Lothian wide PBS strategic plan incorporating information on training, competence and supervision. There is close, collaborative working between the social work, mental health officers, police and the NHS team when it comes to	To develop, and implement, a West Lothian specific strategy to support those who present with significant behaviour that challenges and who are likely to require highly specialist multi-agency input within a PBS framework. This plan should be in keeping with best practice guidelines from NICE and the PBS Academy. The plan needs to clearly outline: roles and responsibilities for different parts of the integrated team and third sector services; training needs and planning to improve competence and upskill across the board; integrated care planning which incorporates clear lines of accountability and governance processes; supervisory structures and arrangements; the interface between the multi-agency team and the third sector teams implementing this service and, related to this, improved and clear processes to address issues around difficulties with implementation within third sector agencies. The resources required to implement this are not currently in place. This will require need to be addressed before developments can be implemented. Maps onto: • Integrated Co-ordinated Care • Managing Our Resources Effectively • Prevention and Early Intervention • Live Healthy and Active Lives • Learn to Reach their Full Potential

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			supporting those who present with significant risk of harm around exploitative relationships. The multi-agency team works within the existing legislative frameworks. There are a range of high quality services (Employment team; Pathways; CIT; Bloom House; Eliburn) which offer our client group structure, connected relationships and meaningful activities. These are some of the core pillars which underpin good mental health. Multiagency working in crisis situations.	To explore whether there is potential to develop a more nuanced approach in supporting those who are being, or are at risk of, sexual exploitation. It is identified within the multi-agency context that the all or nothing approach to reducing the risk of harms in these cases often results in significant distress and disempowerment and can sometimes result in increasing the risk of harm in the future. Developing a more nuanced approach would be influenced by the sexual exploitation risk assessment framework and also the British Psychological Society's recent guidelines on assessing capacity to consent to sexual relationships. Maps onto: • Integrated & Co-ordinated Care • Live healthy and active lives • Reaching their full potential • Contribute to a fair, equal and safe Scotland. Robust, community support is required for those who do not meet the threshold of critical or substantial care as they cannot independently search and access resources which provide meaningful activities and connected relationships resulting in deteriorating mental health. This maps onto: • Prevention and early intervention • Managing our resources effectively • Live Healthy and Active Lives • Learn to Reach their Full Potential There is a gap in the availability of residential resources in response to emergency situations or when specialist placements are required (ie for those who present with significant behaviour that challenges). There are families who support their loved one with significant risk of harm towards themselves as a result of the person with LD presenting behaviour. There are some cases where the family have asked for appropriate residential placement but there is none available and they have to experience

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
				significant risk and heightened stress over an extended period of time. Whilst there is a medium term plan that may address some of this demand (in the complex care unit) there continues to be unmet need within the short term. This maps onto: • Prevention and early intervention • Managing our resources effectively • Integrated and co-ordinated care • Live Healthy and Active Lives • Learn to Reach their Full Potential Contribute to a fair, equal and safe Scotland.
Community Learning disability Team – Nursing Response	Email Feedback		**Day services/Care providers** Timely intervention of the onsite learning disability health services at Eliburn. There is a current proposal to remove the nurses from Eliburn. Retention of nurses on site at Eliburn is vital as they have the ability to provide proactive early health interventions. This cannot be replicated by nurses within the community team. Providing training to paid and unpaid carers often preventing inpatient admission or readmission. **MDT** Being in the same building as social work colleagues and having	**Nursing response** Service affected by current staffing levels. Four vacancies are substantive posts. Additional staff required to allow for percentage of per capita of increasing WL population. Due to above noted staff deficit, We are unable to provide input to patients with regard to Scottish Government LD Vision and IJB Strategic Priorities. **Full complement of Nursing Staff would allow us to make an impact in the following areas.** **Patients –** Reduce the lengthy wait for a service, currently 17 months, this wait is causing stress, anxiety and risk of harm. This wait does not comply with Scottish government targets. Prevention of injury to carers, both support staff and parents/families as well as prevention of the patient sustaining injury. Breakdown of placements.

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			the ability to discuss cases directly They are some areas of excellent service provision for example, Local Authority Service Provision, (Deans House and Burnside, Pathways, Eliburn) Enable Supported Living, The Action Group. New Directions. **Patients** Patients, carers families, and service providers that we are able to provide a service to have reported that we provide an excellent service.	Forward planning, and promotion of independent living skills, leading to a prevention of patients who have relatives or parents who are dying or have died with no service in place and no strategy in place to provide long term care. Nursing used to be able to provide a Carer Support service, which could identify elderly parents providing support to adults. Crisis intervention. Nursing being able to provide a robust service to patients to prevent crisis, and breakdown of placement. **Nursing staff** Retention of staff will reduce stress levels and improve mental health of nurses. The Scottish Government has identified that there is currently a shortage of nurses in Scotland and the Government have recruited more student nurses. As a result of current nursing levels within the West Lothian team, the nursing team have had to refuse requests for nursing students. Edinburgh Napier University recently completed an audit and have now reduced the number of students on placement. This is a temporary situation as it is a requirement of Nurse Registration, to mentor student nurses and 50% of Student's training requires to be on placement to comply with Lothian Health / Napier agreement , **IJB.** An increase in understanding of the challenges faced by learning disability nurses. **PBS** There is currently no PBS service in West Lothian, this lack of service is having a detrimental impact on patient's families and their carers, there is high risk of injury, stress and breakdown of placement and potential out of

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
				area placement as there are rarely Health board beds available in Lothian with a planned reduction in the number of beds available n. A prompt resolution of this is required. **Context** E-mail was received 13/08/2019, the nursing team were able to discuss a nursing response at the nursing team meeting, however it would have been beneficial to discuss this as a whole team, with the views of the different disciplines taken into consideration.
Learning Disability Day services	Email feedback	Day services	Access to CLDT for support in specialist areas. Reliability of council run day services/ the key working role/ for many service user's consistency and routine are important/ we are open five days a week and there is always staff on hand/ service users and parents/carers are able to develop positive working relationships with familiar staff / staff build up a good working knowledge of their key clients and are committed to providing the best service for each individual with the resources available. Joint work with SRUC Oatridge Joint work with Healthy Living	Transition from children to adults services. Would dedicated transition workers help make this process smoother for parents/carers/service users by working with the schools and services from an early onset/ getting them into adults services in a timely fashion? How are parents/carers finding this process? If social workers are carrying heavy workloads would bringing back the role of social work assistant's help? Transition from adult to older peoples services. Should the retirement age for service users be increased in line with the rest of the country to an optional 67yrs? (We currently have a spritely older client who is clear that he doesn't want to retire at 65 yrs). Could the Supported Employment team also handle voluntary placements? As it stands, service users are supported only if working toward employment. Many of our substantial/critical service users are not working toward employment but would gain a lot from volunteering experience. They would need a dedicated worker to take them through this process. Training tailored specifically for LD staff/ raise awareness of LD issues e.g. supporting people with Autism / Down Syndrome / other genetic syndromes e.g. fragile X / associated health issues e.g.NEAD / mental / emotional / physical development / BSL / working with people who are

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
				hard of hearing / vision /aids /Makaton Modernise day service resources/ provide onsite computer stations and/or tablets /provides access to a plethora of free interactive learning resources that engage younger and older customers alike/ support service users learning important life skills such as using a touch screen/using a mouse/literacy/numeracy etc.., Self-travel support: Adults with LD regularly complain that their bus pass has run out. Most are unable to read the expiry dates on the cards. They usually find out when they go out to get their bus and are told they can't get on without buying a ticket. Could this upset be avoided/ a notification system be devised that works for them? I believe most buses now have modern technology/ might that be able to give card holders an early warning e.g. you've got two weeks left on your card? More accessible self- travel support to increase independence – I have been told that there are issues with getting accepted with present provider i.e. block funding means that this can only go ahead once certain number of people require Looking at setting up Social Enterprise to give opportunity for supported employment Investment in IT eg Wi-Fi, tablets or up to date PCs & other forms of media specifically for communication or skills development this could range from simple matching programmes or apps that enable people to talk to development & maintenance of webpages or Facebook pages. This could lead to having technology and skill to hold presentations of film or music of activities, drama productions, event or make own music. Explore appointing communication workers accessible within Units to better facilitate things like Easy Read & use of technology

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
West Lothian College	3	all	General comments: - Gap in service provision for those that are risk of becoming socially isolated. - Transition for children leaving full time secondary education going into college or another positive destination require more focused support. This also needs to be down further in advance. - Sharing information could be better between the college, schools and social work department. - Pupils at the college would benefit if they better understood what they could use their SDS for to support them to maintain a college placement. - No formal planning when it comes to children moving into adult services, this is apparent when they leave school. Seems to be very ad-hoc around dates for children leaving school. - There has been some positive progress made recently with one of the special education schools in West Lothian. Children are being identified and highlighted for college placements earlier. - MCMC supporting children into positive destinations is a plus. - FABB are an excellent programme however limited in spaces. - The hour between 8am and 9am in the morning when the college delivers additional service is a lifeline for many students with additional support needs.	

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
Thera Scotland	2	Peer support and social activates	Good routes of communication to inform services users of activities Great sense of community in West Lothian Social activates hosted by Thera are always well attended Parents and carers are always happy to share advice amongst each other. Starting to run West Lothian inclusive club nights	With a large geographical area and a reducing number of services it is becoming more difficult to find meaningful activities for those living with a learning disability in West Lothian. Public transport is a barrier. Dedicated co-ordinator has been employed for West Lothian to support the growth of activities available to people with a learning disability. It is a barrier to get volunteers in West Lothian; more work could be down with the Volunteer fair to open it up to a wider range of people. It is noted that this may be specific to Thera, it may simply be down to bad luck. Younger people (+16) face barriers to activities that their non-disabled peers experience. Travel training for those without a social worker is a problem; people are at risk of becoming socially isolated.
West Lothian Council Adult Protection Lead	2	all	Funding received from the Scottish Government to deliver training programme for appropriate adults.	With new legislative powers that will ensure the local authority will provide an appropriate adult to those that are in custody with a learning disability. Unknown the amount of resource this will require when launched later in 2019.

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
COWL – research into local services for people with a disability	78	all	General Comments: COWL carried out research in March 2019 which they were happy to share to shape the priorities for Learning disability and physical disability commissioning. Highlights: - Over 60% of people with a disability got their information and advice from either parents, carers or the internet. - Over 65% of those asked stated they preferred to have their information and advice delivered face to face. - 62.67% of those asked stated it was difficult to develop friendships and relationships. - 58.67% of those asked stated they don't feel confident - Around 70% of those asked felt they couldn't do what they wanted to do - Due to this research COWL stated that they have attached additional funding from a national funding source to deliver social activates to those with a learning disability and physical disability in West Lothian. COWL felt this was a gap based on their research.	
Learning Disability Providers Forum – CIC, Arc Housing, A.I, Leonard Cheshire, EARS, COWL and The Action Group.	8	Complex needs relating to challenging behaviour; Access to Information	General Comments: - There is a gap in provision that supports young people to see a clear pathway into adult services. "Full Life Approach" - There seems to be a lack of understand of assessment process between providers and LD social work. Can this be mapped out better? Process seems very ad-hoc. - Parents become "desperate" and that is when they end up at service. A more supportive pathway to show how to access STAT and non-STAT service would be good. - Should there be an automatic referral process if you are on the LD register.	

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			- Peer volunteering would be beneficial to show those how to access service. - Information shared with providers with allow providers to support smother transition process. - Clearer pathways and relationship built between social workers and providers to access care home spaces. This could free up a tenancy for someone looking. - More Core services would be welcomed. - Providers keen to bid to deliver these services. - Providers keen to continue to de register residential units to allow those eligible to claim housing benefit. - There needs to be a better understand of what housing options are available. RSLs could support by ensuring that housing stock is available to Learning Disabled people. - What are we doing about waste land, can providers work closer with the council to develop housing options. - Those living out of area due to no suitable housing options should be seen as homeless. This should be a priority. - Community Assets transfers could be better used. - Seeking further thoughts if the council can work with providers to promote ILF? Would this be beneficial with new contributions policy and eligibility criteria? - Gig buddies is good however can't support everyone. - Group activities and emotional support are needed. - Council transport is not being used, yet providers cannot get people to social clubs, this makes no sense.	

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			- Can the council facilitate a West Lothian provider's forum, to discuss what's happening in West Lothian with regards to service? Closer working relationships are needed. - Placed based approached must be taken. - Peer volunteering must be allowed in contracts. - Mapping out services. Vol sector gateway is a start, however all info must be maintained and kept up to date. - There must be a liaison officer that understands the contracts. This has recently been lost at WLC. - One stop shop would be welcomed, people having to travel to No.6 in Edinburgh makes no sense. - Info and advice should be delivered by an autism specific provider. This could be done in partnership. - Providers would welcome training in Autism services, paid for. Providers, with no training budget feel that this a challenge. - Diluting service too much is dangerous. - Can West Lothian College offer placements again? If they are can they be opened to allow more people to benefit from them? - Can the council support to hold events to better network provider and college to ensure that people are better supported in the community ensure they don't reach crisis and accessing STAT services? - Asset transfers, can the council encourage those to build employment into their plans when buying over space to develop. - There are great challenges in recruitment and retention of staff in social care. Scot Gov, Local authorities, 3rd sector and independent sector must work together to tackle this. - Some ways in which West Lothian could support is advertising vacancies in one place (HSCP website?)	

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			Case studies around working in social care. Can events be ran to promote social care as a career. - Inverclyde and Aberdeen Council have looked into and are now delivering Outcome based commissioning. Can West Lothian consider the same?	
West Lothian public engagement events	44	all	General Comments: Two public engagements events were held covering all of the commissioning plans which are older people, people living with a learning disability, people living with physical disabilities and people living with mental health problems. Information about these events was circulated widely, posted on West Lothian Council's social media and circulated to learning disability social care providers, community centres, contacts and projects throughout West Lothian. The events were on 8 October in Howden Park Centre in the afternoon and on 10 October in Bathgate Academy in the evening. 44 people attended the events and 12 people participated in the learning disability discussions, the main groups that were represented were from third sector service providers and parents and carers of those living in West Lothian.	
CRABIS	Email feedback	all	Pain Management team and Fatigue Management service good communication between clinicians Lanfine Unit – good relationships and cross agency working Weight management clinics Stroke Unit, St Johns Hospital – joint working and handover of clients in preparation for discharge	could be better with other disciplines and satellite clinics would be helpful as it is difficult for patients to travel particularly can be 2 hours travel to Edinburgh which would exacerbate symptoms and stops clients in engaging with the service. Subsequently other services are then requested to pick up on areas of pain management that essentially is not their remit. Fatigue management is similar to pain management see comments above additionally there is no OT specialist within this service which evidence supports increase benefit to the clients. Due to changes in the restructure of the Lanfine there is a lack of clarity on the service that is available and when/ who can access it.

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			planning and further rehabilitation in the community Keycomm – works well as it bridges gaps between health and council – no issues with funding Ability Centre – short term rehab – helps self-management and input timely Excite – community based and provides (most gyms) accessible Stroke Club – good resource Clinical nurse specialists; MS, MND, Brain Injury, stroke, Huntingtons – good outreach to WL who provide good support to clients awaiting input from CRABIS and ensures that they don't slip through the net. Housing Options – resource to support clients who have housing issues Carers of West Lothian – good communication and changes to support a wider range of residents with physical disabilities Hydrotherapy – good resource	Inpatient support for symptoms that prevent ongoing rehab would be an advantage if this was available. Limited support available and lacks flexibility for clients who have difficulty engaging and lack of psychology/psychiatric support in the community. Pathway could be clearer with regards discharge planning and the services involved pre and post discharge. No exercise for wheelchair users Transport can be a barrier AHP leadership required to embed rehabilitation approached into the development of services. Emphasis on work and vocational rehabilitation required for individuals with physical disabilities, this requires exploration in partnership with GP's and local employers. Opportunities required developing and trial preventative and early intervention approaches, current intervention is often reactive and provided too late in someone's journey. AILP offers AHP led focus for projects. Investment in developing and exploring technology options and solutions required. This again would benefit from AHP leadership as is successfully implemented elsewhere. AHP leadership and engagement in community development/ community lead support to work with 3rd sector organisation to embed rehabilitation approaches. Pathway development required in the community for PD.

Engagement Feedback From	Event Representing numbers	Themed Priority	What works well	Suggested areas of improvement
			Headway – good resource Local community centres – range of activities and supports available within local area CRABIS offer multi-disciplinary participation focused rehabilitation to individuals in West Lothian this is a valuable model providing effective rehabilitation. The scope of this is however limited due to minimal resource, waiting lists are often long and intensity of intervention limited. Vocational rehabilitation is available from CRABIS, widening the access to vocational rehabilitation and developing AHP's skills in this area is essential. Provision of equipment however disjointed. Provision of care however disjointed.	Improvement with west Lothian integration essential. Pathway for equipment provision needs for PD to be streamlined. More integration with primary care /GP regarding rehab input and outcome. Improvement around encouraging health promotion & self-management. Improvement around training managing clients with PD.